REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

REVISED/NEW INDIGENT HEALTH CARE TRUST FUND

(COPN FOLLOW-UP)

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Preface

This report is a follow-up to the Joint Commission on Health Care's (JCHC) recent activities related to Virginia's Certificate of Public Need (COPN) program. In December 2000, the JCHC issued a report entitled A Plan to Eliminate the Certificate of Public Need Program Pursuant to Senate Bill 337. Following publication of that report, the JCHC introduced legislation during the 2001 Session (SB 1084 and HB 2155) which would have substantially eliminated the state's COPN program in three separate phases. Among the provisions of that legislation concerning providers of deregulated services was language directing the JCHC, during Phase 1 of deregulation, to "design a proposal for incorporating deregulated services into the Indigent Health Care Trust Fund or a new indigent care program." While the JCHC's deregulation plan (as provided in SB 1084/HB 2155) was not approved by the 2001 Session of the General Assembly, at its May 1, 2001 meeting, the JCHC directed staff to complete this study.

Based on our research and analysis during this review, we concluded the following concerning the Indigent Health Care Trust Fund (IHCTF) and its possible modification to incorporate providers of deregulated specialty services:

- The IHCTF attempts to equalize the burden of providing charity care among hospitals.

- The IHCTF is administered by DMAS.

- Historically, the IHCTF has been able to reimburse about 40 percent of qualifying charity care costs above the statewide median level of charity care.

- The total state appropriation to the IHCTF is $12 million. However, this amount has consistently been underspent. Only $3.7 million of the $6 million non-general fund (i.e., hospital contribution) appropriation is spent.

- State appropriations to the IHCTF comprise a very small part of state spending on indigent health care.

- DMAS staff describe the IHCTF as being expensive and labor intensive to administer.

- Establishing the purpose of a new or revised IHCTF should be the first step in any design process to incorporate providers of deregulated specialty services. Other elements of a design process could include:

    - Expanding the definition of indigent care,

    - Establishing data collection and reporting requirements,

    - Recognizing financial differences between physician practices and hospitals,

    - Establishing an indigent care benchmark, and

    - Determining whether there should be any constraints of the size of the fund.

- The JCHC received four preliminary design proposals, which are summarized in this report.

A number of policy options were offered for consideration by the Joint Commission on Health Care regarding the issues discussed in this report. These policy options are listed on page 35.

Our review process on this topic included an initial staff briefing, which comprises the body of this report. This was followed by a public comment period during which time interested parties forwarded written comments to us regarding the report. The public comments (attached at Appendix A) provide additional insight into the various issues covered in this report.

On behalf of the Joint Commission on Health Care and its staff, I would like to thank the Department of Medical Assistance Services, the Virginia Hospital and Healthcare Association, the Medical Society of Virginia, the Virginia Association of Regional Health Planning Agencies,

and Kemper Consulting for their cooperation and assistance during this study.

Patrick W. Finnerty
Executive Director

December 2001

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I.
Authority and Background for the Study

Background

This report is a follow-up to the Joint Commission on Health Care's (JCHC) recent activities related to Virginia's Certificate of Public Need (COPN) program. In December 2000, the JCHC issued a report entitled A Plan to Eliminate the Certificate of Public Need Program Pursuant to Senate Bill 337. Following publication of that report, the JCHC introduced legislation during the 2001 Session (SB 1084 and HB 2155) which would have substantially eliminated the state's COPN program in three separate phases.

In developing the COPN deregulation plan, the JCHC recognized that there was a need to ensure continued access to care on the part of indigent and/or uninsured individuals following deregulation of COPN. To address this issue, the deregulation plan recommended by the JCHC included access provisions related to insurance coverage enhancements, academic health centers, and providers of newly deregulated services. Among the provisions of that legislation concerning providers of deregulated services was language directing the JCHC, during Phase 1 of deregulation, to "design a proposal for incorporating deregulated services into the Indigent Health Care Trust Fund or a new indigent care program." The same legislation also required providers of specialty services, as a condition of state licensure, to "participate and contribute to any new or revised mechanism for funding of indigent health care." This provision was intended to help equalize the burden of providing charity care among hospitals and providers of newly deregulated services.

