



***REASSESSING THE PROVISION OF CHARITY  
CARE AND THE DISTRIBUTION OF CHARITY  
CARE PAYMENTS IN THE STATE OF NEW  
JERSEY***


*The NJCTH Charity Care Task Force*

*August 21, 2002  
Revised September 5, 2002*

**154 West State Street, Trenton, NJ 08608**

## Acknowledgement

The NJCTH Board of Trustees requested that the Council form a ***Charity Care Task Force*** to thoroughly examine and make recommendations to improve the current system of Charity Care in New Jersey. The CFO members of the Task Force dedicated considerable time and effort to this very important issue during the last several months. The result of their labor is this document which I believe is a thoughtful and balanced approach to improve the current valuation, payment, and funding of Charity Care in New Jersey. I thank each and every member of the Task Force for their work.



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September 5, 2002

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# **Reassessing the Provision of Charity Care and the Distribution of Charity Care Payments in the State of New Jersey**

## **Executive Summary**

NJCTH's Charity Care Task Force proposes that the methodology for the funding and distribution of Charity Care be changed in both the short-term and long-term. The first phase describes immediate, short-term changes (2003–2004) in the level of funding and the distribution methodology. The second phase (SFY 2005 and beyond) recommends fundamental changes to the provision of care to uninsured and underinsured patients, fairer compensation to the hospitals for such care, and shared financial responsibility by the providers, the government, and the payers (including business and labor).

### **A. Phase One – Immediate, Short-Term Changes**

#### **1. Eliminate the Current Distribution Formula**

The current formula for distributing Charity Care should be abandoned. The formula was initially intended as a short-term transition formula to bridge the gap from the prior all-payer system (Chapter 83) to the deregulated, more competitive environment in which hospitals now operate. The transition formula that was created (and that is still used today) is not an appropriate or equitable long-term methodology for distributing Charity Care payments to hospitals, nor was it intended to be. By including such factors as profitability and shiftability, the current formula maintains an outdated standard of allocating Charity Care.

#### **2. Combine the Two Funds and Pay Hospitals a Greater Percentage of Their Charity Care Costs**

The State should move toward paying hospitals a higher percentage of the costs of providing needed medical services to the Charity Care population. The Council's short-term proposal would reimburse hospitals on a straight line distribution basis, between 4 percent of the cost of providing Charity Care and 70 percent. This would increase the level of funding from the current 50 percent of Charity Care costs (based on Medicare rates) to 60 percent. Over the next several years, these percentages should increase to pay hospitals a greater percentage of their costs of providing these services, ultimately reaching 100% as suggested in our long term Recommendation Number 4.

#### **3. Use Medicare Rates to Value the Charity Care that Hospitals Provide**

The size of the pool must be truer to the actual costs of the care provided and should vary annually as the need for Charity Care changes. Using New Jersey's Medicaid rates, which are among the lowest in the nation and below actual cost, as a benchmark is unfair and unreasonable. Valuation of Charity Care at Medicare rates must be the standard, because Medicare rates more accurately reflect the actual costs of providing care.

**4. Require a 2% Minimum Level of Charity Care from All Hospitals Prior To Drawing**

**Any Charity Care Funds: Value: \$211M in SFY 2000**

Prior to receiving any reimbursement for Charity Care, hospitals should be required to provide Charity Care in an amount equal to 2 percent of the hospital's net patient service revenue.

**5. Distribute Funds Based on a "Straight Line" Percentage of Net Patient Revenue**

We recommend a simple, straight-line distribution methodology based on a percentage of a hospital's net patient service revenue. Hospitals that provide the highest percentage of Charity Care would receive the highest percentage of Charity Care payments, with a carve out for the State's six safety net hospitals (defined as urban/major teaching). This methodology assures that safety net hospitals (see Footnote, page 6) are protected.

**6. Include a Percentage of Hospitals' Emergency Department (ED) "Bad Debt" as Charity Care**

Many Charity Care cases that present in the ED are unable to be documented under the current Charity Care system because of patient factors (incomplete information, lack of an address of the patient, etc.) and the very detailed Charity Care documentation requirements. We recommend that the State immediately make a change to the hospital SHARE Form to include a required field that will capture the Emergency Department (ED) bad-debt write-offs as a separate, auditable category. Once the information is obtained, an appropriate percentage of ED write-offs can be included in hospitals' Charity Care valuations.

**B. Phase Two - Long-Term Changes starting in 2004**

**1. Establish a Broad-Based Uncompensated Care Funding Pool: The 25% Solution**

We recommend that charity care be funded in equal shares by the hospitals, the private sector (payers, including business and unions), and the State and Federal governments.

**2. Reduce the Cost of the Financial Eligibility Documentation Process**

We recommend an optional alternative methodology to the expensive financial eligibility documentation process that hospitals are required to perform for reimbursement. By using a well thought out proxy process, scarce health care dollars would be most appropriately used to provide direct patient care services.

**3. Recognize Charity Care Costs that are Currently Not Included in the Valuation Process**

We recommend that certain costs not currently recognized, such as Charity Care costs incurred in hospital Emergency Departments, and the cost of paying physicians to care for Charity Care patients, be recognized in hospitals' Charity

Care valuations.

**4. Fluctuate the Size of the Charity Care Pool According to Demand**

The current “fixed pool” method of funding Charity Care should be abandoned. The pool of Charity Care funds must allow for increases and decreases in funding levels to ensure that patients continue to receive equal treatment and appropriate access to needed services. The funding level should be at 100 percent of the cost based on Medicare rates.

**5. Promote Efforts to Expand Medicaid Eligibility**

The State should continue to pursue options to expand Medicaid to all potentially eligible persons.

**6. Mandate Health Insurance Coverage/Insurance Incentives**

The State should continue to use all resources at its disposal to create programs/incentives that provide insurance for uninsured and underinsured residents of the State.

**7. Petition the Federal Government to Raise the Federal Poverty Level for Medicaid Eligibility to Reflect the Cost of Living in New Jersey**

New Jersey is one of the most expensive states to live in, with the 2<sup>nd</sup> highest median household income in the nation, yet the same federal poverty level is applied for Medicaid eligibility in New Jersey as in West Virginia, the state with the lowest median household income. The poverty level should be used to make geographical adjustments similar to the labor rate factors. New Jersey should petition CMS to redefine poverty levels based on geographic differences in the costs of living.

**8. Evaluate Medicaid Rates for Physicians**

New Jersey has one of the lowest Medicaid reimbursement rates for physicians in the country (49<sup>th</sup> lowest in the nation). At such low payment rates, in a state with such a high cost of living, physicians cannot afford to participate in the Medicaid program to any significant degree. These rates are significant because ultimately, the hospitals become the provider of care for the indigent as well as the uninsured and underinsured. Additionally, such low reimbursement rates increase physicians’ need to have payment for their services subsidized by hospitals.

