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INCENTIVIZING PATIENT FINANCIAL ASSISTANCE:

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How to Fix New York's Hospital Indigent Care Program

by Elisabeth R. Benjamin, Arianne Slagle, and Carrie Tracy

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Executive Summary

Hospitals are a vital source of health care for uninsured New Yorkers. Indeed, for the roughly 2.8 million New Yorkers who do not have health insurance—and for the many who are underinsured—hospitals and community health centers are often the only source of health care available. While the full implementation of the Affordable Care Act (ACA, or federal health reform) will significantly reduce the numbers of uninsured, as many as 1.8 million New Yorkers may remain uncovered.[1] Accordingly, hospitals will continue to be an important safety net for uninsured New Yorkers.

In order to offset the costs of providing care to uninsured and underinsured patients, New York operates an uncompensated care system, known as the hospital Indigent Care Pool (ICP) program. Today, the hospital ICP program allocates nearly $1.2 billion in State and federal funds through a complex funding methodology. A majority of the State funding is derived from surcharges on hospital patient bills. A smaller, and less fiscally complicated, program also exists for community health centers.

Over the past decade, good government groups, patient advocates, the media, and some government officials have scrutinized both the alleged failure of hospitals to consistently notify and provide financial assistance to patients and the lack of accountability and transparency in the allocation of public funds to hospitals. The State responded to this public scrutiny in two ways. First, in 2006, New York enacted the Hospital Financial Assistance Law (HFAL), which requires hospitals to adopt written financial assistance policies, make information about them available to the public, and offer financial assistance to eligible patients in exchange for drawing down ICP funds. The State Department of Health (DOH) further clarified the HFAL in "guidance" memoranda sent to hospitals. Second, in 2007, the State convened an Indigent Care Technical Advisory Committee (TAC) to address the transparency and accountability issues in ICP funding allocations. Acting upon the TAC recommendations, the State adopted a new "units of service" distribution methodology to allocate a portion of ICP funding. This report evaluates both of these responses.

Today, the effective functioning of the ICP has renewed urgency because the ACA also brings two important changes to New York's ICP program. First, the ACA substantially reduces federal funding available to New York for indigent care. Second, the ACA and new federal audit rules change the types of costs that can be supported by this funding. For example, while the State now allocates ICP funding based on a hospital's spending on both financial assistance (where the patient's bill is reduced) and bad debt (where the hospital cannot collect debts from a patient though it continues to try), the ACA prohibits the State from including bad debt in these calculations.

In 2011, the discussion about how to best administer the hospital ICP program repeatedly resurfaced in the State's Medicaid Redesign Team (MRT). Understanding the importance of these changes, the MRT Payment Reform Subcommittee called for a workgroup to, for the first time, "consider appropriate links" between the hospital ICP distribution methodologies and the HFAL.[2]

New York must now consider how to best protect the State from impending federal cuts; how to distribute the remaining funds more appropriately; and how to ensure that eligible needy New Yorkers receive hospital financial assistance. To better inform this policy discussion, this report evaluates the current effectiveness of New York's hospital ICP system.

Findings

This report assesses the financial assistance programs of the 201 hospitals which participate in the hospital ICP program. Financial assistance materials of the majority of New York hospitals violate the HFAL, fail to comply with the DOH's HFAL guidance, or otherwise impose additional barriers to financial assistance.

- Of the 201 hospitals surveyed by the Community Service Society (CSS), 20 (10%) did not release information about their financial assistance policies upon request and do not publicly post HFAL applications on their websites.[3] In 2010, these hospitals received $87,397,389 in ICP payments. CSS obtained application materials from 181 hospitals.
- Of the 181 hospital financial aid applications obtained and reviewed by CSS, 120 (66%) violate the law, fail to comply with DOH guidance, or impose additional barriers to accessing hospital financial assistance. In 2010, these hospitals collectively received $463,675,462 in ICP payments.
    - 102 (56%) do not comply with four basic requirements under the HFAL. In 2010, these hospitals received $400,025,366 in ICP payments.
    - 63 (35%) include requirements that do not comply with the DOH guidance on the HFAL. In 2010, these hospitals received $204,845,679 in ICP payments.
    - 45 (25%) impose additional financial information verification requirements for financial assistance beyond those laid out in the law and guidance. In 2010, these hospitals received $169,259,198 in ICP payments.

This report further reviews data reported to the State by New York hospitals claiming ICP funds and finds significant inconsistencies, errors, and other areas of concern in these data submissions.

- Hospitals that provide the most financial assistance often receive the least amount of funding from the ICP program on a per application basis. For example, St. Barnabus Hospital received an average of $561 in ICP funds for each of the 51,210 financial assistance applications it approved, while Brookdale Hospital received an average of $93,929 in ICP funds for each of the 278 applications it approved.
- Hospitals using unlawful HFAL applications approved far fewer financial assistance applications than their HFAL-compliant counterparts (e.g., in 2008, hospitals with *unlawful* policies approved an average of 10 applications per hospital bed;[4] hospitals with *lawful* policies approved an average of 24 applications per bed). In 2010, the hospitals using unlawful HFAL applications received $400,025,366 in ICP payments.
- The current ICP distribution methodology supports bad debts and liens. For example, 70 percent of hospitals reported that more than 50 percent of their uncompensated care costs were bad debt, with a number of hospitals reporting as much as 90 percent of their costs were related to bad debt. This will soon be impermissible under federal law. In 2010, hospitals reporting more than 50 percent bad debt received $673,510,656 in ICP payments.
    - Many hospitals send patients who cannot pay into collections and are aggressively pursuing liens on patients' homes. In 2010, the State provided $246,174,421 in ICP payments to hospitals which had collectively placed over 4,000 liens on patients' homes.
- Many hospitals which claim the highest amounts of "targeted need" (described later in this report) for uncompensated care report providing lower-than-average financial assistance to their patients. In 2008, 39 hospitals reported higher than the statewide average level of targeted need but, on average, approved far fewer financial assistance applications, relative to hospital size, than their counterparts. In 2010, these 39 hospitals received $266,008,905 in ICP payments.
- In many cases, hospital ICP program reporting is facially flawed and/or internally inconsistent. In 2010, hospitals reporting flawed and/or inconsistent data received $80,068,364 in ICP payments.

Recommendations

Based on these findings, and the need for New York to maximize federal funding for health care, this report makes the following recommendations.

The State Should Improve Patient Access to Financial Assistance

- Adopt a uniform statewide hospital financial assistance application to be used by all hospitals receiving ICP funds.
- Publically post hospital financial assistance policies on the detailed hospital profile section of the DOH's website.
- Perform regular hospital compliance audits and enforcement of the HFAL.
- Conform the HFAL with federal health reform in 2014 by raising the income eligibility floor to 400 percent of the federal poverty level and barring the use of asset tests.
- Allow pre-qualification for financial assistance.

The State Should Incentivize Hospital Compliance with the HFAL and the ACA

- Only make ICP payments to hospitals to compensate for the costs of financial assistance to uninsured (or, if permissible, financial assistance to the underinsured) patients who have been certified eligible for financial assistance in compliance with the HFAL and the ACA.
- Issue remaining ICP funds (if any) to hospitals with higher volumes of Medicaid patients in compliance with the ACA.
- Prohibit ICP payments based on patient bad debt, in compliance with the ACA.

The State Should Improve Transparency of Hospital ICP Payments

- Adopt a consistent and transparent methodology for allocating ICP payments, which prioritizes payments to hospitals that report costs directly attributable to patients certified for financial assistance under the HFAL. In other words, the State should fully adopt the "units of service" methodology and only distribute ICP pool funding for those services provided to patients certified eligible for financial aid.
- New federal DSH (disproportionate share hospital) funding rules will require a more stringent methodology for discerning among types of costs. Uncompensated care costs should only reflect financial assistance provided to uninsured and self-pay patients.

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 and hospital association representatives, policy analysts, Department of Health staff, consumer and patient advocates, and other key stakeholders.

Hospital Financial Assistance Policies. In June 2010, CSS sent a letter to the Chief Financial Officer (CFO) of every hospital in New York State. The letter sought copies of each hospital's financial assistance application form and policy summary or other pertinent material. CSS reviewed every hospital's website and downloaded any relevant financial assistance material. In October 2010, CSS sent additional correspondence to each hospital's CFO to either verify the accuracy of the financial assistance material received or to reiterate the request for information to those hospitals that did not respond or did not have materials posted online. Of the 201 hospitals surveyed, 163 responded. In August 2011, CSS sent a list of the hospitals that did not provide materials or that asked us not to post their materials to the leaders of the two major New York hospital trade associations. One group, the Healthcare Association of New York State, responded and further facilitated our efforts to acquire hospital financial assistance policies. In all, CSS received and reviewed 181 hospital financial assistance policy summaries and/or applications to determine whether they: (1) complied with four components of the HFAL; (2) complied with the Department of Health's HFAL Guidance; and (3) imposed additional barriers to financial assistance.

Hospital ICP Data. In June 2010, CSS submitted a Freedom of Information Law (FOIL) request to the Department of Health and received electronic copies of all hospitals' Institutional Cost Reports (ICR) from 2005-2008 and indigent care pool distributions for all New York State hospitals from 2005-2010. In March 2011, CSS submitted an additional FOIL request for: (1) ICR Exhibit 50 data for all hospitals for the years 2007-2009; (2) spreadsheets detailing calculation of pool distributions for all hospitals for the years 2009 and 2010; and (3) the New York State 2007 DSH Report and related materials. CSS also reviewed the pool distribution calculations for the years 2005-2008 and the 2010 ICR Instruction Manual. CSS conducted an analysis of the Exhibit 50 data and the hospital ICP pool distribution data received.

Introduction

Hospitals are an important source of health care for the 2.8 million New Yorkers who do not have health coverage.[5] The Affordable Care Act (ACA), the new federal health reform law, will offer insurance coverage to millions of these uninsured New Yorkers come 2014. But as many as 1.8 million New Yorkers may remain uncovered.[6] Concurrently, beginning in 2014, the ACA significantly phases down the amount of federal funds available to New York's hospitals to offset the costs they incur providing care to the uninsured.

Currently, New York State allocates nearly $1.2 billion in Medicaid funds annually through the State's Indigent Care Pool (ICP) to compensate hospitals for the cost of providing care to people who either cannot or will not pay their medical bills. The ICP program, created in 1983, is financed with State funds derived from various sources of revenue, including New York's Health Care Reform Act (HCRA) taxes and hospital patient bill surcharges. Federal matching dollars come from Medicaid Disproportionate Share Hospital (DSH) funds.[7] See Appendix A (A Brief History of New York's Charity Care Policies).

As described in Section II below, the allocation of hospital ICP funds is extremely complex. The hospital ICP program is run through 10 separate pools, with many hospitals receiving funds from multiple pools. The State's annual allocation of ICP funding is based on costs reported in the hospitals' annual Institutional Cost Reports (ICRs). These ICRs are compiled based on accounting procedures and policies which vary from hospital to hospital.[8] Because the ICP allocation methodology is time-lagged, payments are issued based on two-year-old hospital ICRs.

The ICP compensates hospitals based on two types of costs: (1) bad debts—unpaid medical bills from insured and uninsured patients which are considered to be uncollectable, although collection efforts may be ongoing; and (2) financial assistance (or "charity care")—free or reduced-cost care given by reducing bills issued to low-income, uninsured patients. The difference is important for patients because patients who are assigned to the bad debt category can be subjected to collection activities—despite the fact they might have been eligible for financial assistance. Hospital payments from the ICP program are not directly tied an individual patient's receipt of financial assistance or assignment to a bad debt account.

Manny's Law

In 2004, Long Island resident Manny Lanza, age 24, was admitted to St. Luke's Hospital in New York City. He had been diagnosed with a severe brain condition and needed immediate treatment.

The hospital told Manny that he needed insurance before he could receive the help he needed.

Manny worked at a fast-food restaurant and did not qualify for health insurance. He applied for Medicaid and scheduled his surgery. But, after his application was denied, the hospital cancelled his surgery.

In January 2006, Manny died of his untreated brain condition.

Even though New York's hospitals were receiving nearly $1 billion in Indigent Care Pool funds, Manny was never offered any financial assistance.

Manny's case attracted widespread media attention and New York's 2006 Hospital Financial Assistance Law is sometimes referred to as "Manny's Law."

Throughout the first two decades of operation of the ICP, hospitals faced few requirements to be eligible to receive funds. This generated scrutiny from the press, patient advocates, and good government groups, leading to passage of the Hospital Financial Assistance Law of 2006 (HFAL).[9] As described in detail in Section I of this report, the HFAL requires all hospitals, as a condition for receipt of ICP funding, to: (1) offer sliding-scale discounts for patients below 300 percent of the Federal Poverty Level (roughly $57,000 annually for a family of three);[10] (2) publicize information about their financial aid policies so that patients are aware of what is available to them;[11] and (3) ensure additional protections for any patients sent to collections.[12] The DOH can impose a $10,000 fine per occurrence on hospitals that fail to comply with the HFAL.[13] To date, no fines have been imposed.

Recently, two policy changes at the federal level underscored the need for New York to rethink its hospital ICP allocation methodology: (1) new DSH audit requirements; and (2) additional new DSH rules and impending cuts under the ACA in 2014.

New Federal DSH Audit Rules

Historically, the federal DSH program was developed to support hospitals serving a disproportionate share of Medicaid and uninsured patients. Over time, states extended these funds to other hospitals as well.[14] Under the DSH rules, the State can consider both bad debt and financial assistance in deciding how to distribute ICP funding, but it cannot pay a hospital more than the hospital spent on financial assistance alone. In 2003, Congress imposed new audit rules requiring more stringent reporting from states, with the first results due at the end of 2010. These new audit rules require states to provide detailed information to the federal government about each hospital's specific costs and revenues related to uninsured and Medicaid patients. Currently, hospital reports aggregate costs of care provided to uninsured patients and patients with insurance who are not covered for a particular benefit (classified as "self-pay"). Under the new audit rules, hospitals must separate uninsured and self-pay figures when reporting costs. Bad debts must also be reported separately from financial assistance for uninsured patients. Failure to comply with the audit requirements, or failure to report costs correctly, could threaten New York's DSH payment allocation.

New ACA DSH Allocation Rules and Cuts

Beginning in 2014, the ACA annually reduces nationwide DSH funding, for a total cut of 50 percent (or $5.6 billion) by 2019.[15] In addition to this significant cut, the ACA directs HHS to develop a new DSH allocation methodology which gives preference to states that: (1) have high rates of uninsurance; and (2) target DSH funds to hospitals with high Medicaid inpatient rates and high levels of uncompensated care (excluding bad debt).[16] New York receives 14 percent of DSH payments, but has only 6 percent of the nation's uninsured.[17] As a result, the total federal DSH funding cuts will disproportionately affect New York. In order to mitigate these DSH cuts, the State must acquire ACA-compliant data on the amount of uncompensated care provided by hospitals, excluding bad debt, and will need to allocate its ICP funds to hospitals providing care to the uninsured or high numbers of Medicaid patients.

This report examines the implications of these new federal measures in light of the current functioning of New York's HFAL and the hospital ICP program based upon a review of hospital financial assistance applications and data acquired from the Department of Health (DOH). Section I surveys hospital practices related to implementation of patient financial assistance programs. Section II analyzes ICP program data submitted by New York hospitals to the DOH. The end of the report summarizes these findings and proposes recommendations on how to ensure that all patients who are eligible for financial assistance receive it; how to ensure that New York complies with the HFAL and the ACA; and how to improve transparency in the ICP program.

Why Are Hospital Financial Assistance Programs Important to Patients?

While not all patients sent to collections fare poorly, a combination of medical illness and debt can prove to be financially and emotionally overwhelming for many families.

- Medical debts and illness account for 62% of all personal bankruptcies in the United States.[1]
- Unmanageable medical bills are the cause of 23% of all home foreclosures in the United States.[2]
- Placement of a lien on a patient's home can impede home sales, complicate mortgage refinancing, and damage personal credit.[3]
- Fear of compounding medical bills can deter patients from seeking necessary medical care until it is too late.[4] Delayed medical care can result in higher medical costs, higher medical bills for the patient, and worse health outcomes.

[1] D. Himmelstein, D. Thorne, E. Warren and S. Woolhandler, "Medical Bankruptcy in the United States, 2007: Results of a National Study," American Journal of Medicine, Vol. 122, No. 8, August 2009.

[2] C. Robertson, R. Egelhof and M. Hike, "Get Sick, Get Out: The Medical Causes of Home Foreclosures," Health Matrix, Vol. 18, 2008.

[3] Connecticut Center for a New Economy, "Don't Lien on Me Yale: The Attack on Homeownership by the Yale-New Haven Health System and Yale School of Medicine," September 2003.

[4] Institute for Medicine, "Care Without Coverage: Too Little, Too Late," May 2002; Collins, S.R., J.L. Kriss, M.M. Doty and S.D. Rustgi, "Losing Ground: How The Loss of Adequate Health Insurance is Burdening Working Families," The Commonwealth Fund, August 2008.

Section One

A Survey of Hospital Practices Under the Hospital Financial Assistance Law

This section examines two issues related to the provision of hospital financial assistance in New York from the patient's perspective. First, CSS assessed the availability of hospital financial aid policies through a series of written inquiries, calls, web-based research and outreach to hospital trade groups. Second, this section examines whether New York hospitals adopted financial assistance policies that comply with the HFAL and DOH implementing guidance, and whether those policies impose additional barriers to accessing financial assistance.

Availability of Hospital Financial Aid Applications

While the DOH's website extensively profiles every hospital in New York State, these unique hospital profiles do not provide information about the hospital's financial aid policy.[18] CSS sent letters to every hospital in New York formally asking for copies of their financial aid applications and policies in order to review them and to post them in a centralized patient-friendly location on the website of its health consumer assistance program, Community Health Advocates.[19] CSS also visited each hospital's website to see if it included information on patient financial assistance.

