FUNDING CHARITY CARE IN NEW YORK:

An Examination of Indigent Care Pool Allocations

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PREPARED BY:
Roosa Tikkanen, M.P.H., M.Res

With:
Steffie Woodhandler, M.D., M.P.H.
David Himmelstein, M.D.

Hunter College,
City University of New York (CUNY)

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Although the authors have made every effort to ensure the accuracy of all figures in this report, errors are inevitable in a report of this scope, especially because data came from administrative databases. We invite comments and suggested corrections.

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Introduction

Many hospitals in New York State, especially safety-net institutions that serve large numbers of uninsured and low-income patients, are financially struggling. Twenty-nine hospitals are on a State "watch list" because of their precarious fiscal positions. To strengthen and preserve these essential providers of health care, available public funds can be distributed in relation to the volume of uncompensated care provided by hospitals, including through the Indigent Care Pool (ICP).

The ICP was established as a public goods pool in 1996 with the explicit goal to redistribute dollars to hospitals "according to their level of need due to providing charity care."[1] The ICP is among a number of supplemental payment programs that compensate hospitals for financial losses incurred for providing care to uninsured and Medicaid patients. One-third, or approximately $700 million[2] of Medicaid-related supplemental payments that New York City hospitals receive, are distributed as ICP payments. However, potential federal policy changes, especially those that reduce funding for the Medicaid program (which currently funds half of the ICP), could spur a rise in the number of uninsured New Yorkers. The ICP and other supplemental payments will therefore continue as a lifeline for New York's safety-net hospitals.

Since its inception, the ICP has received attention over how it allocates payments to hospitals, particularly whether its allocation methodology (drawn from reforms in 2012) appropriately

[1] Simmons AG. 1997 New York Health Care Reform Act of 1996 – Summary of Major Provisions. New York City Office of Management and Budget, December 1997.

[2] Authors' analyses of 2015 ICP allocations, using data received from the New York State Department of Health. Approximately $229 million of total ICP distributions are paid as Upper Payment Limit (UPL) payments to voluntary (private) hospitals. See Appendix 4 for further details.

rewards the hospitals that provide the greatest amount of uninsured services.[3,4,5,6,7,8,9,10] This report reviews whether the changes in ICP allocation since 2012 have resulted in a payment system that adequately matches ICP dollars to hospitals according to levels of uninsured (indigent) care provided. This report also examines which hospitals in New York City provide the highest volume of uncompensated care, and are therefore in greatest need of supplemental payments, including ICP payments.

The data reveal a misalignment between the distribution of ICP dollars and those hospitals that provide the most indigent care in New York City. To better support struggling safety-net hospitals, this report offers policy recommendations to better align ICP funding allocations with hospital needs.

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[3] Daines RF. A Report on the Hospital Indigent Care Pool As Required by Chapter 58 of the Laws of 2007. New York State Department of Health, January 2008. Available at: **https://www.health.ny.gov/facilities/hospital/indigent_care/2008_indigent_care_report.htm**, Accessed March 2017.

[4] Medicaid Redesign Team (MRT) Health Disparities Work Group. Final Recommendations, October 2011. New York State Department of Health. Available at: **https://www.health.ny.gov/health_care/medicaid/redesign/docs/health_disparities_report.pdf**, accessed March 2017.

[5] Medicaid Redesign Team (MRT) Payment Reform and Quality Measurement Work Group. Final Recommendations, November 2011. New York State Department of Health. Available at: **https://www.health.ny.gov/health_care/medicaid/redesign/payment_reform_work_group.htm**, accessed March 2017.

[6] Benjamin ER, Slagle A, Tracy C. Incentivizing Patient Financial Assistance: How to Fix New York's Hospital Indigent Care Program. The Community Service Society of New York, February 2012. Available at: **http://www.cssny.org/publications/entry/incentivizing-patient-financial-assistanceFeb2012**, accessed March 2017.

[7] Sager A. 2011. Paying New York State Hospitals More Fairly for Their Care to Uninsured Patients – A Report To The Commission On The Public's Health System (CPHS). Available at: **http://www.cphsnyc.org/cphs/reports/paying_new_york_state_hospitals/Sager_Paying_New_York_StateHospitals_More_Fairly_for_Their_Care_of_Uninsured_Patients_FINAL31Aug11A.pdf**, accessed March 2017.

[8] New York City Comptroller Scott M. Stringer. Holes in the Safety Net: Obamacare and the Future of New York City's Health & Hospitals Corporation. Bureau of Policy and Research Bureau of Fiscal & Budget Studies, May 2015. Available at: **http://comptroller.nyc.gov/wp-content/uploads/documents/Holes_in_the_Safety_Net.pdf**, accessed March 2017.

[9] Commission on the Public's Health System (CPHS). Charity Care Payments to New York City Hospitals - Is there any relationship between providing care and the dollars distributed? February 2010. Available at: **http://www.cphsnyc.org/cphs/reports/february_2010-_charity_care/http__cphsnyc_org_pdf_CharityCarePayments.pdf**, accessed March 2017.

[10] Calman N, Ruddock C, Golub C, Le L. Separate and Unequal: Medical Apartheid in New York City. The Institute for Urban Family Health / Bronx Health REACH, 2005. Available at: **https://www.monroecollege.edu/uploadedFiles/_Site_Assets/PDF/MedicalApartheidNYC.pdf**, accessed March 2017.

Background

New York City has a unique hospital landscape. It operates the largest public hospital system in the country, NYC Health + Hospitals, which includes 11 acute care hospitals. The City also houses some of the country's most prestigious academic medical centers (AMCs), which train medical professionals and conduct research in addition to providing patient care. Many AMCs also serve as national and international referral centers for patients requiring highly specialized care. The majority of New York City hospitals, however, are neither public hospitals nor AMCs, but nonacademic, privately owned hospitals (also known as voluntary hospitals). Collectively, all of these hospitals serve nearly 8.5 million New Yorkers, of whom approximately two in five (43%) are estimated to be either uninsured or covered by Medicaid.[11,12,13,14] These New Yorkers mainly rely on the City's safety-net providers to meet their health care needs, which include public hospitals and a number of private hospitals with high concentrations of low-income patients.[15,16,17] However, all private hospitals in New York State are required to provide care to Medicaid and uninsured

[11] U.S. Census Bureau (2017) American Community Survey Table B27007 Medicaid/Means-Tested Public Coverage By Sex By Age, 2015 American Community Survey 1-Year Estimates for New York City, New York. Available at: **https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml**, accessed March 2017.

[12] U.S. Census Bureau (2017) American Community Survey Table S2701 Selected Characteristics of Health Insurance Coverage in the United States, 2015 American Community Survey 1-Year Estimates for New York City, New York. Available at: **https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml**, accessed March 2017.

[13] New York City Independent Budget Office (2013) Growth in New York's Medicaid Enrollment and Costs: While Enrollment Highest in the City, Recent Increases Mostly in the Suburbs and Upstate. Fiscal Brief, October 2013. Available at: **http://www.ibo.nyc.ny.us/iboreports/medicaid2013.pdf**, accessed March 2017.

[14] New York City Comptroller Scott M. Stringer. Holes in the Safety Net: Obamacare and the Future of New York City's Health & Hospitals Corporation. Bureau of Policy and Research Bureau of Fiscal & Budget Studies, May 2015. Available at: **http://comptroller.nyc.gov/wp-content/uploads/documents/Holes_in_the_Safety_Net.pdf**, accessed March 2017.

[15] Commission on the Public's Health System (CPHS). Charity Care Payments to New York City Hospitals - Is there any relationship between providing care and the dollars distributed? February 2010. Available at: **http://www.cphsnyc.org/cphs/reports/february_2010-_charity_care/http__cphsnyc_org_pdf_CharityCarePayments.pdf**, accessed March 2017.

[16] Commission on the Public's Health System (CPHS). Safety Net Hospitals in New York City. Last updated March 11, 2011. Available at: **http://www.cphsnyc.org/cphs/What_We_Do/safety-net/MRT_CPHS_safetynethospitals_3_8.pdf**, accessed March 2017.

[17] Fass S, Cavanaugh S. New York City Hospitals' Finances Improve Overall in 2009, but Many Struggle to Survive. United Hospital Fund, Hospital Watch, February 2011. Available at: **https://www.uhfnyc.org/assets/884**, accessed March 2017.

patients as a condition of receiving tax exemptions worth $10 million per hospital, on average.[18] Because the State requires that all private hospitals operate as nonprofit entities,[19] they are required by the IRS to provide community benefits, which include care to uninsured patients, in return for receiving tax breaks (**Table A**).[20]

TABLE A: HOSPITAL COMMUNITY BENEFITS

- All private (voluntary) hospitals in New York State are mandated by law to operate as nonprofit entities.
- The Internal Revenue Service (IRS) allows nonprofit hospitals to be exempt from paying taxes in exchange for providing community benefits, including corporate income, sales, and property taxes.
- Originally, community benefits were defined as charity care to uninsured patients unable to pay for their care.
- This definition has gradually expanded to include research activities, health professions education, community outreach programs (such as health screenings), and a range of other activities.
- Nonprofit hospitals must annually submit detailed information to the IRS on the costs and types of community benefits provided.
- Some states monitor and set minimum requirements for hospital community benefit provisions; these are mainly tied to property tax liability.[21]

In New York State, nonprofit hospitals receive on average $10 million in tax exemptions per year.[22] For hospitals in New York City, this figure is likely to be much higher as a result of the expensive real estate market.

Most hospitals in New York State (88%) receive payments from the ICP.[23] Currently, the ICP allocates nearly $700 million to acute care hospitals in New York City. It is funded in part through federal Medicaid Disproportionate Share Hospital (DSH) payments and a New York State tax

[18] Rosenbaum S, Kindig DA, Bao J, Byrnes MK, O'Laughlin C. The value of the nonprofit hospital tax exemption was $24.6 billion in 2011. *Health Affairs* (Millwood), 2015, 34(7):1225–1233.

[19] New York Public Health Law §2801-a(4)(e).

[20] Rosenbaum S, Kindig DA, Bao J, Byrnes MK, O'Laughlin C. The value of the nonprofit hospital tax exemption was $24.6 billion in 2011. *Health Affairs* (Millwood), 2015, 34(7):1225–1233.

[21] Hilltop Institute, 2016. Community Benefit State Law Profiles - A 50-State Survey of State Community Benefit Laws through the Lens of the ACA. Available at: **http://www.hilltopinstitute.org/hcbp_cbl.cfm**, accessed March 2017.

[22] Rosenbaum S, Kindig DA, Bao J, Byrnes MK, O'Laughlin C. The value of the nonprofit hospital tax exemption was $24.6 billion in 2011. *Health Affairs* (Millwood), 2015, 34(7):1225–1233.