**Conclusion**

Underlying the recommendations contained in this document are two basic assumptions: (1) New Jersey has a moral responsibility to provide the same level of hospital based healthcare services to the uninsured population and (2) The State wants hospitals to provide services to all State residents comparable to those provided by the best hospitals in the nation. These goals are not compatible without fair and effective strategies to provide and pay for Charity Care. We believe the recommendations detailed above

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<sup>1</sup> Alaska has the highest median household income at \$61,318 per year; New Jersey is second at \$55,149; Arkansas is 49<sup>th</sup> at \$30,582.

provide the necessary framework for an equitable, solvent healthcare system that will ensure that New Jersey residents continue receiving the finest healthcare available.

More fundamentally, however, the State and the healthcare industry should explore all viable options to reduce the number of uninsured. The New Jersey Council of Teaching Hospitals is committed to working with the State and all interested and affected parties to improve the State's Charity Care Program.

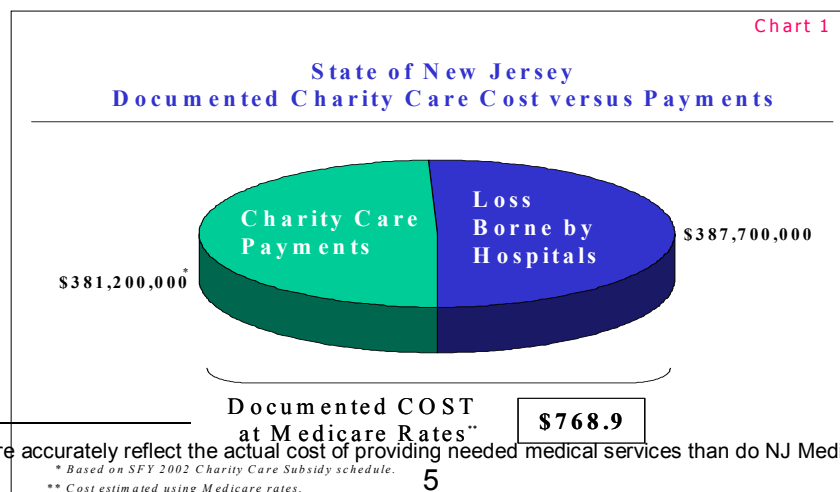
## I. Introduction

New Jersey hospitals provide the highest quality healthcare in a more efficient manner than ever before. They do so while operating in an environment of increased competition among providers and decreased payments from governmental and non-governmental third party payers. Operating margins are dangerously thin with more than 40 percent of New Jersey hospitals operating in the red. Capital for new technology is not keeping pace and the under-funding of Charity Care has reached record heights exacerbating the situation.

Despite these pressures, New Jersey hospitals remain committed to providing the highest quality care to all New Jersey residents, including the most vulnerable and under-served populations. In fact, New Jersey's acute care hospitals remain the primary source of healthcare for New Jersey residents that are uninsured and/or underinsured. Currently, there are more than 1 million New Jersey residents without any health insurance coverage. This is approximately 13 percent of our state's total population.

In 2000, the cost of providing Charity Care to New Jersey residents based on Medicare was \$768.9 million.\*

When calculating hospitals' Charity Care payments, the State values Charity Care at Medicaid rates set by the State, which are below costs. In 2000, the value of Charity Care was reduced from the cost of providing the care (\$768.9 million) to \$624.4 million, simply by valuing the care provided at New Jersey Medicaid rates. For that same year, however, the State only reimbursed hospitals \$381.2 million dollars for Charity Care. Thus, hospitals were paid \$387.7 million less than the cost of providing needed medical services to Charity Care patients. This loss was absorbed by the hospitals. Additionally, the \$768.9 million figure does not include other unrecoverable costs related to providing Charity Care, such as paying physicians to deliver care to the uninsured and underinsured population; the costs of providing care in hospital Emergency Departments to eligible patients who are unable, or refuse, to provide complete and accurate information required to qualify for Charity Care; and the considerable costs borne by hospitals to document the financial eligibility of Charity Care recipients.

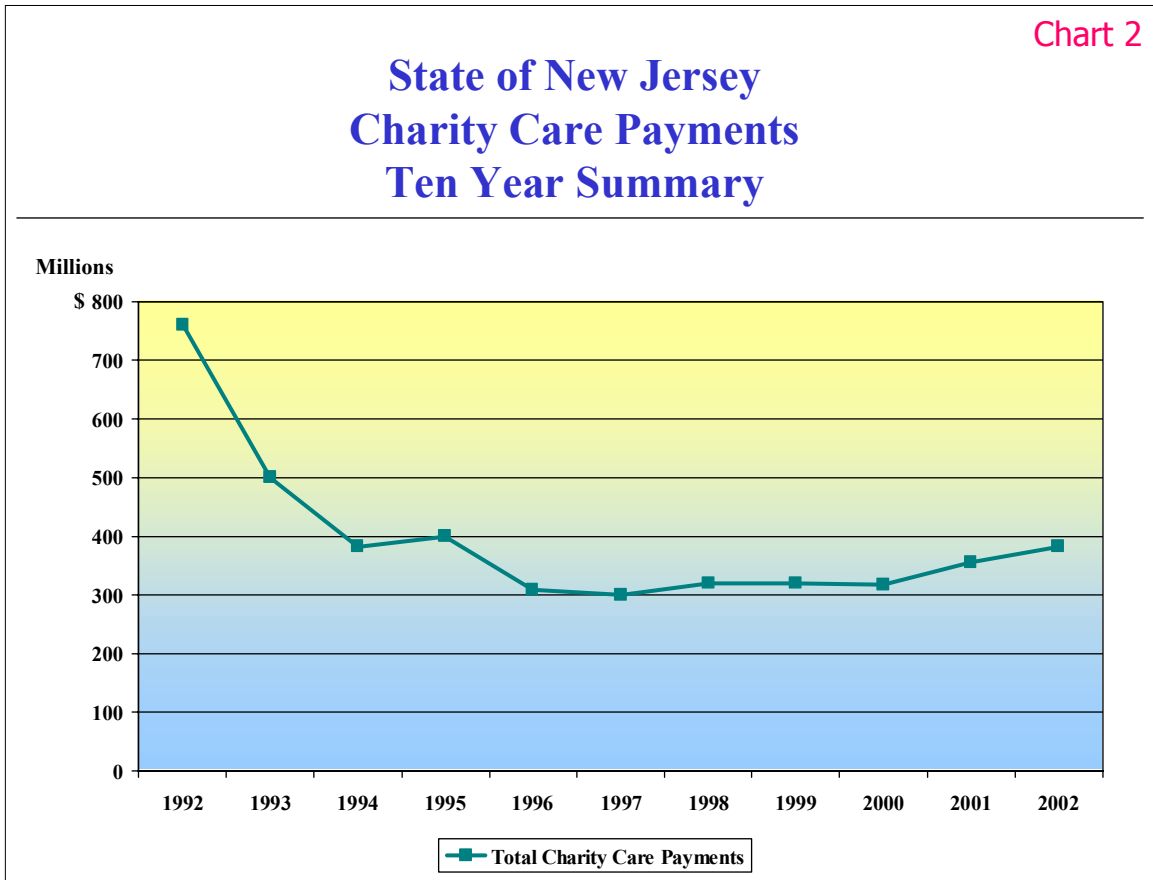


\* Medicare rates more accurately reflect the actual cost of providing needed medical services than do NJ Medicaid rates.

