



**Testimony of Greater New York Hospital Association at a
Public Hearing on Hospital Indigent Care Funding**

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Good morning Commissioner Daines, Chairman Gottfried, and Chairman Hannon. My name is Pat Wang and I am a Senior Vice President at the Greater New York Hospital Association (GNYHA), which represents nearly 125 non-for profit and public hospitals in New York State and the surrounding areas. We very much appreciate the opportunity to testify before you on the New York State (NYS) Hospital Indigent Care Pool, which I will here refer to by its long-held colloquial name, the Bad Debt and Charity Care (BDCC) Pool.

The BDCC pool provides \$847 million to NYS hospitals annually to help offset approximately \$1.6 billion in reported uncompensated care costs from providing care to uninsured and underinsured patients. Of this \$847 million, \$268 million will be self-funded by hospitals this year through a 1% tax on inpatient revenues. In addition to providing \$1.6 billion in uncompensated care, hospitals also incur \$2 billion in losses from treating Medicaid patients, according to a recent report by the Urban Institute.¹ Many of the hospitals that treat a high volume of Medicaid patients also have a high uninsured patient population and it is therefore not surprising that these institutions, located in the most medically underserved communities, continue to experience extreme financial distress.

The questions posed for this hearing are extremely important and we appreciate the opportunity to explore them fully with you. However, we urge that they be considered within context in order to avoid recommendations that could de-stabilize hospitals, particularly those serving predominantly low income populations, and compromise patient access to needed services. This context includes numerous other initiatives currently underway to reform fundamentally the way that Medicaid pays for inpatient services, outpatient services, behavioral health and chemical dependency services, and graduate medical education, to name a few. These initiatives will all have material impacts on hospital finances and, by extension, the communities they serve. We believe it is critically important to keep all of these moving parts in mind to ensure that the net result of system reform actually improves access and quality of care for patients.

We have spent the past several months examining, analyzing, and considering different possible distribution methodologies for the pool and have concluded that there are ways that could and should be explored to improve equity and accountability in current pool distributions. However, we also believe that reliable and consistent data do not exist today to move to a distribution system based on units of service to uninsured and underinsured patients. In evaluating alternatives, we used the following principles as our guide:

- Pool distributions should be *adequate* to meet hospital uncompensated care need.

¹ “Caring for the Uninsured in New York,” Urban Institute (October 2006) page 37. This report also documents \$1.7 billion in hospital-based uncompensated care need.

- Pool distribution methodologies should be *consistent with other laws*.
- Pool distributions should be *equitable*, meaning that the same rules and definitions should apply to all hospitals and that greater support should be provided as hospitals' uncompensated care responsibilities increase.
- The distribution methodology should provide as much *accountability and transparency* regarding the costs and services supported by the pool as possible.
- Procedures for providing, tracking, and supplying data related to uncompensated care should impose the *least possible administrative burden and cost*.
- Data used to make pool distributions should be *consistent and reliable* across hospitals.
- Any contemplated changes in pool distribution methodologies must be *capable of being modeled*, and should be modeled in advance of proposal or adoptions, to ensure that theory achieves the desired outcomes in practice.

At this stage in our analysis, we make the following observations. The current pool distribution system has unfortunately created consternation among policymakers and others because it does not facilitate knowledge of what uncompensated care services have been provided to which patients. We discuss ways we think this situation can and should be improved below. Given this important caveat, however, we believe the pool has actually done a relatively good job of targeting limited funds to hospitals that bear the highest proportions of uncompensated care costs.

Proposals that would tie uncompensated care cost-finding to specific services and patients seem reasonable in theory, but we have not yet been able to identify a way to evaluate them for real world applicability based upon current data. Current data is derived from hospital cost reports, which in turn is summarized from internal hospital patient accounting and work process systems which have been designed to elicit the information needed for the current pool system. Sensible changes in those systems can probably be made, but this will require time and resources. We do, however, believe that current reporting requirements and definitions can be improved in order to achieve greater consistency in hospital reporting that will increase the confidence of all parties in the appropriateness of the distributions.

We also continue to believe strongly that pool distributions should be available for uncompensated care provided in accordance with hospital financial assistance policies, that they should be consistent with PHL 2807-k(9-a) which sets minimum standards for those policies, and that they should cover financial assistance for insured patients who are unable to afford their cost-sharing (i.e., coinsurance and deductible) obligations, in addition to covering fully uninsured units of service.

