



## **Charity Care 101**

### **Background**

New Jersey Hospital Care Payment Assistance Program (Charity Care) is a state program designed to help provide free and reduced cost care to the uninsured. Many states maintain a state or local government owned public hospital system to provide care to these patients, however NJ does not have any such hospitals. Our “healthcare safety net” relies on non-profit private hospitals and federally qualified health centers for the un- and underinsured.

According to N.J.S.A. 26:2H-18.64, every acute care hospital in the state is required to provide care to anyone who walks through their doors regardless of their ability to pay. However, hospitals cannot afford to provide this care alone. Most healthcare payers (i.e. Medicare, Medicaid, many managed care insurers, etc) already reimburse hospitals at rates below their actual cost of providing care. As a result 40 percent of hospitals are operating at a loss. Because these non-profit hospitals cannot afford to provide services to the state’s uninsured without financial help, in 1993, the state deregulated hospitals and created the Healthcare Subsidy Fund and the charity care program. These programs were put in place to partially reimburse hospitals for a portion of their costs of treating the uninsured.

### **Who Qualifies For Charity Care?**

New Jersey residents with incomes below 301 percent of the federal poverty level that do not qualify for Medicaid are eligible to receive charity care services for both inpatient and outpatient care at any of the state’s acute care hospitals. Families with incomes up to 200 percent of the federal poverty level will receive free care, whereas families between 200-300 percent of the federal poverty level will be responsible for a portion of their hospital bill.

### **How Are Hospitals Reimbursed For Treating Charity Care Patients?**

Charity care reimbursement was a claims-based system where hospitals were reimbursed based on the actual healthcare services that they provided to qualified New Jersey residents. These facilities would submit claims to the state for charity care payment based on the Medicaid payment system. The Department of Health and Senior Services would audit these claims annually and distribute charity care reimbursement based on the state’s charity care reimbursement formula.

However, in SFY 13 the state Department of Health utilized a new regression based formula which documented charity care claims for calendar year 2010 and adjusted the distribution from year-to-year based on the increase or decrease of charity care claims over the prior year. The funding formula has accounted for the amount of subsidy received by a facility in the prior SFY 2012 budget to mitigate large increases or decreases in funding. Under this new formula, a

hospital will receive 90 percent of its SFY 2012 Charity Care Subsidy amount. The remaining 10 percent of its SFY 2012 amount is adjusted based on two factors: the percent rate of change in actual documentation between CY 2009 and CY 2010, and the hospital's percent to total of the statewide documentation in 2010 (\$1.028 billion at Medicaid rates). One of the key principles the formula seeks to guarantee is that every hospital with an increase in documentation from CY 2009 to CY 2010 will see an increase in their subsidy and vice versa.

### **Charity Care Changes In the Last Decade**

The state deregulated New Jersey hospitals in 1993 and established the Health Care Subsidy Fund and charity care program to help hospitals care for the uninsured. In the following year, the state reimbursed hospitals at a rate slightly above their costs for providing care to these patients which demonstrated a strong commitment to fund healthcare services to the states most vulnerable residents. However, as the charity care burden increased over the following decade, the state gradually reduced its share and required hospitals to pay a greater portion of the costs of treating charity care recipients. That trend was reversed in 2005 when the NJ Legislature infused over \$200 million new dollars into the charity care program.

NJHA applauded the Legislature for restoring the state's partnership with the hospitals to provide a viable safety net to un- and underinsured. Since then, the state has seen gradual increases to charity care in each year following.

### **Charity Care for SFY 2013**

In SFY 13 charity care funding saw an increase from \$665 to \$675 million. The New Jersey's hospitals consider charity care a partnership with the state. While the 2013 budget appropriates \$675 million in charity care reimbursement, hospitals will deliver more than \$1.3 billion in care to New Jersey's uninsured residents. According to survey results released in January 2010, 82 percent of hospitals statewide reported an increase in charity care demands. In addition to providing an essential social service, New Jersey hospitals are also critical to the state's economic health, therefore maintaining charity care funding in New Jersey is extremely vital to the providing quality care to all patients.

### **State-Funded Programs: Uncompensated Care**

Uncompensated care pools have been used by several states in an attempt to aid hospitals and increase the volume of care provided to patients without health insurance. According to the *National Conference of State Legislatures*, 34 states besides New Jersey have some form of a state-funded program to provide health care access to their low-income residents.<sup>[1]</sup> These programs differ across states by the services and providers that the program covers, the eligible population, and the level of reimbursement. They are usually funded out of general state revenues, though a dedicated tax is sometimes also used.

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<sup>[1]</sup> National Conference of State Legislatures, [www.ncsl.org](http://www.ncsl.org)

## Examples Include:

- (1) **Massachusetts:** The Uncompensated Care Pool, also known in Massachusetts as the “Health Safety Net,” was established in 1985, reimburses hospitals and community health centers for providing free or discounted health care to the uninsured and the indigent. A mixture of sources including contributions from hospitals and insurance companies, government funds, DSH funds, and monies from tobacco settlements finance this uncompensated care pool.<sup>[2]</sup> Full uncompensated care is offered to those with an income equal to or below 200% of the federal poverty level (FPL). The pool was funded in FY13 with 30 million dollars from the state, 160 million in assessment to hospitals and 160 million in assessment to insurers. The state saw a shortfall of 130 million dollars which was picked up by the hospitals.
  
- (1) **Washington:** The state’s comprehensive charity care legislation<sup>[3]</sup> requires hospitals to provide full charity care to indigent individuals, namely those with an income equal to or below 100 percent of the FPL. This legislation also considers families with incomes ranging from 100 to 200 percent of the FPL to be indigent qualifying them for charity care. This state defines charity care as “appropriate hospital based medical services provided to indigent persons.”<sup>[4]</sup>

## **Conclusion:**

This review of charity care in the United States reveals a highly complex issue. Charity care and the uncompensated care pools have historically not had a clear, universal definition to guide the implementation and practice of these concepts, however charity care eligibility and funding levels may be changed as healthcare reform continues to be fully implemented. In recent years, facilitating consistency in charity care has been ultimately laid out in the development of legislation on the individual state level.

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<sup>[2]</sup> The Missouri Foundation for Health Health Policy Committee, Prepared by: MFH Health Policy Staff, 2005

<sup>[3]</sup> Comprehensive legislation encompasses carefully structured and integrated laws and regulations. Often a designated state agency oversees compliance with the regulations. Such legislation includes clear definitions of what constitutes charity care and community benefits and clearly outlines very specific eligibility requirements for the patient, as well as reporting responsibilities for the hospitals. These laws often prescribe penalties for noncompliance.

<sup>[4]</sup> The Missouri Foundation for Health Health Policy Committee, Prepared by: MFH Health Policy Staff, 2005