NYC HEALTH + HOSPITALS

New York City Council Hearing

Examining the Status of

"One New York: Health Care for Our Neighborhoods"

What Progress Has Been Made, and What Challenges Lie Ahead?

Committee on Hospital Systems

Mitchell Katz, M.D.

NYC Health + Hospitals

President

&

Chief Executive Officer

February 28, 2018

Good afternoon Chairperson Rivera and members of the Committee on Hospital Systems. I am Mitch Katz, M.D., President and Chief Executive Officer of the NYC Health + Hospitals ("Health + Hospitals").

This is my first City Council hearing and I am so honored to be here before you. I am a Brooklyn boy, a product of the New York City public school system. Growing up my family received their care at Coney Island Hospital and Kings County Hospital, and so I know how critical public hospitals are to the well-being of families and their communities.

At heart, I am a primary care doctor. I will begin my New York City medical practice as an outpatient doctor at our community health center on the Lower East Side, NYC Health + Hospitals/Gouverneur, as my New York State license came through last week and I have submitted my application for privileges. I will work as an inpatient doctor at all of our hospitals on a rotating basis. I love public hospitals and clinics and the people who work in them and the patients who come to them.
I can assure the committee members that Health + Hospitals is filled with mission driven doctors, nurses, social workers, pharmacist and other professionals. The quality of medical and nursing care provided at Health + Hospitals is excellent, and above the community standard. Every day our hospitals save the lives of critically ill patients in our emergency rooms, intensive care units, and hospital units. However, our system suffers from several serious problems related to access if you are not critically ill. And these access problems compound our financial problems because they discourage paying patients from seeking our care. I was charged by the Mayor to take the work on transformation to another level – to turbocharge it – in order to ensure long term stability and quality. I want to work with this Council and the Mayor to make the "system" as good as the people working in it.

To date, Health + Hospitals has been successful in reducing expenses and increasing revenue in order to lessen the budget gap. For example, through our work to standardize purchases and get the best price we can for products, we have saved more than $106 million over the past two fiscal years. By improving our billing and revenue collection processes, we have garnered more than $107 million in the last fiscal year. Most prominently, Health + Hospitals has managed personnel expenses closely over the past three fiscal years for savings estimated at more than $400 million. This is progress but more needs to be done.

My three top priorities are: invigorate and expand primary care, improve access to needed specialty care, and bring fiscal solvency to Health + Hospitals. By focusing on all three, we will better address community health needs, improve the patient

experience and maximize opportunities for new revenue. I am certain we can achieve these three goals.

A large body of evidence demonstrates that longitudinal care provides higher quality care at lower costs. Every clinician can tell you why. When you know patients over time, you know their preferences; you know how they respond to illness; you understand their social situation. And longitudinal relationships facilitate the healing role of therapeutic relationships. And you don't have to be a doctor to make a difference. One of the most therapeutic relationships I ever saw develop was between a middle-aged female receptionist in a San Francisco AIDS clinic and a frightened young man who came there for treatment.

We need to connect every patient in our system who has a chronic disease to a primary care provider. We need to expand primary care teams throughout our systems, including case managers, pharmacists, and community health workers to improve access, quality, and patient satisfaction. We will use the tools of population health management to ensure we are reaching all who need us.

We must also move swiftly to improve specialty care by shortening wait times. We will do this through an expanded electronic consultation system. This effort is underway now in 28 clinics at 4 facilities. Electronic consults enable primary care doctors to consult with specialists about the needs of their patients. They result in decreased wait times and more efficient specialty visits. We must also continue our work on our Call Center operations for scheduling our patients and directing them to the appropriate facility. When we expand our primary care capacity and have a robust electronic consultation system in place we will be able to successfully increase enrollment from insured persons, which will improve our revenues.

Our health plan, MetroPlus is a valuable asset for us. It provides us an important opportunity to enroll and provide care to new patients. Overall membership, as well as membership in the MetroPlus plan for city employees, has grown in recent months. While this is positive news, growth is only part of the equation. For MetroPlus to realize its potential, we need to improve access to care so that MetroPlus members can receive their care at Health + Hospitals facilities to the greatest extent possible.

As the Council knows from our budget hearings, our financial situation is precarious. As the City's largest single provider of care to uninsured patients, approximately 415,000 last year, we will always need help from the City of New York to support

the care of the uninsured. But that amount must be predictable and defensible as an appropriate subsidy for care provided.

Similarly, we will need continued support from the federal government to pay for care provided to our uninsured patients. Earlier this month, Congress delayed implementation of cuts to Disproportionate Share Hospital (DSH) funding for two years. This was a very welcome reprieve - albeit temporary - and I want to thank the members of New York's Congressional delegation and all of our elected officials who worked on this issue. This was an important victory for hospitals who see large numbers of uninsured patients. Moving forward though, it is important to remember that these cuts were not eliminated. Rather, Congress pushed the cuts out into the future and expanded the cuts dramatically to pay for the two-year delay. This remains a significant risk for Health + Hospitals.

As I think about the path forward for this system, I am a big believer in the adage of the nuns that created many safety net systems: there is no mission without a margin. For Health + Hospitals to be viable and to provide the services our community needs, we must take the following seven actions:

1. **Reduce administrative expenses.** In recent months, we have eliminated a number of consultant contracts, with an estimated savings of $16 million. You cannot fix public systems with outside consultants. We should use consultants to answer specific highly specialized questions. Otherwise we need people who live and breathe the Health + Hospitals mission and we need to focus our resources on doctors, nurses, pharmacists, social workers and the people that directly support them. Health + Hospitals has already decreased administrative positions to save $62 million and we will be decreasing further in the coming months so that we can devote more of our resources to the care of our patients.
2. **Bill insurance for insured patients.** As is true of many public systems, the history of Health + Hospitals is as a provider of care to the uninsured. But dating back to President Lyndon Johnson's creation of Medicare for older persons and Medicaid for the disabled, there has been an increase in the number of low income people who have insurance. This has been furthered through the ACA, which gave low income people who were not disabled insurance via Medicaid and the exchange. Health +Hospitals has been slow to learn how to bill. However, under our Interim President Stan Brezenoff, an effort on revenue cycle work was begun and is already reaping benefits. It will take us two to three years to fully realize this lost revenue.

3. **Code and document effectively so that we can receive the payment we deserve.** Billing insurance is not efficient unless the bills contain the information necessary to receive the full payment. Teaching people how to code records correctly can be the difference between fair payment from insurance companies and tens of millions of dollars in underpayments.

4. **Stop sending away paying patients.** In my nearly two months here, I have learned that in many different parts of our system we discourage or even prohibit the care of insured people. There is a widespread urban myth at Health + Hospitals that insured patients should be referred out so that we can focus on care for the uninsured. This results in lost revenue and Health + Hospitals paying outside providers for the care of our own MetroPlus patients.

5. **Invest resources into hiring positions that are revenue generating.** I understand that when you have a large deficit, people look at requests for new positions with skepticism. I certainly would in their position. But to get Health + Hospitals out of its current crisis, I need to hire revenue generating positions, including primary care doctors, nurse practitioners, pharmacists, and other specialized professionals. I am happy to present business plans that will meet the rigor of any financial analyst.

6. **Start providing those specialized services that are well reimbursed.** Health + Hospitals is the largest provider of behavioral health in NYC, and one of the largest providers in the country. These services are poorly reimbursed, but I am happy to do them because they fit our mission. What I do not agree with is the idea that we would not do services such as cardiac angioplasty that are well reimbursed. In the case of angioplasty, not only do we lose money when we need to send our patients elsewhere (we do this common cardiac procedure only at Bellevue right now) but ambulances with patients with chest pain have to bypass our hospitals because we are not providing the right mix of services.

7. **Convert uninsured people who qualify for insurance to be insured.** New York City has had success in increasing insurance for those eligible, but there is more that we can do to make it easier for patients to gain insurance. This helps them and helps us because insurance payments will be much larger than the copays low income uninsured people can afford.

If we succeed, with the help of this Council, the Mayor, our organized labor partners, and the incredibly dedicated staff of Health + Hospitals, in fulfilling these seven

entirely achievable goals, I believe we will be able to markedly resolve our financial issues. We will still face challenges from federal policy around DSH and we will continue to face unique costs of caring for our patient population, but I am confident that the system will be in a much stronger position.

Thank you for the opportunity to testify. I look forward to answering your questions and to partnering with you to help care for Health + Hospitals' patients in the years ahead.

FOR THE RECORD

Testimony

NY City Council Hospitals Hearing- One City Health

Thursday February 28, 2018

By Ralph Palladino, 2nd Vice President AFSCME DC 37 Local 1549

Thank you for these hearings. We have advocated for them for the last two years.

Local 1549 represents roughly 5,000 city tax payers and employees of the New York City Health and Hospitals (H+H) and its' HMO Metro Plus. I am a former Legislative Chair for the Bellevue Community Advisory Board; former member of Governor Spitzer's Healthcare Transition Team; employee and patient of Bellevue Hospital 37 years.

I choose to be a patient at an HHC facility. I have received excellent care in primary care and various specialties. The medical staff including nurses have always help keep me healthy. My life was saved in the Bellevue Emergency Room. The ancillary staff have always been helpful. These wonderful care givers have done a great job despite the obstacles they face.

It is a fact that the cost of care in HHC is higher than what Medicaid reimburses. Private insurance is a small part of H+H's income. The state Hospital Indigent Care Pool does not fund H+H adequately. Disproportionate Share (DSH) funding though saved from elimination recently is still scheduled to be ended in a couple of years.

The state's distribution of DSRIP funding and Medicaid dollars is not fair to H+H. The financial support should be proportionate to the needs of the institution based on the number of indigent and Medicaid patient load.

Why does a disproportionate share of this funding go to "non-profit" private institutions most of whose CEO earn upper amounts of hundreds of thousands of dollars? Some earn millions of dollars.

H+H has an overhead of 3 to 5%. It is far more efficient than the private sector. Yet the delivery of services is excellent. Yet we are treated unfairly in state funding.

H+H is a network of institutions are of critical importance for health care for people that need it most. This network employs thousands of tax payers. In addition employees' and patients support for small businesses located near H+H facilities is critical to their survival. H+H's survival is about the survival of employees, patients and the economy of New York City.

What Employees Go Through

Our employees should not have to feel panicked about hearing that H+H is having trouble meeting its payroll as it was recently. It is amazing that we can continue to do more with less in such a professional and caring way when something like that is hanging over our heads.

Our Local's members are the first people that the public sees when coming through the doors. Our Client Navigators provide information to patients and the public. They also can translate. Financial Counselors (Clerical Associate level IV and V) provide insurance information. Those who register patients also make appointments for them. They provide phone information, admitting of inpatients. Medical records maintenance and Medical Correspondence for patients and court proceedings are handled by our members. The list of what we do to serve patients and generate revenue is long. We are understaffed and in some areas severely.

Some of our jobs have been taken over by higher paid and too often non-civil service employees. This is a waste of H+H and taxpayers funds. In some cases managers do our work.

Our members in Metro Plus HMO work long hour signing up people for health insurance. But too often new sign ups leave since they have to wait too long for their appointments. Our understanding is that the wait is 3 to 6 months.

What a patient goes through

Unfortunately the lines of people and waiting times for patients on the phones are also long. Too long. This is due to short staffing. I should not have to wait four months for my primary care appointment and almost three months for my specialties appointment. The scheduling has improved at Bellevue Hospital somewhat but I still have to make appointments far in advance.

I can document to you how many times I have tried getting through the call centers to make appointments. Aside from waiting for appointments we wait a long time to speak to a call center person to make an appointment. Unlike private facilities we cannot ever get through directly to a provider service area. Once in the clinic to see the doctor after registering. I had to wait two hours in a clinic one time just for a blood pressure check from a nurse. The waits in the emergency rooms are too long. Emergency rooms are at times overcrowded because of the long wait for clinic visits.

H+H thanks to negotiations with DC 37 has reduced the number of office temps working in clerical jobs. But the temps left have been there longer than they should. In one hospital I know of all the staff are private temps. H+H says this is necessary in order to save money.

I do not want my Medical Record numbers and other private data such as address, insurance carrier, etc in the hands of temporary employees not employed by H+H. Proper vetting can only really be done by having full time paid H+H performing the functions of patient appointments, registration, financial counseling, etc. H+H says that temporary employees are also vetted. But having worked for a temp agency I know how far that really goes.

All the translation services are outsourced or performed by either non-employee volunteers or employees who volunteer. This is problematic. H+H should have resources to hire the amount of properly trained and licensed translators needed. Proper translation is done face to face. This is documented by a NY Immigration Coalition study that is online and I know it since I worked in Ambulatory Care.

Give What is needed: <u>Support Public health and Genuine partnership with management.</u>

The Delivery System Reform Incentive Payment Program-DSRIP, is supposed to be playing a critical role in changing and reforming the H+H system. It is supposed to be a partnership between management and labor. In fact it has been a one-way street in practice whereby management announces all the changes to us. That is how this "cooperative" venture has worked.

We hope that under a new regime at H+H this will change. Our ideas are based on our working in the institutions and being served by it as patients. Next to the patients we have the biggest stake in making sure H+H improves and survives.

The plight and needs for public health institutions like H+H is critical in this time of healthcare transition. Do you want lower costs? If so then no one beats H+H. Do you want quality? H+H provides it but can do much better by getting the proper support it needs and deserves.

The City Council's assistance in reaching out to the state for financial support fairness is welcomed. Hopefully with your assistance we can get the support we need and deserve. The city began doing its part two years ago. Now even more must be done.

cphs*

*putting the public back in public health

February 28, 2018

Commission on the Public's Health System Testimony at Hospital Committee Oversight Hearing on status of "One New York Health Care for Our Neighborhoods".

Good afternoon, my name is Anthony Feliciano, Director for Commission on the Public's Health System (CPHS). The public hospitals are paramount to New Yorkers, especially low-income, immigrant, communities of color and other underserved communities, being well and successfully contribute to the city.

We want to congratulate Councilwoman Rivera in her appointment to a critically needed committee to address all hospitals within the health care system. We also welcome Dr. Mitchell Katz to New York City and welcome his leadership in working with communities, health care advocates and community based organizations like us, and labor to ensure a stronger and better resourced public health safety-net system.

We understand that HHC is striving to transform their care delivery systems and comply with the various health care reforms against a backdrop of unprecedented financial challenges. While we understand that the hearing is focused on One New York Health Care, the role HHC plays in New York City's health care infrastructure and access to health care for all New Yorkers is key.

We hope that this Hospital Committee along with other committees could work with underserved communities, CBO's and labor to change the narrative of New York City's tale of two health care systems, in which the wealthy and those with better insurance coverage receive VIP care and others face obstacles to timely care and lesser quality services. This disparity disproportionately affects low income and working class neighborhoods, immigrant communities and people of color. We have a public health system that serves all and a private voluntary system that serves the few

I do want to be clear that they are voluntary hospitals who are true safety-net providers and they too like NYCHH absorbs systemic social costs that other private voluntary hospitals are able to avoid or evade. This is the cause of the large losses of the public system and the profits of the private hospitals. NYCHH provides a disproportionate share of the care provided to people who are uninsured and on Medicaid. NYCHH hospitals provide care to people of color at much higher rates than nearby private facilities (Bellevue and NYU Langone, for example, are located adjacent to each other in lower Manhattan – Bellevue's patient population is 82% non-white, while NYU Langone's is 35%).

New York State has a federally funded Indigent Care Pool (ICP) that is set up in 1996 "with the explicit goal to redistribute dollars to hospitals 'according to their level of need due to providing charity care." An analysis of ICP pool spending for private hospitals in 2016, shows that, in the vast majority of cases, how much a hospital received had nothing to do with how much care it provided -- to the poor or anyone else. (Funding Charity Care in New York: An Examination of Indigent Care Pool Allocations Roosa Tikkanen. March 2017 New York State Health Foundation).

This situation is unacceptable. The private providers must be forced to do their fair share.

The City Council needs to push for Fair Distribution of State and Federal Funding. Pressure must be mounted on Governor Cuomo to sign the Enhanced Safety Net Hospital legislation (A7763 (Gottfried) and S5661B (Little) passed by the legislature in 2016 and 2017 to increase reimbursement levels for public hospitals and private safety net providers.

The City Council should make it a priority to create a more comprehensive uninsured care program that builds off ActionHealth NYC. ActionHealth NYC and the Mayor's Taskforce on Immigrant Health Care Access recommended a direct access program for uninsured immigrants and nothing has come of it since and the ActionHealth NYC pilot was canceled. A real, funded uninsured care program would have a big impact on H+H so should be again on the City Council's and this Committee's radar.

The City of New York must take a more assertive role in setting local health care priorities, based on comprehensive local needs assessments, and demanding that all providers work cooperatively to meet the health care needs of the People of the City of New York.

The City should establish local health planning bodies to systematically analyze health needs, set City-Wide health care priorities and coordinate efforts by public and private providers to address and meet these needs at a holistic or systemic level.

In carrying out these functions, the local health planning bodies should include not only elected or appointed representatives of government bodies and agencies, but should also allow wide democratic input by local communities, patient and community advocates, front line health care workers and other service providers.

Both the Mayor' administration and H+H have developed and released reports (One City NY & Vision 2020). The plans in the report fall short in the following ways:

- Addressing understaffing at H+H facilities
- Identifying resources and funds to expand services (primary care)
- Details on long-term solutions to systemic issues like reduction of wait times for both medical and specialty services.
- Better Connecting and integrating recommendations and projects required under the current New York State approved Medicaid waiver program called DSRIP. Right now, changes are being tested and developed on how New York State delivers its own Medicaid-funded programs and delivery of health care.

We along with other advocates have been also concerned with the inconsistency of NYCHH and the Mayor's office to include community and labor in the decisions around our public hospitals. We hope that NYCHH creates a more transparent, inclusive and participatory restructuring process. The ongoing effort to restructure NYCHH is based on the false premises that NYCHH is too costly or inefficient in providing care and that the solution to its financial crisis is to cut costs, reduce staffing and eliminate money losing services. NYCHH is thus analyzing and planning service changes with little or no information to or input from the public, the community or health care workers. This

approach is doomed to failure, with potentially severe consequences to our entire health care system. Any restructuring of NYCHH must be based on a holistic analyses of the role of NYCHH within the broader health care system in New York and must give a direct voice and democratic input to the people and the communities that will be affected by any changes to the system.

NYCHH must stop using financial problems as an excuse to reduce health care staff or close vital services – any changes in staffing or health services must be based on community needs and not financial considerations.

NYCHH must conduct any restructuring with complete transparency and should make available to the public all relevant analyses, data and performance standards that are being used in this process.

The affected communities, patients, health care workers that will be affected by any restructuring efforts must have a direct role in formulating any proposed changes in NYCHH structure or services.

The decision making process for any changes to the system must be conducted with real and meaningful public input before any changes are decided upon or implemented.

Finally, we need more assurances for all New Yorkers, especially low-income, immigrant and communities of color that there will be no public health facilities closures or reductions in vital community health services.

Thank you!

Testimony for NYC Council Hospitals Committee Hearing on behalf of Henry Garrido, Executive Director, District Council 37, AFSCME, AFL- CIO Wednesday February 28th

Chair – Carlina Rivera,

Good afternoon, Councilmember Rivera and members of the Committee. We are pleased that the council created a committee to examine and oversee NYC hospitals, both public and private. Health care is a major economic sector in NYC. Improving the successful provision of health care is an important goal for improving the health and well being of all New Yorkers.

In this hearing we are focusing on the NYC Health and Hospitals system, where 18,000 of our union members work every day and night. In order to stabilize the financial health of NYC H & H, the Mayor invested nearly $1B in tax levy money to support the ongoing provision of care since 2016. In exchange, the city wanted to see reform and transformation in the system. We have seen progress as well as some difficulties in the process so far.

On the positive side:

No workers have been laid off, true to the Mayor's commitment. He, and the City Council recognize the critical value of the over 35,000 workers who care for our fellow New Yorkers every day, whether in the labor and delivery room, the emergency room or the mental health clinics. Without these workers, the care for low income, medically needy and uninsured would not take place at nearly the rate it is now, and would not have as good outcomes as we provide.

The use of temporary workers is down across the system. Permanent workers provide stable care with knowledgeable, dedicated staff.

There has been limited movement or redeployment of staff, mainly due to consolidation of small programs or to centralization of Finance and Supply Chain. Sometimes there is a change in physical location but often only a change in cost center and reporting structure. It will eventually affect layoff units as a person's seniority moves from the facility to the central office unit. Initial recommendations of the Blue Ribbon Commission includes possible closings of facilities which would be incredibly disruptive to the system. Instead, there has been a more careful look at the services and where they can best be provided efficiently.

The main criticisms:

There is continued reliance on consultants instead of directly engaging workers and managers together on areas to improve. Consultants develop plans which are poorly communicated to the facility level.

There is heavy reliance on overtime or not staffing areas at all. Areas that are direct patient care are not subject to a hiring freeze but there are lengthy delays in hiring. Areas that NOT direct patient care do not usually get any replacement of lines when there is a retirement or separation.

Many staff complain of stress due to overwork, not approved for vacation time, managers that are disrespectful.

Managers are more scared than every after several hundred were laid off or bumped back. Many high level staff have retired taking their institutional knowledge with them.

There are high number of provisionals (staff who have not been appointed from a civil service list) in clerical titles. Little progress is made to move existing provisionals into permanent lines, even if they are already working.

Challenges

The flu crisis is testing the limits of many facilities. It is also evidence of the critical need for H & H, the system that serves everyone, regardless of ability to pay, in order to protect overall public health and reduce the impact of greater spread of flu. The rate of staff immunization is much improved over last year. 92% this year, 75% last year. Our members are aware in these short staffing times they must be extra careful not to get sick and further stress their co-workers.

The Federal Budget – planned cuts as a result of lower DSH payments tied to the Affordable Care Act have been postponed but may come eventually and be over 1.2B.

The State Budget – Over and over it has been proven that NYS provides more funds to hospitals that provide less care to Medicaid and uninsured patients. Yet the inequity continues, directed by Albany and the powerful lobbies of the voluntary hospitals. This year's Executive Budget continues to shift costs back to NYC and to require more services for less reimbursement.

We strongly urge you as Council members to weigh in at the State legislative and Executive level to pass once again the fair funding of safety net funds, and to press for equitable distribution of any conversion or windfall funds. Health and Hospitals, as you will hear many times, provides more care, and better care, to the low income and uninsured populations of this city. As income inequality in NYC rises, we must address

ways to provide health care, including primary and preventative care, and is must be provided by workers who themselves have steady, reliable jobs with good wages and benefits.

I will close with this brief story.

Last November, on a cold and snowy day, Woodhull Service Aide William Vega saw a woman in heavy labor getting off the bus in front of the hospital. He ran inside and got a wheelchair and brought her directly up to the labor and delivery floor where she delivered in front of the nurse's station. His quick action saved her from delivering in the freezing cold parking area. (from DC 37 blog) He is but one example of the the dedication of all of our members to the H & H system. We must be protect these workers and patients for the good of us all.

Testimony of the United Hospital Fund to the Council of the City of New York, Committee on Hospitals: Oversight - Examining the Status of "One New York: Health Care for Our Neighborhoods": What Progress Has Been Made and What Challenges Lie Ahead?

Chad Shearer, JD, MHA, Vice President for Policy, Medicaid Institute Director
Misha Sharp, Research Analyst
February 28, 2018

The United Hospital Fund (UHF) is an independent nonprofit organization dedicated to building a more effective health care system for every New Yorker. Since 1879 UHF has helped solve vexing problems in the health care system, collaborated on addressing critical health care issues facing New York, and along the way facilitated the creation of many of the organizations and institutions that today help define the city's health care landscape. Our current priorities include promoting quality and efficiency in a changing health care delivery system; ensuring universal, affordable and comprehensive access to coverage and health care services; and fostering collaboration between the health care delivery system and community-based social services to improve health and well-being.

We thank the Council for the opportunity to testify. UHF has always been concerned with the sustainability of the health care safety net, all the way back to our original roots organizing charitable support for voluntary, nonprofit hospitals in New York City. A thriving NYC Health + Hospitals (H+H) is vital to the overall success of the health care delivery system in New York. However, due to federal, state, and local pressures, as well as the rapidly changing health care environment, H+H is currently facing one of the most challenging times in its history. UHF's recent work in Medicaid, health insurance, primary care transformation, quality improvement, and clinical-community partnerships, provide unique insights for the Council to consider as it assesses the issues *One New York Health* was designed to address.

The Changing Landscape of Coverage and Access

More New Yorkers have health insurance now than ever before due to the Affordable Care Act, but there are still more than one-million uninsured across the state, a large majority of which reside in New York City. Theoretically, the growth in coverage should have been a boon for H+H, increasing the number of patients served that have insurance, thereby reducing the amount of charity care and associated uncompensated costs. However, because Medicaid hospital

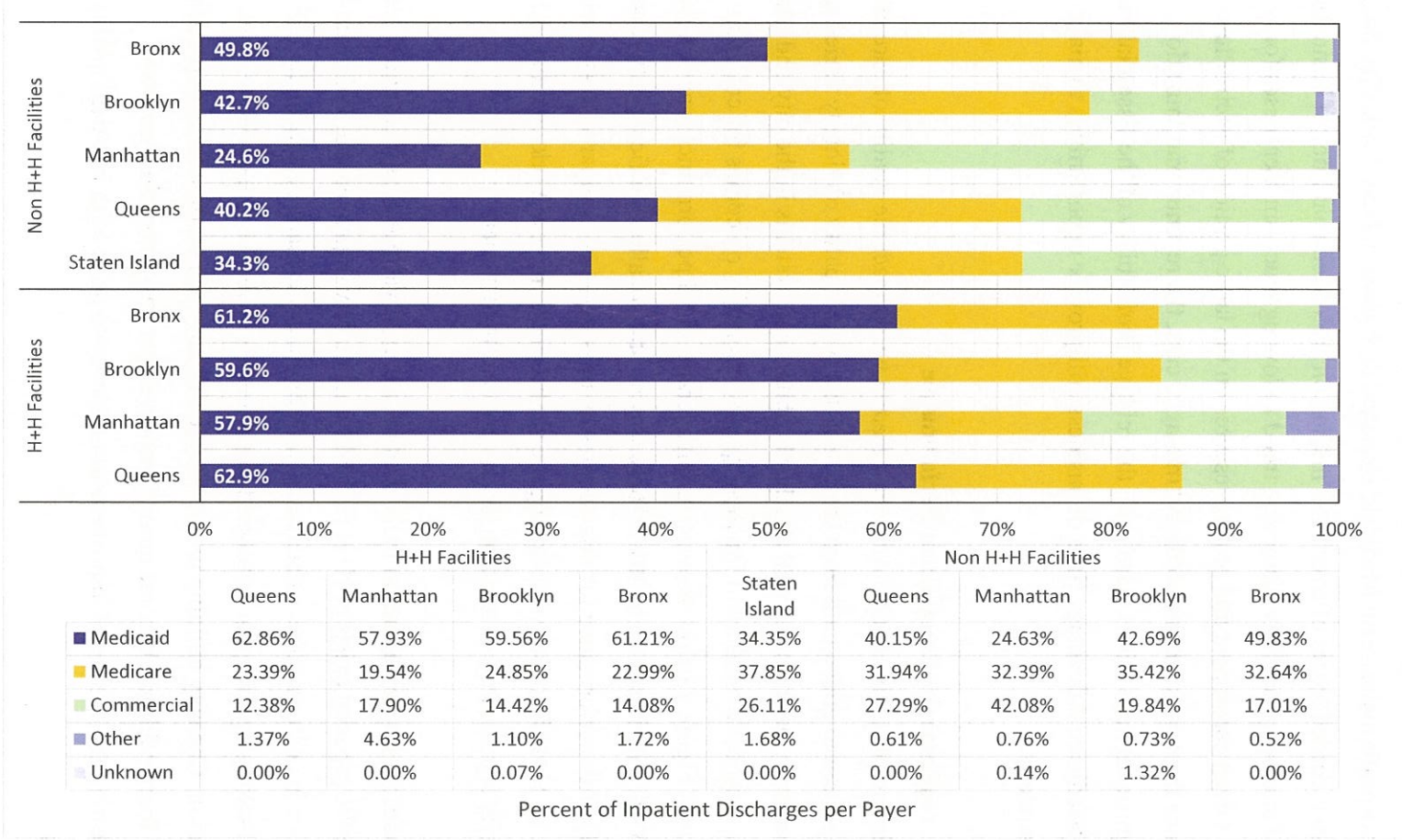
reimbursements do not fully cover the cost of providing those services, an increase in Medicaid payer-mix alone would be insufficient even with reduced uncompensated care costs. The data suggests this is what has happened at H+H.

UHF analyzed the payer-mix of hospital discharges at H+H facilities compared with all other hospitals in the city. The 2016 data presented in Figure 1 below show that a much higher percentage of discharges at H+H facilities were covered by Medicaid than at other hospitals across the city. The difference in Manhattan was particularly stark with Medicaid making up 57.9 percent of discharges at H+H hospitals compared with 24.6 percent at all other Manhattan hospitals. When comparing 2016 discharges by payer for H+H facilities with the same data from 2013 (not shown) in all boroughs, the percentage of discharges covered by Medicaid increased for H+H hospitals while the percentage of discharges covered by commercial insurance decreased. Despite the overall decrease in the number of uninsured New Yorkers (which did decrease the uncompensated care represented in the "other" category for H+H between 2013 and 2016), the overall payer-mix and high percentage of Medicaid patients remains a fiscal challenge for the system.

Part of the strategy for *One New York Health* is to enroll eligible individuals in coverage when they touch the H+H system. Through UHF's work with H+H on its Options charity care program,[1] we know that the historical connection of patients to coverage has varied greatly across H+H facilities. While there is likely still room for improvement enrolling eligible patients in coverage, most of this enrollment would be in Medicaid, so these efforts alone are unlikely to turn the financial tide for H+H. Increasing the number of Medicare and commercially insured patients that choose H+H facilities may be a valid future goal, but achieving that goal is likely dependent on the success of many other strategies elucidated in *One New York Health.*

[1] H+H Options is a payment plan to help individuals and families who have no other health insurance options, reducing fees to an affordable amount based on family size and annual income. In 2015 and 2016, UHF provided grant funding to H+H to assess and consider opportunities for improving H+H Options. Throughout the grant period, UHF was engaged in helping H+H understand its current Options program, uninsured utilization, and costs. During the process it became clear that efforts to connect patients with available coverage and the Options program varied across H+H facilities. UHF has not followed any process improvements made by H+H as a result of our grant funded work that may have improved enrollment in available coverage since 2016. The decrease in "other" payers (mostly uninsured) between 2013 and 2016 could be a combination of H+H operational improvements and broader coverage outreach associated with the Affordable Care Act.

Figure 1. Inpatient Discharge Payer Mix for H+H Facilities versus Non-H+H Facilities by New York City Borough, 2016



	H+H Facilities				Non H+H Facilities				
	Queens	Manhattan	Brooklyn	Bronx	Staten Island	Queens	Manhattan	Brooklyn	Bronx
Medicaid	62.86%	57.93%	59.56%	61.21%	34.35%	40.15%	24.63%	42.69%	49.83%
Medicare	23.39%	19.54%	24.85%	22.99%	37.85%	31.94%	32.39%	35.42%	32.64%
Commercial	12.38%	17.90%	14.42%	14.08%	26.11%	27.29%	42.08%	19.84%	17.01%
Other	1.37%	4.63%	1.10%	1.72%	1.68%	0.61%	0.76%	0.73%	0.52%
Unknown	0.00%	0.00%	0.07%	0.00%	0.00%	0.00%	0.14%	1.32%	0.00%

Source: UHF Analysis of All Payer Hospital Inpatient Discharges by Facility (SPARCS De-Identified): Beginning 2009. Accessed February 20, 2018: https://health.data.ny.gov/Health/All-Payer-Hospital-Inpatient-Discharges-by-Facilit/ivw2-k53g/data

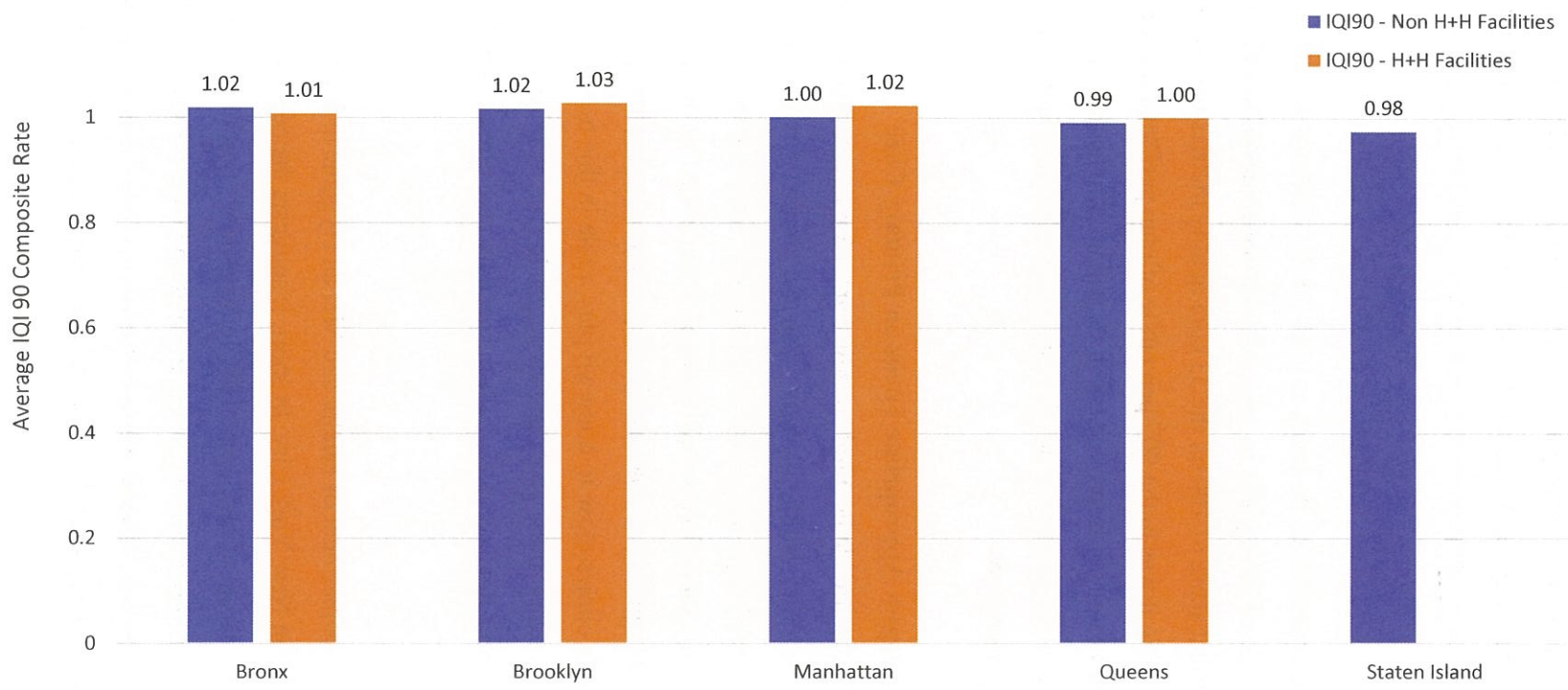
On the H+H as insurer side, there are also pressures making it difficult to deliver on the *One New York Health* strategy to maximize revenue through MetroPlus. Enrollment in MetroPlus' Mainstream managed care plans decreased from 385,900 to 380,600 from January 2017 to January 2018. Non-profit mainstream Medicaid managed care plans in New York City (inclusive of MetroPlus) also recorded losses of over $153 million on their Medicaid lines of business in 2016, evidence of another potentially disturbing trend following much smaller losses (only $22 million) in 2015. Given enrollment and profit pressures on the large portion of MetroPlus business that comes from mainstream Medicaid managed care, the revenue maximization strategy faces significant head winds. That said, the relative profitability of the Essential Plan, Marketplace and Medicare Advantage lines of business still provide opportunities to make progress on this strategy.

Quality as a Pre-requisite for Long-Term Performance

Many of the goals and strategies in *One New York Health* will impact the quality of care at H+H facilities. It is important to understand from the outset that while quality obviously varies across facilities, H+H generally performs as well as other hospitals and systems in the city and across the state on a key composite measure of inpatient quality, mortality outcomes for common inpatient procedures. Figure 2 below shows that, on average, H+H performance was comparable with other New York City hospitals in 2015. There was no statistically significant difference in individual H+H facility performance for this composite measure when compared to statewide performance, but no H+H facilities were among the six hospitals in New York city that did perform statistically significantly better than the statewide rate that year.

There remains room for improvement on individual measures at various facilities, and there is reason to believe the capacity exists at H+H for additional quality improvement. For years H+H leadership and staff have been active participants in UHF quality initiatives, especially our Clinical Quality Fellowship Program conducted in partnership with the Greater New York Hospital Association. Capacity building programs like this have long term effects in participating organizations, as former fellows become quality improvement champions in their own organizations, creating the culture of improvement necessary to drive high inpatient quality composite scores.

Figure 2. Average Inpatient Quality Indicator Composite (IQI 90) for H+H Facilities vs. Non-H+H Facilities by New York City Borough (Oct. 2014 - Sept. 2015)



Note : IQI composites summarize quality metrics across multiple IQIs, and IQI 90 composites compile mortality rates for selected procedures like CABG mortality rates or hip replacement mortality rates. They are the weighted average of the observed-to-expected ratios for the selected IQIs calculated using a multistep process. ***Lower rates represent better results.***

Source: UHF Analysis of All Payer Inpatient Quality Indicators (IQI) Composite Measures by Hospital (SPARCS): Beginning 2009. Accessed February 26, 2018: https://health.data.ny.gov/Health/All-Payer-Inpatient-Quality-Indicators-IQI-Composi/ba3n-bkk4

Unfortunately, similar universal measures for outpatient quality at the individual practice level do not exist, but we do know from the hospital discharge data that there are many inpatient stays for ambulatory sensitive conditions citywide that could arguably be avoided through better, more coordinated outpatient care.

MetroPlus also performs well in comparison to its peers, at least for its Medicaid line of business. In 2016 MetroPlus was one of three plans in the top performance tier of the Medicaid Quality Incentive program. Its perfect score of 100 on the 33 core quality metrics was unique among plans across the state, meaning it was in the 90th percentile of plan performance for each of the measures. MetroPlus still has room for improvement in its patient satisfaction scores, and on prevention quality indicators measuring hospital admissions that could likely have been avoided through high quality outpatient care.

Shifting Care Delivery Trends Suggest Appropriate Focus on Primary Care

For the year ending January 2017, nationwide hospital spending grew 3 percent, down from 5.7 percent growth in 2016. At the same time, ambulatory physician and clinical services grew 5.3 percent. This may be the first real sea change in the data reflecting the long-awaited reality that more and more services and spending going forward will happen outside the four walls of hospitals. Advances in surgical techniques, the broad availability of ambulatory imaging and labs, and patient desire to get care in clinics close to home all play a role in this trend. Given this growing reality, it makes sense that many of the goals and strategies in *One New York Health* recognize the need for improved ambulatory services, both in specialty care clinics and the primary care network.

In 2016 UHF collaborated with the Department of Health and Mental Hygiene to lay out a strategy for improving primary care in New York City. In short, it suggests the need for movement towards a medical home model of care, especially in high-need communities. Figure 3 below identifies high need communities based on several population health indicators. The communities identified (most of the Bronx, Harlem, central Brooklyn, Coney Island, Staten Island's north shore, Jamaica, and the Rockaways) are well known pockets of poor health.

Figure 3. Figures from: *A Strategy for Expanding and Improving the Impact of the Medical Home Across New York City*

Figure 1. Map of New York City's Community Districts by Health Zone

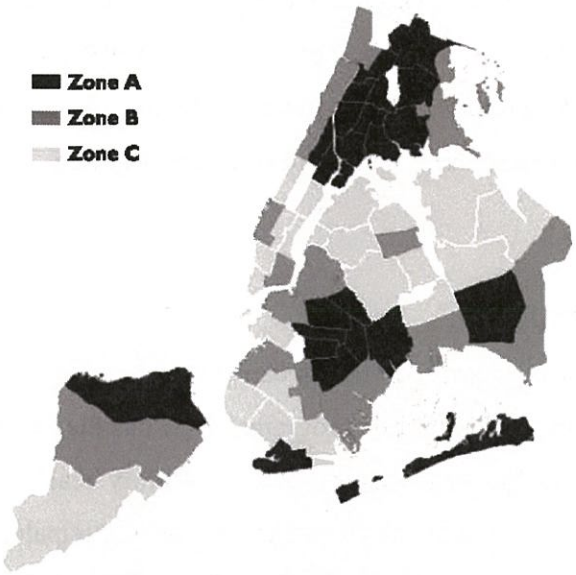


Figure 2. New York City "Health Zones" by Population Health Indicators

	Zone A Mean (min, max)	Zone B Mean (min, max)	Zone C Mean (min, max)	NYC Total Mean (min, max)
Disease Prevalence *(CHS 2013)*				
% Asthma	15.6 (9.2, 20.6)	12.3 (7.3, 15.6)	9.6 (5.5, 14.2)	12.6 (5.5, 20.6)
% Hypertension	33.8 (30.1,37.9)	27.6 (18.7, 32.6)	24.0 (16.6, 31.9)	28.7 (16.6, 37.9)
% Obesity	31.2 (26.8, 35.4)	23.4 (10.4, 34.3)	17.2 (8.3, 30.2)	24.2 (8.3, 35.4)
% Diabetes	13.8 (9.5, 17.7)	10.7 (3.7, 15.2)	7.4 (3.4, 13.8)	10.7 (3.4, 17.7)
Avoidable Hospitalizations *(SPARCS 2012)*				
Asthma (per 100,00)	484.1 (217.2, 785.9)	198.2 (114.2, 280.8)	106.0 (45.6, 230.6)	276.8 (45.6, 785.9)
Hypertension (per 100,00)	178.0 (115.5, 316.7)	98.3 (64.9, 136.4)	60.1 (20.4, 101.2)	115.8 (20.4, 316.7)
Diabetes (per 100,00)	532.8 (334.8, 748.1)	273.7 (155.9, 381.4)	151.2 (54.5, 314.1)	331.1 (54.5, 748.1)
Social Determinants of Health *(ACS 2013)*				
% Foreign-born	34.6 (19.0, 55.0)	36.7 (20.0, 66.0)	37.7 (15.0, 63.0)	36.2 (15.0, 66.0)
% Limited English Proficiency	22.0 (8.0, 46.0)	23.1 (9.0, 53.0)	23.0 (6.0, 48.0)	22.7 (6.0, 53.0)
% Below FPL	30.3 (17.0, 44.0)	19.5 (9.0, 30.0)	14.0 (6.0, 32.0)	21.8 (6.0, 44.0)
% Black or Hispanic	82.6 (30.0, 98.0)	49.7 (17.0, 78.0)	23.0 (8.0, 70.0)	53.0 (8.0, 98.0)
% with Less than HS Diploma	28.0 (16.0, 45.0)	20.0 (5.0, 42.0)	14.0 (3.0, 31.0)	20.9 (3.0, 45.0)
Behavioral Health *(SPARCS 2013)*				
Psychiatric Hospitalizations (per 100,000)	986.0 (554.0, 2016.0)	592.5 (385.0, 989.0)	415.5 (259.0, 891.0)	682.9 (259.0, 2016.0)

Transforming primary care isn't easy, especially in high-need communities, but H+H appears to be leveraging available resources to make positive strides. The Medicaid Delivery System Reform Incentive Payment (DSRIP) program provides incentives for OneCity Health to move its associated primary care practices towards a medical home model. The integration of behavioral health services in primary care is also a project OneCity Health is pursuing under DSRIP, which is one of the most important components of creating high functioning medical homes. Given the map and health indicators noted above, it would make sense for H+H to consider targeting efforts in those communities first.