Of the 201 hospitals surveyed,[20] CSS found that:

- 181 (90%) hospitals and hospital systems provided us with their policy summary and/or application, or had the information publicly posted on their website. Initially, only 163 hospitals (81%) provided policies and/or applications to CSS. However, after CSS sent a follow-up letter indicating the preliminary results of its survey to the Hospital Association of New York State, a hospital trade group, 18 additional hospitals agreed to provide us with their materials.
- 20 (10%) hospitals refused to provide CSS any information, had nothing publicly posted on their website, or did not respond to inquiries.

In 2010, the 20 hospitals that did not provide any information about their financial aid policies received $87,397,389 in ICP funds. While these results are not dispositive of what a patient may experience when seeking the same information, it appears that one in ten hospitals in New York State either remain unwilling to provide HFAL information or are only doing so on a selective basis—both practices are in violation of the law.

Assessment of New York's Hospital Financial Assistance Policies in Relation to the Law, Guidance, and Additional Patient Barriers to Access

Under the HFAL, hospitals must design and implement a financial assistance program for patients below 300 percent of the federal poverty line (approximately $57,000 for a family of three) as a "condition" for receiving funding from the ICP program.[21] The HFAL permits each hospital to design its own application, procedure, or outreach strategy, but requires each hospital to:

- "establish financial aid policies and procedures"[22] that are "clear, understandable, in writing, and publicly available in summary form;"[23]
- reduce charges for qualifying patients based on guidelines related to the federal poverty measures;[24]
- ensure that "every patient is made aware of the existence of such policies and procedures and is provided, in a timely manner, with a summary" upon request;[25] and
- provide application forms printed in the "primary languages" of patients served by the hospital.[26]

CSS specifically evaluated the hospital financial assistance applications and the policy summaries it received[27] to determine if they contained the following four basic components required by the HFAL: (1) an explanation of income-level eligibility;[28] (2) information on geographic service area;[29] (3) explanation on how to apply;[30] and (4) instruction to ignore bills while application is pending.[31]

Of the 181 hospital financial assistance materials reviewed by CSS, 102 (56%) do not comply with the four basic legal requirements under the HFAL. In 2010, these 102 hospitals received $400,025,366 in ICP payments.

CSS also evaluated the hospital financial assistance applications and policy summaries in light of guidance issued by DOH to clarify permissible practices under the HFAL in 2007 and 2009.[32] In order to facilitate uniform simple adoption of financial policies throughout the State, the DOH guidance provided a model one-page application and provided additional interpretation about legitimate areas of inquiry about a patient's ability to pay.[33] The guidance explicitly prohibits hospitals from: (1) requiring a patient to have a Medicaid denial before applying for financial aid;[34] (2) requiring patients to provide tax returns;[35] and (3) considering a patient's monthly bills or financial obligations in income determinations.[36]

Of the 181 hospital financial assistance materials reviewed by CSS, 63 (35%) seek additional information which is non-compliant with the DOH guidance, such as demanding the provision of tax returns, monthly bill information, or a Medicaid denial. In 2010, these 63 hospitals received $204,845,679 in ICP payments.

Finally, CSS evaluated each hospital's financial assistance application and policy summary to determine if it imposed additional financial disclosure burdens beyond what was contemplated in the HFAL or guidance. For example, a hospital may only consider a patient's assets if the patient's income is below 150 percent of the federal poverty level. Yet some hospitals ask every patient to provide information about assets, creating additional paperwork barriers and privacy concerns for patients who are not subject to the asset test. Additional barriers to financial assistance identified by CSS include requiring patients to provide account numbers or statements for their checking, savings, and credit card accounts. While not expressly in violation of either the HFAL or the DOH guidance, hospital requests for patient banking or credit card information are neither recommended on the DOH model form nor encouraged.

Of the 181 hospital financial assistance materials reviewed by CSS, 45 (25%) impose additional barriers to financial assistance, such as requests for checking, savings, or credit card account numbers or statements. In 2010, these 45 hospitals received $169,259,198 in ICP payments.

In summary, CSS's evaluation determined widespread non-compliance with the HFAL and the DOH's implementing guidance. A significant minority of hospitals will not make their applications and policy summaries publicly accessible. Of the 181 hospitals that make their application materials publicly available, 66 percent (collectively receiving $464 million in 2010) of the hospitals used unlawful, non-complaint, or otherwise problematic materials, suggesting systemic enforcement problems.

Section Two

An Assessment of the Indigent Care Pool Data Submitted by Hospitals to New York State

As described in the prior section, the HFAL requires hospitals to establish financial assistance policies for patients as a condition of receiving hospital ICP payments. But the law does not include meaningful fiscal incentives or a statutory enforcement mechanism to ensure widespread compliance. And, unlike insurance payments, the State does not tie funds requested by hospitals to services provided to specific patients. Instead, hospitals submit aggregated costs (including patients' bad debts), units of service, and financial assistance data.

The HFAL requires each hospital to submit an annual institutional cost report (ICR) to the DOH and provide an annual certification by an independent certified public accountant that the hospital's billing, collection, and accounting write-off procedures are consistent with the law and regulations.[37]

On the ICRs, hospitals report aggregated data to DOH on the following subjects:

- Hospital charges incurred and uncollected amounts due to patient bad debt and financial assistance provided (with bad debt and financial assistance reported separately). Methods of calculating charges vary from hospital to hospital.
- Units of service provided to all uninsured patients (including patients whose bills were determined to be bad debt or eligible for financial assistance) and payments made by uninsured patients.

- The number of patients (by zip code) who applied for financial assistance and how many applications were approved, denied, pending, or deemed incomplete.
- The amount of reimbursement funds received from the ICP.
- The number of liens placed on primary residences through the hospital collection process.[38]

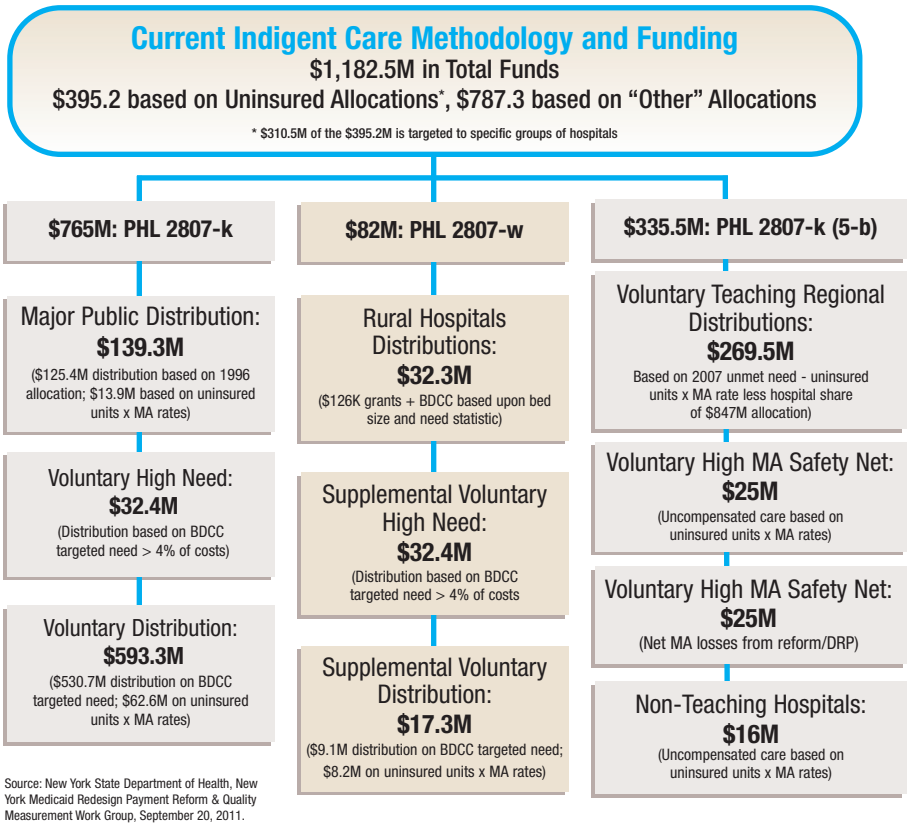
There are two key metrics used to measure uncompensated care losses in order to draw down ICP funds: the "bad debt/charity care" (BDCC) methodology—often called the "existing," "old" or "90% method," and the "units of service" methodology, also known as the "10% method."[39] Under both methods, hospitals use their own unique accounting policies and procedures.

Under the BDCC reporting method, hospitals report what they charged for care provided in aggregate. These charges are then reduced to "cost" by the DOH using a converter formula. BDCC uncompensated care costs include bad debts and financial assistance provided to: (1) uninsured patients; (2) self-pay patients who have insurance which does not cover a particular service provided; and (3) insured patients who do not pay their co-pays or deductibles, or co-insurance.[40] Charges attributable to bad debts and financial assistance provided are reported separately.

In 2007, New York State established an Indigent Care Technical Advisory Committee Panel (TAC), to evaluate the BDCC method of allocating ICP funds. The TAC found the BDCC methodology lacked clarity and transparency, and it raised questions about the consistency, uniformity and accuracy of the data it relies on.[41] The TAC recommended adopting a new methodology based on units of service provided to uninsured patients.[42]

In response, beginning in 2009, the State started to allocate a portion of the ICP funds using the "units of service" reporting methodology.[43] Under this method, the number of inpatient and outpatient units of service provided to uninsured patients[44] is multiplied by the applicable Medicaid reimbursement rate, less any payments made by the patients.[45] Like the BDCC method, hospital losses reported include both bad debts and financial assistance provided to: (1) uninsured patients; and (2) self-pay patients who have insurance which does not cover a particular service provided. Uncompensated costs for services to insured patients—permissible under the BDCC methodology—are not allowable for ICP reimbursement under the units of service methodology.[46] However, the units of service reported include all services provided to uninsured patients, including patients whose bills have been classified as bad debt. Accordingly, neither methodology incentivizes the provision of financial assistance.

Figure 1 - Current Indigent Care Pool Funding Distributions



Source: New York State Department of Health, New York Medicaid Redesign Payment Reform & Quality Measurement Work Group, September 20, 2011.

The ICP program itself is made up of several smaller sub-pools, each with different criteria and distribution methodologies (see Figure 1). For example, for major voluntary hospitals, the allocation is based on each hospital's share of total reimbursable costs relative to the total reimbursable costs for all major hospitals. These hospitals receive a greater distribution amount based on a sliding scale which provides more funds for hospitals with a higher "targeted need," which is the ratio of uncompensated care relative to total patient volume (described in greater detail below). Hospitals are generally reimbursed for only a portion of their reported costs for uncompensated care.

Analysis of New York's Hospital Indigent Care Pool Data

In 2006, New York State enacted the HFAL, which for the first time, made the adoption of patient financial assistance policies a condition of receiving ICP program funds. However, the HFAL did not change the underlying methodology for distributing the funds to hospitals. To this day, the ICP distributions do not overtly favor hospitals that provide significant amounts of financial assistance to their patients. This report seeks to determine if the adoption of the HFAL has incentivized hospitals participating in the ICP program to direct financial assistance to eligible patients.

Overall, New York allocates $1.2 billion through the ICP program. In 2010, the largest amount received by a hospital was $60 million (Bronx Lebanon) and the smallest amount received by a hospital was $93,000 (Rockefeller Institute). As described in Table 1, the average amount a hospital in New York received in 2010 was $5.5 million. Table 1 presents also presents the statewide averages for other key measures which are described in further detail later in this report.[47]

The following sections of this report analyze the ICP program in five areas: (1) levels of financial assistance provided by hospitals relative to the amount of ICP funds received; (2) ICP distributions to hospitals that follow and do not follow the HFAL and related guidance; (3) reported bad debt and liens placed on patients relative to levels of financial assistance provided; (4) levels of targeted need relative to approved financial assistance applications; and (5) accuracy and consistency of ICR data submitted by hospitals receiving ICP distributions.

The Relationship Between the Provision of Financial Assistance and ICP Funds Allocation

This section analyzes hospital data submissions regarding the amount of financial assistance provided in relation to the amount of ICP program funds allocated to New York's hospitals. According to DOH data, statewide, hospitals approved an average of 5,151 applications and received an average of $1,083 in ICP funds for each approved application.

Table 1: Statewide Averages of ICR Data

Report measures	Statewide Average
2010 Indigent Care Pool distribution	$5,500,000
ICP dollars distributed per approved application	$1,083
Targeted need	4.3%
Number of financial assistance applications approved per certified bed	15.8
Percentage of uncompensated care costs due to bad debt	65%
Number of liens placed on primary residences	20

An analysis of DOH data reveals that hospitals that provide the most financial assistance often receive the least amount of funding from the ICP program on a per application basis. (See Table 2). For example, when comparing ICP reimbursement dollars to applications approved, Jacobi Medical Center received $167 in 2010 for each of the 52,702 financial assistance applications it approved in 2008. While Jacobi is a public hospital and receives other supplemental funding, other private voluntary hospitals, such as the Bronx-based St. Barnabas Hospital—which receives only $561 dollars per application—do not.

On the other hand, Brookdale Hospital approved only 278 financial assistance applications in 2008, and on average received $93,929 in ICP funds per application. Similarly, Lenox Hill Hospital approved only 130 applications that year, resulting in the receipt of $84,469 in ICP per application. Under the current reporting system, these calculations do not take into account the complexity of care provided to each recipient of financial assistance.

Table 2 - Financial Assistance Applications Approved vs. Indigent Care Funds Received Per Application [Selection Only—For Complete List, See Appendix C]

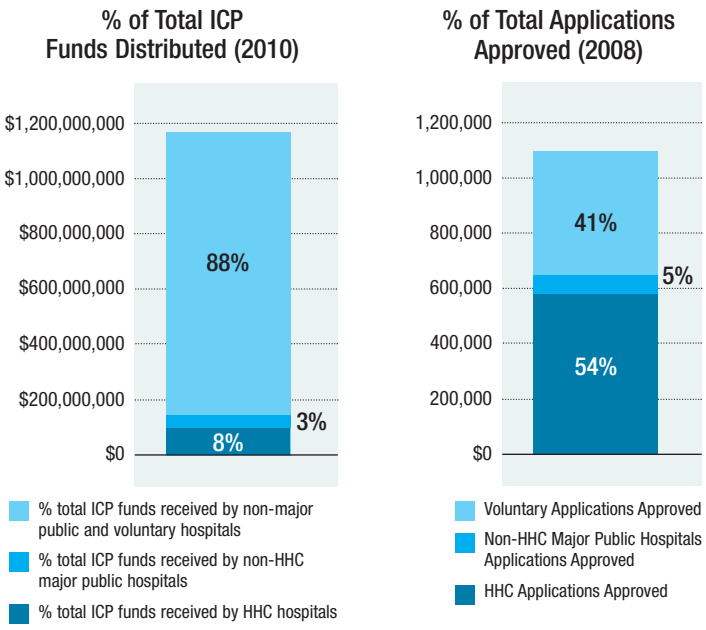
Hospital Name	FA applications approved (2008)	Indigent care funds rec'd (2010) per 2008 approved app.	# Apps. approved per certified bed (2008 apps, 2011 beds)
Statewide average	***5,151***	***$1,083***	***15.8***
Jacobi Medical Ctr	52,702	$167	115.3
Bellevue Hospital	69,636	$208	76.4
St Barnabas Hospital	51,210	$561	114.8
Lutheran Medical Ctr	29,761	$1,273	63.6
Bronx-Lebanon	18,549	$3,235	32
Strong Memorial	15,480	$870	20.9
Mercy Hosp Buffalo	8,583	$369	22.2
Erie County Med Ctr	3,706	$1,137	6.7
Kenmore Mercy	3,078	$308	16.7
Montefiore	2,287	$21,093	2
Maimonides	2,260	$7,870	3.2
Jamaica Hospital	1,365	$26,292	3.6
Stony Brook	1,243	$5,104	2.2
Beth Israel Med Ctr	691	$41,065	0.8
Kaleida Health	683	$8,782	0.7
Rochester General	620	$20,176	1.2
Brookdale Hospital	278	$93,929	0.5
NYU Hospital Ctr	256	$41,984	0.2
Corning Hospital	161	$13,892	1.6
Lenox Hill Hospital	130	$84,469	0.2

Note: Major public hospitals also receive an additional $1.8 billion in UPL and IGT DSH payments.

The ICP payment system itself does not appear to reward key safety net institutions, such as Mercy and Kenmore Mercy Hospitals in Buffalo, St. Barnabas Hospital in the Bronx or New York City's Health and Hospital Corporation facilities (e.g., Jacobi and Bellevue), all of which provide significant financial assistance to needy New Yorkers. As detailed in Figure 2, public hospitals, which give out the greatest amounts of financial assistance, receive far lower amounts of ICP funds than other hospitals.[48] However, public and quasi-public hospitals are not uniformly compliant with the letter and the spirit of the law. (See Box, Some Public Hospitals Could Better Serve the Public.)

In conclusion, it appears that the ICP program does not incentivize hospitals to offer financial assistance under the HFAL. Moreover, the extreme variability in the amount of funding received per approved applicant by hospital indicates a need for changes in State policy and enhanced regulatory interventions.

Figure 2: Hospital Applications Approved vs. ICP Funds Distributed



Note: Major publics receive an additional $1.5 billion in DSH intergovernmental transfers and upper payment limit payments.
ICP funds distributed reflect a 2 year lag in costs incurred (i.e., 2010 payments reflect 2008 costs). Numbers may not sum due to rounding.

Some Public Hospitals Could Better Serve the Public

Under the HFAL, 21 public hospitals receive a total of $139 million in funding each year through the Major Public Distribution sub-pool. Public hospitals as a whole provide a disproportionate share of financial assistance to uninsured patients. But some public hospitals provide surprisingly little financial assistance.

For example, the State University of New York (SUNY) Downstate Medical Center refuses to publicly disclose its financial assistance materials upon request. SUNY Downstate imposed by far the largest number of liens on its patients' homes—incurring 25 percent of all hospital liens on patients' homes in New York State in 2008.

Similarly, the financial assistance materials provided by Roswell Park, a Public Benefit Corporation, failed to comply with the HFAL and imposed additional barriers. Data reported by Roswell Park is also problematic: it reports a targeted need rate of 0.4 percent, well below the standard required of voluntary hospitals to receive ICP funding; offers a very low number of approved financial assistance applications per bed; and has a relatively high number of liens on patient's homes.