[23] Simmons AG. 1997 New York Health Care Reform Act of 1996 – Summary of Major Provisions. New York City Office of Management and Budget, December 1997.

mechanism known as the Health Care Reform Act. Currently, the State determines hospital allocations using a methodology that calculates the value of hospital uncompensated care as the number of services provided to uninsured patients multiplied by average Medicaid payment rates. This calculation is followed by a series of adjustments for collections from patients, proportion of Medicaid patients, hospital ownership, and previous years' allocations (**Table B**).[24,25]

From the beginning, the ICP has been examined over how it allocates payments to State hospitals. For example, prior reports by a former State Health Commissioner,[26] the Governor's

TABLE B: ICP ALLOCATION METHODOLOGY

1) **Uncompensated care:** Number of uninsured services provided in the two years prior to the allocation year multiplied by hospital- and service-specific average Medicaid rates.
2) **SWAF:** Adjustment by the Statewide Adjustment Factor.
3) **Net losses:** Payments are reduced by collections from patients, including out-of-pocket payments.
4) **Nominal need (targeted need):** Adjusts payments using a nominal need factor, which incorporates the Medicaid inpatient utilization rate (% of inpatients).
5) **Payment based on group cap (public/private):** Payments are adjusted in proportion to the total nominal need among hospitals in group and the total amount available to hospitals in group:
   - Public hospitals allocated $139.4 million; and
   - Private (voluntary) hospitals allocated $994.9 million.
6) **Transition Payment Formula:** Sets a floor and ceiling for hospital losses and gains relative to allocations received in the previous three years (see Table 5 in Appendix 3).
7) **Financial Assistance Compliance Pool (FACP):** Hospitals are withheld 1% of their total Medicaid DSH allocations, which are returned if they are found to be in compliance with the Hospital Financial Assistance Law.

[24] McLeod B. 'Indigent Care Pool'. A presentation at the Central New York Healthcare Financial Management Association (HFMA), March 2015. Available at: **cnyhfma.org/images/meeting/031215/nys_programs.pptx**, accessed March 2017.

[25] Medicaid Redesign Team (MRT) Payment Reform Work Group. Disproportionate Share Program (DSH) - (New Yorker's Indigent Care). Presentation, September2011. Available at: **https://www.health.ny.gov/health_care/medicaid/redesign/docs/2011-09-27_mrt_payment_reform_dsh.pdf**, accessed March 2017.

[26] Daines RF. A Report on the Hospital Indigent Care Pool As Required by Chapter 58 of the Laws of 2007. New York State Department of Health, January 2008. Available at: **https://www.health.ny.gov/facilities/hospital/indigent_care/2008_indigent_care_report.htm**, accessed March 2017.

Medicaid Reform Team workgroups,[27,28] and community organizations[29,30,31] have shown that ICP payments were not adequately related to levels of care provided to uninsured patients. As a result, the ICP allocation methodology has undergone a series of reforms that have aimed to better allocate funds to hospitals in relation to the levels of uninsured care that they provide. The most recent reform in 2012 resulted in the current allocation methodology, which is more closely related to hospital uninsured volumes than previously. However, the current allocation methodology is being phased in very gradually; consequently, ICP payments continue to be tied to the old methodology.

[27] Medicaid Redesign Team (MRT) Health Disparities Work Group. Final Recommendations, October 2011. New York State Department of Health. Available at: **https://www.health.ny.gov/health_care/medicaid/redesign/docs/health_disparities_report.pdf**, accessed March 2017.

[28] Medicaid Redesign Team (MRT) Payment Reform and Quality Measurement Work Group. Final Recommendations, November 2011. New York State Department of Health. Available at: **https://www.health.ny.gov/health_care/medicaid/redesign/payment_reform_work_group.htm**, accessed March 2017.

[29] Benjamin ER, Slagle A, Tracy C. Incentivizing Patient Financial Assistance: How to Fix New York's Hospital Indigent Care Program. The Community Service Society of New York, February 2012. Available at: **http://www.cssny.org/publications/entry/incentivizing-patient-financial-assistanceFeb2012**, accessed March 2017.

[30] Sager A. 2011. Paying New York State Hospitals More Fairly for Their Care to Uninsured Patients – A Report To The Commission On The Public's Health System (CPHS). Available at: **http://www.cphsnyc.org/cphs/reports/paying_new_york_state_hospitals/Sager_Paying_New_York_StateHospitals_More_Fairly_for_Their_Care_of_Uninsured_Patients_FINAL31Aug11A.pdf**, accessed March 2017.

[31] Commission on the Public's Health System (CPHS). Charity Care Payments to New York City Hospitals - Is there any relationship between providing care and the dollars distributed? February 2010. Available at: **http://www.cphsnyc.org/cphs/reports/february_2010-_charity_care/http__cphsnyc_org_pdf_CharityCarePayments.pdf**, accessed March 2017.

Project Scope

This report examines whether the most recent reform to the ICP allocation methodology has resulted in a payment system that adequately targets ICP dollars to hospitals according to levels of uninsured (indigent) care provided, with a focus on hospitals in New York City. In addition, the report examines which of the City's hospitals provide significant amounts of care to uninsured and Medicaid patients that result in high uncompensated care costs—and are therefore in greatest need of supplemental payments, including ICP payments. Specific aims are to:

1	Characterize the relationship between the number of uninsured services provided and ICP payments received;
2	Characterize the relationship between hospital uncompensated care costs and ICP payments received;
3	Examine whether provisions in the current allocation formula affect the distribution of ICP payments in relation to levels of uninsured care provided or uncompensated care costs; and
4	Document those hospitals in New York City that provide the most community benefits in the form of uninsured and Medicaid services.
5	Provide policy recommendations to improve alignment of ICP funding allocations with the volume of uncompensated care provided.

Methodology

To meet these aims, the report summarizes data on uninsured and Medicaid patient volumes (services provided and uncompensated care costs). Main data sources include ICP workbooks obtained from the New York State Department of Health through a Freedom of Information request, hospital Institutional Cost Reports (ICRs), and inpatient discharge data (SPARCS). Because ICP allocation is based on patient volumes two years prior, the report compares hospital ICP allocations for 2015 with uninsured patient volume in 2013. Former ICP administrators, State legislators, and hospital representatives have also been interviewed to gain insights into the ICP's history, recent reforms, and policy landscape. See Appendix 2 for detailed methodology and data sources.

Analyses are presented separately for public hospitals and private hospitals, as the ICP distributes dollars to these hospital groups from separate pools. Private AMCs are considered separately from other private (nonacademic) hospitals.

Key Findings

A poor relationship exists between ICP allocations and uninsured patient volumes. Hospitals that provided the least uninsured services received more ICP funds per each uninsured service provided than hospitals that provided the most services to the uninsured.

This study found that public hospitals provided more than half (58%) of the total uninsured care in New York City but received only one-seventh of all the ICP dollars allocated to all types of hospitals (15%). See Table 2 in Appendix 3 for an overview of average and total uninsured volumes and ICP payments, by hospital type.

With the exception of Bronx-Lebanon Hospital Center and Lutheran Medical Center, the 10 hospitals in New York City that provided the greatest number of services to uninsured patients were public hospitals. These 10 hospitals provided between 94,000 and 187,000 services to uninsured patients in 2013, which represented between 15% and 33% of their total service volume. In return, they received between $4 million and $64 million in ICP payments. Translated into payments per each uninsured service provided, these hospitals received between $39 and $593 for each service—with private hospitals earning considerably more than public hospitals. See Table 1 in Appendix 3 for ICP allocations for New York City hospitals ranked by uninsured volume.

In contrast, among the 10 hospitals that provided the lowest number of services to uninsured patients, the majority were private hospitals and two were specialty AMCs—no public hospitals ranked among the bottom 10. These hospitals provided between 90 and 10,000 uninsured services in 2013, which represented between 1% and 9% of their total service volume. In return, they received between $0.5 million and $12.7 million in ICP payments.

Translated into ICP payments received per uninsured service, these bottom-ranking hospitals all received greater payments than did the top 10-ranking hospitals for each uninsured service provided.[32]

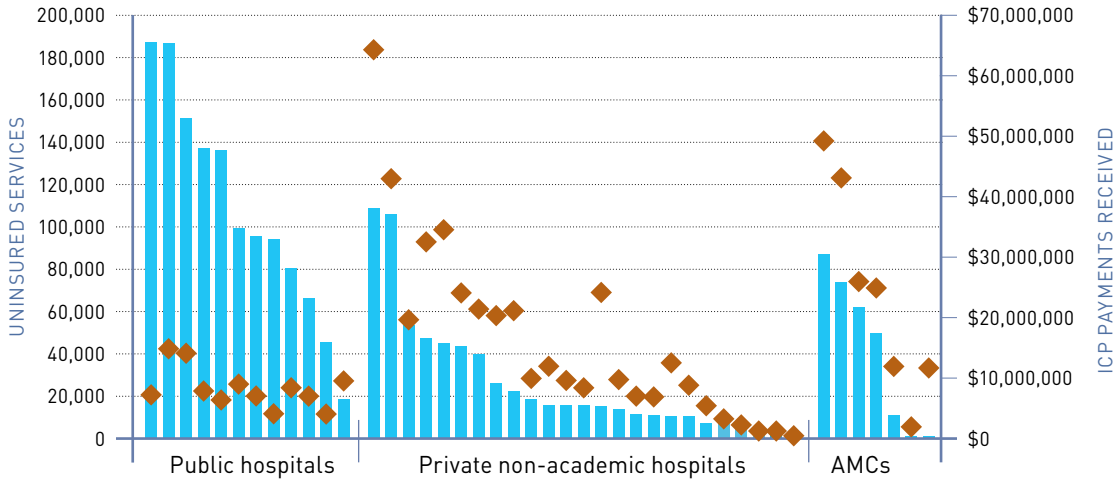
[32] Because ICP is allocated based on patient volumes two years prior, hospital ICP allocations for 2015 are compared with uninsured patient volume in 2013. See Appendix 4 for methodology for calculating ICP allocation.

On average, some AMCs and private hospitals received several thousands of ICP dollars per patient encounter because of a combination of low uninsured volumes and relatively large ICP payments. Notably, the Hospital for Special Surgery and the Memorial Sloan Kettering Cancer Center each had fewer than 900 uninsured patient encounters in 2013 but received $2 million and $12 million in ICP payments in 2015, respectively. Translated into average amounts per uninsured patient encounter, these hospitals received approximately $2,000 and $13,000 for each uninsured encounter.

As shown in **Figure A**, there are large variations in ICP payments received by hospitals. At the upper end of service provision, three New York City hospitals provided one-third of their total service volume to uninsured patients in 2013. At the low end, the three hospitals that provided the fewest uninsured services provided 1–2% of their services to uninsured patients. The three New York City hospitals that provided the most services to uninsured patients provided from 151,000 to 187,000 services to uninsured patients and received between $7 million and $15

FIGURE A

Number of Uninsured Services Provided by New York City Hospitals and ICP Payments Received



Uninsured services (Y axis on the left) are indicated using blue bars for individual hospitals, representing the sum of uninsured inpatient discharges and outpatient visits. ICP payments received (Y axis on the right) refer to ICP payments made in 2015 as indicated by red diamonds.

Data source: New York State Department of Health workbooks (ICP payment data for 2015; uninsured service data for 2013).

million in ICP payments. The three New York City hospitals that provided the least percentage of their services to uninsured patients all provided less than 1,000 services to uninsured patients yet received between $2 million and $12 million in ICP payments.