The recommended deregulation plan stated that the "new or revised trust fund will define and track indigent care for all providers, including hospitals, at 200% FPL, and the rules governing this program will specify a minimum set of standards for reporting and valuing qualified charity care costs (e.g., by adopting current cost reporting principles)." The deregulation plan stated further that "additional state dollars will have to be appropriated to supplement amounts contributed by providers of newly deregulated services." While the JCHC's deregulation plan (as provided in SB 1084/HB 2155) was not approved by the 2001 Session of

the General Assembly, at its May 1, 2001 meeting, the JCHC directed staff to complete this study.

Organization of Report

This report is presented in four major sections. Following this section, the second section provides an overview of the current Indigent Health Care Trust Fund (IHCTF). The third section discusses a number of issues that will need to be addressed in order to design a final proposal for incorporating deregulated service providers in the IHCTF or a new indigent care program. The fourth section summarizes, compares and contrasts preliminary design proposals that were prepared by four different stakeholder organizations. The fifth and final section presents some policy options.

II.
Overview of Indigent Health Care Trust Fund

The Virginia IHCTF is a Public/Private Partnership Involving the State Government and Acute Care Hospitals In an Effort to Equalize the Burden of Providing Charity Care Among Hospitals

The statutory purpose of the IHCTF is to "receive moneys appropriated by the Commonwealth and contributions from certain hospitals and others for the purpose of distributing these moneys to certain hospitals...." In practice, the IHCTF reimburses hospitals who meet certain criteria for part of their cost of charity care. Section 32.1-332 of the *Code of Virginia* defines charity care as hospital care for which no payment is received and which is provided to any person whose family income is less than 100 percent of the federal poverty level (FPL).

The IHCTF is administered by the Department of Medical Assistance Services (DMAS). The Board of Medical Assistance Services is authorized to promulgate regulations for administration of the fund. While formal regulations have not been issued, policies and procedures for operating the fund have been developed by the Technical Advisory Panel (TAP). The TAP, which is the policy body for the IHCTF, consists of members of the Board of Medical Assistance Services, the Commissioner of Health, the Commissioner of Insurance, as well as representatives of the hospital industry, the small business community, the insurance industry, and the medical community.

Health Care Projects for the Uninsured. Section 32.1-335 of the Code of Virginia requires the TAP to "establish pilot health care projects for the uninsured...." Item 320(B) of the Appropriations Act requires DMAS to use funds donated to the IHCTF "for the purpose of a demonstration project in select sites across the Commonwealth to assist low-income employees in purchasing employer-sponsored health insurance." However, prior attempts to implement such pilot projects, most recently in Northern Virginia during the late 1990's, have been unsuccessful.

Each Hospital Is Required to Submit a Statement of Charity Care to DMAS

Pursuant to the policies governing the IHCTF, hospitals are required to maintain certain information on each patient who is provided charity care. Qualifying inpatient and outpatient medical services are those that are covered by the Virginia Medicaid program. Only items that are actually charged to charity care on the hospital's financial records during that fiscal year are eligible for the charity care log during that year.

The patient specific data that hospitals must maintain are limited to gross family income, family size, admission date/discharge date, principal diagnosis and total charges related to the stay. Hospitals are not allowed to include bad debt (i.e., unpaid bills for which the hospital expected payment) or contractual allowances from third-party payers in their statements of charity care. Hospitals are also required to submit an audit report to DMAS which attests to the following:

- the data collected for each charity patient is complete,
- the amount of gross family income is appropriate,
- the amount of total charges coincides with the hospital's accounts receivable records, and
- the total charges all apply to the fiscal year reported.