Report measures	Roswell Park	SUNY Downstate	Statewide Average
Number of liens placed on primary residences	71	1053	20
Targeted need	0.4%	4.5%	4.3%
Number of FA applications approved per certified bed	1.1	17.8	15.8
Percentage of uncompensated care costs due to bad debt	68.9%	85.2%	65.2%
2010 ICP distribution	$2,227,030	$5,411,530	$5,500,000

An Analysis of Hospitals that Fail to Comply with the HFAL and the SDOH Guidance Relative to the Amount of Financial Assistance Provided

This section assesses the capacity of those hospitals that fail to either follow the HFAL or DOH's HFAL guidance, as described in Part I, above, to provide meaningful access to financial assistance, as reported in their ICRs. In Part I, above, this report found that out of 181 hospital financial assistance materials reviewed, 102 hospitals fail to comply with the letter of the HFAL, and 63 hospitals have financial assistance materials that fail to comply with the DOH HFAL guidance (e.g., included requests for tax returns, monthly bill information, or a Medicaid denial). This section reviews these findings relative to data reported by the hospitals about the numbers of financial assistance applications they received, approved, denied or pended.

Table 3 reveals that hospitals that fail to follow the HFAL approved an average of 9.6 applications per certified bed in 2008, while those hospitals that do follow the HFAL approved 24 applications per certified bed. Consistent with this finding, these same hospitals deny financial assistance applications much more often than their counterparts. Although they only received 22.5 percent of all financial assistance applications in the State, they accounted for 62 percent of all denials. In 2010, these hospitals received over $400 million in hospital ICP funds.

Similarly, Table 3 indicates that the 63 hospitals that do not comply with DOH's HFAL guidance only approved 5.4 applications per certified bed in 2008, while the 118 hospitals that do comply approved 22.5 applications per certified bed. Additionally, while these 63 noncompliant hospitals report receiving only eight percent of all the financial assistance applications in the State, they appear to deny the few applications they receive at a disproportionate level (resulting in 33.9 percent of all denied applications). In 2010, these hospitals collectively received nearly $205 million in ICP funds.

Table 3 - Hospital Financial Assistance Application Content and Financial Assistance Provided

Application Data from 2008 ICR Exhibit 50	Hospitals that Follow the HFAL	Hospitals that Violate HFAL	Hospitals that Follow DOH HFAL Guidance	Hospitals that Violate DOH HFAL Guidance
# of Hospitals	79	102	118	63
# Apps. Rec'd./ Hospital	10,389	2,534	8,343	1,482
% of Total Apps. Received	71.3%	22.5%	85.5%	8.1%
% of Total Apps. Approved	71.9%	21.6%	86.1%	7.4%
% of Total Apps. Denied	30.9%	62.2%	59.0%	33.9%
% of Total Apps. Pending	73.2%	25.9%	80.4.%	16.7%
% of Total Apps. Incomplete	72.8%	27.7%	84.9%	14.6%
Avg. # Apps. Approved / Certified Bed	24.3	9.6	22.5	5.4
Total ICP Funds Received	$663,352,416	$400,025,366	$830,897,666	$204,845,679

Note: The statewide average number of approved applications per certified bed is 15.8.

As described above, significant amounts of ICP funds are distributed to hospitals that either fail to comply with the HFAL or its guidance. Distributions from the ICP program should be directly tied to the provision of financial assistance so that hospitals will better comply with the law. Likewise, State regulators should engage in meaningful enforcement activities.

An Assessment of New York's ICP Distribution Methodology Relative to Hospital Bad Debts and Lien Activity

This section examines the hospital reporting on financial assistance and the ICP distributions in light of hospital reporting to DOH about patient "bad debt" and "liens." Patient who are not offered financial assistance are often categorized as "bad debt" and can be subject to aggressive collection activities, including the imposition of home liens. Currently, New York hospitals report patient bad debts in order to enhance their ICP distribution payments —a practice which is to be discontinued under the ACA.[49] Distributions of DSH funding for bad debt is disfavored because it does not necessarily target limited government resources to those most in need. Bad debts can be for both insured and uninsured patients who could not or would not pay their hospital bills. In addition, under the current methodology, hospitals can continue collection activities on bad debts that they reported under the ICP methodology (though they must make an adjustment to the State if the debt is eventually paid). Accordingly, the patient does not accrue the same

Table 4 - Uncompensated Care Costs Due to Bad Debt and Financial Assistance Applications Approved [Selection Only—For Complete List, See Appendix C]

Hospital Name	Percent of uncompensated care costs due to bad debt (2008)	Indigent Care pool payment (2010)	Apps approved (2008) per cert. bed (2011)
Statewide Average	*65%*	*$5,500,000*	*15.8*
Stony Brook	96%	$6,344,162	2.2
Cortland Memorial	93%	$1,462,926	4.4
Glens Falls Hosp	92%	$6,321,820	2.5
NYU Hospital Center	90%	$10,747,952	0.2
Corning Hospital	90%	$2,236,620	1.6
Beth Israel Med Ctr	89%	$28,375,694	0.8
Jamaica Hospital	89%	$35,889,008	3.6
Bertrand Chaffee Hosp	86%	$412,954	0.0
Brookdale	85%	$26,112,334	0.5
SUNY Downstate	85%	$5,411,530	17.8
John T Mather Mem	85%	$2,344,368	5.2
Nassau Univ Med Ctr	85%	$7,434,717	57.7
Brookhaven Mem Hosp	82%	$7,680,614	2.8
Rochester Gen Hosp	81%	$12,509,009	1.2
Wyckoff Heights Hosp	75%	$20,510,496	23.1
St Lukes / Roosevelt	74%	$37,643,016	9.4
St Barnabas Hospital	17%	$28,708,796	114.8

benefits that would come from an approved financial assistance application.

The statewide average of reported uncompensated care costs due to bad debt in 2008 was 65 percent, with 70 percent of hospitals reporting more than half of uncompensated care costs due to patient bad debts. The rate of approved financial assistance applications per certified hospital bed among many of those hospitals that reported more than 50 percent of their uncompensated care costs were attributable to bad debt was significantly below the statewide average of 15.8 per certified bed. Some hospitals with the highest rates of bad debt related costs reported as few as one or two applications per bed per year—indicating the existence of a less than robust financial assistance program. For example, Stony Brook Hospital reported 96 percent of its uncompensated care costs were due to bad debt, and only approved on average two financial assistance applications per certified bed in 2008.[50] (See Table 4.) By contrast, St. Barnabas Hospital, which reported approving 115 financial assistance applications per bed, only reported 17 percent of its uncompensated care costs as bad debt.

Together, those hospitals with over 50 percent of their uncompensated care costs related to bad debt received $674 million in ICP funds in 2010.

A large ratio of bad debt indicates that patients may not be adequately informed of their right to financial assistance, particularly for a hospital that reports low numbers of approved applications relative to its size. Patients who do not receive financial assistance may be sent to collections, even if the hospital has claimed the cost of their care as bad debt. Collection practices can have lasting repercussions on household finances, credit history, and future health outcomes. (See Box, Why Are Hospitals Financial Assistance Programs Important to Patients?)

State law currently permits hospitals to place liens on patients' primary residences as part of the hospital collection process in order to ensure payment. Placement of a lien can have lasting detrimental effects for patients and can impede home sales, complicate mortgage refinancing, and damage personal credit.[51]

The DOH data reveals that a significant number of hospitals are aggressively pursuing the collection of bad debt by placing liens on patient homes. Forty-nine hospitals (24 percent) reported liens on homes in 2008, with just over half reporting 20 liens or less. Statewide, hospitals reported an average of 20 liens. However, the top five hospitals reporting liens reported a startlingly high number of liens, with the publicly-run SUNY Downstate Hospital reporting 1,053 liens placed on homes in 2008 (see Table 5). Relative to hospital size, Massena Memorial Hospital in the North Country placed the highest number, with nearly five liens placed per hospital bed. In 2010, the State provided $246,174,421 in ICP payments to hospitals which had collectively placed over 4,000 liens on patients' homes in 2008.

Hospitals reporting the most liens also reported high rates of uncompensated care costs due to bad debt. For example, Stony Brook Hospital, which reported one of the highest levels of bad debt (as described in Table 5), imposed the second highest number of liens (680) on its patients' homes. While not dispositive, these numbers imply that some of the affected homeowners may have been eligible for financial assistance.

Table 5 - Hospital Liens and Financial Assistance Provided
[Selection only - for complete list see Appendix C]

Hospital Name	Total Liens (2008)	Liens (2008) per bed (2011)	Apps approved (2008) per certified bed (2011)	% uncompensated costs due to bad debt (2008)	Total ICP funds received (2010)
Statewide Average	*20*	*.10*	*15.8*	*65%*	*$5,500,000*
Univ Hosp Bklyn/SUNY Dwnst	1053	2.80	17.8	85%	$5,411,530
Univ Hosp Stony Brook	680	1.19	2.2	96%	$6,344,162
Saratoga Hospital	450	2.63	4.8	47%	$2,314,574
Good Samaritan Hospital Med Ctr	406	0.93	40.1	16%	$8,480,429
Massena Memorial Hosp	249	4.98	6.3	60%	$1,263,935
Crouse-Irving Mem Hosp	92	0.18	1.4	68%	$6,462,589
Brooks Mem Hosp	77	1.18	8.8	74%	$606,969
Vassar Brothers Hosp	72	0.20	43.0	33%	$5,961,049
Roswell Park Mem Inst	71	0.53	1.1	69%	$2,227,030
United Health Svcs Hosp Inc	70	0.15	5.0	78%	$8,005,842
St Francis Hosp-Poughkeepsie	68	0.20	18.8	45%	$4,304,773
St Josephs Hosp Of Elmira	66	0.29	1.6	89%	$1,221,417
Cortland Mem Hosp Inc	66	0.37	4.4	93%	$1,462,926
Niagara Falls Mem Med Cter	63	0.37	1.7	90%	$1,858,979
Arden Hill/Orange Reg Med Ctr	52	0.12	0.7	88%	$2,778,459
Champlain Valley Phys Hosp	51	0.16	1.5	78%	$2,178,680
Erie County Med Ctr	44	0.08	6.7	54%	$4,213,019
Nathan Littauer Hospital	38	0.51	15.1	82%	$2,244,666
Our Lady Of Lourdes Mem Hosp	37	0.14	11.6	89%	$3,785,336

This section assessed how the current ICP distribution methodology—which includes bad debt—supports hospital practices of assigning patients to bad debt and damaging collection activities, such as liens, instead of incentivizing the appropriate offers of financial assistance. Under the ACA, New York will no longer be able to use bad debts in its ICP distribution methodology. Accordingly, in order to maximize federal funding, the State should bar the use of bad debt in its ICP distribution and closely scrutinize the financial assistance practices at hospitals reporting high bad debts and lien activity.

An Assessment of the Use of the Targeted Need Metric in the ICP Distribution Methodology

This section evaluates the effectiveness of the ICP program's use of the "targeted need" metric as a measure of a hospital's uncompensated care in order to distribute ICP funds. Because targeted need includes bad debt, hospitals that report very high levels of targeted need do not necessarily provide financial assistance to many patients.

A hospital's "targeted need," the ratio of uncompensated care relative to total patient volume, is a critical number

used to determine ICP pool distributions. A hospital must have a targeted need rate of greater than ½ of 1 percent (0.50 percent) of the hospital's total annual inpatient and outpatient costs in order to be able to access funding through the largest sub-pool, the Voluntary Distribution pool. Many of the sub-pools use targeted need as a basis for distributing funding. (See Figure 1.) This targeted need calculation is performed by DOH using ICR data.[52] In New York, the average targeted need reported in 2008 (the data on which 2010 distributions were based) was 4.3 percent. Sixty hospitals reported a higher than average targeted need, with the highest ratio reported at 14.2 percent.

Logically, hospitals supplying the greatest amount of uncompensated care should also be the ones reporting the highest numbers of financial assistance applications approved. But this was not the case for several hospitals.

In fact, many of the hospitals reporting the highest targeted need actually reported lower than average numbers of approved financial assistance applications, relative to their size. For example, Ellenville Regional Hospital reported a targeted need of 12.4 percent in 2008, yet reported approving only 12 financial assistance applications for the entire year. Bon Secours Community Hospital reported a targeted need of eight percent without approving a single application for financial assistance. (See Table 6).

In 2008, 39 hospitals reported higher than the statewide average level of targeted need (around 4 percent) but, on average, approved far fewer financial assistance applications, relative to hospital size, than their counterparts. In 2010, these 39 hospitals received $266,008,905 in ICP payments.

Table 6: Hospital Reporting Higher Than Average Targeted Need and Lower Than Average Applications Approved.
[Selection Only—For Complete List, See Appendix C]

Hospital Name	Targeted need (2008) [Cost in BDCC Method]	Apps approved (2008)	Apps approved (2008) per certified bed (2011)
Statewide Average	*4.3%*	*5,151*	*15.8*
Mount Vernon Hospital	13.5%	1553	8.8
Ellenville Reg Hospital	12.4%	12	0.5
Jamaica Hospital	10.8%	1365	3.6
Catskill Regional Med Ctr	10.3%	647	3.9
St Josephs Hosp Yonkers	10.2%	157	0.8
Sound Shore Westchester	9.3%	1341	5.3
Interfaith Medical Center	9.1%	2012	7.0
Brookdale Hosp Med Ctr	8.1%	278	0.5
Bon Secours Comm Hosp	8.0%	0	0
Ira Davenport Mem Hosp	7.7%	159	4.2
Mt Sinai Hosp Of Queens	7.3%	1187	5.1
SUNY Health Science Ctr	7.0%	381	0.9
Wayne Health Care	6.8%	130	1.1
Margaretville Hospital	6.0%	48	3.2

High rates of "targeted need" often do not result in the robust provision of financial assistance—even in areas with high rates of uninsurance. Hospitals reporting a high "targeted need" serve a patient population that appears to have significant difficulties paying medical bills and are typically situated in areas with high rates of uninsurance. The average statewide (nonelderly) rate of uninsurance is 13 percent,[53] but this rate varies by region. For example, the rate of uninsurance in Queens County, where Jamaica Hospital is located, is 18.4 percent.[54] Kings County, which is home to both Interfaith Medical Center and Brookdale Hospital, has a rate of 15.4 percent.[55] Both Jamaica Hospital and Interfaith Medical Center report over double the statewide average in targeted need (10.8% and 9.1%, respectively) of four percent, but offer well below the statewide average in financial assistance (.5 and 7 applications per certified bed, respectively) of 15.8 applications per certified bed.

A similar situation occurs in a number of upstate communities. The upstate average rate of uninsurance of 10.7 percent,[56] but, in Westchester, Ulster, Sullivan and Orange counties, where Mt. Vernon Hospital, Ellenville, Catskill Regional Medical Center, and Bon Secours are located, respectively, the rate of uninsurance is 12 percent.[57] Despite this relatively high rate of uninsurance in their respective catchment areas, these four hospitals report providing very little financial assistance to their patient populations (Mt. Vernon Hospital approves 8.8 applications per bed; Ellenville approves 0.5 applications per bed; Catskill Regional Medical Center approves 3.9 applications per bed; and Bon Secours reports approving none).

Importantly, 84 percent of New York's uninsured residents have incomes below 300 percent of the federal poverty level or $57,000 for a family of three.[58] The demographics and reported spending on uncompensated care by these hospitals auger for much higher rates of approved applications per bed. However, the data reported to the State does not explain these discrepancies.

The findings above indicate that many hospitals report high levels of targeted need, but do not provide correspondingly high levels of financial assistance to patients. Accordingly, the targeted need metric is not an effective measure of the provision of indigent care to needy uninsured or underinsured patients, and should not be used in the ICP payment methodology.

An Assessment of the Quality of ICR Data Submissions

CSS reviewed the content of the hospital ICP data submissions to the DOH to determine if hospitals were taking their reporting obligations seriously, and to determine if DOH auditors were carefully reviewing the submissions received.

This report finds significant discrepancies in the reporting of uncompensated care costs by a number of hospitals to the DOH. For example, hospitals eligible for ICP funds are required to report total costs for all uninsured patients as well as total costs incurred for just those uninsured deemed eligible for financial assistance.[59] As described in Table 7, the statewide average amount of uninsured costs incurred by patients determined eligible for financial assistance is 45 percent. Uninsured patients eligible for financial assistance by definition represent a subset of the total uninsured.

Yet some hospitals actually report more than 100 percent of uninsured costs for patients eligible for financial assistance—often significantly more. One hospital reported that 826 percent of uninsured costs were attributable to financial assistance patients—a feat that is not possible.[60] While these numbers fluctuate each year (see Table 7), 13 hospitals reported over 100 percent in at least two out of the three years for which data was reviewed.

Other hospitals reported no costs for uninsured patients eligible for financial aid, but were still able to draw down ICP funds.[61] Eight hospitals reported provided no financial assistance for at least two out of the three years for which data was reviewed, and two hospitals reported providing no financial assistance for all three years.

However, there is no apparent fiscal or regulatory consequence to a hospital that reports—and in a number of cases repeatedly reports—patently flawed data. Hospitals that reported facially flawed data received $80,068,364 in ICP payments in 2010.

Table 7: Hospital Reporting on Uninsured Costs Attributable to Patients Eligible for Financial Assistance.[62]

	2007	2008	2009
Hospitals reporting over 100% of uninsured costs for uninsured patients eligible for financial assistance	9	16	15
Hospitals reporting 0% of uninsured costs for uninsured patients eligible for financial assistance	9	9	18

Hospital reporting on financial assistance application approval rates is also inconsistent across hospitals. Out of the 200 hospitals that submitted ICRs in 2008,[63] 118 claimed application approval rates of 85 percent or more; 20 approved less than 50 percent; 9 approved none. Application denial rates, pending rates, and incomplete rates held similar results: 44 hospitals reported no denials, while 54 reported denial rates of over 10 percent; 94 reported no pending applications, while 25 had more than 10 percent pending; and 109 claimed no incomplete applications, while 36 had more than 10 percent incomplete. Hospitals reporting 100 percent acceptance rates or zero pending or incomplete applications warrant closer scrutiny by DOH regulators.