Large discrepancies in ICP payments are found between pairs of hospitals, relative to their uninsured volume. For example, the hospital that provided the fewest uninsured services in New York City was Memorial Sloan Kettering Cancer Center,[33] a specialty AMC with fewer than 900 uninsured services. This hospital received $5 million more in ICP payments than NYC Health + Hospital/Elmhurst, a public hospital that provided the most uninsured services in the City—more than 187,000. See Table 4 in Appendix 3 for comparisons of pairs of hospitals that had similar uninsured volumes or ICP payments.

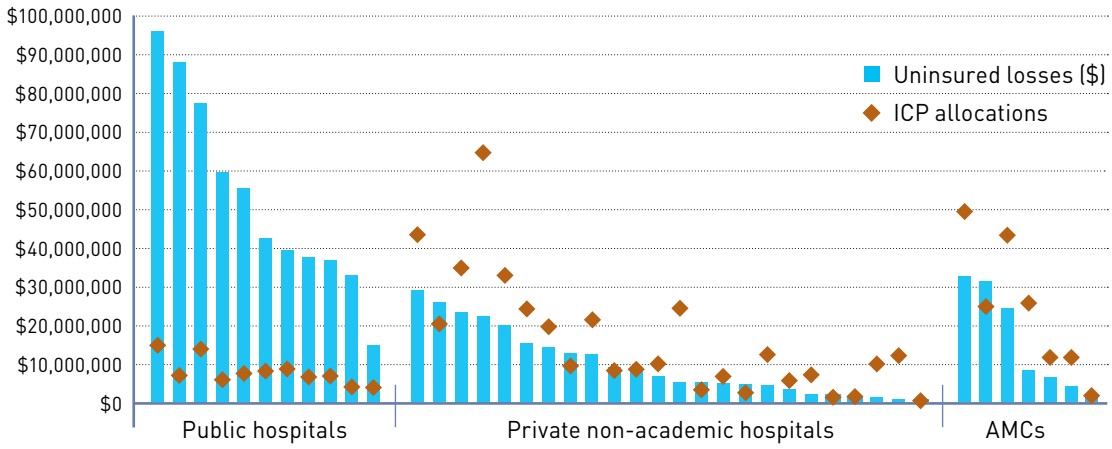
ICP payments are not related to a hospital's uncompensated care costs. On average, ICP payments to private hospitals were higher than their uninsured losses, whereas public hospitals were reimbursed less than their uninsured losses.

The ICP is designed to compensate hospitals for their financial losses incurred from providing care to uninsured patients who are unable to pay for part or all of their medical bills. Yet ICP payments overcompensated most private hospitals and AMCs relative to their self-reported uninsured losses, but undercompensated public hospitals, as shown in **Figure B**. For public hospitals, ICP payments compensated only a small fraction—on average less than one-fifth (18%)—of their total self-reported losses from services to uninsured patients. The opposite was true for private hospitals and AMCs. On average, private hospitals received ICP payments that were 52% higher than their uninsured losses, and AMCs received ICP payments that were 78% higher than their uninsured losses. This imbalance has a greater negative impact on public hospitals' finances, as uninsured losses represented a much larger share of net patient revenues and operating expenses for public hospitals (10–12%) as compared with private hospitals (1–2%; at most 6%). These findings suggest that public hospitals depend to a greater extent on supplemental payments, such as ICP payments, and that ICP payments are more

[33] Calvary Hospital provided the fewest uninsured services (87 services); however, this hospital is a long-term acute care hospital and may not be comparable to other hospitals in the report's sample.

FIGURE B

Hospital ICP Allocations in Relation to Hospital Self-Reported Uninsured Financial Losses



The blue bars reflect individual hospitals' financial losses from services rendered to uninsured patients. Hospitals are ranked in descending order by their uncompensated care costs, within hospital group. Red diamonds reflect ICP allocations in 2015.

Data source: New York State Department of Health workbooks (ICP allocations, 2015 data); 2013 ICRs (uninsured losses); see further details on data sources in Appendix 2.

important for the financial health of public hospitals relative to private hospitals. See Table 3 in Appendix 3 for data on uninsured losses in relation to ICP allocation.[34]

Because their ICP payments are set at a far lower level than payments to private hospitals, public hospitals receive ICP payments that are far below their need. For each uninsured service provided, private hospitals received 7–8 times more in ICP payments than public hospitals did, on average.

New York City public hospitals had nearly 1.3 million uninsured patient encounters in 2013. The City's 12 public hospitals provided the majority of all uninsured care (58%) yet received only one-seventh of total ICP payments (15%). In contrast, private hospitals (including AMCs) provided 42% of all uninsured care but received twice as much (85%) in ICP payments.

[34] Similar results were obtained when ICP payments were compared with hospital uncompensated care costs as calculated under the current ICP methodology (nominal need in Step 4 of the formula).

For each uninsured service provided, private hospitals received 7–8 times more on average than public hospitals did ($578 for private hospitals and $658 for AMCs versus $85 for public hospitals). A private hospital (Jamaica Hospital Medical Center) with the same uninsured volume as a public hospital (NYC Health + Hospitals/North Central Bronx) received eightfold more in ICP payments. Reflecting that dynamic, two private hospitals received approximately the same amount in ICP payments as a public hospital, although they provided 17–18 times fewer uninsured services. See Table 4 in Appendix 3.

This variation is likely explained by the fact that the total amount of ICP dollars available to the State's public hospitals is currently capped by law to approximately one-seventh ($139 million) of the dollar amount that is allocated to voluntary/private hospitals ($994 million). The statutory amount available for private hospitals ($994 million) acts as a payment floor that guarantees that these hospitals receive ICP payments in excess of their uncompensated care need.

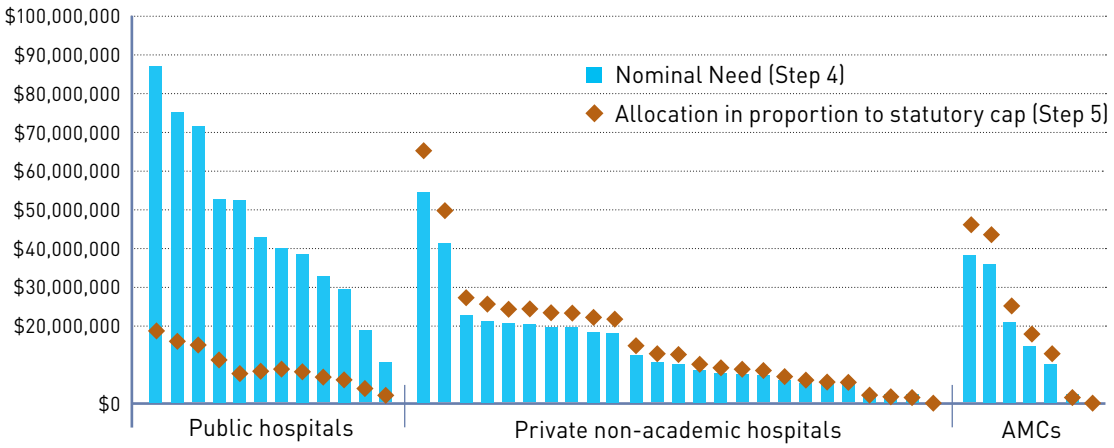
All private hospitals in New York City gained ICP dollars, on average $3 million each, as a result of the ICP formula's methodology step that adjusts payments to the statutory amount available for the State's private hospitals ($994 million). See Box 1 in Appendix 3. Private hospitals gained 21% more in ICP dollars relative to their total uncompensated care costs (based on what their group nominal need was). In contrast, the total amount allocated to public hospitals is capped at a level ($139 million) that acts as a payment ceiling. As a result, ICP payments to public hospitals are far below these hospitals' actual uncompensated care need (nominal need) as shown in **Figure C**. Because of this cap, public hospitals lost on average $36 million each, representing an average 78% reduction relative to their uncompensated care costs (based on their group nominal need).

Because of the Transition Payment Formula, ICP payments remain tied to an old allocation methodology that reimbursed hospitals for bad debt. The formula ensures that public hospitals continue to be at a disadvantage relative to their need while boosting payments to most AMCs.

In 2012, the State approved a new allocation methodology that was more closely related to levels of uninsured care than the previous methodology, which allocated only a small fraction (10%) of ICP payments to hospitals based on their uninsured volume. The old methodology also reimbursed hospitals for their bad debt—a practice that is now disallowed by Centers for

FIGURE C

The Effect of Statutory Caps ($139 Million for Public; $994 million for Private) on the Distribution of Hospital ICP Allocations Relative to Uncompensated Care Need (Nominal Need)



Bars represent nominal need calculated in Step 4 of the ICP allocation methodology (see Box 1 in Appendix 3) for individual hospitals in New York City. Diamonds represent ICP payments to hospitals calculated in Step 5 of the ICP allocation methodology, which adjusts payments by the statutory caps (total amounts available to distribute) for public hospitals ($139 million) and private hospitals ($994 million).

Data source: New York State Department of Health workbooks, 2015 ICP allocations and nominal need in 2013.

Medicare & Medicaid Services (CMS). At the same time, the State introduced a Transition Payment Formula to protect hospitals from large fluctuations in revenues under the new allocation methodology.[35] This formula gradually phases in the new allocation methodology by limiting how much a hospital can lose or gain in ICP payments, relative to what it received in the previous three years. See Table 5 in Appendix 3 for the caps on gains and losses for public and private hospitals.

When this formula was applied in step 6 of the methodology (see Box 2 in Appendix 3), most public hospitals and nearly half of private (nonacademic) hospitals were at a disadvantage: They received on average $3–4 million less each, relative to what they would have received without the formula **(Figure C)**. In contrast, most AMCs gained ICP dollars under the formula, on average $5 million each.

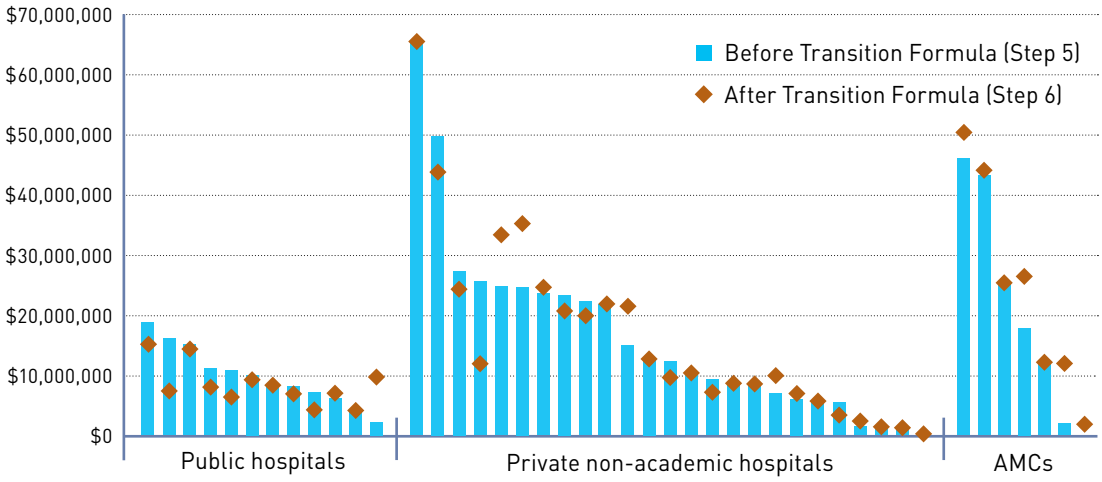
[35] Some private hospitals outside the New York City (in rural New York State) would have lost up to 50% of their ICP payments under the new formula, had the Transition Payment Formula not been implemented (confirmed by a hospital association representative).