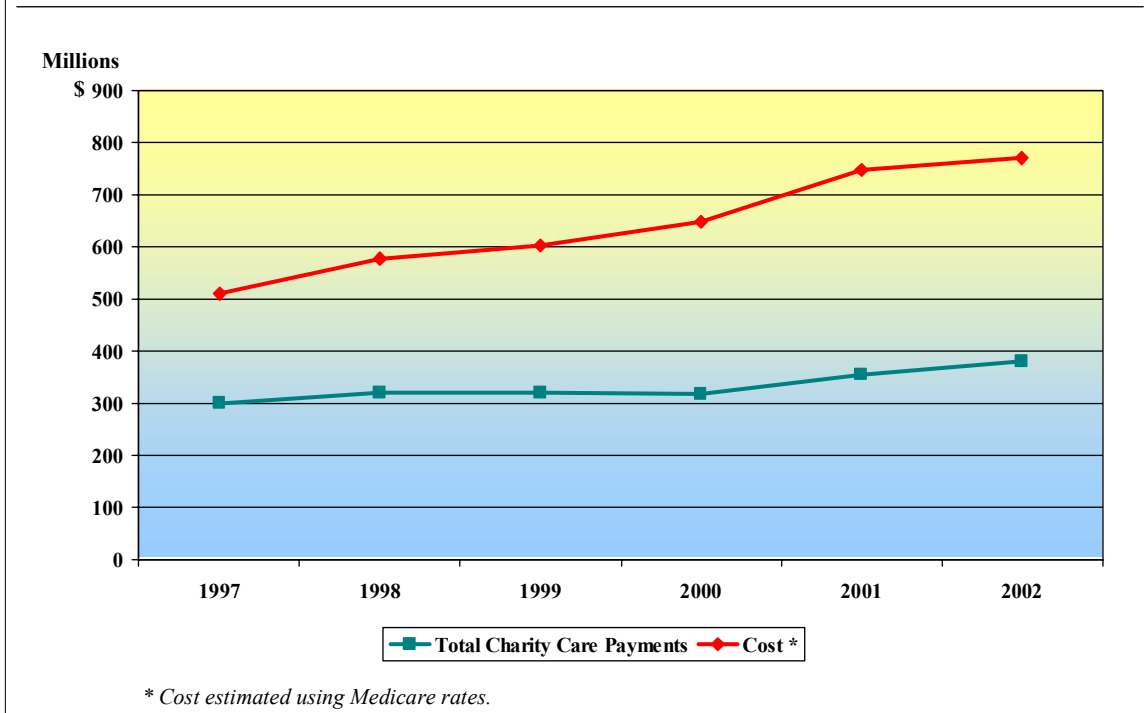
\* Based on SFY 2002 Charity Care Subsidy schedule.

\*\* Cost estimated using Medicare rates.

A brief look at figures over the last 10 years shows that although the cost of treating the uninsured and underinsured has been increasing, State funding for such care has not. In fact, State funding for Charity Care remains well below the level of funding a decade ago.



## State of New Jersey Charity Care Payments versus Cost Summary by Year



The above graphic illustrates the growing gap between the costs of charity care and the reimbursement.

To address the serious issues continuing to face New Jersey hospitals regarding equitable reimbursement and distribution of State payments for Charity Care, the **New Jersey Council of Teaching Hospitals** created its *Charity Care Task Force*. The Charity Care Task Force performed an in-depth appraisal of the current system of funding Charity Care in New Jersey, including how other states deal with caring for the uninsured. (A brief summary of how certain other states address “Charity Care” is contained in Appendix A of this report.)

Out of this process, the Task Force quickly reached consensus on two key points. First, New Jersey must continue its prominent role in financially supporting the safety net hospitals<sup>2</sup> in the State. Second, the Charity Care system in New Jersey must be revamped if hospitals and the State are to be able to meet their legal and moral obligations to the uninsured and underinsured residents of New Jersey by providing the same levels of care as the insured. The short-term and long-term recommendations that follow are designed to accomplish fundamental change, including protecting all safety net hospitals.

<sup>1</sup> Using the State’s definition of urban and major teaching, safety net hospitals would include: Cathedral Health System; Jersey City Medical Center; Newark Beth Israel Medical Center; St. Joseph’s Medical Center; The Cooper Health System; and UMDNJ-University Hospital.

## **II. The Current Charity Care System in New Jersey**

According to State statute, New Jersey acute care hospitals must provide medical care regardless of a patient's ability to pay. To accomplish this mandate, the true costs of providing Charity Care must be identified, adequate funds to pay for Charity Care must be made available, and an equitable formula to establish Charity Care funds must be in place. Currently, none of these fundamental requirements have been fully met.

### **A. The Charity Care Formula**

The current formula used to distribute Charity Care funds was initially intended as a short-term transition formula to bridge the gap from the prior all-payer system (Chapter 83) to a deregulated, more competitive environment in which hospitals operate today. In 1992, the State, through the Essential Health Services Commission, was to propose and implement a claims-based system of Charity Care. This did not happen. The transition formula that was created (and that is still used today) is not an appropriate or equitable long-term methodology for distributing Charity Care payments to hospitals, nor was it intended to be. By including such factors as profitability and shiftability, the current formula maintains an outdated standard of allocating Charity Care funds more in line with the transition system created after deregulation. Hospitals have much less profit and the payers that hospitals once used to defray losses (cost shift) no longer exist. As Charity Care costs continue to increase and payors continue to cut back, the current formula exaggerates the inequity in distribution.

Although all hospitals provide some Charity Care, the formula for distributing Charity Care funds affects hospitals differently based on several hospital-specific factors. Factors such as the hospital's "profitability" and "shiftability" affect the amount of payment a hospital receives from the Charity Care pool – which consists of a fixed, limited pool of funds that does not fluctuate when the number of uninsured persons changes. Because of these factors, certain distortions occur resulting in several large hospital providers of Charity Care receiving very little reimbursement. As a temporary fix, the Legislature created a Supplemental Charity Care Fund that was intended to ensure that all hospitals received a minimum of 30 cents for every dollar (based on Medicaid rates) of Charity Care provided. Unfortunately, the new pool was under funded and has not accomplished its purpose. At the same time, the numbers of uninsured and the amount of Charity Care provided has continued to increase.

### **B. The Current Funding Methodology**

#### **1. The Regular Charity Care Pool (Funded at \$345 million for SFY 2003)**

A complicated and outdated formula determines a hospital's eligibility for and the amount of a "regular" Charity Care payment received. First, each hospital's Charity Care is valued at New Jersey's Medicaid rates. The State then adjusts the valuation for "profitability." The next step takes into consideration each hospital's "revenue from private payers" ("shiftability"). The final step in the process reduces the payment to qualifying hospitals based on the fixed amount

of funding available. A detailed description of the Charity Care payment formula is included in Appendix B.

## **2. Supplemental Charity Care (Funded at \$36.2 million for SFY 2003)**

The Supplemental Charity Care Fund, established by the Legislature in SFY 2000, was designed to provide all hospitals a minimum Charity Care payment of 30 cents for each dollar of documented Charity Care (valued at Medicaid rates) the hospitals provide. Because of funding issues, the Supplemental Fund has yet to meet this minimal threshold level.