Under the current ICP reporting system, it impossible to determine whether all eligible patients received financial assistance, and whether hospitals' reported costs for these patients are accurate. This appears to be the inevitable consequence of not tying financial assistance to ICP payments and the lack of any apparent regulatory ramifications or penalties imposed on those hospitals that submit inaccurate, internally inconsistent, or incomplete data. The DOH should either rigorously audit or require its external auditor (KPMG LLP) for New York's hospital DSH program to review hospitals' ICP data to determine whether the data is flawed, internally inconsistent, or incomplete.

As described above, this section of this report reviewed the ICP program data submitted by hospitals in five areas. In the first area, CSS found that some hospitals that approved relatively higher numbers of applications received lower levels of ICP funding, indicating problems with the funding methodology. In the second area, CSS found that hospitals that failed to follow the HFAL law or guidance were less likely to provide financial assistance to patients, demonstrating the need for State enforcement of the HFAL and financial incentives to hospitals to follow the law. In the third area, CSS found that some hospitals reported very high rates of bad debt and liens, but simultaneously reported very low rates of approved applications for financial assistance. In the fourth area, CSS found that some hospitals claiming the highest levels of targeted need approved relatively few financial assistance applications, underscoring the need to incentivize the provision of financial assistance by tying it squarely to ICP payments. And in the fifth area, which reviews the hospital ICP program data about spending on uninsured patients who qualify for financial assistance, CSS uncovered patent flaws and internal inconsistencies in the data which warrant closer scrutiny by State regulators.

Conclusions & Recommendations

Seven years after the death of Manny Lanza, and five years after the passage of the New York Hospital Financial Assistance Law, this report finds that New York's Indigent Care Pool program continues to be plagued with problems.

A minority of hospitals still refuse to provide the public access to their financial assistance policies. And of those that have issued financial assistance policies, a significant majority—66 percent—either violate the letter of the HFAL and/or fail to comply with DOH's HFAL guidance, and/or have adopted their own unique barriers to assistance. Collectively, these hospitals drew down approximately $464 million in hospitals ICP program funds in 2010 alone. Instead of aggressively regulating the HFAL, DOH has apparently had neither the resources nor the inclination to effectively enforce the law—even though the receipt of ICP funds is supposed to be conditioned upon compliance.

With billions of federal Disproportionate Share Hospital Funds at issue, the stakes could not be higher for New York State. The hospital ICP program distribution methodology offers no incentives for hospitals to offer financial assistance to needy patients and, conversely, has no adverse repercussions for those hospitals with financial assistance programs that violate the HFAL or DOH guidance. Significantly, the allocation methodology is issuing roughly 50 percent of the pool to hospitals—$674 million in 2010—based on costs that are mostly attributable to "bad debt"—a practice that has been repeatedly and, ultimately, explicitly rejected by federal regulators. This report also documents the ramifications of an ICP system that has no fiscal incentive to encourage hospitals to offer financial assistance: many of the hospitals with high "targeted need" levels offer little financial assistance in geographic areas with high rates of uninsurance. Finally, a minority of hospitals submit reports that are facially inaccurate, internally inconsistent and flawed, underscoring the need for aggressive regulatory action.

The State of New York's uncompensated care system has long been a source of concern for the media, consumer advocates and State officials alike. This report identifies that fundamental problems persist within New York's ICP program. The changes brought about by the new DSH audits and future reductions in funding provide an important opportunity to achieve a systemic change in policies and the regulatory enforcement. To do so, this report offers three areas of recommendations to: (1) improve patient access to financial assistance; (2) incentivize hospital compliance with the HFAL; and (3) improve transparency of hospital reporting.

Recommendations to Improve Patient Access to Hospital Financial Assistance

This report identifies a number of front end problems with accessing financial assistance under New York's current hospital ICP program. To address these issues, to improve access to care for millions of low- and moderate-income New Yorkers, and to maximize federal financing, this report makes the following recommendations:

- **Adopt a uniform statewide application.** In its HFAL guidance, DOH issued a model uniform application. Given that a majority of the hospitals in New York either use unlawful, non-complaint or burdensome applications or will not make their applications public, it is time for the State to mandate the use of a single uniform application form. The adoption of the uniform application should be a condition for receipt of ICP funds. DOH's financial assistance policy summary template should be a "floor" that all hospitals must meet at a minimum.
- **Public dissemination of hospital financial assistance information on the internet.** While the HFAL requires all hospital to publicize their policies, some hospitals do not make their policies publicly available. As a condition of receipt of hospital ICP funding, each hospital's website should include its own policy summary as well as the statewide uniform application (in a downloadable format), and each hospital facility should include prominently posted information on both financial assistance policies and on how to apply. The DOH website, which already profiles every hospital in the State, should post specific hospital policies and the statewide application in this area of its website.
- **Perform hospital audits and enforcement of the HFAL.** The DOH should audit each hospital's financial assistance policies and annual ICR submissions to ensure compliance with the HFAL and its own guidance. This assessment should evaluate the accuracy of reporting on numbers of applications received, approved, denied, pending or incomplete in light of uncompensated care cost reporting. The assessment should evaluate hospital liens to ensure that an excessive amount of liens are not being secured by selected hospitals. The DOH should impose appropriate enforcement mechanisms including reductions to any unlawful or non-compliant hospital's ICP allocations

and the issuance of statements of deficiencies/corrective action plans. Hospitals that fail this review should be referred to the Office of Medicaid Inspector General for additional enforcement actions.

- **Revise financial assistance eligibility to be consistent with the ACA and current State law.** To correspond with the ACA and current State law, the HFAL should be revised to require hospitals to provide financial assistance up to 400 percent of the federal poverty level ($76,000 annually for a family of three). To correspond with current Medicaid law, any imposition of asset testing through the hospital financial assistance law should be removed. This would allow more patients to benefit from getting financial assistance versus being sent to collections.
- **Allow pre-qualification for financial assistance.** Starting with the launch of the statewide health insurance Exchange in 2014, New Yorkers who are uninsured and do not qualify for or cannot afford insurance products on the Exchange should be allowed to fill out a financial aid application annually to pre-qualify for financial assistance, if they require medical care during the year.

Recommendations to Incentivize Hospital Compliance with the Hospital Financial Assistance Law and the ACA

This report recommends that the State adopt an overt link between the distribution of ICP funds and the HFAL, specifically:

- **ICP payments to hospitals should be based only on the costs of financial assistance to uninsured (or, if permissible, financial assistance to the underinsured) patients who have been certified eligible for financial assistance in compliance with the HFAL and the ACA.**
- **Any remaining ICP funds should be allocated to higher volume Medicaid providers consistent with the ACA.**
- **No ICP payments should be based on patient bad debt.** In order to comply with the ACA, no payments should be made to hospitals based on patient bad debt.

Recommendations to Improve Transparency of Hospital Payments

The current complexities of hospital reporting on uncompensated care are exacerbated by different accounting mechanisms employed by hospitals, which results in inaccurate and inconsistent data. This muddled reporting obscures real patient need and makes it impossible to determine how many eligible patients do not receive financial aid. Moreover, the current DSH audits and upcoming changes to the federal funding allocation methodology put New York at risk for significant cuts to this funding stream. To avoid this outcome, this report recommends:

- **Adopting a 100 percent units of service methodology for reporting services provided to qualified patients.** Providing a single, statewide methodology for reporting costs should cut down on the amount of variation between hospitals currently employing different accounting methodologies and allow the DOH to make "apples to apples" comparisons among hospitals.
- **Separate reporting of different costs for different populations.** New DSH audits will require a more stringent methodology for discerning among types of costs. Uncompensated care costs should only reflect financial assistance provided to uninsured and self-pay patients. This will allow the State to target funds appropriately and maximize New York's ability to avoid federal DSH funding cuts.

Endnotes

[1] P. Boozang, M. Dutton, A. Lam and D. Bachrach, "Implementing Federal Health Care Reform: A Roadmap for New York State," New York State Health Foundation, August 2010.

[2] Medicaid Redesign Team, "Final Recommendations of the Payment Reform and Quality Measurements Workgroup," December 2011.

[3] Individual hospitals which are part of a larger hospital system are counted separately in this report. Initially, 38 (19%) of the hospitals did not release information about their financial assistance policies. After advocacy by CSS, and intervention from the Hospital Association of New York State, this number decreased to 20 hospitals.

[4] Certified bed numbers are for 2011, obtained from the New York State Department of Health hospital profiles website, available at: http://hospitals.nyhealth.gov/.

[5] Under federal and New York State law, New Yorkers have the right to seek care in a hospital emergency room for treatment, regardless of whether they are insured or have the means to pay for the care they receive. *See* 42 U.S.C. §1395dd; N.Y. Pub. Health L. §2805-b. Hospitals may then bill patients for care received.

[6] *Supra* n. 1.

[7] The ICP program was formerly known as the Bad Debt and Charity Care or the "BDCC" pool.

[8] New York State Department of Health, "A Report on the Hospital Indigent Care Pool as required by Chapter 58 of the Laws of 2007," January 2008.

[9] *See e.g.*, Long Island Health Access Monitoring Project, "Hospital Community Benefits and Free Care Programs: An Initial Study of Seven Long Island Hospitals," March 2001; "Neglected and Invisible: Understanding the Unmet Healthcare Needs of People on Long Island," August 2002; "Hospital Free Care Programs: A Study of Sixteen Long Island Hospitals, Part II," April 2003; Commission on the Public's Health System, "CHCCDP: Monitoring the Use of Community Health Care Conversion Demonstration Project Funds," April 2003; Public Policy and Education Fund of New York, "Hospital Free Care: Can New Yorkers Access Hospital Services Paid for by Our Tax Dollars?" September 2003; Legal Aid Society, "State Secret: How Government Fails to Ensure That Uninsured and Underinsured Patients Have Access to State Charity Funds," 2003; Public Policy and Education Fund of New York, "Hospital Financial Aid: Can New Yorkers in the Capital District Access Hospital Services Paid for by Our Tax Dollars?" November 2004; "Charity Care in Rochester," Finger Lakes Health Systems Agency, September 2005; E. Benjamin and K. Gabriesheski, "The Case for Reform: How New York State's Secret Hospital Charity Care Pool Funds Fail to Help Uninsured and Underinsured New Yorkers," NYU Journal of Legislation and Public Policy, Volume 8, Number 1, Fall 2005; C. Pryor, M. Rukavina, A. Hoffman, A. Lee, "Best Kept Secrets: Are Non-Profit Hospitals Informing Patients about Charity Care Programs?" The Access Project and Community Catalyst, May 2010; A. Sager, "Paying New York State Hospitals More Fairly for Their Care to Uninsured Patients," Commission on the Public's Health System, August 2011. *See also,* L. Lagnado, "A Young Woman, An Appendectomy, and a $19,000 Debt," Wall Street Journal, March 17, 2003; L. Lagnado, "Hospitals Will Give Price Breaks to Uninsured, if Medicare Agrees," Wall Street Journal, Dec. 17, 2003, at A1; L. Lagnado, "A Nonprofit Hospital Fights to Win Back Charitable Halo," Wall Street Journal, June 29, 2004; L. Lagnado, "New York State Hospitals Agree to Cut Prices for Uninsured," Wall Street Journal, February 2, 2004; R. Perez-Pena, "Hospitals Agree to Lower Fees for Uninsured," New York Times, February 3, 2004, M. Pacenza; "Charity care to rise at hospitals, facilities vow to ease the financial burden of uninsured," Albany Times Union, February 7, 2004; A. Givens, "North Shore LIJ to join program to help uninsured," Newsday, February 13, 2004; L. Lagnado, "Cold Case Files: Dunned for Old Bills, Poor Find Some Hospitals Never Forget," Wall Street Journal, June 8, 2004.

[10] There are currently 2.7 million uninsured New Yorkers, nearly 1.9 million of which have incomes below 300 percent of the federal poverty level. CSS analysis of 2008-2010 Current Population Survey (CPS) Annual Social and Economic Supplement (ASEC), U.S. Census Bureau.

[11] N.Y. Pub. Health L. §2807-k(9-a)(c).

[12] N.Y. Pub. Health L. §2807-k(9-a)(b), (h).

[13] Letter from James W. Clyne, Jr., Deputy Commissioner, Office of Health Systems Management, New York State Department of Health, May 11, 2009 ("2009 Guidance").

[14] D. Bachrach, M. Dutton, Manatt Health Solutions, "Medicaid Supplemental Payments: Where Do They Fit in Payment Reform?" Center for Health Care Strategies, August 2011.

[15] Health Care and Education Reconciliation Act of 2010 §1203.

[16] *Id.*

[17] *See* Kaiser Family Foundation Federal Medicaid Disproportionate Share Hospital (DSH) Allotments, FY 2011; Health Insurance Coverage of the Total Population, states (2008-2009), U.S. (2009), available at www.statehealthfacts.org.

[18] *See* New York State Department of Health hospital profiles website, available at http://hospitals.nyhealth.gov/.

[19] Excluding closed facilities and rehabilitation centers.

[20] Individual hospitals which are part of a larger hospital system are counted separately in this report.

[21] N.Y. Pub. Health L. §2807-k(9-a)(a)-(b).

[22] N.Y. Pub. Health L. §2807-k(9-a)(a).

[23] N.Y. Pub. Health L. §2807-k(9-a)(c).

[24] N.Y. Pub. Health L. §2807-k(9-a)(b).

[25] N.Y. Pub. Health L. §2807-k(9-a)(c).

[26] N. Y. Pub. Health L. § 2807-k(9-a)(e).

[27] Some hospitals provided their application form, some provided their policy summary, and some provided both. CSS evaluated whether the provided materials met the requirements of the HFAL and SDOH guidance.

[28] N.Y. Pub. Health L. §2807-k(9-a)(c).

[29] *Id.*

[30] *Id.*

[31] *Id.*

[32] Letter from David Wollner, Director, Office of Health Systems Management, New York State Department of Health to General Hospital Chief Executive Officers, February 16, 2007 ("2007 Guidance"); *supra* n. 13, 2009 Guidance.

[33] *Supra* n. 13, 2009 Guidance (Attachment D).

[34] *Supra* n. 13, 2009 Guidance at 2.

[35] *Id.*

[36] *Supra* n. 13, 2009 Guidance (Attachment A at 7).

[37] N.Y. Pub. Health L. §2807-k(9),(9-a)(i).

[38] N.Y. Pub. Health L. §2807-k(9-a)(i).

[39] Some ICP funds are distributed using other methodologies. For example, funds in the $139.3 million Major Public Distribution sub-pool are distributed according to the amount hospitals received from the old Bad Debt and Charity Care Regional Pool in 1996.

[40] 2010 Instructions Institutional Cost Report, June 9, 2011.

[41] *Supra* n. 8.

[42] *Id.*

[43] Recent changes to the ICP pool resulted in approximately a 30 percent allocation of funds distributed under the units of service methodology. *See* Appendix A.

[44] Units of service categorized as Uninsured/Self-pay and Free (charity, Hill Burton) are used in this methodology.

[45] N.Y. Pub. Health L. §2807-k(5-a)(c).

[46] *Supra* n. 40.

[47] ICP distributions are from 2010 data provided to CSS by the New York State Department of Health. Certified bed numbers are for 2011, obtained from the SDOH hospital profiles website, available at http://hospitals.nyhealth.gov/. All other data is 2008 ICR data; 2010 distributions are based on data obtained from 2008 ICRs provided to CSS by the New York State Department of Health.

[48] Major public hospitals also receive an additional $1.5 billion in funding from DSH intergovernmental transfers and upper payment limits. *See* Appendix B.

[49] Health Care and Education Reconciliation Act of 2010 §1203 (DSH health reform methodology will favor states that compensate hospitals with "high volumes of Medicaid inpatients" and "hospitals that have high levels of uncompensated care (excluding bad debt)."

[50] Certified bed numbers are for 2011, obtained from the SDOH hospital profiles website available at http://hospitals.nyhealth.gov/.

[51] *See* Connecticut Center for a New Economy, "Don't Lien on Me Yale: The Attack on Homeownership by the Yale-New Haven Health System and Yale School of Medicine," September 2003.

[52] Targeted need is the ratio of uncompensated care relative to total patient volume. N.Y. Pub. Health L. §2807-k(1)(c).

[53] United Hospital Fund, "Health Insurance Coverage in New York, 2009," September 2011.

[54] *Id.*

[55] *Id.*

[56] *Id.*

[57] *Id.*

[58] *Id.*

[59] *Supra* n. 32, 2007 Guidance (describing protocol for new Exhibit 50).

[60] Coler Memorial Hospital reported that 826% of its total costs for the uninsured in 2008 were attributable to financial assistance patients.

[61] These hospitals included: Arnot Ogden Medical Center, Bertrand Chaffee Hospital, Elizabethtown Community Hospital, Carthage Area Hospital, St. Mary's Hospital Amsterdam Memorial Campus, Schuyler Hospital, Calvary Hospital, and Richmond University Medical Center.

[62] Chart includes only those hospitals which reported costs for all three years (excludes Monroe, Manhattan Eye, Ear & Throat, St. Vincent's, St. Joe's–Cheektowaga, Tri-town Regional, and Albert Lindley Lee).

[63] Exhibit 50 data provided to CSS by the New York State Department of Health.