Becoming a Broader Force for Community Health

Social determinants of health may be the latest buzz word in the health care system, but as a public hospital with inherent connections to so many other public programs, H+H has the unique opportunity to address social determinants in a way that broadly improves community health. Over the past year pediatric clinics at Gouverneur and Coney Island hospitals have participated in UHF's Partnerships for Early Childhood Development program. Through this effort they have started screening young children and their families for social needs that could impact healthy early childhood development. Working with partner community-based organizations, the clinics have ensured that the children and families get connected with services to address those social needs. This effort, along with certain DSRIP projects, and a strategic decision to focus on population health, bodes well for H+H to make exponential progress in this space over the next few years.

H+H is currently pilot testing social determinants screening tools in three hospital-based clinics, to get a better understanding of the resources necessary to integrate these screens into practice workflows and the social needs of their patients. If successful, the screening approach would be ripe for spread to the entirety of the ambulatory system at H+H. Understanding the coming need for a broader connection to community-based organizations to help address identified social needs, H+H is also testing the use of a new technology tool called NowPow, that makes it easier for practices to "prescribe" social services for their patients and make direct referrals to those services. Eventually, the technology could be used to conduct referrals, track the social services provided, and provide information back to H+H practices on what services patients received in

the community. Success will depend greatly on getting community-based organizations connected with and trained on the technology, which is why H+H's coordination with other health systems using the same tool in their DSRIP programs is a very positive sign.

Addressing social determinants will not be easy. We know from our work with pediatric clinics that there are substantial challenges, not the least of which is sharing information electronically. Developing partnerships with community-based social service providers is time-consuming and requires a personal touch and understanding of each other's goals, capacities, and challenges. An electronic connection, no matter how good, cannot replace the need for people talking with one another for the specific purpose of trying to meet the needs of a patient or group of patients.

As H+H embarks on this journey towards the social determinants of health, it must take advantage of many of the agencies and other resources across the city that are working toward the same goal. The DOHMH, NYCHA, DHS, DFTA and many others should be partners in this work. This requires thoughtful and efficient collaboration on all sides, focused on the shared goals of improving community health and well-being, and getting beyond the turf-battles associated with "my people" or "my programs" thinking. The Council can play an important role in helping to break down the silos and encouraging collaboration across the programs it oversees that can be helpful to the ultimate success of the whole of the *One New York* strategy.

Conclusion

The goals and strategies of *One New York* are consistent with how UHF sees the health care delivery system moving over the next decade. As the shift towards value-based payment and away from paying for volume continues, it will be necessary to deliver wholesale on those goals and strategies in order to prove value to payers and patients alike. While this is no small task, there are many positive signs that H+H is on the right path, but substantial challenges remain. In addition to the operational realities, there are also major externalities (e.g., uncertain federal policy pressures) that may add new challenges moving forward. UHF encourages the Council to remain data-driven in its assessment of progress and ongoing challenges. It is always important to remember, however, that the public hospital system in New York City provides a unique

public good that benefits all citizens and hospitals, and can't always be measured in services provided, or dollars and cents.

Thank you again for the opportunity to testify. Moving forward, UHF hopes to be a trusted and independent source of information for the Council on many issues coming before this newly formed Committee.

PRIMARY CARE DEVELOPMENT CORPORATION

pcdc.org

Testimony from the Primary Care Development Corporation to the New York City Council Committee on Hospitals Oversight Hearing "Examining the Status of 'One New York: Health Care for Our Neighborhoods': What Progress Has Been Made and What Challenges Lie Ahead?" February 28, 2018

Thank you for the opportunity to testify before the committee today. I am Louise Cohen, Chief Executive Officer of the Primary Care Development Corporation (PCDC). Founded in 1993 by Mayor David Dinkins and a visionary group of health and civic leaders, PCDC is a non-profit organization and Community Development Financial Institution (CDFI) that has partnered with the City of New York for 25 years to catalyze excellence in primary care for millions of New Yorkers in neighborhoods across all five boroughs.

Our mission is to create healthier and more equitable communities by building, expanding, and strengthening primary care through strategic capital investment, practice transformation, and policy and advocacy. We believe every New Yorker in every neighborhood should have access to high quality primary care.

We have worked with over 400 health care sites across New York City and hundreds more in the Empire State, including seven DSRIP (Delivery System Reform Incentive Program) Performing Provider Systems (PPS) in all corners of the state. We have provided financing for community health centers in all five boroughs – and for half of all Federally Qualified Health Centers (19 out of 39) in the City.

Nationally, we have invested almost $875 million in 130 primary care health center projects, leveraging more than $5 of private investment for each $1 of public investment. These projects have provided primary care access for millions of patients, created more than 8,500 jobs in low-income communities, and transformed more than 1.6 million square feet of space. We have assisted more than 450 practices to become recognized as Patient Centered Medical Homes. PCDC has also trained and coached more than 7,000 health workers to deliver superior patient-centered care, including at NYC Health + Hospitals, where we have provided technical assistance for ambulatory care redesign for more than 15 years.

Expand Primary Care Infrastructure to Support Healthy, Thriving Communities

Twenty-five years ago when PCDC was founded, New York City's primary care landscape was bleak. A front page *New York Times* story reported on a "severe deficit of doctors in poor urban neighborhoods" and a devastating study that found "only 28 properly qualified doctors to serve a population of 1.7 million in nine low-income neighborhoods in Harlem, north central Brooklyn and the South Bronx." The 1993 story also highlighted PCDC's founding to finance health facilities to bring high quality and culturally competent care to underserved communities

through a $17 million investment by the City. At the same time, then-Mayor David Dinkins also provided the Health and Hospitals Corporation with $48 million in capital and operating funds to build 20 family health care centers in 13 of New York City's most medically underserved communities in what was then called CommuniCare, and which is now known as Gotham Health.

While New York City's primary care infrastructure has improved dramatically over the last 25 years, looming federal actions are creating a bleak outlook for the city's health care safety net, directly undermining health care access, coverage, and service delivery for millions of New Yorkers. Now is a critical time to examine and work to accelerate access to quality health care for all New Yorkers. We thank the City Council for today's hearing on the status of the *One New York: Health Care for Our Neighborhoods* transformation plan for NYC Health + Hospitals to support our essential public health care system and to help expand comprehensive health care, especially in high-need communities.

PCDC applauds the vision of NYC Health + Hospitals' (H+H) new president Dr. Mitchell Katz to focus on primary care. His commitment to "turn the nation's largest public health care network into an agency that focuses less on hospital care and more on primary care," is right in keeping with PCDC's vision and H+H's historic mission as not only a safety net provider but also to improve the health of New York City communities.

At PCDC, we believe that primary care is the heart of the health care system. High quality, affordable, accessible, and well-resourced primary care is the key to healthier people and communities and to achieving health equity. Studies show that primary care can bend the health care cost curve – but the costs for primary care will go up before total cost of care goes down. Primary care centers – including those of H+H -- are anchor institutions in communities, providing valuable jobs and good career paths.

The Promise – and Cost -- of Health System Transformation and Building a Bridge to Better Health

H+H has been a leader in what health system reform – or what many people refer to as "transformation," meaning transformation from a reimbursement system driven by patient visits to one that is rewarded for access, quality and patient and provider satisfaction. Yesterday's *Health Affairs* blog post by H+H's Chief Population Health Officer and PCDC Board Member David Chokshi demonstrates the type of action that the rest of the health system needs to emulate: the objective assessment of primary care along a variety of key domains of access, quality, connectivity, innovation, patient experience and patient safety, cost, and outcomes, that is then used to spur additional movement towards a high performing, equitable, and cost effective primary care system both for H+H's own primary care and for its network of

primary care partners. PCDC is proud to be a technical assistance provider for H+H's OneCity PPS network.

The entire premise of health system reform rests on a robust primary care system.

Primary care makes the difference between a life-threatening chronic condition and a manageable or treatable condition. Primary care is the first point of comprehensive care, addressing all that contributes to a person's health and well-being, from childhood through old age. It includes family and adult medicine as well as community behavioral health, women's health care, and geriatrics. It is screening, diagnosis, and treatment; referral to and coordination with other care settings and providers; health education, preventive services, and more. It is the steady, incremental care provided in doctors' offices, large group practices, federally qualified health centers, women's reproductive health centers, and hospital ambulatory care.

Without primary care, families risk illness that can threaten their well-being and financial security as well as worsen health, social, and economic inequities.

In this light, it's easy to see why PCDC considers access to this kind of primary care to be a social determinant of health. We believe that many primary care providers – including and especially those at H+H -- are working hard to provide this kind of care in many communities.

However, today in our health care system, primary care gets about 7 cents on the health care dollar. Just reporting quality metrics can cost $50,000 per provider per year. Achieving Patient Centered Medical Home recognition costs about $14,000 per FTE and to maintain it, another $8,000 monthly.

Today, there are additional resources from the New York State Delivery System Reform Incentive Program, but that program will end soon and those dollars will not be sufficient to maintain the system into the future. As the health reform discussion has evolved, primary care is expected to enter into new payment arrangements aligned with the outcomes we all want to see. The One New York report, in almost every strategy, highlights the need to invest in patient centered coordinated care that improves the health of communities. PCDC believes that this will be accomplished through H+H's own efforts and the work of many partners, including ourselves. What this requires is upfront, robust, and steady payment. We applaud the Council and the Administration for your strong financial commitment to the vital health care system that is H+H.

Additional Primary Care Expansion is Necessary for H+H to achieve its Goal to Address the Social Determinants of Health

PCDC strongly supports the investments made by H+H, the City Council, and the de Blasio administration to expand and build new community health centers to connect more New

Yorkers to accessible quality primary care under the *One New York* and *Caring Neighborhoods* initiatives. The City and H+H's commitment to build five new primary care centers in Manhattan, Queens, Brooklyn and Staten Island, as well as expanding services at six existing primary care sites in the Bronx, Brooklyn and Queens is critically important. This, along with the *Caring Neighborhoods* support for non-H+H facilities – in which PCDC has been a financing partner with the City – has already brought significant new primary care capacity to communities. This is a long-lasting legacy to improve the health of poorer communities in New York City, and one which we applaud.

PCDC has been a strong and willing partner to the City across administrations. In addition to our technical assistance capacity, we have a variety of financing mechanisms and technical assistance available to support new or renovated primary care facilities – which we have used to support new primary care facilities in East New York, the Rockaways, the Bronx, East Harlem, Harlem, and Chelsea, to name a few. We are most successful when we leverage our resources to partner with the City and other entities to jointly finance projects for community primary care providers without recourse to bank capital. In particular, we believe that leveraging grant capital through the City, State or Federal government by providing a percentage of debt to finance key projects ensures that scarce public resources are matched with private dollars to finance more and larger projects.

We strongly support the *One New York* recommendation to invest in new community-based care in underserved neighborhoods and to build primary care sites on vacant and under-utilized parcels on H+H campuses and in the community. We stand ready to partner with the Council, H+H, and the Administration, to make this strategy a reality.

Thank you for this opportunity to testify before the City Council Committee on Hospitals. We look forward to working with you and H+H to strengthen the City's primary care infrastructure.

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Contact:
Patrick Kwan, Senior Director of Advocacy and Communications
Primary Care Development Corporation
45 Broadway, 5th Floor, New York, NY 10006
(212) 437-3927 | pkwan@pcdc.org

New York State NURSES ASSOCIATION One strong, united voice for nurses and patients

Oversight Hearing of the New York City Council Committee on Hospitals

Examining the Status of "One New York: Health Care for Our Neighborhoods": What Progress Has Been Made and What Challenges Lie Ahead?

February 28, 2018

Testimony of Judith Cutchin, RN
President of the NYCHH and Mayoral Executive Council
New York State Nurses Association

My name is Judith Cutchin and I am the elected President of the NYSNA NYC Health + Hospitals and Mayoral Executive Council. I am here today as the representative of the nearly 9,000 registered nurses that provide direct patient care in the Health + Hospitals system. In addition to my role as President of the Executive Council, I have ample direct experience of the vital role played by the public hospitals – I was born at Kings County Hospital and have worked as a front line nurse at Woodhull Hospital for more than 25 years.

The NYC Health + Hospitals (NYCHH) system is undoubtedly facing a serious financial crisis, with projected operating deficits that reach as much as $1.8 billion in FY 2020. These projections could be further affected by the impact of ongoing efforts by the Republican Congress and the President to slash Medicare, Medicaid and ACA funding in order to provide huge tax cuts that will largely flow to for-profit corporations, the wealthiest Americans and real estate and private equity interests.

The NYCHH system is already receiving substantial direct and indirect financial support from the City of New York to close current operating deficits, with direct City support for the system ranging from $300 million to $700 million between 2016 and 2020. At the same time, NYCHH is seeking to increase revenues and reduce expenses in an effort to close its looming budget gaps.

On the revenue side, NYCHH seeks to increase federal and state Medicaid and charity care support, expand enrollment and revenue from the NYCHH's MetroPlus insurance company, improve billing efficiency, and monetize NYCHH real estate and infrastructure assets. It is hoped that these initiatives will provide roughly $1.1 billion per year in added revenue by FY 2020.

On the cost side, NYCHH is seeking to cut costs by $700 million per year through improved supply chain and billing processes, substantial reductions in personnel through attrition and lay-offs, and an as yet unspecified "restructuring" of services. Though there has been no public announcement of concrete plans to restructure services, there are indications that the City and NYCHH were seriously considering a

substantial reduction in in-patient bed capacity, closure of facilities, and the elimination or reduction of services currently available in many H+H hospitals and community clinics.

NYSNA nurses at NYCHH are not opposed to efforts to increase revenues and reduce costs and we understand that NYCHH services can and must be improved.

We are concerned, however, that "One New York" Report, which reflects the thinking of the City of New York and of the prior leadership of NYCHH is based on faulty premises and an incorrect understanding of the underlying problems faced by NYCHH.

It is our position that reducing capacity, closing facilities, reducing staff and slashing expenses will not and cannot address the financial problems faced by NYCHH. The public system does not lose money because it is inefficient, has high labor costs or fails to provide needed services. NYCHH loses money because it provides essential health services for which it is not compensated or poorly compensated. NYCHH loses money because it assumes burdens and costs of care for services and populations that private sector hospitals and other providers are not willing provide. NYCHH loses money, in short, because it is designed to – its role within the broader healthcare system in the city is to pick up the losses and costs associated with health care services that are costly and generate losses. In fact, NYCHH's losses are thus directly correlated to the large and increasing profits enjoyed by the private sector health care providers that can focus on profit generating services because NYCHH is there assume the social costs of health care that they are able to avoid.

The NYCHH system accounts for roughly 17% of the total hospital beds in New York City, but it bears a wildly disproportionate share of the social costs of providing health care to New Yorkers:

Care for the uninsured: NYCHH accounts for 48% of uninsured patient discharges, 53% of uninsured emergency visits, 68% of uninsured ambulatory surgeries and 80% of uninsured clinic visits on a city-wide basis – these are services for which NYCHH by definition receives no compensation.

Level I Trauma Services: NYCHH operates almost half of the most advanced Level 1 adult trauma services upon which all New Yorkers rely. Maintaining trauma services is costly because the system is required to have a wide array of specialists and surgeons in a state of readiness at all times, and many private hospitals have discontinued their trauma services.

Providing Services with Low Reimbursement Rates: NYCHH provides 39% of alcohol dependence, 49% of bi-polar disorder, 37% of cocaine dependence, 44% of major psychological disorder and 59% of schizophrenia inpatient treatments city-wide. These services are costly and labor intensive and are poorly reimbursed.

Disproportionate share of Uninsured and Medicaid patients: NYCHH patient mix is disproportionately composed of uninsured and Medicaid patients and has a low percentage of commercially insured patients. This patient payer mix means that NYCHH is not able to generate enough revenue from its commercially insured patients to subsidize the costs of its Medicaid and uninsured patients.

Providing Care to Communities of Color: Many private hospitals and other private health care providers avoid caring for people of color. At Bellevue, for example, 80% of patients are people of color, compared to only 34% at the adjacent NYU Langone hospital complex.

NYCHH thus assumes the costs of providing care to a wide range of services and populations that private sector providers are able to avoid precisely because NYCHH is there to provide these services to our communities.

These private hospitals are able to focus on increasing their market share in richer communities and on providing services with higher reimbursement rates, and they often do this at the expense of NYCHH. In fact, in many NYCHH hospitals, medical services are provided by Mount Sinai, NYU Langone and other private entities that siphon well-insured patients and high reimbursement services away from NYCHH to their own facilities. We are inundated with costly advertising by these private hospitals that is very revealing if you pay attention – these advertisements are not aimed at bringing in more uninsured patients with psychiatric or substance use related complications.

These private providers also receive billions in tax exemptions even though they act a lot like for-profit corporations and give their executives multi-million dollar pay packages.

This structural dynamic goes a long way to explaining how the five major private hospital systems (NY Presbyterian, NYU, Mount Sinai, Montefiore and Northwell) were able to report profits of more than $876 million in 2016, about the same amount of NYCHH's operating losses.

What this means is that NYCHH and the people of the City of New York are directly and indirectly paying the price to allow these rich private hospital systems to reap huge profits. We are not subsidizing NYCHH – we are subsidizing the large private hospitals networks *through* NYCHH.

In response to the deficits caused by inadequate payments for its services, NYCHH's prior leadership and the authors of the "One New York" sought to slash health services and reduce personnel in order to promote sustainability. This approach is wrongheaded and we are encouraged that the new leadership of NYCHH recognizes that it will be ineffective and self-defeating.

NYCHH costs for treating its patients are comparable to or lower than those of private voluntary hospitals, and its labor costs are not higher than those of the private sector hospitals. The "One New York" report and the City rely upon a flawed analytical model that falsely inflates NYCHH costs while underestimating private sector hospital costs.

In fact, NYCHH labor costs per discharge are actually lower than most private hospitals, and the quality of care is comparable to that of the private sector hospitals. For a more detailed analysis of the cost and quality issue, I would refer the members of the Committee to the NYSNA commissioned report "On Restructuring the NYC Health + Hospitals Corporation", copies of which we are making available to you today.

We believe that any transformation plan that focuses only on the NYCHH hospital system's finances, without considering the role that it plays in the broader healthcare system is doomed to failure. NYCHH is the core of the entire New York City health care system and its existence allows the private hospitals to thrive.

In this context, we find that the approach being adopted by the new leadership of NYCHH under Dr. Katz is very encouraging.

As front line nurses, we believe that he City must take a more assertive and bolder role in coordinating and guiding the delivery of healthcare services.

Any restructuring of NYCHH must be based on meeting objectively established local community needs and creating a fairer distribution of both the burdens of providing needed services and of revenue flows between NYCHH and the private hospitals.

Quality of care must be maintained to prevent a vicious downward cycle, and the key to improving quality is to ensure that there is proper staffing of nurses and other direct care workers. This means we have to stop spending money on outside consultant and private contractors and expand our direct care workforce. The current process of staff reductions and hiring freezes is ultimately self-defeating.

The public hospitals of NYCHH are the backbone of the entire health care system in our city. To improve health care and health outcomes for New Yorkers, we need to expand the NYCHH system and not shrink it.

To address the financial issues faced by NYCHH, we must increase the availability of services and reduce wait times for patients – this will be key to getting more patients into the system and encouraging them to stay with us for all their health care needs.

Nurses and other care givers know what needs to be done to fix NYCHH, and we are encouraged that the new leadership at NYCHH seems to share our view. We urge the members of this committee and the broader City Council to work with NYCHH and its front line nurses and other care givers to expand and support the vital services that NYCHH provides to the people of New York.

ON RESTRUCTURING THE NYC HEALTH+HOSPITALS CORPORATION

PRESERVING AND EXPANDING ACCESS TO CARE FOR ALL NEW YORKERS

A report by Barbara Caress and James Parrott to the New York State Nurses Association (NYSNA)

October 2017

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October 2017

EXECUTIVE SUMMARY

The New York City Health+Hospitals (NYCH+H) system may be facing the most profound challenge in its 48-year history. Even before the new Washington administration's threat of devastating changes in Medicaid funding and unraveling of the Affordable Care Act (ACA), the City was projecting a $1.6 billion deficit by 2019, rising to $1.8 billion in 2020. This deficit—nearly one-fourth of its operating expenses—is expected even though the City has raised its total annual level of financial support to NYCH+H from $1.3 billion in 2013 to $1.8 billion this year and to a planned $1.9 billion in 2020. Though the efforts to repeal the ACA have thus far been defeated, ongoing threats of drastic cuts to Medicaid and reduced support for private insurance coverage on the group and individual markets are likely to worsen the NYCH+H deficit projections.

In April 2016, the Mayor released his reconfiguration plan *One New York: Health Care for Our Neighborhoods*, then convened a Blue Ribbon Commission on Health Care for Our Neighborhoods. Meanwhile, the NYCH+H Board authorized its own study and instituted a series of revenue raising and cost-containment actions to deal with the fiscal difficulties. Despite these efforts, the deficit is still expected to reach $1.8 billion and many observers doubt that substantial new federal revenues are likely to materialize.

The Mayor's Commission recently released its *Recommendations on NYC Health+Hospitals' Transformation* along with three issue briefs that provide more detail on the system's clinical infrastructure and challenges. These latest documents, however, continue to misconstrue the relevant NYCH+H operating cost data and fail to situate NYCH+H's challenges in the broader context of New York City's overall healthcare system which is 70 percent publicly supported, and in which the private hospitals heavily rely on the public system. Within the broader hospital sector, public funding covers more than two-thirds of expenditures.

NYCH+H's fiscal problems cannot be fixed by closing hospitals, laying off staff, and cutting services. In fact, evidence suggests that there are few immediate financial benefits to closing a hospital. Nor can the solution be increased reliance on and payments to the costlier and less responsive private hospital system. Unfortunately, given the current alignment of reimbursement policies, it is very unlikely that NYCH+H will be reimbursed adequately for the cost and quality of services it provides.

Fiscal relief can come, in part, from other sources. The private healthcare system needs to be made more accountable for the care of all New Yorkers—regardless of ability to pay or medical problem. The broader hospital system in New York City is essentially a single system with multiple managements. The private or voluntary sector is making money, the public sector is not, but not because it is high-cost or provides poor quality health services. No solution to NYCH+H's fiscal woes will succeed without understanding and acknowledging NYCH+H's interaction with the city's broader healthcare system. Nor will success happen without recognition that the burden of caring for the neediest and most vulnerable should be more equitably distributed.

In the following report, we reach several conclusions.

1. *NYCH+H's structural deficit is not an expense problem. It's a revenue problem.*

NYCH+H spends more for care than it is reimbursed. This is because of its role and function within the broader healthcare delivery system in New York City, and not because it is failing as a system.

NYCH+H provides the bulk of under-financed medical care to the city's uninsured, Medicaid patients with poorly-reimbursed health conditions (substance abuse and psychiatric disorders), and Level One emergency trauma care. It is not adequately compensated for the care it provides—that the private hospitals do not.

2. *The NYCH+H System's cost structure is reasonably efficient and its care of good quality*

NYCH+H testimony before the City Council Health Committee this spring and the recently released Blue Ribbon Commission Report are both premised on the argument that NYCH+H has an unsupportable and high cost structure. This assumption is directly related to the unstated premise that public hospitals (like the common perception of government services) are less efficient, costlier and of lower quality than private sector service providers.

These spoken and unspoken premises are not supported by the facts. NYCH+H costs for treating patients are comparable to or lower than those of voluntary hospitals. As a group, NYCH+H hospitals are among the lower-cost NYC hospitals. The majority have payroll expenses per adjusted discharge (a widely used standard) in the lower half of NYC hospital costs.

Nor is the quality of care inferior to that provided by private hospitals, particularly the large Academic Medical Centers (AMCs). For example, surveys by the Leapfrog Group, which is a national hospital industry quality measure organization that rates hospitals on a set range of patient safety metrics, have consistently found that NYCH+H hospitals as a group provide higher than average quality. According to the Leapfrog report issued in November 2016, the only hospitals to receive a grade of "A" or "B" were five NYCH+H institutions. In the March 2017 report, six of seven NYC hospitals rated higher than a "C" were NYCH+H.

3. *Private hospital networks prosper, in part, at the expense of the public hospitals*

The fact of the matter is that NYCH+H increasingly picks up the costs of a wide range of services and populations that private sector providers can avoid precisely because NYCH+H is there to assume this load. Despite their nonprofit charitable charters, NYC's private hospital systems have been shifting the burden of caring for the uninsured and for people with psychiatric and substance abuse diseases to the public system. Even as the number of uninsured New Yorkers declines, NYCH+H's share grows.

It is, in part, the very existence of NYCH+H that enables the large private hospital networks to operate with huge surpluses. In 2016, the five major private systems reported net operating revenues (profits) totaling $877 million while NYCH+H has faced recurring and mounting losses. These "nonprofit" entities have been recording significant operating surpluses while enjoying substantial tax exemption benefits, excessive payments from state and federal indigent care pools not proportionate to the amount of charity care they provide, while paying generous compensation to scores of executives.

This year might mark a unique moment in the history of New York City's hospital system. A fiscal crisis in the public hospital and safety net care systems and an uncertain future for full federal support of Medicaid and for the uninsured converge with a near universal recognition that the U.S. healthcare system is failing to provide the care we need at a price we can afford. Both the Mayor and the Governor have committed very significant resources to the continued support of NYC's necessary safety net institutions. We need to take advantage of this confluence of factors to reshape the system for the 21st century.

Recommendations

1. A reshaped public care system based upon need

Creating a public health system that reflects and responds to low-income and vulnerable New Yorkers through a newly created community-based care network (NYCH+H working with Deptartment of Health and Mental Hygiene) while maintaining a geographically dispersed community hospital network. This must include maintaining sufficient capacity (and staff) in the public hospital system to fulfill its mission as provider to both residents of adjacent communities as well as the unique populations served by NYCH+H. The future system needs to be reshaped based on local needs—some communities will need increased services, and others might need less. Most of the data necessary to construct a rational system has been collected and analyzed. Now is the time to use it.

2. A more equitable distribution of healthcare burdens and resources

The major private hospital systems need to take more responsibility for the needs of all New Yorkers. This will require that current funding formulas be revised. City and State governments need to be proactive. First, distribution of the state-specific Indigent Care Pool, as well as the state-administered Medicaid and Medicare charity care add-ons, should be modified to recognize NYCH+H's significant contribution to caring for the uninsured, especially immigrants, and the underinsured. Second, those hospitals that do not operate Level 1 trauma centers and depend on NYCH+H and others to maintain these costly operations should contribute to a trauma center funding pool. Third, the State and the Medicaid payers it regulates must change the reimbursement weighting system that underpays the cost of treating psychiatric and substance abuse disorders and fails to financially acknowledge the critical contribution of social services and use their bully pulpits to influence commercial payers to do the same.

3. City/State actions to push private hospitals to do or pay their fair share

The City and State should consider whether tax benefits, permitting, and zoning exceptions awarded to private, nonprofit hospitals ought to be based on a demonstrated contribution to caring for the sick, regardless of ability to pay.

Property tax and commercial income tax exemptions are awarded to charitable enterprises. Are all of NYC's private healthcare networks entitled to these exemptions? A Morristown, New Jersey judge recently revoked a local hospital's nonprofit status—finding that the hospital behaved more like a business than a charity.

The City might consider a program like one implemented by San Francisco. The Charity Care Ordinance of 2001 tied local approval of construction permits to demonstrated provision of charity care. As related by Elizabeth Rosenthal in her book, *American Sickness*, Sutter's California Pacific Medical Center had to promise $1.1 billion in concessions before the city would issue the required permits. Among the items the hospital promised were a freeze on prices charged to city employees' insurance plans, operation of a nearby safety net hospital, affordable housing investments and upgrading of nearby transit facilities and sidewalks. New York City might want to broaden the scope of such a program to include conditional property tax forgiveness.

4. City leadership on creating an NYC health system for the 21st century

A transformation plan that focuses only on the NYCH+H hospital system's finances, without considering the role that it plays in the broader healthcare system, is doomed to failure. NYCH+H cannot become self-sustaining because it absorbs the costs that the private providers are unwilling to shoulder.

The NYCH+H system thus has a symbiotic relationship with the private providers, absorbing costs and assuming obligations for services that the City needs but that the other hospitals can avoid because of the existence and role of the public system.

Given this dynamic, any restructuring of NYCH+H or path toward sustainability must include maintenance of effort to support NYCH+H's quality of care. The alternative is a vicious downward cycle of cuts that affect quality, causing further loss of market share and more revenue losses, which in turn cause more cuts in service and further losses.

The City working with the State must also take on a more assertive role in shaping the structure of the entire public and private hospital care system. The goal of any restructuring merely cannot be to fix the finances of NYCH+H but to create an integrated city-wide healthcare system in which the private and public provider systems work together to provide health services to the people of New York.

Key Findings

1. **Financial pressures facing the NYCH+H** are mounting as the public system's share of Medicaid funding in NYC declines and additional reductions estimated at $1.2 billion loom in federal safety net funding over the next two years. The outlook was dire even before the new administration in Washington launched its ongoing efforts to slash federal healthcare funding and increase the number of uninsured. Though efforts to repeal the ACA have been defeated thus far, we can expect ongoing attempts to reduce total federal healthcare spending that will add to the projected financial crisis faced by NYCH+H.

2. **The future and finances of NYCH+H** need to be rethought in a broader context that recognizes the important role of the public hospital system in NYC's $125-$150 billion healthcare landscape.

   - In a city with 40 percent of the population covered by Medicaid and 700,000 uninsured (many of them undocumented), NYCH+H has long served as the safety net provider, assuming the burden of serving those the private sector cannot or is unwilling to serve.
   - NYCH+H plays a traditional and vital role of a public system—providing essential services that most private hospitals choose not to provide. Its hospitals disproportionately provide care for the uninsured, Medicaid patients with poorly reimbursed health conditions, and substance abuse and psychiatric patients who need social as well as medical services.
   - Public hospitals are major providers of high-cost Level 1 trauma capacity serving residents, visitors and uniformed service members, relieving most private hospitals of that obligation and cost.
   - NYCH+H has resumed direct responsibility for providing healthcare services for both prisoners and jail employees in the City's jail system.
   - NYCH+H, together with the New York City Department of Health and Mental Health, is the first-line protector of the public's health. For example, public hospitals took the lead in the early days of the AIDS epidemic and as the city reacted to the re-emergence of TB and SARS. In 2015, Bellevue was the epicenter of the local response to Ebola.

3. **Even prior to the passage of the ACA**, a host of changes in technology, the practice of medicine and funding have reduced the need for hospital beds and driven the delivery of healthcare services toward outpatient and community settings.

   The large private hospitals have grown into multi-site healthcare networks and have positioned themselves to benefit from changes in the healthcare sector. While NYCH+H downsized by 30 percent in the late 1990s and has made many changes since then, it clearly has further to go in reorienting itself to better serve NYC's 21st century healthcare needs. NYCH+H, however, should neither be expected nor designed to compete with AMCs. Its unique role should be recognized and appropriately compensated.

   The resurgence of AMCs and their associated networks over the last decade is primarily due to four interconnected factors:

   - A net loss of 5,000 hospital beds due to closure/merger and consolidation resulting in greater pricing leverage with commercial insurers.

- A hugely increased pool of insured patients with the wherewithal to pay the cost of high technology/tertiary services.
- AMCs' ability and willingness to shift resources and change service, payor and personnel mix to focus on more profitable services and to exploit new reimbursement offerings and methodologies.
- An accelerating shift of underinsured and uninsured patients and of poorly reimbursed services to the public system and the few remaining unaffiliated, financially struggling safety net private hospitals.

In comparison with the private networks, NYCH+H has been slow to transform itself, and while it might need to adjust bed capacity in some facilities and develop more community-oriented ambulatory care capacity (and retrain portions of its workforce), NYCH+H cannot and should not adopt the same revenue maximizing model. Instead there is a need to rethink and possibly reconfigure the overall flows of public financing to more closely align with community healthcare needs.

4. **The financial pressures on NYCH+H** primarily stem from the revenue side rather than the cost side of the ledger.
   - NYCH+H relies on Medicaid for nearly two-thirds of all patient service revenue but, despite the continued growth in overall Medicaid expenditures in the city, Medicaid revenues have been declining at NYCH+H hospitals as the private hospital networks have been more adept at garnering Medicaid reimbursements for the more lucrative services, especially surgery.
   - In recent years, NYCH+H has assumed an even greater share of the burden in caring for the uninsured, but its share of state indigent care pool payments, already inequitable, has not risen along with its greater responsibility.
   - While the City of New York has stepped up the value of its annual NYCH+H support to $1.8 billion in Fiscal Year 2017 (FY 2107) from $1.3 billion four years ago, federal safety net funding is expected to fall off as scheduled Disproportionate Share Hospital (DSH) cuts are phased in under current law. This is projected to widen the operating loss at NYCH+H to $1.8 billion in 2019, or nearly 24 percent of total operating expenses. If the ACA is repealed and federal Medicaid funding is cut back, these projected deficits will be enormous—threatening the existence of many healthcare providers.

5. **NYCH+H hospitals and health centers** are the local healthcare providers to thousands of residents of nearby low-income, demographically diverse communities, primarily communities of color. Its losses can be attributed to meeting the unreimbursed and under-reimbursed health needs of these communities.
   - Many of the city's public hospitals are in the poorest neighborhoods that have relatively few other local healthcare providers. For example, residents of the Bronx, Brooklyn, Queens and Staten Island have less primary care access than 70 percent of Americans. The shortage is even more severe in the boroughs' poorer neighborhoods.
   - While NYCH+H hospitals account for about 20 percent of inpatient discharges city-wide, they disproportionately serve lower-income patients. Thus, NYCH+H accounts for 50

percent of uninsured inpatient discharges, 80 percent of all uninsured hospital clinic visits and half of all Medicaid patients (and these shares have been rising further since 2014).

- NYCH+H accounts for 30 percent to 60 percent of poorly reimbursed inpatient services to people with psychiatric and substance abuse disorders.
- NYCH+H disproportionately serves New Yorkers of color. When looked at side by side, adjacent and nearby private and public hospitals—NYU and Bellevue, and Mt. Sinai and Presbyterian and Harlem Hospital—have patient populations with very different racial makeups. Many of the leading AMCs serve a largely white patient population.

6. **Relative to the city's private hospitals**, NYCH+H facilities are a more cost-effective alternative and of comparable quality. The cost comparisons presented to the recent Blue Ribbon Commission and reflected in its final report rely on a flawed analysis which assumes that public and private hospitals both operate and allocate expenses in a similar fashion. Neither assumption is correct:

   - Payroll expenses (wages, benefits, training) recorded in eight of the 11 NYCH+H hospitals rank in the lower half of all New York City hospitals; the remaining three are in the next quartile.
   - The cost comparisons are further distorted by reliance on flawed acuity and out-patient "adjustment factors" that inflate NYCH+H's relative cost structure.
   - Based on the Inpatient Quality Indicators measure, all but one of NYCH+H's facilities score in the top half of New York City hospitals.

7. **Given the co-dependence** of the public and private hospital systems in NYC, the fact that healthcare is 70 percent publicly funded, and that NYC government provides direct funding for contracted services and indirect subsidies to the private hospital systems, any examination of NYCH+H's financial health should involve a careful analysis of NYCH+H's relationship to the private hospital system and the role that system plays in serving New Yorkers.

   - In FY 2017, the City of New York provided $669 million in real property tax exemptions to private nonprofit healthcare providers, one-third more than in 2011. Likely, the increase is attributable to the major private hospital networks' rapidly expanding affiliated medical physician practices and extension of the exemption to the high-value commercial real estate they occupy.
   - Mainly through the State Dormitory Authority, NYS has permitted the major private hospitals to use $3.9 billion in tax-exempt bond financing that saves an estimated $71 million annually in interest costs.
   - The combined net revenues of the five major private hospital networks were $877 million in 2016, up by over one-third from $650 million for all five in 2014 and 2015.
   - The five private hospital networks benefit from tax-exempt status despite being run by very highly-paid executives whose salaries rival those in the for-profit corporate sector. As of 2015, the five networks reported 108 executives were paid over $1 million each annually, with an average compensation of $2.2 million. The private hospitals as a group have over 150 executives who are paid more than the highest-paid NYCH+H official. At one of the

larger private networks, New York Presbyterian, executive compensation soared 18 percent in 2015 over 2014 and pay packages resemble those on Wall Street, with bonus pay comprising a large part of total compensation.

8. **The city's remaining non-affiliated** private safety net hospitals (Brookdale, Wyckoff, Interfaith, Bronx Lebanon, Flushing and Jamaica) are in a similar position to NYCH+H—absorbing a greater share of under- and non-insured patients and under-reimbursed services not provided by the five large private networks and shouldering the associated losses. The core problem for both public and private safety net hospitals is not incompetent management or inefficient staffing. It is underfinancing of care for the uninsured and for treatment of psychiatric and substance abuse ailments.

ON RESTRUCTURING NYC HEALTH+HOSPITALS

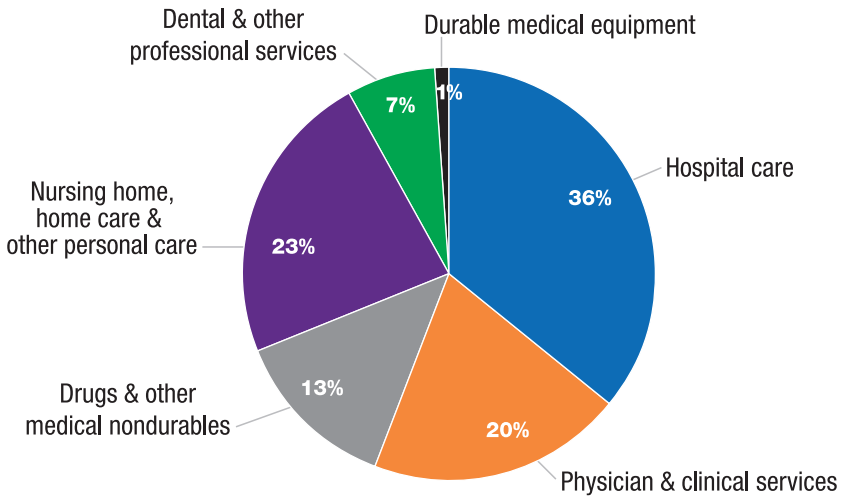
BACKGROUND

New York's health system

New York's health system is unique in many ways. Its size, however, is typical. The city is home to 2.7 percent of the country's population and a proportional number of hospital beds and hospital discharges. What is unusual is the predominance of medical schools, AMCs, and teaching hospitals. Fully five percent of U.S. medical students are studying in one of New York City's six medical schools. By comparison, there are 10 schools in all California—a state with 39 million residents. Every New York City hospital participates in training of medical residents. One-tenth of the doctors-in-training in the U.S. are working/learning at a New York City hospital. Less than half (45 percent) of New York State medical residents plan to practice in New York State upon completion of their programs.[1] Training the country's future doctors is expensive and training and research imperatives have a very large influence on the shape and types of services hospitals provide.[2]

CHART 1

Estimated NYC healthcare spending by service, 2009



Source: Based on data presented in Health Care Costs and Spending in New York State February 2014
Prepared by: Diana Rodin and Jack Meyer. Public Hospital Share based on NYC HHC Financial Plan FY 2010.

1 Center for Health Workforce Studies 2015 New York Residency Training Outcomes A Summary of Responses to the 2015 New York Resident Exit Survey http://www.chwsny.org/wp-content/uploads/2016/06/NY_Residency_Training_Outcomes_2015-1.pdf

2 See for example, Joseph Newhouse "Accounting For Teaching Hospitals' Higher Costs And What To Do About Them" Health Affairs November 2003.

Most of the money that supports the city's healthcare delivery system comes from public sources—Medicare because it covers healthcare expenses of people most likely to use services—the aged and disabled—and Medicaid which, because of ACA expansion, covers 43 percent of New Yorkers. In addition, the City's payments for insurance for its employees, their dependents and eligible retirees tops $7 billion annually. Other public money comes from state and federal government-financed health benefits for their workers who receive healthcare in the city.

PUBLIC SPENDING/ PUBLIC ACCOUNTABILITY

Almost 60 years ago, at the dawn of the Medicaid/Medicare era, the City Commission on the Delivery of Personal Health Services (the "Piel Commission") noted that public financing created an opportunity to shape the health system. "All of the voluntary hospitals are now, or shortly will be, dependent on public funds for half or more of their operating income. Thus, along with the former City hospitals, they will owe much the same accounting of costs and performances to public authority. It is now possible . . . to bring about the integration of public and private resources into a single, high quality health service." (December 1967)

Using Bureau of Economic Analysis data on Medicare and Medicaid transfers in New York City and Centers for Medicare and Medicaid Services estimates of National Health Expenditures, it is estimated that NYC total health expenses for 2015 were approximately $127 billion.[3] The bulk of this spending is used to directly support personal health services—doctors, hospitals, pharmacies, nursing homes, home care agencies, medical supply companies, etc. The rest is spent for public health agencies, the Veterans Administration (VA) and other city, state and local programs. Hospitals consume the largest chunk of healthcare spending—about $40 billion. An estimated 500,000 people work in New York City's private healthcare sector (164,000 work in private hospitals) and another 50,000 provide services in the public sector.

While more New Yorkers are insured than ever before, an estimated 700,000 people are still uninsured. Prior to the ACA there were an estimated 2.3 million uninsured New Yorkers.[4] As of January 2017, 1.6 million had enrolled in an ACA plan—three-quarters covered by Medicaid and another 18 percent in the heavily subsidized Essential Plan. Enrollment in the private plan marketplace was a modest 105,000.[5]

A health system evolving—private system growth—public system losses

In part in response to pressures from payers, the city's health system is changing. While much of the shift in the locus of care began prior to the passage of the ACA, there is no question that post-passage the pace accelerated and the character of change deepened.

To quote the Centers for Disease Control and Prevention:

> The American healthcare system is in the midst of unprecedented change. The U.S. healthcare and public health systems are both now positioned to place greater emphasis on better care, smarter spending, and healthier people.

3 A very rough alternative estimate can be derived by applying the CMS figure for the health expenditure share of national GDP, 17.8 percent for 2015, to the current dollar estimate for NYC Gross City Product as published by the City's Office of Management and Budget in April 2017 ($836 billion). This alternative method would yield an estimate of $149 billion for 2015. Since there is no reason to believe that NYC's share of health expenses should deviate much from the national share, it is reasonable to conclude that total NYC health expenses for 2015 were in the $125-$150 billion range.

4 Fred Blavin, Linda Blumberg, Matthew Buettgens, Uninsured New Yorkers After Full Implementation of the Affordable Care Act: Source of Health Insurance Coverage by Individual Characteristics and Sub-State Geographic Area Revised, May 2013.

5 NY State of Health 017 OEP Number of Enrollees, By Program and County. https://info.nystateofhealth.ny.gov/sites/default/files/2017%20OEP%20Number%20of%20Enrollees%2C%20By%20Program%20and%20County.pdf

> Key elements emerging in this transformation include new structures for integrating and coordinating services, a renewed focus on patient engagement and patient-centered care, and new payment models based on the value of population-based health outcomes rather than the volume of services delivered. This period of change is creating important opportunities to establish effective, more sustainable models to improve population health.
>
> Office of the Associate Director for Policy, April 2, 2017

The large voluntary hospital networks have positioned themselves to benefit financially from change. NYCH+H has done less.