Finally, current pool resources are inadequate to meet uncompensated care need, particularly after considering hospitals' own self-funding of the pool.

Current BDCC Pool Funding and Distribution Methodology

It is useful to review the pool funding mechanisms and distribution methodology as background to this discussion.

Funding

The pool is subject to the annual appropriations process but has been funded at its current level of \$847 million since 2000. The BDCC pool is considered Medicaid hospital disproportionate share (DSH) funding and thus qualifies for Federal matching funds of 50%, or \$423.5 million. As shown in Table 1 below, the State is responsible for the other 50%. To help fund its share, the State imposes a 1% assessment on inpatient hospital revenues that the NYS Division of the Budget estimates will raise approximately \$268 million in SFY 2007-2008. This means that the net amount of funding available to hospitals is only \$579 million, and that the hospitals contribute over 30% of the total BDCC pool funds and over 60% of the State share through the revenue assessment.

Table 1. Funding Sources for \$847 Million BDCC Pool

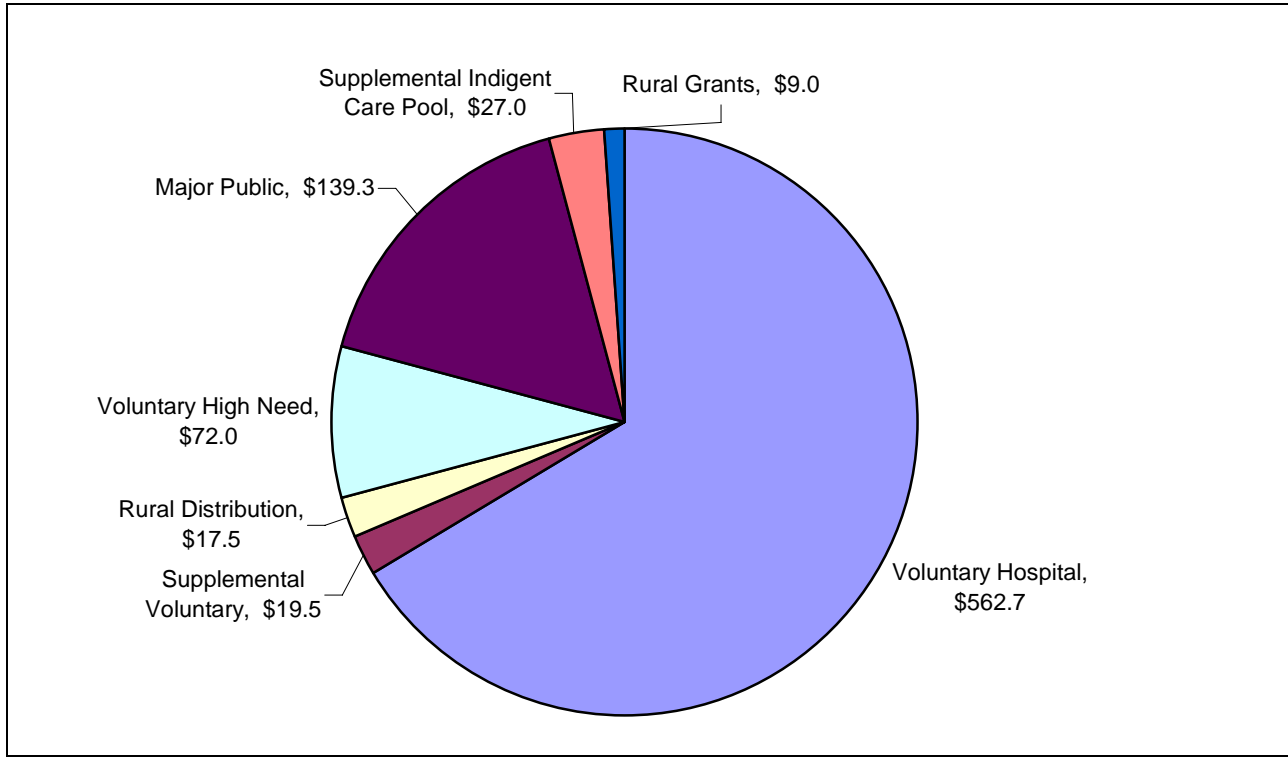
Funding Source	\$ (in mill.)	%	
		Total	State Share
Total	\$ 847.0	100%	N/A
Federal share	\$ 423.5	50%	N/A
State share	\$ 423.5	50%	100%
Hospital assessment	\$ 268.0	32%	63%
State contribution	\$ 155.5	18%	37%