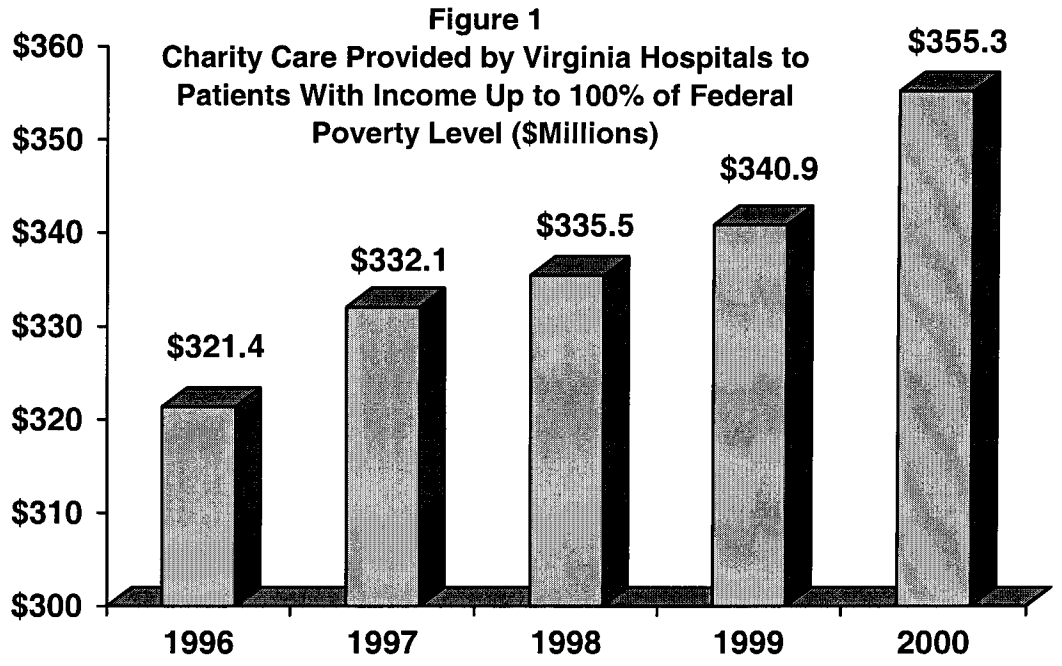
DMAS receives hospital financial data for IHCTF calculations from Virginia Health Information (VHI). VHI annually collects financial data, including audited financial statements, from each Virginia hospital, including outpatient surgical hospitals, as part of its Efficiency and Productivity Information Collection System (EPICS).

The Dollar Amount of Charity Care Provided by Virginia Hospitals Has Been Increasing But, As a Percentage of Gross Revenue, Reported Charity Care Has Been Decreasing

As illustrated in Figures 1 and 2, the amount of charity care provided by Virginia hospitals to patients with incomes up to 100 percent of the federal poverty level increased from $321 million in 1996 to $355 million in 2000. However, when measured as a percent of gross patient

revenues, the amount of reported charity care declined from 3.33 percent to 2.55 percent over the same time period.

When measured in terms of the amount of charity care provided to individuals with incomes up to 200 percent of the federal poverty level, the amount of charity care reported by hospitals increased from $355 million in 1996 to $416 million in 2000. However, when expressed as a percentage of gross patient revenues, the amount of reported charity care declined from 3.69 percent to 2.99 percent over the same time period.



Source: Virginia Health Information

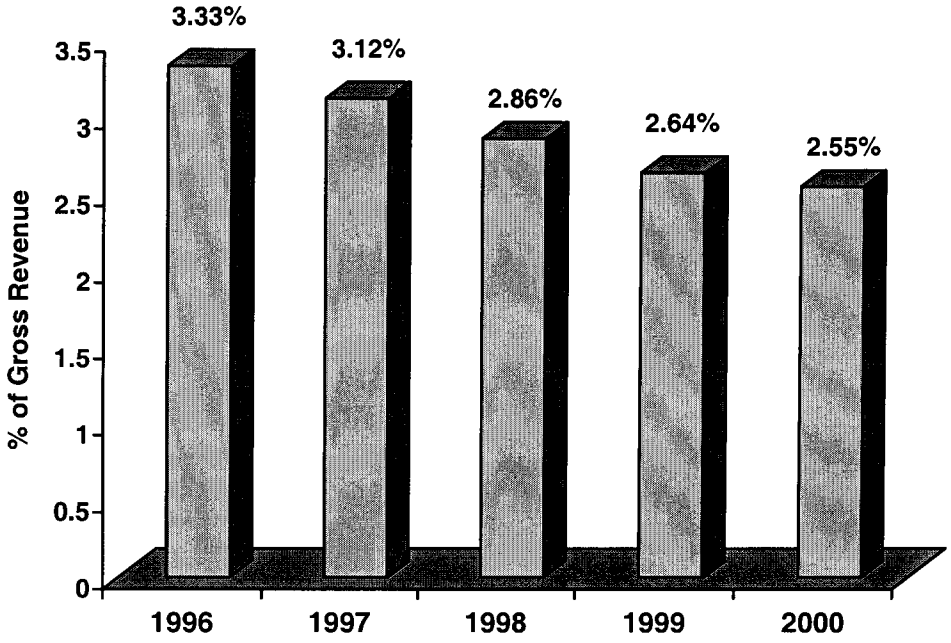
IHCTF Contributions and Payments Are Prescribed by §§ 32.1-337 and 32.1-338 of the *Code of Virginia*