### **C. The Unrecognized Costs of Charity Care**

#### **1. The Provider Costs of Determining Charity Care Eligibility**

If a patient is ineligible for Medicaid or federal aid programs, and the patient can demonstrate financial need, the hospital is required not only to provide the care, but also to document rigorously the patient's poor financial status based on specific guidelines. Thus, hospitals are not only providing the medical care, they are also required to act as a gatekeeper by completing the documentation required to support financial eligibility. Once a determination of eligibility is made in favor of the patient, the hospital receives a less than actual cost payment for providing the medical service. No financial consideration is given for the substantial costs incurred in the documentation processes required for payment by the Charity Care Program.

#### **2. Emergency Department (ED) "Bad Debt"**

Many Charity Care cases that present in the ED are unable to be documented under the current Charity Care system because of patient factors (incomplete information, lack of an address of the patient, etc.) and the very detailed Charity Care documentation requirements. These cases are unable to be documented as noted above despite extensive efforts by hospitals (e.g. tracking patients, visiting their home with portable copiers, etc.).

Another factor preventing hospitals from fully documenting ED Charity Care cases is the restrictive nature of EMTALA regulations. The ED is required to and should treat all urgently ill patients prior to getting the required financial information. Because so many patients provide incomplete information, too many Charity Care cases are often reflected as "bad-debt write-offs."

### **D. Transferring Other Program Services to Charity Care for Payment**

The Charity Care pool has historically been designated for acute care hospitals. Beginning July 1, 2002, the Division of Medical Assistance has initiated changes to the FamilyCare program that will revert payment for mental health and substance abuse treatments/care to Charity Care. Payment for the General Assistance and WorkFirst New Jersey population will also be directed to Charity Care for payment of mental health and substance abuse care as of July 1, 2002. Reverting these treatments to the Charity Care Fund will only increase the

burden already borne by our State's acute care hospitals.

### **III. Problems with the Current System of Charity Care Payments**

There are a number of problems with the current Charity Care system. These problems include the following:

1. The current method of determining Charity Care payments does not ensure that the hospitals that provide the greatest percentage of Charity Care, as a percentage of the hospital's net patient service revenue, receive the greatest percentage of Charity Care payments made.
2. The current method for determining Charity Care payments utilizes outdated, flawed concepts (i.e., profitability and shiftability).
3. The current funding levels for both the Charity Care Subsidy Fund and the Charity Care Supplemental Fund are fixed amounts that do not fluctuate with increases or decreases in the annual amount of documented Charity Care provided by New Jersey's acute care hospitals.
4. The current valuation of Charity Care claims at Medicaid rates is significantly less than the true cost of the care provided.
5. The current Charity Care documentation process is highly labor intensive and very expensive, causing tens of millions of dollars to be spent by hospitals to document Charity Care cases, thereby siphoning funds away from direct patient care needs and services.
6. The current Charity Care documentation requirements do not recognize Charity Care cases that are undocumentable (some patients give inaccurate, and/or incomplete identity and financial information) which means these medical bills are inappropriately characterized as "bad debt" and are not recoverable from the Charity Care funding pool.
7. The funding for the Charity Care Supplemental Fund is dependent on the annual appropriations process and is therefore uncertain and subject to external budgetary pressures and the political process.
8. Changes have been made to the FamilyCare program that will revert payment for mental health and substance abuse treatments/care to Charity Care. Payment for the General Assistance and WorkFirst New Jersey population will also be directed to Charity Care for payment of mental health and substance abuse care as of July 1, 2002. The additional drawdown on the Fund has been made without a corresponding increase in Charity Care funding.

## **IV. Proposed Charity Care Reimbursement and Distribution Changes**

NJCTH's Charity Care Task Force proposes that the methodology for the funding and distribution of Charity Care be changed in both the short-term and long-term. The first phase describes immediate, short-term changes (2003 – 2004) needed to make Charity Care funding more equitable in the level of funding and the distribution methodology. The second phase (SFY 2005 and beyond) recommends fundamental changes to the provision of care to uninsured and underinsured patients, fairer compensation to the hospitals for such care, and shared financial responsibility by the providers, the government, and the payers (including business and labor).

### **A. Phase One – Immediate, Short-Term Changes**

The short-term changes outlined by the Council's Charity Care Task Force are a package of inter-related changes that together result in a fairer, balanced distribution of Charity Care payments. A modeling, using SFY 2002 data, of the short term changes being proposed by the Council's Charity Care Task Force is set forth in Appendix C.

The Council proposes that this entire package of changes be adopted and implemented beginning July 1, 2003.

#### **1. Eliminate the Current Distribution Formula**

The problems with the current formula have been described previously. Tinkering with the formula creates unintended consequences. The best solution is to eliminate the formula and create a fair distribution methodology (described in paragraph 5, below).

The formula was initially intended as a short-term transition formula to bridge the gap from the prior all-payer system (Chapter 83) to a deregulated, more competitive environment in which hospitals now operate. In 1992, the State, through the Essential Health Services Commission, was to propose and implement a claims-based system of Charity Care. This did not happen. The transition formula that was created (and that is still used today) is not an appropriate or equitable long-term methodology for distributing Charity Care payments to hospitals, nor was it intended to be. By including such factors as profitability and shiftability, the current formula maintains an outdated standard of allocating Charity Care funds. Hospitals' margins have continued to decline as hospital payments from all payers have been reduced, thereby eliminating hospitals' ability to cost shift. As the amount of Charity Care provided continues to increase, the current formula exaggerates the inequity in the charity care payment

distribution.

**2. Combine the Two Funds and Pay Hospitals a Greater Percentage of Their Charity Care Costs**

The Charity Care Subsidy (“regular”) Fund and the Supplemental Charity Care Fund should be combined. Current combined funding for the two pools is \$381.2 million. The Council’s proposal would reimburse hospitals on a straight line distribution basis between 4 percent of the cost of providing Charity Care and 70 percent (based on Medicare rates). Additionally, safety net hospitals would receive **75** percent of their total Charity Care provided valued and distributed based upon Medicare rates. If this methodology were in place for SFY 2002, the total funding amount required would have been \$462.3 million, or an additional \$81 million. This would increase the level of funding from the current 50 percent of Charity Care costs (based on Medicare rates) to 60 percent. Over the next several years, these percentages should increase, ultimately reaching 100 percent as suggested in our long term Recommendation Number 4.

**Provide**

**3. Use Medicare Rates to Value the Charity Care that Hospitals**

Charity Care cases should be valued at Medicare rates to more accurately reflect the cost of providing care to Charity Care patients. Medicare is not a generous payer but at least it is a fair payer that attempts to base its reimbursements on true costs. New Jersey Medicaid rates are set artificially and are among the lowest in the country. On average, New Jersey Medicaid rates reimburse hospitals substantially less (approximately 25 percent) than the cost of providing care.

In addition to being more equitable, there is precedent to valuing Charity Care at Medicare rates. In fact, when it comes to maximizing federal dollars for Medicaid, the State of New Jersey itself values Medicaid cases at Medicare rates. The excess dollars are used elsewhere in the State’s budget.