Thus, while the average coverage ratio for the pool is about 50% (\$847 million/\$1.6 billion in reported need), once the hospital assessment is netted out, the average coverage ratio falls to 36%. We also note that while the State has collected increasing amounts each year from the 1% hospital revenue assessment, the annual allocation under the pool has remained flat since 2000, in effect decreasing the net distributions that hospitals are receiving from the BDCC pool. In fact, according to DOB, in SFY 2000-2001 the 1% revenue assessment raised \$149 million, so the net BDCC funding available to hospitals in 2000 was \$698 million, or 20% more in 2000 than it is today.

Distribution Methodology

The \$847 million BDCC pool is divided into several component pools. Within these, \$139 million is allocated for public hospitals and \$708 million is allocated to voluntary hospitals. The chart below shows the various funding pools and the amounts of funding for each.

**Chart 1. NYS Bad Debt and Charity Care Pool Distributions
(\$ in millions)**



Source: NYS Department of Health.

There are different distribution methodologies for the pools for public and voluntary hospitals. BDCC pool distributions to public hospitals are fixed at the amounts that they received in 1996 and public hospital uncompensated care losses are addressed principally through other funding mechanisms unique to public institutions. The distribution formula for the majority of the voluntary hospital funding is determined based on the amount of uncompensated care costs for inpatient and outpatient services provided to uninsured individuals and underinsured patients. These amounts are reported by hospitals on a specific cost report schedule that is required to be audited each year by independent auditors based on standards and protocols developed by the Department of Health (DOH).

Hospitals report their uncompensated care amounts on the cost report as either free allowances (charity care) or bad debts. Bad debts are reported by payer and the pool formula includes bad debts from all payers except Medicare.² DOH calculates each hospital's BDCC "need" by reducing the amounts reported on the hospital cost reports to cost using the hospital-specific ratios of cost to charges (RCC).

² The Medicare program has a separate policy which reimburses hospitals for 70% of the bad debt associated with unpaid coinsurance and deductible amounts from its beneficiaries, so these amounts are excluded from the calculation of each hospital's need.

The formula assumes that all amounts reported by the hospitals for charity care and bad debts are reported at charges but since many patient coinsurance and deductible amounts are already recorded at “cost”, the actual dollar amount that the hospital would expect to collect, the formula inappropriately discounts these amounts. This underestimates the value of the BDCC provided by hospitals for these amounts.

Each hospital receives a distribution from the pool based on its need as a proportionate share of the total pool. The distributions are based on a progressive scale that provides higher distributions to hospitals that provide higher amounts of uncompensated care as a percent of their total operating cost. Additional distributions are also made to hospitals that are defined as “high need” hospitals (those that provide uncompensated care that is more than 6% of their total cost), rural hospitals and teaching hospitals. In order to qualify to receive pool distributions, a hospital’s BDCC need must be at least 0.5% of its total cost.

Financial Assistance Law

In addition to providing uncompensated care that is at least 0.5% of its total cost, hospitals are required to meet new statutory minimum standards to provide hospital financial assistance to patients who are unable to pay their bills. These standards were implemented by Public Health Law section 2807-k(9-a) effective January 1, 2007, and any hospital wishing to receive funds from the BDCC pool beginning January 1, 2009 must comply with them. While the law has many complexities that have proved challenging, the hospitals have worked very hard to develop and implement charity care policies to meet the requirements of the law and to reflect the needs of the communities that they serve.

The financial assistance law sets a floor for hospital financial assistance policies. Among other things, it requires hospitals to, at a minimum, provide financial assistance to uninsured individuals with income levels up to 300% of the Federal Poverty Line (FPL) as follows: to all New York State residents for emergency services and to individuals residing in the hospital’s primary service area (PSA) for any non-emergency, medically necessary service that the hospital offers. For hospitals in New York City, the PSA is the entire City, plus Nassau for hospitals in Queens and plus Westchester for hospitals in the Bronx. For hospitals in the rest of the State, the responsibility is for residents in the county in which the hospital is located and all contiguous counties. It also provides requirements related to application and appeal procedures, notification, language access, collection procedures, nominal payment amounts, and reporting. Many hospitals have developed charity care policies that are more expansive than these minimum requirements, especially with respect to income levels, PSAs, and discounts.

