cphs*
COMMISSION ON THE PUBLIC'S HEALTH SYSTEM
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A New Proposal for Charity Care in New York State

This proposal contains three major recommendations:

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

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

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

Background

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

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

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

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

The Proposal

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

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

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

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

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

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

*We support the Principles of Medicaid Matters New York.

In addition, we believe that:

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

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

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

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

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

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

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

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