The amount of payments from and contributions to the IHCTF are calculated by DMAS using an algorithm that corresponds to provisions contained in §32.1-337 and §32.1-338 of the *Code of Virginia*. The first half of the algorithm calculates trust fund payments to hospitals. Upon receiving all hospital charity care reports, DMAS calculates a charity care standard, which is the statewide median amount of charity care provided

by hospitals. The charity care charges reported by each hospital are converted to charity care costs using the cost to charge ratio derived from each hospital's Medicare cost report. The amount of charity care costs of each hospital is then compared to the statewide median. The outcome of this part of the algorithm, being the total amount that the trust fund is required to pay to each hospital, is either zero or some positive number, based on a hospital's level of charity care.

Figure 2

Charity Care Provided by Virginia Hospitals to Individuals with Incomes Up to 100% of the Federal Poverty Level



Source: Virginia Health Information

Pursuant to §32.1-337 of the *Code of Virginia*, a "disproportionate share level" is established by DMAS "as a percentage above the standard not to exceed three percent above the standard." Payments for hospital charity care provided above this disproportionate share level are made entirely with state general funds. For FY 2001, the disproportionate share level was set at 1.0076 percent of gross patient revenue above the statewide standard (median) level of charity care of 1.0994 percent. This "DSA allowance percentage" is applied to the total trust fund payment

(previously calculated based on the hospital's charity care costs) in order to determine the amount of the total payment that will be made entirely with state general funds. Thereafter, the remaining trust fund payment to each hospital is divided equally among state general funds (50%) and hospital contributions (50%).

The second half of the DMAS algorithm computes a hospital's required contribution to the IHCTF. This calculation is based primarily on a hospital's operating margin and state corporate income tax payments. For-profit hospitals receive a credit toward their required contribution for the amount of state corporate income taxes that they pay. The contribution calculation is also a function of a statewide hospital "assessment" rate, which is computed as a constant for all hospitals (Figure 3). In effect,

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Figure 3

Calculation of IHCTF Hospital Assessment Rate – FY 2001
(Statewide Totals)

Charity Care Cost of Contributing Hospitals $65,591,293 + State Corporate Income Taxes $12,986,761 = $78,578,054

$78,578,054 / Gross Patient Revenue of Contributing Hospitals $5,459,947,556 = 1.4392%

1.4392% x Positive Operating Margin $441,013,446 = $6,346,943

$6,346,943 + Trust Fund Payments by Hospitals $4,104,919 = $10,451,862

$10,451,862 / Positive Operating Margin $441,013,446 = 2.37%

2001 HOSPITAL ASSESSMENT RATE = 2.37%

Source: JCHC staff analysis of Department of Medical Assistance Services data.

therefore, a hospital's contribution rate is calculated as either a positive or negative adjustment to the hospital assessment rate. Pursuant to the *Code of Virginia*, no hospital is required to contribute more than 6.25 percent of its operating margin to the IHCTF.

Constraints on IHCTF Contributions and Payments. The two major constraints on IHCTF contributions and payments are the $6 million state general fund appropriation, and the fact that hospitals must comprise 40 percent of the total trust fund contribution. Consequently, the state contributes 60 percent of the trust fund amount, and hospitals contribute only 40 percent.

