

Charity Care- In Some States

This paper compares and contrasts differences and similarities among several states and their management of Charity Care. The Commission on the Public's Health System (CPHS) is concerned about the allocation of charity care dollars to hospitals in New York State and this paper was produced to show how the allocation is done in other states.

Since 2007, New York State law requires notification of charity care policies and fee-scaling for low-income, uninsured residents as a condition of participating for Pool distribution. The distribution mechanism has received criticism for lack of accountability and connection to uncompensated care actually provided for the uninsured.¹

New York, New Jersey and Massachusetts are the three states that deregulated their hospital reimbursement rates in the 1990s and all three maintained their Charity Care pools. Two of the states, Massachusetts and New Jersey, shifted their focus from uncompensated care to charity care and cut back pool support for bad debts (Massachusetts continued to cover emergency bad debt). New York continued to use pool funding for charity care and bad debt.¹

Massachusetts

When **Massachusetts** dismantled its all-payer rate setting at the end of 1991, it maintained the Charity Care pool and cut back support for hospital bad debt. It was felt that reimbursing hospitals for bad debt provided a disincentive for hospitals to pursue collections from individuals and payers. Therefore, Massachusetts changed its pool and excluded bad debt reimbursement unless it was generated by emergency services provided to uninsured patients.¹

The number of uninsured people increased in Massachusetts, while the cap on the free care pool remained in place. So, in the initial 1991 reform, Massachusetts changed the distribution of pool funds to protect hospitals with high proportions of charity care through a method called the "greater proportional requirement". Based on this method, of two hospitals with equal total patient care costs, the hospital with greater charity care costs would have a higher proportion of those costs reimbursed.

In 1997, in addition to the free care pool, Massachusetts created two separate subsidy programs that targeted over \$50 million to public hospitals or those serving mainly public beneficiaries.

The Health Safety Net Trust replaced the Uncompensated Care Pool in 2007 when coverage expanded.¹

New Jersey

New Jersey, like Massachusetts, used its 1992 deregulatory reform to create a more targeted pool for charity cases only. NJ's distribution formula was adjusted to focus pool support on higher-needs hospitals, which had to be in the top 80% in terms of charity care as a percentage of costs in order to qualify for funds. Once eligible for funds, they were reimbursed for charity care costs at Medicaid payment rates up to the maximum available in the pool. To provide a disincentive to inappropriate emergency care, these encounters were reimbursed at primary care rates. Shortly after the 1993 changes in pool funding and distribution, NJ also instituted additional special subsidies for hospitals with very high levels of uncompensated care. One funding mechanism covers institutions with particularly high caseloads of patients with AIDS, TB, mental illness, substance abuse, or high-risk pregnancies. The other mechanism covers those hospitals serving the mentally ill and developmentally disabled.

In 1995- NJ changed its distribution formula again in order to maintain funding for the highest need hospitals. The new distribution took into account measures of payer mix (shiftability) and profitability. Charity care funding was mainly dependent on a hospital's percentage of nongovernmental payers relative to other hospitals.

Bad debt was perceived as a major reason for the huge growth in the pool toward the end of rate setting. In 1996, this formula was modified in order to eliminate bad debt from the percentage calculation, but the profitability and shiftability criteria remained in effect.¹

In New Jersey, the reporting requirements are more stringent than in New York and Massachusetts. For example, New Jersey's Hospital Care Payment Assistance Program (HCPAP) mandates free or reduced-charge care to qualifying patients who receive necessary inpatient and outpatient services at acute care hospitals in NJ. Hospitals are required to submit quarterly information to the Department of Health and Senior Services for all patients who were screened for charity care in that quarter and should include demographics.

Hospitals are required to submit all claims for charity care cost reimbursement, as well as demographic information about the persons who qualify for charity care, to the department in a manner and time frame specified by the Commission of Health and Senior Services, in order to be eligible for a charity care subsidy.²

Demographic information about pool patients is required in both Massachusetts and New Jersey, because eligibility for charity is related to patient income. In both states, patients with incomes above 200% of the federal poverty level are subject to cost-sharing.¹

Systems in other states

There are other states that reimburse hospitals for uncompensated care, even though they do not appear to have Charity Care pools in the same way as Massachusetts, New Jersey, and New York.

South Carolina

South Carolina has a Medically Indigent Assistance Program (MIAP), which is a county-based program that funds inpatient hospital services for needy individuals that meet the eligibility criteria. MIAP covers the same inpatient hospital services that are covered by the state Medicaid program. A patient is eligible for full sponsorship if his/her gross family income is equal to or less than 100% of FPL. Patients whose gross family income are between 100 and 200% of FPL will be eligible for a partial sponsorship that is based on a sliding scale. The MIAP sponsorship formula is the prospectively determined rate.