**4. Require 2% Minimum Level of Charity Care from All Hospitals Prior To Drawing Any Charity Care Funds: Value: \$211M**

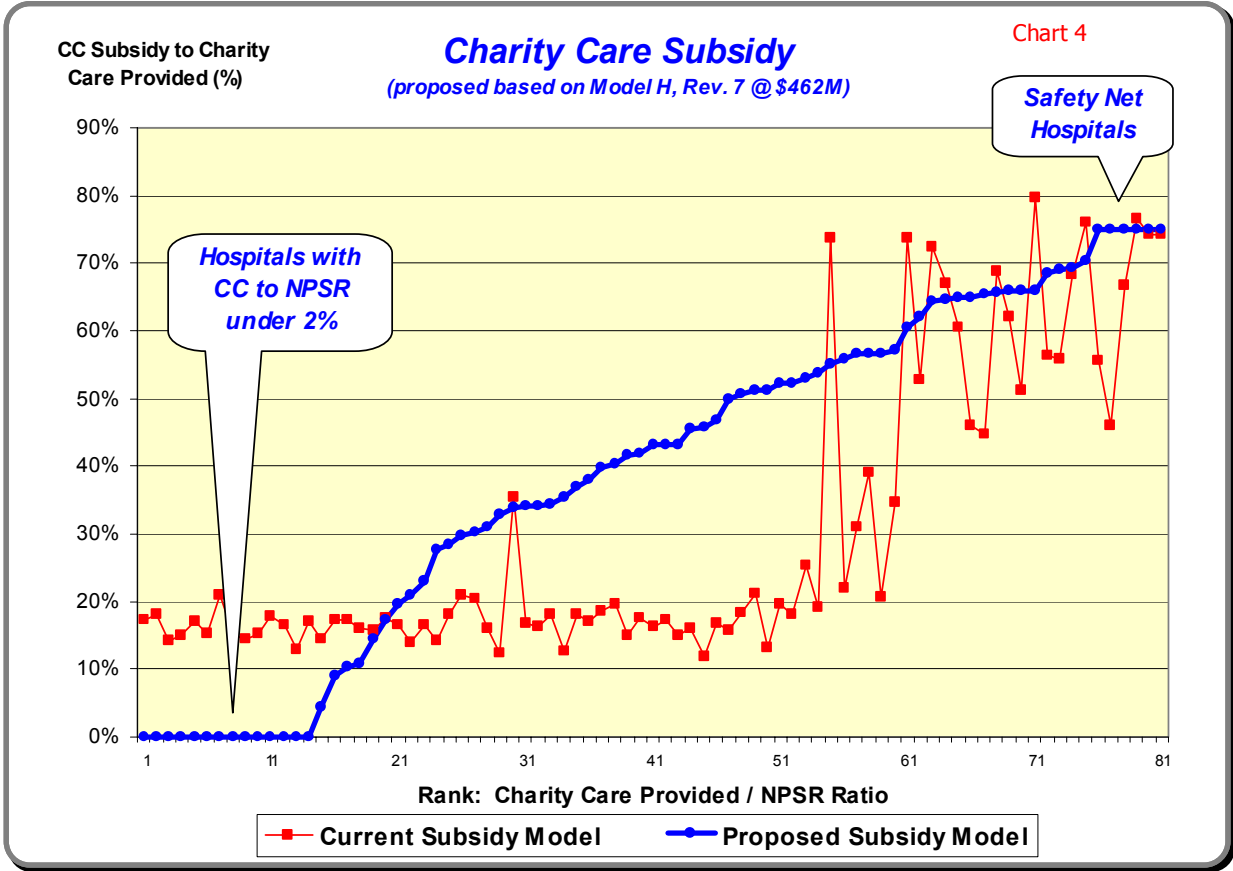
Prior to receiving any reimbursement for Charity Care, hospitals should be required to provide Charity Care in an amount equal to 2 percent of the hospital’s net patient service revenue. Such a level is consistent with hospitals’ charitable missions and the tax-exempt status that all New Jersey acute care hospitals currently maintain. If a hospital provides less than the 2 percent, they would be ineligible to receive any Charity Care payments. Hospitals that provide a minimum of 2 percent would receive Charity Care payments less the 2 percent Charity Care contribution.

**5. Distribute Funds Based on a “Straight Line” Percentage of Net Patient Revenue**

The Task Force recommends a straight-line approach to distributing Charity Care. Under this approach, each hospital’s ratio of Charity Care Provided (CCP) to Net Patient Service Revenue (NPSR) would be calculated annually.

Based on the mathematical distribution of all hospitals' ratios of CCP to NPSR, an industry-wide minimum and maximum percentage of Charity Care reimbursement would be established. The specific amount received by an individual hospital would be based on that hospital's ratio of CCP to NPSR. Safety net hospitals would be protected by initially receiving Charity Care payments of 75 percent of the Charity Care they provide, valued at Medicare rates. By distributing funds based on the amount of Charity Care provided as a percentage of net patient service revenue, and recognizing safety net hospitals, the State would protect safety net hospitals while ensuring that other hospitals are properly recognized and equitably reimbursed for the Charity Care they provide.

**Simply put, safety net hospitals will receive the highest percentage of their Charity Care costs, 75 percent. Those hospitals that provide Charity Care at less than 2 percent of their net patient service revenue will receive no payment and all remaining hospitals will receive between 4 and 70 percent of their Charity Care costs.**



This graphic illustrates the difference between the current formula (red) and the Council’s proposal (blue). Our proposal awards hospitals on a more even basis, with the amount of charity care subsidy based on the percent of charity care delivered.

**6. Include a Percentage of Hospitals' Emergency Department (ED) "Bad Debt" as Charity Care**

Many Charity Care cases that present in the ED are unable to be documented under the current Charity Care system because of patient factors (incomplete information, lack of an address of the patient, etc.) and the very detailed Charity Care documentation requirements. Another factor preventing hospitals from fully documenting ED Charity Care cases is the restrictive nature of EMTALA regulations. The ED is required to and should treat all urgently ill patients prior to getting the required financial information. Because so many patients provide incomplete information, too many Charity Care cases are often reflected as "bad-debt write-offs." To correct for this underreporting of Charity Care cases, a percentage of ED bad-debt "write-offs" should be included in hospitals' Charity Care cases. This change cannot be implemented or modeled at this time due to insufficient data. However, the State can immediately make a change to the hospital SHARE Form to include a required field that will capture the ED bad-debt write-offs as a separate, auditable category. In addition, the State can initiate a demonstration project in certain areas of the State for the purpose of pricing out ED bad debt cases and auditing the cases for Charity Care eligibility. Once the information is obtained, an appropriate percentage of ED write-offs can be included in hospitals' Charity Care valuations.

**B. Phase Two - Long-Term Changes starting in 2004**

The Council proposes that the State create a broad-based Charity Care Commission, representative of all stakeholders, to examine and implement the issues identified in the following recommendations.