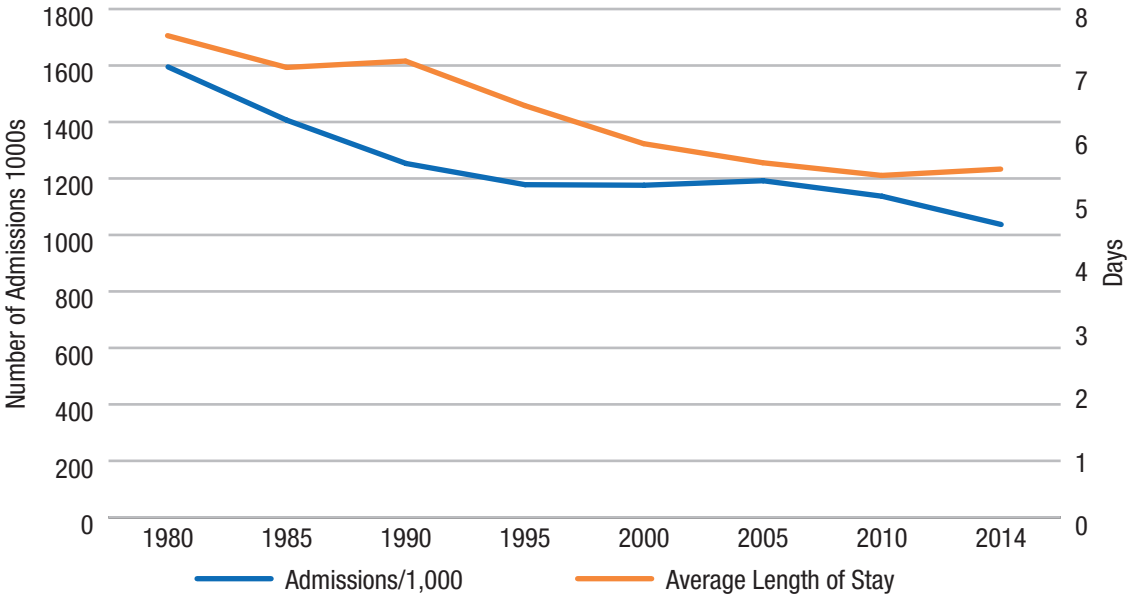
The great 19th century discovery was that illness was often caused by identifiable infectious agents. During the 20th century scientists and doctors perfected methods of preventing and curing those infections. The hospital played a key role as the center of care, health professional classroom, and laboratory for the study of disease. While some people, because they were too poor or the wrong color or ethnicity, were denied full access to the wonders of 20th century medicine, the scourges of the 19th century—TB, maternal death, diphtheria, polio, yellow fever, measles, malaria—were controlled or eliminated. What remained were chronic diseases that killed slowly and debilitatingly. It was soon discovered that heart disease, cancer, hypertension, asthma, diabetes and other similar conditions were not easily cured with one pill or one operation. And the hospital, while still key to treating the most extreme manifestations, was not necessarily the best location of cure for chronic illnesses.

As the demand for medical care changed, so did practice and technology. At midcentury, hospital beds were filled by women giving birth, people recovering from surgery, those who survived bouts of infectious disease, strokes and heart attacks, and people whose ailments were mysterious and who were undergoing invasive diagnostic procedures. All these types of inpatient admissions were transformed in the subsequent 50 years. Postpartum care, for example, went from nine days to 48 hours. With the development of quick-acting anesthesia and perfection of surgical techniques and micro-surgery, upwards of three-quarters of surgeries are now done on an outpatient basis. A profound change in care and treatment of heart attack and stroke took place—the protocol is no longer bed rest but up-and-about and non-hospital rehabilitation.

And lastly, the development of machines that can see inside the body (CATs, MRIs, PETs, etc.) has completely transformed diagnostic testing. The net result—relatively fewer admissions to the hospital and shorter stays.

CHART 2

Changes in admissions & length of stay, 1980-2014



Sources: AHA Trendwatcher Chartbook 2016, p. A-26. Trendwatch Chartbook, 2002 p. 96.

While our understanding of the most effective preventive strategies and treatment protocols moved ahead, the system remained rooted in reimbursement methods and payment incentives developed 40 years ago. Even though the paradigm has shifted to emphasize community and home based care, the most generous payment is made for inpatient care. As Dr. Don Berwick, former Centers for Medicare & Medicaid Services (CMS) administrator commented in 2011, "Today, a hospital [still] makes money from keeping beds full, not from keeping them empty."

There are payment paradigm changes underway. CMS, which regulates Medicare, is moving toward a reimbursement system that will tie half of all payments to value (processes and outcome) rather than volume (visits and procedures) within the next two years. Value-based payments mean that a hospital can maximize its revenue when its patients are receiving the types of services that have been shown to improve/advance healing, such as post-discharge care, home care and social services (or by avoiding taking on patients who don't/can't fully benefit from non-hospital services because they are homeless, addicted, or inadequately housed). The new model of care is being extended to Medicare's payment to physicians. A key element of the 2016 Congressional action on physician payment (MACRA) is the inclusion of value modifiers that will significantly affect the amount a physician will be paid.[6]

Likewise, the NYS Department of Health issued a "Roadmap" to chart its plan to move Medicaid payment away from fee-for-service.[7] In fact, NYS's Delivery System Reform Incentive Payment (DSRIP) Program is supposed to finance the building of the infrastructure that will support a new health system—one that delivers "the right care in the right place at the right time." Often that means in the community or in the home.

6 See for example, CMS Hospital Value-Based Purchasing, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HVBP/Hospital-Value-Based-Purchasing.html, Delivery System Reform, Medicare Payment Reform Delivery System Reform, Medicare Payment Reform.

7 NYS DOH A Path toward Value Based Payment—New York State Roadmap For Medicaid Payment Reform (June 2015) https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/vbp_roadmap_final.pdf

What might these changes mean for NYC's inpatient hospital system? No question, the health systems of the future will need to shift their focus from inpatient service and provide many, many more community and home-based services. Despite enormous differences in history, operations and stated mission, the city's large AMCs have staked out remarkably similar courses. Desperate to secure their place in the health system of the 21st century (and to keep filling their well-regarded, still well-paid tertiary and quaternary care beds), NYC's five large voluntary hospital systems—Montefiore, Mt. Sinai, NY Presbyterian, NYU, and Northwell—have each acquired a vast array of smaller hospitals, physician practices, freestanding diagnostic, laboratory, surgical and other treatment facilities. [See the maps, Appendix B] They are engaged in a race for control of resources, facilities and, not least, market share and public approval. Witness their robust and quite extensive advertising campaigns. Despite the costs of acquisitions, newly announced building programs and significant investments in new, esoteric technology and world-renowned specialists/surgeons, each ended 2016 with a surplus (up more than a third compared to 2015).

The changes wrought by new medical practices, technologies, and public policies over the past decade have resulted in the closure of over 20 New York City hospitals and the consolidation of many of the remaining ones into five major private hospital systems. The five private systems have been adept at transforming themselves to take advantage of new reimbursement offerings as they shift greater responsibility for the care of under- and un-insured patients and under-reimbursed services to the public system.

Hospital Advertising & Branding

"Another Day, Another Breakthrough"
–Mt. Sinai

"Amazing Things Are Happening Here"
–New York Presbyterian

"Look North" *–Northwell*

"Made for New York" *–NYU Langone*

"Doing More" *–Montefiore*

NYCH+H—PUBLIC HOSPITALS

The New York City Health+Hospitals network consists of 11 acute care hospitals, five longterm care facilities, and a network of neighborhood health centers and clinics. In addition, NYCH+H operates a home care agency and MetroPlus, a health insurance company. The network is both a vital safety net provider for New Yorkers who might otherwise not have access to healthcare services and a key and unique component of the entire NYC healthcare system. It delivers many services that the private sector cannot or will not take on. Indeed, it is the existence of the NYCH+H system that allows many of the large and growing private hospital systems to flourish.

The importance of the public hospital system to the broader healthcare delivery system in New York City is evident from the scale of services provided by NYCH+H. More than 1.1 million individual New Yorkers received care at one of New York City's public hospitals in 2016. Many of these patients are not welcome elsewhere because of their insurance status, medical condition or background. Though NYCH+H is quite large, its $7.8 billion annual spending is dwarfed by the $127 billion in spending on the overall health system in New York City.

A little history

From their earliest beginnings, New York State's public hospitals were first and foremost charged with caring for the city's most vulnerable people—the poor, the sick, the aged, new immigrants and prisoners. It continues to play this vital role today.

- In 1736, Bellevue, the first public hospital in the US, opened its doors on the City Common (now the site of City Hall) as an almshouse.
- A century later (1836) Lincoln Hospital was founded by local philanthropists as the Home for the Colored Aged. It moved to the Bronx, changed its name to Lincoln, and became a public hospital in 1899.
- Elmhurst was created in 1832 adjacent to a penitentiary the City constructed on the southern tip of Blackwell (now Roosevelt) Island. In 1862, the federal government paid the City to care for wounded Union soldiers there. Elmhurst Hospital was moved to Queens as the City government's first post-WWII construction project. It opened in March 1957.
- Harlem Hospital opened in 1887 in a three-story wooden building, located at the foot of East 120th Street and the East River in New York City, with 54 beds. Initially it was used as a reception center for patients awaiting transfer to Ward's Island, Randall's Island and Bellevue Hospital. At the turn of the 20th century the City acquired the land at 136th Street and Lenox Avenue and constructed a 150-bed hospital. It opened in 1907.
- Metropolitan Hospital Center, first on Ward's Island, joined Elmhurst on Blackwell Island in 1894. It had been founded in September 1875 as the Homeopathic Hospital. Renamed Metropolitan Hospital, it moved to East Harlem in 1955.
- Responding to the passage of Medicare and Medicaid, Mayor Lindsay and Governor Rockefeller proposed the construction of Woodhull hospital in 1967 to replace Cumberland and Greenpoint hospitals, as a modern facility with single-bed rooms and the same amenities found in private hospitals. It opened in 1982.

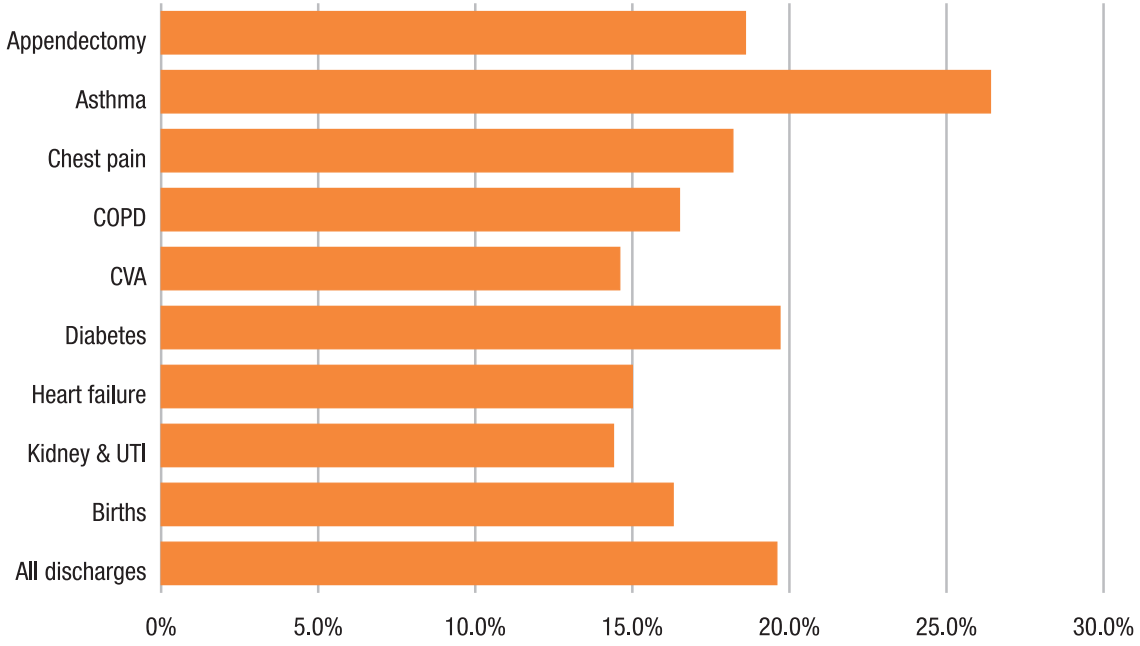
Taking care of the community

The public hospitals are a vital and unique part of the city's health system. They serve as local community providers to many residents of low-income communities. And they do so competently and efficiently.

As they have throughout their history, public hospital providers see their share of patients with those typical illnesses that need inpatient care. As can be seen on the chart below, NYCH+H hospitals cared for one in five inpatients city-wide in 2014. Among selected diagnoses (DRGs), with 7,500 or more discharges, NYCH+H's share ranged from 14 percent to 27 percent—a rate that is generally proportional to its bed share in New York City.

CHART 3

NYCH+H share of common New York City inpatient discharges, selected DRGs, 2014



Source: SPARCS, APR DRG by facility, 2014

The cost of care

The question of how NYCH+H hospital costs compare with other NYC hospitals is a critical one. While there are no readily-available metrics for comparing operating costs between the public and private sectors overall, it does appear that NYCH+H hospital labor costs fall in the lower two-thirds of all NYC hospitals.

Cost per inpatient discharge or inpatient day was once the standard measure of hospital efficiency and utilization. It was a valid measure to compare most hospitals until the 1980s, when hospital activity began transitioning from an inpatient foundation to include more outpatient services.[8] Today it is not unusual for outpatient services to account for half of a hospital's revenue.[9]

8 Since the inception of the NYCH+H outpatient and emergency services have been an important part of public hospitals' operations.

9 *American Hospital Association TrendWatch* Chartbook 2016

In this context, traditional hospital cost accounting methods offered no adequate or standard way to measure costs associated with outpatient compared to inpatient services or to compare costs of hospitals with varying mixes of inpatient and outpatient services. As the share of outpatient services grew, the cost per inpatient discharge became less accurate as a measure of hospital cost structures.

To address this problem, hospitals developed a widely-used and now well-established method based on gross charges for services performed to establish common values across settings. This formula uses the charges (or list prices) for inpatient and outpatient services performed to create a variable named "adjusted discharges" that recognizes outpatient as well as inpatient services. Adjusted discharges is simply the ratio of total outpatient charges to inpatient charges or to total hospital charges. The resulting "outpatient adjustment" factor or ratio is applied to the actual number of inpatient discharges as a multiplier to determine the adjusted discharges for a hospital. This adjusted discharge number is then divided into total hospital costs for all services to yield a cost per adjusted discharge. The "outpatient adjustment factor" and the "adjusted cost per discharge" are thus surrogate measures to account for outpatient activity.[10]

Though widely used, this outpatient adjustment methodology likely underestimates the differences between the NYC public and private hospitals. The City of New York used this methodology to calculate an outpatient adjustment factor of 1.754 for NYCH+H and 1.508 for other New York City private sector hospitals.[11] Gross charges are likely to be consistent within a single hospital system—i.e., NYCH+H could use one chargemaster or price list for all 11 hospitals. But it doesn't work as well between institutions- particularly hospitals with different service mix and operations. Most charges associated with NYCH+H's outpatient gross charges are for clinic and ER visits. NYCH+H accounts for almost half of all clinic visits and a third of ER visits. Typically, these types of visits have a lower chargemaster value with many fewer components that can add to the total charge than the services that make up a large component of the voluntary hospitals' gross charges—outpatient surgery, chemo and other infusions, specialized lab tests, and high-tech diagnostic services.

It should also be noted that hospital charges or prices are subject to huge variations from hospital to hospital and have little or no correlation to the true costs for services or actual reimbursement rates. Government payers generally pay set rates for services and private insurers negotiate rates with each hospital or hospital system. The chargemaster or price list is thus only relevant for "self-pay" patients or for exploiting regulatory loopholes or market power to receive higher payments for particular services or patients.[12] Because of the arbitrary nature of chargemaster rate setting and the incentives and goals flowing from the particular pricing strategies of individual hospital systems, the autonomously determined prices/charges that are used to calculate "adjusted discharges" do not necessarily give an accurate indicator of relative costs between the public and private hospital systems.

Though this methodology likely understates the true outpatient footprint of NYCH+H relative to the private sector hospitals, it still appears that NYCH+H hospitals provide services at the lower end of the cost spectrum. Chart 4 arrays "Payroll Expenses per Adjusted Discharge," a calculation that uses this methodology to estimate labor costs per adjusted discharge for NYC hospitals. The core data variables—inpatient discharges, gross charges for outpatient and inpatient services, and wages and benefit expenditures were compiled from the 2014 Institutional Cost Reports (ICRs) collected by the NYS Department of Health.

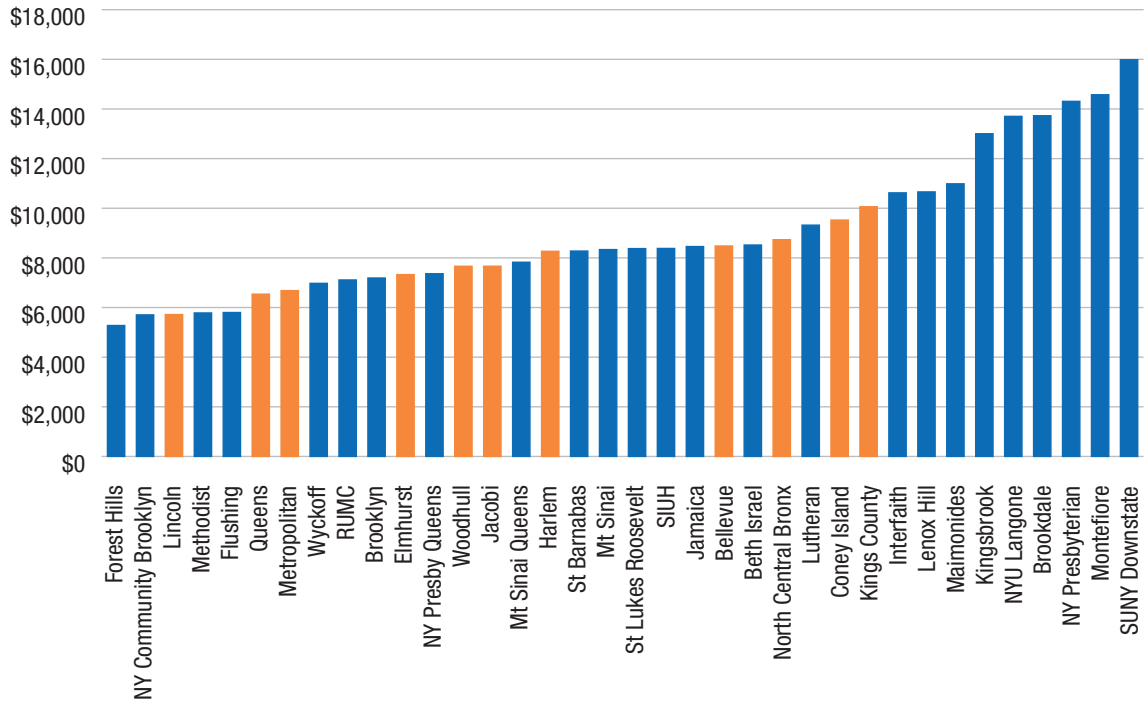
10 The formula is as follows: Adjusted discharges equal actual inpatient discharges multiplied by the outpatient adjustment factor. The outpatient adjustment factor is the ratio of outpatient charges to inpatient charges or of outpatient charges to total hospital charges (1+ (gross outpatient charges/total charges)). The resulting "adjusted" discharges are then divided into total costs to yield the cost per adjusted discharge that is the basis for comparing hospital cost structures.

11 See Footnote 15 below.

12 See: Reinhardt, U.E., "The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy" Health Affairs, Jan/Feb 2006; Ge Bai and Gerard F. Anderson, "US Hospitals Are Still Using Chargemaster Markups To Maximize Revenues" Health Affairs, Sept 2016; Alex Kacik, "Stricter chargemaster regulations needed to rein in healthcare pricing" Modern Healthcare, April 22, 2017 http://www.modernhealthcare.com/article/20170422/MAGAZINE/304229971

CHART 4

Payroll expense per adjusted discharge, 2014



Sources: SPARCS Discharges by facility, 2014 adjusted and NYS DOH Institutional Cost Reports Exhibit 35, 2014

Chart 4 does not adjust for case mix because we do not believe that the variable Case Mix Index (CMI) as presently devised allows for a valid comparison between public and voluntary hospitals. Since 2007, CMI has been calculated based on Medicare Severity Diagnosis Related Group (MS-DRG), Medicare's basic reimbursement tool. Most Diagnosis-related group's (DRGs) have three subtypes: (1) no complication/co-morbidity, (2) complication/co-morbidity, or (3) major complication/co-morbidity. It takes considerable documentation to locate a patient in the third and best reimbursed category. A study by Mendez et al. reported that "CMI underestimates the true severity of illness of patients seen at public hospitals because there is a diminished motive to maximize financial reimbursement at public hospitals [because of the relatively small number of Medicare patients], and such hospitals lack the resources needed to implement coding and documentation improvement."[13]

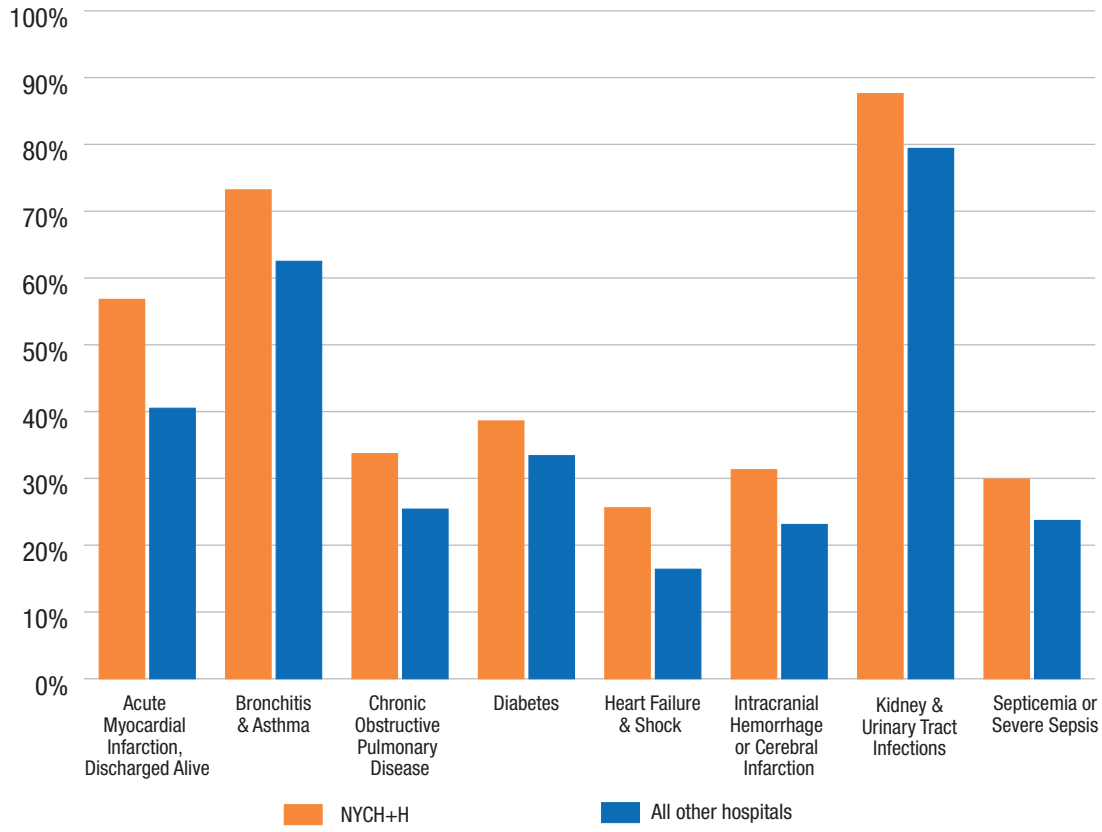
To test whether the Mendez finding should be applied to NYC public hospitals, we looked at the prevalence of "no complications" assessments among NYCH+H patients admitted with common emergency diagnoses compared to patients with the same DRGs admitted to NYC voluntary

13 Mendez, C. M., Harrington, D. W., Christenson, P., & Spellberg, B. (2014). Impact of Hospital Variables on Case Mix Index as a Marker of Disease Severity. Population Health Management, 17(1), 28-34. http://doi.org/10.1089/pop.2013.0002

hospitals[14]. There is no systematic reason why people brought to one of NYCH+H's emergency rooms would be less likely to have a major or minor complication for any of these conditions. If anything, it should be opposite because most NYCH+H hospitals are designated Level 1 trauma centers, while few of the city's voluntaries are willing to assume that obligation. As can be seen on Chart 5, there are consistently fewer patients coded with complications among NYCH+H patients—likely indicating that NYCH+H does not fully "capture" the CMI or acuity of its patients and that the CMI adjustments do not accurately reflect the public hospitals' relative costs.[15]

CHART 5

Discharges with selected MS-DRGs—% without complications or major complications, 2014



Source: SPARCs DRG by facility, 2014

14 Each DRG condition or illness that presents in a hospital setting is ranked in one of three tiers, depending on the seriousness or acuity of the condition – 1. No complications; 2. Complications; 3. Major Complications. A patient presenting with major complications will be assigned a higher acuity rating than a patient with no complications, leading to a higher CMI average.

15 The City produced relative cost estimates finding that NYCH+H costs per discharge, adjusted for both outpatient services and for average CMI data, were on average more than 22 percent higher than those of private sector hospitals in the city. See: NYCH+H Labor Committee presentation on July 7, 2016, titled "Cost Benchmarking: Methods and Results" and Mayor's Commission Brief "Reenvisioning Clinical Infrastructure" (March 2017), which presents the same data on page 9, available at http://www.nychealthandhospitals.org/wp-content/uploads/2017/03/CommissionBrief_ReenvisioningClinicalInfrastructure.pdf. The City cost estimates presented in the above reports use an "outpatient adjustment" factor of 1.754 for NYCH+H and 1.508 for the private hospital and a "CMI adjustment" factor of 1.004 for NYCH+H and 1.245 for the privates. The adjusted inpatient discharges are then divided by the city into the total costs of the hospital to arrive at the 22.6 percent higher cost per adjusted discharge for NYCH+H.

Thus, we used the outpatient adjustment factor (even though imperfect) that changed the discharge number to reflect the importance of outpatient activities, but not the CMI adjustment. Our findings resonate with our understanding of NYCH+H's patient mix. There is a smaller proportion of people using the very intense surgical and medical services available only at the city's tertiary or quaternary care facilities; therefore, there are somewhat fewer high paid healthcare workers per discharge. The bottom line is that NYCH+H hospitals spend less on their hospital workers than do many of the voluntaries.

NYCH+H's costs are in the same ballpark as those of their private counterparts. There is no adequate yardstick for what it *ought* to cost. Even relative cost comparisons are often elusive.

The most meaningful and accurate method might be comparing the actual cost to care for a similar patient in different hospitals. But this is extremely challenging. The NYS Department of Health collects both hospital institution-wide cost (ICR) and patient-specific discharge data (SPARCS). It marries the two with a very significant caveat.

> When interpreting New York's data, it is important to keep in mind that variations in cost may be attributed to many factors. Some of these include overall volume, teaching hospital status, facility specific attributes, geographic region and quality of care provided. Additionally, costs derived from billing data are based upon a ratio that is submitted by a facility to the state and may not necessarily reflect a final price of the service delivered. Cost data presented in this dataset was calculated using facility specific audited RCCs [ratio of cost-to-charges] file.[16]

With these limitations in mind, the State produced reports comparing costs for specific common diagnoses. For example, the median cost of a patient discharged in 2014 after a cesarean delivery with minor severity ranged from $18,620 reported by NY Presbyterian Downtown to $6,985 at Mt. Sinai Roosevelt. NYCH+H's hospitals stretched along that continuum from a high of $17,117 (Harlem) to a low of $8,700 (Elmhurst).[17] It is extremely difficult to explain why care at one hospital appears to be nearly three times the cost of care at another. We suspect that there are only modest differences between Harlem Hospital and Elmhurst Hospital labor and delivery care protocols, staffing and unit costs. Rather, the enormous reported cost differences reflect differences in the ways the two institutions allocate and report costs.

Based on these difficulties, we conclude that the most reliable yardstick for comparing costs at one institution with those at another is payroll costs per adjusted discharge.[18] Of all the categories of data required by the Institutional Cost Report (ICR), labor is one with clear instructions: "count everyone and every expense including those jobs and workers who are subcontracted or on other payrolls."[19] Wages, benefits and training costs are typically 65-70 percent of total hospital operating expenses. NYC public hospitals array towards the bottom of NYC hospital costs. We understand that patient acuity as well as intensity and setting of service (i.e., inpatient versus outpatient) drive differences in staffing, but because of measurement limitations the available data do not allow a precise and accurate measure. *Nevertheless, within these parameters we can conclude that public hospitals are neither particularly expensive nor especially inexpensive.*

16 See: NYS Department of Health, Hospital Inpatient Cost Transparency data, available at https://health.data.ny.gov/Health/Hospital-Inpatient-Cost-Transparency-Beginning-200/7dtz-qxmr

17 Cesarean Delivery: Hospital Inpatient Median Costs and Median Charges: Latest Data NYS DOH Statistical Reports and Briefs https://health.data.ny.gov/Health/Cesarean-Delivery-Hospital-Inpatient-Median-Costs-/fr8u-haei

18 Adjusted discharge=inpatient discharges x (1+ (gross outpatient charges/gross inpatient charges)). We did not case mix adjust because it has been shown that public hospitals systematically underestimate DRG complexity compared with non-public institutions. See, for example, Mendez, C. M., Harrington, D. W., Christenson, P., & Spellberg, B. (2014). Impact of Hospital Variables on Case Mix Index as a Marker of Disease Severity. *Population Health Management*, *17*(1), 28–34. http://doi.org/10.1089/pop.2013.0002

19 2010 Instructions Institutional Cost Report (NYSICR) https://health.data.ny.gov/api/assets/329F8BC6-D396-4902-A9C2-F6B27E143924?download=true

On the issue of comparative costs, we should also note that reimbursement rates to hospitals generally support our conclusion about the costs of NYCH+H hospitals. Medicaid and Medicare payments for services are still tied to the cost of providing care. Thus, the payment rate for relatively expensive services like complex surgery is higher than the rate for simple pneumonia. However, rates paid by commercial payors are subject to negotiation between the insurance company and the hospital and reflect non-cost related issues including reputation and relative market share. In this case, NYCH+H hospitals receive among the lowest payments regardless of the service provided, according to a recent study commissioned by the NYS Health Foundation.[20] All study hospitals were grouped into five relative price groups. Eight of the nine NYCH+H hospitals included in the study were in the lowest price group and the ninth (Lincoln) was in the second lowest.

Comparing quality

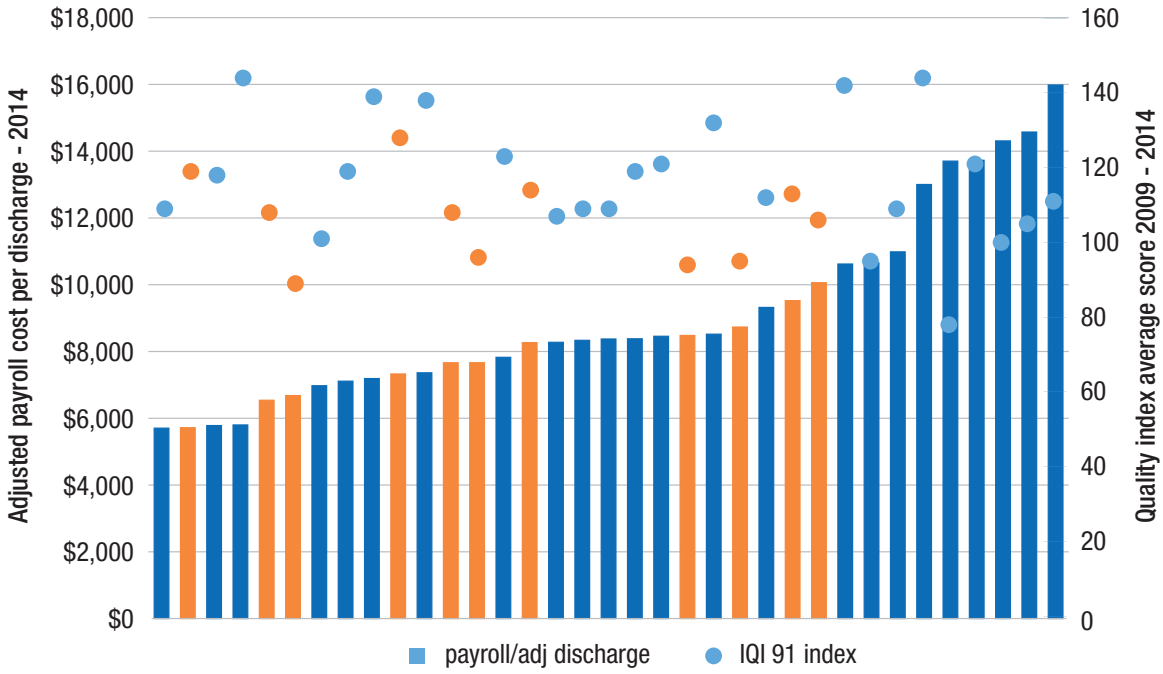
Spending a lot does not necessarily produce high quality. Cost and quality are rarely correlated. Like cost, quality is difficult to assess. However, as medical care reimbursement transitions from fee-for-service to value-based purchasing, numerous new, validated measures of the quality of care have been developed and adopted by public and private payors. Among the most tested are the tools incorporated into the Inpatient Quality Indicators program first developed by CMS/AHRQ for Medicare and adopted by New York State. For the most recent reported years (2009-2014), all but one of NYCH+H's Inpatient Quality Indicator scores have been in the top half of NYC hospitals.[21] There is no apparent correlation between quality and cost. See Chart 6, which shows the hospitals' payroll cost per adjusted discharge (with NYCH+H hospitals represented by the orange bars and the private hospitals represented by the blue bars) and the quality index scores (with NYCH+H hospitals represented by orange dots and private hospitals by blue dots, in which lower scores indicate better quality). NYCH+H tends toward the higher quality and lower cost areas.

20 Gorman Actuarial, Inc. Why are Hospital Prices Different? An Examination of New York Hospital Reimbursement, December 2016

21 The IQIs are a set of measures that provide a perspective on hospital quality of care using hospital administrative data. These indicators reflect quality of care inside hospitals and include inpatient mortality for certain procedures and medical conditions; utilization of procedures for which there are questions of overuse, underuse, and misuse; and volume of procedures for which there is some evidence that a higher volume of procedures is associated with lower mortality. See Appendix for full chart.

CHART 6

Labor costs and quality scores



Source: SPARCS All Payer Inpatient Quality Indicators (IQI) by Hospital 2009-2014. The average of the observed-to-expected mortality ratio for IQI 91—acute myocardial infarction, heart failure, acute stroke, gastrointestinal hemorrhage, hip fracture, pneumonia; and Institutional Cost Report, Exhibit 35, 2014

A recent report by RAND on the association between healthcare cost and quality reviewed 61 major studies published between 1990 and 2012. They found that 21 showed a positive correlation between spending and quality, 18 negative, and 22 no correlation. The authors noted that "the associations were of low to moderate clinical significance in many studies."[22]

Further evidence of the relatively good quality provided by NYCH+H hospitals can be found in the patient safety ratings published by the Leapfrog Group, an independent nonprofit organization founded a decade ago by the National Business Group on Health. In the fall 2016 report, only five New York City area hospitals received a quality rating of "A" or "B"—all five were NYCH+H facilities. In the spring 2017 report, of the seven NYC hospitals that received a "B" (no NYC area hospital received an "A" rating), six were NYCH+H.[23]

NYCH+H—Serving the public in unique ways

NYC's public hospitals do much more than care for residents of nearby low-income communities. They are literally the backbone of the city's hospital system. They serve a disproportionate number of underinsured and uninsured people. They provide most of the Level I trauma care. They form the network of first responders to epidemics and unusual outbreaks. They provide care for the City's jail inmates and prison staff. And, together with the NYC Department of Health and Mental Health (DOHMH), they protect the public's health.

22 The Association Between Health Care Quality and Cost: A Systematic Review. Published In: Annals of Internal Medicine, v. 158, no. 1, Jan. 2013, p. 27-34. Posted on RAND.org on January 01, 2013

23 See: Leapfrog Group, Hospital Safety Grade, at http://www.hospitalsafetygrade.org/search?findBy=state&zip_code=&city=&state_prov=NY&hospital=

Taking care of the uninsured

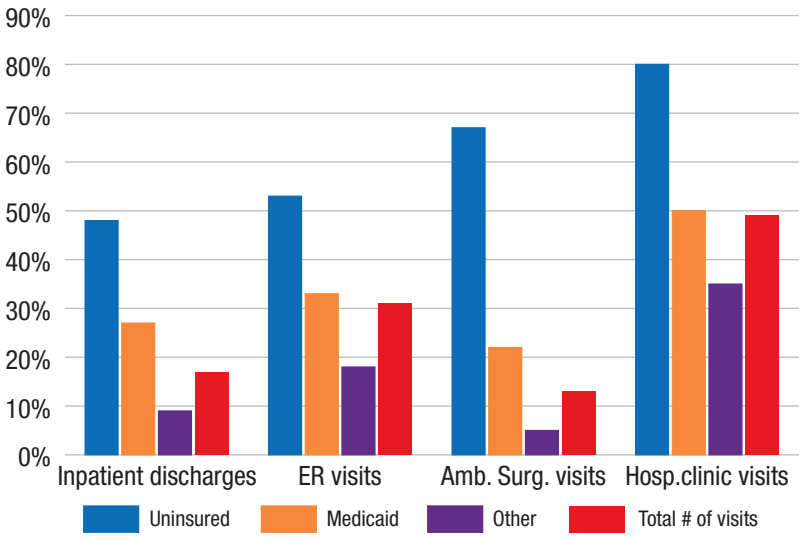
As the ACA has moved to cover much more of the population, care for the remaining uninsured population is increasingly concentrated in the City's public hospitals.

Half or more than half of the uninsured who sought inpatient, outpatient and/or emergency care in 2014 went to one of NYCH+H's hospitals. As Chart 7 shows, while NYCH+H hospitals accounted for 17 percent of all inpatient discharges from New York City hospitals, NYCH+H accounted for nearly half (48 percent) of uninsured discharges, a share that is nearly three times the NYCH+H share of all inpatient discharges.

Further, the inpatient discharge data significantly understates the role NYCH+H facilities play in delivering healthcare services to the uninsured. As the chart below indicates, NYCH+H handled 31 percent of all emergency room visits, and 49 percent of all hospital-based clinic visits in the city. Over half (53 percent) of ER visits by the uninsured are handled by NYCH+H facilities, and two-thirds (67 percent) of ambulatory surgery for uninsured patients is performed by NYCH+H hospitals. An overwhelming share (80 percent) of hospital clinic visits for the uninsured are in NYCH+H hospitals.

CHART 7

NYCH+H share of NYC hospital visits, 2014



Source: City of NY *One New York Health Care For Our Neighborhoods Transforming Health+Hospitals*, April 2016

Taking care of the underinsured—unwanted by the private system

NYCH+H's hospitals function as community hospitals in many underserved neighborhoods and provide a lifeline for the uninsured. Equally important, they are the primary source of care for those suffering from psychiatric and substance abuse disorders and illnesses.

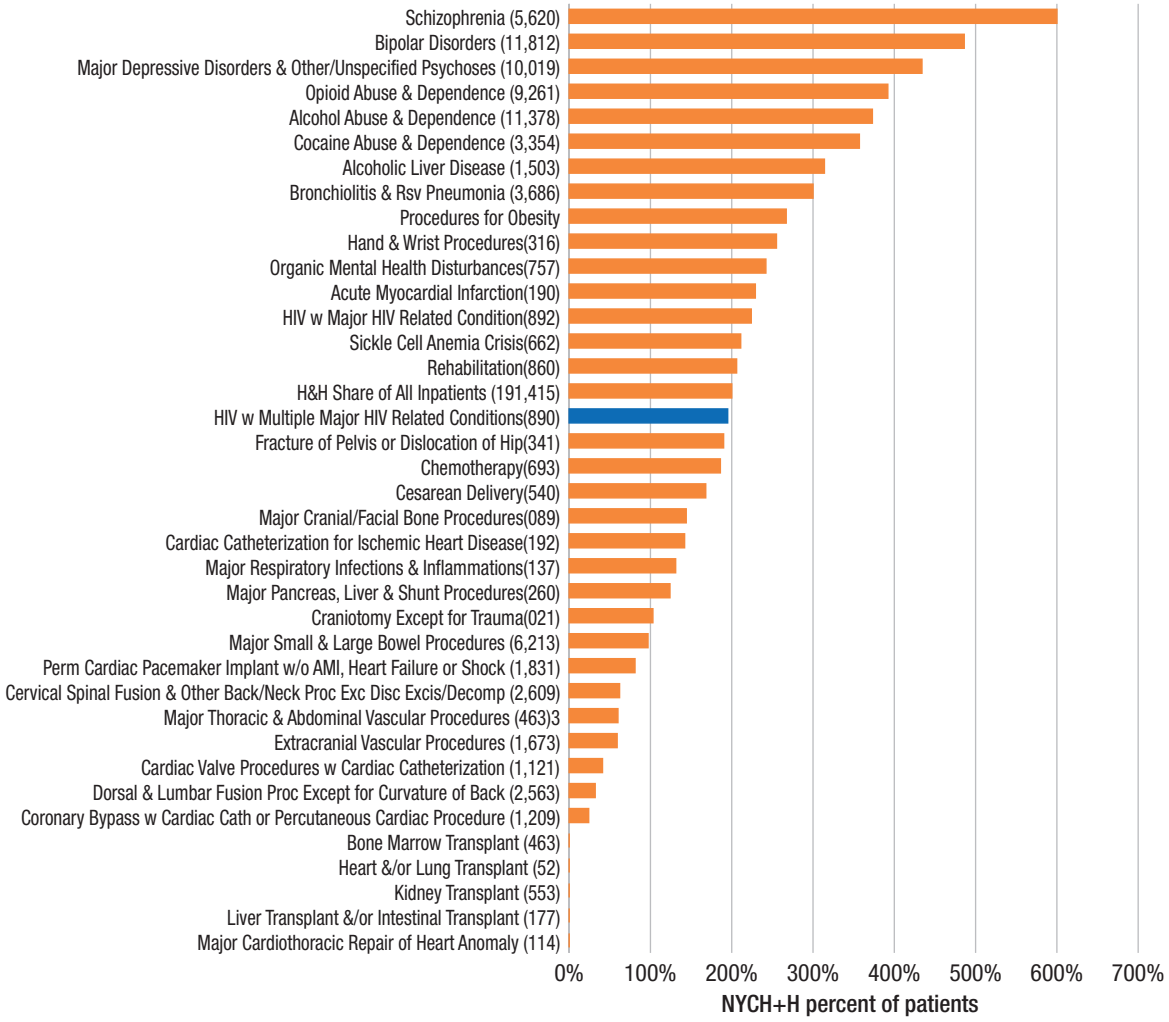
As with other publicly financed services for lower income communities, these conditions are historically underpaid. For example, 2014 base inpatient Medicare reimbursement was $9,476 for an inpatient stay for schizophrenia and $10,249 for someone diagnosed with a major depressive

disorder. Conversely, its payment rates for major surgical services were substantially higher—liver transplants—$80,001, coronary bypass—$33,405, major bowel procedures—$21,532. More important than the difference in payment rates are the (profit) margins. Surgical procedures produce the largest margins—especially when accompanied by surgical complications.[24]

As can be seen on Chart 8 below, where the blue bar represents NYCH+H share of all discharges, the public hospitals did very few of those more complex, well-paid surgical procedures that require well-appointed high-tech operating rooms, highly experienced surgeons and many well-trained (and well-paid) nurses and ancillary personnel. Not coincidentally, these are the types of inpatient services that are most handsomely reimbursed.