The Department of Health and Environmental Control oversees the licensing of hospitals and the Certificate of Need (CON) program. The Department of Health and Human Services Finance Commission is responsible for developing uniform criteria and materials for the MIAP.

South Carolina's CON program requires hospitals and other health facilities to attain state approval before expanding the type or scope of health services or before undertaking a new health service (i.e. building a new facility, purchasing expensive and potentially duplicative medical equipment). The CON application requires that hospitals submit an Indigent Care Plan that includes:

- the amount and percent of gross revenues that the facility provided in indigent care during the past 3 fiscal years,
- the amount (in dollars and as a percentage of gross revenues) of indigent care the facility projects to provide during the existing and next fiscal year,
- a discussion of why the figures are adequate or inadequate for the needs of the community and any proposals or plans by the facility to better address the indigent care problem in the service area
- how the proposed service will meet the health needs of medically underserved groups

- the extent to which medically underserved populations currently use the applicant's services compared to the percentage of the population in the applicant's service area that is medically underserved and
- the extent to which Medicare, Medicaid and medically indigent patients are served by the applicant.³

In South Carolina, the definition of indigent care does not include bad debt, contractual adjustments or care that is reimbursed by a government program.

Ohio

Ohio's Hospital Care Assurance Program (HCAP) provides partial reimbursement to hospitals for uncompensated care. HCAP funds come from the state's Indigent Care Pool. Hospitals that receive HCAP funding are required to provide free, basic, medically necessary care to eligible individuals. Patients must apply to have their care covered by HCAP funds. The amount allocated to pay hospitals is based on any combination of the following indicators of indigent care: total costs, volume, or proportion of services to Medicaid recipients and low-income patients in addition to Medicaid recipients, and the amount of uncompensated care provided by the hospital.

Hospitals are required to write off the costs of any "hospital level services" provided to an uninsured Ohioan with an income below 100% FPL. This is not an automatic write-off, however. The hospital must include a notice on patients' bills and the patient must request HCAP on time.

Each hospital must submit to the Department of Job and Family Services a financial statement for the preceding year that reflects the income, expenses, assets, liability and net worth of the hospital. The financial statement must show bad debt and charity care separately from courtesy care and contractual allowances. Each hospital must also report annually information on the number and identity of patients receiving free care under HCAP, and the number and categorical identity of patients served under HCAP.

In the distribution of HCAP funds, preference is given to hospitals that provide a disproportionately high share of indigent care in relation to the total care provided by the hospital or in relation to other hospitals.⁴

Ohio's uncompensated care is defined as including payment for both bad debt and charity care.

Florida

Florida compensates hospitals for the costs of serving low-income and uninsured patients through several Medicaid funding mechanisms. In addition to the regular reimbursement hospitals receive for providing Medicaid services, supplemental Medicaid payments are also given to compensate for charity care to the uninsured, the underinsured and to help offset unreimbursed costs for providing Medicaid services.

Medicaid participating hospitals report their financial data and utilizations by using a uniform chart of accounts called the Florida Hospital Uniform Reporting System.⁵ Florida's Hospital Medicaid Reimbursement Plan⁶ are a set of methods and standards that guide Florida's Agency for Health Care Administration (AHCA) in the setting of facility specific per diem rates, based on each facility's cost report. The reimbursement rate is set specific to each facility. Florida's reimbursement plan uses historical data from individual hospital reports to establish rates for following reimbursement periods. To offset concerns that this rate methodology may not reflect the actual cost growth faced by hospital providers and that Medicaid reimbursement rates are insufficient to meet the cost of providing services, Florida uses the aforementioned supplemental Medicaid payments.

The largest supplemental Medicaid funding mechanism for hospitals is a federally authorized Low Income Pool (LIP) Program. Florida also has 3 LIP-related programs and policies that also provide supplemental Medicaid payments to hospitals. These include the Disproportionate Share (DSH) program, the Hospital Exemptions to Medicaid Reimbursement Ceilings program (Exemptions program) and the Buy-Back program.

The LIP program was established to “ensure continued government support for the provision of health care services to Medicaid, underinsured and uninsured populations.”⁷ The Waiver set a capped annual allotment of \$1 billion for each year of the 5-year demonstration. This annual \$1 billion allocation is distributed into three LIP program components: the “Regular” LIP or Hospital payments, the Special LIP payments, and the Non-Hospital Providers payments.⁸

For purposes of hospital reporting, ACHA defines charity care as the “medical care provided by a health care entity to a person who has insufficient resources or assets to pay for needed medical care without utilizing his resources which are required to meet his basic needs for shelter, food, or clothing.”⁷ Hospitals may only claim services as charity care for individuals with family incomes up to 150% FPL. In Florida, charity care excludes bad debt.

Prepared by Mary Li and Judy Wessler – Commission on the Public's Health System

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