We note that many hospitals are expending significant resources to administer the new processes required by the law and to gather and report the mandated information.

The Financial Assistance Law does not require hospitals to provide financial assistance to insured patients who are unable to afford their deductible and cost-sharing obligations but sets standards that would apply if the hospital chose to do so. It was appropriate for the Legislature to refrain from mandating financial assistance for cost-sharing amounts because a mandate could

have encouraged the proliferation of even more high deductible health plans on the theory that they would not be burdensome for patients eligible for financial assistance. But, the reality is that many patients are unable to meet high cost-sharing obligations, particularly if they are seriously ill, and we believe it is completely appropriate for hospitals to provide and the pool to support financial assistance in these situations.³ We have encouraged our members to include provisions for deductibles and cost-sharing in their financial assistance policies.

Questions Posed for Hearing

Today's hearing notice posed several specific questions and I have organized our remarks to respond to them. However, I have left what I believe is the most complicated -- possible changes in the methodology for distributing funds to focus on units of service to uninsured patients -- to the end.

Should pool funds be available to cover unpaid co-payments and deductibles for insured patients? Should pool payments be available to cover claims denied by third party payers?

As noted above, we strongly believe that hospitals should be encouraged to continue providing financial assistance to insured patients who are not able to pay required cost-sharing amounts and that the pool should continue to cover these amounts. Most hospitals must already absorb extensive losses for uncompensated care due to limited pool funding. If pool distributions are not available to cover patient cost-sharing amounts, it would send the wrong message to the provider community. We believe these provisions are necessary and appropriate to meet the needs of all patients who are unable to pay their bills.

Today, pool payments should not be covering claims denied by third party payers. Such denials should be recorded as contractual allowances and not as free allowances or non-Medicare bad debts. The fact that questions about the inclusion of such amounts continue to be raised underscores the need to clarify and improve reporting definitions and requirements.

The question also invites a statement about the need to engage in as hard a look at private payer practices as is being undertaken for hospital BDCC pool, Medicaid, and related payments. Hospitals experience significant losses as a result of inappropriate payer practices, and administrative denials in particular deprive hospitals of payment for medically necessary services that they have rendered in good faith. There is no source to cover these losses.

Should additional requirements be imposed on hospitals in order to participate in the pool?

In order to receive distributions from the pool, hospitals must provide uncompensated care that is at least 0.5% of its total costs. PHL 2807-k(9-a) also established significant new requirements for pool participation that hospitals have spent the better part of a year preparing for and it is still too early to know what kinds of modifications, if any, would be needed to those requirements.

³ See, e.g., "Insured But Not Protected: How Many Adults are Underinsured?", Schoen et al, Health Affairs (June 14, 2005); "Seeing Red: Americans Driven into Debt by Medical Bills," Doty, et al, The Commonwealth Fund (August 2005 Issues Brief).

Given that hospitals have been working on meeting participation requirements that have only been effective for seven months, we do not think it is appropriate or necessary to impose additional requirements for pool participation.

Should hospitals be required to absorb a certain percentage of the cost of care of uninsured patients?

Because the pool only covers 36% of aggregate reported need (50% without consideration of the 1% inpatient tax), hospitals already absorb a great deal of the cost of care to the uninsured. To the extent that some hospitals receive a higher coverage ratio because of their high proportion of uncompensated care, and therefore absorb fewer losses, we believe this is appropriate and should not be changed. When hospitals' uncompensated care costs increase as a proportion of total costs it signifies that they have less ability to shift those losses to other payers through higher rates. In such situations, additional support from government sources is appropriate.

Should coverage ratios differ for hospitals as uncompensated care costs increase as a percentage of total operating costs?

The BDCC pool distribution methodology should continue to provide distributions on a progressive scale such that hospitals that provide higher amounts of uncompensated care should have higher coverage ratios. In addition, the funding pools for high need, rural hospitals, and teaching hospitals should be maintained. The varying coverage ratios reflect important policy decisions that the Legislature has made with respect to providing additional funding for institutions with special circumstances.

To what extent should PHL 2907-k(9-a) alter the methodology for distributing pool funds?