According to DMAS staff, the disproportionate share level percentage, and the state disproportionate share allowance pay percentage are allowed to vary within the algorithm in order to ensure that hospitals contribute 40 percent of the total, and to ensure that the state pays as close to $6 million as possible, without exceeding the appropriation.

Some Hospitals Are Required to Make Contributions to the IHCTF Based on the Amount of Charity Care They Provide; Others Receive Payment from the IHCTF

In FY 2001, 32 hospitals were "net receivers" from the IHCTF, 31 were "net payers", and 20 did not pay or receive any amount. The IHCTF will pay up to 60 percent of a hospital's charity care costs that are above the state median. In recent years, due to a fixed state general fund appropriation and increasing charity care costs, the IHCTF has only been able to pay about 40 percent of charity care costs. For example, in FY01, the IHCTF paid 43.4 percent of hospital charity care costs above the statewide median. Figure 4 identifies those hospitals that received the largest IHCTF payments, and those that made the largest contributions, in FY 2001.

It is possible for a hospital to provide charity care above the median but, due to the size of its operating margin, nonetheless be required to contribute to the IHCTF (Figure 5). Under the DMAS algorithm, these hospitals are calculated to receive payment from the trust fund and, at the same time, are required to make a contribution. However, the size of their required contribution exceeds the payment due, therefore they are "net

Figure 4

Indigent Health Care Trust Fund – Largest Payments and Contributions, FY 01

Hospital	Payment	Contribution
Sentara Norfolk General	$1,610,150	N/A
Mary Washington	$851,441	N/A
Arlington	$801,341	N/A
INOVA Alexandria	$771,118	N/A
INOVA Mount Vernon	$633,335	N/A
Bon Secours St. Mary's	N/A	$276,431
Sentara Leigh	N/A	$248,208
Chippenham and Johnston-Willis	N/A	$183,931
Henrico Doctors'	N/A	$178,437
Lewis-Gale Medical Center	N/A	$135,669

Source: JCHC staff analysis of DMAS data.

contributors" to the IHCTF. As a matter of convenience to DMAS, an actual check for the payment amount is not sent to these hospitals.

The Total Appropriation to the IHCTF is $12 Million, However the IHCTF Has Consistently Under Spent its Appropriation

The Appropriations Act reflects a $12 million program when in fact the IHCTF is only a $10 million program or less. Item 320 of the Appropriations Act provides a total of $12 million to the IHCTF. Six million of that amount is state general funds. While the Act indicates that there are $6 million in non general funds (i.e., hospital contributions), the actual hospital amount is approximately $4 million. The IHCTF has never spent the full amount of this appropriation. DMAS staff does not know why the Appropriations Act has not been changed to reflect the fact that the IHCTF is only $10 million program or less. Irrespective of any potential changes to the IHCTF as a result of COPN deregulation, the provisions of the Appropriations Act should be changed to reflect the true nature of the IHCTF's operations.

Figure 5

Hospitals With Charity Care Costs Above the Median Who Are Net Contributors to the Indigent Health Care Trust Fund