The hospitals that gained the most from the formula were two specialty AMCs that provided the fewest services to uninsured patients among all hospitals in New York City. Memorial Sloan Kettering Cancer Center gained 500% ($10.5 million) relative to what it would have been paid without the formula, despite providing fewer than 900 uninsured services in 2013. The Hospital for Special Surgery gained $2 million in ICP payments under the formula despite having no uncompensated care need ($0) before the formula was applied (this hospital recovered all its losses from uninsured services through patient collections). These findings show that the Transition Payment Formula distorts the relationship between hospital uninsured care provided and ICP payments received.

In effect, the vast majority of ICP dollars continue to be allocated based on an old methodology, which allowed hospitals to be reimbursed for their bad debt expenses—a practice now disallowed under federal Medicaid rules. The current ICP allocation methodology would be more equitable than the previous formula, particularly for hospitals that are providing

FIGURE D

Effect of the Transition Payment Formula on Hospital ICP Allocations



Blue bars represent individual hospitals' ICP allocations before the Transition Payment Formula was applied in Step 4 of the ICP allocation methodology (see Box 1 in Appendix 3). Red diamonds refer to ICP allocations calculated after the Transition Payment Formula was applied in Step 5 of the methodology.

Data source: New York State Department of Health workbooks; 2015 calculations.

considerable amounts of uninsured care. However, the Transition Payment Formula is dampening this beneficial effect and distorting the relationship between uncompensated care provided and ICP allocations.

Some New York City hospitals almost exclusively serve uninsured or Medicaid patients, whereas at other hospitals, only 1 in 10 services are provided to these patients. Specifically, public hospitals provided on average three times more of their inpatient and outpatient services to uninsured patients as compared with private hospitals and AMCs.

Hospitals that devote large shares of their resources to caring for uninsured and Medicaid patients are typically considered safety-net hospitals. These hospitals tend to have the greatest need for supplemental payments, such as ICP payments, as they incur substantial losses from serving uninsured and Medicaid patients. They also have relatively small shares of privately insured patients, and thus have less potential than nonsafety-net hospitals to make up for these losses through higher reimbursement rates on privately insured patients. Hospitals in New York City varied with regard to their community benefit provisions: Some almost exclusively cared for Medicaid and uninsured patients (81%), whereas at others, only one-twentieth (5%) of inpatient and outpatient services were provided to these patients. On average, public and private nonacademic hospitals provided a similar percentage of their services to Medicaid patients (51-52%), whereas AMCs provided one-third of services to Medicaid patients (31%) and some outlier private hospitals had very low shares of Medicaid patients (less than 10%). The difference was largely a result of services provided to uninsured patients. Public hospitals provided disproportionately high shares of uninsured care: on average, one-quarter (28%) of services at these hospitals were provided to uninsured patients as compared with only 5-7% of services at private nonacademic hospitals or AMCs. Private hospitals that provided services to Medicaid and uninsured patients at similar levels to public hospitals included St. Barnabas Hospital, Jamaica Hospital, Brookdale University Hospital Medical Center, Flushing Hospital Medical Center, Bronx-Lebanon Hospital Center, Wyckoff Heights Medical Center, Interfaith Medical Center, and NYU Lutheran Medical Center. See Table 6 in Appendix 3. Two AMCs provided Medicaid care (but not uninsured care) at levels (as a percentage of services) comparable to safety-net and public hospitals: Mount Sinai Beth Israel and Montefiore Medical Center (data not shown).

In inpatient settings, public hospitals devoted a larger share of services to Medicaid and uninsured patients than private nonacademic hospitals or AMCs.

Inpatient discharges were investigated separately, as the majority of all hospital services (95%) represented outpatient services and because uncompensated care costs are higher in the inpatient setting.[36] New York City's public hospitals provided more than half of inpatient services to Medicaid patients (56%) as compared with 37% at private nonacademic hospitals and 26% at AMCs, on average. The lowest Medicaid volumes were found at three specialty AMCs, where at most 7% of discharges were made to Medicaid patients. Public hospitals provided on average three to eight times more of their services to the uninsured (9%), relative to private nonacademic hospitals (1%) or AMCs (1%). (Data not shown).

[36] Providing inpatient care is more costly than providing outpatient care; thereby, a hospital that devotes a large share of its inpatient services to uninsured and Medicaid patients will incur greater uncompensated care costs (losses) than a hospital that devotes an equally large share of its outpatient services to these patients.

Conclusion

Preserving and strengthening safety-net hospitals is in everyone's interest. The ICP was established to pay hospitals "according to their level of need due to providing charity care."[37] However, the data reveal that ICP payments received by New York City hospitals are not fully related to the number of uninsured services provided or uncompensated care costs. Some hospitals received ICP payments that exceed their need, whereas others were underpaid relative to their need. The reforms of 2012 sought to address this imbalance, but two provisions in the current allocation methodology merit attention.

First, the Transition Payment Formula ensures that the majority of ICP dollars continue to be allocated using the old methodology, which reimbursed hospitals for bad debt.

Second, the statutory caps for public and private hospitals are set at levels that bear no relation to the relative share of uninsured care that these hospitals provide. Public hospitals receive one-seventh of ICP payments despite providing more than half of all uninsured care in New York City. The evidence suggests that there is a disconnect between hospital community benefits provided and reimbursement received from the ICP.

POLICY RECOMMENDATIONS

Hospitals in New York City and elsewhere face an uncertain future. The new administration is set to repeal the Affordable Care Act (ACA), which is expected to increase the number of uninsured individuals in New York State and nationally. In addition, the future of the Medicaid program, which currently funds half of the ICP, is uncertain. The ICP and other supplemental payments are a lifeline for New York's safety-net hospitals. Public safety-net hospitals are facing a $1.8 billion operating deficit over the next few years,[38] whereas private safety-net hospitals have been closing at an alarming rate or consolidating with New York City's largest health systems. The City's safety-net hospitals may become increasingly unable to provide

[37] Simmons AG. 1997 New York Health Care Reform Act of 1996 – Summary of Major Provisions. New York City Office of Management and Budget, December 1997.

[38] The City of New York Office of the Mayor Bill de Blasio. One New York: Health Care For Our Neighborhoods - Transforming Health + Hospitals, 2016. Available at: http://www1.nyc.gov/assets/home/downloads/pdf/reports/2016/Health-and-Hospitals-Report.pdf, accessed March 2017.

high-quality care to its most vulnerable residents. This in turn has the potential to worsen the health gap between rich and poor, uninsured and insured, and white and minority New Yorkers.

Policymakers may consider the following recommendations to bring the ICP closer to its goal of reimbursing hospitals according to need.

Accelerate the Transition Payment Formula.

Currently, the formula states that no hospital can lose more than 12.5% of what it was paid in the previous three years, and this cap on losses (floor) increases by 2.5% each year. Consequently, the ICP will not be fully detached from the old formula, which reimbursed hospitals for bad debt, until 2052. It is recommended that the State accelerate the annual rate at which the floor increases each year. This would free up funds for hospitals with the greatest need for ICP payments, as well as ensure that the ICP is compliant with CMS requirements that prohibit states from using federal Medicaid DSH funds to reimburse hospitals for bad debt.[39]

Introduce caps on hospital ICP payments relative to their uncompensated care costs (nominal need).

As some hospitals received millions in ICP payments without having any uncompensated care costs and others received payments that exceeded their uncompensated costs by severalfold, the State should introduce a limit (cap) on hospital payments that would ensure that no hospital receives more in ICP payments than what its uncompensated care costs are (measured either as nominal need or as reported by hospitals in institutional cost reports, or ICRs). Alternatively, the cap could reflect the combined losses from Medicaid and charity care to the uninsured. The New York State Department of Health already collects this information through ICRs and could supplement this information with IRS Form 990 data. This provision would be analogous to the facility cap set by CMS on federal Medicaid DSH payments to hospitals, which stipulates that no hospital can receive more in DSH payments than were its net losses from providing care to

[39] Medicaid and CHIP Payment and Access Commission (MACPAC). Report to Congress on Medicaid Disproportionate Share Hospital Payments, February 2016. Available at: https://www.macpac.gov/publication/report-to-congress-on-medicaid-disproportionate-share-hospital-payments/, accessed March 2017.

uninsured and Medicaid patients.[40] Any amount withheld (exceeding the hospital cap) could be distributed to more needy hospitals according to their proportional nominal need. Other states currently have similar caps in place, including New Hampshire and Massachusetts.[41,42]

Limit pool participation to the neediest hospitals.

The majority of hospitals in the State[43] and New York City currently receive ICP payments, regardless of how much uninsured care they provide. This dilutes the potential beneficial effect of these crucial funds on hospitals with the greatest uncompensated care costs. Other states, such as California, Maine, and Massachusetts, make Medicaid DSH payments to only a small proportion—less than one-fifth—of hospitals.[44] In Massachusetts, payment allocations from the Health Safety Net Trust Fund prioritize hospitals that receive 63% or more of their gross patient service revenues from public payers and free care. Similarly, Massachusetts has a separate pool for hospitals that provide at least 2.7% of the state's overall Medicaid discharges.[45]

New York State should consider targeting ICP payments to hospitals with the least favorable payer mix or ones that devote a large share of their financial resources to providing indigent care. The State already uses such criteria to target ICP payments to Diagnostic & Treatment Centers (D&TCs).[46] New York State's D&TCs must demonstrate that at least 5% of their patient

[40] Mitchell A. Medicaid Disproportionate Share Hospital Payments. Congressional Research Service. June 2016. Available at: **https://www.fas.org/sgp/crs/misc/R42865.pdf**, accessed March 2017.

[41] Massachusetts Executive Office of Health and Human Services (2016). 101 CMR 614.00: Health Safety Net Payments And Funding. Final Adoption, December 2016. Available at: **http://www.mass.gov/eohhs/docs/eohhs/eohhs-regs/101-cmr-614.pdf**, accessed March 2017.

[42] Hospitals can only receive payments from the Public Service Hospital Safety Net Care pool in amounts that do not exceed the hospitals' total unreimbursed free care and Medicaid charges for the fiscal year.

[43] Medicaid and CHIP Payment and Access Commission (MACPAC). Report to Congress on Medicaid Disproportionate Share Hospital Payments, February 2016. Available at: **https://www.macpac.gov/publication/report-to-congress-on-medicaid-disproportionate-share-hospital-payments/**, accessed March 2017.

[44] Medicaid and CHIP Payment and Access Commission (MACPAC). Chapter 1: Overview of Medicaid Policy on Disproportionate Share Hospital Payments. March 2016. Available at: **https://www.macpac.gov/wp-content/uploads/2016/03/Overview-of-Medicaid-Policy-on-Disproportionate-Share-Hospital-Payments.pdf**, accessed March 2017.

[45] Massachusetts Executive Office of Health and Human Services. 101 CMR 614.00: Health Safety Net Payments And Funding. Final Adoption, December 2016. Available at: **http://www.mass.gov/eohhs/docs/eohhs/eohhs-regs/101-cmr-614.pdf**, accessed March 2017.