CHART 8

NYCH+H share of inpatient discharges—selected DRGs, 2014*



*The values for the last five categories are too small (less than one percent) to show on chart.
Source SPARCS, APR DRG by facility, 2014

24 Average surgical margins ranged from $16,936-$55,953 per case from commercial payers and $1,880- $3,687/case from Medicare https://www.hsph.harvard.edu/news/press-releases/patients-with-surgical-complications-provide-greater-hospital-profit-margins/

Trauma centers—providers of first resort

Most in-patient admissions come through the emergency department.[25] NYCH+H cares for a majority of the City's Level 1 trauma patients—the most grievously ill and seriously hurt. Bellevue is the emergency department of choice for any serious accident or incident that occurs in Midtown Manhattan—at construction sites, on the streets, in hotels, restaurants and theaters. Being the backbone of the trauma response system is an entirely appropriate function for a public hospital system. This role, however, comes at a high cost.

Trauma centers are expensive—the same care is about twice as expensive when provided in a trauma center compared to a non-trauma center.[26] Maintaining a trauma center means having oncall a wide array of professionals and facilities able to respond to just about anything that crosses the threshold.

According to NYS Department of Health Regulations:

> A regional trauma center is a facility with the ability to provide definitive treatment to the full-range of trauma patients including a commitment to trauma research and education. Such a facility has 24-hour availability of specialists in varied surgical and non-surgical fields. A regional trauma center can treat 1,000 severely injured patients per year. The minimum number of severely injured patients treated at a regional trauma center is 400 patients per year.[27]

NYC Adult Level I/Regional Trauma Centers:

Bellevue Hospital Center
Jacobi Medical Center
Lincoln Medical & Mental Health Center
Jamaica Hospital Medical Center
Lutheran Medical Center
New York-Presbyterian/Queens
Richmond University Medical Center
Elmhurst Hospital Center
Harlem Hospital Center
Kings County Hospital Center
NY Presbyterian/Weill Cornell Med. Cen.
Staten Island University Hospital North

The second reason is the fact that capacity invites use. New Yorkers and visitors in need of immediate medical care know about the NYCH+H emergency capacity and know they will not be turned away. Whether suffering from indigestion, a knife wound, a fever or fearing a heart attack, more people, especially residents of poor communities who have a paucity of alternative community-based care, use the 11 public hospitals emergency rooms more often than visit the 36[28] voluntary hospital emergency departments. NYCH+H hosts 1.2 million of the City's four million ER visits. NYCH+H emergency room utilization far outstrips its share of inpatient beds. There are 30 ER visits for every 10 inpatient beds in the NYCH+H system compared to 18 visits for every 10 beds among voluntary hospitals.

From orphans to orphan diseases—the role of public hospitals in public health

NYCH+H hospitals are responsive to yet another kind of emergency—that is, public health emergencies. In the 1980s and early 1990s, it was mostly NYCH+H hospitals, together with the Catholic hospitals, that cared for thousands of New Yorkers afflicted with AIDS. As described by the CDC, HHC was a *Featured Partner* because:

From the start of the AIDS epidemic 30 years ago, NYCH+H has been a leader in HIV/AIDS treatment and care. In 1981, before HIV or AIDS had been identified, Bellevue Hospital reported one

25 Kristy Gonzalez Morganti, et al., The Evolving Role of Emergency Departments in the United States, The Rand Corporation, 2013.O R P
26 R Durham, et al., Evaluation of a mature trauma system, Annals of Surgery, 2006; 243(6):775–83.
27 See: New York State DOH, Listing of Trauma Centers, at https://www.health.ny.gov/professionals/ems/state_trauma/docs/traumastds7085.pdf
28 Many hospitals have multiple sites. There are 55 unique hospital buildings scattered across the 5 boroughs

of the first of the three cases of unexplained immunodeficiency in the U.S. By the mid-1980s, HHC hospitals were seeing growing numbers of patients with AIDS and started developing treatment plans and services, including

- The first hospital-based HIV nutrition program in the country opened at Bellevue Hospital.
- The first long-term care beds in the United States for people living with AIDS were at Coler Memorial Hospital.
- Kroc Day Care Center for Children with HIV operated at Jacobi Medical Center (the nation's first such facility).
- NYCH+H has also participated in important research over the years, such as studies of HIV infection in women at Kings County Hospital in 1986, which led to the development of the country's first guidelines for care of HIV-infected women.[29]

There are numerous examples of special NYCH+H clinics and inpatient units providing care for some new or rare and/or expensive condition.

- Bellevue is one of 16 U.S. hospitals that U.S. Health & Human Services (HHS) designated as a leprosy treatment center. The leprosy clinic sees 25 patients a week. Altogether there are 400 leprosy patients registered for care at the oldest hospital in the city.
- During the recent Ebola panic, NYCH+H took the lead in preparing for any possible outbreak. The one NYC patient was taken care of by the nurses and doctors at Bellevue.
- 10,000 victims of the World Trade Center have been or are being followed/cared for at one of NYCH+H's three WTC Environment Centers—Bellevue, Elmhurst or Gouveneur.

As with its role as a provider of trauma care, it makes perfect sense for NYCH+H to partner with the City's Health Department in responding to new threats to the public's health and to New Yorkers' unusual diseases and injuries. In other cities without robust public hospital systems, these responsibilities, while paid with public funds, are imperfectly apportioned to various parts of the private system. Those places have neither the same quality nor the quantity NYC enjoys. Nor do they have a potential system that could, if properly led and financed, be the catalyst for change. It is only the public hospitals that are motivated by concern for the public's health and for the care of each person who arrives at their door—without regard for illness, station or price.

Race Matters—at least in New York City hospitals

Just as insurance status varies from hospital to hospital, so do the race/ethnicity of the people served by NYCH+H hospitals. The 11 public hospitals are in demographically diverse communities. Bellevue, for example, is in predominately white Kips Bay. Harlem Hospital Center is in the heart of NYC's historic Black community, which has become increasingly diverse over the last decade. The communities around Jacobi in the East Central Bronx and North Central Bronx in the North Bronx are similar—overwhelmingly non-white and about evenly divided between Black and Latino. In each of these cases there is also an adjacent or nearby private AMC.

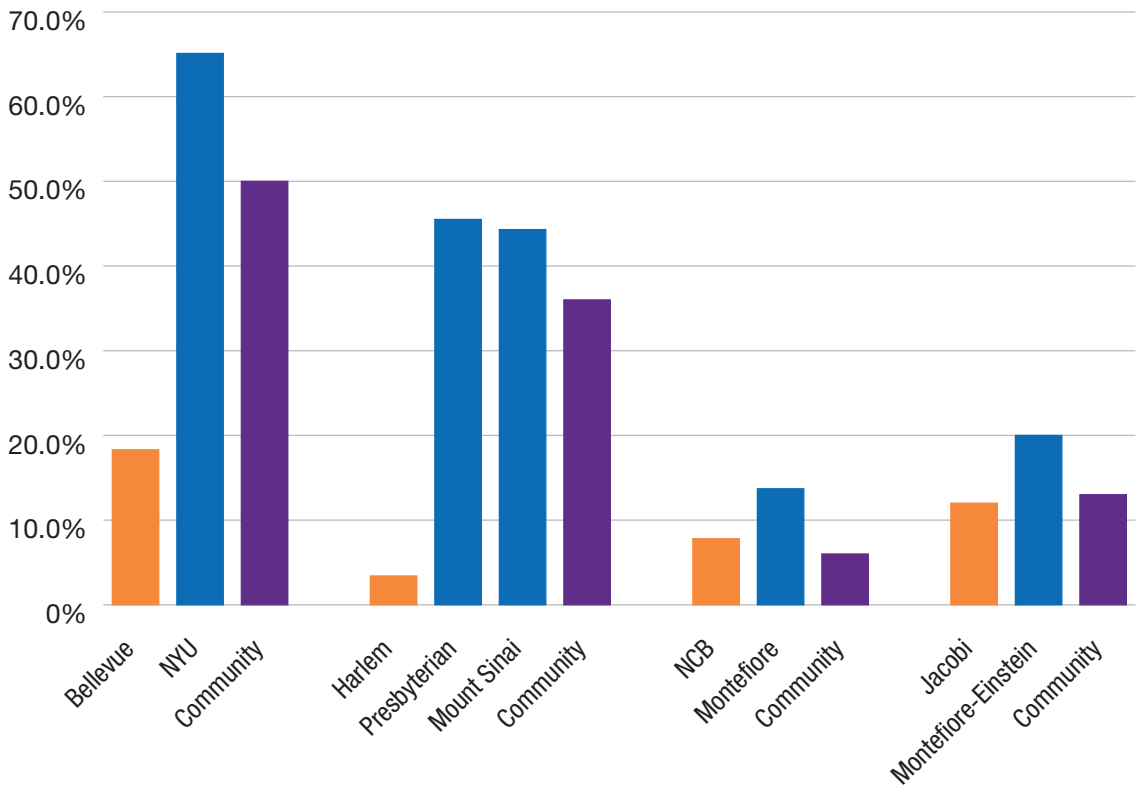
We would expect some correlation between the racial composition of the nearby neighborhoods and that of the hospital. Only the Montefiore/Einstein pairs look similar. The other two are quite different. The patients are predominantly white at NYU Hospital, Mt. Sinai, and NY Presbyterian, while people admitted to the two nearby public facilities are more than 80 percent people of color. These large disparities cannot be due to chance. A recent paper on New York City AMCs reached the same conclusion.[30]

29 See CDC, National Prevention Information Network, Featured Partner, at https://npin.cdc.gov/featured-partner/new-york-city-health-and-hospitals-corporation-hhc

30 RS Tikkanen, et al., Hospital Payer and Racial/Ethnic Mix at Private Academic Medical Centers in Boston and New York City, International Journal of Health Services, Feb. 2, 2017.

CHART 9

Percent of white patients among inpatient discharges—NYCH+H and nearby private medical centers and percent white population in the surrounding community[31]



Sources: 2014 SPARCS, Inpatient discharges by race, NYC DOHMH Community Health Profiles 2015

31 The Bellevue/NYU community or service area includes the Lower East Side, Chinatown, Stuyvesant Town and Turtle Bay; Harlem/Presbyterian/Mt Sinai includes the Upper East Side, East Harlem, Central Harlem, Washington Heights and Inwood; NCB/Montefiore includes Kingsbridge Heights, Bedford, Williamsbridge and Baychester; Jacobi/Montefiore includes Morris Park, Bronxdale, Throgs Neck, Co-op City, Parkchester and Soundview.

NYC PRIVATE HOSPITALS

As of January 2017, there were 36 non-public, general care, community hospitals in NYC. All were private, nonprofit voluntary institutions. And all but seven were part of a system organized by one of the five large hospital networks—Montefiore, NY Presbyterian, Mt. Sinai or Northwell (formerly North Shore LIJ, operator of seven NYC-based institutions).

CHART 10

	Number of hospitals	Staffed beds	Patient days	Gross patient revenue ($000s)
Voluntary hospitals	36	18,157	4,397,147	$78,698,134
NYCH+H hospitals	11	4,692	880,046	$10,016,112
NYCH+H share	23.4%	20.5%	16.7%	11.3%

Source: American Hospital Association American Hospital Directory updated 1/1/2017

A decade ago the city's voluntary hospital system was in such serious distress that the United Hospital Fund issued a clarion call:

> New York City's nonprofit hospitals continue to face significant financial hardship, and the survival of many small and safety net hospitals is in doubt. Since 2000, eleven hospitals have closed and an additional six are in, or have recently emerged from, bankruptcy. Per this year's update of hospital financial ratings by the United Hospital Fund ("the Fund"), more than one-half of hospitals (eighteen of thirty-four) were either "in jeopardy" or "at risk" in 2006, and facing such serious financial problems that some will not survive without a significant change in their operations or circumstances.[32]

The Governor and Legislature commissioned a 2006 study of the situation. Its report recommended closure and consolidation of many of the most vulnerable safety net facilities.[33]

Since the Great Recession, the AMCs have reinvented themselves as multi-hospital, geographically dispersed, vertically integrated mini-empires. They merged with, bought or acquired 35 nearby

32 United Hospital Fund, *The Deteriorating Financial Condition of New York City's Nonprofit Hospitals, and Its Effect on Capital Investment*, 2008.

33 It is instructive to recall some of the 2006 conclusions:

The Commission reaches a stark and basic conclusion: our state's healthcare system is broken and in need of fundamental repairs. Today, New York is struggling to maintain a 20th century institutional infrastructure in the face of mounting costs, excess capacity, and unmet needs for community-based alternatives.

- Turbulence afflicts our healthcare providers; facility closures and declarations of bankruptcy are too common. Since 1983, 70 hospitals and over 63 nursing homes have closed in New York State. Some of our oldest and proudest names in healthcare struggle under the unintended consequences of bankruptcy proceedings. Patient access to stable healthcare services is at risk.
- Our healthcare providers are in weak financial condition. For the past eight years, the state's hospitals as a group have lost money.
- Negative or inadequate fiscal margins limit the ability of providers to reinvest in their systems, obtain the latest technologies, access capital, and upgrade their physical plants.
- Reimbursement mechanisms distort patterns of service delivery and induce facilities to pursue high margin services, sometimes at the expense of more essential community needs. The current rate paradigm is encouraging a medical arms race for duplicative provision of high-end services and discouraging the provision of preventive, primary, and other baseline services.

Commission on Health Facilities in the 21st Century Final Report, Executive Summary, pp. 4-5, https://nyhealthcarecommission.health.ny.gov/docs/final/executivesummary.pdf

hospitals, numerous labs, freestanding surgery and urgent care centers, and many primary care practices. At first, they accomplished this far-reaching transformation with small amounts of capital—more promises than money—grabbing up financially weak hospitals and physician groups looking for a buyer. Over the last several years, the risk has paid off with significantly increased net revenues for both the mother ships (the AMCs) and many of the associated facilities.

Four factors contributed to the turn-about.

1. Reduced competition for paying patients; purchase/merger/consolidation of 35 local area hospitals into one of five networks; and closure of 20+ NYC hospitals since the turn of the century. There has been a net loss of 4,967 beds. The result has been increased leverage with commercial payers and higher reimbursement rates.[34]
2. A hugely increased pool of insured patients with the wherewithal to pay the cost of high technology/tertiary services.
3. AMCs' ability and willingness to shift resources and change service, payor and personnel mix toward more profitable services and to exploit new reimbursement offerings and methodologies—particularly changes initiated by Medicare such as accountable care organization value-based reimbursement.
4. Accelerating shift of under- and non-insured patients and under-reimbursed services to the NYCH+H system and to the few remaining non-affiliated struggling safety net private hospitals (e.g., Brookdale, Wyckoff, Interfaith, Bronx Lebanon, Jamaica).

In addition to the direct payment for services, private healthcare providers are also the recipients of huge indirect subsidies. Medicare and Medicaid, augmented by insurance payments on behalf of public employees and workers comp beneficiaries provide two-thirds of voluntary hospital income. In addition, the City of New York gives sizable real property, income and sales tax exemptions to private nonprofit providers (hospitals, health centers and some nursing home and home care agencies). The real property tax exemptions from the City of New York, totaling $669 million in FY 2017, were up by 34 percent from FY 2011. As the major private hospital networks have rapidly expanded their affiliated physician practices in recent years, it is likely that they have extended those exemptions to the highly valued commercial real estate these practices occupy.

In addition, the big five private hospital systems also benefit from being able to issue tax-exempt bonds through the Dormitory Authority of New York State (DASNY). As of 2014, the five networks reported a total of $3.9 billion in outstanding tax-exempt bonds, generating a conservatively estimated $71 million in annual interest savings.

Public support for hospitals and other healthcare providers is also extended through the exemption of employer-paid health benefits from income taxation. This provides enormous indirect support to the health insurance industry, as well as private employers. In total, between the benefits conferred to charitable institutions and income tax exemptions, it is estimated between 65 percent and 70 percent of all healthcare spending is supported by public funds.[35]

Since the early days of the 21st century consolidation, transformation, generous public financing, good commercial insurance deals and the benefits of "charitable" status have redounded to the benefit of the bottom lines of the major private networks. In 2014 and 2015, the five systems collectively had about $650 million in net revenues each year, and that rose to $877 million in 2016.

34 Gorman Actuarial prepared for the New York State Health Foundation, Why Are Hospital Prices Different? An Examination of New York Hospital Reimbursement, December 2016, http://nyshealthfoundation.org/uploads/resources/an-examination-of-new-york-hospital-reimbursement-dec-2016.pdf

35 Public Funds Account for Over 70 Percent of Health Care Spending in California Andrea Sorensen, Narissa J. Nonzee, and Gerald F. Kominski http://healthpolicy.ucla.edu/publications/Documents/PDF/2016/PublicSharePB_FINAL_8-31-16.pdf

CHART 11

Operating revenues and expenditure, five major hospital networks

		NY Presbyterian	NYU Hospitals	Montefiore Med. Ctr.	Mt. Sinai Med. Ctr.	Northwell Health	Total 5 Networks
	in $000s All FYs end 12/31 except NYU 8/31						
2016	Operating revenue	$7,421,079	$3,582,121	$3,905,334	$2,368,257	$9,938,268	$27,215,059
	Operating expense	$7,096,220	$3,303,731	$3,887,351	$2,208,521	$9,842,401	$26,338,224
	Net	$324,859	$278,390	$17,983	$159,736	$95,867	$876,835
	% increase 2015-2016	43.5%	21.6%	1174.5%	51.7%	6.9%	34.5%
2015	Operating revenue	$5,928,217	$2,637,049	$3,672,439	$2,127,173	$8,722,655	$23,087,533
	Operating expense	$5,701,825	$2,408,172	$3,671,028	$2,021,865	$8,632,957	$22,435,847
	Net	$226,392	$228,877	$1,411	$105,308	$89,698	$651,686
2014	Operating revenue	$5,262,742	$2,346,453	$3,472,342	$2,016,551	$7,435,046	$20,533,134
	Operating expense	$5,036,864	$2,131,662	$3,432,175	$1,941,757	$7,347,534	$19,889,992
	Net	$225,878	$214,791	$40,167	$74,794	$87,512	$643,142

Source: audited financial statements

The City subsidizes these growing margins of the voluntary hospitals. Some changes that have taken place in the city healthcare system might suggest there needs to be an assessment undertaken to revisit the continued tax-exempt charitable status of the five major systems. Charitable tax status for private hospitals typically has been based, in significant part, on providing unreimbursed care for the indigent, insufficiently reimbursed Medicaid services, and maintaining high-cost trauma care capacity. The trends described in this report regarding these three criteria all indicate a shift of this charitable burden from the private hospitals toward NYCH+H. Complicating the charitable tax status question are increased advertising expenditures and a growth in the number of highly compensated executives.

Further, despite their tax-exempt status, the five networks are being run by very highly paid executives whose salaries rival those in the for-profit corporate sector. As of 2015, the five networks reported 108 executives were paid over $1 million each annually, with an average compensation of $2.2 million. The private hospitals as a group have over 150 executives who are paid more than the highest paid NYCH+H official. At one of the larger private networks, New York and Presbyterian, executive compensation soared 18 percent in 2015 over 2014, and pay packages resemble those on Wall Street, with bonus pay comprising a large part of total compensation

CHART 12

Compensation for highly paid executives, five major private hospital networks, 2015

Range for highest paid executive at each network	$3.7-$11.1 million
Number of hospital executives with total compensation greater than $1 million	108
Average compensation of $1 million+ plus executives	$2.2 million
Total compensation for these $1million+ plus executives	$234.2 million

Source: IRS 990 Schedule J Compensation

A closer look at compensation practices for New York Presbyterian, the second-largest of the five private hospital networks, reveals that their executive compensation packages look a lot like those on Wall Street, with base pay accounting for 44 percent of total compensation and a very large portion comprising bonuses and other forms of compensation. Moreover, executive pay rose sharply in 2015, with total compensation soaring by 18 percent from the year before for 28 executives working at New York Presbyterian in both years. Executive pay practices appear to be very similar at the other four private hospital networks.[36]

In addition to their favored tax status, private hospitals are beneficiaries of overly generous allocations of public safety net funding. While NYCH+H provides well over half of the care to the uninsured, private hospitals receive 85 percent of the NYS pool created to offset the costs of caring for these patients.[37]

Private hospitals are also at the top of a series of funding pools for distribution of federal payments to institutions that care for higher proportions of Medicaid and uninsured patients—federal Disproportionate Share Hospital (DSH) payments. Created in 1981 to help offset some of the costs of caring for Medicaid and uninsured patients, DSH payments to NYS as a whole are determined annually by the federal government, but the distribution of the total pool of federal funds allocated for New York to individual hospitals is largely determined by the State.

The need for disproportionate share payments was expected to decline as the number of ACA-covered individuals increased. The ACA (which continues to remain in effect despite recent efforts in Washington) calls for a $43 billion nationwide reduction in DSH allocations between 2018 and 2025, beginning with a $2 billion reduction in FY 2018. Currently NYS receives 17 percent of all DSH payments for the entire country. As such it is most vulnerable to the projected cut.

NYS DSH distributions are arranged in five pools. NYCH+H receives funding from three of the pools.[38] The amount in NYCH+H's residual pool depends on how much the State receives. First, voluntary and non-NYCH+H public hospitals are given their mandatory share. NYCH+H receives the rest.

In FY 2017, voluntary and non-NYCH+H public hospitals were guaranteed $995 million. As DSH payments decline, the amount in the funnel left after the non-NYCH+H guarantee becomes smaller and smaller. NYCH+H's budget professionals are expecting its DSH payments to decline from $2.2 billion in FY 2016 to $1.4 billion in FY 2020. Reporting on the allocation of these payments, the Citizens Budget Commission recently recommended

> The State should reconsider its priorities in distributing Medical supplemental payments. The fixed size of available federal funding means that redirection to H+H comes at the expense of other

36 New York Presbyterian IRS 990s for 2014 and 2015.

37 Roos Tikkanen et al. *Funding Charity Care in New York: An Examination of Indigent Care Pool Allocations*. NYS Health Foundation March 2017. P. 11

38 NYCH+H, *One New York Health Care For Our Neighborhoods Transforming Health+Hospitals*, 2016. p. 27

institutions. Pending cuts should not fall only on H+H and adjustments, such as reduced payments to voluntary hospitals with limited reliance on supplementary payments, may be needed.[39]

The large private networks would not have been able to position themselves as beneficiaries of New York City's transforming healthcare system without the public hospital system. NYCH+H hospitals thus contribute directly to the financial health of the private system. They absorb many of the broader hospital system's losses—first as a source of community healthcare to low-income residents of nearby communities, and second as guarantor of the public obligation to take care of the sick and suffering regardless of circumstance or cost. NYC's mammoth private hospital networks report larger and larger gains. They net more than a $1.5 billion (the total of their net income and the value of avoided taxes and expenses). The private hospital networks prosper at the expense of the public system.

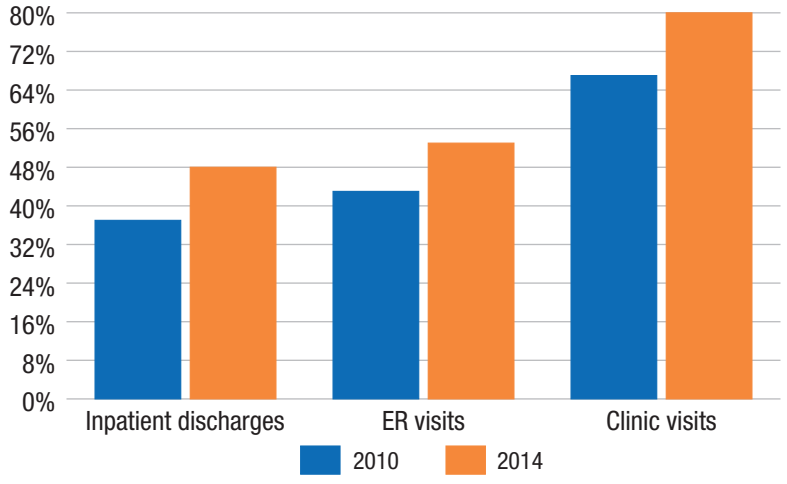
NYCH+H AND THE PRIVATE SYSTEMS MOVING FURTHER APART

The changes brought by the ACA, especially the significant decrease in the number of uninsured New Yorkers, have not lessened the differences between the public and private systems. In fact, the payor and diagnostic mix differences between them have widened in recent years.

NYCH+H hospitals were already a major provider of care to the uninsured prior to the ACA. Since then its share increased even as the number of uninsured declined. For the period 2010-2014, NYCH+H took on an additional burden of uninsured patients—on the inpatient side its proportion of uninsured patients increased from 37 percent to 48 percent. Apparently, the rate of change accelerated further in 2017. During the first four months of the 2017 fiscal year, the number of uninsured patients *increased* by 4,059 while the total patient volume *decreased* by 9,674. Simple arithmetic shows that NYCH+H lost 13,000 insured patients (probably to private providers) and added 4,000 uninsured in their place.[40]

CHART 13

NYCH+H share of services to the uninsured



Source: SPARCS Discharges by DRG by facilities, 2010 & 2014

39 P. Orecki Medicaid Supplemental Payments The Alphabet Soup of Programs Sustaining Ailing Hospitals Faces Risks and Needs Reform. CBCNY, August 31, 2017

40 NYC Mayor's Office of Operations, Preliminary Mayor's Management Report, February 2017, p. 159.

In the four years between 2010 and 2014, as NYCH+H's share of all inpatient discharges declined slightly, its hospitals have seen an *increase* in their already large share of total psychiatric and substance abuse-related discharges.

CHART 14

NYCH+H share of selected psychiatric & substance abuse discharges, 2010 & 2014

	2009	2014
Alcohol abuse & dependence	38.9%	39.4%
Alcoholic liver disease	26.1%	33.1%
Bipolar disorders	47.0%	49.5%
Cocaine abuse & dependence	29.9%	37.2%
Drug & alcohol dependence	33.8%	34.5%
Major depressive disorders & other/unspecified psychoses	41.5%	44.2%
Schizophrenia	59.7%	59.8%

Sources: SPARCS, DRG by facility 2010 and 2014

A HEALTH SYSTEM FOR THE 21st CENTURY

NYCH+H's financial and fiscal problems can be solved only within the context of New York City's entire health and hospital system. Our 8.5 million people are cared for at 47 general care hospitals, 31 community health centers and thousands of offices and clinics staffed by one or more of the city's 44,000 active physicians, 97,000 nurses and 50,000 other providers. On paper, it looks like enough money to give each person sufficient care. It isn't, because of (1) the profound inequality of healthcare needs; (2) maldistribution of resources among communities; and (3) historic imbalance in the ways healthcare is valued and paid for, particularly services for the poor and disabled.

Health disparities

Not every neighborhood in NYC needs enhanced healthcare service. Some are already well served, while others are in desperate need. The community needs assessments created for DSRIP planning published in December 2014 document many of the variations from neighborhood to neighborhood.[41] While the availability of healthcare does not necessarily lead to better health outcomes, there is little doubt that outcomes cannot improve if there is no access to needed care. Communities suffering excessive amounts of disease and death need more health services than other areas. A 10-year gap between communities with the longest life expectancy and the shortest is not inevitable. It's a consequence of hard lives and poor access to the sorts of services and programs that ameliorate the effects of racism, poverty and need. Or as Dr. Mary Bassett, New York City Commissioner of Health, put it, "This is unfair and avoidable. A person's health should not be determined by his or her ZIP code."[42]

41 See for example, One City Health, NYCH+H Community Needs Assessments http://www.onecityhealth.org/community-needs-assessments/

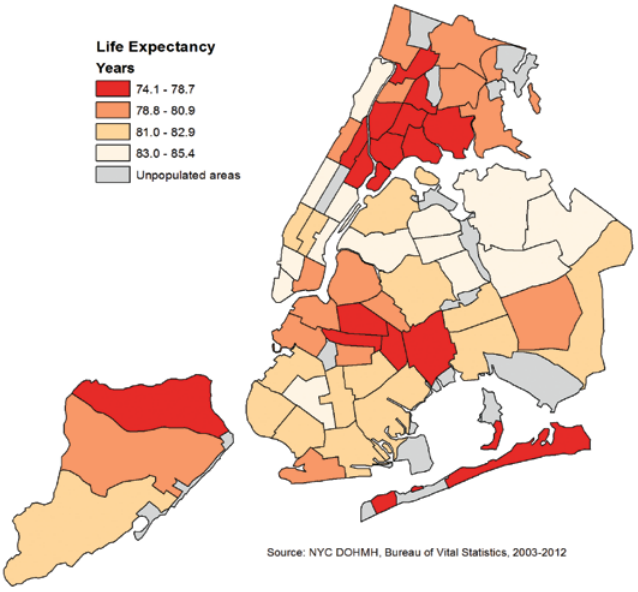
42 Community Health Profiles 2015

CHART 15
Life expectancy at birth

Life expectancy at birth

Highest		Years
1	Financial District	84.5
2	Stuyvesant Town and Turtle Bay	85.3
3	Upper East Side	85.0
4	Greenwich Village and Soho	84.3
5	Elmhurst and Corona	84.1

Lowest		Years
59	Brownsville	74.1
58	Bedford Stuyvesant	75.1
57	Central Harlem	75.1
56	Morrisania and Crotona	75.3
55	Rockaway and Broad Channel	75.9



Reproduced from NYC DOHMH Community Profiles, 2015

Maldistribution of resources

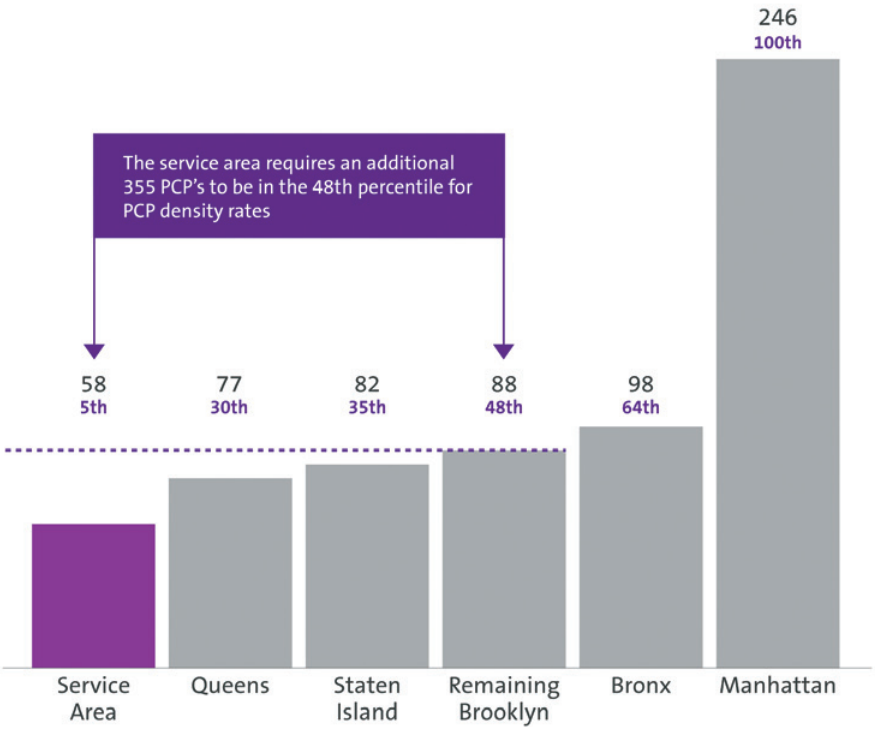
Most people need to be able to visit a doctor/nurse for the acute and chronic problems they encounter every day. Everyone should have quick access to emergency services for both better outcomes and peace of mind. A recent study of hospital closures in California found the *very act of closing down an emergency department* had serious consequences—"that one-quarter of hospital admissions in this period [1996-2009] occurred near an ED closure and that these admissions had 5 percent higher odds of inpatient mortality than admissions not occurring near a closure."[43] For best outcomes, the primary and emergency services should be linked to a local hospital that can deliver a baby, treat a heart attack, stop a stroke, and stabilize a patient who needs transfer for more complex treatment.

The most effective primary care is provided by professionals who know their patients, speak their languages, and are in their community.[44] There are not enough primary care physicians (PCPs) in New York City to provide that type of care. The maldistribution is both geographic and income determined. The Bronx, Brooklyn, Queens and Staten Island have less primary care coverage than 70 percent of Americans. The inequality is further deepened within the boroughs. In Brooklyn, for example, the authors of Northwell's recent study of central and east Brooklyn described such a severe shortage in those low-income neighborhoods that the addition of 355 PCPs in that community would only put the area in the 48th percentile, nationally.[45]

43 Charles Liu, Tanja Srebotnjak and Renee Y. Hsia, "California Emergency Department Closures Are Associated With Increased Inpatient Mortality At Nearby Hospitals," Health Affairs, August 2014, vol. 33 no. 8 (1323-1329).
44 Patient Centered Medical Home. For a summary of current effectiveness research see NCQA *Latest Evidence: Benefits of PCMH Recognition*, October 2016, at http://www.ncqa.org/Portals/0/Programs/Recognition/PCMH/NCQA1005-1016_PCMH%20Evidence_Web.pdf
45 Northwell Health *The Brooklyn Study: Shaping the Future of Healthcare*, 2016, p 76.

CHART 16

Comparison of primary care physician density for service area and NYC counties per 100,000 population, 2015



Source: Northwell Health *The Brooklyn Study: Shaping the Future of Healthcare*, p. 76, 2016

Unfair payment paradigm—you get what you pay for

The average charge for a heart transplant is $1.2 million. There were 175 heart transplants performed in New York City in 2014. New York City has more heart transplant centers than 33 *states* (and the state has just approved two more). On the other hand, Medicare's payment schedule for inpatient treatment of cirrhosis is very modest: $9,782 for a patient with cirrhosis and alcoholic hepatitis with major complications and/or co-morbidity; and $3,682 if the patient has no major complications. Montefiore, NY Presbyterian and Mt. Sinai advertise their transplant services. None has a sign out welcoming someone suffering from serious alcohol-related illness.

Worse than the distortion inherent in payment schemes is the absence of fair reimbursement for the social and personal services that have proven to make and keep people healthy. "We have the wrong balance of social and medical spending," according to a recent Brookings blog post, "if one of our priorities is improving health overall and measures such as infant mortality and life expectancy. This pattern from the international evidence is reflected in data from within our own borders. States with a higher ratio of social to health spending also have significantly better health outcomes for such conditions as adult obesity, asthma, mental health indicators, mortality rates for lung cancer, high blood pressure, heart attack, and Type 2 diabetes."[46]

46 Stuart M Butler, et al., "Re-balancing medical and social spending to promote health: Increasing state flexibility to improve health through housing," February 15, 2017 https://www.brookings.edu/blog/up-front/2017/02/15/re-balancing-medical-and-social-spending-to-promote-health-increasing-state-flexibility-to-improve-health-through-housing/

RECOMMENDATIONS

NYCH+H's fiscal problems cannot be fixed by closing hospitals, laying off staff, and cutting services. Nor can the solution be increased reliance on and payments to the costlier and less responsive private hospital system. Unfortunately, given the current alignment of reimbursement policies, it is very unlikely that NYCH+H hospitals will be reimbursed adequately for the cost and quality of services it provides.

Fiscal relief can come, in part, from other sources. The private healthcare system needs to be made more accountable for the care of all New Yorkers—regardless of ability to pay or medical problem. The hospital system in New York City is a single system with multiple managements. The voluntary sector is making money, the public sector is not, but not because it is high-cost or provides poor quality. No solution to NYCH+H's fiscal woes will succeed without acknowledging NYCH+H's interaction with the city's broader healthcare system. Nor will success happen without recognition that the burden of caring for the neediest and most vulnerable should be more equitably distributed.

1. A reshaped public care system based upon need

We must create a public health system that reflects and responds to low-income and vulnerable New Yorkers through a newly created community-based care network (NYCH+H working with DOHMH) while maintaining a geographically dispersed community hospital network that's welcoming to all community residents. This must include maintaining sufficient capacity in the public hospital system to fulfill its mission as provider to both residents of adjacent communities as well as the unique populations served by NYCH+H. The future system needs to be reshaped based on local needs—some communities will need increased services, and some might not. Most of the data necessary to construct a rational system has been collected and analyzed. Now is the time to use it.

2. More equitable distribution of healthcare burdens and resources

The major private hospital systems need to take more responsibility for the needs of all New Yorkers. This will require that current funding formulas be revised. City and State government needs to be proactive. First, redesigning the distribution of the state-specific Indigent Care Pool, as well as the state-administered Medicaid and Medicare charity care add-ons, to recognize NYCH+H's significant contribution to caring for the uninsured, especially immigrants, and the underinsured. Second, those hospitals that do not operate Level 1 trauma centers and depend on NYCH+H and others to maintain these costly operations should contribute to a trauma center funding pool. Third, the State and the Medicaid payers it regulates must change the reimbursement weighting system that underpays the costs of treating psychiatric and substance abuse disorders and fails to financially acknowledge the critical contribution of social services.

3. City actions to push private hospitals to do/or pay for their share

The City and State should consider whether tax benefits, permitting, and zoning exceptions awarded to private, nonprofit hospitals ought to be based on a demonstrated contribution to caring for the sick, regardless of ability to pay—and in the absence of such contribution, the collection of special taxes to help offset the costs of services currently borne by NYCH+H. Property tax and commercial income tax exemptions are awarded to charitable enterprises. Are all of NYC's private healthcare networks entitled to these exemptions? A Morristown,

New Jersy, judge, for example, recently revoked a local hospital's nonprofit status—finding that the hospital behaved not like a charity, but like a business.[47] Perhaps the City of New York should apply similar criteria for awarding property tax exemptions and granting zoning and construction permits.

The City might consider a program like one implemented by San Francisco. The Charity Care Ordinance of 2001 tied local approval of construction permits to demonstrated provision of charity care. As related by Elizabeth Rosenthal in her book, *American Sickness*, Sutter's California Pacific Medical Center had to promise $1.1 billion in concessions before the city would issue the required permits. Among the items the hospital promised were a freeze on prices charged city employees insurance, operation of a nearby safety net hospital, some affordable housing investments and upgrades of transit and sidewalks.[48] New York City might want to broaden the scope of such a program to include property tax forgiveness.

4. City leadership on creating a New York City health system for the 21st century

A transformation plan that focuses only on the NYCH+H hospital system's finances, without considering the role that it plays in the broader healthcare system, is doomed to failure. NYCH+H cannot become self-sustaining because it absorbs the losses that the private providers are unwilling to shoulder.

The NYCH+H system thus has a symbiotic relationship with the private providers, absorbing costs and assuming obligations for services that the City needs but that the other hospitals can avoid because of the existence and role of the public system.

Given this dynamic, any restructuring of NYCH+H or path toward sustainability must include maintenance of effort to support NYCH+H's quality of care. The alternative is a vicious downward cycle of cuts that affect quality, causing loss of market share and more revenue losses that in turn cause further losses and more cuts in service.

The City working with the State must also take on a more assertive role in shaping the structure of the entire public and private hospital care system. The goal of any restructuring cannot be merely to fix the finances of NYCH+H but to create an integrated city-wide healthcare system in which the private and public provider systems work together to provide health services to the people of New York.

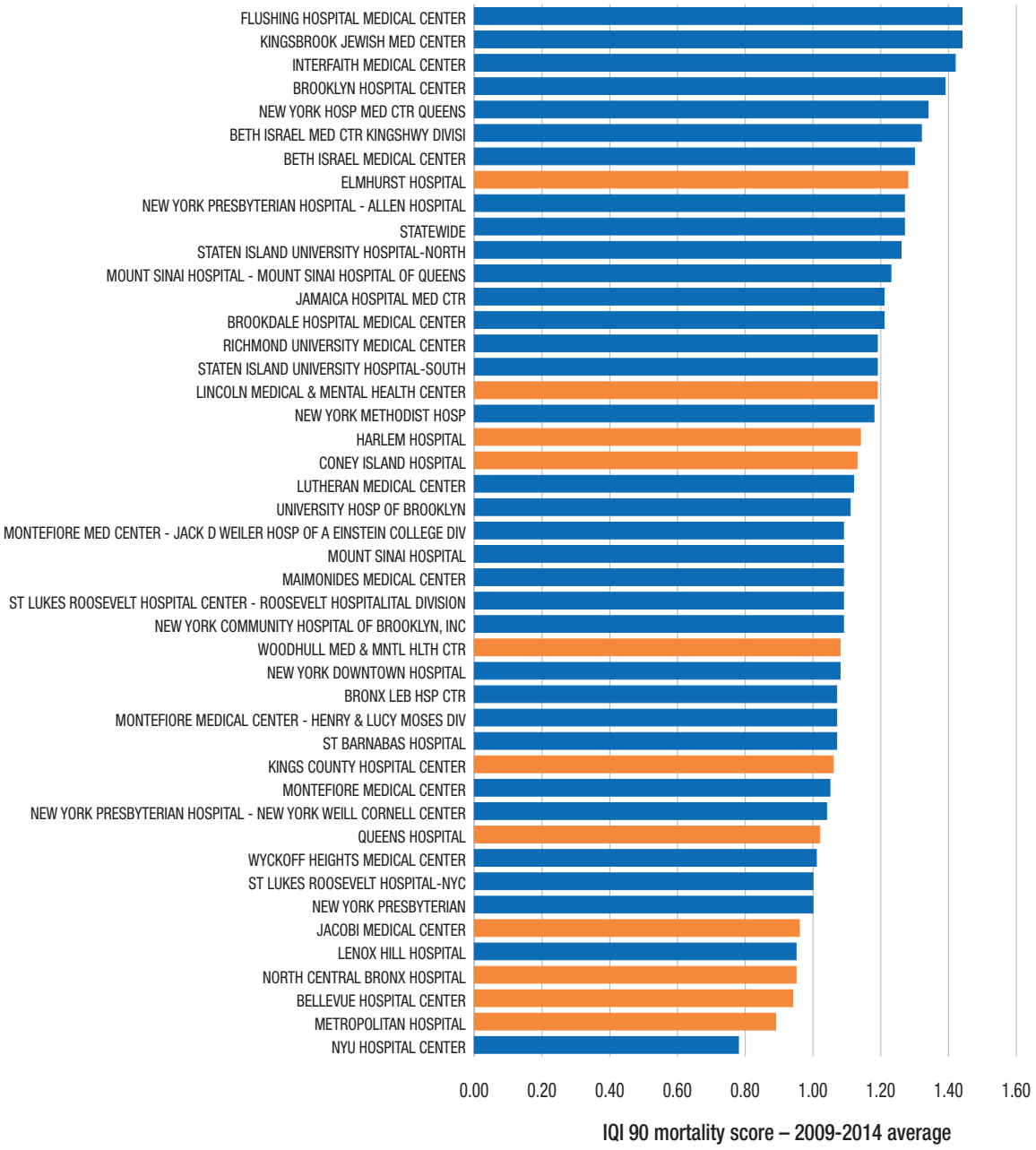
47 A recent judgment against New Jersey's Morristown Medical Center nonprofit status was based on two factors, according to *Modern Healthcare.* http://www.modernhealthcare.com/article/20150708/NEWS/150709925) Frist, the hospital had relationships with for-profit subsidiaries and owned a number of MD practices. Second, the Medical Center paid its executives high salaries. "If it is true that all nonprofit hospitals operate like the Hospital in this case," the judge observed, "then for purposes of the property-tax exemption, modern nonprofit hospitals are essentially legal fictions."