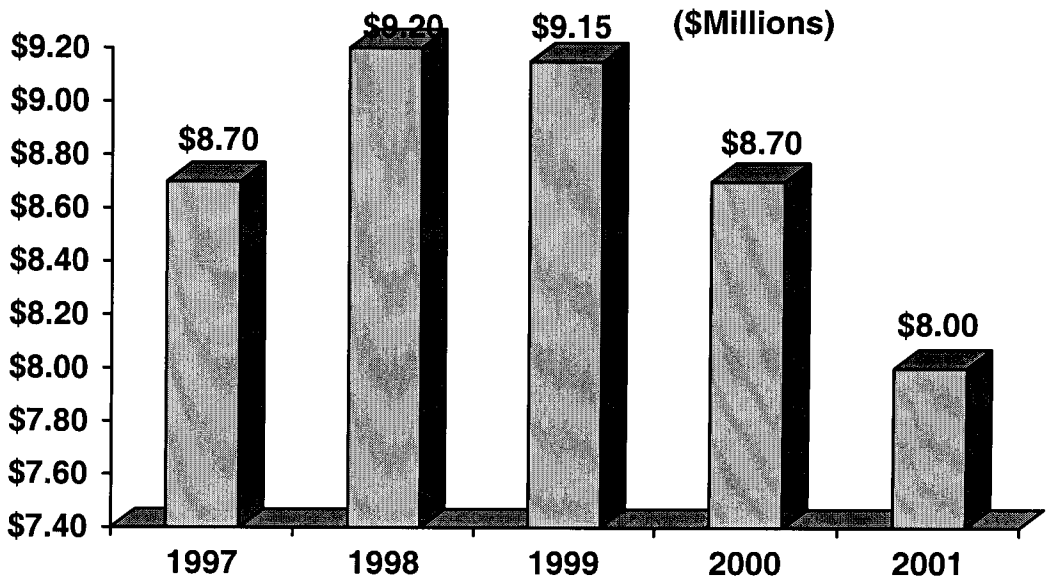
Hospital	Excess Charity Care Costs (above State Median)	Positive Operating Margin	Required Contribution to IHCTF
Augusta Health Care	$247,707	$987,5728	$9,924
Carilion Medical Center (Roanoke)	$387,517	$22,636,375	$73,635
Clinch Valley Medical Center (Richlands)	$1,003	$6,598,480	$2,031
Danville Regional Medical Center	$144,047	$6,439,967	$16,056
INOVA Fair Oaks	$30,736	$9,233,458	$117,865
Carilion Franklin Memorial	$21,197	$1,884,578	$17,540
Memorial Health System (Martinsville)	$91,861	$4,583,124	$17,966
Norton Community Hospital	$22,809	$3,029,546	$31,277
Riverside Regional Medical Center (Newport News)	$482,259	$18,895,349	$13,610
Winchester Medical Center	$42,420	$6,767,014	$72,210

Source: JCHC staff analysis of DMAS data

As previously mentioned, some hospitals are both contributors and recipients. This results in the annual net payments from the fund being somewhat less than $10 million (Figure 6). Gross payments in FY 01 were approximately $9.7 million. As shown in Figure 7, the IHCTF is administered such that the $6 million general fund appropriation is expended nearly in its entirety. However, only 61 percent of the $6 million non-general fund (hospital contribution) appropriation is spent.

Figure 6

Indigent Health Care Trust Fund – Annual Net Payments to Hospitals



Source: Department of Medical Assistance Services

Figure 7
Calculation of Indigent Health Care Trust Fund Payments – FY 2001

Hospital Gross Contributions	$3,787,217
Payments Netted*	($1,767,114)
Hospitals Pay Into Trust Fund	$2,020,103
State Matching Payments	$4,422,621
State Disproportionate Share Payment	$1,575,916
Net IHCTF Payments	$8,018,640
Gross IHCTF Payments	$9,785,754

Note: Payments Netted reflects those hospitals whose charity care costs are above the state median and who are calculated to receive a payment but who, due to the size of their positive operating margin, are nonetheless required to contribute to the IHCTF.

Source: JCHC staff analysis of DMAS data.

State Appropriations to the IHCTF Comprise a Very Small Part of Total State Spending on Indigent Care

The $10 million IHCTF accounts for a very minor part of total state spending on indigent health care. Most state spending for indigent care is made through the Medicaid disproportionate share hospital (DSH) program. Currently, total regular DSH payments to 27 Virginia hospitals are in the amount of $36 million dollars ($17.4 million general funds). In Virginia, hospitals become eligible for DSH payments when the percentage of their Medicaid inpatient bed days exceeds 15 percent of their total inpatient bed days. MCV and UVA receive an additional $122 million ($59 million general funds) in "enhanced" DSH payments. In fiscal year 2000, MCV received $86 million ($41.6 million general funds) in enhanced DSH payments while UVA received $36 million ($17.4 million general funds). The purpose of the enhanced DSH payments is to both compensate for the cost of serving low-income patients and to subsidize the teaching and research missions of the academic medical centers. Due to the fact that they receive this additional funding, MCV and UVA do not participate in the IHCTF. One other component of state spending for indigent care which should be mentioned is the $13 million state and local hospitalization program ($11.5 million general funds).