[46] Gahan JW Jr. Medicaid reimbursement for D&TC's. A presentation at the 2011 Annual Conference of the Community Health Care Association of New York State (CHCANYS). Available at: **http://www.chcanys.org/clientuploads/2011_Annual_Conference/Presentations/10-17-11/PM/MedicaidReimbursement-JGahan.pdf**, accessed March 2017.

visits represent self-pay/free-care patients to receive ICP payments and their operational losses must be larger than revenues received from self-pay/free visits.[47]

Adjust statutory payment caps currently imposed on public hospitals ($139 million) and private hospitals ($994 million) to closer reflect levels of indigent care provided.

In New York City, public hospitals provided 57% of all uninsured care but received only 15% of total payments made to the City's hospitals. It is recommended that the State increase the payment cap currently imposed on public hospitals to more closely reflect the level of uninsured care that these hospitals provide.

Set minimum community benefit requirements for nonprofit hospitals that are tied to Medicaid and uninsured care provision.

New York State currently requires private hospitals to run as charities (nonprofits) and grants them tax exemptions, but it does not monitor or set requirements for charity care provision. It is recommended that private hospitals in the State be required to deliver an established amount of care to uninsured and Medicaid patients as a condition for retaining their tax exemptions and ICP payments. These requirements should be tied to uninsured and/or Medicaid care, as these activities result in considerable financial losses to hospitals in contrast to other community benefits, such as medical education or research activities, which are generously remunerated.[48]

In New York State, the Public Health and Health Planning Council currently establishes minimum charity care requirements for for-profit ambulatory surgery centers, and it could potentially play a role in establishing similar requirements for nonprofit hospitals. Several states already monitor and set minimum criteria for nonprofit hospitals to qualify for tax exemptions.[49] Most of these

[47] Gahan JW Jr. Medicaid reimbursement for D & TC's. A presentation at the 2011 Annual Conference of the Community Health Care Association of New York State (CHCANYS). Available at: http://www.chcanys.org/clientuploads/2011_Annual_Conference/Presentations/10-17-11/PM/MedicaidReimbursement-JGahan.pdf, accessed March 2017.

[48] Nguyen NX, Sheingold SH. Indirect medical education and disproportionate share adjustments to Medicare inpatient payment rates. *Medicare Medicaid Res Rev.*, 2011, 1(4):E1–E19.

[49] Hilltop Institute, 2016. Community Benefit State Law Profiles - A 50-State Survey of State Community Benefit Laws through the Lens of the ACA. Available at: http://www.hilltopinstitute.org/hcbp_cbl.cfm, accessed March 2017.

requirements are tied to property tax liability. For example, in Illinois, nonprofit hospitals must provide charity care at levels that amount to at least the equivalent of the hospital's property tax liability. In 2011, the Illinois Department of Revenue stripped property tax exemptions from three nonprofit hospitals because they did not provide enough charity care.[50] Similarly, in Pennsylvania, nonprofit hospitals can meet their community benefit requirements by providing uncompensated services in an amount that represents at least 3% of their total operating expenses. In 2013, the City of Pittsburgh demanded that the University of Pittsburgh Medical Center, an AMC, pay back six years' worth of property taxes after it emerged that the hospital had spent less than 2% of its revenues on charity care.[51] By imposing a fee on hospitals that do not meet minimum charity care criteria, or those that do not have any uncompensated care costs at all, the State could add revenues to the ICP. This could be one way in which the State could support its safety-net hospitals, should hospital uncompensated care costs increase as a result of a repeal of the ACA.

[50] Japsen B. State Challenging Hospitals' Tax Exemptions. *New York Times*, September 2011. Available at: http://www.nytimes.com/2011/09/11/us/11cnchospitals.html?pagewanted=all, accessed March 2017.

[51] Balingit M. Pittsburgh lawsuit challenges UPMC's tax status. *Pittsburgh Post-Gazette*, March 2013. Available at: http://www.post-gazette.com/local/city/2013/03/21/Pittsburgh-lawsuit-challenges-UPMC-s-tax-status/stories/201303210210, accessed March 2017.

Appendix 1: Abbreviations and Definitions

Bad debt: Hospital financial losses incurred from providing services to insured patients, for whom payment for services was expected (e.g., by a commercial insurance company or a public payer such as Medicaid or Medicare), but was not received. Hospitals may continue to seek payments for bad debts, either from the insurer or the patient themselves. The latter contributes to personal medical debt, which can be detrimental to a patient's long-term financial status.

Centers for Medicare & Medicaid Services (CMS): Federal agency responsible for administering care for elderly (age 65 or older) and disabled Americans through the Medicare program; overseeing state administration of care for low-income Americans through the Medicaid program; and overseeing administration of the Children's Health Insurance Program (CHIP), in addition to other functions.

Charity care: Hospital services provided to uninsured patients or to patients who are underinsured (defined as having insurance but not being covered for a particular service). Most hospitals have charity care policies, under which hospital bills to uninsured individuals that pass income eligibility criteria (have low incomes) are reduced using a sliding-fee scale. Charity care policies may result in the provision of free care. Also known as financial assistance.

Disproportionate Share Hospital (DSH): A form of federal supplemental payment (supplements low direct provider reimbursements) that compensates hospitals for financial losses incurred from providing care to uninsured and Medicaid patients. Half of DSH funds are paid to states by the federal government (CMS), and half is paid by state governments. In New York State, federal DSH dollars are channelled into the ICP. Such supplemental top-up payment funds are necessary for the Medicaid program, since direct provider reimbursements are insufficient to reimburse providers for the actual costs of providing care.

Financial Assistance Compliance Pool (FACP): A special pool of funds that collects 1% of total hospital DSH distributions (which include public hospital DSH funds and intergovernmental transfers in addition to ICP payments) for their compliance with the 2006 Hospital Financial Assistance Law (HFAL, definition below). Since 2014, the New York State Department of Health has contracted hospital audits for compliance with HFAL to accounting firm KPMG. Hospitals found to be noncompliant (below the minimum required compliance level) must submit a corrective action plan and demonstrate substantial compliance; otherwise, FACP amounts are forfeited and reallocated to other hospitals with greater need.

NYC Health + Hospitals: A public benefit corporation that governs public hospitals in New York City. It is the largest municipal health care organization in the country, providing care to 1.3 million New Yorkers. NYC Health + Hospitals functions as an integrated health care delivery system, which includes 11 acute care hospitals. It was renamed from NYC Health and Hospitals Corporation in 2015.

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Health Care Reform Act (HCRA): A law from 1996 that levies a set of assessments and surcharges on payers and providers. It combines these funds with cigarette tax revenues, covered lives assessment, New York City cigarette tax transfers, and proceeds from Empire Blue Cross Blue Shield's stock conversion proceeds to pay for the State proportion (50%) of the ICP, as well as other health programs, including public health, Medicaid assistance, stem cell research, medical malpractice programs, graduate medical education programs, and worker retraining.

Hospital Financial Assistance Law (HFAL): A State law enacted in 2006 that requires hospitals to offer financial assistance on a sliding scale to patients earning up to 300% of the federal poverty level (at a minimum) and free care to patients earning below the poverty level. Hospitals must make these policies publicly available. Since 2009, New York State hospitals are required to comply with HFAL to be eligible to receive ICP payments. The Attorney General has the power to fine individual hospitals $10,000 for noncompliance. The law is also known as Manny's Law, after Manny Lanza, who died at the age of 24 after being denied treatment for a brain condition at a New York City hospital and after receiving a rejection on his Medicaid eligibility application.

Indigent Care Pool (ICP): A pool of funds managed by the New York State Department of Health that compensates hospitals for financial losses from services provided to uninsured patients. The ICP is funded by federal Medicaid DSH payments (50%) and through a State tax mechanism (HCRA, see above; 50%). ICP is paid on a two-year lag, whereby allocations are determined based on the volume of uninsured services provided two years prior to the allocation year.

Institutional Cost Report (ICR): Reports maintained by the New York State Department of Health for all State hospitals on hospital characteristics, expenses, volumes of care provided, and other key metrics. Portions of the report are derived from Medicare cost reports (CMS-2552) that hospitals submit to CMS. ICRs are used to calculate ICP allocations, based on uninsured care provided two years prior to the allocation year.

Uncompensated Care (UCC): Hospital financial losses incurred from services provided to uninsured patients (charity care) and underinsured patients (who have insurance but are not covered for a medically necessary service, also known as bad debt), less any payments received from insurers or patient collections. May in some cases include losses from services provided to Medicaid patients, as Medicaid provider payments are typically lower than the actual costs of providing care. For the purposes of calculating ICP, the New York State Department of Health defines uninsured UCC as the number of uninsured service units provided, priced at (multiplied by) the Medicaid rates that are hospital- and service-specific.

Appendix 2: Details on Data Sources and Methodology

DATA VARIABLE	DATA SOURCE, VARIABLES, AND NOTES ON CALCULATIONS
Uninsured volume (patient encounters)	**Data source:** New York State Department of Health worksheets, 2013 data from 2015 ICP allocation workbook. **Units:** Sum of inpatient discharges (see below) and outpatient visits and procedures (see below) in 2013. **Inpatient:** Inpatient Acute Care Self-Pay and Free Discharges. Does not include self-pay and free care inpatient days in the categories: Psychiatric Care Exempt Self-Pay and Free Days (n= 25,619 for New York City hospitals); Chemical Dependency Detoxification Exempt Uninsured and Free Days (n= 4,588); Specialty Hospital Exempt Self-Pay and Free Days (n= 3,129); Chemical Dependency Rehabilitation Exempt Uninsured and Free Days (n= 759); Critical Access Hospital Uninsured and Free Days (n=0); Medical Rehabilitation Exempt Uninsured and Free Days (n= 7,350). **Outpatient:** Sum of 17 services reporting uninsured and free visits or procedures: Clinic Services; Emergency Services; Ambulatory Surgery; Renal Dialysis/Hemodialysis; Oncology Clinic; Rehabilitation Clinic; MMTP Weekly; Other-Outpatient Specialty; Federally Qualified Health Center (FQHC); HIV Clinic; OASAS; Mental Health (MH) Day Treatment; MH Clinic; Emergency Psychiatric; MH Continuing Day Treatment; MH Intensive Psychiatric Rehab (IPRT); and MH Partial Hospitalization.
Final hospital ICP dollar allocations	**Data source:** New York State Department of Health worksheets, 2015 data from 2015 ICP allocation workbook. **Variable:** Allocation After 1% FACP Reduction (Rounded) **Note:** For private (voluntary) hospitals, a portion of final ICP allocations are paid as UPL payments, rather than ICP payments. For further details, see Appendix 4.
Hospital uninsured losses	**Data source:** Unaudited 2013 hospital Institutional Cost Reports (ICRs) **Variable:** Exhibit 49 - Uncompensated and Indigent Care Cost Computation **ICR line code:** 123, column 04805 Cost of Charity Care – Uninsured patients (represents Cost of Initial Obligation of Patients Approved for Charity Care [Total Initial Obligation at Full Charges * Cost to Charge Ratio], less Partial Payments Received from Patients)
Hospital net patient revenue	**Data source:** Unaudited 2013 hospital ICRs **Variable:** Exhibit 26A - Statement of Revenues and Expenses **ICR line code:** 005 - Net patient revenues
Hospital operating expenses	**Data source:** Unaudited 2013 hospital ICRs. **Variable:** Exhibit 26A - Statement of Revenues and Expenses **ICR line code:** 006 - Total Operating Expenses
ICP - nominal need	**Data source:** New York State Department of Health worksheets, 2015 data. **Variable:** Nominal Need – Nominal Payment