48 Elizabeth Rosenthal, *An American Sickness*, Penguin Press 2017 p. 52

APPENDIX 1

CHART 17

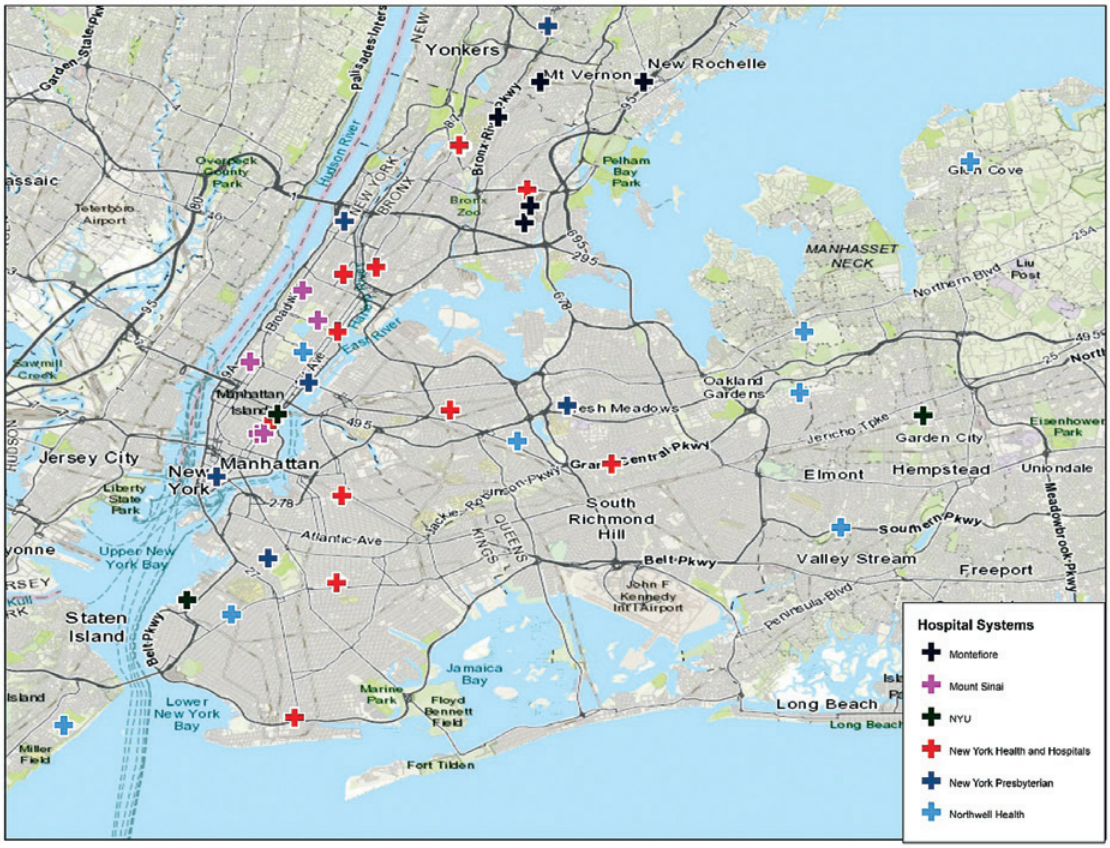
Quality Indicator—observed to expected mortality ratios, average 2009-14



Source: NYS Department of Health All Payer Inpatient Quality Indicators (IQI) by Hospital (SPARCS): 2009-14 . The average of the observed-to-expected weighted average mortality ratios: IQI 91—Acute Myocardial Infarction (AMI) • Heart Failure • Acute Stroke • Gastrointestinal Hemorrhage • Hip Fracture • Pneumonia

APPENDIX 2

NYC and environs hospital networks



New York State Nurses Association
131 West 33rd Street, 4th Floor, New York, NY 10001
212.785.0157
nysna.org nynurses @nynurses

Community Service Society | Fighting Poverty Strengthening New York

633 Third Avenue 10th Floor
New York, NY 10017
PH 212.254.8900
FAX 212.260.6218
www.cssny.org

David R. Jones
President & Chief Executive Officer

Steven L. Krause
Executive Vice President &
Chief Operating Officer

New York City Council Committee on Hospitals

Testimony for Oversight Hearing: Examining the Status of "One New York: Health Care for Our Neighborhoods": What Progress Has Been Made and What Challenges Lie Ahead?

February 28, 2018

Submitted by:
Community Service Society of New York

The Community Service Society of New York (CSS) would like to thank the Chair and members of the New York City Council Committee on Hospitals for the opportunity to submit this testimony on the status of efforts to protect and strengthen New York's critical public healthcare system. CSS is a 173-year-old 501(c)(3) non-profit dedicated to fighting poverty and strengthening New York. The organization pioneers innovative programs and encourages policy reforms that promote self-sufficiency and create a stronger, more inclusive democracy. CSS recognizes that access to quality affordable health care is essential to building strong, equitable, and economically secure communities. For more information on CSS, visit us on the web at www.cssny.org.

CSS's testimony will focus on the first goal identified in *One New York: Health Care for Our Neighborhoods*, ensuring funding to provide sustainable coverage and access to care for the uninsured. *One New York* points out the important role that federal Disproportionate Share Hospital (DSH) funding plays in supporting hospitals that provide uncompensated care to low-income patients.

As *One New York* notes, New York City's Health + Hospitals system is the largest provider of care to uninsured patients and patients covered by the Medicaid program in the city. While uninsurance rates in New York state have been cut in half under the Affordable Care Act (ACA), NYC Health + Hospitals facilities continue to serve a disproportionate share of the city's remaining uninsured.[1] Because members of racial and ethnic minority communities continue to have higher rates of uninsurance and are more likely to be insured by public programs such as Medicaid, hospitals that serve uninsured and publicly-insured patients have a strong role to play in reducing racial and ethnic health disparities.[2]

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In January 2018, CSS published a report examining New York's distribution of DSH funding through the Indigent Care Pool, *Unintended Consequences: How New York State Patients and Safety-Net Hospitals are Shortchanged.* New York distributes about $3.6 billion in DSH funding to hospitals annually in four stages. Through the second tranche of DSH funding, called the Indigent Care Pool (ICP), New York distributes $1.13 billion in funding, including $995 million for voluntary (private, non-profit), and $139.4 million for public hospitals. Unlike most states, New York chooses to distribute ICP funds to virtually all hospitals—including private voluntary hospitals—in the state.

Nearly all policymakers agree that DSH funding should be targeted to "safety-net" hospitals. The question is, then, what is a "safety-net" hospital? National experts, such as the Institute of Medicine and the Agency for Healthcare Research and Quality (AHRQ) have resolved this question by defining a "safety-net" hospital as one that provides "a significant level of health care and other health-related services to uninsured, Medicaid, and other vulnerable patients."[3] Using the AHRQ definition and 2015 data, CSS found that nine of the top ten safety-net hospitals in New York state are NYC Health + Hospitals facilities; 22 of the top 25 safety-net hospitals in the state are located in New York City.

In 2012, New York reformed the State's ICP distribution formula so that now roughly 85 percent of it is distributed in an accountable fashion that supports hospitals that provide services to uninsured and Medicaid patients. However, the law included a three-year transition "collar," based on the old, unaccountable formula, which limits losses and gains to allow hospitals to adjust to the new system. In 2015, without public discussion, this unaccountable transition collar was extended for another three years.

These delays in implementing the more accountable ICP distribution formula meant that hundreds of millions of dollars flowed away from struggling true safety-net hospitals serving large numbers of uninsured and low-income patients to hospitals with healthier bottom lines. For example, in 2015 the transition collar took $138 million from 54 losing hospitals and distributed it among 93 winning hospitals. Losing hospitals, on average, provided twice as much financial assistance to low-income uninsured patients as winning hospitals. The attached maps show how extending the transition collar hurts many of New York's true safety-net institutions, while benefiting wealthier hospitals that provide significantly less care to needy patients.

While public hospitals in New York currently receive the maximum amount of DSH funding allowed under federal law, the bulk of funding for NYC Health + Hospitals comes in the fourth stage. As a result, cuts to New York's DSH funding would affect Health + Hospitals first. The ACA mandated billions of dollars in cuts to DSH funding, which were slated to take effect in 2014 but have been delayed until 2019. Before these cuts take effect, New York state should ensure that its system for distributing funding is best designed to prioritize compensating institutions that serve the most low-income, uninsured patients.

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The allocation of hundreds of millions of dollars away from true safety-net hospitals matters to patients. In *Unintended Consequences*, CSS recommended that New York allow the transition collar to sunset in 2018. Ultimately, New York should move to an even more accountable system, like Massachusetts, that ensures that ICP money directly reimburses uninsured patient care.

Governor Cuomo's Executive Budget extended the transition collar for one year, and the state has said that it will work with hospitals and stakeholders to identify a new formula for ICP distribution during that time. The Governor's State of the State also indicated that it is time for all hospitals to use a uniform financial assistance application, so that hospital-imposed barriers to financial assistance (sometimes called charity care) become a thing of the past.

We urge the City Council to be mindful of these important hospital financing and patient protections concerns as it moves forward in its deliberations.

Thank you for the opportunity to submit this testimony. Should you have any further questions, please do not hesitate to contact Carrie Tracy at ctracy@cssny.org.

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[1] United States Census Bureau, 2013 American Community Survey 1-Year Estimates; United States Census Bureau 2016 American Community Survey 1-Year Estimates; Barbara Caress and James Parrott, "On Restructuring the NYC Health + Hospitals Corporation," a report to the New York State Nurses Association, October 2017 at 22; 2014 certified beds data.

[2] United States Census Bureau, 2016 American Community Survey 1-Year Estimates; Kaiser Family Foundation analysis of March 2016 Current Population Survey, Annual Social and Economic Supplement.

[3] M.E. Lewin, S. Altman, eds., America's Health Care Safety Net: Intact but Endangered, National Academies Press, 2000 at 21-22; J.P. Sutton et al., "Statistical Brief #213: Characteristics of Safety-Net Hospitals, 2014," Healthcare Cost and Utilization Project, Agency for Healthcare Research and Quality, October 2016.

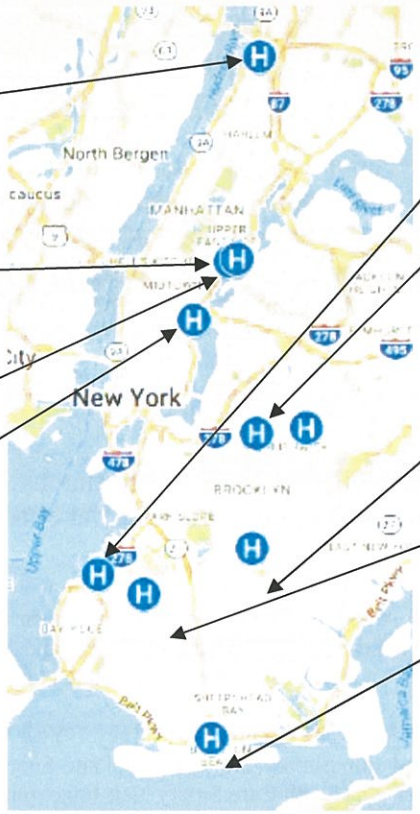
Indigent Care Pool transition collar takes funding from true safety-net hospitals in Brooklyn (2013-2015)

NY Presbyterian
$9,660,757

Memorial Sloan Kettering
$35,563,969

Hospital for Special Surgery
$6,120,832

NYU Medical Center
$5,278,089



NYU Lutheran
-$16,570,434

NYC H+H Woodhull
-$10,507,984

Wyckoff Heights
-6,494,391

NYC H+H Kings County
-$12,060,846

Maimonides
-$10,804,486

NYC H+H Coney Island
-$11,809,769

Total Windfalls
$56,623,647

Total losses
-68,247,910

2012 reforms to the $1.13 billion Indigent Care Pool (ICP) made pool distributions more accountable, but a "transition collar" still redistributes about 15% of funds

From 2013-2016, the collar gave $558 million windfall to transition winners

- Transition winners provide less financial assistance to patients
- The transition collar is based on an old bad debt formula that is unaccountable and illegal and rewards hospitals that fail to serve the uninsured
- Federal Disproportionate Share Hospital dollars are more critical than ever; NY should spend them wisely

Solution: End the transition collar and tie ICP payments to a streamlined Hospital Financial Assistance patient care program.

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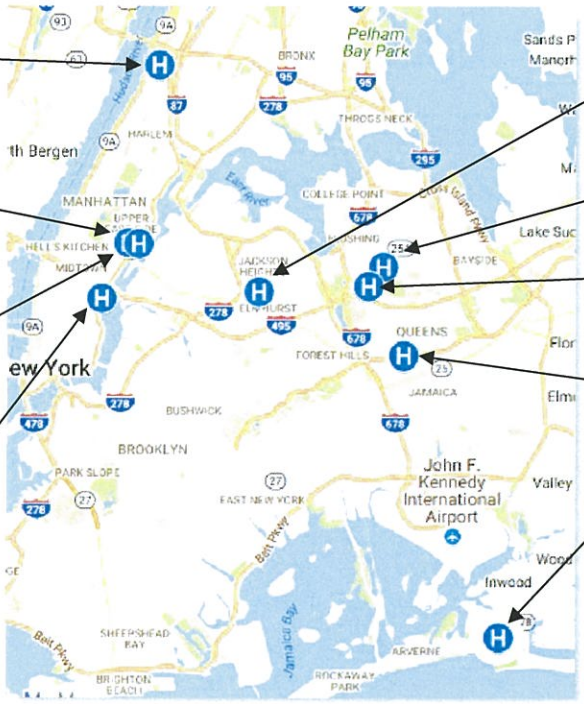
Indigent Care Pool transition collar takes funding from true safety-net hospitals in Queens (2013-2015)

NY Presbyterian
$9,660,757

Memorial Sloan Kettering
$35,563,969

Hospital for Special Surgery
$6,120,832

NYU Medical Center
$5,278,089



NYC H+H Elmhurst
-$22,934,177

Flushing Hospital
-$12,274,090

NY Presbyterian Queens
-$5,642,850

NYC H+H Queens
-$13,775,563

St. John's Episcopal
-$983,378

Total Windfalls
$56,623,647

Total losses
-$55,610,058

2012 reforms to the $1.13 billion Indigent Care Pool (ICP) made pool distributions more accountable, but a "transition collar" still redistributes about 15% of funds

From 2013-2016, the collar gave $558 million windfall to transition winners

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Solution: End the transition collar and tie ICP payments to a streamlined Hospital Financial Assistance patient care program.

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UNINTENDED CONSEQUENCES

HOW NEW YORK STATE PATIENTS AND SAFETY-NET HOSPITALS ARE SHORTCHANGED

Community Service Society | Fighting Poverty Strengthening New York

JANUARY 2018

ABOUT THE AUTHORS

Carrie Tracy, JD, is Senior Director of the Health Initiatives Department at CSS, where she conducts health policy analysis. Previously, she conducted policy analysis on health care, immigration, and other issues at the Northwest Federation of Community Organizations. She has a BSFS from Georgetown University School of Foreign Service and a JD from the University of Washington School of Law.

Elisabeth R. Benjamin, MSPH, JD, is Vice President of Health Initiatives at CSS where she oversees the Society's health policy, advocacy, and health consumer assistance programs. Previously she worked at the New York Civil Liberties Union, The Legal Aid Society, and Bronx Legal Services. She attended Columbia Law School, Harvard School of Public Health, and Brown University.

Amanda Dunker, MPP, is a Health Policy Associate at CSS, where she focuses on consumer advocacy around payment and delivery system reform. Previously, she worked as a Senior Policy Analyst for the Health Division at the National Governors Association Center for Best Practices, where she conducted policy analysis and provided consulting services to states on health workforce development and other topics. She has a BA in Media Studies from the University at Buffalo and an MPP from the University of Chicago's Harris School of Public Policy.

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NYS HEALTH FOUNDATION
Improving the state of New York's health

The Community Service Society of New York (CSS) is an informed, independent, and unwavering voice for positive action representing low-income New Yorkers. CSS addresses the root causes of economic disparity through research, advocacy, and innovative program models that strengthen and benefit all New Yorkers.

David R. Jones, Esq., President & CEO

Steven L. Krause, Executive Vice President & COO

EXECUTIVE SUMMARY

New York State has a long and illustrious history of ensuring access to health care for its residents. From piloting the nation's first comprehensive health insurance program for children, called Child Health Plus, to the launch of the New York State of Health Marketplace under the Affordable Care Act, New York has created high quality affordable health coverage. Due to these policies and others, the state has managed to cut its uninsurance rate in half, from 11 percent to just 4.7 percent between 2010 and 2017. Of those who remain uninsured, many are either ineligible for, or unable to afford, health coverage. These New Yorkers often turn to hospital financial assistance programs (sometimes called charity care) for life-saving treatment.

For more than 30 years, New York has robustly supported the uncompensated care burden of its hospitals. Annually, the state distributes about $3.6 billion in federal, state, and local Disproportionate Share Hospital (DSH) funding to help hospitals provide care to the uninsured. Public hospitals currently receive as much DSH funding as New York is permitted to pay them under federal law. However, with the reduction in the number of remaining uninsured, the federal portion of DSH funding for these hospitals is being cut, beginning in October 2017. In the first year alone, New York will lose $329 million in DSH funding. The DSH cuts are slated to accelerate through 2025. The first cut would come entirely from New York City's public system, Health + Hospitals, which serves the most uninsured patients (more than 400,000 uninsured patients annually) and is by far the largest provider of care to uninsured and low-income patients in the state.[1] The media, local officials, and consumer advocates have all raised concerns about this inequitable outcome and its impact on low-income New Yorkers.

New York State law establishes an Indigent Care Pool (ICP) that distributes $1.13 billion of the total $3.6 billion in DSH funding to public and voluntary hospitals. Unusually, New York provides DSH funding to virtually all its hospitals through the ICP, not just safety-net hospitals as is the practice in other states. The Institute of Medicine (IOM) defines "safety-net" hospitals to be those that provide a significant level of health care to "uninsured, Medicaid, and other vulnerable patients."[2] As a condition of receiving ICP funding, the state's Hospital Financial Assistance Law (HFAL) requires hospitals to offer free or discounted care to uninsured low- and moderate-income patients. Over the past 15 years, in response to numerous patient and media stories, the state has attempted to better direct DSH funding to the hospitals that serve the most uninsured patients and offer financial assistance.

Of those who remain uninsured, many are either ineligible for, or unable to afford, health coverage. These New Yorkers often turn to hospital financial assistance programs (sometimes called charity care) for life-saving treatment.

New York has provided $2.05 billion of non-DSH funding to 35 financially distressed hospitals through the Interim Access Assurance Fund (IAAF), the Vital Access Provider Assistance Program (VAPAP) and Value Based Payment Quality Improvement (VBP-QIP) programs since 2014. This funding is intended to help hospitals redesign their healthcare delivery systems to improve their financial stability and the continued availability of essential health care services.

In 2012, the Community Service Society of New York issued a report, *Incentivizing Patient Financial Assistance: How to Fix New York's Hospital Indigent Care Program*, which identified a number of implementation issues resulting from the bifurcation of the ICP and the HFAL and proposed a set of policy recommendations.

Later in 2012, New York State adopted several important reforms, directed only at the ICP: (1) it targeted ICP funding to compensate hospitals for actual services provided to uninsured patients; and (2) it established a HFAL compliance audit process to validate hospital financial aid programs, with a small bonus pool reserved

for compliant hospitals. To smooth sudden declines in hospital ICP funding, the 2012 law included a three-year transition payment adjustment period: hospital distributions would be subjected to a collar—a floor and ceiling limiting their exposure. But in 2015, without public discussion, the transition collar was extended for another three years, resulting in unforeseen excessive windfalls for some hospitals that are not providing care to financially needy patients.

This report assesses the impact of the 2012 reforms on ICP distributions and patient access to hospital financial assistance and makes the following findings.

Transition Payments Result in Unintended Financial Windfalls for Certain Hospitals

In 2015, the transition payment adjustments took $138 million in funding from 54 hospitals and distributed it among 93 other hospitals. In total, between 2013 and 2016, hospitals received windfalls of over $558 million.

The transition formula also ensures that hospitals receive more funding than they actually spend on patients eligible for hospital financial assistance. As a result, in 2015 alone, 119 hospitals received over $318 million more than they spent on financial assistance-eligible patients.

The Audit Improves Performance, But is Flawed in Implementation

The HFAL compliance audit is designed to test whether hospitals comply with state law and Department of Health (DOH) guidance. HFAL compliance is important because hospitals that comply are more likely to provide financial assistance to eligible patients. The audit consists of two parts: a desk audit and a field audit. CSS's review of the audit data reveals that while the audit improved some hospital practices, its impact is limited because: (1) DOH does not count all of its own questions; (2) hospitals self-report answers on the desk audit and so DOH does not, and cannot, identify errors that hospitals do not report; and (3) hospitals that pass the audit overall do not have to correct any errors identified in the audit.

RECOMMENDATIONS

Recommendation #1: End transition adjustment payments and distribute DSH cuts equitably.

New York should fully implement the accountable ICP funding distribution methodology by allowing the transition adjustments to sunset in 2018. New York should not extend the transition adjustments again. New York should mitigate any harm that eliminating the transition adjustments would cause for true safety-net hospitals.

As New York contemplates reductions in future DSH funds, starting as soon as this year, it should ensure that DSH cuts overall are equitable and promote the principle that DSH funds should prioritize compensating those institutions that serve the most low-income, uninsured patients, who are disproportionately racial and ethnic minorities. Ultimately, New York should move to an even more accountable system, like Massachusetts, that ensures that ICP money directly reimburses uninsured patient care.

Recommendation #2: Improve the patient experience.

New York should improve the patient experience by: adopting a uniform statewide financial assistance application and other materials to be used by all hospitals; requiring hospitals to accept NYSOH income and residence determinations; and eliminating any asset tests.

In the alternative, if hospitals are permitted to continue adopting their own unique HFAL protocols, the state should adopt a legitimate audit process that: (1) counts all audit questions; (2) field audits hospitals' self-reported compliance by reviewing answers to all 52 questions in the audit tool; and (3) only awards HFAL compliance pool funds if and when a hospital has corrected all errors found in the audit.

BACKGROUND

Disproportionate share hospital funding in New York State

Medicaid Disproportionate Share Hospital (DSH) funding is available to hospitals that serve Medicaid and uninsured patients.[3] New York distributes about $3.6 billion in state and federal DSH funding.[4] This funding is distributed in four stages under state law. First, $605 million is distributed to state hospitals, including mental hospitals and university hospitals.[5] Second, about $1.13 billion in funding is set aside for the Indigent Care Pool (ICP), the focus of this report: $995 million for Voluntary and Non-Major Public Hospitals, and $139.4 million for Major Public Hospitals.[6] Third, county hospitals outside of New York City receive about $300 million. The non-federal portion of this funding must come from local budgets, not the state.[7] Finally, any DSH funding remaining within New York's state-specific DSH cap is available to NYC Health + Hospitals. This allocation is funded solely by the federal and New York City governments. In 2016, this remaining funding available to NYC Health + Hospitals was about $800 million.[8] In 2018, that amount is slated to be cut by about 40 percent, or $329 million.

DSH funding is intended to help hospitals that "serve a disproportionate number of low-income patients with special needs." New York is one of only three states that provides DSH payments to 90 percent or more of its hospitals.

Under federal law, payments to a hospital may not exceed the hospital's cost of providing services to Medicaid and uninsured payments (called the facility-specific cap).[9] New York currently funds public hospitals up to their facility-specific DSH caps. Voluntary hospitals generally receive funding that is less than their facility-specific caps.

Federal funding cuts

Impending cuts to federal DSH funding increase the urgency for New York to move toward a funding approach that equitably drives dollars to the hospitals that provide the most care to the low-income and uninsured residents of this state. One approach is to target ICP funding to hospitals that serve the uninsured. The Affordable Care Act (ACA) includes reductions in DSH funding that were to take effect in 2014. The DSH cuts were based on the assumption that uninsurance rates would drop nationwide as a result of the ACA's coverage expansion. The DSH cuts were delayed for several years, but ultimately started on October 1, 2017. DSH funding for federal fiscal year 2018 is reduced by $2 billion (16 percent of the total) nationwide, and the cuts increase annually through 2025.[10]

New York State should allocate DSH cuts in an equitable and lawful manner, consistent with the principle that the money should follow the patients. On July 28, 2017, the Centers for Medicare & Medicaid Services (CMS) issued an estimate of what each state might lose under the proposed regulations and determined that New York would lose $329 million (18.7 percent).[11] According to the Medicaid and CHIP Payment and Access Commission (MACPAC), New York is one of 20 states that will lose more in DSH allotments than it saved on uncompensated care between 2013 and 2014 when insurance rates increased under the ACA.[12] Under the state's current statutory allocation formula, described above, the entirety of the $329 million cut would be taken from the funding available to NYC Health + Hospitals at the fourth stage of DSH distribution.[13]

DSH funding is intended to help hospitals that "serve a disproportionate number of low-income patients with special needs."[14] New York is one of only three states that provides DSH payments to 90 percent or more of its hospitals.[15] In light of the impending DSH cuts, MACPAC recommended that DSH payments should be "better

targeted to hospitals that serve a high share of Medicaid-enrolled and low-income patients and that have higher levels of uncompensated care."[16]

The ICP is the only source of New York DSH funding for voluntary, nonprofit hospitals. Because patients in many areas of the state do not have access to a public hospital with a mandate to serve low-income patients, the ICP funds virtually all hospitals in the state. While the state's Hospital Financial Assistance Law (HFAL) requires hospitals that receive ICP funds to establish financial aid policies for their patients, the ICP funding stream is not a reimbursement that is tied directly to any specific patient's care. Stakeholders have long argued that this bifurcation of a hospital's uncompensated care funding from any specific patient financial assistance has led to an opaque and unaccountable indigent care system in New York State.[17] This report examines whether the ICP's share of New York's shrinking DSH budget is serving the hospitals and patients that need it most.

Uninsured rates dropping but not evenly distributed

Under the ACA, New York's rate of uninsured was reduced by half between 2013 and 2017.[18] However, not all communities in New York have experienced the same reductions in uninsurance. In 2016, county-level uninsured rates ranged from the lowest, 2.8 percent in Livingston County, to the highest, 10.1 percent in Queens County.[19] Uninsurance rates also remain higher for immigrant New Yorkers. For example, in 2015, 27.2 percent of non-citizens remained uninsured, compared to 4.5 percent of native-born New Yorkers.[20]

With the rollout of the ACA Marketplace in 2013, New York's hospitals have not experienced equal reductions providing uncompensated care. For example, between 2012 and 2014, New York City's private and voluntary hospitals saw a 12.2 percent decline in uninsured emergency department visits, but NYC Health + Hospitals only saw a 6.5 percent decrease in uninsured emergency department visits during that time.[21] NYC Health + Hospitals facilities' share of hospital bed capacity in New York City was only 19 percent in 2014, but they served almost 50 percent of the city's uninsured inpatient discharges, over 50 percent of uninsured emergency room visits, and almost 70 percent of uninsured ambulatory surgery visits.[22]

Across the state, between 2013 and 2014, voluntary hospitals reported a 15 percent median decrease in spending on all uninsured patients and a 12 percent median reduction in spending on uninsured patients eligible for financial assistance. Public hospitals, however, reported an 11 percent median increase in spending on all uninsured patients, and only a 3 percent median reduction of spending on uninsured patients eligible for financial assistance.[23] DSH cuts should not fall entirely on public hospitals that have seen this growth in spending for uninsured patients while other hospitals have largely seen declines.

DSH cuts and racial and ethnic health disparities

Racial and ethnic minority consumers face barriers to accessing care and have lower health care utilization rates. Black and American Indian consumers have worse health status and outcomes than other consumers on most measures.[24] While uninsurance rates have dropped significantly in New York since implementation of the ACA, black and Hispanic New Yorkers continue to have higher rates of uninsurance (6.8 and 11.8 percent respectively) than their white counterparts (4.5 percent).[25] Nationally, public insurance programs like Medicaid and the Children's Health Insurance Program cover 28 percent of black adults and 25 percent of Hispanic adults, but only 16 percent of white adults.[26] Hospitals that serve uninsured and publicly insured patients, therefore, have a strong role to play in addressing disparities.

Nationally, numerous studies have reported a disparate usage of hospitals by race.[27] In 2017, a New York report found that black patients were two to three times less likely than whites to be treated at academic medical centers than other hospitals in New York City. It also found that uninsured patients were about five times less likely than insured patients to be treated at academic medical centers.[28]

Access to affordable medical care for uninsured and low-income people is essential to eliminating health disparities. For example, another recent study found that lack of insurance was responsible for 37 percent of the disparity in mortality rates between black women and white women diagnosed with early stage breast cancer.[29] Targeting DSH funds to hospitals that treat a larger share of low-income uninsured and Medicaid patients can augment other interventions to help address racial and ethnic disparities in health outcomes.

Targeting DSH funds to hospitals that treat a larger share of low-income uninsured and Medicaid patients can augment other interventions to help address racial and ethnic disparities in health outcomes.

Table 1 shows New York's top quartile of hospitals ranked by the percentage of the hospital's discharges that are Medicaid and uninsured patients. This cohort includes all of NYC Health + Hospitals, most other public hospitals around the state, and some private hospitals serving low-income communities. While many hospitals in the top quartile are in New York City, others are located around the state, including some rural regions.

WHAT IS A SAFETY-NET HOSPITAL?

There is general agreement that DSH funding should be targeted to "safety-net" hospitals, but this term is sometimes incorrectly used to describe nearly all voluntary, nonprofit hospitals in New York State. According to the Institute of Medicine (IOM), a "safety-net" hospital is one that provides "significant level of health care and other health-related services to uninsured, Medicaid, and other vulnerable patients."[30] The Agency for Healthcare Research and Quality (AHRQ) further specifies safety-net hospitals as the top quartile of hospitals in a state by percentage of Medicaid and uninsured discharges.[31] Adopting these standards, in 2017 both houses of New York's legislature passed a bill that defined an "enhanced safety net hospital" as one with a patient mix of: (1) not less than 50 percent Medicaid or uninsured; (2) not less than 40 percent Medicaid; and (3) not more than 25 percent commercially uninsured.[32] Table 1 lists New York's safety-net hospitals, according to the AHRQ definition.

Table 1: New York State's Top Safety-Net Hospitals

Hospital Name	Percent of all Hospital Discharges that are Medicaid and Self-Pay	Hospital Name	Percent of all Hospital Discharges that are Medicaid and Self-Pay
NYC H+H/Coney Island Hosp.*	83%	NYU Lutheran Medical Center	53%
NYC H+H/Elmhurst Hosp. Center*	77%	Erie County Medical Center*	52%
NYC H+H/Queens Hosp. Center*	76%	St. John's Riverside	51%
NYC H+H/Woodhull*	74%	Nassau University Medical Center*	51%
NYC H+H/Metropolitan*	73%	St. Joseph's Medical Center	51%
NYC H+H/North Central Bronx*	71%	Eastern Long Island Hospital	51%
NYC H+H/Lincoln*	69%	University Hospital of Brooklyn*	49%
NYC H+H/Kings County*	68%	NYC H+H/Henry J. Carter*	47%
Bronx-Lebanon Hospital Center	68%	Clifton Springs Hosp. and Clinic	46%
NYC H+H/Harlem Hosp. Center*	67%	St. John's Episcopal Hosp.	46%
SBH Health System (St. Barnabas)	67%	Montefiore Medical Center	45%
NYC H+H/Bellevue*	65%	Niagara Falls Memorial Med. Center	42%
NYC H+H/Jacobi*	65%	HealthAlliance Hospital Mary's Ave.	42%
Blythedale Children's Hosp.	63%	NY Hosp. Medical Center of Queens	41%
Flushing Hosp. Medical Center	62%	Westchester Medical Center*	40%
Interfaith Medical Center	58%	Nyack Hospital	40%
Jamaica Hosp. Medical Center	58%	Our Lady of Lourdes	39%
Brookdale Hosp. Medical Center	56%	Richmond University Medical Center	38%
NY Eye and Ear Mt. Sinai	56%	St. Joseph's Hospital	38%
Burdett Care Center	55%	Mount Sinai Beth Israel	38%
Wyckoff Heights Medical Center	54%	Montefiore Mount Vernon Hosp.	37%
Maimonides Medical Center	54%	Bon Secours Community Hosp.	37%
Brooklyn Hospital	53%		

*Public Hospital

Data source: 2015 Hospital Inpatient Discharges (SPARCS De-identified), Bureau of Health Informatics, Office of Quality and Patient Safety, New York State Department of Health.

HOSPITAL FINANCIAL ASSISTANCE IS A LIFELINE FOR UNINSURED PATIENTS

In June 2013, Amanda D. went to Alice Hyde Medical Center (AHMC) in Malone, where she had emergency surgery for an ectopic pregnancy. She had no insurance and no income.

Amanda met with a social worker at AHMC, who didn't tell her about Emergency Medicaid or hospital financial assistance. She would have qualified for both programs. Amanda recalled, "the hospital staff never informed me about charity care, which I only learned about afterwards, from a neighbor. I was turned away because of my immigration status and I thought that there was no hope."

After learning about financial assistance from her neighbor, Amanda returned for an application. She submitted a completed application form, but AMHC told her that her immigration papers had to clear first. However, HFAL prohibits hospitals from adopting a citizenship or immigration status requirement for hospital financial assistance.

"I was turned away because of my immigration status and I thought that there was no hope."

Amanda applied again when she received her green card, and was told that she had been approved for hospital financial assistance, but only prospectively. A Community Health Advocate at the Community Service Society of New York helped Amanda appeal this decision, outlining violations of New York's Hospital Financial Assistance Law.

In March 2015, AHMC issued a written decision to withdraw the bill from collections and close her account.

PART ONE: PROGRESS AND LIMITS OF THE 2012 ICP DISTRIBUTION REFORMS

Part one of this report is divided into several sections. It first describes the ICP reforms adopted in 2012 and how the new "units of service" methodology works. Second, it explains how the 2012 reforms adopted a temporary "transition" collar that has distorted the allocation of over $500 million in ICP funds from 2013–2016. Third, it shows that the transition payments extend New York's reliance on bad debt, in violation of federal regulations. Fourth, it demonstrates how the transition collar has led to unintended consequences where "winner" hospitals are handsomely rewarded even if they do not provide material financial assistance to their patients, and demonstrating how these consequences play out in one region—Western New York. Finally, it shows how the ICP units of service methodology still fails to incentivize adequately the provision of financial assistance to needy New Yorkers. This section closes with a set of recommendations for New York.

New York adopted more accountable ICP methodology in 2012

New York has used two methodologies to determine how much funding a hospital should receive from the Indigent Care Pool. Until 2013, the state used the "Bad Debt and Charity Care" or "BDCC" methodology. Under the BDCC formula, the New York State Department of Health (DOH) based payments on hospitals' costs for bad debt and charity care. "Bad debt" represents charges for care that a hospital has determined cannot be collected from patients. Before declaring a charge to be bad debt, a hospital attempts to collect payment, using tactics that may include sending repeated bills, selling the debt to a collection agency, and placing a lien on the patient's property. Federal regulations also treat unpaid cost-sharing charges to insured patients as bad debt.[33] "Charity care" represents charges that a hospital has reduced or forgiven entirely because the patient has been determined to need financial assistance. Using the BDCC formula, DOH treated bad debt and charity care equally, so hospitals received ICP funding even when their patients did not receive any financial aid. This formula did not incentivize hospitals to offer financial assistance to patients. It also violated a federal regulation prohibiting states from using DSH funding to pay for bad debt.

In 2008, the state started to phase in a second, more accountable, units of service methodology for 10 percent of ICP funding.[34] The units of service methodology counts up the number of services a hospital provides to uninsured patients and values them at Medicaid reimbursement rates. DOH subtracts payments the hospital has received from uninsured patients, and factors in hospitals' Medicaid inpatient volume.[35]

In 2012, based on the recommendations of the New York Medicaid Redesign Technical Assistance Team, the law was amended to end use of the BDCC methodology entirely. Instead, starting in 2013, DOH began distributing ICP funding based on the more accountable units of service methodology. However, the 2012 law also included a provision for three years of transition adjustments to

How the transition collar works

DOH annually calculates a hospital's prior three-year average of ICP payments, and ensures that the hospital's ICP payment does not fall outside a set collar—a limit on losses and gains. The transition creates a "winner" and "loser" paradigm.

For example, in 2015:

- No hospital could be paid less than 92.5 percent of its three-year average (floor).
- No public hospital could be paid more than 107 percent of its three-year average (ceiling).
- No voluntary hospital could be paid more than 119 percent of its three-year average (ceiling).

allow hospitals to adjust to the full adoption of the units of service methodology.[36] The three-year transition period was adopted to allow hospitals time to evaluate their provision and reporting of care to uninsured patients before the full impact of the new formula was to take place.

In 2013, the first year of the new formula, transition payments ensured that no hospital received less than 97.5 percent of its previous three-year average (or a 2.5 percent loss). Each year, the amount a hospital could lose from its three-year average increased by 2.5 percent. By the end of the three years, the transition collar would terminate at a maximum 7.5 percent loss. In effect, the transition collar funds maintained the old BDCC methodology for 10 to 15 percent of all ICP funds. In 2015, the state budget included three additional years of transition payments, which are set to end with the 2018 fiscal year.[37] In 2018, no hospital will receive less than 85 percent of its previous three-year average payments, or a maximum 15 percent loss. Altogether, hospitals have been given six years to adjust to the new payment system.

The remainder of this section describes how the transition collar has led to unintended consequences and recommends that it should be permitted to sunset permanently in 2018.

Recent studies support changes to ICP distributions

Several recent reports have examined issues related to the ICP:

- *Funding Charity Care in New York: An Examination of Indigent Care Pool Allocations*, by the New York State Health Foundation, examines the impact of the new formula and transition adjustments on hospitals in New York City.[38] This report recommends that New York accelerate the transition adjustment formula, cap ICP payments at actual uncompensated costs, limit ICP participation to the neediest hospitals, increase funding for public hospitals, and set a minimum community benefit requirement for nonprofit hospitals.
- The Empire Center has released two reports examining ICP distributions in 2017.
  - *Hooked on HCRA: New York's 20-Year Health Tax Habit*, recommends that New York distribute ICP funding based on vouchers for uncompensated care or another methodology based on the principle that "money should follow patients, not institutions."[39]
  - *Indigent Carelessness: How not to subsidize hospital charity care*, finds that the transition adjustments payments penalized hospitals that provided more hospital financial assistance and recommended reform.[40]
- *Medicaid Supplemental Payments: The Alphabet Soup of Programs Sustaining Ailing Hospitals Faces Risks and Needs Reform*, by the Citizens Budget Committee, finds that DSH cuts would have a disproportionate impact on NYC Health + Hospitals, and recommends that New York make changes to its DSH distributions.[41]

The collar delays ICP accountability

Because the sums in question are so large, the transition collars have a significant effect on how ICP funding is distributed. Table 2 shows that in 2015, the transition formula took $138 million from 54 hospitals and distributed it among 93 other hospitals, moving 12.2 percent of the $1.13 billion in ICP funding. Transition payments move funding within a pool, so a transition adjustment that increases a voluntary hospital's funding reduces funding to another voluntary hospital. A similar transfer occurs between the public hospitals.[42]

Table 2: Winners and Losers Under the Transition Formula 2015

	Winners	Losers
Number of Hospitals	93	54
Average Gain/Loss per Hospital	$1,483,000	($2,091,000)
Average Gain/Loss per Bed	$13,200	($10,200)

Data sources: NYS DOH 2015 Indigent Care Pool distributions data; 2013 certified beds data.

Table 3 reveals that some hospitals received significant windfalls because of the transition payments. For example, in 2015, Roswell Park Memorial Institute should have only received a payment of less than four thousand dollars under the units of service formula. But the transition collar ensured that Roswell Park's payment could not be less than 92.5 percent of the average of its ICP payments for 2012–2014. As a result, Roswell Park received a transition payment of $1,932,307, bringing its final ICP payment to $1,936,189, a 49,776 percent increase. Table 3 lists the hospitals that received the highest percentage increases in ICP funding in 2015 resulting from the transition collar.

Table 3: The Winning Hospitals Experienced Large Percentage Increases in ICP Payments Under the Transition Formula in 2015

Hospital Name	Percentage change
Roswell Park*	49776%
Helen Hayes Hosp.*	8583%
Elizabethtown Comm. Hosp.	2337%
Calvary Hosp.	724%
Memorial Sloan Kettering Hosp.	500%
Schuyler Hosp.	419%
Tri Town Regional Healthcare	415%
Ira Davenport Mem. Hosp.	361%
Soldiers and Sailors Mem. Hosp.	351%
Cuba Memorial Hosp.	337%
SUNY Hosp. Downstate Med. Cen.*	336%
O'Connor Hosp.	319%
Wyoming County Comm. Hosp.	317%
Blythedale Childrens Hosp.	269%
Moses-Ludington Hosp.	255%
HealthAlliance Hosp. Mary's Avenue	246%
Cobleskill Regional Hosp.	220%
Margaretville Memorial Hosp.	210%
Ellenville Comm. Hosp.	195%
Westchester Medical Center*	186%

*Public Hospital

Data source: NYS DOH 2015 Indigent Care Pool distributions data.

Table 4 reveals that the first three-year transition period (2013–2015) led to the unintended result that some hospitals received substantial windfall payments. The 20 hospitals with the highest three-year windfalls received an additional $280 million.

Table 4: Windfall Amounts for the Top 20 Winning Hospitals

Hospital Name	3-year Total Windfall (2013-2015)
Mem. Sloan Kettering Hosp.	$35,563,969
Mt. Sinai St. Luke's	$29,713,316
Brookdale Hosp.	$29,102,060
Mt. Sinai Beth Israel	$25,183,820
Jamaica Hosp.	$19,988,227
SUNY Hosp. Downstate Med. Cen.*	$16,498,077
Montefiore Mount Vernon Hosp.	$15,858,669
Westchester Medical Center*	$14,866,932
Catskill Regional Hosp. - Harris	$11,369,085
Montefiore New Rochelle Hosp.	$10,374,440
NY Presbyterian	$9,660,757
HealthAlliance Hosp. Broadway	$8,953,958
Mercy Medical Center	$7,758,652
Goldwater Mem. Hosp.*	$7,121,219
SUNY Health at Syracuse*	$7,042,827
HealthAlliance Mary's Avenue	$6,990,464
Montefiore Hosp.	$6,133,657
Hospital for Special Surgery	$6,120,832
Roswell Park*	$5,922,010
NYU Medical Center	$5,278,089
	$279,501,060

*Public Hospital

Data source: NYS DOH 2013-2015 Indigent Care Pool distributions data.

Table 5 shows that these windfalls led to significant three-year losses for other hospitals. The 20 hospitals with the most substantial transition reductions over this three year period lost a total of $263 million. NYC Health + Hospitals lost a total of $68 million over this three year period.

Table 5: Loss Amounts for the Bottom 20 Loser Hospitals

Hospital name	3-year loss (2013-2015)
St. Joseph's Hosp. Yonkers	($54,329,217)
NYC H + H/Elmhurst*	($22,934,177)
Faxton - St Luke's Health Care	($21,352,289)
Lutheran Medical Center	($16,570,434)
NYC H + H/Queens Hosp.*	($13,775,563)
Flushing Hosp.	($12,274,090)
NYC H + H/Kings County*	($12,060,846)
NYC H + H Coney Island*	($11,809,769)
United Health Services	($11,626,140)
Highland Hosp. of Rochester	($10,810,396)
Maimonides	($10,804,486)
NYC H + H/Woodhull*	($10,507,984)
Our Lady of Lourdes Mem. Hosp.	($9,071,487)
NYC H + H/Bellevue*	($8,083,009)
Lenox Hill Hosp.	($7,660,216)
St. Elizabeth Hosp.	($6,546,867)
Wyckoff Heights Hosp.	($6,494,391)
NY Medical Center of Queens	($5,642,850)
Bronx-Lebanon - Fulton Div.	($5,383,048)
Long Island Jewish Forest Hills	($5,211,813)
	$(262,949,070)

*Public Hospital

Data source: NYS DOH 2013-2015 Indigent Care Pool distributions data.