As noted earlier, the financial assistance law has only been in effect for about seven months and the impact of the new statutory obligations on BDCC pool need and distributions is not yet known. However, we believe the rule of general applicability should be that hospitals receive pool payments for uncompensated care provided in accordance with their financial assistance policies.

Hospitals are required to provide financial assistance for all medically necessary hospital services to individuals in their PSA and uncompensated care costs that are incurred as a result should be eligible for pool distributions. In addition, under the current pool rules, referred ambulatory services are excluded from the calculation of a hospital's uncompensated care need. We believe this is inappropriate in light of the financial assistance law, which requires hospitals to discount charges for qualifying patients.

As noted, we believe the financial assistance law anticipated the need for hospitals to continue providing financial assistance for cost-sharing amounts and if they do so, we believe they should be eligible for pool coverage.

Can the distribution of pool funds be better targeted through modifications to the existing methodologies, e.g., based upon units of services to uninsured patients? If so, how should the service be valued, e.g., at hospital costs, Medicare or Medicaid rate, etc.?

As noted above, we strongly believe that the pool should continue to cover losses from providing financial assistance to insured patients who cannot afford cost-sharing amounts and that it should not be limited to covering only fully uninsured patients. We also do not believe that current data is consistently available or reliable to convert to a payment system based upon units of service at this time. However, we believe that current information can be improved through more rigorous definitions and reporting guidelines and that this would go a long way to improve payment equity and data consistency and reliability.⁴

We observe that the pool reporting definitions and requirements are old and, while there was an update in May, 2007, a few weeks before the 2006 cost report filing deadline, we believe that more can and should be done to ensure consistency, clarity, and accountability in how hospitals report uncompensated care need. Because the size of the pool is fixed, consistency is important to ensure that hospitals are receiving their “fair share” of the pool and that distributions are equitable relative to the policy intentions of the distribution methodology.

Over the past six months we and others including DOH have extensively analyzed the data reported on the cost report to understand current data issues and examine whether other distribution methodologies could be explored using such data. In this section of our testimony, we spend a bit more time reviewing our understanding of the type and source of information provided by hospitals on their cost reports related to uncompensated care.

In addition to our observations on improvements that could be made to the cost reports and our commitment to continue working with DOH, the Legislature, and our member hospitals on these issues, we encourage DOH to continue to use GNYHA and HANYS as well as other groups such as the Health Finance Management Association (HFMA) to sponsor further provider education.

Reporting of Patient Statistics and Revenues on the Cost Report

There are three cost report exhibits that have been discussed in relationship to making possible changes to the BDCC system to pay according to units of service. These are Exhibits 32 and 33, where hospitals report “units of service” by payer for inpatient and outpatient services, respectively, and Exhibit 46, which provides patient service revenue by payer. In evaluating an approach that would pay according to self-pay units of service, DOH has sought to link these schedules (e.g., multiply uninsured units of service times a payment rate and offset by self-pay revenue collections) and observed that the data does not appear to be consistent across the cost report exhibits.

⁴ Given the fact that health care administrative costs are already too high, we strongly endorse reliance on data that is already being reported to the greatest extent possible, subject, however, to improved definitions and guidelines and other efforts to improve the quality of the data collection.

In particular, the charity care and bad debt amounts reported on the revenue schedule (Exhibit 46) did not appear to align with the payer classifications reported on the utilization schedules (Exhibits 32 and 33). After researching this question extensively with our member hospitals, we concluded that this is because of the way that most patient accounting systems register and track services and charges and payments for them. These systems were designed for the principle purpose of billing and collection to meet a business function.

Limitations of current reporting systems include the following. A “unit of service” on Exhibit 32 or 33 can only be assigned to one payer. If the patient is privately insured, that unit of service will be included in a private payer category. If the patient is self-pay, that unit of service will be included in the self-pay category, though it should be noted that even these statistics have complexities. For example, if a patient received a service as a member of ABC health plan, that unit of service would be assigned to ABC. However, if ABC issues a retroactive eligibility termination eight months after the service is rendered, it is possible that the original statistic will not be re-assigned to the self-pay category.⁵ If the ABC patient has a \$5,000 deductible, the hospital will only assign one payer to that unit of service, i.e., ABC, and not ABC for the portion paid by the insurer and self-pay for the deductible paid by the patient. The utilization exhibits, 32 and 33, therefore do not identify underinsured patients at all and there is complexity in the identification of self-pay patients.