**1. Establish a Broad-Based Uncompensated Care Funding Pool: The 25% Solution**

There are four primary players that together should fund Charity Care:

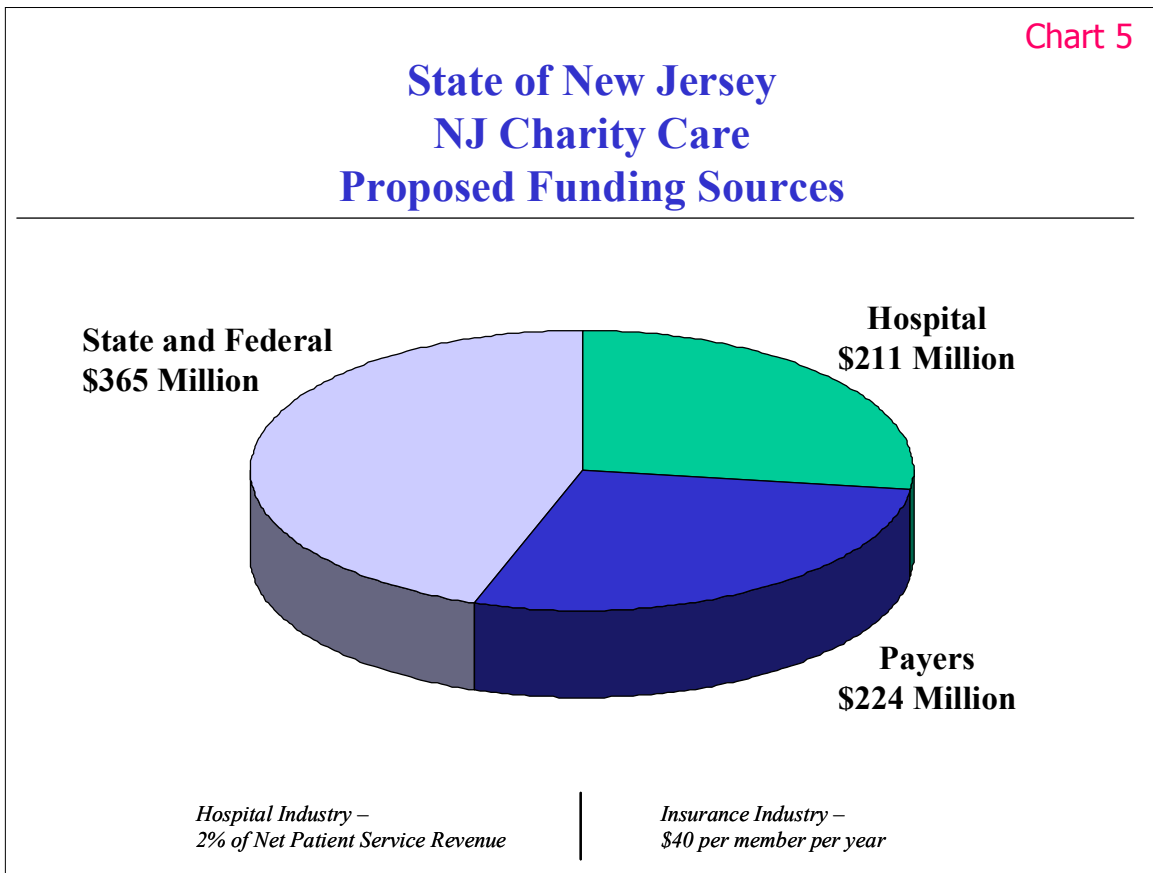
- Hospitals;
- Private Sector (Payers including Business and Unions);
- State Government; and
- Federal Government.

Because the Public Sector consists of both the State and the Federal governments, we propose that they each contribute 25 percent, with hospitals and the Private Sector also contributing 25 percent each.

If the recommendations in this White Paper are adopted, the Charity Care pool would be funded at approximately \$800 million, based on a Medicare cost standard. The hospital industry would contribute its 25 percent (approximately \$200 million,) in the form of free care which is equal to 2 percent of their net patient service revenue. No hospital would receive any Charity Care funding until the 2 percent threshold was achieved.

Payers and ERISA companies would pay their 25 percent in the form of an annual \$40 per member surcharge (approximately \$200 million).

The State and Federal governments combined would contribute 50 percent (the State receives a 50/50 match from the federal government which means that each pays 25 percent). This amounts to approximately \$400 million, which is about what the State currently pays.



## **2. Reduce the Cost of the Financial Eligibility Documentation Process**

In order to not provide free care to someone who can actually afford to pay, the State has created a cumbersome, time-consuming, and costly financial verification process that is borne entirely by the hospitals. This process is expensive resulting in a waste of resources. We believe the hospital industry is spending as much as \$50 million or more annually for external parties to document Charity Care cases. This figure is at least 13 percent of the current Charity Care funding. These figures do not include the financial resources spent internally by hospitals.

The documentation process should be replaced with an equitable and simplified proxy method so that the current dollars being spent to document eligibility can be appropriately utilized to provide direct patient care and services.

## **3. Recognize Charity Care and Charity Care Costs that are not Currently Included in the Charity Care Valuation Process**

A significant percentage of Charity Care provided in hospital Emergency Departments is inappropriately classified as “bad debt” as a result of a stringent and voluminous Charity Care eligibility documentation process. By immediately modifying hospitals’ SHARE Forms, proper data may be collected and an equitable proxy process put in place to capture a portion of the Charity Care being miscategorized.

Another significant cost incurred by hospitals is payment to physicians to care for Charity Care patients. Many physicians, especially in poorer areas, are unable to care for patients without reimbursement for their time. Hindered by inadequate reimbursement rates from other payers, many physicians literally cannot afford to care for the Charity Care population without some remuneration. Many hospitals have had to pay physicians for the care they provide Charity Care patients; these costs are not recognized by the current Charity Care valuation process.

## **4. Fluctuate the Size of the Charity Care Pool According to Demand**

The current “fixed pool” method of funding Charity Care should be abandoned. The pool of Charity Care funds must allow for increases and decreases in funding levels to ensure that patients continue to receive equal treatment and appropriate access to needed services. The funding level should be at 100 percent of the cost based on Medicare rates.

The Council’s short-term proposal pays hospitals a minimum of 45 percent of the cost of providing Charity Care and a maximum of 75 percent. Over the next several years, these percentages should increase to pay hospitals a greater percentage of their costs of providing these services.

## **5. Promote Efforts to Expand Medicaid Eligibility**

The State should continue to pursue options to expand Medicaid to all potentially eligible persons. The more persons insured under the Medicaid program, the better, since this directly reduces the size of the uninsured population. New Jersey currently ranks 43<sup>rd</sup> in the nation for Medicaid enrollment. Out of a total population of 8.2 million persons, 627,000 are enrolled in the New Jersey

Medicaid program. In Massachusetts, for example, of a total population of 6.2 million, 911,000 are enrolled in their Medicaid program.

Among other options, various waiver or demonstration project options should be considered. In some cases, waiver or demonstration project options might have ancillary benefits for hospitals and the State. For example, expanding Medicaid eligibility might increase some hospitals' Medicare disproportionate share payments by "adding" eligible days to the formula.

New Jersey should examine expanding Medicaid eligibility and enrollment by increasing the percentage of the Federal Poverty Level (FPL) for Medicaid eligibility. Currently, New Jersey Medicaid eligibility is up to 200 percent of the FPL. In Massachusetts, for example, Medicaid eligibility is up to 400 percent of the FPL.