The transition windfalls often led to the unintended consequence where funding is taken from struggling hospitals and given to hospitals with healthier bottom lines. For example, the highly profitable Memorial Sloan Kettering received the biggest three-year windfall although it had a net income in 2016 of $147.8 million. On the other hand, St. Joseph's Hospital, with the biggest three-year transition loss, reported a net loss of $10.7 million.[43]

While the transition payments ensure that a portion of ICP funding is still based on the old BDCC formula, most funding is now based on the new units of service formula. That said, the windfall sums in question are significant, ranging from $132 million to $156 million per year. (See Table 6.)

Transition payments extend ICP reliance on bad debt

New York's decision to move from the BDCC methodology to the units of service methodology is an important step forward for several compelling reasons. First, federal DSH payment regulations do not allow states to use DSH funds to reimburse hospitals for the cost of bad debt. Second, uninsured patients who are sent to collections instead of receiving hospital financial assistance suffer lasting financial harm. Favoring hospitals with high bad debt levels over hospitals that diligently provide eligible patients with hospital financial assistance harms safety-net hospitals and patients alike.

Transition payments, however, extend New York's reliance on historical bad debt by using prior years' ICP awards as the floor for ICP distributions. The BDCC formula was used to calculate 90 percent of ICP distributions in 2012. The ICP payments will continue to include the 2012 bad debt as part of the payment formula as long as the transition payments tie ICP distributions to prior years' awards.

Favoring hospitals with high bad debt levels over hospitals that diligently provide eligible patients with hospital financial assistance harms safety-net hospitals and patients alike.

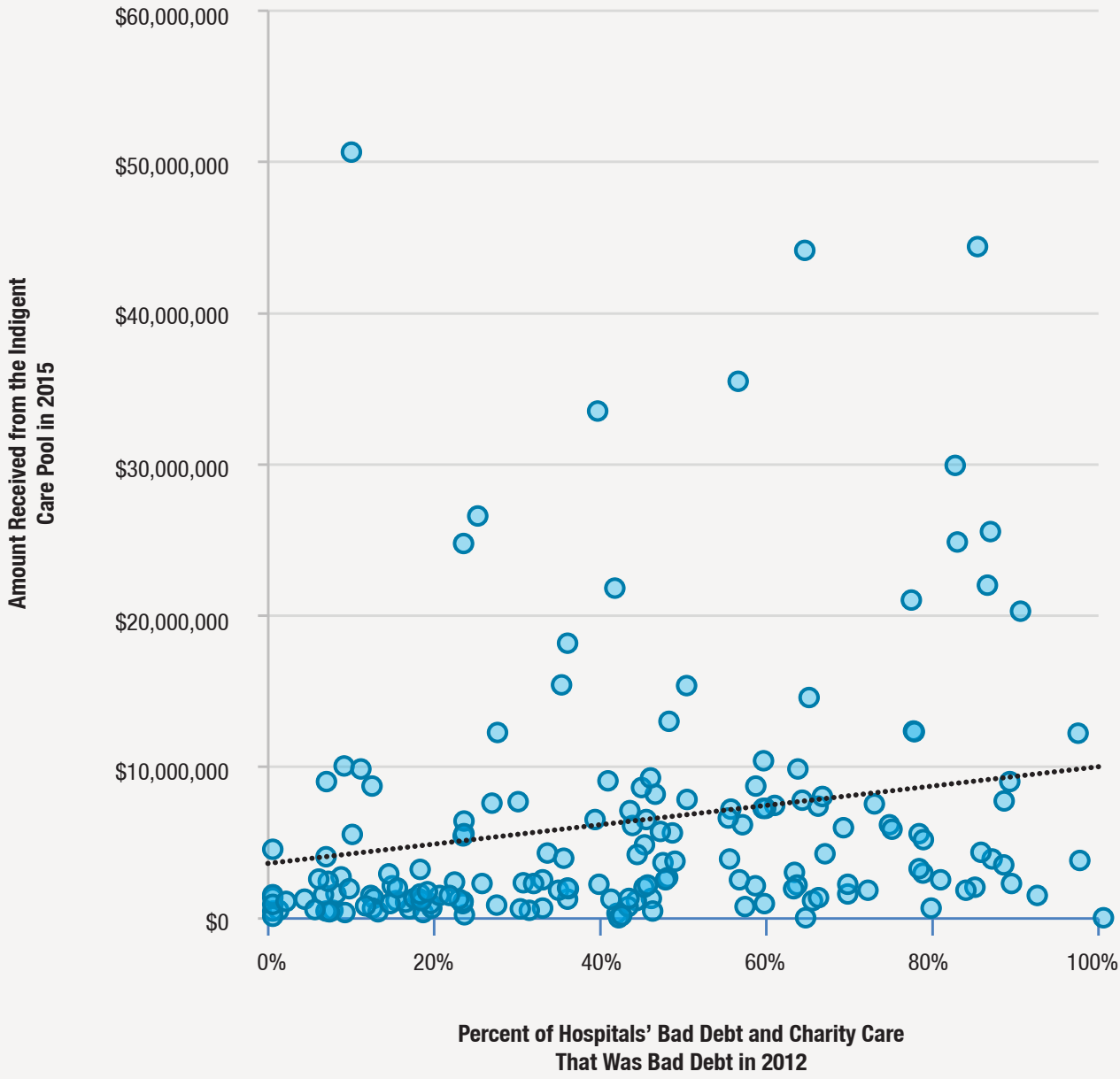
Graph 1 below shows that hospitals that received more ICP funding in 2015 were significantly more likely to have reported higher proportions of bad debt to charity care in 2012 (p=.01). Table 7 shows that some of the hospitals with the highest transition payment bonuses from 2013 to 2015 were hospitals that had reported a high percentage of bad debt compared to charity care in 2012. Together, Graph 1 and Table 7 demonstrate that hospitals reporting high proportions of bad debt in 2012 continue to financially benefit at the expense of hospitals that did not.

Table 6: While the Percentages May Be Small, the Transition Distributions are Substantial Sums of Money

	2013	2014	2015	2016
Amount redistributed by transition adjustments	$131,957,394	$156,139,473	$137,911,778	$132,222,515
Percentage of ICP funds redistrubuted by transition adjustments	11.6%	13.8%	12.2%	11.7%

Data source: NYS DOH 2013-2016 Indigent Care Pool distributions data.

Graph 1: Hospitals with Larger 2015 ICP Distributions Were More Likely to Report Higher Bad Debt Levels in 2012



Data sources: NYS DOH 2015 Indigent Care Pool distributions data; NYS DOH 2012 Indigent Care Pools distributions data.

Table 7: Transition Payments for Many Big Winners Rely Substantially on Bad Debt		
Hospital	2013-2015 Windfalls	% of free care (charity care vs. bad debt) that was bad debt, 2012 ICP calculations
Memorial Sloan Kettering Hospital for Cancer and Allied Diseases	$35,563,969	97%
Catskill Regional Hospital - Harris	$11,369,085	66%
NY Presbyterian	$9,660,757	70%
Mercy Medical Center	$7,758,652	78%
Montefiore Hospital and Medical Center	$6,133,657	85%
NYU Medical Center	$5,278,089	77%
St. Barnabas Hospital	$2,970,214	82%
Bon Secours Hospital	$2,803,292	78%

Data sources: NYS DOH 2013 - 2015 Indigent Care Pool distributions data; NYS DOH 2012 Indigent Care Pool distributions data.

Should New York extend the transition adjustments for another three years, totaling nine in all, the state will likely allocate over $1 billion of indigent care funding on bad debt (as reported in 2012 and earlier) instead of targeting these funds more accountably to the hospitals, and patients, that need financial assistance.

Transition payments take funding from hospitals that help uninsured

The transition formula preserves a system in which hospitals are receiving scarce ICP funds while avoiding serving uninsured patients, or only serving uninsured patients who are wealthy enough to pay for their care out of pocket.

Under HFAL, hospitals are required to report information about how much they spend on uninsured patients who are eligible for hospital financial assistance, how many applications for financial assistance they have received, how many applications they have approved, and how many liens they have placed on patients, among other items.

Table 8: Transition Winners Provide Less Financial Assistance		
	Winners	Losers
Number of hospitals	93	54
Approved applications per bed	20	39
Spent on uninsured financial assistance-eligible patients per bed	$21,300	$39,800

Data sources: NYS DOH 2015 Indigent Care Pool distributions data; DOH 2013 certified beds data; 2013 Institutional Cost Report Exhibit 50 data.

Table 8 shows that the winner transition payment hospitals are unlikely to share their windfalls with uninsured patients. The winner hospitals, on average, provided about half as much financial assistance to patients, per hospital bed, than the loser hospitals.

An examination of funding distribution and financial assistance data for Western New York's hospital Region 6, which includes Buffalo and Rochester, is illustrative.

In 2015, 32 voluntary hospitals[44] in Region 6 received ICP funding:

- 16 gained funding through transition adjustments (biggest gain: $1,014,528);
- 10 lost funding through transition adjustments (biggest loss: $2,337,904); and
- 6 had no changes in funding through the transition adjustments.

The transition formula preserves a system in which hospitals are receiving scarce ICP funds while avoiding serving uninsured patients, or only serving uninsured patients who are wealthy enough to pay for their care out of pocket.

Table 9: On Average, Western New York Transition Winners Provide $3.5 Million Less Financial Assistance than their Loser Counterparts

	2013 financial assistance applications approved per bed	Spent on patients eligible for financial assistance in 2013
Average: transition winners	16	$1,180,100
Average: transition losers	24	$4,079,000
Median: transition winners	7	$157,000
Median: transition losers	24	$2,960,000

Data sources: NYS DOH 2015 Indigent Care Pool distributions data; 2013 certified beds data; 2013 Institutional Cost Report Exhibit 50 data.

Table 9 shows that the hospitals within Western New York that lost funding through the transition adjustments approved many more patients for financial assistance per bed and spent significantly more on uninsured patients who qualified for financial assistance than hospitals that received transition windfalls.

A comparison of the 2015 ICP payments with hospital reports of care provided to financially needy patients indicates that as many as 118 hospitals received more funding from the ICP in 2015 than they reported spending on financial assistance-eligible patients in 2013. These 118 hospitals received a total of over $740 million. Together they received almost $318 million more than they reported spending, an average of $2.7 million each. Table 10 shows that of the 10 hospitals that received the highest ICP payments in 2015, eight received more than they reported awarding in financial assistance to needy patients—totaling over $100 million.

Eliminating the transition collar could reduce funding for somesafety-net hospitals listed in Table 1. For example, St. Barnabas Hospital in the Bronx reports that 67 percent of its discharges are either uninsured or have Medicaid. Eliminating the transition collar would have cost them $2 million in 2016. Similarly, Brooklyn's Brookdale Hospital, which serves 56 percent Medicaid/uninsured patients, would have lost $5 million in 2016 without the transition collar. New York State will need to mitigate the damage to these and other safety-net hospitals when it eliminates the transition collar.

Table 10: Eight Out of the Top 10 ICP Payment Hospitals got $101 Million More than they Reported Spending on Financial Assistance Eligible

Hospital name	2015 ICP payment	Cost of providing Financial Assistance (2013)	ICP payment exceeding cost of financial assistance
Bronx-Lebanon Hospital Center - Fulton Division	$65,827,409	$30,771,309	$35,056,100
New York Presbyterian	$50,618,624	$37,790,080	$12,828,544
Montefiore Hospital & Medical Center	$44,383,875	$26,389,407	$17,994,468
Lutheran Medical Center	$44,149,821	$38,836,169	$5,313,652
Jamaica Hospital	$35,451,039	$32,196,751	$3,254,287
Mount Sinai St. Luke's	$33,507,734	$36,778,044	($3,270,310)
North Shore University Hospital	$29,920,121	$21,836,178	$8,083,943
Mount Sinai Beth Israel	$26,567,764	$11,001,786	$15,565,978
Mount Sinai Hospital	$25,545,084	$29,180,636	($3,635,553)
St. Barnabas Hospital	$24,826,466	$21,561,855	$3,264,611
			$101,361,584

Data sources: NYS DOH 2015 Indigent Care Pool distributions data; 2013 Institutional Cost Report Exhibit 50 data.

Units of service formula awards funding regardless of patient financial outcome

While the units of service formula is an improvement over the BDCC formula, New York could do even more to better target ICP funds to those hospitals that provide the most financial assistance and care to patients.

The units of service formula is based on hospital reports of inpatient and outpatient services provided to uninsured patients.[45] DOH multiplies each set of services by the amount that Medicaid would reimburse the hospital for that kind of service, and subtracts any payments made by the uninsured patients.

This methodology does not distinguish between patients who qualify for hospital financial assistance and patients who do not. A patient whose care is included in the tally could be:

- an uninsured billionaire who received care and didn't pay the bill;
- a low-income patient who should have received financial assistance but was sent to collections instead of being offered an application; or
- a low-income patient who received financial assistance.

As a result, the methodology encourages hospitals to serve uninsured patients, but does not encourage hospitals to screen patients for financial assistance eligibility and offer financial assistance to eligible patients. Patients who are not appropriately screened are hurt because they can be subjected to onerous collection actions.

Summary: ICP funding should follow the patient

This section demonstrates that profound flaws remain in New York's Indigent Care Program. The state has extended the temporary transition collar from the original three years to six years. This has led to over $500 million in windfalls to hospitals that do not provide adequate financial assistance to needy patients. Moreover, it maintains a system that allocates payments based on bad debt, in violation of federal regulations.[46]

New York should allow the transition adjustments to sunset once and for all in 2018. Should the elimination of the transition collar harm some safety-net hospitals, New York should work with advocates and hospitals to limit this unintended consequence. In addition, in the face of enormous federal cuts to the program that funds New York's ICP, this funding should be allocated solely on the basis of services provided to uninsured patients who have received hospital financial assistance. Only this will ensure that the interests of New York's most needy patients and taxpayers alike will be fully served.

New York should allow the transition adjustments to sunset once and for all in 2018.

PART TWO: PROGRESS AND LIMITS OF HFAL COMPLIANCE AUDIT

In 2012, the Community Service Society of New York issued a report, *Incentivizing Patient Financial Assistance: How to Fix New York's Hospital Indigent Care Program*, which assessed hospital compliance with the HFAL through a review of hospital financial assistance applications and related materials. Part two of this report reexamines hospital compliance under the new HFAL audit process in four sections.

First, it explains the new HFAL audit process and shows that it has resulted in modest improvements in hospitals' compliance with HFAL requirements that make it easier for consumers to apply for financial assistance. Second, it demonstrates that DOH's lenient scoring undermines the audit's effectiveness. Third, it shows that allowing hospitals to self-evaluate their own compliance compromises DOH's ability to identify and correct errors. Finally, it describes how DOH can improve consumer access to hospital financial assistance.

The HFAL audit can increase hospital compliance with critical HFAL requirements

The 2012 New York Medicaid Redesign ICP Technical Assistance Team (TAT) recommended that DOH implement a hospital compliance scoring system to be audited by KPMG with the results posted on DOH's website.[47] The goal of the audit is to ensure that hospitals receiving ICP funding comply with the consumer-facing requirements of the HFAL and the implementation guidance letters DOH provided to hospitals.

The TAT also recommended that DOH establish a compliance pool of funds equal to 1 percent of the total ICP funding.[48] In 2012, the DOH initiated the implementation of both the audit and compliance pool recommendations.

The audit tool covers a variety of topics, including: outreach and education about financial assistance (for example, if the policy is posted on the hospital website or in person at the hospital); impermissible barriers to completing the application (such as requiring a Social Security Number or income tax returns); and onerous or impermissible collection tactics (such as placing a lien on a person's home or using acceleration clauses).

The audit process has two components:

1. Desk Audit: The desk audit employs a questionnaire (audit tool) with 52 questions; each hospital uses the audit tool to self-report compliance with HFAL.

2. Field Audit: The DOH accounting contractor, KPMG, follows up the desk audit with a field audit in which it verifies a selected group of hospitals' answers to a subset of the questions in the audit tool.

The first compliance audit was conducted in 2012. Hospital scores on the first four audits conducted show that the audit is having a limited positive impact. Five of the 21 hospitals that failed the first audit also failed the second audit. Two hospitals have failed three times.[49]

But over time, an analysis of the DOH audit data reveals that fewer hospitals fail the audit.[50]

- 2010 audit (conducted 2012): 21 hospitals failed
- 2012 audit (conducted 2014): 9 hospitals failed
- 2013 audit (conducted 2015): 3 hospitals failed
- 2014 audit (conducted 2016): 1 hospital failed

These audit results have not be publicly posted on the Department's website.

Table 11 further shows that hospital performance on some of the most commonly failed questions has improved over time.

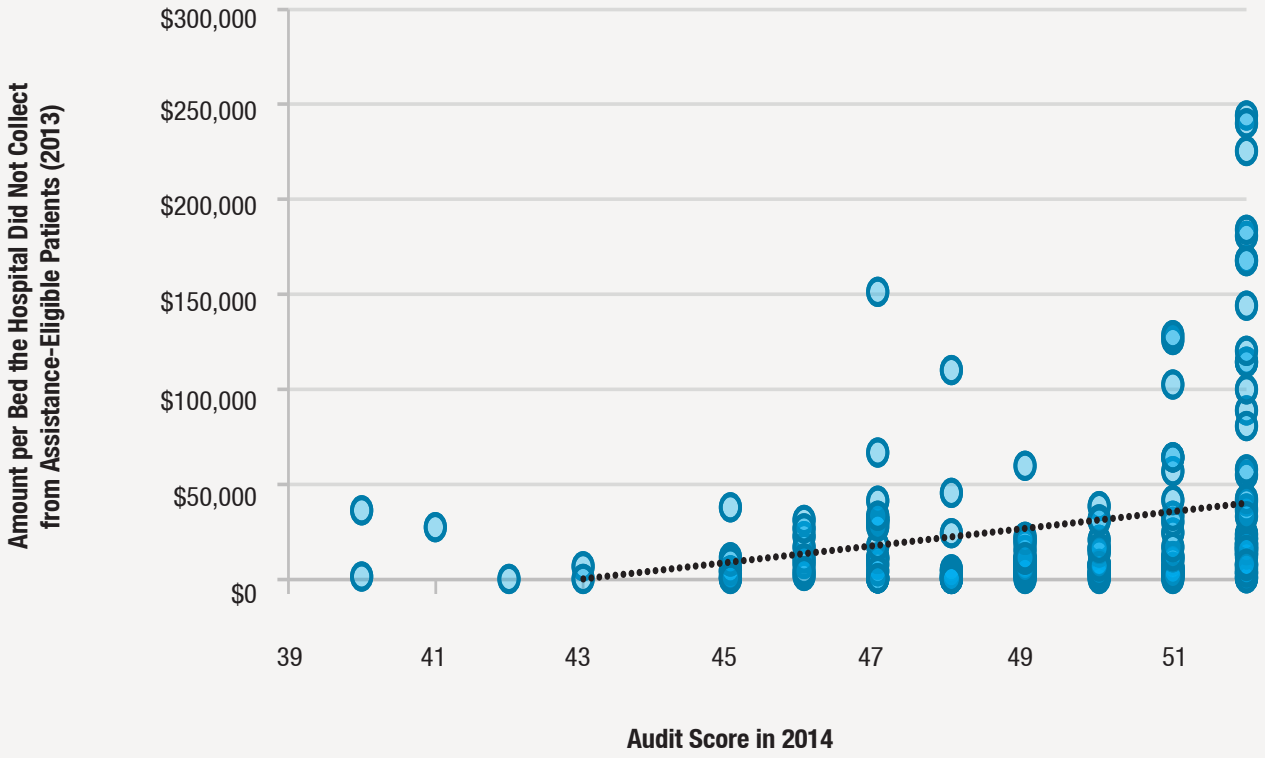
Table 11: Hospitals Have Improved Over Time on the Most Commonly Failed Questions			
Most Commonly Failed Questions	**2012**	**2013**	**2014**
Denial form did not include DOH contact information.+	96 (52%)	48 (26%)	39 (21%)
Application required Medicaid denial.^	54 (29%)	39 (21%)	36 (20%)
Application requires tax returns.^	54 (29%)	39 (21%)	32 (17%)
Does not have a policy prohibiting acceleration clauses.*	45 (25%)	27 (15%)	39 (21%)
Does not have an internal policy to assess HFAL compliance.*	51 (28%)	32 (17%)	23 (12%)
Applies asset test to patients with incomes over 150 percent of the federal poverty level or without permission from DOH.*	90 (49%)	3 (2%)	11(6%)
Application requires monthly bills or proof of other financial obligations.^	38 (21%)	30 (16%)	31 (17%)
Application requires Social Security number.^	35 (19%)	28 (15%)	30 (16%)
Policies and applications are not available online.+	44 (24%)	25 (14%)	16 (9%)

Highlighting means question not counted that year
*Required by law
^Required by DOH 2007 or 2009 guidance letter
+Required under 2012 reform

Sources: DOH 2012 HFAL compliance report data; DOH 2013 HFAL compliance report data; DOH 2014 HFAL compliance report data.

An analysis of the DOH/KPMG audit and the hospital-reported data about their provision of financial assistance reveals that the auditing regime is associated with an improved financial assistance process for consumers. A comparison of hospital audit scores with hospital-reported measures of consumer access to hospital financial assistance reveals that hospitals with passing scores appear to do a significantly better job providing financial assistance to patients (p=.001). Graph 2 indicates that hospitals with higher audit scores provided more care to uninsured consumers eligible for financial assistance.

Graph 2: Better Audit Performance Was Associated with More Financial Assistance for Patients



Data sources: DOH 2012 HFAL compliance report data; DOH 2013 certified beds data; 2013 Institutional Cost Report Exhibit 50 data.

Lenient scoring of the audit undermines effectiveness

The section above shows that the DOH/KPMG auditing protocol appears to have had a positive impact on the provision of financial assistance. However, this next section shows that the impact of the DOH audit regime is undermined significantly in its implementation because: (1) DOH does not count the questions that hospital commonly fail; and (2) DOH continues to pass and financially reward hospitals, even when they fail the same questions year after year.

A close review of DOH's audits between 2012 and 2016 reveals that there are structural problems with the audit process established by DOH and its sub-contractor KPMG. The first problem is that each year, DOH decides that some questions do not count toward a passing score after seeing how many hospitals failed them, not before administering the survey. These "passed-but-in-reality-failed" hospitals are rewarded with full funding.

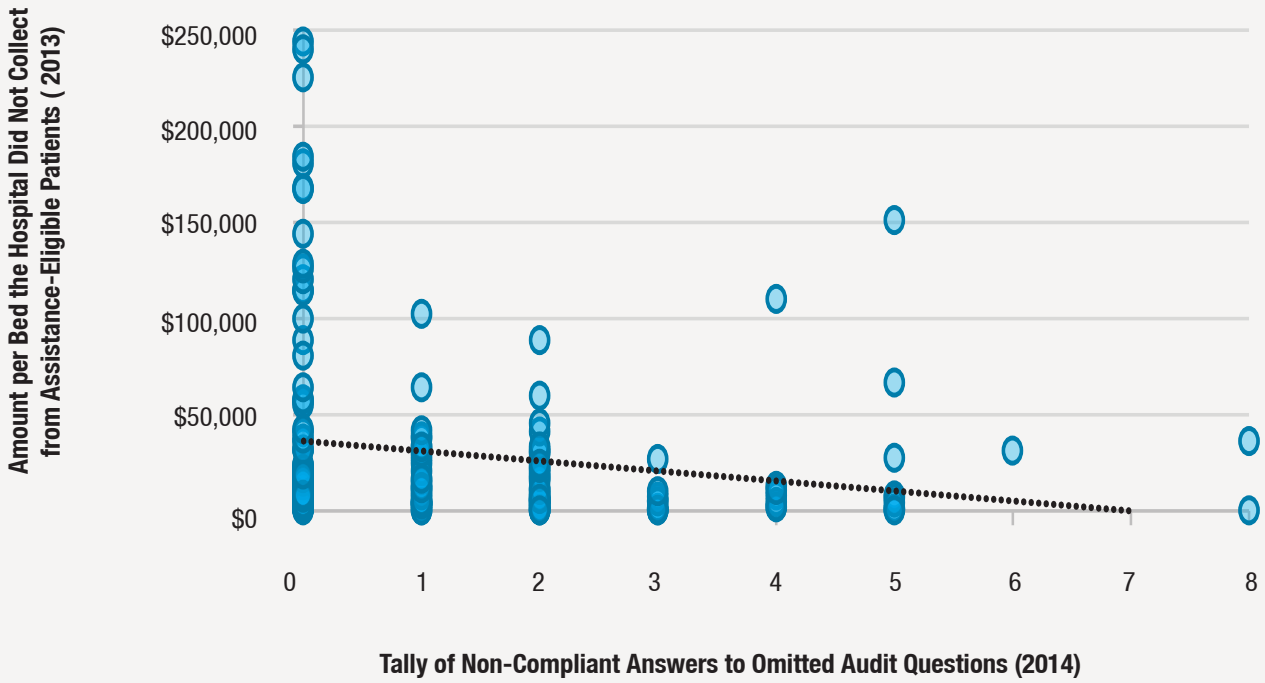
A passing score for hospitals in the most recent year was purportedly 83 percent, but only 40 of the 52 audit questions counted toward that grade (omitting 12 in all). As a result, a hospital actually only has to get 33 of the 52 questions right—a score of 63 percent. For students, 63 percent is widely considered a failing grade, or maybe a "D," at best. Yet under the DOH's audit protocol, hospitals that answer 33 of 52 questions correctly: (1) pass the audit; (2) are not required to submit a corrective action plan; and (3) receive compliance pool funding (described at the beginning of this section) without addressing any incorrect answers in the self-assessing audit tool.

Table 11 shows the nine out of the 52 questions that were most commonly failed from 2102–2014. In 2013 and 2014, DOH did not count six of those nine most commonly failed questions. The frequency with which hospitals failed these questions suggests that hospitals need retraining about HFAL requirements. Allowing hospitals to fail these questions repeatedly without consequence eliminates any incentive for hospitals to implement the correct procedures and vitiates the purpose of the audit/compliance pool regime. A robust system would count the audit questions, re-word questions that are confusing, and train hospital staff on questions that are commonly failed.

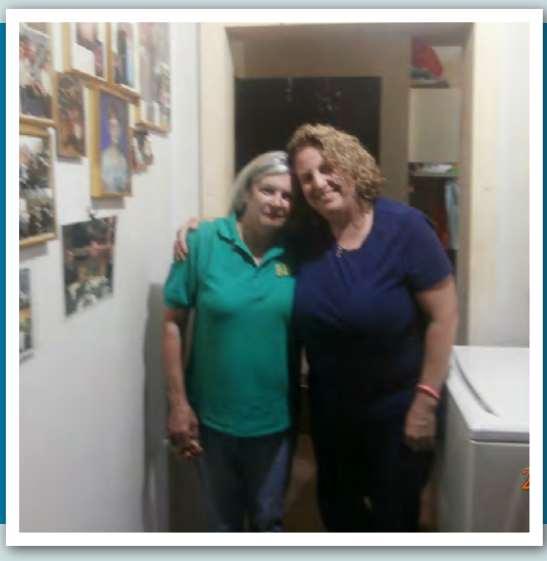
A robust system would count the audit questions, re-word questions that are confusing, and train hospital staff on questions that are commonly failed.

These omitted questions test concepts that significantly impact the ability of a consumer to secure financial assistance under HFAL. For example, DOH omitted questions from the audit process that test whether a hospital is creating a barrier that would prevent patients from learning about or applying for financial assistance. Compliance with these HFAL requirements makes a difference for patients on the ground. Graph 3 shows that the more of the 12 omitted questions a hospital failed, the less care they provided to uninsured patients who were eligible for assistance.[51] This association is statistically significant (p=.01). The vertical axis shows the amount of spending a hospital makes on patients eligible for financial assistance. The horizontal axis shows the number of questions failed on the audit. The hospitals that failed no questions spent significantly more on financial assistance than those who failed many.

Graph 3: Hospitals That Failed the Omitted Questions Provided the Least Care to Financially Needy New Yorkers



Data sources: DOH 2014 HFAL compliance report data; 2013 Institutional Cost Report Exhibit 50 data.



HFAL REQUIREMENTS HAVE REAL-LIFE IMPACT ON PATIENTS

Patricia M. and her family faced two linked ordeals—her emergency gallbladder surgery, and worries about how to pay the subsequent bills. Lewis County General Hospital, where she first went, did not have a surgeon available for her surgery, and sent her to Faxton St. Luke's Hospital. She had no insurance at the time.

Staff at Faxton St. Luke's said that the surgery would cost $13,000 and that she must pay the bill before having surgery. DOH's guidance states that "Deposits may be required prior to the provision of medically necessary, non-emergency care. However, in no case should the deposit amount serve as a barrier to the receipt of medical care."[52] When Patricia's daughter, Nicole, told them she had only $200, they agreed to a down payment of $200. "Getting the news from Faxton St. Luke's that because I did not have insurance there was nothing they could do for me—looking at my husband with tears in my eyes, I could only ask, 'what do I do?'" Patricia said. "This surgery was a matter of life and death."

Nicole spoke to the financial aid office, which asked for her mother's tax returns. Nicole told them the tax returns weren't accurate because her mother's income had dropped significantly in the following year. DOH's guidance prohibits hospitals from requiring patients to submit tax returns as proof of income for this reason.[53] The financial aid officer said they wouldn't take any other documents and insisted on seeing her tax returns.*

Patricia's application was denied; the hospital said that her income was too high for her to qualify for financial assistance. The decision was based on her last filed tax return, which did not reflect her income at the time of her surgery. The hospital denied the application and she was told that she would "need to take a loan out against her home." The written denial included no information about appeal rights.[54]*

Patricia spoke to a Community Health Advocate, Kim Long, at North Country Prenatal/Perinatal Services. Kim called the hospital, which told her that there was no way to appeal the hospital's decision. Kim told them that HFAL requires an appeals process and faxed the hospital staff a copy of the law. Patricia's application was re-reviewed and approved at 100 percent.

*Requirements tested in questions omitted from audit scoring.

DOH desk/field audit fails to provide adequate review of hospitals' self-reported compliance

The DOH desk audit allows hospitals to self-report their compliance with HFAL and DOH's related guidance materials. Because DOH does not review hospitals' self-reported compliance, errors remain uncorrected from year to year. DOH only reviews a hospital's responses to 10 of the 52 questions in the audit tool during the field audit. As a result, DOH cannot find errors in the hospitals' self-reported compliance with the requirements tested in the other 42 questions. If a hospital's compliance team misunderstands the law or guidance, the hospital can incorrectly report that it is in compliance.

A review of materials available on the websites of 185 hospitals in 2017 revealed that 78 percent of hospitals failed at least one of nine questions that were not field audited in 2015, despite the hospital self-reporting compliance with that same question in the 2015 desk audit.[55] It is likely that many of these errors existed in the hospitals' materials in 2015, but were not identified by DOH because those questions were not field audited. DOH failure to field audit all questions misses an important opportunity to identify failures to comply with HFAL.

For example, a review of hospital financial assistance policies reveals that many hospitals still do not understand HFAL's rules about asset testing. The HFAL states that a hospital may only consider the assets of patients with incomes up to 150 percent of the federal poverty limit, and that a hospital may not consider certain assets, including a patient's primary residence.[56] Some hospital policies, however, said that they would only consider assets of patients with incomes above 150 percent, would reserve the right to apply the asset test to all patients, or would consider disallowed assets such as a primary residence.

Other hospitals asked about patient immigration status or stated that financial assistance would only be available to US citizens, despite DOH guidance that clearly states, "Immigration status is not an eligibility criterion under this statute."[57] And many hospitals provided outdated or incorrect tables illustrating federal poverty guidance income levels.

These errors reveal that hospital staff in charge of compliance with HFAL do not understand all DOH guidance. Self-reporting of compliance is not an effective tool to identify errors of this kind. A field audit of all questions, however, would allow DOH to identify errors, educate hospital staff about the law and guidance, and require hospitals to correct errors.

New DOH rule makes application materials more available

In preparing its 2012 report, *Incentivizing Patient Financial Assistance: How to Fix New York's Hospital Indigent Care Program*, CSS discovered that 93 out of 207 hospital websites (45 percent) reviewed did not post HFAL application materials. This issue was raised in the 2012 MRT process and DOH adopted a rule that all hospitals must post their financial assistance application, plain language summary, and policy on their websites.

In 2017, CSS found that only 6 hospitals failed to post any of these documents on their websites.

DOH can take affirmative steps to improve consumer access to hospital financial assistance

Permitting 185 hospitals to design and implement their own applications has been the subject of nearly two decades of consumer advocacy testing and failures. Despite DOH guidance and the compliance audit, hospitals continue to use application forms, policy summaries, and formal policies that contain numerous errors. After six years of an ineffective auditing regime, the time has come for DOH to adopt a simple, single standard application form for all hospitals to use. Requiring hospitals to use a unified and standardized DOH-designed form and a standardized DOH-designed application process would eliminate both common errors and the need to expend limited state resources on a sub-contractor auditor that appears to pass hospitals that in reality are failing the audit.

Alternately, DOH could require hospitals to accept income and residence determinations made by the New York State of Health (NYSOH) Marketplace. Most hospitals have Navigators or certified application counselors (CACs) working on site, who could help consumers apply through the NYSOH. These NYSOH eligibility determinations use federal and state data matches to precisely identify a consumer's income under the federal poverty level, thereby obviating the need to use flawed hospital-specific forms. Hospitals could also use income-deeming systems or other non-intrusive methods, such as self-attestation of income.

New York could also eliminate a common source of confusion by eliminating the option for hospitals to consider the assets of consumers with income below 150 percent of the federal poverty level. As described above, hospital compliance staff do not appear to understand the restrictions, and many applications ask all applicants about their assets, regardless of income. While Medicaid considered applicants' assets at the time HFAL was passed, Medicaid and other Marketplace financial assistance programs do not look at assets today. Eliminating the asset test would remove a source of confusion and align hospital financial assistance eligibility with that of other health care related financial assistance programs in New York.

DOH can also help patients by continuing to improve its hospital profiles website. First, DOH can ensure that all profiles on the site include a link to the hospital's website. Next, DOH can correct errors in its descriptions of hospital primary service areas.[58] Finally, DOH could begin posting the results of the HFAL compliance audits to its website to educate patients about the law and hospital compliance.

Requiring hospitals to use a unified and standardized DOH-designed form and a standardized DOH-designed application process would eliminate both common errors and the need to expend limited state resources on a sub-contractor auditor that appears to pass hospitals that in reality are failing the audit.

CONCLUSION

This report has demonstrated that the majority, over 85 percent, of New York's ICP funds are allocated in a transparent and accountable manner based on services provided to uninsured and Medicaid patients. That said, the remaining 15 percent -- a fiscally significant amount totaling nearly $1 billion over the past five years -- is still allocated using a controversial, bad-debt based formula that is unrelated to low-income patient need or care, the purported rationale for the ICP pool. This report has also shown that a less-than-rigorous auditing regime is unable to ensure that hundreds of hospital-unique financial assistance applications and policies can comply with the HFAL and ensure access to New York's hospital consumers

Actionable policy solutions are simple to identify. For patients, the State should adopt uniform hospital financial assistance materials to be used by all hospitals getting ICP funds. For the hospitals, there are myriad ways the State could responsibly allocate the remaining 15 percent of ICP funds. For example: only allocate ICP funds based on financial assistance actually provided (like Massachusetts); offer ICP funds solely to the top 25 percent of safety-net institutions; and/or disqualify ICP allocations to hospitals with positive operating incomes that fail to demonstrate that they provide meaningful levels of financial assistance. All of these ideas, and more, bear further discussion and timely action.

Recommendation #1: End transition adjustment payments and distribute DSH cuts equitably

New York should fully implement the existing ICP funding distribution methodology by allowing the transition adjustments to end in 2018. New York should not extend the transition collar again. New York should allay any harm that eliminating the transition adjustments would cause for the true safety-net hospitals, which serve disproportionately high shares of uninsured and Medicaid patients.

As New York contemplates reductions in future DSH funds, starting as soon as this year, it should ensure that DSH cuts overall are equitable and promote the principle that DSH funds should prioritize compensating those institutions that serve the most low-income, uninsured patients, who are disproportionately racial and ethnic minorities. Ultimately, New York should move to an accountable system, like Massachusetts, that ensures that ICP money follows the patient.

Recommendation #2: Improve the patient experience

New York should fully implement the audit process by: (1) counting all desk audit questions toward a hospital's score; and (2) field-auditing hospitals' self-reported compliance by reviewing answers to all 52 questions in the audit tool. Funding from the HFAL compliance pool should only be allocated after a hospital has corrected all errors found in the audit.

DOH should further improve the patient experience by: adopting a uniform statewide financial assistance application and other materials to be used by all hospitals; requiring hospitals to accept NYSOH income and residence determinations; and eliminating any asset tests.

Endnotes

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50 A total of 27 out of 190 hospitals have failed at least once. The hospitals that failed the audit at least once are: Brunswick Hospital Center, Burke Rehabilitation Hospital, Calvary Hospital, Chenango Memorial, Claxton Hepburn Medical Center, Clifton Springs Hospital & Clinic, Clifton-Fine Hospital, Edward John Noble Hospital (now Gouverneur Hospital), Ellenville Regional Hospital, Ellis Hospital, Helen Hayes Hospital, Little Falls Hospital, Medina Memorial Hospital, Newark-Wayne Community Hospital, Northern Dutchess Hospital, O'Conner Hospital, Our Lady of Lourdes Memorial Hospital, Putnam Hospital Center, Samaritan Medical Center, Saratoga Hospital, Schuyler Hospital, Seton Health, United Memorial Medical Center, Vassar Brothers Medical Center, Westchester Medical Center, Westfield Memorial, and Woman's Christian Association. Source: DOH 2010-2012 Financial Assistance Compliance Report data.
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53 *Id.* "For example, copies of state or federal tax returns should not be required to verify income since they do not directly address current income and may be burdensome to produce."
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55 Eight of these nine questions tested requirements of the HFAL and related guidance that CSS included in its review of hospital application materials for the 2012 report "Incentivizing Patient Financial Assistance: How to fix New York's Hospital Indigent Care Program." The ninth question tested the new (2012) DOH requirement that hospitals post their financial assistance application, summary, and policy on their website.
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57 *Supra*, n.52.
58 Some hospital profiles on the site have incorrect information about the counties that are covered by its primary service area for medically necessary care, and the PSA description for each hospital does not mention that hospitals are required to provide financial assistance to all income-eligible New York residents for emergency care.

Appendices

Appendix A: Evolution of Indigent Care Pool Distribution

New York's hospital Indigent Care Pool (formerly called the "Bad Debt and Charity Care Pool") was created in 1983. Since it was created, the state has made several efforts to reform the ICP, with significant input from consumer advocates and other stakeholders. The following is a timeline outlining some of these changes:

- 1983–2006: Indigent Care Pools created
  - Multiple sub-pools
  - Payments based on hospitals' reported bad debt and charity care write-offs, with hospital charges reduced to costs (BDCC methodology)
  - Consumer advocates document failure of hospitals to provide financial assistance to uninsured consumers who need it
- 2006: Hospital Financial Assistance Law—"Manny's Law"—passed
  - Manny Alvarez, uninsured patient, died of untreated brain cancer when hospital denied him surgery until he got health insurance. Media coverage of his death led to HFAL passage.
  - New requirements that hospitals provide patients with access to financial assistance
  - Hospitals required to comply with new requirements by 2009 to in order to receive ICP funding
- 2008: Technical Advisory Committee met and recommended changes. Legislature changed methodology
  - Retained multiple sub-pools
  - 90 percent of funding based on old BDCC methodology
  - 10 percent of funding based on new "uninsured units" methodology – distributions based on hospital-reported units of service provided to uninsured consumers, minus payments from uninsured patients, adjusted by Medicaid utilization rate
- 2012–2013: New York Medicaid Redesign Technical Assistance Team, made up of DOH, hospitals and hospital groups, and consumer advocates met, recommended changes. Legislature changed methodology:
  - Collapsed all voluntary sub-pools into one pool, retained public pool
  - All funding to be distributed according to uninsured units of service methodology
  - 3 year transition period: hospital losses under new formula would be limited to 2.5 percent first year, growing by 2.5 percent each year.
  - Additional $25M for voluntary pool to permit transition payments
  - DOH to "evaluate efficacy" during transition period
  - KPMG to audit hospital compliance with HFAL requirements
    - One percent funding reserved for hospitals that pass audit (held for hospitals that fail and paid when they pass in subsequent year)
- 2015: State extended three-year transition period by additional three years (2018 – 15 percent = maximum loss)

Appendix B: Report Methodology

The findings of this report are based on original policy research performed by the Community Service Society (CSS). The findings were reviewed and discussed with hospital administrators, policy analysts, Department of Health staff, consumer and patient advocates, and other key stakeholders.

CSS obtained data through Freedom of Information Law (FOIL) requests to the New York State Department of Health (DOH), including: (1) Indigent Care Pool distributions and transition payments for 2013–2016; (2) Indigent Care Pool calculation spreadsheets for 2013–2016; (3) Institutional Cost Report data for 2013 and 2014; (4) HFAL compliance audit reports for 2010, 2012, 2013, and 2014; (5) non-compliant hospitals in years 2010–2016; and (6) hospital certified bed data for 2013–2015. CSS obtained 2015 Statewide Planning and Research Cooperative System (SPARCS) data from the DOH website.[1] CSS obtained 2013 DSH audit data from the Medicaid.gov website.[2] CSS staff also interviewed DOH and KPMG staff about the audit process by telephone and email.

CSS conducted a review of hospital financial assistance materials available on 2017 websites of 185 hospitals to determine whether they complied with HFAL requirements tested in 9 of the questions in the audit tool. None of these questions were reviewed by KPMG in field audits in 2012, 2014, and 2015.

These questions were:

- Does the summary of policies and procedures contain information as to income levels used to determine eligibility for assistance?
- Does the summary of policies and procedures a description of the primary service area of the hospital for emergency and non-emergency services?
- Does the summary of policies and procedures contain the means of applying for assistance?
- Does the hospital require as a condition of receiving financial assistance, or deny financial assistance, based on tax returns?*
- Does the hospital require as a condition of receiving financial assistance, or deny financial assistance, based on Medicaid denials?*
- Does the hospital require as a condition of receiving financial assistance, or deny financial assistance, based on information regarding patients' monthly bills or financial obligations?*
- Are the policies and procedures, policy summary, and financial aid applications present on the hospital's Web site?^
- Does the hospital comply with the application process requirement that application materials include a notice to patients that upon submission of a completed application, the patient may disregard any bills until the hospital has rendered a decision on the application?
- Does the hospital only apply an asset test to patients who are below 150 percent of the FPL and only if they have received explicit permission from the N.Y. State Department of Health to do so?

^Not counted in 2012 audit
*Not counted in 2013 and 2014 audits

Statistical Outputs for Graphs

Graph 1 illustrates an association between the total amount each hospital received from the indigent care pool in 2015 and the proportion of bad debt in the amount of uncompensated care the hospitals reported in 2012 (the last year in which they were allowed to include bad debt). Hospitals that received higher amounts from the indigent care pool in 2015 were more likely to have included high amounts of bad debt in their uncompensated care total in 2012.