As the billing and payment for the units of service recorded in Exhibits 32 and 33 move through the system, one unit of service may split into various types of revenue accounts and be recorded in more than one category on the revenue exhibit, Exhibit 46. For example, let’s say that the service provided to the ABC Health Plan member above had charges of \$15,000, that ABC had negotiated to pay the hospital \$10,000, that ABC denied \$1,000 as not medically necessary, and that the patient received financial assistance for \$3,000 of her \$5,000 deductible. The revenue exhibit should include the following entries: The \$15,000 charge would be assigned to the private payer category with \$6,000 in contractual allowances (the difference between charges and the negotiated rate plus the medical necessity denial). The patient’s financial assistance amount of \$3,000 would be recorded in the “free allowance” section pursuant to DOH’s May 2007 instructions. The free allowance would not be assigned to the original unit of service on Exhibit 32. In addition, the free allowance associated with the deductible would be co-mingled with payments by fully-uninsured, self-pay patients.

Another reason that the service and revenue amounts may not align is that the payer categories for the gross charges, allowances, and bad debts sections on the cost report exhibit do not exactly

⁵ We note that different hospitals seem to have different capabilities and practices related to reporting information on the cost report. Thus, some hospitals have told us that their systems will automatically change the payer classification in the example given, while others have told us that this is not a certainty. Similarly, some hospitals, particularly those that are part of larger health care systems, seem able to retroactively identify and segregate fully uninsured from underinsured statistics and revenue. However, many of our member hospitals have told us it is impossible for them to do so within their current system constraints. We do not believe that major changes should be made with the knowledge that there will be a lack of reliability in the data due to an inability by a good portion of the hospital sector to produce it.

match. In the bad debts section, for example, only a subset of the payers is listed and there is an “Other” category that does not exist in the gross charges or allowances sections. The cost report exhibit can be modified so that the payer classifications listed in the bad debts section match those listed in the gross charges and allowances sections. This would facilitate improved hospital reporting of bad debt payer classifications if this is information that DOH would find relevant.

In May 2007, DOH clarified that it expected hospitals to report all statistics for an account (the unit of service, charges, allowances, and bad debts) in only one payer classification so that each case would fall into only one “bucket” for reporting purposes. As described above, this directive is not consistent with standard hospital patient accounting practices. In speaking with our hospital members and some of the major patient accounting systems vendors, we believe that changes may be possible to keep units, charges, allowances, and bad debts all connected to one account, but this will require significant changes to reporting mechanisms from the patient accounting systems and extensive staff education efforts. We believe it would be in everyone’s interest to work towards these changes.

Separating Bad Debts from Charity Care

While some hospitals use both the free allowance and bad debt categories, others report all or nearly all of their uncompensated care as bad debt. DOH’s analysis of the cost reports showed that hospitals report twice as much bad debt as charity care. There are two main reasons for the lack of differentiation.

First, identification of any patient qualifying for charity care should be based on an individualized determination, but this is difficult to achieve in practice. Our hospitals have consistently reported, even prior to passage of PHL 2807-k(9-a), that their greatest challenge is to help patients complete a financial assistance application and that it is often difficult to obtain information from patients about their financial status. This is particularly true for ambulatory care services given the brief nature of the encounter, and it is therefore not surprising that more than two-thirds of hospital uncompensated care originates from emergency room, outpatient clinic, and other ambulatory settings. This challenge is especially overwhelming in the emergency room where there is little opportunity to start, much less complete, a financial assistance application, and where extensive questioning can discourage patients, especially those with undocumented status, from seeking needed care.

Second, the definition on cost report instructions for the “free” payer classification was ambiguous, which left the definition subject to interpretation and caused hospitals to report inconsistently. Prior to May 2007, when DOH issued a clarification on the cost report instructions, the definition of the “free” payer classification for cost reporting purposes was “services provided to a patient free of charge.” Technically speaking, “free of charge” means the patient was not asked to pay anything. Since a great deal of financial assistance is provided at a reduced charge or fee (rather than completely free), many hospitals did not report any services or revenues in this “free” payer classification and instead reported such uncompensated care losses in the “bad debt” category or as part of the “self-pay” allowances category (the latter not being eligible to be considered for pool coverage). In addition, those that did use this classification for the revenue exhibit did not necessarily report charges for the services since they were provided “free of charge,” but rather only reported charity care allowances.