Collaborative efforts of the State and providers could help increase the number of persons enrolled in available health insurance programs. Currently in New Jersey, it is estimated that more than 400,000 eligible New Jersey residents are enrolled in one of the State sponsored health insurance programs. If Medicaid eligibility were increased to 400 percent of the FPL as in Massachusetts, the number of eligible persons would increase to approximately 600,000.

## **6. Mandate Health Insurance Coverage/Insurance Incentives**

The State should continue to use all resources at its disposal to create programs/incentives that provide insurance for uninsured and underinsured residents of the State. FamilyCare and KidCare have been important vehicles to reduce the number of uninsured. Other options, such as additional tax benefits or incentives for employers to provide insurance for their workers, could result in long-term permanent savings for the State by reducing the number of uninsured. The State should also investigate measures such as "mandatory insurance" by business or insurance incentives to encourage maximum health insurance coverage in the State.

## **7. Petition the Federal Government to Raise the Federal Poverty Level for Medicaid**

### **Eligibility to Reflect the Cost of Living in New Jersey**

New Jersey is one of the most expensive states to live in. New Jersey has the 2<sup>nd</sup> highest median household income in the nation,<sup>3</sup> yet the same federal poverty level is applied for Medicaid eligibility in New Jersey as in West Virginia, the state with the lowest median household income. The poverty level should be geographically adjusted similar to the method in which labor rates for Medicare payments are geographically adjusted. New Jersey should petition CMS to redefine poverty levels based on geographic differences in the costs of living.

## **8. Evaluate Medicaid Rates for Physicians**

New Jersey has one of the lowest Medicaid reimbursement rates for physicians in the country (49<sup>th</sup> lowest in the nation). At such low payment rates, in a state with

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<sup>3</sup> Alaska has the highest median household income at \$61,318 per year; New Jersey is second at \$55,149; West Virginia is 51<sup>st</sup> at \$27,663 (based on 50 states plus the District of Columbia).

such a high cost of living, physicians cannot afford to participate in the Medicaid program to any significant degree. The current State budget included an increase in physician payment rates of \$17.5 million. While this is a step in the right direction, a \$70 million increase in the reimbursement rates would only have moved New Jersey to the 42<sup>nd</sup> lowest paying state in the country. These rates are significant because ultimately, the hospitals become the provider of care for the indigent as well as the uninsured and underinsured. Additionally, such low reimbursement rates increase physicians' need to have payment for their services subsidized by hospitals.

## **Conclusion**

Underlying the recommendations contained in this document are two basic assumptions: (1) New Jersey has a moral responsibility to provide the same level of hospital based healthcare services to the uninsured population and (2) The State wants hospitals to provide services to all State residents comparable to those provided by the best hospitals in the nation. These goals are not compatible without fair and effective strategies to provide and pay for Charity Care. We believe the recommendations detailed above provide the necessary framework for an equitable, solvent healthcare system that will ensure that New Jersey residents continue receiving the finest healthcare available.

More fundamentally, however, the State and the healthcare industry should explore all viable options to reduce the number of uninsured. The New Jersey Council of Teaching Hospitals is committed to working with the State and all interested and affected parties to improve the State's Charity Care Program.

# Appendix A

## **TEXAS**

Counties in Texas are required by state law to have programs to serve the medically indigent. They usually fulfill this requirement by forming hospital districts, which have taxing authority.

In addition, non-profit hospitals are required to develop a community benefits plan that identifies community needs, includes Charity Care and government-sponsored indigent health care, and that states how such identified community needs will be met. For-profit hospitals are not required to provide Charity Care, unless otherwise required to do so by law (e.g. EMTALA).

A nonprofit hospital or hospital system may elect to provide community benefits, which include Charity Care and unreimbursed government-sponsored indigent health care, according to any of the following standards:

1. Charity Care and government-sponsored indigent health care are provided at a level which is reasonable in relation to the community needs, as determined through the community needs assessment, the available resources of the hospital or hospital system, and the tax-exempt benefits received by the hospital or hospital system;
2. Charity Care and government-sponsored indigent health care are provided in an amount equal to at least 100 percent of the hospital's or hospital system's tax-exempt benefits, excluding federal income tax; or
3. Charity Care and community benefits are provided in a combined amount equal to at least five percent of the hospital's or hospital system's net patient revenue, provided that Charity Care and government-sponsored indigent health care are provided in an amount equal to at least four percent of net patient revenue.

A nonprofit hospital that has been designated as a disproportionate share hospital under the state Medicaid program in the current fiscal year or in either of the previous two fiscal years shall be considered to have provided a reasonable amount of Charity Care and government-sponsored indigent health care.

## **PENNSYLVANIA**

Act 55 of 1997 provides detailed tests that organizations must meet to be considered "institutions of purely public charity," and hence be granted tax-exempt status under the Pennsylvania constitution. One of the tests in Act 55 is that an institution of purely public charity must donate or render gratuitously a substantial portion of its services. One of the ways a non-profit hospital can meet this test is by maintaining an open admissions policy and providing uncompensated goods and services at least equal to 75 percent of net operating income but not less than 3 percent of total operating expenses.

In Pennsylvania, the Community Access Fund was created in 1996 by the Pennsylvania Legislature, providing \$24.4 million in FY 2001 for care provided to persons losing coverage under the GA program, which was being cut back at the same time. In 1999,

the Community Access Fund was expanded to include funding for hospitals whose inpatient Charity Care costs exceeded the statewide average. For SFY 2001, the Legislature made available \$18.6 million in state and federal dollars for this portion of the Community Access Fund.

Following receipt of tobacco settlement funds, Pennsylvania dedicated a portion of these funds to reimburse hospitals for some of the uncompensated care they provide. In August of 2001, the state released \$15 million for this purpose.

## **FLORIDA**

In 1977, the Florida Legislature enacted the Health Care Responsibility Act to ensure that adequate and affordable health care is available to all Florida residents. The Act places the ultimate financial obligation for an indigent's out-of-county emergency care on the county in which the indigent patient resides.

In order to qualify as an HCRA-participating facility, a hospital must meet certain minimum standards. Eligibility is determined annually and is based on information from the hospital's previous fiscal year.

All eligible hospitals must meet a two percent Charity Care obligation. This obligation is measured as the ratio of uncompensated Charity Care days to the total acute care inpatient days based on the hospital's most recent audited actual experience.

Participating HCRA providers must be either –

1. A regional referral hospital which has met its two percent Charity Care obligation; or
2. A hospital that has met its two percent Charity Care obligation and has a formal signed agreement with a county or counties to treat the county's indigent patients; or
3. A hospital that has met its two percent Charity Care obligation and has demonstrated to the Agency for Health Care Administration, Bureau of Certificate of Need/Financial Analysis, that at least 2.5 percent of its uncompensated Charity Care was generated by out-of-county residents.

The county must reimburse hospitals under HCRA for up to a maximum of 45 days of inpatient services and up to \$1000 of emergency outpatient hospital services per eligible recipient per county fiscal year. Inpatient services are paid at the provider's per diem unless otherwise negotiated. Emergency outpatient services are reimbursable at the line-item Medicaid rate. Certain surgical services are excluded from the \$1000 outpatient reimbursement limit for certain surgical or medical services.