Graph 1 Regression Statistics	
Multiple R	0.194195
R Square	0.037712
Adjusted R Square	0.032149
Standard Error	0.265616
Observations	175

	Coefficients	Standard Error	t Stat	P-value	Lower 95%	Upper 95%
Intercept	0.381274	0.024101	15.81992	1.92E-35	0.333703989	0.428843
X Variable (Total ICP Distribution, 2015)	5.46E-09	2.1E-09	2.603803	0.010021	1.32192E-09	9.6E-09

Statistical Outputs for Graphs (Cont.)

Graph 2 illustrates an association between a hospital's performance on the financial assistance compliance audit and total amount the hospital reported losing on uncompensated care per bed. Hospitals that performed better on the audit were more likely to spend more on uncompensated care than hospitals that performed worse.

Graph 2 Regression Statistics	
Multiple R	0.2364345
R Square	0.05590127
Adjusted R Square	0.05053708
Standard Error	45022.8086
Observations	178

	Coefficients	Standard Error	t Stat	P-value	Lower 95%	Upper 95%
Intercept	-170448.527	62013.02144	-2.74859	0.006609	-292833.357	-48063.696
X Variable (Raw Audit Score, 2014)	4030.00763	1248.381688	3.228185	0.001486	1566.28343	6493.73182

Graph 3 illustrates an association between negative results on audit questions that were not counted by the state towards a final score and the total amount the hospital reported losing on uncompensated care per bed. Hospitals that failed more of these questions were likely to provide less uncompensated care than others.

Graph 3 Regression Statistics	
Multiple R	0.179281
R Square	0.032142
Adjusted R Square	0.026642
Standard Error	45585.82
Observations	178

	Coefficients	Standard Error	t Stat	P-value	Lower 95%	Upper 95%
Intercept	36284.2364	4436.087645	8.179333	5.49E-14	27529.4649	45039.008
X Variable (Omitted Question Tally, 2014)	-5339.88823	2208.756787	-2.4176	0.016644	-9698.9457	-980.8308

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2 https://www.medicaid.gov/medicaid/financing-and-reimbursement/dsh/index.html.

Table 1: Hospitals by percentage of discharges that are Medicaid and uninsured, 2015

Hospital Name	Percent of all Hospital Discharges that are Medicaid and Self-Pay
Coney Island Hospital	83%
Elmhurst Hospital Center	77%
Queens Hospital Center	76%
Woodhull Medical & Mental Health Center	74%
Metropolitan Hospital Center	73%
North Central Bronx Hospital	71%
Lincoln Medical & Mental Health Center	69%
Kings County Hospital Center	68%
Bronx-Lebanon Hospital Center	68%
Harlem Hospital Center	67%
St. Barnabas Hospital	67%
Bellevue Hospital Center	65%
Jacobi Medical Center	65%
Blythedale Childrens Hospital	63%
Flushing Hospital Medical Center	62%
Interfaith Medical Center	58%
Jamaica Hospital Medical Center	58%
Brookdale Hospital Medical Center	56%
New York Eye and Ear	56%
Burdett Care Center	55%
Wyckoff Heights Medical Center	54%
Maimonides Medical Center	54%
Brooklyn Hospital	53%
NYU Lutheran Medical Center	53%
Erie County Medical Center	52%
St. John's Riverside	51%
Nassau University Medical Center	51%
St. Joseph's Medical Center	51%
Eastern Long Island Hospital	51%
University Hospital of Brooklyn	49%

Hospital Name	Percent of all Hospital Discharges that are Medicaid and Self-Pay
Henry J. Carter Specialty Hospital	47%
Clifton Springs Hospital and Clinic	46%
St. John's Episcopal Hospital	46%
Montefiore Medical Center	45%
Niagara Falls Memorial Medical Center	42%
HealthAlliance Hospital Mary's Ave.	42%
New York Hospital Medical Center of Queens	41%
Westchester Medical Center	40%
Nyack Hospital	40%
Our Lady of Lourdes	39%
Richmond University Medical Center	38%
St. Joseph's Hospital	38%
Mount Sinai Beth Israel	38%
Montefiore Mount Vernon Hospital	37%
Bon Secours Community Hospital	37%
Oswego Hospital	37%
Nathan Littauer Hospital	36%
Good Samaritan Hospital of Suffern	35%
Woman's Christian Association	35%
Montefiore New Rochelle Hospital	35%
Forest Hills Hospital	35%
Staten Island University Hospital	34%
Memorial Hosp of Wm F & Gertrude F Jones A/K/A Jones Memorial Hosp	34%
Upstate University Hospital	33%
Carthage Area Hospital	33%
New York Methodist Hospital	32%
Seton Health System - St Marys Campus	32%
Brooks Memorial Hospital	32%
Long Island Jewish Medical Center	32%

Table 1: Hospitals by percentage of discharges that are Medicaid and uninsured, 2015

Hospital Name	Percent of all Hospital Discharges that are Medicaid and Self-Pay
Newark-Wayne Community Hospital	32%
New York Presbyterian Hospital	31%
Chenango Memorial Hospital Inc	31%
Cortland Regional Medical Center Inc	31%
St Luke's Cornwall Hospital/Newburgh	30%
Good Samaritan Hospital Medical Center	30%
Mount Sinai St. Luke's/Roosevelt	30%
Eastern Niagara Hospital	30%
Faxton-St. Luke's Healthcare	30%
Southside Hospital	30%
St. James Mercy Hospital	30%
St. Mary's Healthcare	30%
Oneida Healthcare Center	29%
United Memorial Medical Center	29%
Mercy Medical Center	28%
Strong Memorial Hospital	28%
Crouse Hospital	28%
Nicholas H. Noyes Memorial Hospital	28%
Mount Sinai Hospital	28%
Kingsbrook Jewish Medical Center	28%
Canton-Potsdam Hospital	28%
Kaleida Health	27%
TLC Health Network Lake Shore Hospital	27%
Albany Medical Center Hospital	27%
St. Charles Hospital	27%
Delaware Valley Hospital Inc	27%
Phelps Memorial Hospital Assn	26%
Olean General Hospital	26%
Columbia Memorial Hospital	26%
Sisters of Charity Hospital	26%
Southampton Hospital	26%
United Health Services Hospitals	26%
Rome Memorial Hospital	26%
Claxton-Hepburn Medical Center	25%
Ellis Hospital	25%
Franklin Hospital	25%
Auburn Memorial Hospital	25%
Arnot Ogden Medical Center	25%
University Hospital	24%
Glens Falls Hospital	24%
Catskill Regional Medical Center	24%
Cayuga Medical Center at Ithaca	23%
Mary Imogene Bassett Hospital	23%
Wyoming County Community Hospital	23%
The Unity Hospital of Rochester	23%
Highland Hospital	23%
Lewis County General Hospital	23%
Samaritan Medical Center	23%
Rochester General Hospital	22%
Samaritan Hospital	22%
New York Community Hospital of Brooklyn, Inc	22%
HealthAlliance Hospital Broadway Campus	22%
Corning Hospital	22%
Peconic Bay Medical Center	22%
Soldiers and Sailors Memorial Hospital	21%
New York-Presbyterian/Lawrence Hospital	21%
Winthrop-University Hospital	21%
St. Peter's Hospital	21%

Table 1: Hospitals by percentage of discharges that are Medicaid and uninsured, 2015

Hospital Name	Percent of all Hospital Discharges that are Medicaid and Self-Pay
University of Vermont Champlain Valley	20%
St. Catherine of Siena Hospital	20%
South Nassau Communities Hospital	19%
White Plains Hospital Center	19%
St. Joseph's Hospital Health Center	19%
Huntington Hospital	19%
Mercy Hospital of Buffalo	19%
St. Elizabeth Medical Center	18%
NewYork-Presbyterian/Hudson Valley Hospital	18%
Adirondack Medical Center-Saranac Lake Site	18%
Ellenville Regional Hospital	18%
Moses-Ludington Hospital	17%
Gouverneur Hospital	17%
Saratoga Hospital	17%
F. F. Thompson Hospital	17%
Orange Regional Medical Center-Goshen Campus	17%
Cuba Memorial Hospital Inc	16%
Lenox Hill Hospital	15%
NYU Hospitals Center	15%
Albany Memorial Hospital	15%
Margaretville Hospital	14%
Ira Davenport Memorial Hospital	14%
Northern Westchester Hospital	14%
St. Anthony Community Hospital	13%
Northern Dutchess Hospital	13%
North Shore University Hospital	13%
Putnam Hospital Center	13%
Vassar Brothers Medical Center	12%
Community Memorial Hospital	11%
St. Joseph Hospital	11%
Geneva General Hospital	11%
Schuyler Hospital	11%
Massena Memorial Hospital	11%
Cobleskill Regional Hospital	11%
River Hospital	11%
Kenmore Mercy Hospital	11%
Glen Cove Hospital	11%
Monroe Community Hospital	10%
Bertrand Chaffee Hospital	10%
Aurelia Osborn Fox Memorial Hospital	10%
John T Mather Memorial Hospital	10%
Little Falls Hospital	9%
Calvary Hospital Inc	8%
Medina Memorial Hospital	8%
Alice Hyde Medical Center	8%
O'Connor Hospital	8%
Brookhaven Memorial Hospital Medical Center	8%
Memorial Sloan Kettering Hospital	8%
Sunnyview Hospital and Rehabilitation Center	7%
Plainview Hospital	7%
Mount St. Mary's Hospital and Health Center	6%
University of Vermont Elizabethtown	6%
Helen Hayes Hospital	6%
St. Francis Hospital	5%
Catskill Regional Medical Center - G. Hermann Site	4%

Table 1: Hospitals by percentage of discharges that are Medicaid and uninsured, 2015

Hospital Name	Percent of all Hospital Discharges that are Medicaid and Self-Pay	Hospital Name	Percent of all Hospital Discharges that are Medicaid and Self-Pay
Summit Park Hospital-Rockland County Infirmary	4%	Winifred Masterson Burke Rehabilitation Hospital	3%
Clifton-Fine Hospital	4%	Roswell Park Cancer Institute	3%
Hospital for Special Surgery	3%	Westfield Memorial Hospital	0%

Source: 2015 Hospital Inpatient Discharges (SPARCS De-identified), Bureau of Health Informatics, Office of Quality and Patient Safety, New York State Department of Health. https://health.data.ny.gov/Health/Hospital-Inpatient-Discharges-SPARCS-De-Identified/82xm-y6g8.

Table 2: Effect of 2015 ICP transition payments on pool distributions				
Hospital Name	**Allocation Before Transition Adjustment**	**Transition Adjustment**	**Total 2015 ICP payment**	**Percentage change**
Roswell Park Memorial Institute	$3,882	$1,932,307	$1,936,189	49775%
Helen Hayes Hospital	$15,214	$1,305,758	$1,320,973	8582%
Elizabethtown Community Hospital	$16,750	$391,469	$408,220	2337%
Calvary Hospital	$67,425	$487,988	$555,413	724%
Memorial Sloan Kettering Hospital for Cancer and Allied Diseases	$2,033,817	$10,178,983	$12,212,800	500%
Schuyler Hospital	$182,292	$764,170	$946,462	419%
Tri Town Regional Healthcare	$126,321	$523,951	$650,272	415%
Ira Davenport Memorial Hospital	$232,454	$840,307	$1,072,761	361%
Soldiers and Sailors Memorial Hospital of Yates County	$181,838	$638,791	$820,629	351%
Cuba Memorial Hospital	$141,230	$476,086	$617,315	337%
State University Hospital Downstate Medical Center	$2,265,376	$7,604,952	$9,870,328	336%
O'Connor Hospital	$106,581	$340,209	$446,790	319%
Wyoming County Community Hospital	$266,655	$845,801	$1,112,456	317%
Blythedale Childrens Hospital	$330,829	$889,875	$1,220,704	269%
Moses-Ludington Hospital	$110,875	$282,892	$393,768	255%
HealthAlliance Hospital Mary's Avenue Campus	$846,586	$2,084,395	$2,930,981	246%
Cobleskill Regional Hospital	$249,128	$548,700	$797,828	220%
Margaretville Memorial Hospital	$117,110	$246,092	$363,202	210%
Ellenville Community Hospital	$415,510	$810,391	$1,225,901	195%
Westchester Medical Center	$3,176,371	$5,902,051	$9,078,422	186%
Gouverneur Hospital	$182,664	$302,433	$485,097	166%
Catskill Regional Hospital - Harris	$2,825,618	$4,583,834	$7,409,452	162%
Adirondack Medical Center	$567,221	$917,137	$1,484,358	162%
Seton Health System	$902,155	$1,423,101	$2,325,256	158%
Corning Hospital	$706,621	$1,014,528	$1,721,149	144%
Little Falls Hospital	$332,702	$454,682	$787,383	137%
Summit Park Hospital - Rockland County Infirmary	$1,062,736	$1,443,036	$2,505,773	136%
River Hospital	$221,855	$279,367	$501,222	126%
Goldwater Memorial Hospital	$2,155,003	$2,632,783	$4,787,786	122%
Lewis County General Hospital	$336,501	$410,882	$747,383	122%
Delaware Valley Hospital Inc	$236,475	$281,167	$517,642	119%
SUNY Health Science Center at Syracuse	$1,846,227	$2,176,239	$4,022,466	118%
Catskill Regional Hospital - Herman	$216,922	$243,063	$459,985	112%
Bertrand Chaffee Hospital	$165,835	$180,421	$346,255	109%
St. Peter's Hospital	$2,772,094	$2,670,113	$5,442,207	96%
Clifton-Fine Hospital	$107,283	$101,619	$208,902	95%
TLC Health Care Network	$590,311	$534,170	$1,124,481	90%
HealthAlliance Hospital Broadway	$2,965,284	$2,619,821	$5,585,105	88%

Table 2: Effect of 2015 ICP transition payments on pool distributions				
Hospital Name	**Allocation Before Transition Adjustment**	**Transition Adjustment**	**Total 2015 ICP payment**	**Percentage change**
Carthage Area Hospital	$325,243	$268,298	$593,541	82%
Geneva General Hospital	$878,862	$611,837	$1,490,699	70%
Memorial Hospital of Albany	$780,610	$507,030	$1,287,640	65%
Bon Secours Hospital	$1,873,522	$1,102,557	$2,976,078	59%
Mercy Medical Center	$3,509,412	$2,041,174	$5,550,586	58%
Oswego Hospital	$1,578,657	$839,794	$2,418,451	53%
Samaritan Hospital of Troy	$1,343,304	$699,745	$2,043,049	52%
Medina Memorial Hospital	$293,119	$138,278	$431,396	47%
St. Francis Hospital of Roslyn	$1,259,460	$588,138	$1,847,598	47%
Beth Israel Medical Center	$18,200,410	$8,367,354	$26,567,764	46%
Brookdale Hospital Medical Center	$15,053,544	$6,722,626	$21,776,170	45%
Jamaica Hospital	$24,888,619	$10,562,419	$35,451,039	42%
Brooklyn Hospital	$7,109,874	$2,953,607	$10,063,481	42%
Nicholas H. Noyes Memorial Hospital	$546,173	$217,220	$763,393	40%
John T. Mather Memorial Hospital	$1,583,668	$587,352	$2,171,020	37%
Olean General Hospital	$1,169,814	$425,677	$1,595,491	36%
Oneida Healthcare Center	$767,657	$274,042	$1,041,699	36%
Putnam Community Hospital	$1,595,026	$548,828	$2,143,854	34%
Mt. Sinai St. Luke's	$25,017,629	$8,490,105	$33,507,734	34%
Erie County Medical Center	$2,731,207	$900,839	$3,632,045	33%
Community Memorial Hospital	$507,682	$161,979	$669,661	32%
Northern Dutchess Hospital	$874,324	$265,294	$1,139,618	30%
Glens Falls Hospital	$3,025,465	$897,264	$3,922,728	30%
Eastern Niagara Hospital	$712,224	$206,902	$919,125	29%
Aurelia Osborn Fox Memorial Hospital	$1,027,639	$253,119	$1,280,758	25%
Eastern Long Island Hospital	$717,550	$163,417	$880,967	23%
St. Anthony Community Hospital	$558,175	$114,631	$672,806	21%
University Hospital at Stony Brook	$4,641,634	$898,976	$5,540,610	19%
Cortland Regional Medical Center	$1,041,320	$193,376	$1,234,696	19%
New Island Hospital	$2,139,513	$388,541	$2,528,054	18%
Nassau Medical Center	$5,433,533	$971,921	$6,405,454	18%
North Shore University Hospital - Glen Cove	$3,218,388	$563,518	$3,781,906	18%
Womans Christian Association	$1,267,111	$199,655	$1,466,765	16%
NY Eye and Ear Infirmary	$6,241,405	$975,875	$7,217,280	16%
Harlem Hospital Center	$6,393,498	$782,499	$7,175,997	12%
St. James Mercy Hospital	$1,188,875	$117,760	$1,306,635	10%
NY Presbyterian	$46,472,397	$4,146,228	$50,618,624	9%
North Shore University Hospital - Plainview	$1,401,972	$95,455	$1,497,427	7%

Table 2: Effect of 2015 ICP transition payments on pool distributions				
Hospital Name	**Allocation Before Transition Adjustment**	**Transition Adjustment**	**Total 2015 ICP payment**	**Percentage change**
Good Samaritan Hospital of Suffern	$4,892,628	$281,098	$5,173,726	6%
Via Health of Wayne	$2,082,725	$90,441	$2,173,166	4%
St. Barnabas Hospital	$23,839,702	$986,764	$24,826,466	4%
Huntington Hospital	$3,149,334	$121,028	$3,270,362	4%
Sunnyview Hospital and Rehabilitation Center	$93,240	$3,315	$96,555	4%
Kingsbrook Jewish Medical Center	$2,450,897	$73,570	$2,524,468	3%
St. Charles Hospital	$2,462,270	$62,250	$2,524,520	3%
Rome Memorial Hospital	$928,110	$22,640	$950,750	2%
Montefiore Hospital & Medical Center	$43,547,242	$836,633	$44,383,876	2%
Interfaith Medical Center	$12,797,974	$193,810	$12,991,784	2%
North Central Bronx Hospital	$4,141,201	$59,683	$4,200,883	1%
Winthrop University Hospital	$6,491,748	$14,401	$6,506,149	0%
Albany Medical Center Hospital	$8,160,052	$0	$8,160,052	0%
Auburn Memorial Hospital	$1,302,446	$0	$1,302,446	0%
Bronx-Lebanon Hospital Center-Fulton Division	$65,827,409	$0	$65,827,409	0%
Brookhaven Memorial Hospital Medical Center	$7,604,040	$0	$7,604,040	0%
Brooks Memorial Hospital	$666,619	$0	$666,619	0%
Burdett Care Center	$458,049	$0	$458,049	0%
Canton-Potsdam Hospital	$1,589,137	$0	$1,589,137	0%
Cayuga Medical Center at Ithaca	$1,950,948	$0	$1,950,948	0%
Champlain Valley Physicians Hospital Medical Ctr.	$2,125,943	$0	$2,125,943	0%
Chenango Memorial Hospital	$1,811,428	$0	$1,811,428	0%
Clifton Springs Hospital and Clinic	$498,172	$0	$498,172	0%
Columbia-Greene Medical Center	$2,722,964	$0	$2,722,964	0%
Crouse-Irving Memorial Hospital	$6,089,117	$0	$6,089,117	0%
Ellis Hospital	$7,793,192	$0	$7,793,192	0%
Episcopal Health Services	$5,711,053	$0	$5,711,053	0%
F. F. Thompson Hospital	$1,187,218	$0	$1,187,218	0%
Flushing Hospital and Medical Center	$10,386,347	$0	$10,386,347	0%
Franklin General Hospital	$3,877,194	$0	$3,877,194	0%
Highland Hospital of Rochester	$5,623,227	$0	$5,623,227	0%
Hudson Valley Hospital Center	$1,832,218	$0	$1,832,218	0%
Jacobi Medical Center	$8,606,180	$0	$8,606,180	0%
Kaleida Health	$6,163,591	$0	$6,163,591	0%
Lawrence Hospital	$1,981,111	$0	$1,981,111	0%
Lincoln Medical and Mental Health Center	$9,275,526	$0	$9,275,526	0%
Long Island Jewish-Hillside Medical Center	$22,010,460	$0	$22,010,460	0%
Mount Sinai Hospital	$25,545,084	$0	$25,545,084	0%

Table 2: Effect of 2015 ICP transition payments on pool distributions				
Hospital Name	**Allocation Before Transition Adjustment**	**Transition Adjustment**	**Total 2015 ICP payment**	**Percentage change**
North Shore University Hospital	$29,920,121	$0	$29,920,121	0%
Nyack Hospital	$3,026,276	$0	$3,026,276	0%
Richmond University Medical Center	$8,715,191	$0	$8,715,191	0%
Rochester General Hospital	$12,252,025	$0	$12,252,025	0%
Samaritan Medical Center	$2,281,848	$0	$2,281,848	0%
South Nassau Communities Hospital	$5,954,195	$0	$5,954,195	0%
Southside Hospital	$7,731,311	$0	$7,731,311	0%
St. Catherine Of Siena	$2,029,720	$0	$2,029,720	0%
Vassar Brothers Hospital	$6,178,113	$0	$6,178,113	0%
NY Methodist Hospital of Brooklyn	$9,058,084	($46,735)	$9,011,349	-1%
Beth Israel Hospital - Kings Highway Division	$1,500,431	($12,590)	$1,487,841	-1%
St. Joseph's Hospital Health Center	$6,605,913	($116,830)	$6,489,083	-2%
NYU Medical Center	$12,562,274	($256,148)	$12,306,126	-2%
St. Joseph's Hospital of Elmira	$1,337,458	($29,391)	$1,308,067	-2%
United Memorial	$1,301,418	($35,514)	$1,265,904	-3%
Hepburn Medical Center	$1,177,309	($38,135)	$1,139,174	-3%
Arnot-Ogden Memorial Hospital	$2,314,923	($87,533)	$2,227,389	-4%
Peconic Bay Medical Center	$2,698,758	($126,875)	$2,571,883	-5%
Jones Memorial Hospital	$1,291,133	($69,238)	$1,221,895	-5%
Orange Regional Medical Center	$6,205,119	($355,485)	$5,849,634	-6%
Bellevue Hospital Center	$15,465,285	($898,897)	$14,566,388	-6%
Mercy Hospital of Buffalo	$4,035,085	($279,430)	$3,755,655	-7%
Faxton - St. Luke's Health Care	$3,495,904	($292,452)	$3,203,452	-8%
Staten Island University Hospital	$22,388,039	($2,100,627)	$20,287,411	-9%
St. Luke's-Cornwall Hospital	$4,841,673	($490,231)	$4,351,442	-10%
Southampton Hospital	$2,512,817	($257,452)	$2,255,364	-10%
Kenmore Mercy Hospital	$1,255,178	($131,442)	$1,123,736	-10%
Wyckoff Heights Hospital	$27,626,619	($2,894,400)	$24,732,218	-10%
Sisters of Charity Hospital	$5,395,983	($566,855)	$4,829,128	-11%
Park Ridge Hospital	$8,215,763	($905,586)	$7,310,177	-11%
Maimonides Medical Center	$23,653,433	($2,663,440)	$20,989,993	-11%
Lutheran Medical Center	$50,122,054	($5,972,233)	$44,149,821	-12%
Northern Westchester Hospital	$2,225,894	($291,700)	$1,934,195	-13%
St. Mary's Hospital at Amsterdam	$2,540,138	($334,277)	$2,205,861	-13%
Strong Memorial Hospital	$17,755,645	($2,337,904)	$15,417,741	-13%
Metropolitan Hospital Center	$8,348,659	($1,109,042)	$7,239,617	-13%
Mary Imogene Bassett Hospital	$5,015,649	($721,355)	$4,294,294	-14%
Niagara Falls Memorial Medical Center	$2,584,436	($372,849)	$2,211,587	-14%

Table 2: Effect of 2015 ICP transition payments on pool distributions				
Hospital Name	**Allocation Before Transition Adjustment**	**Transition Adjustment**	**Total 2015 ICP payment**	**Percentage change**
Good Samaritan Hospital of West Islip	$10,545,081	($1,525,527)	$9,019,555	-14%
Kings County Hospital Center	$18,814,955	($3,435,222)	$15,379,732	-18%
Kaleida Health - Women and Children	$4,799,083	($891,660)	$3,907,423	-19%
Saratoga Hospital	$3,296,313	($642,552)	$2,653,761	-19%
NY Medical Center of Queens	$12,395,466	($2,551,476)	$9,843,990	-21%
White Plains Hospital Medical Center	$3,683,445	($788,663)	$2,894,782	-21%
St. Johns Riverside - Yonkers	$9,915,687	($2,245,567)	$7,670,121	-23%
NY Community - Brooklyn	$1,756,269	($409,870)	$1,346,399	-23%
Mount Sinai Hospital of Queens	$9,309,964	($2,241,748)	$7,068,216	-24%
Nathan Littauer Hospital	$3,149,106	($776,622)	$2,372,484	-25%
Our Lady of Lourdes Memorial Hospital	$6,052,004	($1,535,880)	$4,516,124	-25%
Woodhull Medical and Mental Health Center	$11,393,540	($3,373,134)	$8,020,406	-30%
Phelps Memorial Hospital Association	$3,436,976	($1,179,305)	$2,257,671	-34%
North Shore Univ. - Forest Hills	$5,488,063	($1,996,714)	$3,491,349	-36%
Alice Hyde Memorial Hospital	$2,389,462	($877,776)	$1,511,686	-37%
Coney Island Hospital	$7,075,576	($2,860,560)	$4,215,016	-40%
Mount St. Mary's Hospital of Niagara Falls	$1,631,159	($670,963)	$960,197	-41%
Queens Hospital Center	$11,351,625	($4,736,846)	$6,614,779	-42%
St. Elizabeth Hospital	$4,553,800	($2,252,788)	$2,301,012	-49%
United Health Services, Inc.	$17,514,699	($8,802,961)	$8,711,738	-50%
Lenox Hill Hospital	$25,836,962	($13,477,411)	$12,359,550	-52%
St. Joseph's Hospital Yonkers	$38,290,773	($20,149,090)	$18,141,683	-53%
Elmhurst Hospital Center	$16,265,508	($8,754,306)	$7,511,203	-54%
Massena Memorial Hospital	$4,210,672	($2,675,282)	$1,535,390	-64%
Burke Rehabilitation Center	$399,874	($265,208)	$134,667	-66%
Hospital For Special Surgery	$0	$1,988,215	$1,988,215	
Monroe Community Hospital	$0	$6,116	$6,116	
Montefiore Mount Vernon Hospital	$0	$7,823,610	$7,823,610	
Montefiore New Rochelle Hospital	$0	$7,417,396	$7,417,396	
Westfield Memorial Hospital	$0	$323,914	$323,914	

Source: NYS DOH 2015 Indigent Care Pool distributions data.

Table 3: Transition adjustments by year and three-year totals, 2013-2015				
Hospital Name	**2013 Transition Adjustment**	**2014 Transition Adjustment**	**2015 Transition Adjustment**	**3-year Total Windfall**
Memorial Sloan Kettering Hospital for Cancer and Allied Diseases	$12,842,111	$12,542,875	$10,178,983	$35,563,969
Mt. Sinai St. Luke's	$11,090,729	$10,132,482	$8,490,105	$29,713,316
Brookdale Hospital Medical Center	$10,716,742	$11,662,691	$6,722,626	$29,102,060
Mount Sinai Beth Israel Medical Center	$6,814,411	$10,002,055	$8,367,354	$25,183,820
Jamaica Hospital	$0	$9,425,808	$10,562,419	$19,988,227
State University Hospital Downstate Medical Center	$1,696,510	$7,196,615	$7,604,952	$16,498,077
Montefiore Mount Vernon Hospital	$0	$8,035,059	$7,823,610	$15,858,669
Westchester Medical Center	$4,502,841	$4,462,040	$5,902,051	$14,866,932
Catskill Regional Hospital - Harris	$2,858,747	$3,926,505	$4,583,834	$11,369,085
Montefiore New Rochelle Hospital	($4,660,823)	$7,617,866	$7,417,396	$10,374,440
NY Presbyterian	$5,514,529	$0	$4,146,228	$9,660,757
HealthAlliance Hospital Broadway	$3,243,617	$3,090,519	$2,619,821	$8,953,958
Mercy Medical Center	$2,934,290	$2,783,189	$2,041,174	$7,758,652
Goldwater Memorial Hospital	$1,627,164	$2,861,272	$2,632,783	$7,121,219
SUNY Health Science Center at Syracuse	$2,716,287	$2,150,302	$2,176,239	$7,042,827
HealthAlliance Mary's Avenue Campus	$2,542,626	$2,363,443	$2,084,395	$6,990,464
Montefiore Hospital & Medical Center	$3,307,443	$1,989,580	$836,633	$6,133,657
Hospital For Special Surgery	$2,090,666	$2,041,951	$1,988,215	$6,120,832
Roswell Park Memorial Institute	$2,009,926	$1,979,778	$1,932,307	$5,922,010
NYU Medical Center	$3,912,232	$1,622,005	($256,148)	$5,278,089
Brooklyn Hospital	$164,028	$2,066,946	$2,953,607	$5,184,581
Interfaith Medical Center	($184,521)	$5,127,974	$193,810	$5,137,264
Long Island College Hospital	$4,911,476	$0	$0	$4,911,476
Harlem Hospital Center	$2,203,156	$1,779,256	$782,499	$4,764,910
St. Peter's Hospital	$913,471	$1,067,211	$2,670,113	$4,650,796
Nassau Medical Center	$1,734,043	$1,860,873	$971,921	$4,566,837
Erie County Medical Center	$1,946,986	$1,642,093	$900,839	$4,489,918
Corning Hospital	$1,809,837	$1,651,542	$1,014,528	$4,475,908
University Hospital at Stony Brook	$1,842,790	$1,378,926	$898,976	$4,120,692
Helen Hayes Hospital	$1,414,384	$1,299,991	$1,305,758	$4,020,134
NY Eye and Ear Infirmary	$1,387,197	$1,134,710	$975,875	$3,497,782
St. Barnabas Hospital	$0	$1,983,450	$986,764	$2,970,214
Blythedale Children's Hospital	$775,897	$1,210,460	$889,875	$2,876,232
Ellenville Community Hospital	$874,026	$1,179,524	$810,391	$2,863,942
Bon Secours Hospital	$1,233,745	$466,991	$1,102,557	$2,803,292
Adirondack Medical Center	$782,536	$863,644	$917,137	$2,563,317
St. Francis Hospital of Poughkeepsie	$574,914	$1,674,711	$0	$2,249,625

Table 3: Transition adjustments by year and three-year totals, 2013-2015				
Hospital Name	**2013 Transition Adjustment**	**2014 Transition Adjustment**	**2015 Transition Adjustment**	**3-year Total Windfall**
Wyoming County Community Hospital	$530,273	$822,584	$845,801	$2,198,659
Huntington Hospital	$1,319,969	$744,389	$121,028	$2,185,385
Seton Health System	$331,863	$416,863	$1,423,101	$2,171,827
Ira Davenport Memorial Hospital	$606,697	$691,625	$840,307	$2,138,629
North Shore University Hospital - Glen Cove	$949,757	$499,509	$563,518	$2,012,784
Winthrop University Hospital	$224,236	$1,746,385	$14,401	$1,985,021
Schuyler Hospital	$525,392	$686,973	$764,170	$1,976,535
New Island Hospital	$868,589	$636,201	$388,541	$1,893,330
Oswego Hospital	$469,215	$519,063	$839,794	$1,828,072
North Shore University Hospital	$1,803,590	$0	$0	$1,803,590
Soldiers and Sailors Memorial Hospital of Yates County	$524,226	$574,969	$638,791	$1,737,986
Cobleskill Regional Hospital	$588,455	$563,247	$548,700	$1,700,403
Tri Town Regional Healthcare	$544,059	$532,570	$523,951	$1,600,580
Calvary Hospital	$546,712	$542,829	$487,988	$1,577,529
Geneva General Hospital	$412,321	$520,747	$611,837	$1,544,905
Little Falls Hospital	$534,000	$530,820	$454,682	$1,519,502
Mount Sinai Hospital	$0	$1,368,897	$0	$1,368,897
Cuba Memorial Hospital	$421,661	$463,146	$476,086	$1,360,893
TLC Health Care Network	$353,104	$464,050	$534,170	$1,351,323
Canton-Potsdam Hospital	$960,910	$361,690	$0	$1,322,600
Putnam Community Hospital	$294,603	$409,786	$548,828	$1,253,217
Elizabethtown Community Hospital	$393,604	$419,253	$391,469	$1,204,326
Summit Park Hospital - Rockland County Infirmary	($262,172)	$0	$1,443,036	$1,180,865
O'Connor Hospital	$365,694	$371,682	$340,209	$1,077,585
North Shore University Hospital - Plainview	$565,558	$413,246	$95,455	$1,074,259
Northern Dutchess Hospital	$481,772	$322,587	$265,294	$1,069,654
Via Health of Wayne	$305,662	$650,064	$90,441	$1,046,167
Moses-Ludington Hospital	$402,641	$265,549	$282,892	$951,083
Olean General Hospital	$0	$518,122	$425,677	$943,799
Delaware Valley Hospital	$392,717	$242,234	$281,167	$916,118
River Hospital	$297,256	$320,118	$279,367	$896,741
Catskill Regional Hospital - Herman	$351,991	$290,663	$243,063	$885,717
Franklin General Hospital	$853,200	$0	$0	$853,200
John T. Mather Memorial Hospital	$0	$262,158	$587,352	$849,510
Gouverneur Hospital	$156,997	$383,035	$302,433	$842,466
Oneida Healthcare Center	$293,714	$259,005	$274,042	$826,761

Table 3: Transition adjustments by year and three-year totals, 2013-2015				
Hospital Name	**2013 Transition Adjustment**	**2014 Transition Adjustment**	**2015 Transition Adjustment**	**3-year Total Windfall**
Nicholas H. Noyes Memorial Hospital	$311,255	$295,035	$217,220	$823,509
Margaretville Memorial Hospital	$263,000	$296,602	$246,092	$805,694
North Central Bronx Hospital	$660,731	$47,284	$59,683	$767,698
Womans Christian Association	$275,751	$290,479	$199,655	$765,885
South Nassau Communities Hospital	$435,968	$325,911	$0	$761,878
Westfield Memorial Hospital	$201,897	$226,888	$323,914	$752,698
Cortland Regional Medical Center	$265,056	$276,509	$193,376	$734,941
New York Downtown Hospital	$677,600	$0	$0	$677,600
Glens Falls Hospital	($302,734)	$0	$897,264	$594,529
St. Anthony Community Hospital	$412,255	$57,380	$114,631	$584,266
Bertrand Chaffee Hospital	$202,740	$194,928	$180,421	$578,088
Carthage Area Hospital	$404,060	($131,221)	$268,298	$541,137
Champlain Valley Physicians Hospital Medical Center	$538,445	$0	$0	$538,445
Medina Memorial Hospital	$214,388	$146,341	$138,278	$499,007
Lewis County General Hospital	($192,651)	$168,762	$410,882	$386,994
St. Francis Hospital of Roslyn	$0	($202,515)	$588,138	$385,623
Clifton-Fine Hospital	$129,837	$130,031	$101,619	$361,487
Eastern Long Island Hospital	$148,536	$25,470	$163,417	$337,423
Good Samaritan Hospital of Suffern	$0	$0	$281,098	$281,098
Samaritan Hospital of Troy	($302,798)	($248,391)	$699,745	$148,557
Clifton Springs Hospital and Clinic	$146,777	$0	$0	$146,777
St. James Mercy Hospital	$19,113	$0	$117,760	$136,873
Community Memorial Hospital	$0	($26,637)	$161,979	$135,342
Memorial Hospital of Albany	($309,857)	($67,209)	$507,030	$129,965
Cayuga Medical Center at Ithaca	$117,725	$0	$0	$117,725
St. Charles Hospital	$36,123	$0	$62,250	$98,374
Columbia-Greene Medical Center	$37,681	$0	$0	$37,681
Monroe Community Hospital	$6,431	$6,281	$6,116	$18,829
NY Westchester Square Medical Center	$5,191	$0	$0	$5,191
Albany Medical Center Hospital	$0	$0	$0	$0
Burdett Care Center	$0	$0	$0	$0
Chenango Memorial Hospital	$0	$0	$0	$0
Crouse-Irving Memorial Hospital	$0	$0	$0	$0
Ellis Hospital	$0	$0	$0	$0
Southside Hospital	$0	$0	$0	$0
Beth Israel Hospital - Kings Highway Division	$1,621	$0	($12,590)	($10,970)

Table 3: Transition adjustments by year and three-year totals, 2013-2015				
Hospital Name	**2013 Transition Adjustment**	**2014 Transition Adjustment**	**2015 Transition Adjustment**	**3-year Total Windfall**
Sunnyview Hospital and Rehabilitation Center	$47,572	($75,662)	$3,315	($24,775)
Lakeside Memorial Hospital	($53,017)	$0	$0	($53,017)
Lawrence Hospital	$0	($55,583)	$0	($55,583)
United Memorial	$253,109	($284,797)	($35,514)	($67,203)
Lincoln Medical and Mental Health Center	($77,996)	$0	$0	($77,996)
Southampton Hospital	$176,545	$0	($257,452)	($80,908)
Eastern Niagara Hospital	($295,776)	$0	$206,902	($88,874)
Rome Memorial Hospital	($124,487)	$0	$22,640	($101,847)
Brooks Memorial Hospital	$0	($105,745)	$0	($105,745)
Hepburn Medical Center	($130,688)	$57,888	($38,135)	($110,935)
St. Joseph's Hospital Health Center	$0	$0	($116,830)	($116,830)
Samaritan Medical Center	($154,851)	$0	$0	($154,851)
Park Ridge Hospital	$298,284	$451,110	($905,586)	($156,192)
Auburn Memorial Hospital	($159,586)	($52,964)	$0	($212,549)
St. Joseph's Hospital of Elmira	($123,132)	($73,527)	($29,391)	($226,050)
Nyack Hospital	($229,612)	$0	$0	($229,612)
Aurelia Osborn Fox Memorial Hospital	$2,800	($505,686)	$253,119	($249,767)
Burke Rehabilitation Center	$51,127	($66,018)	($265,208)	($280,099)
Jones Memorial Hospital	($178,981)	($81,533)	($69,238)	($329,752)
St. Catherine of Siena	($334,674)	$0	$0	($334,674)
Kingsbrook Jewish Medical Center	($468,013)	$0	$73,570	($394,442)
Jacobi Medical Center	$0	($409,055)	$0	($409,055)
Kenmore Mercy Hospital	$0	($324,239)	($131,442)	($455,682)
Brookhaven Memorial Hospital Medical Center	($415,226)	($89,999)	$0	($505,224)
Northern Westchester Hospital	($106,446)	($111,490)	($291,700)	($509,636)
Alice Hyde Memorial Hospital	$0	$358,463	($877,776)	($519,313)
Saratoga Hospital	$0	($5,139)	($642,552)	($647,692)
Arnot-Ogden Memorial Hospital	($251,841)	($452,826)	($87,533)	($792,201)
NY Methodist Hospital of Brooklyn	($12,836)	($738,044)	($46,735)	($797,615)
F. F. Thompson Hospital	$0	($879,996)	$0	($879,996)
Episcopal Health Services	$70,009	($1,053,387)	$0	($983,378)
Orange Regional Medical Center	($379,317)	($268,330)	($355,485)	($1,003,133)
Metropolitan Hospital Center	$0	$0	($1,109,042)	($1,109,042)
Mercy Hospital of Buffalo	($555,096)	($434,337)	($279,430)	($1,268,863)
Niagara Falls Memorial Medical Center	($465,477)	($478,133)	($372,849)	($1,316,459)
St Mary's Hospital at Amsterdam	($374,351)	($689,930)	($334,277)	($1,398,558)

Table 3: Transition adjustments by year and three-year totals, 2013-2015				
Hospital Name	**2013 Transition Adjustment**	**2014 Transition Adjustment**	**2015 Transition Adjustment**	**3-year Total Windfall**
White Plains Hospital Medical Center	($400,065)	($228,887)	($788,663)	($1,417,615)
Nathan Littauer Hospital	($313,909)	($407,179)	($776,622)	($1,497,709)
Richmond University Medical Center	($41,298)	($1,618,420)	$0	($1,659,718)
Sisters of Charity Hospital	($21,190)	($1,074,020)	($566,855)	($1,662,064)
Good Samaritan Hospital of West Islip	$40,405	($190,968)	($1,525,527)	($1,676,090)
Phelps Memorial Hospital Association	($118,429)	($457,515)	($1,179,305)	($1,755,249)
Peconic Bay Medical Center	($1,642,516)	$0	($126,875)	($1,769,391)
St. Luke's-Cornwall Hospital	($369,866)	($950,614)	($490,231)	($1,810,711)
Vassar Brothers Hospital	($1,327,812)	($566,959)	$0	($1,894,771)
Long Island Jewish-Hillside Medical Center	($15,711)	($2,050,156)	$0	($2,065,868)
NY Community - Brooklyn	($702,971)	($973,192)	($409,870)	($2,086,032)
Hudson Valley Hospital Center	($1,604,063)	($484,413)	$0	($2,088,476)
Mount St. Mary's Hospital of Niagara Falls	($749,870)	($832,390)	($670,963)	($2,253,223)
Strong Memorial Hospital	$0	$0	($2,337,904)	($2,337,904)
Massena Memorial Hospital	$37,822	$179,205	($2,675,282)	($2,458,255)
Rochester General Hospital	($2,535,816)	$0	$0	($2,535,816)
Kaleida Health	($1,763,709)	($908,724)	$0	($2,672,433)
Mary Imogene Bassett Hospital	($1,611,461)	($635,847)	($721,355)	($2,968,662)
Staten Island University Hospital	($695,975)	($2,075,524)	($2,100,627)	($4,872,126)
Kaleida Health - Women and Children	($2,382,510)	($1,658,208)	($891,660)	($4,932,378)
Mount Sinai Hospital of Queens	($1,934,869)	($829,609)	($2,241,748)	($5,006,227)
St Johns Riverside-Yonkers	($1,149,043)	($1,635,352)	($2,245,567)	($5,029,961)
North Shore University - Forest Hills	($967,538)	($2,247,561)	($1,996,714)	($5,211,813)
Bronx-Lebanon Hospital Center- Fulton Division	($258,328)	($5,124,720)	$0	($5,383,048)
NY Medical Center of Queens	($1,201,717)	($1,889,657)	($2,551,476)	($5,642,850)
Wyckoff Heights Hospital	($3,046,768)	($553,223)	($2,894,400)	($6,494,391)
St. Elizabeth Hospital	($1,482,387)	($2,811,692)	($2,252,788)	($6,546,867)
Lenox Hill Hospital	$3,394,803	$2,422,392	($13,477,411)	($7,660,216)
Bellevue Hospital Center	($3,218,123)	($3,965,989)	($898,897)	($8,083,009)
Our Lady of Lourdes Memorial Hospital	($885,256)	($6,650,351)	($1,535,880)	($9,071,487)
Woodhull Medical and Mental Health Center	($3,939,758)	($3,195,091)	($3,373,134)	($10,507,984)
Maimonides Medical Center	($2,954,091)	($5,186,955)	($2,663,440)	($10,804,486)
Highland Hospital of Rochester	($3,724,311)	($7,086,084)	$0	($10,810,396)
United Health Services	$0	($2,823,178)	($8,802,961)	($11,626,140)
Coney Island Hospital	($4,315,963)	($4,633,247)	($2,860,560)	($11,809,769)