continued ➜

DATA VARIABLE	DATA SOURCE, VARIABLES, AND NOTES ON CALCULATIONS
ICP – allocation in proportion to group cap	**Data source:** New York State Department of Health worksheets, 2015 data. **Variable:** Allocation Before Transition Adjustment
ICP – allocation after Transition Payment Formula	**Data source:** New York State Department of Health worksheets, 2015 data. **Variable:** Allocation After Transition Adjustment
Medicaid and uninsured patient volumes	**I. Overall patient volumes (inpatient + outpatient)** **Data source:** Unaudited 2013 hospital ICRs, hospital-level analyses. **Inpatient:** Exhibit 32 - Patient Days and Discharges by Source of Payment • **Discharges:** Columns entitled Adults & Pediatrics Discharges (Excl. Newborn) and Discharges • **Sum of individual services:** Acute; Chemical Dependency Detox; Chemical Dependency Rehab; Psychiatric; CPEP Observation Beds; Physical Medicine Rehabilitation; Traumatic Brain Injury/Coma; Other; and Critical Access Hospital. **Outpatient:** Exhibit 33 - Statistical Data, Patient Visits, Patient Characteristics by Source of Payment • **Visits and procedures:** Columns entitled Visits Excl. Inpatient Admissions and Procedures Excl. Inpat. Admissions • **Sum of individual services:** Adult Day Care; Alcohol/Chemical Dependency Clinic; Ambulatory Surgery; Cancer Treatment Service; Child Rehabilitation Clinic; Clinic; CPEP; OASAS Programs; Early Intervention; Emergency Service; FQHC/Hospital-Based FQHC Clinics; Mental Health (MH) Clinic; PROS; MH Continuing Day Treatment; MH Day Treatment; MH Intensive Psych Rehab; MH Partial Hospitalization; All Other OMH Programs; Methadone Maintenance; Referred Ambulatory; and Renal Dialysis. **Uninsured:** Includes Uninsured/Self Pay and Free (Charity, Hill Burton) categories. **Medicaid:** Includes Medicaid (FFS) and HMO/PHSP Medicaid categories **Notes:** Missing data - Unaudited ICR data was missing for SUNY Downstate Medical Center/ University Hospital Brooklyn (a public State-owned hospital), Long Island Jewish Medical Center (a private nonacademic hospital) and NYU Hospital for Joint Diseases (an AMC). **II. Inpatient volumes** **Data source:** SPARCS 2014 inpatient discharge data, aggregated at the hospital facility level. **Uninsured:** Self-Pay. **Medicaid:** All discharges with Medicaid as the primary expected source of payment, as well as those with Medicaid as the secondary expected source of payment and Blue Cross/ Blue Shield, Managed Care, Unspecified, Private health insurance, or Misc./Other as the primary expected source of payment. This approach was used to capture those individuals on Medicaid Managed Care plans. **Privately insured:** Primary expected source of payer Blue Cross/Blue Shield or private health insurance with any secondary expected source of payment apart from Medicaid or Medicare.

FURTHER DETAILS ON ANALYSES

DATA SOURCES:

- **New York State Department of Health ICP calculation workbooks** obtained through a Freedom of Information (FOI) request that was submitted January 2016 and received April 2016. Data were extracted for 44 New York City hospitals (some hospitals report data for multiple facilities in a consolidated manner) for the following variables: number of uninsured services provided in 2013 in inpatient and outpatient settings; ICP allocations and calculation steps for the 2015 allocation year; and hospital uncompensated costs as calculated per the ICP methodology (nominal need).
- **Hospital 2013 Institutional Cost Reports (ICRs)** maintained by the New York State Department of Health that were obtained through a previous FOI request by a third party. ICRs contained data for 42 acute care hospitals in New York State (data were missing for three hospitals) for: service volumes (inpatient and outpatient) by patient insurance; hospital self-reported losses from services provided to uninsured patients; net patient revenues; and operating expenses.
- **Statewide Planning and Research Cooperative System (SPARCS)** inpatient discharge data (de-identified) for 53 New York City hospital facilities (aggregated from patient-level data) for the most recent year available (2014). Data were downloaded from the freely accessible Health Data NY website (health.data.ny.gov) in March 2016.

HOSPITAL SYSTEMS VERSUS INDIVIDUAL FACILITIES: Some hospitals in New York City comprise more than one hospital facility. For example, the NewYork-Presbyterian hospital system comprises seven facilities, five of which were in this sample (the additional two are a children's hospital and one located outside the City). Most data sources listed above included data at the hospital system level, reporting data for all facilities in a consolidated manner. Only one data source (SPARCS) was available at the facility level. For this reason, the total number of hospitals (or hospital facilities) for which the above data were available varied between data sources.

HOSPITAL CATEGORIES: These analyses focused on general acute care hospitals in New York City and on services provided to adults (where possible). Therefore, long-term care facilities and children's hospitals were excluded from this sample. Hospitals were categorized into three groups: **(1)** public hospitals that comprise the City's NYC Health + Hospitals facilities and the State-owned University Hospital of Brooklyn/SUNY Downstate; **(2)** private (voluntary) nonacademic hospitals, referred to in the report as simply private nonacademic hospitals; and **(3)** private academic medical centers (AMCs). The report's focus was on large, private AMCs listed as major AMCs in a previous report by

the United Hospital Fund,[52] in addition to their affiliated hospitals. This report's final list of AMCs includes Montefiore Medical Center, Mount Sinai Health System, NYU Langone Medical Center, NYU Langone Hospital for Joint Diseases, NewYork-Presbyterian Hospital, Memorial Sloan Kettering Cancer Center (affiliated with NewYork-Presbyterian), Hospital for Special Surgery (affiliated with NewYork-Presbyterian), and Mount Sinai Beth Israel (affiliated with Mount Sinai and listed as an integrated member of the Association of American Medical Colleges' Council of Teaching Hospitals and Health Systems[53]). Because this report's focus was on these hospitals, the analyses classify two hospitals that are typically considered AMCs, SUNY Downstate and Staten Island University Hospital, as public (State-owned) and private nonacademic hospitals, respectively.

[52] Fass S, Cavanaugh S. The Financial Condition of the Leading Academic Medical Centers in New York City and the Nation. United Hospital Fund, 2010 Available at: **https://www.uhfnyc.org/publications/880641**, accessed March 2017.

[53] Confirmed through authors' private communication with an AAMC representative.

Appendix 3: Additional Data Tables and Figures

TABLE 1. ICP allocations for the City's top 10 and bottom 10 hospitals ranked by uninsured volume

HOSPITAL			UNINSURED ENCOUNTERS IN 2013		ICP ALLOCATION IN 2015	ICP PER UNINSURED ENCOUNTER
RANK	NAME	TYPE	N	%	$	$ / N
Top 10 hospitals by uninsured volume						
1	Elmhurst	Public	187,143	30%	$7,338,779	$39
2	Kings County	Public	186,780	30%	$15,026,682	$80
3	Bellevue	Public	151,254	31%	$14,232,011	$94
4	Woodhull	Public	136,995	28%	$7,836,294	$57
5	Queens	Public	135,912	31%	$6,462,933	$48
6	Bronx-Lebanon	Private	108,471	17%	$64,292,388	$593
7	Lutheran	Private	105,913	15%	$43,120,295	$407
8	Lincoln	Public	99,075	18%	$9,062,602	$91
9	Metropolitan	Public	95,267	24%	$7,073,427	$74
10	Coney Island	Public	93,742	33%	$4,118,258	$44
Bottom 10 hospitals by uninsured volume						
35	Interfaith	Private	10,244	6%	$12,688,830	$1,239
36	NY Methodist	Private	10,041	5%	$8,801,214	$877
37	St. John's Episcopal	Private	6,836	5%	$5,577,878	$816
38	Forest Hills	Private	6,672	9%	$3,409,935	$511
39	Kingsbrook Jewish	Private	5,423	5%	$2,465,600	$455
40	Beth Israel - Kings Highway	Private	2,828	7%	$1,453,146	$514
41	NY Comm. Brooklyn	Private	1,788	7%	$1,315,003	$735
42	Special Surgery	AMC	942	1%	$1,941,852	$2,061
43	Memorial Sloan Kettering	AMC	899	1%	$11,928,010	$13,268
44	Calvary *	Private	87	2%	$542,461	$6,235

This table presents the top and bottom 10 ranking hospitals in New York City (n=44) by their total uninsured patient volume (patient encounters), defined as the sum of services provided to uninsured patients in inpatient (discharges) and outpatient settings (visits/procedures).

*Calvary is an acute long-term care hospital and may not be comparable to other acute care hospitals presented here.

Data source: New York State Department of Health worksheets for 2015 data on ICP allocations; 2013 ICR data for patient volumes.

TABLE 2. Uninsured volumes and ICP payments received by New York City's public hospitals, private nonacademic hospitals, and academic medical centers (AMCs)

	UNINSURED ENCOUNTERS IN 2013		ICP ALLOCATION IN 2015	ICP PER UNINSURED ENCOUNTER
	N	%	$	$ / N
Public hospitals				
Minimum per hospital	18,329	5%	$4,104,450	$39
Average per hospital	97,171	26%	$7,587,537	$85
Maximum per hospital	187,143	33%	$15,026,682	$526†
Sum for all hospitals (n=12)	**1,296,376**		**$100,319,073**	**$77**
Private nonacademic hospitals				
Minimum per hospital	87	2%	$542,461	$372
Average per hospital	15,176	7%	$10,144,149	$658
Maximum per hospital	108,471	17%	$64,292,388	$6,235
Sum for all hospitals (n=25)	**648,417**		**$406,624,014**	**$627**
Academic medical centers				
Minimum per hospital	899	1%	$1,941,852	$419
Average per hospital	49,670	8%	$24,949,400	$587
Maximum per hospital	86,913	9%	$49,438,252	$13,268
Sum for all hospitals (n=7)	**284,806**		**$169,573,797**	**$595**
Sum for all New York City hospitals	**2,229,599**		**$676,516,884**	**$303**

"N" refers to number of uninsured encounters (services) provided in 2013, which represents that sum of all inpatient discharges and outpatient visits and procedures. "%" represents the proportion of all services provided by a given hospital that represented uninsured patients. "$" represents ICP payments made to a given hospital (or group of hospitals, last row) in 2015. "$/n" represents ICP dollars per each uninsured encounter (service) provided, calculated as ICP payments received by the hospital (or group of hospitals, last row) in 2015 divided by the number of uninsured encounters (services provided) in 2013. Data presented in columns for the first three rows (minimum, average, and maximum) do not necessarily come from the same hospital.

†The highest average ICP payment per uninsured encounter ($526) was received by the State-owned SUNY Downstate. This amount is comparable to the per-encounter payment received by private hospitals, all of which received at least $372 per uninsured encounter. In contrast, all City-owned public hospitals (NYC Health + Hospitals) received a per-encounter reimbursement of $106 (at a maximum) and $39 (at a minimum).

