American Cancer Society ☙ Children's Defense Fund/New York ☙ Community Service Society of New York ☙
Make The Road New York ☙Metro New York Health Care for All Campaign
New Yorkers for Accessible Health Coverage ☙ New York Immigration Coalition
Public Policy and Education Fund of New York/Citizen Action of New York ☙ Raising Women's Voices ☙
Schuyler Center for Analysis and Advocacy

February 16, 2012

Secretary Kathleen Sebelius
Centers for Medicare and Medicaid Services,
Department of Health and Human Services
Attention: CMS-2315-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Comments on proposed rule on Disproportionate Share Hospital Payments – Uninsured Definition

Dear Secretary Sebelius:

Health Care For All New York (HCFANY) writes to comment on the proposed rule regarding Disproportionate Share Hospital Payments – Uninsured Definition. HCFANY is a statewide coalition of 120 organizations which seek to achieve affordable, quality health care for all New Yorkers. We thank you for the opportunity to provide our comments on this important regulation.

Disproportionate Share Hospital (DSH) payments are critical to ensuring that uninsured New Yorkers receive timely affordable care. These funds, with matching state funds, provide $1.2 billion in funding for New York hospitals to cover uncompensated care to patients through

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the state's Indigent Care Pool (ICP). But, for many years, the media, patients and advocates criticized the distribution of the funds, which were not directly linked to patients seeking financial assistance. In 2006, New York enacted the state's Hospital Financial Assistance Law, which requires hospitals that receive ICP funding to adopt written financial assistance policies, make information about these policies available to the public, and offer uninsured patients with incomes under 300 percent FPL discounted care. In 2007, New York convened an Indigent Care Technical Advisory Committee (TAC) to make recommendations to bring more transparency and accountability to the distribution of these funds. Those recommendations led to some changes in how ICP funds are disbursed. Despite these reforms, indigent and low income uninsured patients continue to struggle to benefit from hospital financial assistance. See "Incentivizing Patient Financial Assistance: How to fix New York's Hospital Indigent Care Program," Community Service Society, February 2012; "Hospitals Flout Charity Care Law," *New York Times*, February 13, 2012.

HCFANY has long advocated for changes to New York's ICP system. HCFANY lead organizations, including the Community Service Society of New York and the Public Policy and Education Fund, have documented problems with the system for over 10 years. HCFANY members around the state continue to report problems with hospitals in their communities. We commend the changes to the DSH regulations contained in the NPRM and urge HHS to take additional steps to increase accountability and patient access to financial assistance.

Definition of Uninsured

HCFANY applauds the NPRM's clarification that the definition of uninsured patient includes individuals who have no coverage for the specific service provided.

We applaud the NPRM's clarification of the definition of uninsured patient, for the purposes of calculating the hospital-specific DSH payment limit, to mean individuals who have no coverage for the *specific service* provided. This parallels a reform proposed in 2007, by the New York State Technical Advisory Committee on Indigent Care. This recommendation, which was officially adopted for the allocation of 10 percent of the State's ICP funding, patients are considered uninsured if they have no insurance at all, or if they have insurance that does not cover the specific service provided.

This definition channels funding in a way that protects patients with minimal coverage – frequently low-wage workers with minimal job-based coverage and patients who purchase minimal coverage on the individual market because they do not have job-based coverage – and the hospitals that serve them. The Affordable Care Act's (ACA) restrictions on annual and lifetime limits and other reforms are already reducing the number of patients with these types of

policies, and new policies available through the Exchange should provide more comprehensive coverage and reduce even further the number of patients who require this kind of assistance.

Definition of Uninsured and the Exchange

After implementation of state-based Exchanges in 2014, the definition of uninsured should include: people who do not qualify for Exchange-based coverage because of immigration status; people who receive an affordability waiver of the individual mandate; patients with coverage that meets the Essential Health Benefits standards or catastrophic plan requirements but does not cover a provided service; and other uninsured consumers.

We urge the Department to issue guidance addressing issues that may be raised by changes to the health insurance landscape when the remaining ACA reforms take effect in 2014, including implementation of state Health Insurance Exchanges and individual mandates.

For example, we expect that an uninsured patient, including patients who receive an affordability waiver of the individual mandate, patients who are barred from purchasing coverage on the Exchange because of immigration status, or patients who simply choose not to enroll in coverage, would be considered uninsured. We also assume that a patient who purchases coverage that complies with requirements applicable to their age group, or who have employer provided coverage, but do not have coverage for specific services would be considered uninsured under this rule. We urge HHS to issue additional guidance addressing these issues.