Appendices

Appendix A: A Brief History of New York's Charity Care Policies

New York's Indigent Care Pool

New York's hospital Indigent Care Pool (ICP) (formerly called the "Bad Debt and Charity Care Pool) was created in 1983. The pool was created in part to compensate hospitals for the costs of caring for uninsured and low-income patients, and also to reduce the provider practice of shifting the costs of caring for uninsured patients to third-party payers.[1]

This pool is funded through a variety of different sources:

- **Health Care Reform Act (HCRA) Assessments:** A comprehensive system of payer surcharges on health care instituted in 1996. A major source of funding for this pool comes from a tax on inpatient and outpatient hospital care, diagnostic and treatment center services, and freestanding ambulatory surgery centers, paid by health insurers and self-pay patients. Medicaid pays a surcharge of 7.04 percent, and all other non-Medicare payers pay a surcharge of 9.63 percent.[2]
- **Hospital Assessments:** As part of the 1996 enactment of HCRA, hospitals must pay an annual assessment of 1 percent on all inpatient revenues.[3]
- **Additional Sources:** Subsequent amendments to HCRA have added additional sources of revenue, including a portion raised by cigarette taxes and proceeds gained through Empire BlueCross and BlueShield stock conversions.[4]

Over the past five years, the State has made several efforts to reform the ICP pool. Some of these efforts were intended to reform how the State allocates ICP

payments in order to promote transparency and to reward hospitals for providing financial assistance to the uninsured; others were designed to increase federal matching funds to the State's Medicaid program. The following is a description of key initiatives:

- **2006 – Hospital Financial Assistance Law (HFAL):** In 2006, New York State enacted the Hospital Financial Assistance Law.[5] This requires all hospitals to implement financial aid policies that provide sliding-scale discounts to uninsured patients with incomes up to 300 percent of the federal poverty level.[6] Beginning in 2009, hospitals were required to comply with the HFAL in order to be eligible to receive pool distributions.
- **2007 – Proposed New Payment Methodology and Creation of the Technical Advisory Committee:** In 2007, the Governor's Executive Budget contained a proposal to establish a new methodology for distributing ICP funds based on losses due to providing services to the uninsured.[7] Under this proposal, ICP funds would be distributed based on units of service provided to uninsured patients multiplied by the applicable Medicaid reimbursement rate.[8] The Legislature declined to approve this proposal, and instead convened a Technical Advisory Committee (TAC) to conduct a detailed review of the ICP.[9]
- **2008 – TAC Report and Subsequent Changes to Distribution Methodology:** The TAC issued its recommendations in January of 2008. Major recommendations were as follows:
  - Collapse the existing sub-pools down to three pools: a major public hospital pool, a voluntary and minor hospitals pool, and a rural pool.
  - ICP distributions should be based on inpatient and outpatient units of service to uninsured patients, valued at the hospital's Medicaid rates.
  - ICP funds should be targeted to uncompensated care provided to uninsured patients first. Bad debts from insured patients should be a second priority.
  - Allocation of ICP funds should be consistent with the requirements of the Hospital Financial Assistance Law.
  - Requirements that patients document their income and insurance status should be designed so as to not unduly burden hospitals and patients.
  - Changes to the ICP allocation formulas should be phased in over a multi-year period.

  As a response to the TAC recommendations, the Legislature agreed to distribute 10 percent of aggregate ICP payments to hospitals based on the payment methodology recommended in the TAC report (and as proposed in the 2007-2008 Executive Budget).[10]
- **2009 – The Professional Education Pool (PEP) moves to the ICP pool:** In 1996, New York established the PEP to address hospital concerns that commercial insurers would not cover the added cost of graduate medical education in their negotiated hospital reimbursement rates following deregulation. These funds were not initially intended to be made as Medicaid payments, and the state did not receive a federal match for them.

  However, in 2009, the state was facing a budget shortfall and a spike in hospital uncompensated care costs attributable to the uninsured. To address both concerns, the $283 million in the PEP was moved to the ICP pool (to be distributed using the units of service methodology) and its allocation formula changed to make these funds eligible for a federal match.[11]

  Most ICP funding is distributed on a statewide basis; however, much of the former PEP funding is distributed on a regional basis to account for regional variation in graduate medical education costs and related HCRA assessments.
- **2010 – Budget cuts and a shift from DSH payments to UPL payments:** With the addition of $283 million from the PEP, New York was quickly nearing its statewide DSH cap for federal matching funds. This presented a problem for the City of New York and the Health and Hospitals Corporation (HHC), which were relying on city intergovernmental transfers (IGTs) to provide additional DSH funds to HHC. To address this problem, the State reduced the ICP by $235.5 million and instead made it up by making $235.5 million in UPL payments to voluntary hospitals.[12] Hospitals who receive these UPL funds will have their ICP payments reduced by an equal amount.[13]

  In addition to this, the State also reduced funding for the ICP by $69.4 million in 2010,[14] and $73.2 million in 2011.[15] However, reductions to ICP payments do not apply to major hospitals, and certain sub-pools created after the PEP additions are also exempt.

Lastly, the 2010-11 Budget established a task force of elected officials and stakeholders to examine the distribution methodology and use of ICP funds.[17] However, members were never appointed, and the task force was never convened.

- **2011 – Additional hospital reporting requirements to comply with federal audit requirements:** The Governor's Executive Budget for fiscal year 2011-2012 included a requirement that hospitals submit a "disproportionate share hospital data collection tool" which will assist the State in calculating the facility-specific cap on DSH payments, as defined in federal statute.[18]

1 New York State Department of Health, "A Report on the Indigent Care Pool," January 2008, at 7.

2 New York State Department of Health, Indigent Care and Health Care Initiatives Surcharges by Payor, available at: http://www.health.state.ny.us/nysdoh/hcra/docs/04-01-09_through_12-31-11_payor_surcharge_rates.pdf.

3 N.Y. Pub. Health L. §2807-d. *See also* New York State Department of Health, *A Report on the Indigent Care Pool*, January 2008, 7; New York State Office of the State Comptroller, *The Health Care Reform Act*, April 2003, 5.

4 N.Y. Pub. Health. L. §2807-v.

5 Chapter 57, Laws of 2006, §39.

6 N.Y. Pub. Health. L. §2807-k (9-a)(b).

7 2007-2008 Executive Budget, Health and Mental Hygiene, §§56-58.

8 New York State reformed Medicaid rates for hospital inpatient and outpatient care in 2009 and 2008, respectively. Hospital inpatient rates now use a statewide base rate adjusted for costs of Graduate Medical Education and regional labor differences.

9 Chapter 58 of Laws of 2007, §57.

10 Chapter 58 Laws of 2008, §28-b.

11 N.Y. Pub Health L. §2807-k (5-b)(b)(1); *see also* State of New York, "Transforming New York's Public Health Insurance Programs: 2007-2009," Health Care Transformation Report, July 2009, 7.

12 N.Y. Pub Health L §2807-k (17). Enacted in Chapter 109, Laws of 2010, Part B. §3-a.

13 N.Y. Pub Health L §2807-k (17). Enacted in Chapter 109, Laws of 2010, Part B. §3-b.

14 N.Y. Pub Health L §2807-k (5-c)(a).

15 N.Y. Pub Health L §2807-k (5-c)(b).

16 N.Y. Pub Health L §2807-k (5-c).

17 Chapter 58, Laws of 2010, Part C, §16.

18 2011-2012 Executive Budget, Health and Mental Hygiene Article VII Bill, Part B § 2.

Appendix B: Supplemental Payments to Hospitals

Typically, the federal government permits states to pay Medicaid payments to providers for specific services rendered to specific patients. However, there are two notable exceptions to this rule: Disproportionate Share Hospital (DSH) funds and Upper Payment Limit (UPL) payments. Both types of payments are a vital source of hospital revenue, though the inability to tie payments to specific services rendered has made both a target for reform in recent years.

Disproportionate Share Hospital Funds

The use of DSH payments came about after the 1981 move by Congress to allow states to promote efficiency in health care delivery and lower costs by shifting Medicaid reimbursement rates from a cost-based system, which varied from provider to provider based on individual costs or charges, to a prospective fixed-payment system.[1] Since this change could potentially have a negative effect on hospitals in low-income areas that relied heavily on Medicaid payments, Congress included a provision to require states to "take into account" the situation of hospitals that serve a disproportionate share of low-income patients when designing their payment systems.[2] In 1987, this mandate was further strengthened by requiring states to make DSH payments to these hospitals on top of their normal Medicaid payments, partially funded by a 50 percent match from the federal government.[3]

To qualify for DSH payments, hospitals must meet one of two basic criteria: (1) they must have a Medicaid

State Sources of DSH Funds: Intergovernmental Transfers

States have a variety of mechanisms available to pay for the state portion of DSH funds, including general tax revenues, provider assessments, and intergovernmental transfers (IGTs).

For IGTs, states can use taxes or donations from local governments in order to generate up to 60 percent of the non-federal portion of a state's DSH payments. The use of IGTs allows a state to draw down federal funds without actually providing a state match.

Often, the source of these funds can affect how supplemental payments are distributed. For example, when a local government funds the non-federal share, it may expect that the supplemental payments will be used to support local public hospitals.

inpatient utilization rate (MIUR) of at least one standard deviation above the mean for all hospitals that serve Medicaid patients; or (2) they must have a low-income utilization rate above 25 percent.[4] States can also designate additional hospitals as DSH hospitals in their state plans, provided they have a MIUR of at least one percent.

States may use the Medicare payment formula to make DSH payments to hospitals, or they may create their own formula. Under the Medicare payment formula, DSH payments are made as increases to a hospital's payment rate based on a variety of hospital factors (e.g., size, urban or rural location). Alternately, states can use their own formula provided it applies equally to all hospitals that fit the criteria and it is "reasonably related to the costs, volume, or proportion of services provided" to Medicaid and other low-income patients.[5]

While each state may determine which hospitals will receive DSH payments as well as how much, states are subject to both statewide and facility-specific caps for federal matching funds related to DSH.[6] Any payments made above these caps are not eligible for federal matching funds. The statewide cap is determined by adjusting the cap listed in statute each year (starting in fiscal year 2003) to reflect the change in the consumer price index.[7] If this adjustment exceeds 12 percent then the cap will remain at the previous level.[8] Statewide caps are published annually in the Federal Register by the Department of Health and Human Services. For fiscal year 2009, New York's statewide DSH cap for federal matching funds was $1.619 billion.

Under the facility-specific cap, or hospital-specific cap, states may not make payments to any hospital that exceeds that hospital's uncompensated care costs. In this respect, uncompensated care costs include only the costs of serving Medicaid and uninsured patients minus any payments received. Bad debts for patients who have insurance may not be included when calculating uncompensated care for the purposes of the facility-specific cap.

Upper Payment Limits

States have an additional limit on how much they may pay to each class of institution, called "upper payment limits" or UPL. The federal government does not allow a state to pay more, in aggregate, for all services rendered by all institutions within a class of institutions than what those institutions would have received under Medicare payment principles.[9] Any payments made above these limits are not eligible for a federal match.

Hospitals are subject to two UPLs – one for inpatient care and one for outpatient care. To determine the applicable UPL, each type of institution is further divided into the following three classes of ownership: (1) state-owned public institutions, (2) non-state-owned public institutions, and (3) private institutions.

Hospitals are subject to different UPLs depending on the class of ownership, and the type of care. For example:

	State-Owned Public	Non-State-Owned Public	Private
Inpatient Hospital Care	UPL 1	UPL 3	UPL 5
Outpatient Hospital Care	UPL 2	UPL 4	UPL 6

While UPLs were originally intended as a mechanism to control costs, states have since re-appropriated this provision in order to allow them to make additional payments to providers.[10] Because the regulations state that aggregate payments to a hospital class above the UPL are not eligible for a federal match, states have taken the position that they may make lump-sum payments to any provider on top of their standard reimbursement as long as the state does not go over the total amount that Medicare would have paid for all services rendered by a class of institutions.[11] As the UPL is tied to services rendered by a class of hospitals, versus individual hospitals, states have a significant amount of discretion in allocating these supplemental payments among hospitals within a class – including payments to single institutions that exceed costs incurred by those institutions.

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1 Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35.

2 R. Mayes & R. Berenson, "Medicare Prospective Payment and the Shaping of U.S. Healthcare," Baltimore: Johns Hopkins University Press, 2006:2.

3 42 U.S.C. §1396r-4.

4 The low-income utilization rate is based on the proportion of hospital revenue that can be attributed to Medicaid payments and cash subsidies from the state, plus the proportion of inpatient charges that can be attributed to financial assistance, net of any cash subsidies from the state. 42 U.S.C. §1396r-4(b)(3).

5 42 U.S.C. §1396r-4(c)(3)(B).

6 State limits on federal financial participation were enacted through the Medicaid Voluntary Contribution and Provider-specific Tax Amendments of 1991, Pub. L. No. 102-234. The hospital-specific limits were enacted through the Omnibus Budget Reconciliation Act of 1993, Pub L. No. 103-66, §13621(b)(1).

7 42 U.S.C. §1396r-4(f)(3).

8 42 U.S.C. §1396r-4(f)(3)(b).

9 42 C.F.R. §447.272(b) (defining upper payment limits for inpatient care); 42 C.F.R. §447.321(b)(1) (defining upper payment limit payments for outpatient care).

10 T. Coughlin, B. Bruen & J. King, "States' Use of Medicaid UPL and DSH Financing Mechanisms," Health Affairs, Vol. 23 (2), pp. 245-257.

11 For a description of the use of UPL payments, see U.S. Government Accountability Office, "CMS Needs More Information on the Billions of Dollars Spent on Supplemental Payments," Pub. No. GAO-08-614.

Appendix C: Full Hospital Tables

Table 1 – Financial Assistance Applications Approved in 2008 vs. Indigent Care Funds Received in 2010, ALL Hospitals

Hospital Name	FA applications approved (2008)	2010 ICP funds received per 2008 approved application	# 2008 applications approved per 2011 certified bed
City Hospital Center At Elmhurst	83,259	$90	152.8
Kings County Hospital Center	75,562	$203	108.7
Bellevue Hospital Center	69,636	$208	76.4
Lincoln Medical & Mental Health Center	64,006	$150	184.5
Woodhull Medical & Mental Health Center	59,045	$136	149.9
Jacobi Medical Center	52,702	$167	115.3
St Barnabas Hospital	51,210	$561	114.8
Queens Hospital Center	42,863	$151	164.2
Metropolitan Hospital Center	41,646	$175	114.7
Harlem Hospital Center	37,259	$221	130.3
Coney Island Hospital	33,846	$123	91.2
Nassau Medical Center	30,570	$243	57.7
Lutheran Medical Center	29,761	$1,273	63.6
North Central Bronx Hospital	25,740	$188	120.8
North Shore University Hospital	24,141	$1,157	29.7
New York Presbyterian	21,212	$2,370	9.2
Bronx-Lebanon Hospital Center	18,549	$3,235	32.0
Good Samaritan Hospital Medical Center	17,539	$484	40.1
Vassar Brothers Hospital	15,691	$380	43.0
Strong Memorial Hospital	15,480	$870	20.9
Mount Sinai Hospital	15,040	$1,683	12.8
Long Island Jewish Medical Center	13,273	$1,465	15.1
NY Eye And Ear Infirmary	13,160	$613	190.7
Nyack Hospital	11,386	$224	30.4
Southside Hospital	10,820	$729	31.7
Mercy Hospital	8,583	$369	22.2
Mercy Medical Center	7,774	$839	20.7
Wyckoff Heights Hospital	7,480	$2,742	23.1
Westchester Medical Center	7,206	$1,132	11.3
University Hospital Of Brooklyn	6,693	$809	17.8
Seton Health Systems Inc	6,365	$356	32.5
Park Ridge Hospital	6,355	$1,043	19.3
St Francis Hospital Of Poughkeepsie	6,247	$689	18.8
Huntington Hospital	5,771	$651	14.1
Comm Hosp Glen Cove/North Shore Univ	5,190	$878	19.6
Joint Diseases Nor/North Gen H*	4,802	$1,581	N/A
St Lukes Roosevelt Hospital	4,744	$7,935	9.4

Hospital Name	FA applications approved (2008)	2010 ICP funds received per 2008 approved application	# 2008 applications approved per 2011 certified bed
Franklin Hospital Medical Center	4,637	$966	15.2
North Shore Univ Hosp At Forest Hills	4,159	$710	13.3
St Charles Hospital	4,159	$728	18.0
Erie County Medical Center	3,706	$1,137	6.7
St Catherine Of Siena	3,670	$498	11.5
Booth Memorial/NY H Med Ctr Of Queen	3,546	$2,255	8.1
North Shore University Hosp At Plain	3,510	$505	17.2
Nassau Hospital/Winthrop Univ H	3,293	$2,322	5.6
Our Lady Of Lourdes Memorial Hospital In	3,102	$1,220	11.6
Kenmore Mercy Hospital	3,078	$308	16.7
St Luke's-Cornwall Hospital	2,981	$1,358	28.9
Highland Hospital	2,979	$1,938	11.4
St Joseph Hospital Of Cheektowaga	2,931	$199	14.4
Putnam Hospital Center	2,683	$889	16.4
House Good Samaritan/Samaritan Med Ctr	2,588	$906	8.8
United Health Services Hospitals Inc	2,379	$3,365	5.0
Montefiore Medical Center	2,287	$21,093	2.0
Maimonides Medical Center	2,260	$7,870	3.2
Interfaith Medical Center	2,012	$7,547	7.0
Brooklyn Hospital Center	1,981	$5,392	4.3
Church Charity Found/Episcopal Health	1,943	$2,470	7.6
Northern Dutchess Hospital	1,930	$793	28.4
Long Beach Medical Center	1,911	$1,882	11.8
St Vincents Hospital & Medical Center*	1,844	$11,528	N/A
St Francis Hospital Of Roslyn	1,843	$1,256	5.1
St Peters Hospital	1,759	$3,383	4.0
South Nassau Communities Hospital	1,556	$3,516	3.6
Mount Vernon Hospital	1,553	$6,774	8.8
Albany Medical Center Hospital	1,384	$5,315	2.2
St Josephs Hospital Health Center - Syracuse	1,382	$4,294	3.2
Benedictine Hospital	1,380	$2,616	9.2
Jamaica Hospital Medical Center	1,365	$26,292	3.6
New Rochelle H Med/Sound Shore Med Ctr	1,341	$8,053	5.3
Phelps Memorial Hospital Association	1,314	$1,383	5.5
University Hospital Stony Brook	1,243	$5,104	2.2
John T Mather Memorial Hospital Of Port	1,199	$1,955	5.2
Astoria General/Western Queens Com H/Mount Sinai H-Queens	1,187	$5,340	5.1
Nathan Littauer Hospital	1,120	$2,004	15.1
St Marys Hospital At Amsterdam	1,089	$1,306	7.6
Glens Falls Hospital	1,043	$6,061	2.5
Mount St Marys Hospital Of Niagara Falls	1,022	$762	5.8
Faxton - St Lukes Memorial Hosp Ctr	1,002	$2,761	2.7
TLC Healthcare	989	$1,714	12.5