TABLE 3. Hospital self-reported losses from uninsured services in relation to ICP allocations, net patient revenue, and operating expenses

HOSPITAL		LOSSES FROM UNINSURED CARE			ICP ALLOCATIONS	
RANK	NAME	DOLLARS ($)	% NET PAT. REV.	% OP. EXP.	DOLLARS ($)	% NET LOSSES
Public hospitals *						
Top 3	Kings County	$95,813,115	15%	12%	$15,026,682	16%
	Elmhurst	$87,773,221	17%	14%	$7,338,779	8%
	Bellevue	$77,404,421	16%	10%	$14,232,011	18%
AVERAGE	▶	**$42,399,834**	**12%**	**10%**	**$7,338,779**	**18%**
Bottom 3	Metropolitan	$36,822,684	12%	11%	$7,073,427	19%
	Coney Island	$32,913,296	10%	8%	$4,118,258	13%
	North Central Bronx	$14,936,381	9%	7%	$4,104,450	27%
Private nonacademic hospitals						
Top 3	Lutheran	$28,917,782	6%	5%	$43,120,295	149%
	Maimonides	$25,843,664	3%	2%	$20,500,529	79%
	Jamaica	$23,468,292	6%	5%	$34,624,358	148%
AVERAGE	▶	**$5,882,440**	**2%**	**2%**	**$9,986,480**	**152%**
Bottom 3	Brooklyn Hospital	$979,307	0.3%	0.3%	$9,828,811	1004%
	Lenox Hill	$938,448	0.1%	0.1%	$12,071,339	1286%
	Calvary **	$129,756	0.1%	0.1%	$542,461	418%
Academic medical centers						
Top 3	NY Presbyterian ***	$32,653,953	1%	1%	$49,438,252	151%
	Mount Sinai	$31,311,800	2%	2%	$24,949,400	80%
	Montefiore	$24,273,391	1%	1%	$43,348,891	179%
AVERAGE	▶	**$8,249,609**	**1%**	**1%**	**$24,949,400**	**178%**
Bottom 3	Mem. Sloan Kettering	$6,687,967	0.4%	0.3%	$11,928,010	178%
	NYU Langone	$4,260,193	0.2%	0.2%	$12,019,160	282%
	Hosp. Special Surgery	$1,826,843	0.3%	0.2%	$1,941,852	106%

Hospitals are presented in descending order according to financial losses (dollars) incurred from services provided to uninsured patients. *Data for SUNY Downstate (State-owned hospital) are not included, as ICR data were missing for uninsured losses, net patient revenue, and operating expenses. **Calvary is an acute long-term care hospital and may not be comparable to other acute care hospitals presented here. ***NewYork-Presbyterian includes Downtown/Lower Manhattan Hospital (Lower Manhattan recently merged with the NewYork-Presbyterian hospital system).

Data source: New York State Department of Health workbooks (ICP allocations in 2015) and hospital 2013 ICRs (uninsured losses, net patient revenue, operating expenses); see further details on data sources in Appendix 2.

TABLE 4. Examples of vertical and horizontal inequities in ICP allocations by uninsured volume between public and private hospitals (including AMCs)

HOSPITAL NAME (TYPE)	UNINSURED VOLUME IN 2013 *	DIFFERENCE IN UNINSURED VOLUME	ICP ALLOCATION IN 2015	DIFFERENCE IN ICP
Vertical inequities				
Jamaica (private)	44,758	—	$34,624,358	**8x more**
North Central Bronx (public)	45,329		$4,104,450	(comparator)
Lutheran (private)	105,913	—	$43,120,295	**5x more**
Bronx-Lebanon (private)	108,471	—	$64,292,388	**7x more**
Lincoln (public)	99,075		$9,062,602	(comparator)
NY Presbyterian** (AMC)	86,913	—	$49,438,252	**6x more**
Montefiore (AMC)	73,811	—	$43,348,891	**5x more**
Jacobi (public)	80,337		$8,408,620	(comparator)
Horizontal inequities				
NY Eye & Ear Infirmary (private)	11,219	**17x less**	$7,048,981	—
Mount Sinai of Queens (private)	10,486	**18x less**	$6,903,393	—
Elmhurst (public)	187,143	(comparator)	$7,338,779	
NY Eye & Ear Infirmary (private)	11,219	**8x less**	$7,048,981	—
Mount Sinai of Queens (private)	10,486	**9x less**	$6,903,393	—
Metropolitan (public)	95,267	(comparator)	$7,073,427	
Vertical and horizontal inequities				
Memorial Cancer Hosp. (AMC)	899	**208x less**	$11,928,010	**$4.6 M more**
NYU Langone (AMC)	10,650	**18x less**	$12,019,160	**$4.7 M more**
Elmhurst (public)	187,143		$7,338,779	(comparator)

Vertical inequities refer to cases where hospitals provided similar numbers of uninsured services but had large variations in their ICP payments. Horizontal inequities refer to cases where hospitals received similar ICP payments but had large differences in the number of uninsured services provided. Differences in uninsured volume are expressed as a ratio between the private hospital/AMC and the public hospital, using the public hospital as a comparator. Differences in ICP allocations are expressed as either a ratio between the private hospital/AMC and the public hospital (for very large differences) or an absolute difference in dollar amount, expressed in millions of dollars (M, for smaller differences).

*Uninsured volume refers to the sum of total uninsured inpatient discharges (acute only) and outpatient visits and procedures (all service categories).

**NewYork-Presbyterian includes Lower Manhattan/Downtown Hospital. A dash (-) indicates no difference in ICP payment received or uninsured volume between hospitals.

Data source: New York State Department of Health workbooks.

BOX 1. ICP allocation methodology, showing hospital nominal need and payments based on statutory caps ($139m and $994m)

INDIGENT CARE POOL (ICP) CALCULATION:

1. **Uncompensated care:** Uninsured volume two years prior to allocation year x Medicaid rates
2. **SWAF:** Adjust by Statewide Adjustment Factor
3. **Net losses:** Reduce by patient collections
4. **Nominal need:** Adjust by nominal need* factor, which incorporates the Medicaid Inpatient Utilization Rate (MIUR)
5. **Payment based on statutory cap:** Allocate funds in proportion to total nominal need among all hospitals in group (% of total), and in proportion to total amount available for public ($139.4m) and private ($994.9m) hospitals
6. **Transition Payment Formula:** Apply floor and ceiling for hospital losses and gains relative to previous 3 years' allocations
7. **FACP:** Reduce ICP payments by Financial Assistance Compliance Pool (FACP) amount (1% of total Medicaid DSH)

ICP CALCULATION STEPS DEFINITIONS

4. **Nominal need:** Hospital uninsured volume multiplied by average hospital- and service-specific Medicaid rates, adjusted by the nominal need factor, which incorporates the hospital Medicaid inpatient utilization rate (MIUR)
5. **Payment based on statutory cap:** Hospital nominal need payments are adjusted by the total nominal need within the hospital group (public/private). Thereafter, funds are allocated in proportion to the total amount available for public hospitals (capped at $139m) and private hospitals ($994m).

EXAMPLE: A private hospital has a nominal need of $5m and the total nominal need for all private hospitals in the State is $500 m. The hospital's nominal need is therefore 1% of the total nominal need for private hospitals. The total ICP amount available (cap) for private hospitals is $994m; the hospital is therefore allocated 1% of $994m = $9.94m (before further adjustments are made in steps 6 and 7).

"m" refers to millions of dollars.

* Nominal need is also known as targeted need.

TABLE 5. ICP Transition Payment Formula (currently enacted 2013–2018)

YEARS	PUBLIC HOSPITALS		PRIVATE HOSPITALS	
	CAP ON GAINS (CEILING)*	CAP ON LOSSES (FLOOR)	CAP ON GAINS (CEILING)*	CAP ON LOSSES (FLOOR)
Year 1 – 2013	6.1%	2.5%	9.3%	2.5%
Year 2 – 2014	4.6%	5.0%	12.2%	5.0%
Year 3 – 2015	6.6%	7.5%	19.1%	7.5%
Year 4 – 2016	N/A	10.0%	N/A	10.0%
Year 5 – 2017	N/A	12.5%	N/A	12.5%
Year 6 – 2018	N/A	15.0%	N/A	15.0%

Percentages refer to the maximum allowed losses (floor) and gains (ceiling) for individual hospitals' ICP allocations under the new ICP methodology, relative to the average ICP allocations in the three years prior to the year on which allocations are based. *Ceiling amounts for 2016–2018 were not yet available (N/A) at the time of the data request, as ceiling amounts are calculated each year based on the total reported uncompensated care cost needs for all hospitals.

Data source: Medicaid Redesign Team Workgroup presentation;[54] Presentation by J Gahan & Choiniere;[55] New York State Department of Health workbooks.

[54] Medicaid Redesign Team (MRT) Payment Reform Work Group. Disproportionate Share Program (DSH) (New Yorker's Indigent Care). Presentation, Sep 27, 2011. Available at: https://www.health.ny.gov/health_care/medicaid/redesign/docs/2011-09-27_mrt_payment_reform_dsh.pdf, accessed March 2017.

[55] Gahan JW Jr, Choiniere D. New York Medicaid 101 Reimbursement Seminar, August 2015.

BOX 2. ICP hospital payment calculation, showing ICP payments based on statutory caps and adjustment by the Transition Payment Formula

INDIGENT CARE POOL (ICP) CALCULATION:

1. **Uncompensated care:** Uninsured volume two years prior to allocation year x Medicaid rates
2. **SWAF:** Adjust by Statewide Adjustment Factor
3. **Net losses:** Reduce by patient collections
4. **Nominal need:** Adjust by nominal need** factor which incorporates the Medicaid Inpatient Utilization Rate (MIUR)
5. **Payment based on statutory cap:** Allocate funds in proportion to total nominal need among all hospitals in group (% of total), and in proportion to total amount available for public ($139.4m) and private ($994.9m) hospitals
6. **Transition Payment Formula:** Apply floor and ceiling for hospital losses and gains relative to previous three years' allocations
7. **FACP:** Reduce ICP payments by Financial Assistance Compliance Pool (FACP) amount (1% of total Medicaid DSH)

ICP CALCULATION STEPS DEFINITIONS

5. **Payment based on statutory cap:** Hospital nominal need adjusted by group need (hospital need as a % of total need among group) and statutory cap amount available in group: $139.4m for public, $994m for private (see Box 1 for example).
6. **ICP payment adjusted by the Transition Payment Formula:** ICP allocation adjusted by floor and ceiling (see Table 5 above) relative to average hospital ICP allocations in the three years immediately preceding the year based on which allocations are calculated.

EXAMPLE: *A public hospital's ICP payment based on the group cap is $4m. Its average allocations in the three years prior to the year which allocations are based on (here 2013, i.e., 2010–2012) was $6m. The floor for public hospitals is 7.5% ($5.55m for this hospital) and ceiling 6.6% ($6.4m). As the hospital's ICP allocation before the Transition Payment Formula ($4m) is below its floor of $5.5m, the hospital's ICP payment gets lifted to the floor and is allocated $5.5m.

"m" refers to millions of dollars.