Exclusion of unpaid coinsurance and deductibles from definition of uninsured

The definition of uninsured should not include unpaid deductibles, co-pays, or co-insurance. HHS should reconsider this decision after implementation of the state-based Exchanges.

The NPRM reiterates the existing policy that unpaid deductibles, coinsurance, and copayments may not be included in the calculation of a hospital-specific DSH limit. While we agree that scarce DSH funds should prioritize uninsured patients and the hospitals that treat them, we recommend that HHS revisit this decision after implementation of the state Exchanges.

New York's Indigent Care Technical Advisory Committee (TAC) considered this question in 2007. After much discussion, the TAC concluded that the state's indigent care funds were not sufficient to meet all of the need for uncompensated care in the state, and should be reserved for patients with no insurance at all and patients with coverage that did not cover the needed service.

Implementation of the state-based Exchanges, where consumers will be able to purchase comprehensive coverage and qualify for subsidies, should reduce the need for uncompensated care. These new measures should reduce the number of patients who are completely uninsured, and improve the quality of coverage that many patients have. At the same time, the ACA will reduce the amount of DSH funding available by half. HHS and the states might choose at that time to re-evaluate how well the existing definition serves needy patients and communities.

Hospitals that serve low-income communities have argued that this rule penalizes them and their patients, who are more likely to have coverage with excessive or unaffordable cost-sharing requirements. After the implementation of these new measures has taken effect, some patients and hospitals might benefit from a change to the rules allowing hospitals to include unpaid cost-sharing for purposes of the hospital-specific limit. Low-income patients may continue to have difficulty paying cost-sharing in some cases. For example, low-income patients might forgo the cost-sharing subsidies available to patients purchasing silver-level coverage (with lower cost-sharing requirements) in order to pay the lower up-front premiums for bronze-level coverage (with higher cost-sharing requirements).

Increasing Accountability

HHS should increase accountability and improve patient access to financial assistance by directing funds to states that condition hospital payments on provision of financial assistance to needy patients.

A recent CSS report, "Incentivizing Patient Financial Assistance: How to Fix New York's Hospital Indigent Care Program," found that a majority of hospitals in the state fail to comply with the state's 2006 financial assistance law. Although the law requires hospitals to make applications available to the public, 10 percent of the 201 hospitals CSS contacted failed to provide a copy of their application materials. CSS reviewed the materials that were made available and determined that 66 percent violated the state financial assistance law, failed to comply with Department of Health (DOH) Guidance, or created additional barriers. Although the DOH has the authority to levy $10,000 fines on hospitals that fail to comply with the law, it has not done so to date.

Additionally, CSS found that hospitals continue to report high levels of bad debt, as compared to financial assistance, and to pursue collection actions against thousands of patients every year. As confirmed by the NPRM, bad debt cannot be included in the calculation of a hospitals-specific limit. However, New York continues to use bad debt in considering how much of the available funding to distribute to each hospital. In 2014, this practice will be in violation of

the ACA § 2551. The report found that 70 percent of hospitals categorized more than half of their uncompensated care as bad debt. Finally, the report found that hospitals with application materials that do not comply with state law approve relatively fewer applications for financial assistance than their counterparts with lawful materials. The existing distribution methodology and lack of enforcement have not created sufficient hospital incentives to make financial assistance available to patients.

New York's Hospital Financial Assistance Law (New York Public Health Law §2807-k) is a model law, but the strong standards of the law mean nothing without enforcement and financial incentives to hospitals to comply. HHS should require states to implement hospital financial assistance rules based on New York's law as a qualification for receipt of DSH funding, including requirements that hospitals:

- Use a uniform simple application form and policy summary that explains clear, objective eligibility criteria, including information about income eligibility levels, the primary service area of the hospital, how to apply, and a notice that the patient does not need to pay any bills while their application is pending
- Make the policy available to all patients in a timely manner, including informing patients about the availability of financial assistance through conspicuous posting of language-appropriate information in the hospital, on bills and statements sent to patients, and through the intake and registration process
- Provide materials in languages spoken by five percent of patients with limited English proficiency or non-English proficient residents comprising one percent of the hospital's primary service area
- Train hospital staff to assist patients in filling out the application form
- Provide sliding scale discounts to qualified patients
- Follow fair collection practices
- Submit auditable documentation of discounts provided to patients eligible for financial assistance
- Provide documentation that patients were screened for financial assistance before any collection activities were initiated

As New York's experience has shown, hospitals will not follow these rigorous requirements unless the distribution of funds is linked to compliance with the law. HHS should only provide DSH funding to states that link distribution of funds directly to provision of financial assistance to eligible patients.

Thank you for considering our comments. If you have any questions, please contact

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Sincerely,

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