Hospital Name	FA applications approved (2008)	2010 ICP funds received per 2008 approved application	# 2008 applications approved per 2011 certified bed
St Elizabeth Hospital	975	$2,059	4.9
Brookhaven Memorial Hospital Med Cen	856	$8,973	2.8
Southampton Hospital	851	$1,987	6.8
Long Island College Hospital	841	$9,896	1.7
Northern Westchester Hospital	826	$1,732	3.5
Saratoga Hospital	824	$2,809	4.8
St Johns Riverside Hospital	815	$7,593	2.2
St James Mercy Hospital	778	$1,893	5.0
Cortland Memorial Hospital Inc	776	$1,885	4.4
Memorial Hospital For Cancer & Allied Di	726	$15,512	1.4
Crouse-Irving Memorial Hospital	718	$9,001	1.4
Beth Israel Medical Center - Petrie Camp	691	$41,065	0.8
Kaleida Health	683	$8,782	0.7
Inter-Community Memorial Hospital At New	679	$802	9.6
Medina Memorial Hospital	668	$777	9.5
Oswego Hospital	662	$2,634	4.0
Catskill Regional Hospital - Harris	647	$14,580	3.9
Mary Imogene Bassett Hospital	625	$5,740	3.5
Genesee Memorial/United Memorial Hosp	624	$1,555	4.8
Rochester General Hospital	620	$20,176	1.2
Aurelia Osborn Fox Memorial Hospital	582	$2,930	5.8
Community-Gen Hospital Of Greater Sy	576	$2,457	1.9
Brooks Memorial Hospital	569	$1,067	8.8
Woman's Christian Association	568	$3,135	1.7
Ellis Hospital	546	$12,120	1.2
F F Thompson Hospital	532	$1,752	4.7
Lawrence Hospital	529	$3,182	1.8
New York Methodist Hospital	509	$15,017	0.9
Cuba Memorial Hospital Inc	503	$1,632	83.8
New York Downtown Hospital	491	$14,664	2.7
Samaritan Hospital	486	$4,900	2.0
Lewis County General Hospital	471	$1,994	8.7
Champlain Valley Physicians Hospital Med	469	$4,645	1.5
Albert Lindley Lee Memorial Hospital*	449	$3,511	6.7
Geneva General Hospital	429	$3,572	3.3
Summit Park Hospital-Rockland County Inf	401	$7,326	3.7
Lockport Memorial Hospital	381	$1,119	2.8
State University Hospital Upstate Medica	381	$10,184	0.9
Hospital For Special Surgery	369	$6,177	2.0
St Josephs Hospital Of Elmira	364	$3,356	1.6
Kingston Hospital	335	$21,185	2.0
White Plains Hospital Center	330	$7,939	1.1
Oneida City Hospital	329	$3,365	3.3

Hospital Name	FA applications approved (2008)	2010 ICP funds received per 2008 approved application	# 2008 applications approved per 2011 certified bed
New Island Hospital	322	$9,296	1.6
Columbia Memorial Hospital	321	$7,152	1.7
Nicholas H Noyes Memorial Hospital	316	$2,843	4.4
Massena Memorial Hospital	316	$4,000	6.3
Arden Hill Hospital/Orange Reg Med Ctr	312	$8,905	0.7
Westfield Memorial Hospital Inc	299	$1,053	74.8
Niagara Falls Memorial Medical Center	288	$6,455	1.7
Brookdale Hospital Medical Center	278	$93,929	0.5
Clifton Springs Hospital And Clinic	271	$1,891	1.8
Claxton-Hepburn Medical Center	269	$3,484	2.1
Canton-Potsdam Hospital	264	$4,394	2.8
NYU Medical Center - Tisch & Rusk	256	$41,984	0.2
Adirondack Medical Center-Lake Placid &	247	$7,894	2.5
Schuyler Hospital	241	$3,115	9.6
Arnot Ogden Medical Center	239	$7,563	1.1
Kingsbrook Jewish Medical Center	236	$11,957	0.7
Soldiers & Sailors Memorial Hospital Of	234	$4,058	6.7
Alice Hyde Memorial Hospital	233	$5,405	3.1
Auburn Memorial Hospital	221	$5,342	2.2
Chenango Memorial Hospital Inc	216	$9,576	3.7
Hudson Valley Hospital Center	211	$9,606	1.6
Community Memorial Hospital Inc	200	$4,227	5.0
Central Suffolk Hospital	182	$11,583	1.5
Rome Memorial Hospital Inc	174	$6,321	1.2
Corning Hospital	161	$13,892	1.6
Ira Davenport Memorial Hospital Inc	159	$8,394	4.2
Coler Memorial Hospital	157	$14,103	0.7
Goldwater Memorial Hospital	157	$20,457	0.4
St Josephs Medical Center - Yonkers	157	$105,216	0.8
Mem Hospital Of Wm F & Gertrude F Jones	153	$5,358	2.2
Roswell Park Memorial Institute	151	$14,749	1.1
Peninsula Hospital Center	145	$30,259	0.8
Albany Memorial Hospital	134	$10,314	0.8
Newark-Wayne Comm/Viahealth Of Wayne	130	$20,345	1.1
Lenox Hill Hospital	130	$84,469	0.2
Edward John Noble Hospital-Gouverneur	129	$4,512	2.7
Calvary Hospital Inc	121	$5,644	0.5
NY Westchester Square Medical Center	120	$10,063	0.9
Olean General Hospital West	118	$15,854	0.6
Beth Israel Medical Center - Kings Highw	112	$11,657	0.5
Cayuga Medical Center At Ithaca	109	$18,731	0.5
Community Hosp Brooklyn	108	$6,921	0.8
Elizabethtown Community Hospital	98	$4,545	6.5

Hospital Name	FA applications approved (2008)	2010 ICP funds received per 2008 approved application	# 2008 applications approved per 2011 certified bed
Carthage Area Hospital Inc	85	$8,081	1.8
Sheehan Memorial Hospital	84	$7,631	1.7
Bassett Reg Hosp Of Schoharie Count	82	$11,616	2.1
Childrens Hosp/Kaleida Health W & C	82	$39,033	0.4
Lakeside Memorial Hospital	79	$5,369	1.3
Little Falls Hospital	79	$10,721	3.2
River Hospital	62	$8,884	4.1
Sunnyview Hospital And Rehabilitation Ctr	53	$2,673	0.5
Margaretville Memorial Hospital	48	$11,429	3.2
Wyoming County Community Hospital	47	$16,307	0.5
Flushing Hospital And Medical Center	40	$217,406	0.1
Moses-Ludington Hospital	31	$14,439	2.1
Clifton-Fine Hospital	29	$7,145	1.5
O'Connor Hospital	25	$18,182	1.1
Tri Town Regional Hospital	23	$26,761	5.8
Delaware Valley Hospital Inc	19	$29,520	0.8
Burke Rehabilitation Hospital Inc	18	$9,768	0.1
Community Hospital At Dobbs Ferry	18	$13,312	1.5
Ellenville Community Hospital	12	$150,239	0.5
Eastern Long Island Hospital	10	$105,592	0.1
Albany Med Center Hosp - South Campus	8	$94,812	0.4
Helen Hayes Hospital	6	$244,543	0.0
Blythedale Childrens Hospital	5	$289,765	0.1
Amsterdam Memorial Hospital	0	$0	0.0
Bertrand Chaffee Hospital	0	$0	0.0
Catskill Regional Hospital - Herman	0	$0	0.0
Good Samaritan Hospital Of Suffern	0	$0	0.0
Manhattan Eye Ear And Throat Hospital*	0	$0	0.0
Bon Secours Community Hospital	0	$0	0.0
Monroe Community Hospital	0	$0	0.0
Richmond University	0	$0	0.0
Rockefeller University Hospital	0	$0	0.0
Sisters Of Charity Hospital	0	$0	0.0
St Anthony Community Hospital	0	$0	0.0
Staten Island University Hospital	0	$0	0.0

*Hospital has since closed or merged with another

Table 2 – Uncompensated Care Costs Due to Bad Debt and Financial Assistance Applications Approved

Hospital Name	% uncompensated care costs due to bad debt (2008)	Indigent Care pool payment (2010)	2008 Applications approved per certified bed
Amsterdam Memorial Hospital	100.0%	$213,735	0.0
Blythedale Childrens Hospital	100.0%	$1,448,824	0.1
Helen Hayes Hospital	100.0%	$1,467,256	0.0
Sheehan Memorial Hospital	100.0%	$641,038	1.7
Sunnyview Hosp And Rehab Ctr	100.0%	$141,678	0.5
Delaware Valley Hospital Inc	98.3%	$560,887	0.8
Medina Memorial Hospital	98.1%	$518,795	9.5
Calvary Hospital Inc	97.6%	$682,959	0.5
Peninsula Hospital Center	97.0%	$4,387,609	0.8
Ellis Hospital	96.5%	$6,617,457	1.2
University Hospital Stony Brook	96.0%	$6,344,162	2.2
Central Suffolk Hospital	95.6%	$2,108,196	1.5
NY Westchester Sq Med Ctr	95.4%	$1,207,509	0.9
Wyoming County Comm Hospital	95.1%	$766,426	0.5
Tri Town Regional Hospital	94.9%	$615,499	5.8
Columbia Memorial Hospital	94.6%	$2,295,884	1.7
Little Falls Hospital	94.5%	$846,962	3.2
Cayuga Medical Center At Ithaca	93.7%	$2,041,718	0.5
State University Hosp Upstate Med	93.5%	$3,879,924	0.9
Cortland Memorial Hospital Inc	93.2%	$1,462,926	4.4
Albany Med Ctr Hosp - South Campus	93.1%	$758,492	0.4
Burke Rehabilitation Hospital Inc	92.9%	$175,826	0.1
Glens Falls Hospital	92.2%	$6,321,820	2.5
O'Connor Hospital	91.9%	$454,547	1.1
Moses-Ludington Hospital	91.6%	$447,611	2.1
Olean General Hospital West	91.5%	$1,870,798	0.6
NYU Medical Center - Tisch & Rusk	90.3%	$10,747,952	0.2
Corning Hospital	90.3%	$2,236,620	1.6
Alice Hyde Memorial Hospital	90.2%	$1,259,410	3.1
Niagara Falls Mem Medical Ctr	90.2%	$1,858,979	1.7
Brooklyn Hospital Center	89.9%	$10,681,623	4.3
Beth Israel Med Ctr - Kings Highw	89.6%	$1,305,601	0.5
Beth Israel Med Ctr - Petrie Camp	89.5%	$28,375,694	0.8
Bassett Reg Hosp - Schoharie Count	89.4%	$952,517	2.1
Jamaica Hospital Medical Center	89.2%	$35,889,008	3.6
St Josephs Hospital Of Elmira	89.0%	$1,221,417	1.6
Our Lady Of Lourdes Mem Hosp In	88.8%	$3,785,336	11.6
Faxton - St Lukes Mem Hosp Ctr	88.2%	$2,766,992	2.7
Lakeside Memorial Hospital	88.0%	$424,143	1.3
Arden Hill Hosp/Orange Reg Med Ctr	87.9%	$2,778,459	0.7
Oneida City Hospital	87.5%	$1,107,006	3.3

Hospital Name	% uncompensated care costs due to bad debt (2008)	Indigent Care pool payment (2010)	2008 Applications approved per certified bed
Chenango Memorial Hospital Inc	86.9%	$2,068,429	3.7
Edward John Noble Hosp-Gouverneur	86.6%	$582,034	2.7
F F Thompson Hospital	86.6%	$932,249	4.7
Lawrence Hospital	86.5%	$1,683,094	1.8
Bertrand Chaffee Hospital	85.9%	$412,954	0.0
TLC Healthcare	85.9%	$1,694,701	12.5
Woman's Christian Association	85.8%	$1,780,561	1.7
Brookdale Hospital Medical Center	85.3%	$26,112,334	0.5
Carthage Area Hospital Inc	85.2%	$686,873	1.8
University Hospital Of Brooklyn	85.2%	$5,411,530	17.8
John T Mather Memorial Hosp Of Port	84.9%	$2,344,368	5.2
Nassau Medical Center	84.7%	$7,434,717	57.7
Claxton-Hepburn Medical Center	83.8%	$937,262	2.1
Auburn Memorial Hospital	82.9%	$1,180,685	2.2
Inter-Community Mem Hosp At New	82.5%	$544,775	9.6
Childrens Hosp/Kaleida Health W & C	82.3%	$3,200,737	0.4
Brookhaven Mem Hosp Medical Cen	82.1%	$7,680,614	2.8
Nathan Littauer Hospital	81.9%	$2,244,666	15.1
Community Hospital At Dobbs Ferry	81.7%	$239,621	1.5
River Hospital	81.7%	$550,778	4.1
New York Downtown Hospital	81.5%	$7,200,129	2.7
Community Memorial Hospital Inc	81.4%	$845,368	5.0
Ellenville Community Hospital	81.3%	$1,802,865	0.5
Rochester General Hospital	81.2%	$12,509,009	1.2
Adirondack Med Center-Lake Placid &	81.1%	$1,949,939	2.5
Long Island College Hospital	81.0%	$8,322,517	1.7
Community-Gen Hosp Of Greater Syracuse	81.0%	$1,414,971	1.9
White Plains Hospital Center	79.3%	$2,619,916	1.1
Rome Memorial Hospital Inc	79.2%	$1,099,806	1.2
Lockport Memorial Hospital	79.1%	$426,516	2.8
Community Hosp Brookl	78.5%	$747,457	0.8
Champlain Valley Physicians Hosp Med	78.0%	$2,178,680	1.5
United Health Services Hospitals Inc	77.9%	$8,005,842	5.0
Samaritan Hospital	77.8%	$2,381,331	2.0
Genesee Mem/United Mem Hosp	77.8%	$970,603	4.8
Ira Davenport Memorial Hospital Inc	77.7%	$1,334,669	4.2
Aurelia Osborn Fox Mem Hospital	77.6%	$1,705,100	5.8
Albany Memorial Hospital	77.1%	$1,382,058	0.8
St Marys Hospital At Amsterdam	76.8%	$1,422,371	7.6
Clifton Springs Hospital And Clinic	76.5%	$512,412	1.8
Elizabethtown Community Hospital	76.4%	$445,441	6.5
Highland Hospital	76.1%	$5,773,225	11.4
Margaretville Memorial Hospital	75.2%	$548,606	3.2

Hospital Name	% uncompensated care costs due to bad debt (2008)	Indigent Care pool payment (2010)	2008 Applications approved per certified bed
Canton-Potsdam Hospital	75.0%	$1,159,957	2.8
Wyckoff Heights Hospital	74.9%	$20,510,496	23.1
St Peters Hospital	74.8%	$5,950,863	4.0
St Elizabeth Hospital	74.2%	$2,007,104	4.9
St Lukes Roosevelt Hospital	74.1%	$37,643,016	9.4
New Island Hospital	74.0%	$2,993,189	1.6
Kaleida Health	73.9%	$5,998,201	0.7
Brooks Memorial Hospital	73.8%	$606,969	8.8
Schuyler Hospital	73.5%	$750,615	9.6
Newark-Wayne Comm/Viahealth-Wayne	72.3%	$2,644,805	1.1
Oswego Hospital	72.2%	$1,743,461	4.0
Arnot Ogden Medical Center	71.9%	$1,807,545	1.1
Nicholas H Noyes Memorial Hospital	71.5%	$898,340	4.4
Geneva General Hospital	70.9%	$1,532,462	3.3
House Good Sam/Samaritan Med Ctr	70.9%	$2,343,934	8.8
Park Ridge Hospital	70.6%	$6,626,999	19.3
St James Mercy Hospital	70.6%	$1,472,765	5.0
Eastern Long Island Hospital	70.2%	$1,055,918	0.1
Mem Hosp Of Wm F & Gertrude F Jones	69.8%	$819,836	2.2
Mary Imogene Bassett Hospital	69.6%	$3,587,503	3.5
Westfield Memorial Hospital Inc	69.3%	$314,937	74.8
Southampton Hospital	69.1%	$1,691,011	6.8
Roswell Park Memorial Institute	68.9%	$2,227,030	1.1
Crouse-Irving Memorial Hospital	68.4%	$6,462,589	1.4
Hospital For Special Surgery	67.9%	$2,279,227	2.0
Soldiers & Sailors Mem Hospital Of	67.7%	$949,561	6.7
Albany Medical Center Hospital	66.9%	$7,355,289	2.2
Mount Sinai Hospital	66.9%	$25,310,172	12.8
St Anthony Community Hospital	66.5%	$487,496	0.0
Clifton-Fine Hospital	66.5%	$207,209	1.5
St Josephs Hosp Health Ctr - Syracuse	66.4%	$5,934,891	3.2
Kingsbrook Jewish Med Center	66.3%	$2,821,757	0.7
Bronx-Lebanon Hospital Center	63.7%	$60,004,354	32.0
Lincoln Med & Mental Hlth Ctr	61.7%	$9,606,604	184.5
Long Beach Medical Center	61.6%	$3,596,842	11.8
Massena Memorial Hospital	60.1%	$1,263,935	6.3
Strong Memorial Hospital	60.0%	$13,461,258	20.9
Summit Park Hosp-Rockland Cty Inf	58.4%	$2,937,870	3.7
Flushing Hospital And Medical Center	58.2%	$8,696,237	0.1
Jacobi Medical Center	58.1%	$8,797,515	115.3
NY Eye And Ear Infirmary	57.6%	$8,063,298	190.7
Astoria Gen/West Qns Com H/Mt Sinai-Qns	56.7%	$6,338,734	5.1
North Central Bronx Hospital	56.5%	$4,845,131	120.8