Table 3: Transition adjustments by year and three-year totals, 2013-2015				
Hospital Name	**2013 Transition Adjustment**	**2014 Transition Adjustment**	**2015 Transition Adjustment**	**3-year Total Windfall**
Kings County Hospital Center	($4,777,992)	($3,847,631)	($3,435,222)	($12,060,846)
Flushing Hospital and Medical Center	($6,410,930)	($5,863,160)	$0	($12,274,090)
Queens Hospital Center	($4,488,388)	($4,550,329)	($4,736,846)	($13,775,563)
Lutheran Medical Center	($4,129,165)	($6,469,036)	($5,972,233)	($16,570,434)
Faxton - St. Luke's Health Care	($9,744,967)	($11,314,870)	($292,452)	($21,352,289)
Elmhurst Hospital Center	($6,448,074)	($7,731,798)	($8,754,306)	($22,934,177)
St. Joseph's Hospital Yonkers	($14,475,598)	($19,704,529)	($20,149,090)	($54,329,217)

Source: NYS DOH 2013-2015 Indigent Care Pool distributions data

Table 4: 2012 bad debt as a percentage of total bad debt and charity care

Hospital name	Percentage of 2012 bad debt and charity care reported that was bad debt
Rockefeller University Hospital	100%
North Shore University Hospital Glen Cove	97%
Memorial Sloan Kettering Hospital for Cancer and Allied Diseases	97%
North Shore University Hospital - Plainview	92%
Staten Island University Hospital	90%
Phelps Memorial Hospital Association	89%
Good Samaritan Hospital of West Islip	89%
Southside Hospital	88%
North Shore University Forest Hills	88%
Franklin General Hospital	87%
Mount Sinai Hospital	86%
Long Island Jewish - Hillside Medical Center	86%
St. Luke's-Cornwall Hospital	85%
Montefiore Hospital and Medical Center	85%
St. Catherine of Siena	85%
Hudson Valley Hospital Center	83%
St. Barnabas Hospital	82%
North Shore University Hospital	82%
St. Charles Hospital	80%
St. Anthony Community Hospital	79%
Good Samaritan Hospital of Suffern	78%
Bon Secours Hospital	78%
Huntington Hospital	78%
Mercy Medical Center	78%
NYU Medical Center	77%
Lenox Hill Hospital	77%
Maimonides Medical Center	77%
Orange Regional Medical Center	75%
Vassar Brothers Hospital	74%
City Hospital Center at Elmhurst	72%
St. Francis Hospital of Roslyn	72%
NY Presbyterian	70%
Niagara Falls Memorial Medical Center	69%
South Nassau Communities Hospital	69%
Coney Island Hospital	66%
Woodhull Medical and Mental Health Center	66%
NY Community - Brooklyn	66%
Catskill Regional Hospital - Harris	66%
Northern Dutchess Hospital	65%
Bellevue Hospital Center	65%
NY Methodist Hospital of Brooklyn	64%
Coler Memorial Hospital	64%
Lutheran Medical Center	64%
Ellis Hospital	64%
NY Medical Center of Queens	63%
Via Health of Wayne	63%
Nyack Hospital	63%
Northern Westchester Hospital	63%
Sound Shore Medical Center of Westchester	60%
Metropolitan Hospital Center	59%
St. Joseph's Medical Center - St. Vincent W Division	59%
Mount St. Mary's Hospital of Niagara Falls	59%
Flushing Hospital and Medical Center	59%
NY Eye and Ear Infirmary	59%
Goldwater Memorial Hospital	59%
Richmond University Medical Center	58%
Putnam Community Hospital	58%
Lewis County General Hospital	57%
Kaleida Health	57%
Summit Park Hospital - Rockland County Infirmary	56%
Jamaica Hospital	56%
Harlem Hospital Center	55%
Kaleida Health - Women and Children	55%
Queens Hospital Center	55%
Mount Vernon Hospital	50%
Kings County Hospital Center	50%
Mercy Hospital of Buffalo	48%
Highland Hospital of Rochester	48%
Interfaith Medical Center	48%

Table 4: 2012 bad debt as a percentage of total bad debt and charity care

Hospital name	Percentage of 2012 bad debt and charity care reported that was bad debt
Saratoga Hospital	48%
Kingsbrook Jewish Medical Center	47%
Erie County Medical Center	47%
Episcopal Health Services	47%
Albany Medical Center Hospital	46%
Catskill Regional Hospital - Herman	46%
Memorial Hospital of Albany	46%
Lincoln Medical and Mental Health Center	45%
John T. Mather Memorial Hospital	45%
Winthrop University Hospital	45%
Sisters of Charity Hospital	45%
Samaritan Hospital of Troy	45%
Jacobi Medical Center	44%
North Central Bronx Hospital	44%
Kenmore Mercy Hospital	44%
Crouse-Irving Memorial Hospital	43%
Seton Health System	43%
Mount Sinai Hospital of Queens	43%
St. James Mercy Hospital	43%
Nicholas H. Noyes Memorial Hospital	43%
Burke Rehabilitation Center	42%
St. Francis Hospital of Poughkeepsie	42%
Westfield Memorial Hospital	41%
Brookdale Hospital Medical Center	41%
Blythedale Childrens Hospital	41%
Westchester Medical Center	40%
Arnot-Ogden Memorial Hospital	39%
St. Luke's - Roosevelt Hospital Center	39%
Peninsula Hospital Center	39%
St. Joseph's Hospital Health Center	39%
Park Ridge Hospital	38%
Roswell Park Memorial Institute	36%
St. Joseph's Hospital Yonkers	36%
Hospital for Special Surgery	35%
Memorial Hospital of Wm. F. & Gertrude F. Jones A/K/A Jones Memorial Hospital	35%
Glens Falls Hospital	35%
Strong Memorial Hospital	35%
Chenango Memorial Hospital	34%
United Memorial	34%
Mary Imogene Bassett Hospital	33%
New Island Hospital	32%
Brooks Memorial Hospital	32%
Long Island College Hospital	32%
Southampton Hospital	31%
Long Beach Medical Center	31%
River Hospital	31%
St. Elizabeth Hospital	30%
Carthage Area Hospital	30%
St. John's Riverside - Yonkers	30%
Rochester General Hospital	27%
Soldiers and Sailors Memorial Hospital of Yates County	27%
St. Mary's Hospital at Amsterdam	27%
Brookhaven Memorial Hospital Medical Center	26%
Samaritan Medical Center	25%
Beth Israel Medical Center	25%
Clifton-Fine Hospital	23%
Nassau Medical Center	23%
Wyckoff Heights Hospital	23%
Ira Davenport Memorial Hospital	23%
St. Peter's Hospital	23%
Schuyler Hospital	23%
Kingston Hospital	23%
Ellenville Community Hospital	22%
Nathan Littauer Hospital	22%
Beth Israel Hospital - Kings Highway Division	21%
Community-General Hospital of Greater Syracuse	21%
Geneva General Hospital	20%
Community Memorial Hospital	19%
Rome Memorial Hospital	19%

Table 4: 2012 bad debt as a percentage of total bad debt and charity care

Hospital name	Percentage of 2012 bad debt and charity care reported that was bad debt
Corning Hospital	19%
Margaretville Memorial Hospital	18%
Hepburn Medical Center	18%
F.F. Thompson Hospital	18%
Faxton - St. Luke's Health Care	18%
Canton-Potsdam Hospital	18%
Auburn Memorial Hospital	18%
Aurelia Osborn Fox Memorial Hospital	17%
Cuba Memorial Hospital	16%
Oneida Healthcare Center	16%
Bronx-Lebanon Hospital Center - Fulton Division	15%
Lawrence Hospital	15%
TLC Health Care Network	15%
Champlain Valley Physicians Hospital Medical Center	14%
Eastern Niagara Hospital	14%
White Plains Hospital Medical Center	14%
Sheehan Memorial Emergency Hospital	14%
HealthAlliance Hospital Mary's Avenue Campus	14%
Bassett Hospital Of Schoharie	13%
Moses-Ludington Hospital	13%
St. Joseph's Hospital of Elmira	12%
Tri-Town Regional Healthcare	12%
United Health Services	12%
Woman's Christian Association	12%
Little Falls Hospital	11%
State University Hospital Downstate Medical Center	11%
Edward John Noble Hospital of Gouverneur	10%
Lakeside Memorial Hospital	10%
University Hospital at Stony Brook	10%
New York Downtown Hospital	9%
Cayuga Medical Center at Ithaca	9%
Bertrand Chaffee Hospital	9%
Brooklyn Hospital	9%
Columbia-Greene Medical Center	8%
NY Westchester Square Medical Center	8%
Adirondack Medical Center	8%
Clifton Springs Hospital and Clinic	7%
Delaware Valley Hospital	7%
Olean General Hospital	7%
Elizabethtown Community Hospital	7%
Oswego Hospital	7%
Suny Health Science Center at Syracuse	6%
O'Connor Hospital	6%
Alice Hyde Memorial Hospital	6%
Central Suffolk Hospital	6%
Calvary Hospital	5%
Cortland Memorial Hospital	4%
Wyoming County Community Hospital	2%
Eastern Long Island Hospital	0%
Helen Hayes Hospital	0%
Massena Memorial Hospital	0%
Medina Memorial Hospital	0%
Our Lady of Lourdes Memorial Hospital	0%
Sunnyview Hospital and Rehabilitation Center	0%

Source: NYS DOH 2012 Indigent Care Pools distributions data.

Table 5: 2015 transition adjustments compared to hospital financial assistance provided to patients in 2013			
Hospital	**Transition adjustment**	**Patients approved for financial assistance per bed, 2013**	**Uncollected amounts from uninsured patients eligible for Financial Aid per bed, 2013**
Jamaica Hospital	$10,562,419	120	$102,212
Memorial Sloan Kettering Hospital for Cancer and Allied Diseases	$10,178,983	2	$8,059
Mount Sinai St. Luke's	$8,490,105	11	$50,312
Mount Sinai Beth Israel Medical Center	$8,367,354	4	$16,745
Montefiore Mount Vernon Hospital	$7,823,610	6	$45,977
State University Hospital Downstate Medical Center	$7,604,952	6	$12,134
Montefiore New Rochelle Hospital	$7,417,396	10	$27,770
Brookdale Hospital Medical Center	$6,722,627	28	$30,697
Westchester Medical Center	$5,902,052	21	$31,529
Catskill Regional Hospital - Harris	$4,583,834	10	$32,080
New York Presbyterian	$4,146,228	13	$18,704
Brooklyn Hospital	$2,953,607	5	$15,807
St. Peter's Hospital	$2,670,113	7	$5,085
Goldwater Memorial Hospital	$9,769,948	11	$24,447
HealthAlliance Hospital Broadway Campus/Kingston	$2,619,821	0	$27,494
SUNY Health Science Center at Syracuse	$2,176,239	1	$3,669
Benedictine Hospital	$2,084,395	3	$21,715
Mercy Medical Center	$2,041,174	15	$8,571
Hospital for Special Surgery	$1,988,215	3	$7,109
Roswell Park Memorial Institute	$1,932,307	6	$48
Summit Park Hospital-Rockland County Infirmary	$1,443,036	13	$36,055
St. Mary's Seton Health System	$1,423,101	26	$5,298
Helen Hayes Hospital	$1,305,758	0	$1,330
Bon Secours Hospital	$1,102,557	48	$23,235
Corning Hospital	$1,014,528	12	$4,009
St. Barnabas Hospital	$986,764	87	$64,172
New York Eye and Ear Infirmary	$975,875	312	$88,644
Nassau Medical Center	$971,921	88	$150,990
Adirondack Medical Center	$917,137	3	$203
Erie County Medical Center	$900,839	10	$56,899
University Hospital at Stony Brook	$898,976	8	$11,486
Glens Falls Hospital	$897,264	22	$14,801
Blythedale Children's Hospital	$889,875	0	$-
Wyoming County Community Hospital	$845,801	1	$379
Ira Davenport Memorial Hospital	$840,307	19	$751

Table 5: 2015 transition adjustments compared to hospital financial assistance provided to patients in 2013			
Hospital	**Transition adjustment**	**Patients approved for financial assistance per bed, 2013**	**Uncollected amounts from uninsured patients eligible for Financial Aid per bed, 2013**
Oswego Hospital	$839,794	7	$5,297
Montefiore Hospital and Medical Center	$836,633	27	$18,377
Ellenville Community Hospital	$810,391	10	$110,081
Harlem Hospital Center	$782,499	95	$143,957
Schuyler Hospital	$764,170	6	$8,129
Samaritan Hospital of Troy	$699,745	10	$3,320
Soldiers and Sailors Memorial Hospital of Yates County	$638,791	36	$22,224
Geneva General Hospital	$611,837	21	$15,180
St. Francis Hospital of Roslyn	$588,138	5	$2,976
John T. Mather Memorial Hospital	$587,352	32	$13,138
Glen Cove North Shore University Hospital	$563,518	47	$31,686
Putnam Community Hospital	$548,828	13	$18,899
Cobleskill Regional Hosp	$548,700	2	$4,076
TLC Health Care Network	$534,170	1	$1,117
Tri-Town Regional Healthcare	$523,951	11	$37,793
Albany Memorial Hospital	$507,030	5	$2,517
Calvary Hospital	$487,988	1	$-
Cuba Memorial Hospital	$476,086	11	$7,799
Little Falls Hospital	$454,682	7	$-
Olean General Hospital	$425,677	3	$2,720
Lewis County General Hospital	$410,882	11	$18,865
University of Vermont Elizabethtown Community Hospital	$391,469	3	$864
St. Joseph New Island Hospital	$388,541	22	$5,417
O'Connor Hospital	$340,209	4	$3,045
Westfield Memorial Hospital	$323,914	130	$59,679
Edward John Noble Hospital of Gouverneur	$302,433	2	$1,897
Moses-Ludington Hospital	$282,892	3	$6,252
Delaware Valley Hospital	$281,167	10	$7,846
Good Samaritan Hospital of Suffern	$281,098	20	$17,734
River Hospital	$279,367	6	$9,933
Oneida Healthcare Center	$274,042	6	$7,207
Carthage Area Hospital	$268,298	22	$3,235
Northern Dutchess Hospital	$265,294	25	$16,342
Aurelia Osborn Fox Memorial Hospital	$253,119	1	$4,528
Margaretville Memorial Hospital	$246,092	3	$18,522
Catskill Regional Hospital - Herman	$243,063	0	$3,587

Table 5: 2015 transition adjustments compared to hospital financial assistance provided to patients in 2013			
Hospital	**Transition adjustment**	**Patients approved for financial assistance per bed, 2013**	**Uncollected amounts from uninsured patients eligible for Financial Aid per bed, 2013**
Nicholas H. Noyes Memorial Hospital	$217,220	7	$7,146
Eastern Niagara Hospital	$206,902	8	$985
Woman's Christian Association	$199,655	3	$544
Interfaith Medical Center	$193,810	2	$80,502
Cortland Regional Medical Center	$193,376	3	$2,325
Bertrand Chaffee Hospital	$180,421	6	$2,971
Eastern Long Island Hospital	$163,417	9	$13,977
Community Memorial Hospital	$161,979	7	$6,135
Medina Memorial Hospital	$138,278	2	$979
Huntington Hospital	$121,028	28	$17,363
St. James Mercy Hospital	$117,760	8	$10,617
St. Anthony Community Hospital	$114,631	25	$14,954
Clifton-Fine Hospital	$101,619	0	$1,090
Plainview North Shore	$95,455	26	$11,419
Via Health Of Wayne/Newark	$90,441	8	$57,775
Kingsbrook Jewish Medical Center	$73,570	6	$66,631
St. Charles Hospital	$62,250	15	$6,222
North Central Bronx Hospital	$59,683	97	$88,699
Rome Memorial Hospital	$22,640	2	$3,357
Winthrop University Hospital	$14,401	11	$7,669
Monroe Community Hospital	$6,116	0	$-
Sunnyview Hospital and Rehabilitation Center	$3,315	18	$146
Albany Medical Center Hospital	$-	6	$12,915
Auburn Memorial Hospital	$-	15	$1,622
Brooks Memorial Hospital	$-	18	$38
Chenango Memorial Hospital	$-	48	$21,428
University of Vermont Champlain Valley	$-	4	$5,689
Columbia-Greene Medical Center	$-	3	$2,514
St. Francis Hospital of Poughkeepsie	$-	25	$19,057
Vassar Brothers Hospital	$-	17	$23,943
Kaleida Health	$-	3	$5,904
Samaritan Medical Center	$-	8	$6,635
Highland Hospital of Rochester	$-	22	$8,164
Rochester General Hospital	$-	2	$54,900
Lakeside Memorial Hospital	$-	0	$778
Franklin General Hospital	$-	66	$30,609

Table 5: 2015 transition adjustments compared to hospital financial assistance provided to patients in 2013			
Hospital	**Transition adjustment**	**Patients approved for financial assistance per bed, 2013**	**Uncollected amounts from uninsured patients eligible for Financial Aid per bed, 2013**
South Nassau Communities Hospital	$-	16	$16,789
North Shore University Hospital	$-	22	$29,954
Crouse-Irving Memorial Hospital	$-	3	$3,676
Clifton Springs Hospital and Clinic	$-	6	$2,077
F.F. Thompson Hospital	$-	29	$4,706
Burdett Care Center	$-	0	$399
Nyack Hospital	$-	67	$16,907
Canton-Potsdam Hospital	$-	7	$10,689
Ellis Hospital	$-	70	$31,688
Brookhaven Memorial Hospital Medical Center	$-	9	$14,154
Southside Hospital	$-	66	$41,109
St. Catherine of Siena	$-	9	$5,899
Cayuga Medical Center at Ithaca	$-	2	$4,716
Hudson Valley Hospital Center	$-	9	$27,559
New York Presbytarian/Lawrence Hospital	$-	7	$3,401
Bronx-Lebanon Hospital Center-Fulton Division	$-	28	$63,974
Jacobi Medical Center	$-	93	$114,541
Lincoln Medical and Mental Health Center	$-	134	$114,203
St. John Episcopal Health Services	$-	68	$30,075
Mount Sinai Hospital	$-	2	$33,311
Rockefeller University	$-	0	$-
Flushing Hospital and Medical Center	$-	64	$41,679
Long Island Jewish-Hillside Medical Center	$-	33	$33,245
Richmond University Medical Center	$-	52	$32,881
Mount Sinai Beth Israel Hospital - Kings Highway Division	$(12,590)	1	$6,574
St. Joseph's Hospital of Elmira	$(29,391)	2	$134
United Memorial	$(35,514)	20	$11,536
Claxton Hepburn Medical Center	$(38,135)	6	$3,098
New York Methodist Hospital of Brooklyn	$(46,735)	17	$15,132
Memorial Hospital of Wm. F. and Gertrude F. Jones A/K/A Jones Memorial Hospital	$(69,238)	3	$11,341
Arnot Ogden Memorial Hospital	$(87,534)	3	$4,431
St. Joseph's Hospital Health Center	$(116,830)	11	$15,994
Peconic Bay Medical Center	$(126,875)	1	$7,738
Kenmore Mercy Hospital	$(131,442)	28	$16,234
NYU Medical Center	$(256,148)	68	$11,611

Table 5: 2015 transition adjustments compared to hospital financial assistance provided to patients in 2013			
Hospital	**Transition adjustment**	**Patients approved for financial assistance per bed, 2013**	**Uncollected amounts from uninsured patients eligible for Financial Aid per bed, 2013**
Southampton Hospital	$(257,452)	6	$31,190
Winifred Burke Rehabilitation Center	$(265,208)	2	$13,057
Mercy Hospital of Buffalo	$(279,430)	33	$16,708
Northern Westchester Hospital	$(291,700)	12	$21,577
Faxton - St. Luke's Health Care	$(292,452)	2	$4,279
St. Mary's Healthcare	$(334,277)	6	$5,188
Orange Regional Medical Center	$(355,485)	4	$40,803
Niagara Falls Memorial Medical Center	$(372,849)	51	$24,485
New York Community Brooklyn	$(409,870)	16	$10,074
St. Luke's - Cornwall Hospital	$(490,231)	42	$35,901
Sisters of Charity Hospital	$(566,855)	41	$17,048
Saratoga Hospital	$(642,552)	7	$20,598
Mount St. Mary's Hospital of Niagara Falls	$(670,963)	10	$6,952
Mary Imogene Bassett Hospital	$(721,355)	6	$9,166
Nathan Littauer Hospital	$(776,622)	15	$11,162
White Plains Hospital Medical Center	$(788,663)	4	$1,540
Alice Hyde Memorial Hospital	$(877,776)	5	$860
Kaleida Health - Women and Children	$(891,660)	3	$4,037
Bellevue Hospital Center	$(898,897)	83	$125,782
Unity Hospital of Rochester/Park Ridge Hospital	$(905,586)	9	$12,825
Metropolitan Hospital Center	$(1,109,043)	132	$167,280
Phelps Memorial Hospital Association	$(1,179,305)	9	$38,546
Good Samaritan Hospital of West Islip	$(1,525,527)	22	$10,556
Our Lady of Lourdes Memorial Hospital	$(1,535,880)	267	$22,459
Forest Hills North Shore University	$(1,996,714)	43	$24,173
Staten Island University Hospital	$(2,100,627)	50	$42,321
Mount Sinai Hospital Of Queens	$(2,241,748)	3	$16,498
St. John's Riverside-Yonkers	$(2,245,567)	2	$4,322
St. Elizabeth Hospital	$(2,252,788)	3	$1,035
Strong Memorial Hospital	$(2,337,904)	37	$20,989
New York Medical Center of Queens	$(2,551,476)	40	$37,212
Maimonides Medical Center	$(2,663,440)	54	$20,510
Massena Memorial Hospital	$(2,675,282)	9	$7,187
Coney Island Hospital	$(2,860,560)	128	$167,954
Wyckoff Heights Hospital	$(2,894,401)	7	$27,322
Woodhull Medical and Mental Health Center	$(3,373,134)	165	$183,814

Table 5: 2015 transition adjustments compared to hospital financial assistance provided to patients in 2013			
Hospital	**Transition adjustment**	**Patients approved for financial assistance per bed, 2013**	**Uncollected amounts from uninsured patients eligible for Financial Aid per bed, 2013**
Kings County Hospital Center	$(3,435,223)	151	$180,580
Queens Hospital Center	$(4,736,847)	165	$239,819
Lutheran Medical Center	$(5,972,233)	102	$120,236
Elmhurst Hospital Center	$(8,754,306)	160	$225,173
United Health Services	$(8,802,961)	6	$884
Lenox Hill Hospital	$(13,477,411)	31	$26,702
St. Joseph's Hospital Yonkers	$(20,149,090)	4	$45,408

Source: NYS DOH 2015 Indigent Care Pool distributions data, 2013 certified beds data, 2013 Institutional Cost Report Exhibit 50 data.

Table 6: Amounts that hospital ICP funding exceeded spending on uninsured patients eligible for financial assistance, 2015			
Hospital Name	**2015 ICP payment**	**Uncollected amounts from uninsured patients eligible for Financial Aid, 2013**	**ICP payment exceeding uncollected costs for Financial Assistance-eligible patients**
Bronx - Lebanon Hospital Center-Fulton Division	$65,827,408	$30,771,309	$35,056,100
New York Presbyterian	$50,618,624	$37,790,080	$12,828,544
Montefiore Hospital and Medical Center	$44,383,876	$26,389,407	$17,994,468
Lutheran Medical Center	$44,149,821	$38,836,169	$5,313,652
Jamaica Hospital	$35,451,039	$32,196,751	$3,254,288
Mount Sinai St. Luke's	$33,507,734	$36,778,044	($3,270,310)
North Shore University Hospital	$29,920,121	$21,836,178	$8,083,943
Mount Sinai Beth Israel Medical Center	$26,567,764	$11,001,786	$15,565,978
Mount Sinai Hospital	$25,545,084	$29,180,636	($3,635,553)
St. Barnabas Hospital	$24,826,466	$21,561,855	$3,264,611
Wyckoff Heights Hospital	$24,732,218	$7,540,999	$17,191,220
Long Island Jewish - Hillside Medical Center	$22,010,460	$25,166,263	($3,155,803)
Brookdale Hospital Medical Center	$21,776,170	$11,173,569	$10,602,601
Maimonides Medical Center	$20,989,994	$13,146,801	$7,843,193
Staten Island University Hospital	$20,287,412	$22,472,424	($2,185,013)
St. Joseph's Hospital Yonkers	$18,141,682	$5,721,395	$12,420,288
Strong Memorial Hospital	$15,417,741	$14,272,838	$1,144,903
Kings County Hospital Center	$15,379,732	$73,315,281	($57,935,548)
Bellevue Hospital Center	$14,566,388	$66,287,076	($51,720,688)
Interfaith Medical Center	$12,991,784	$13,443,757	($451,973)
Lenox Hill Hospital	$12,359,550	$12,282,829	$76,721
NYU Medical Center	$12,306,126	$6,571,896	$5,734,230
Rochester General Hospital	$12,252,025	$26,461,801	($14,209,776)
Memorial Sloan Kettering Hospital for Cancer and Allied Diseases	$12,212,800	$3,779,665	$8,433,135
Flushing Hospital and Medical Center	$10,386,347	$11,461,797	($1,075,450)
Brooklyn Hospital	$10,063,481	$5,089,859	$4,973,622
State University Hospital Downstate Medical Center	$9,870,328	$7,025,594	$2,844,734
New York Medical Center of Queens	$9,843,991	$15,182,488	($5,338,498)
Lincoln Medical and Mental Health Center	$9,275,526	$32,890,401	($23,614,874)
Westchester Medical Center	$9,078,422	$16,805,041	($7,726,619)
Good Samaritan Hospital of West Islip	$9,019,555	$4,612,997	$4,406,558
New York Methodist Hospital of Brooklyn	$9,011,349	$7,807,971	$1,203,378
Richmond University Medical Center	$8,715,191	$9,502,514	($787,323)
United Health Services	$8,711,738	$348,480	$8,363,258
Jacobi Medical Center	$8,606,180	$37,340,493	($28,734,314)

Table 6: Amounts that hospital ICP funding exceeded spending on uninsured patients eligible for financial assistance, 2015			
Hospital Name	**2015 ICP payment**	**Uncollected amounts from uninsured patients eligible for Financial Aid, 2013**	**ICP payment exceeding uncollected costs for Financial Assistance-eligible patients**
Albany Medical Center Hospital	$8,160,052	$8,059,128	$100,924
Woodhull Medical and Mental Health Center	$8,020,406	$43,747,801	($35,727,396)
Montefiore Mount Vernon Hospital	$7,823,610	$4,597,717	$3,225,893
Ellis Hospital	$7,793,193	$11,090,824	($3,297,632)
Southside Hospital	$7,731,312	$9,742,755	($2,011,444)
St. John's Riverside - Yonkers	$7,670,121	$1,633,832	$6,036,289
Brookhaven Memorial Hospital Medical Center	$7,604,040	$3,142,217	$4,461,823
Elmhurst Hospital Center	$7,511,203	$78,810,654	($71,299,448)
Montefiore New Rochelle Hospital	$7,417,396	$5,054,085	$2,363,311
Catskill Regional Hospital - Harris	$7,409,452	$53,810	$7,355,642
Unity Hospital of Rochester/Park Ridge Hospital	$7,310,177	$3,539,657	$3,770,520
Metropolitan Hospital Center	$7,239,617	$32,786,827	($25,547,210)
New York Eye and Ear Infirmary	$7,217,280	$2,836,598	$4,380,682
Harlem Hospital Center	$7,175,997	$31,958,411	($24,782,414)
Mount Sinai Hospital of Queens	$7,068,216	$3,167,563	$3,900,653
Queens Hospital Center	$6,614,779	$45,565,678	($38,950,900)
Winthrop University Hospital	$6,506,150	$3,872,681	$2,633,469
St. Joseph's Hospital Health Center	$6,489,083	$6,893,484	($404,401)
Nassau Medical Center	$6,405,454	$56,168,188	($49,762,736)
Vassar Brothers Hospital	$6,178,113	$8,739,041	($2,560,928)
Kaleida Health	$6,163,591	$4,368,931	$1,794,660
Crouse-Irving Memorial Hospital	$6,089,118	$1,841,497	$4,247,620
South Nassau Communities Hospital	$5,954,195	$5,506,682	$447,513
Orange Regional Medical Center	$5,849,634	$13,424,265	($7,574,632)
St. John Episcopal Health Services	$5,711,054	$6,075,140	($364,087)
Highland Hospital of Rochester	$5,623,228	$1,934,932	$3,688,295
Healthalliance Hospital Broadway Campus/Kingston	$5,585,105	$3,766,743	$406,908
Mercy Medical Center	$5,550,586	$2,562,825	$2,987,761
University Hospital at Stony Brook	$5,540,610	$6,454,853	($914,243)
St. Peter's Hospital	$5,442,207	$2,415,349	$3,026,859
Good Samaritan Hospital of Suffern	$5,173,727	$5,976,271	($802,545)
Sisters of Charity Hospital	$4,829,129	$6,785,179	($1,956,051)
Goldwater Memorial Hospital	$4,787,786	$68,548,571	($63,760,785)
Our Lady of Lourdes Memorial Hospital	$4,516,125	$3,323,931	$1,192,193
St. Luke's-Cornwall Hospital	$4,351,443	$6,749,312	($2,397,870)

Table 6: Amounts that hospital ICP funding exceeded spending on uninsured patients eligible for financial assistance, 2015			
Hospital Name	**2015 ICP payment**	**Uncollected amounts from uninsured patients eligible for Financial Aid, 2013**	**ICP payment exceeding uncollected costs for Financial Assistance-eligible patients**
Mary Imogene Bassett Hospital	$4,294,294	$1,466,570	$2,827,724
Coney Island Hospital	$4,215,016	$29,391,891	($25,176,874)
North Central Bronx Hospital	$4,200,883	$12,683,985	($8,483,102)
SUNY Health Science Center at Syracuse	$4,022,466	$2,352,114	$1,670,352
Glens Falls Hospital	$3,922,729	$5,372,860	($1,450,132)
Kaleida Health - Women and Children	$3,907,423	$807,330	$3,100,093
Franklin General Hospital	$3,877,194	$5,999,293	($2,122,099)
Glen Cove North Shore University Hospital	$3,781,905	$4,816,215	($1,034,309)
Mercy Hospital of Buffalo	$3,755,655	$6,081,643	($2,325,988)
Erie County Medical Center	$3,632,045	$15,704,250	($12,072,205)
Forest Hills North Shore University	$3,491,349	$5,487,338	($1,995,989)
Huntington Hospital	$3,270,362	$4,809,485	($1,539,123)
Faxton - St. Luke's Health Care	$3,203,453	$945,676	$2,257,776
Nyack Hospital	$3,026,277	$4,683,165	($1,656,889)
Bon Secours Hospital	$2,976,078	$3,485,222	($509,144)
HealthAlliance Hospital Mary's Avenue Campus	$2,930,981	$1,411,454	$1,519,527
White Plains Hospital Medical Center	$2,894,782	$449,820	$2,444,962
Columbia-Greene Medical Center	$2,722,964	$261,419	$2,461,545
Saratoga Hospital	$2,653,761	$3,522,195	($868,434)
Peconic Bay Medical Center	$2,571,883	$905,307	$1,666,576
St. Joseph New Island Hospital	$2,528,055	$1,099,603	$1,428,451
St. Charles Hospital	$2,524,520	$964,459	$1,560,061
Kingsbrook Jewish Medical Center	$2,524,468	$11,993,502	($9,469,034)
Summit Park Hospital-Rockland County Infirmary	$2,505,773	$2,055,160	$450,613
Oswego Hospital	$2,418,450	$699,200	$1,719,251
Nathan Littauer Hospital	$2,372,484	$814,849	$1,557,636
St. Mary's Seton Health System	$2,325,256	$847,744	$1,477,512
St. Elizabeth Hospital	$2,301,012	$183,168	$2,117,844
Samaritan Medical Center	$2,281,848	$1,094,813	$1,187,035
Phelps Memorial Hospital Association	$2,257,671	$6,552,739	($4,295,068)
Southampton Hospital	$2,255,365	$2,931,867	($676,503)
Arnot Ogden Memorial Hospital	$2,227,390	$890,690	$1,336,699
Niagara Falls Memorial Medical Center	$2,211,587	$3,256,561	($1,044,974)
St. Mary's Healthcare	$2,205,861	$518,756	$1,687,105
Via Health Of Wayne/Newark	$2,173,166	$6,008,625	($3,835,459)

Table 6: Amounts that hospital ICP funding exceeded spending on uninsured patients eligible for financial assistance, 2015			
Hospital Name	**2015 ICP payment**	**Uncollected amounts from uninsured patients eligible for Financial Aid, 2013**	**ICP payment exceeding uncollected costs for Financial Assistance-eligible patients**
John T. Mather Memorial Hospital	$2,171,020	$2,561,888	($390,868)
Putnam Community Hospital	$2,143,855	$2,721,492	($577,638)
University of Vermont Champlain Valley	$2,125,943	$1,826,209	$299,734
Samaritan Hospital of Troy	$2,043,049	$494,703	$1,548,346
St. Catherine of Siena	$2,029,721	$1,569,163	$460,557
Hospital for Special Surgery	$1,988,215	$1,435,935	$552,280
New York Presbytarian/Lawrence Hospital	$1,981,111	$955,800	$1,025,312
Cayuga Medical Center At Ithaca	$1,950,949	$669,668	$1,281,280
Roswell Park Memorial Institute	$1,936,189	$6,381	$1,929,808
Northern Westchester Hospital	$1,934,194	$3,754,434	($1,820,239)
St. Francis Hospital of Roslyn	$1,847,598	$1,083,300	$764,298
Hudson Valley Hospital Center	$1,832,218	$3,444,857	($1,612,639)
Chenango Memorial Hospital Inc	$1,811,427	$1,242,811	$568,617
Corning Hospital	$1,721,149	$328,722	$1,392,427
Olean General Hospital	$1,595,491	$407,962	$1,187,529
Canton-Potsdam Hospital	$1,589,137	$1,004,744	$584,393
Massena Memorial Hospital	$1,535,390	$359,333	$1,176,057
Alice Hyde Memorial Hospital	$1,511,686	$65,359	$1,446,327
Plainview North Shore	$1,497,427	$2,078,169	($580,742)
Geneva General Hospital	$1,490,700	$1,776,063	($285,364)
Mount Sinai Beth Israel Hospital - Kings Highway Division	$1,487,841	$1,373,928	$113,913
Adirondack Medical Center	$1,484,359	$16,822	$1,544,024
Womans Christian Association	$1,466,765	$85,406	$1,381,359
New York Community Brooklyn	$1,346,399	$1,349,955	($3,556)
Helen Hayes Hospital	$1,320,973	$23,931	$1,297,042
St. Joseph's Hospital of Elmira	$1,308,067	$9,365	$1,298,702
St. James Mercy Hospital	$1,306,636	$1,008,633	$298,002
Auburn Memorial Hospital	$1,302,446	$137,879	$1,164,567
Albany Memorial Hospital	$1,287,640	$415,315	$872,325
Aurelia Osborn Fox Memorial Hospital	$1,280,758	$362,224	$918,534
United Memorial	$1,265,904	$1,511,196	($245,292)
Cortland Regional Medical Center	$1,234,696	$248,821	$985,875
Ellenville Community Hospital	$1,225,902	$1,651,220	($425,319)
Memorial Hospital of Wm. F. & Gertrude F. Jones A/K/A Jones Memorial Hospital	$1,221,896	$793,904	$427,991

Table 6: Amounts that hospital ICP funding exceeded spending on uninsured patients eligible for financial assistance, 2015			
Hospital Name	**2015 ICP payment**	**Uncollected amounts from uninsured patients eligible for Financial Aid, 2013**	**ICP payment exceeding uncollected costs for Financial Assistance-eligible patients**
Blythedale Childrens Hospital	$1,220,704	$0	$1,220,704
F.F. Thompson Hospital	$1,187,218	$531,817	$655,401
Northern Dutchess Hospital	$1,139,619	$947,816	$191,802
Claxton Hepburn Medical Center	$1,139,174	$269,493	$869,681
TLC Health Care Network	$1,124,481	$120,614	$1,003,867
Kenmore Mercy Hospital	$1,123,736	$2,662,347	($1,538,611)
Wyoming County Community Hospital	$1,112,456	$34,107	$1,078,349
Ira Davenport Memorial Hospital	$1,072,761	$26,268	$1,046,493
Oneida Healthcare Center	$1,041,699	$727,892	$313,807
Mount St. Mary's Hospital of Niagara Falls	$960,197	$1,077,531	($117,334)
Rome Memorial Hospital	$950,751	$305,529	$645,221
Schuyler Hospital	$946,463	$203,222	$743,240
Eastern Niagara Hospital	$919,125	$158,651	$760,474
Eastern Long Island Hospital	$880,967	$936,464	($55,497)
Soldiers And Sailors Memorial Hospital of Yates County	$820,629	$555,599	$265,030
Cobleskill Regional Hospital	$797,828	$163,058	$634,770
Little Falls Hospital	$787,383	$0	$787,384
Nicholas H. Noyes Memorial Hospital	$763,393	$514,518	$248,875
Lewis County General Hospital	$747,383	$1,018,717	($271,334)
St Anthony Community Hospital	$672,806	$1,091,624	($418,818)
Community Memorial Hospital	$669,661	$220,863	$448,798
Brooks Memorial Hospital	$666,619	$2,486	$664,133
Tri-Town Regional Healthcare	$650,272	$151,170	$499,102
Cuba Memorial Hospital	$617,315	$155,985	$461,330
Carthage Area Hospital	$593,541	$109,987	$483,554
Calvary Hospital	$555,413	$0	$555,413
Delaware Valley Hospital	$517,642	$196,161	$321,481
River Hospital	$501,222	$238,382	$262,840
Clifton Springs Hospital and Clinic	$498,172	$182,770	$315,402
Edward John Noble Hospital of Gouverneur	$485,097	$70,181	$414,916
Catskill Regional Hospital - Herman	$459,985	$3,657,095	($3,197,110)
Burdett Care Center	$458,049	$5,980	$452,069
O'Connor Hospital	$446,790	$48,723	$398,067
Medina Memorial Hospital	$431,396	$52,873	$378,523
University of Vermont Elizabethtown Community Hospital	$408,220	$21,599	$386,621

Table 6: Amounts that hospital ICP funding exceeded spending on uninsured patients eligible for financial assistance, 2015			
Hospital Name	**2015 ICP payment**	**Uncollected amounts from uninsured patients eligible for Financial Aid, 2013**	**ICP payment exceeding uncollected costs for Financial Assistance-eligible patients**
Moses-Ludington Hospital	$393,768	$93,773	$299,995
Margaretville Memorial Hospital	$363,202	$277,826	$85,376
Bertrand Chaffee Hospital	$346,256	$68,325	$277,931
Westfield Memorial Hospital	$323,914	$238,717	$85,197
Clifton-Fine Hospital	$208,902	$21,806	$187,096
Winifred Burke Rehabilitation Center	$134,667	$391,703	($257,036)
Sunnyview Hospital and Rehabilitation Center	$96,555	$2,482	$94,073
Monroe Community Hospital	$6,116	$0	$6,116

Source: NYS DOH 2015 Indigent Care Pool distributions data, 2013 Institutional Cost Report Exhibit 50 data.

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A United Voice for Doctors, Our Patients, & the Communities We Serve

National Office
50 Broadway
11th Floor Suite 1101
New York, NY 10004
P: 212.532.7690
F: 212.481.4137
info@doctorscouncil.org
www.doctorscouncil.org

Testimony of Doctors Council SEIU
Kevin Collins, Executive Director
Before the New York City Council Committee on Hospitals
February 28, 2018

Doctors Council SEIU represents thousands of doctors in the Metropolitan area, including in every NYC Health + Hospitals facility, the New York City Department of Health and Mental Hygiene, correctional facilities including Rikers Island, and other New York City agencies.

Our member doctors are committed to ensuring that H+H remain a quality safety-net system for all New Yorkers. The front-line doctors in the public hospital system have been at the forefront of providing care to all those who walk through our doors regardless of their country of origin or insurance status.

We welcome the new President and CEO of H+H, Dr. Mitchell Katz, and look forward to working together with him. Dr. Katz met with us and nearly 100 of our members just last week. He stayed for nearly 2 1/2 hours giving a presentation and answering questions. Most importantly, Dr. Katz listened and welcomed comments and suggestions on the issues doctors and patients face at H+H and how we can make improvements. It is fair to say that doctors feel a renewed sense of energy and hope.

Doctors Council supports empowering front line clinical staff to problem solve and grow our system. We support spending less money on consultants and administration and more on clinical care. Our doctors are happy to work together on solving the H+H issues so that instead of shrinking we can grow.

The system may be faced with many challenges, but that creates opportunities for us to all work together to improve the system for our patients and communities through an engaged and motivated workforce.

And while we recognize that the H+H budget crisis needs special attention and that we are faced with a changing healthcare landscape, we strongly believe the answer is not to close, consolidate or privatize facilities or layoff workers. If we want the public system to be a glowing example that serves all New Yorkers with quality care, new funding models are needed that respect the services and the care provided to underserved communities.

We also need to ensure that communities and local stakeholders are engaged in the future of H+H. In March 2017, the New York City Blue Ribbon Commission on Healthcare stated, "Clinical restructuring should reflect thorough community assessment, taking into account geographic access and other patient needs, and include a process for community input and engagement." Community groups and the constituencies who rely heavily on these public healthcare services must be consulted in this process.

Recognizing that innovation and best practices are critical for patient care and the fiscal health of the system, the leadership of Doctors Council SEIU and H+H jointly launched an innovative partnership known as the Collaboration Councils. The purpose of these councils, both at the facility level and system-wide, is to provide front-line doctors greater engagement with administration and a venue for direct dialogue to develop results-driven projects that will improve the quality of care and patient experience within H+H. Collaboration Councils have already proven effective in helping enhance labor-management communication.

The Collaboration Councils synergize with the goals in the Mayor's Transformation Plan. We believe they could serve a forum to look at new models such as integrating government and community-based social services with health care services in particular hospitals.

We need to think about creative ways to engage with New Yorkers and to bring new patients into the system. We encourage the City to explore synergy between H+H doctors and the School Health program and to potentially pilot a program that allows H+H doctors to visit schools. As you may know, there are very few physicians in the School Health program today. This pilot could center around one public hospital in a high-needs community with several schools in the vicinity.

Over the last two years, we have been extra focused on efforts to ensure equitable funding at the Federal and State level. For some time now, we have

called for adequately funding our safety net hospitals by making them eligible for higher Medicaid reimbursement rates and ensuring that resources go where they are needed the most - and that the money should follow the patient. Yet, money has continued to flow to large private hospitals despite their poor record of caring for the uninsured.

We ask our Council Members and City Hall to recognize this disparity and call on the Governor to create a more equitable state funding formula in the State Budget by ensuring that resources go where they are needed the most.

Thank you for the opportunity to submit this testimony.

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I represent: Primary Care Development Corporation

Address: 45 Broadway NYC 10006

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Name: KEVIN GILLIND

Address: 50 Broadway, 11 Floor, NY NY 10004

I represent: Doctors Council SEIU

Address: 50 Broadway, 11 Floor NY NY 10004

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Name: Chad Shearer

Address: 1411 Broadway, 12th Fl

I represent: United Hospital Fund

Address: 1411 Broadway 12th Fl

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Name: Judith Certchin

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I represent: NYSNA New York State Nurses Association

Address: 131 West 33rd St. NYC.

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I represent: CPHS / Save our Safety-net Campaign

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I represent: CPHS and nurser

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I represent: NYC Health + Hospitals

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Name: CV Ananthram

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I represent: NYC Health Hospitals

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Name: Dr Mitchell Katz

Address: _____

I represent: NYC Health + Hospitals

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Address: _____

I represent: District Council 37

Address: 125 Barclay Street

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Name: Leon Bell

Address: 131 W 33rd St. NY NY

I represent: New York State Nurses Association

Address: same as above

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