*This fictional example is based on the floor and ceiling in 2015 (see Table 5).

**Nominal need is also known as targeted need.

TABLE 6. New York City hospitals that met safety-net definitions based on inpatient volume

HOSPITAL		INSURANCE (% discharges)	
NAME	TYPE	UNINSURED	MEDICAID
Bronx-Lebanon, Fulton division	Private	0.2%	80%
Interfaith	Private	1%	77%
Woodhull	Public	9%	64%
Metropolitan	Public	11%	61%
Harlem	Public	10%	57%
Kings County	Public	11%	55%
Queens Hospital Center	Public	6%	60%
St Barnabas	Private	12%	54%
Lincoln	Public	5%	60%
North Central Bronx	Public	9%	55%
Elmhurst	Public	9%	54%
Bronx-Lebanon, Concourse division	Private	1%	62%
Jacobi	Public	5%	57%
Bellevue	Public	14%	48%
NY Eye and Ear Infirmary	Private	19%*	36%
Coney Island	Public	5%	49%
Flushing	Private	4%	50%
Brookdale	Private	6%	46%
Jamaica	Private	5%	47%
NY-Presbyterian, Allen Hospital	Private	2%	49%

Safety-net hospitals were defined as hospitals that devoted at least half (50%) of their inpatient volume to Medicaid and uninsured patients.[56,57] *It is suspected that many of these represent privately insured patients who pay out-of-pocket for elective health care services (such as cosmetic surgery), as this report defines uninsured patients as those with self-pay as their primary insurance type in the SPARCS database.

Data source: SPARCS 2014 inpatient discharge data. See Appendix 2 for details on how we classified patient insurance.

[56] Fass S, Cavanaugh S. New York City Hospitals' Finances Improve Overall in 2009, but Many Struggle to Survive. United Hospital Fund, Hospital Watch, February 2011. Available at: https://www.uhfnyc.org/assets/884, accessed March 2017.

[57] Commission on the Public's Health System (CPHS). Safety Net Hospitals in New York City. Last updated March 11, 2011. Available at: http://www.cphsnyc.org/cphs/What_We_Do/safety-net/MRT_CPHS_safetynethospitals_3_8.pdf, accessed March 2017.

Appendix 4: Indigent Care Pool Allocation Methodology

NOTE: The below formula is current as of date of publication (March 2017) and has been in use since 2013 (New York Codes, Rules and Regulations (NYCRR) Title 10 (Health) 86-1.47, Public Health Law (PHL) 2807-k(5-d)). The numbering of steps below may not necessarily correspond with the numbering of steps shown in Table B on page 7, which represents a summary of the full methodology shown below.

1.

Calculate total hospital uncompensated care in dollars two years prior to allocation year (e.g., uncompensated care in 2013 for 2015 pool allocations):

- Calculate total **uninsured units of services** separately for inpatient (discharges or days) and outpatient (visits or procedures) services.
- Multiply each individual service with hospital-specific inpatient and outpatient **Medicaid rates**, for total uncompensated care costs (UCC).
- Adjust total UCC by the **Statewide Cost Adjustment Factor (SWAF)**, separately for inpatient and outpatient, for the year two years prior to the allocation year.
  - SWAF is a ratio of: The sum of the total costs of uncompensated care at costs (units of service to uninsured x unit costs) for all hospitals, divided by the sum of the total costs of uncompensated care at Medicaid rates (units of services to uninsured x Medicaid rates for that service) for all hospitals. Thereby, it represents a factor that indicates how much higher actual costs of providing care were, relative to what Medicaid rates would have paid for providing these services.
- Calculate total uncompensated care **collections** from patients.
- Calculate **Net UCC** by reducing SWAF-adjusted total UCC by total collections from patients.

2.

Adjust net UCC by nominal need (targeted need) factor

- Calculate the **Medicaid Inpatient Utilization Ratio (MIUR)**, defined as the proportion (percent) of Medicaid patients, including patients dually eligible for Medicaid and Medicare, two years prior to the allocation year, in the inpatient setting (discharges).
- Calculate **nominal need factor**: 40% + (60% x MIUR).
- Calculate **nominal need** by multiplying net UCC by nominal need factor (e.g., net UCC $100,000 x nominal need factor 0.49 = $49,000 nominal need for hospital).

3.

Allocate dollars to each hospital in proportion to the total dollar amount available for hospital group

- Major public hospitals are allocated $139.4 million in total; allocation is a proportion of hospital targeted need relative to group total targeted need:
  - **Public hospital allocation:** (Hospital nominal need / sum of nominal need for all public hospitals) x $139.4m
- Voluntary (private) hospitals allocated $994.9 million (increased from $969.9 in 2012)
  - **Voluntary hospital allocation:** (Hospital nominal need / sum of nominal need for all voluntary hospitals) x $994.9m

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4.

Limit ICP allocations by transition formula (floor and ceiling)

- Prior to 2013, the ICP was calculated in proportion to allocations in 1996, and starting in 2013, allocations have been based solely on units of service provided (as shown above). To minimize the financial impact of the allocation methodology on individual hospitals, a transition formula was introduced that sets a floor (limitation on losses) and a ceiling (limitation on gains) for hospital ICP payments, relative to previous years' allocations (average of past three years). These are currently enacted until 2018 but may be extended:
  - **Floor** (same for public and voluntary hospitals): Increasing by 2.5% each year:
- 2013: 2.5%
- 2014: 5%
- 2015: 7.5%
- 2016: 10%
- 2017: 12.5%
- 2018: 15%
  - **Ceiling:** Different by hospital ownership, calculated to provide necessary funding to bring all hospitals below the floor up to the floor:
- 2013: **Public:** Approx. 2% - **Voluntary:** Approx. 10%
- 2014: **Public:** 4.6% - **Voluntary:** Approx. 12.2%
- 2015: **Public:** 6.6% - **Voluntary:** 19%

5.

Adjust by Financial Assistance Compliance Pool (FACP)

- Since 2013, 1% of total DSH distributions (of a total of $2.64 billion or $26.4 million) that are paid out as ICP payments are withheld in a Financial Assistance Compliance Pool (FACP). The New York State Department of Health has contracted with accounting firm KPMG to complete audits of a random selection of hospitals for years 2012 and 2013 (60 hospitals for 2012 audit) that were conducted in 2014 and 2015, respectively, for their compliance with the 2006 Hospital Financial Assistance Law (HFAL) through a self-administered paper survey. This law mandates that hospitals provide financial assistance to patients earning up to 300% of the federal poverty level so as to be eligible to receive funds from the ICP. 2014 was the first audit year, and hospitals found to be below the minimum compliance level (38 of 46 areas tested for 2012 audits; increasing to 44 of 49 areas tested for 2013 audits) were mandated to submit a corrective action plan and demonstrate substantial compliance; otherwise, funds were to be forfeited and reallocated.

6.

Adjust voluntary hospitals' allocations by voluntary upper payment limit (UPL) amounts

- Since 2013, voluntary hospitals have been provided an additional $25 million as part of the voluntary hospital UPL payment.
- **Final voluntary ICP hospital allocation:** Includes voluntary UPL amount, and the remaining ICP amount is paid as "other indigent care."

Appendix 5: Report Limitations

ICR data: Only unaudited versions of hospital ICRs were available (2013). It is a possibility that these data are slightly less accurate than audited ICR data; however, a former State administrator confirmed that large differences between audited and unaudited ICRs are unlikely (personal communication with report's authors). In addition, ICRs for public hospitals represent the State fiscal year, which runs from July to June. Most private hospitals, in contrast, report data for a calendar year that runs from January to December. For public hospitals, the 2013 data year represents 2012–2013 data, which may not be fully comparable to calendar year 2013 data reported by private hospitals.

Discrepancies between SPARCS and ICR data on hospital inpatient discharge volumes: In some cases, discrepancies were noted between inpatient volumes reported in SPARCS data and ICR data. For example, for Bronx-Lebanon, ICRs for 2013 reported nearly 2,000 uninsured patient discharges, whereas SPARCS data only reported ~200 (for both Fulton and Concourse divisions, all inpatient services combined). For this reason, comparisons of overall hospital volume that includes inpatient and outpatient services (using 2013 ICRs) may not be fully compatible with SPARCS 2014 inpatient findings. SPARCS 2014 data were downloaded in March 2016; however, the SPARCS database has since been updated (June 2016, last checked January 2017). It is therefore possible that unaudited ICR or SPARCS data contained errors. It is not clear which of the data sources is more reliable; however, it should be noted that ICR data form the basis upon which the New York State Department of Health calculates ICP allocations.

Hospital facilities versus systems: Most of this report's data sources, apart from SPARCS inpatient discharge data, reported data in a consolidated fashion for individual hospital facilities. For example, NewYork-Presbyterian health system consists of seven hospital facilities, five of which are in this sample (the remaining two are a children's hospital and a facility outside of New York City borders). NewYork-Presbyterian acquired New York Downtown Hospital in 2013 and renamed it NewYork-Presbyterian/Lower Manhattan Hospital. SPARCS 2014 analyses treat Lower Manhattan and Allen Hospital as private nonacademic hospitals, but Cornell and Columbia as AMCs. However, for ICR data, NewYork-Presbyterian and Downtown/Lower Manhattan hospitals are listed separately, whereas for ICP allocation data from New York State Department of Health workbooks, Lower Manhattan and all other NewYork-Presbyterian facilities are included in the NewYork-Presbyterian health system (reported in a consolidated fashion). The consolidation of individual hospital facilities into larger systems, and the differences in reporting between data sources (as individual facilities versus in a consolidated manner), may introduce some errors in the interpretation of this report's data.

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Other factors affecting hospital payer mix: Analyses of hospital payer mix and numbers of services provided to Medicaid and uninsured patients are descriptive in nature and do not consider factors that may affect hospital payer mix. For example, this report does not account for hospital location and neighbourhood insurance composition or patient clinical severity. For AMCs in particular, which are largely located in Manhattan and tend to care for more severely ill patients than other hospitals, these factors may have a large influence on the types of patients they serve (including Medicaid and uninsured).

Regional scope and ICP analyses: Analyses focus on hospitals in New York City. However, the State allocates ICP dollars to all hospitals in New York. Limiting analyses to New York City hospitals only (that represent approximately one-quarter of all hospitals in the State) may introduce errors in interpreting the relative influence of various steps in the allocation formula on the fairness of payments.

Other ICP methodology considerations that affect payments: This report provides a detailed analysis of only two of the steps in the current ICP allocation methodology: statutory caps for public and private hospitals and the Transition Payment Formula. There are additional factors that could impact ICP payments that are not considered in the analyses, such as the Statewide Adjustment Factor (SWAF, step 2 in Table B on page 7), collections from uninsured patients (step 3 in Table B on page 7), the relative nominal need of other hospitals in the group (step 4 in Table B on page 7) and the Financial Assistance Compliance Pool (FACP) reduction (step 7 in Table B on page 7). However, some of these provisions (SWAF and FACP) apply uniformly to all hospitals in the State, whereas the rest are anticipated to have only a small effect in determining ICP allocations.

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VOICE: 212-664-7656
FAX: 646-421-6029
MAIL: 1385 Broadway,
23rd Floor
New York, NY 10018
WEB: www.nyshealth.org