Hospital Name	% uncompensated care costs due to bad debt (2008)	Indigent Care pool payment (2010)	2008 Applications approved per certified bed
St Josephs Medical Center - Yonkers	56.1%	$16,518,883	0.8
St Johns Riverside Hospital	56.0%	$6,188,646	2.2
Bon Secours Community Hospital	55.7%	$3,146,112	0.0
Nassau Hospital/Winthrop Univ H	55.4%	$7,645,244	5.6
Erie County Medical Center	54.3%	$4,213,019	6.7
Queens Hospital Center	53.7%	$6,484,084	164.2
South Nassau Communities Hospital	53.5%	$5,471,205	3.6
Church Charity Fnd/Episcopal Hlth Ser	53.1%	$4,800,095	7.6
Harlem Hospital Center	52.9%	$8,244,813	130.3
Seton Health Systems Inc	51.4%	$2,267,885	32.5
St Joseph Hospital Of Cheektowaga	51.2%	$583,283	14.4
Good Samaritan Hospital Of Suffern	50.7%	$4,742,680	0.0
Kingston Hospital	50.6%	$7,096,970	2.0
Booth Memorial/NY H Med Ctr Of Queen	50.3%	$7,997,890	8.1
Kings County Hospital Center	50.0%	$15,311,814	108.7
Kenmore Mercy Hospital	49.9%	$947,769	16.7
Mount Vernon Hospital	48.6%	$10,519,805	8.8
Benedictine Hospital	48.2%	$3,609,954	9.2
Westchester Medical Center	47.7%	$8,155,289	11.3
Northern Westchester Hospital	47.1%	$1,431,028	3.5
Saratoga Hospital	46.7%	$2,314,574	4.8
Mercy Hospital	46.1%	$3,170,646	22.2
Lewis County General Hospital	46.1%	$939,321	8.7
Bellevue Hospital Center	45.5%	$14,493,110	76.4
St Francis Hospital Of Poughkeepsie	44.8%	$4,304,773	18.8
Interfaith Medical Center	44.6%	$15,184,018	7.0
Metropolitan Hospital Center	43.9%	$7,294,829	114.7
Coler Memorial Hospital	43.5%	$2,214,115	0.7
Catskill Regional Hospital - Herman	43.1%	$558,104	0.0
Joint Diseases Nor/North Gen H*	42.3%	$7,592,009	N/A
Woodhull Med & Mental Health Ctr	41.7%	$8,013,809	149.9
Cuba Memorial Hospital Inc	41.4%	$820,807	83.8
Richmond University	40.2%	$9,038,402	0.0
Putnam Hospital Center	40.0%	$2,385,719	16.4
Goldwater Memorial Hospital	39.3%	$3,211,714	0.4
Lutheran Medical Center	37.2%	$37,882,759	63.6
Mount St Marys Hosp Of Niagara Falls	36.9%	$778,614	5.8
City Hospital Center At Elmhurst	36.1%	$7,525,677	152.8
New York Methodist Hospital	36.0%	$7,643,536	0.9
Nyack Hospital	35.7%	$2,550,517	30.4
Catskill Regional Hospital - Harris	34.7%	$9,433,473	3.9
Maimonides Medical Center	34.6%	$17,785,846	3.2
New Rochelle H. Med./Snd Shore Med Ctr	34.2%	$10,798,541	5.3

Hospital Name	% uncompensated care costs due to bad debt (2008)	Indigent Care pool payment (2010)	2008 Applications approved per certified bed
Vassar Brothers Hospital	33.2%	$5,961,049	43.0
Northern Dutchess Hospital	32.0%	$1,530,256	28.4
Coney Island Hospital	31.9%	$4,160,312	91.2
St Luke's-Cornwall Hospital	30.7%	$4,047,879	28.9
St Vincents Hospital & Medical Center*	30.3%	$21,256,945	N/A
Sisters Of Charity Hospital	29.7%	$3,864,891	0.0
Lenox Hill Hospital	28.9%	$10,981,005	0.2
Hudson Valley Hospital Center	28.9%	$2,026,842	1.6
New York Presbyterian	28.4%	$50,267,593	9.2
Phelps Memorial Hospital Association	26.4%	$1,817,798	5.5
St Catherine Of Siena	25.1%	$1,827,894	11.5
Huntington Hospital	23.6%	$3,759,643	14.1
Memorial Hosp For Cancer & Allied Di	23.1%	$11,261,372	1.4
Montefiore Medical Center	22.7%	$48,239,368	2.0
Franklin Hospital Medical Center	21.2%	$4,481,604	15.2
North Shore Univ Hosp At Forest Hills	21.1%	$2,954,199	13.3
Southside Hospital	20.3%	$7,891,002	31.7
Comm Hosp Glen Cove/North Shore Univ	19.6%	$4,558,465	19.6
Long Island Jewish Medical Center	18.1%	$19,447,249	15.1
North Shore University Hospital	17.6%	$27,931,321	29.7
St Francis Hospital Of Roslyn	17.6%	$2,314,472	5.1
North Shore University Hosp At Plain	17.4%	$1,771,506	17.2
St Barnabas Hospital	16.6%	$28,708,796	114.8
Mercy Medical Center	16.0%	$6,520,620	20.7
Good Samaritan Hosp Medical Ctr	15.7%	$8,480,429	40.1
St Charles Hospital	14.6%	$3,029,229	18.0
Staten Island University Hospital	8.9%	$17,629,325	0.0
Albert Lindley Lee Memorial Hospital*	N/A	$1,576,514	6.7
Manhattan Eye Ear And Throat Hospital*	N/A	$0	N/A
Monroe Community Hospital	N/A	$0	0.0
Rockefeller University Hospital	N/A	$93,008	0.0

*Hospital has since closed or merged with another

Table 3 – Hospital Liens Placed and Financial Assistance Provided

Hospital Name	Total Liens on Primary Residences (2008)	2008 Liens per 2011 Certified beds	2008 Applications Approved per 2011 Certified Bed	% of 2008 Uncompensated Costs Due to Bad Debt	Indigent Care Pool Funds Received (2010)
Univ Hosp Bklyn/Suny Dwnst	1053	2.80	17.8	85%	$5,411,530
Univ Hosp Stony Brook	680	1.19	2.2	96%	$6,344,162
Saratoga Hospital	450	2.63	4.8	47%	$2,314,574
Good Sam Hosp Med Ctr	406	0.93	40.1	16%	$8,480,429
Massena Memorial Hosp	249	4.98	6.3	60%	$1,263,935
Crouse-Irving Mem Hosp	92	0.18	1.4	68%	$6,462,589
Brooks Memorial Hosp	77	1.18	8.8	74%	$606,969
Vassar Brothers Hosp	72	0.20	43.0	33%	$5,961,049
Roswell Park Mem Inst	71	0.53	1.1	69%	$2,227,030
United Health Svcs Hosp Inc	70	0.15	5.0	78%	$8,005,842
St Francis Hosp-Poughkeepsie	68	0.20	18.8	45%	$4,304,773
St Josephs Hospital Of Elmira	66	0.29	1.6	89%	$1,221,417
Cortland Memorial Hospital Inc	66	0.37	4.4	93%	$1,462,926
Niagara Falls Memorial Medical Center	63	0.37	1.7	90%	$1,858,979
Arden Hill Hospital/Orange Regional Med Ctr	52	0.12	0.7	88%	$2,778,459
Champlain Valley Physicians Hospital Med	51	0.16	1.5	78%	$2,178,680
Erie County Medical Center	44	0.08	6.7	54%	$4,213,019
Nathan Littauer Hospital	38	0.51	15.1	82%	$2,244,666
Our Lady Of Lourdes Memorial Hospital In	37	0.14	11.6	89%	$3,785,336
Putnam Hospital Center	37	0.23	16.4	40%	$2,385,719
Kingston Hospital	32	0.19	2.0	51%	$7,096,970
Chenango Memorial Hospital Inc	30	0.52	3.7	87%	$2,068,429
Aurelia Osborn Fox Memorial Hospital	28	0.28	5.8	78%	$1,705,100
Samaritan Hospital	23	0.10	2.0	78%	$2,381,331
New Rochelle H. Med./Sound Shore Med Ctr	20	0.08	5.3	34%	$10,798,541
St Peters Hospital	19	0.04	4.0	75%	$5,950,863
Woman's Christian Association	19	0.06	1.7	86%	$1,780,561
Benedictine Hospital	18	0.12	9.2	48%	$3,609,954
Albany Memorial Hospital	16	0.10	0.8	77%	$1,382,058
Nassau Hospital/Winthrop Univ H	16	0.03	5.6	55%	$7,645,244
North Shore University Hospital	13	0.02	29.7	18%	$27,931,321
Northern Dutchess Hospital	11	0.16	28.4	32%	$1,530,256
St Charles Hospital	10	0.04	18.0	15%	$3,029,229
Community Memorial Hospital Inc	9	0.23	5.0	81%	$845,368
Long Island Jewish Medical Center	9	0.01	15.1	18%	$19,447,249
Albany Medical Center Hospital	8	0.01	2.2	67%	$7,355,289
Mount Vernon Hospital	7	0.04	8.8	49%	$10,519,805
O'Connor Hospital	6	0.26	1.1	92%	$454,547
Franklin Hospital Medical Center	6	0.02	15.2	21%	$4,481,604
Queens Hospital Center	5	0.02	164.2	54%	$6,484,084
Southside Hospital	5	0.01	31.7	20%	$7,891,002

Hospital Name	Total Liens on Primary Residences (2008)	2008 Liens per 2011 Certified beds	2008 Applications Approved per 2011 Certified Bed	% of 2008 Uncompensated Costs Due to Bad Debt	Indigent Care Pool Funds Received (2010)
Medina Memorial Hospital	3	0.04	9.5	98%	$518,795
St James Mercy Hospital	3	0.02	5.0	71%	$1,472,765
City Hospital Center At Elmhurst	3	0.01	152.8	36%	$7,525,677
North Shore University Hosp At Plain	3	0.01	17.2	17%	$1,771,506
Comm Hosp Glen Cove/North Shore Univ	2	0.01	19.6	20%	$4,558,465
Coney Island Hospital	1	0.00	91.2	32%	$4,160,312
North Shore Univ Hosp At Forest Hills	1	0.00	13.3	21%	$2,954,199
Kings County Hospital Center	1	0.00	108.7	50%	$15,311,814
Albert Lindley Lee Memorial Hospital*	0	0.00	6.7	N/A	$1,576,514
Bertrand Chaffee Hospital	0	0.00	0.0	86%	$412,954
Childrens Hosp/Kaleida Health W & C	0	0.00	0.4	82%	$3,200,737
Cuba Memorial Hospital Inc	0	0.00	83.8	41%	$820,807
Geneva General Hospital	0	0.00	3.3	71%	$1,532,462
Inter-Community Memorial Hospital At New	0	0.00	9.6	83%	$544,775
Kaleida Health	0	0.00	0.7	74%	$5,998,201
Kenmore Mercy Hospital	0	0.00	16.7	50%	$947,769
Lockport Memorial Hospital	0	0.00	2.8	79%	$426,516
Memorial Hospital Of Wm F & Gertrude F Jones	0	0.00	2.2	70%	$819,836
Mercy Hospital	0	0.00	22.2	46%	$3,170,646
Mount St Marys Hospital Of Niagara Falls	0	0.00	5.8	37%	$778,614
New York Methodist Hospital	0	0.00	0.9	36%	$7,643,536
Olean General Hospital West	0	0.00	0.6	91%	$1,870,798
Sisters Of Charity Hospital	0	0.00	0.0	30%	$3,864,891
St Joseph Hospital Of Cheektowaga	0	0.00	14.4	51%	$583,283
Westfield Memorial Hospital Inc	0	0.00	74.8	69%	$314,937
Wyoming County Community Hospital	0	0.00	0.5	95%	$766,426
Alice Hyde Memorial Hospital	0	0.00	3.1	90%	$1,259,410
Clifton Springs Hospital And Clinic	0	0.00	1.8	76%	$512,412
F F Thompson Hospital	0	0.00	4.7	87%	$932,249
Highland Hospital	0	0.00	11.4	76%	$5,773,225
Monroe Community Hospital	0	0.00	0.0	0%	$0
Newark-Wayne Community/Viahealth Of Wayne	0	0.00	1.1	72%	$2,644,805
Nicholas H Noyes Memorial Hospital	0	0.00	4.4	72%	$898,340
Park Ridge Hospital	0	0.00	19.3	71%	$6,626,999
Rochester General Hospital	0	0.00	1.2	81%	$12,509,009
Soldiers & Sailors Memorial Hospital Of	0	0.00	6.7	68%	$949,561
Strong Memorial Hospital	0	0.00	20.9	60%	$13,461,258
Arnot Ogden Medical Center	0	0.00	1.1	72%	$1,807,545
Auburn Memorial Hospital	0	0.00	2.2	83%	$1,180,685
Cayuga Medical Center At Ithaca	0	0.00	0.5	94%	$2,041,718
Community-General Hospital Of Greater Sy	0	0.00	1.9	81%	$1,414,971
Edward John Noble Hospital-Gouverneur	0	0.00	2.7	87%	$582,034

Hospital Name	Total Liens on Primary Residences (2008)	2008 Liens per 2011 Certified beds	2008 Applications Approved per 2011 Certified Bed	% of 2008 Uncompensated Costs Due to Bad Debt	Indigent Care Pool Funds Received (2010)
Ira Davenport Memorial Hospital Inc	0	0.00	4.2	78%	$1,334,669
River Hospital	0	0.00	4.1	82%	$550,778
Schuyler Hospital	0	0.00	9.6	74%	$750,615
St Josephs Hospital Health Center - Syracuse	0	0.00	3.2	66%	$5,934,891
State University Hospital Upstate Medica	0	0.00	0.9	93%	$3,879,924
Adirondack Medical Center-Lake Placid &	0	0.00	2.5	81%	$1,949,939
Carthage Area Hospital Inc	0	0.00	1.8	85%	$686,873
Claxton-Hepburn Medical Center	0	0.00	2.1	84%	$937,262
Faxton - St Lukes Memorial Hospital Center	0	0.00	2.7	88%	$2,766,992
House Good Samaritan/Samaritan Med Ctr	0	0.00	8.8	71%	$2,343,934
Lakeside Memorial Hospital	0	0.00	1.3	88%	$424,143
Lenox Hill Hospital	0	0.00	0.2	29%	$10,981,005
Lewis County General Hospital	0	0.00	8.7	46%	$939,321
Little Falls Hospital	0	0.00	3.2	94%	$846,962
Mary Imogene Bassett Hospital	0	0.00	3.5	70%	$3,587,503
Oneida City Hospital	0	0.00	3.3	88%	$1,107,006
Oswego Hospital	0	0.00	4.0	72%	$1,743,461
Rome Memorial Hospital Inc	0	0.00	1.2	79%	$1,099,806
Sheehan Memorial Hospital	0	0.00	1.7	100%	$641,038
TLC Healthcare	0	0.00	12.5	86%	$1,694,701
Albany Medical Center Hospital - South Campus	0	0.00	0.4	93%	$758,492
Amsterdam Memorial Hospital	0	0.00	0.0	100%	$213,735
Bassett Regional Hosp Of Schoharie Count	0	0.00	2.1	89%	$952,517
Canton-Potsdam Hospital	0	0.00	2.8	75%	$1,159,957
Church Charity Found/Episcopal Health Ser Inc	0	0.00	7.6	53%	$4,800,095
Elizabethtown Community Hospital	0	0.00	6.5	76%	$445,441
Ellis Hospital	0	0.00	1.2	97%	$6,617,457
Moses-Ludington Hospital	0	0.00	2.1	92%	$447,611
Seton Health Systems Inc	0	0.00	32.5	51%	$2,267,885
St Marys Hospital At Amsterdam	0	0.00	7.6	77%	$1,422,371
Sunnyview Hospital And Rehabilitation Ctr	0	0.00	0.5	100%	$141,678
Beth Israel Medical Center - Petrie Camp	0	0.00	0.8	89%	$28,375,694
Blythedale Childrens Hospital	0	0.00	0.1	100%	$1,448,824
Burke Rehabilitation Hospital Inc	0	0.00	0.1	93%	$175,826
Catskill Regional Hospital - Harris	0	0.00	3.9	35%	$9,433,473
Catskill Regional Hospital - Herman	0	0.00	0.0	43%	$558,104
Clifton-Fine Hospital	0	0.00	1.5	67%	$207,209
Community Hospital At Dobbs Ferry	0	0.00	1.5	82%	$239,621
Delaware Valley Hospital Inc	0	0.00	0.8	98%	$560,887
Ellenville Community Hospital	0	0.00	0.5	81%	$1,802,865
Good Samaritan Hospital Of Suffern	0	0.00	0.0	51%	$4,742,680
Helen Hayes Hospital	0	0.00	0.0	100%	$1,467,256