## **MASSACHUSETTS**

When deregulation in 1992, Massachusetts shifted pool contributions from a surcharge on rates, seen as essentially an imposition on private payers, to an assessment on hospitals' private payer revenue, which was clearly a hospital obligation. The rationale was that ERISA would have preempted any assessment on payers. The pool-funding cap stayed at \$315 million.

In 1997, pool financing was reformed again, as political opposition to redistribution had grown, demand for a rise in the cap had increased, and state options had expanded in the wake of the Supreme Court's loosening of ERISA restrictions. Prior to the second reform, hospitals agreed that it had become more and more difficult to add their assessment into their charges, since insurers were negotiating lower rates without regard to hospital obligations. The shortfall grew larger, and hospitals faced with competitive forces began to feel a greater pinch from uncompensated care. Consequently, they became less willing to support the pool. As the two largest safety net hospitals claimed ever-larger shares of the limited pool, support for redistribution ebbed.

Political dispute over reform culminated in a 1996-97 special blue-ribbon commission. The resulting 1997 legislation lowered hospital assessments to \$215 million in aggregate. To make up the shortfall, private payers are to contribute \$100 million directly to the state. Beginning in 1998, private payers – including individuals and third party administrators paying on behalf of self-insured plans – are being billed by hospitals but must remit approximately 2 to 3 percent of hospital payments directly to the state. If they do not, they face a higher levy in the form of a sales tax on hospitals that the legislation authorizes hospitals to collect from payers, plus a collection fee paid to the hospital.

In addition, pool funding for the two big safety net hospitals was cut by some \$70 million, increasing the amount available to other hospitals that provide Charity Care. The two hospitals instead got that amount in separate additional funding from a managed care initiative under a new Medicaid demonstration. Other hospital will have to contribute less to the pool than previously and because the two hospitals are taken out of the pool, will receive more in return.

## **NEW YORK**

New York's 1996 reform sought to tap both hospitals and payers to fund uncompensated care and other initiatives, somewhat similar to the second Massachusetts pool reform that followed in 1997. Although the financing changed, the total amount of funds to hospitals did not. Starting in 1997, hospitals are required to pay a 1 percent assessment on inpatient revenue. In addition all payers, except Medicare, are requested to register a pay a patient services assessment on payments for hospital inpatient or outpatient care, clinics, and laboratories (not physicians' services), as part of the cost of purchasing such institutional services. Paid directly to the state pool, the amount of the patient services assessment is 5.98 percent for Medicaid and 8.18 percent for private payers and workers compensation. Private payers negotiate payment rates directly with providers and may elect to pay the service assessment on an encounter basis without paying the state directly. In that case, however, hospitals are entitled to charge an additional 24 percentage-point surcharge to such payers (on top of the 8.18 percent assessment).

This elective feature was designed to keep the assessment from being a mandatory tax but to strongly discourage payers from paying as part of their providers' rates. Providers felt that if they had to collect the 8 percent from competitive payers, the payers would just reduce the hospital payment rate as an offset. So hospitals wanted payments made directly to the state in order to separate negotiation over rates and collection of the assessment. New York also relied less heavily than Massachusetts on the provider assessment because there was the fear that, without mandatory rate regulation, it could not be effectively passed through to payers.

## Appendix B

**Step 1** Charity Care, valued at Medicaid rates and adjusted for profitability. Using a three (3) year rolling average, the State compares the hospital-specific operating margin (adjusted for Charity Care subsidies) to the statewide median. For hospitals above the statewide median the documented Charity Care at Medicaid rates is reduced by the following formula, which reduces ½ of the hospitals in the State's documented Charity Care at Medicaid rates by 0% to 75%:

$$\frac{1 - (.75 \times \text{Hospital OM} - \text{Statewide Median OM})}{\text{Highest OM} - \text{Statewide Median OM}}$$

**Step 2** Adjustments for Revenue from Private Payers – “Payer Mix.” First, a Statewide Payer Mix Factor is calculated using the following formula:

$$\frac{\text{Charity Care Adjusted for Profitability} - \text{Charity Care Subsidy}}{\text{Private Payer Revenue}}$$

**Step 3** Hospital-specific Payer Mix Factor and Resultant Subsidy. The hospital-specific Charity Care subsidy is determined by adjusting the Statewide Payer Mix Factor so that the sum of the hospital-specific factor minus the Statewide Mix Factor multiplied by the hospital-specific Private Payer Revenue equals the statewide Charity Care funding available

# **Appendix C**

## **Financial Model**

PROPOSED CHARITY CARE SUBSIDY DISTRIBUTION MODEL
Medicare Rates, Straight Line Distribution Method - (w/o CC in NPSR, w/2% Reduction)
Major Teaching Inner City Hospitals Receive Minimum of 75% of CC @ Medicare Rates / Other 4% to 70%

Table with 14 columns: No., Hospital Name, Total Documented Charity Care @ Medicare Rates (D), Net Patient Service Revenue (NPSR) (E), 2% Minimum Charity Care Contribution of Net Patient Service Revenue (F), Adjusted Documented Charity Care @ Medicare Rates (Adj'd for the 2% Min.) (G), CC Provided b/o M'Care Value inc. DIME versus NPSR (H), CC Provided b/o Percent Reduced by 2% (I), % of CC Subsidy to CC Provided b/o M'Care Value inc DIME (FY Current) (J), SFY02 Charity Care Subsidy b/o O'Conco Calc. (Reg. & Supp.) (K), Charity Care Subsidy Calculated per Model (L), % CC Subsidy to Charity Care Provided Ratio (M), and Change in Subsidy (N). Rows include hospitals such as Newcomb Medical Center, Wm. B. Kessler Memorial Hospital, Southern Ocean County Hospital, Pascoack Valley Hospital, West Jersey Hospital, St. Barnabas Medical Center, Chilton Memorial Hospital, Valley Hospital, Shore Memorial Hospital, Bayshore Community Hospital, St. Clare's / Dover, JFKennedy Med Ctr (Edison), Robert Wood Johnson at Hamilton Memorial Hospital of Burlington County, Elmer Community / SJHS, Overlook Hospital, St. Clare's Hospital / Sussex WKV, Medical Center of Ocean County, Memorial Hospital of Salem County, Medical Center @ Princeton, Rahway Hospital, Holy Name Hospital, Burdette Tomlin, Meadowlands Hospital Medical Ctr, Somerset Medical Center, St. Clare's Hospital / Denville, Union Hospital, Rancocas Hospital, Hackettstown Community Hospital, St. Francis (Jersey City), General Hospital Center @ Passaic, Riverview Medical Center, Community Memorial Hospital, Hunterdon Medical Center, CentraState Medical Center, Mountainside Hospital, Robert Wood Johnson Univ. Hosp., West Hudson Hospital, Jersey Shore Medical Center, Clara Maass Medical Center, Morrisown Memorial Hospital, Our Lady of Lourdes Medical Center, Hackensack Medical Center, Underwood Memorial Hospital, Warren Hospital, Capital Health System at Mercer, and Kimball Medical Center.