In the May 2007, directive to hospitals, DOH modified the definition of the “free” payer classification to read: “Services provided to a patient free of charge or at a reduced charge as a result of a patient’s indigent income status and/or the hospitals charity care policy.” (emphasis added). In addition, in a conference call with the hospital industry the Department clarified that if a hospital’s charity care policy includes a discount policy for all uninsured individuals regardless of financial status (e.g., an automatic reduction from charges if the patient is uninsured, with further discounts available if the patient applies for assistance), then these discounted amounts should be reported as charity care. This clarification needs to be included in the written cost report instructions to ensure that hospitals are applying this standard uniformly. We very much appreciate DOH’s effort to clarify the written instructions and verbal clarifications but since these were issued just a few weeks before the 2006 cost reports were due, despite the hospitals’ extensive efforts to comply, we think it is unlikely that the clarification is fully reflected in the data yet.

We believe it would be beneficial for hospitals to differentiate between bad debt and charity care more effectively and consistently, for example by establishing “financial assistance” financial classes in their patient accounting systems if they have not already done so. We expect the 2007 reports to be significantly improved in this area due to staff education efforts, the implementation of the financial assistance law and associated reporting requirements, and the cost reporting clarifications that were issued by DOH, among other things.

Defining Bad Debts for Purposes of Qualifying for Pool Distributions

We have discussed in detail some of the technical reporting issues faced by hospitals in reporting bad debts and charity care. We also recommend that DOH issue updated instructions and definitions about what should be reported as bad debts and allowances to address concerns about the comparability of reporting among hospitals.

We recommend as well that DOH update the regulations on bad debt and charity to reflect the current statute. The regulations on bad debt and charity care in Part 86-1.11(g) do not reflect the current statutory provisions regarding the distribution of these funds but rather the previous methodology from the 1990s that included “outpatient deficits” in the calculation of BDCC need. The regulation must be updated to reflect the current pool distribution in order to eliminate any confusion that may exist about the methodology set forth in statute and in effect today.

Cost Report and Systems Changes

We have identified what we understand to be characteristics of the data reported on relevant cost report exhibits and would like to work with DOH to continue comparing notes to ensure that the information reported is what DOH desires. We are also committed to working with DOH and with our hospitals to move in the direction of being able to differentiate low-income self-pay statistics and financial information from other self-pay services, i.e., those that would not qualify for financial assistance, which we believe would further the match between services eligible for pool distributions and hospital financial assistance policies. To do this, and recognizing the challenges posed by completing financial assistance applications particularly in emergency room and outpatient settings, we would welcome suggestions about ways that DOH would find acceptable to assign services and related financial information to financial assistance categories.

As the first step, we recommend that a collaborative effort be made to update current pool definitions and other reporting rules along the lines that have been discussed to improve the quality and consistency of data being reported today.

We appreciate your patience with the amount of detail presented in this section. We believe that it is important to understand what data is currently being produced consistently and reliably by hospital systems and what the limitations of that data are with respect to making certain changes to pool distribution methodologies. We believe that improvements can and should be made to current reporting rules and that a thorough review and tightening of current definitions and requirements would make a material contribution to increasing equity, accuracy, and consistency of pool distributions. Having said that, we reiterate that we believe the current pool methodology actually works relatively well in targeting funding towards institutions that provide high levels of uncompensated care.

Other Reforms

In addition to these changes, we would like to emphasize the urgent need to create a patient-level database for outpatient services. DOH currently collects this patient-specific data for inpatient services, emergency room, and ambulatory services through the SPARCS system and we understand that the Department is in the planning phase to begin collecting this information for outpatient services as well. We fully support these efforts and urge that they be expedited. The lack of outpatient SPARCS data makes it impossible at the current time to understand which ambulatory services are being provided to uninsured individuals and to perform any valuation of outpatient services at a proxy rate if appropriate. The outpatient SPARCS database is necessary not only for this effort but is imperative as well for the broader ambulatory care restructuring initiative, as well as distributing language assistance funds and other important initiatives. We are committed to continuing our work with DOH and our member hospitals on the consistency and quality of reporting and on identifying any new data needs that would be required to meet the State's policy goals.

We very much appreciate the opportunity to discuss these issues with you today and hope you will call upon us to clarify, discuss, or further explore them as you see fit. We would also very much like to work with you as you continue to explore different methodologies and approaches.