Hospital Name	Total Liens on Primary Residences (2008)	2008 Liens per 2011 Certified beds	2008 Applications Approved per 2011 Certified Bed	% of 2008 Uncompensated Costs Due to Bad Debt	Indigent Care Pool Funds Received (2010)
Hudson Valley Hospital Center	0	0.00	1.6	29%	$2,026,842
Lawrence Hospital	0	0.00	1.8	86%	$1,683,094
Bon Secours Community Hospital	0	0.00	0.0	56%	$3,146,112
Northern Westchester Hospital	0	0.00	3.5	47%	$1,431,028
Nyack Hospital	0	0.00	30.4	36%	$2,550,517
Phelps Memorial Hospital Association	0	0.00	5.5	26%	$1,817,798
St Anthony Community Hospital	0	0.00	0.0	67%	$487,496
St Johns Riverside Hospital	0	0.00	2.2	56%	$6,188,646
St Josephs Medical Center - Yonkers	0	0.00	0.8	56%	$16,518,883
St Luke's-Cornwall Hospital	0	0.00	28.9	31%	$4,047,879
Summit Park Hospital-Rockland County Inf	0	0.00	3.7	58%	$2,937,870
Tri Town Regional Hospital	0	0.00	5.8	95%	$615,499
Westchester Medical Center	0	0.00	11.3	48%	$8,155,289
White Plains Hospital Center	0	0.00	1.1	79%	$2,619,916
Astoria General/Western Queens Com H/Mount Sinai H-Queens	0	0.00	5.1	57%	$6,338,734
Bellevue Hospital Center	0	0.00	76.4	46%	$14,493,110
Beth Israel Medical Center - Kings Highw	0	0.00	0.5	90%	$1,305,601
Booth Memorial/NY H Med Ctr Of Queen	0	0.00	8.1	50%	$7,997,890
Bronx-Lebanon Hospital Center	0	0.00	32.0	64%	$60,004,354
Brookdale Hospital Medical Center	0	0.00	0.5	85%	$26,112,334
Brooklyn Hospital Center	0	0.00	4.3	90%	$10,681,623
Calvary Hospital Inc	0	0.00	0.5	98%	$682,959
Coler Memorial Hospital	0	0.00	0.7	43%	$2,214,115
Columbia Memorial Hospital	0	0.00	1.7	95%	$2,295,884
Community Hosp Brooklyn	0	0.00	0.8	78%	$747,457
Corning Hospital	0	0.00	1.6	90%	$2,236,620
Flushing Hospital And Medical Center	0	0.00	0.1	58%	$8,696,237
Genesee Memorial/United Memorial Hospital	0	0.00	4.8	78%	$970,603
Glens Falls Hospital	0	0.00	2.5	92%	$6,321,820
Goldwater Memorial Hospital	0	0.00	0.4	39%	$3,211,714
Harlem Hospital Center	0	0.00	130.3	53%	$8,244,813
Hospital For Special Surgery	0	0.00	2.0	68%	$2,279,227
Interfaith Medical Center	0	0.00	7.0	45%	$15,184,018
Jacobi Medical Center	0	0.00	115.3	58%	$8,797,515
Jamaica Hospital Medical Center	0	0.00	3.6	89%	$35,889,008
Joint Diseases Nor/North Gen H*	0	N/A	N/A	42%	$7,592,009
Kingsbrook Jewish Medical Center	0	0.00	0.7	66%	$2,821,757
Lincoln Medical & Mental Health Center	0	0.00	184.5	62%	$9,606,604
Lutheran Medical Center	0	0.00	63.6	37%	$37,882,759
Maimonides Medical Center	0	0.00	3.2	35%	$17,785,846
Manhattan Eye Ear And Throat Hospital*	0	N/A	N/A	N/A	$0
Margaretville Memorial Hospital	0	0.00	3.2	75%	$548,606

Hospital Name	Total Liens on Primary Residences (2008)	2008 Liens per 2011 Certified beds	2008 Applications Approved per 2011 Certified Bed	% of 2008 Uncompensated Costs Due to Bad Debt	Indigent Care Pool Funds Received (2010)
Memorial Hospital For Cancer & Allied Di	0	0.00	1.4	23%	$11,261,372
Metropolitan Hospital Center	0	0.00	114.7	44%	$7,294,829
Montefiore Medical Center	0	0.00	2.0	23%	$48,239,368
Mount Sinai Hospital	0	0.00	12.8	67%	$25,310,172
New York Downtown Hospital	0	0.00	2.7	82%	$7,200,129
New York Presbyterian	0	0.00	9.2	28%	$50,267,593
New York University Medical Center - Tisch & Rusk	0	0.00	0.2	90%	$10,747,952
North Central Bronx Hospital	0	0.00	120.8	56%	$4,845,131
NY Eye And Ear Infirmary	0	0.00	190.7	58%	$8,063,298
NY Westchester Square Medical Center	0	0.00	0.9	95%	$1,207,509
Peninsula Hospital Center	0	0.00	0.8	97%	$4,387,609
Richmond University	0	0.00	0.0	40%	$9,038,402
Rockefeller University Hospital	0	0.00	0.0	N/A	$93,008
St Barnabas Hospital	0	0.00	114.8	17%	$28,708,796
St Catherine Of Siena	0	0.00	11.5	25%	$1,827,894
St Elizabeth Hospital	0	0.00	4.9	74%	$2,007,104
St Francis Hospital Of Roslyn	0	0.00	5.1	18%	$2,314,472
St Lukes Roosevelt Hospital	0	0.00	9.4	74%	$37,643,016
St Vincents Hospital & Medical Center Of*	0	N/A	N/A	30%	$21,256,945
Staten Island University Hospital	0	0.00	0.0	9%	$17,629,325
Woodhull Medical & Mental Health Center	0	0.00	149.9	42%	$8,013,809
Wyckoff Heights Hospital	0	0.00	23.1	75%	$20,510,496
Brookhaven Memorial Hospital Medical Cen	0	0.00	2.8	82%	$7,680,614
Central Suffolk Hospital	0	0.00	1.5	96%	$2,108,196
Eastern Long Island Hospital	0	0.00	0.1	70%	$1,055,918
Huntington Hospital	0	0.00	14.1	24%	$3,759,643
John T Mather Memorial Hospital Of Port	0	0.00	5.2	85%	$2,344,368
Long Beach Medical Center	0	0.00	11.8	62%	$3,596,842
Long Island College Hospital	0	0.00	1.7	81%	$8,322,517
Mercy Medical Center	0	0.00	20.7	16%	$6,520,620
Nassau Medical Center	0	0.00	57.7	85%	$7,434,717
New Island Hospital	0	0.00	1.6	74%	$2,993,189
South Nassau Communities Hospital	0	0.00	3.6	53%	$5,471,205
Southampton Hospital	0	0.00	6.8	69%	$1,691,011

*Hospital has since closed or merged with another

Table 4 – Hospital Reporting Higher Than Average Targeted Need and Lower Than Average Applications Approved.

Hospital Name	Targeted need (2008)	Applications approved (2008)	Applications approved (2008) per certified bed
Kings County Hospital Center	14.2%	75562	108.7
Queens Hospital Center	13.9%	42863	164.2
Mount Vernon Hospital	13.5%	1553	8.8
Metropolitan Hospital Center	13.4%	41646	114.7
Lincoln Medical & Mental Health Center	13.2%	64006	184.5
City Hospital Center At Elmhurst	13.2%	83259	152.8
Ellenville Community Hospital	12.4%	12	0.5
Harlem Hospital Center	12.2%	37259	130.3
Woodhull Medical & Mental Health Center	11.8%	59045	149.9
Bellevue Hospital Center	11.6%	69636	76.4
Nassau Medical Center	11.2%	30570	57.7
North Central Bronx Hospital	11.0%	25740	120.8
Bronx-Lebanon Hospital Center	10.9%	18549	32.0
Jamaica Hospital Medical Center	10.8%	1365	3.6
Summit Park Hospital-Rockland County Inf	10.4%	401	3.7
Tri Town Regional Hospital	10.3%	23	5.8
Catskill Regional Hospital - Harris	10.3%	647	3.9
St Josephs Medical Center - Yonkers	10.2%	157	0.8
Lutheran Medical Center	10.2%	29761	63.6
Coney Island Hospital	10.1%	33846	91.2
St Barnabas Hospital	9.4%	51210	114.8
New Rochelle H. Med./Sound Shore Med Ctr	9.3%	1341	5.3
Jacobi Medical Center	9.3%	52702	115.3
Interfaith Medical Center	9.1%	2012	7.0
Cuba Memorial Hospital Inc	8.3%	503	83.8
Catskill Regional Hospital - Herman	8.2%	0	0.0
Brookdale Hospital Medical Center	8.1%	278	0.5
Bon Secours Community Hospital	8.0%	0	0.0
Ira Davenport Memorial Hospital Inc	7.7%	159	4.2
Astoria Gen/ W. Queens Comm H/Mt Sinai-Qns	7.3%	1187	5.1
State University Hospital Upstate Medica	7.0%	381	0.9
Newark-Wayne Comm/Viahealth Of Wayne	6.8%	130	1.1
Southside Hospital	6.6%	10820	31.7
Wyckoff Heights Hospital	6.3%	7480	23.1
Margaretville Memorial Hospital	6.0%	48	3.2
Flushing Hospital And Medical Center	6.0%	40	0.1
Brookhaven Memorial Hospital Medical Cen	5.9%	856	2.8
St Francis Hospital Of Poughkeepsie	5.8%	6247	18.8
Joint Diseases Nor/North Gen H*	5.7%	4802	N/A
Richmond University	5.5%	0	0.0
Soldiers & Sailors Memorial Hospital Of	5.3%	234	6.7

Hospital Name	Targeted need (2008)	Applications approved (2008)	Applications approved (2008) per certified bed
University Hospital Stony Brook	5.3%	1243	2.2
St Lukes Roosevelt Hospital	5.3%	4744	9.4
Erie County Medical Center	5.1%	3706	6.7
River Hospital	5.0%	62	4.1
TLC Healthcare	4.9%	989	12.5
St Luke's-Cornwall Hospital	4.9%	2981	28.9
Good Samaritan Hospital Medical Center	4.9%	17539	40.1
Little Falls Hospital	4.8%	79	3.2
Bassett Regional Hosp Of Schoharie Count	4.7%	82	2.1
Long Beach Medical Center	4.7%	1911	11.8
Comm Hosp Glen Cove/North Shore Univ	4.7%	5190	19.6
Eastern Long Island Hospital	4.7%	10	0.1
St Johns Riverside Hospital	4.6%	815	2.2
Samaritan Hospital	4.5%	486	2.0
Adirondack Medical Center-Lake Placid &	4.5%	247	2.5
Franklin Hospital Medical Center	4.5%	4637	15.2
Central Suffolk Hospital	4.5%	182	1.5
University Hospital Of Brooklyn	4.5%	6693	17.8
Kingston Hospital	4.4%	335	2.0
Corning Hospital	4.3%	161	1.6
Moses-Ludington Hospital	4.3%	31	2.1
Nathan Littauer Hospital	4.3%	1120	15.1
Edward John Noble Hospital-Gouverneur	4.3%	129	2.7
Maimonides Medical Center	4.2%	2260	3.2
Lewis County General Hospital	4.2%	471	8.7
Seton Health Systems Inc	4.2%	6365	32.5
NY Eye And Ear Infirmary	4.1%	13160	190.7
Benedictine Hospital	4.1%	1380	9.2
St Josephs Hospital Of Elmira	4.0%	364	1.6
Coler Memorial Hospital	4.0%	157	0.7
Niagara Falls Memorial Medical Center	4.0%	288	1.7
St James Mercy Hospital	4.0%	778	5.0
Delaware Valley Hospital Inc	4.0%	19	0.8
Hudson Valley Hospital Center	3.9%	211	1.6
Oswego Hospital	3.9%	662	4.0
O'Connor Hospital	3.9%	25	1.1
Huntington Hospital	3.9%	5771	14.1
Chenango Memorial Hospital Inc	3.9%	216	3.7
Beth Israel Medical Center - Petrie Camp	3.8%	691	0.8
Aurelia Osborn Fox Memorial Hospital	3.8%	582	5.8
Southampton Hospital	3.7%	851	6.8
Goldwater Memorial Hospital	3.7%	157	0.4
Peninsula Hospital Center	3.7%	145	0.8

Hospital Name	Targeted need (2008)	Applications approved (2008)	Applications approved (2008) per certified bed
House Good Samaritan/Samaritan Med Ctr	3.7%	2588	8.8
Columbia Memorial Hospital	3.7%	321	1.7
Glens Falls Hospital	3.6%	1043	2.5
Long Island College Hospital	3.6%	841	1.7
Putnam Hospital Center	3.6%	2683	16.4
Saratoga Hospital	3.6%	824	4.8
Vassar Brothers Hospital	3.6%	15691	43.0
Cortland Memorial Hospital Inc	3.6%	776	4.4
Helen Hayes Hospital	3.6%	6	0.0
Rome Memorial Hospital Inc	3.6%	174	1.2
Woman's Christian Association	3.5%	568	1.7
Albany Memorial Hospital	3.5%	134	0.8
Canton-Potsdam Hospital	3.5%	264	2.8
Good Samaritan Hospital Of Suffern	3.5%	0	0.0
Ellis Hospital	3.4%	546	1.2
Northern Dutchess Hospital	3.4%	1930	28.4
Schuyler Hospital	3.4%	241	9.6
Cayuga Medical Center At Ithaca	3.4%	109	0.5
Nyack Hospital	3.4%	11386	30.4
New York Downtown Hospital	3.3%	491	2.7
St Vincents Hospital & Medical Center Of*	3.3%	1844	N/A
Oneida City Hospital	3.3%	329	3.3
Rochester General Hospital	3.3%	620	1.2
North Shore University Hospital	3.3%	24141	29.7
Inter-Community Memorial Hospital At New	3.3%	679	9.6
Mercy Medical Center	3.2%	7774	20.7
Bertrand Chaffee Hospital	3.2%	0	0.0
Lakeside Memorial Hospital	3.2%	79	1.3
Alice Hyde Memorial Hospital	3.2%	233	3.1
Sisters Of Charity Hospital	3.1%	0	0.0
Booth Memorial/NY H Med Ctr Of Queen	3.1%	3546	8.1
Wyoming County Community Hospital	3.1%	47	0.5
Lenox Hill Hospital	3.1%	130	0.2
Geneva General Hospital	3.1%	429	3.3
Brooklyn Hospital Center	3.0%	1981	4.3
Lockport Memorial Hospital	3.0%	381	2.8
United Health Services Hospitals Inc	2.9%	2379	5.0
Massena Memorial Hospital	2.9%	316	6.3
Arnot Ogden Medical Center	2.9%	239	1.1
New Island Hospital	2.9%	322	1.6
Montefiore Medical Center	2.9%	2287	2.0
Elizabethtown Community Hospital	2.8%	98	6.5
Westchester Medical Center	2.8%	7206	11.3

Hospital Name	Targeted need (2008)	Applications approved (2008)	Applications approved (2008) per certified bed
Clifton Springs Hospital And Clinic	2.8%	271	1.8
Carthage Area Hospital Inc	2.8%	85	1.8
Auburn Memorial Hospital	2.8%	221	2.2
Beth Israel Medical Center - Kings Highw	2.8%	112	0.5
South Nassau Communities Hospital	2.8%	1556	3.6
Staten Island University Hospital	2.7%	0	0.0
St Josephs Hospital Health Center - Syracuse	2.7%	1382	3.2
Crouse-Irving Memorial Hospital	2.7%	718	1.4
NY Westchester Square Medical Center	2.7%	120	0.9
Olean General Hospital West	2.6%	118	0.6
John T Mather Memorial Hospital Of Port	2.6%	1199	5.2
North Shore Univ Hosp At Forest Hills	2.6%	4159	13.3
Westfield Memorial Hospital Inc	2.6%	299	74.8
Mary Imogene Bassett Hospital	2.5%	625	3.5
Nicholas H Noyes Memorial Hospital	2.5%	316	4.4
Champlain Valley Physicians Hospital Med	2.5%	469	1.5
Park Ridge Hospital	2.5%	6355	19.3
Mount Sinai Hospital	2.4%	15040	12.8
Community-General Hospital Of Greater Syracuse	2.4%	576	1.9
Community Hospital At Dobbs Ferry	2.4%	18	1.5
Phelps Memorial Hospital Association	2.4%	1314	5.5
St Charles Hospital	2.4%	4159	18.0
Church Charity Found/Episcopal Hlth	2.4%	1943	7.6
St Peters Hospital	2.4%	1759	4.0
Our Lady Of Lourdes Memorial Hospital In	2.4%	3102	11.6
Mem Hospital Of Wm F & Gertrude F Jones	2.4%	153	2.2
Lawrence Hospital	2.4%	529	1.8
Community Memorial Hospital Inc	2.3%	200	5.0
Medina Memorial Hospital	2.3%	668	9.5
St Elizabeth Hospital	2.3%	975	4.9
Albany Medical Center Hospital	2.2%	1384	2.2
St Marys Hospital At Amsterdam	2.1%	1089	7.6
Brooks Memorial Hospital	2.1%	569	8.8
Strong Memorial Hospital	2.1%	15480	20.9
Northern Westchester Hospital	2.1%	826	3.5
Mount St Marys Hospital Of Niagara Falls	2.1%	1022	5.8
Mercy Hospital	2.1%	8583	22.2
Genesee Mem/United Mem Hospital	2.1%	624	4.8
Nassau Hospital/Winthrop Univ H	2.0%	3293	5.6
Long Island Jewish Medical Center	2.0%	13273	15.1
St Joseph Hospital Of Cheektowaga	2.0%	2931	14.4
White Plains Hospital Center	2.0%	330	1.1
Calvary Hospital Inc	2.0%	121	0.5

Hospital Name	Targeted need (2008)	Applications approved (2008)	Applications approved (2008) per certified bed
Kenmore Mercy Hospital	1.9%	3078	16.7
Faxton - St Lukes Memorial Hospital Center	1.9%	1002	2.7
Claxton-Hepburn Medical Center	1.8%	269	2.1
Community Hosp Brooklyn	1.8%	108	0.8
St Anthony Community Hospital	1.8%	0	0.0
F F Thompson Hospital	1.8%	532	4.7
New York Methodist Hospital	1.7%	509	0.9
New York Presbyterian	1.7%	21212	9.2
Highland Hospital	1.6%	2979	11.4
St Catherine Of Siena	1.6%	3670	11.5
Childrens Hosp/Kaleida Health W & C	1.6%	82	0.4
Clifton-Fine Hospital	1.5%	29	1.5
Arden Hill Hospital/Orange Reg Med Ctr	1.4%	312	0.7
North Shore University Hosp At Plain	1.4%	3510	17.2
Kingsbrook Jewish Medical Center	1.3%	236	0.7
Memorial Hospital For Cancer & Allied Di	1.3%	726	1.4
Kaleida Health	1.3%	683	0.7
NYU Medical Center - Tisch & Rusk	1.1%	256	0.2
Sunnyview Hospital And Rehabilitation Ctr	1.0%	53	0.5
Amsterdam Memorial Hospital	0.9%	0	0.0
Burke Rehabilitation Hospital Inc	0.8%	18	0.1
St Francis Hospital Of Roslyn	0.7%	1843	5.1
Hospital For Special Surgery	0.7%	369	2.0
Blythedale Childrens Hospital	0.6%	5	0.1
Albany Med Ctr Hospital – S. Campus	0.4%	8	0.4
Roswell Park Memorial Institute	0.4%	151	1.1
Sheehan Memorial Hospital	0.2%	84	1.7
Monroe Community Hospital	0.0%	0	0.0
Rockefeller University Hospital	0.0%	0	0.0
Albert Lindley Lee Memorial Hospital*	N/A	449	N/A
Manhattan Eye Ear And Throat Hospital*	N/A	0	N/A

*Hospital has since closed or merged with another

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