DMAS Staff Describe the IHCTF As Being Expensive and Labor-Intensive to Administer

According to DMAS staff, the administrative costs associated with the IHCTF are very high, particularly given the fact that it is only a $10 million program within a $3 billion dollar agency. However, since DMAS does not specifically allocate administrative costs to the IHCTF, its actual administrative costs were not available to JCHC staff. DMAS staff stated that every year there are a few providers from whom it is very difficult to obtain the required charity care reports. DMAS staff also stated that, since they do not actually audit the submitted data, it lacks independent knowledge of its accuracy. Finally, DMAS staff described the charity care submissions as lacking in consistency from one hospital to the next.

III.
Issues Affecting Incorporation of Deregulated Service Providers Into IHCTF

Establishing the Purpose of the New or Revised Indigent Care Program Should Be The First Step in the Design Process

As a prerequisite for determining what a new indigent care financing system should look like and how it should function, the purpose of the system needs to be clearly and specifically defined. During interviews with various stakeholder organizations, the following were offered as various potential objectives (in no particular order of priority) of any new or revised system:

1. stabilize if not improve access to health care by indigent persons,

2. redistribute the financial burden of providing indigent care among all providers in a deregulated marketplace,

3. give all providers of deregulated specialty services (regardless of the setting in which the service is provided) an equitable opportunity to receive reimbursement for indigent care costs that they have incurred,

4. expand access to care for the uninsured through insurance coverage, or

5. provide grants to eligible organizations (e.g., community health centers, free clinics, social services programs) which deliver health care services to indigent persons.

The purpose of the current IHCTF, given that it is inherently redistributive in nature, is probably aligned most closely with objective number 2, although it could be argued that administration of the IHCTF is also consistent with objective 1. As was previously mentioned, the TAP has attempted to use the IHCTF to expand insurance coverage (objective 4), but implementation has proven unsuccessful. The IHCTF has never attempted to engage in the provision of grants, as contemplated by objective 5.

Objective number 3 has particular significance in terms of its relationship to the structure and operation of any new or revised indigent care program. Specifically, if the program is not properly designed in terms of the definition of charity care, the selection of the charity care benchmark, and the organization of the fund, there is some potential that this objective would not be met. For example, some stakeholders interviewed by JCHC staff contend that the amount of charity care provided by non-hospital providers should not be measured relative to a hospital-based charity care benchmark.

IHCTF Definition of Indigent Care Is Fairly Restrictive and Could Be Expanded

As was previously mentioned, health care services are counted as charity care by the IHCTF only if no payment is received. Therefore, if a patient is able to pay only $100 on a $10,000 medical bill, the difference of $9,900 could not be counted as qualified charity care for purposes of the IHCTF. That type of restriction may be appropriate when, as is currently the case, charity care is defined as being provided to individuals with incomes up to 100 percent of FPL, as it is rare that such individuals would actually be able to pay any amount. However, if the definition of charity care were expanded to 200 percent of FPL, partial payments are more likely to occur and therefore it may be appropriate to further expand the definition to incorporate some partial payments. However, if the definition is broadened, it will result in an overall increase in the amount of charity care reported. This will have implications for the statewide benchmark and the amount of state matching funds.

Currently, if a patient makes a partial payment and the hospital attempts unsuccessfully to collect the balance, the hospital will eventually write-off the balance due as "bad debt". Between 1996 and 2000, the dollar amount of hospital bad debt increased from $281 million to $425 million, a fifty percent increase (Figure 8). Unlike reported charity care, which increased by only 17 percent from 1996 to 2000, bad debt expense also increased slightly as a percentage of gross patient revenue (GPR). Hospital bad debt expense as a percentage of GPR for the five-year period was as follows:

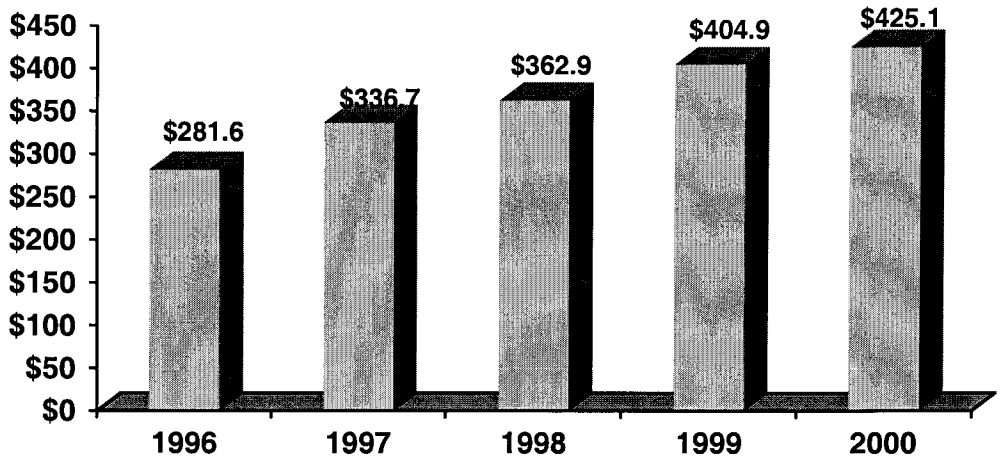
1996 – 2.91%,
1997 – 3.16%,
1998 – 3.09%,

1999 – 3.13%, and
2000 – 3.05%.

Whether or not some portion of the amount currently written-off as bad debt should be counted as qualified charity care in a new or revised indigent care program was raised as an issue. The State of Massachusetts, in its uncompensated care pool, counts bad debt from emergency room services as qualified uncompensated care. During JCHC staff interviews with stakeholder organizations, it was suggested that, as a matter of policy, no bad debt write offs be allowed to count toward charity care, with the possible exception of bad debt resulting from emergency room visits, assuming that the patient was not subsequently admitted to the hospital.

Figure 8

Hospital Bad Debt Expense
($ Millions)



Source: Virginia Health Information

DMAS staff have expressed some concern that hospitals may be including bad debt amounts in their charity care log submissions. This is because care provided as long as two years prior to the log submission date is being included on some logs. In fact, there is no time limit in terms of including care in the log (i.e., care provided several years prior to the charity log submission can be included in the submission.)

Decisions Need to Be Made Concerning the Type of Data That Need to be Collected In Order for the Indigent Care Financing Mechanism to be Administered in an Efficient and Effective Manner

A certain amount of standardized financial data will need to be submitted by providers of newly deregulated services in order for the new system to be administered efficiently and effectively. During interviews with JCHC staff, stakeholder groups emphasized the importance of having a data reporting mechanism that is consistent across providers. The Medical Society of Virginia agreed that there should be a common, consistent reporting mechanism for all providers, but noted that the mechanism should be one that recognizes that there are different internal accounting methods and structures used by various providers.

Since the IHCTF is a program for hospitals, its financial framework is premised on the accounting systems and other types of financial and administrative infrastructure typically used by hospitals. However, it is possible, if not likely, that many of the providers of newly deregulated services will not be hospitals but rather free-standing entities that are owned by physicians. The difference in financial infrastructure and accounting practices between hospitals and physicians could affect the structure and operation of any new indigent care financing program.

Financial Differences Between Physician Practices and Hospitals. Some of the differences between hospitals and physicians include use of different accounting systems: hospitals tend to use accrual accounting while many physician practices use cash accounting. This difference in accounting methods may have implications for the type of indigent care data that are routinely generated, collected and maintained and readily available for reporting by physicians as opposed to hospitals. Management of one ambulatory surgery center interviewed by JCHC staff stated that, although it uses cash accounting, it maintains a second set of financial data prepared under accrual accounting for purposes of EPICS reporting to VHI. Management of the ASC stated that it is much easier and less labor intensive for a facility to track charity care charges using accrual accounting rather than cash accounting.

Other differences include the preparation of an audited financial statement. These are routinely prepared for hospitals but many physician practices do not utilize them. The information contained in audited financial statements is a key underpinning of the EPICS system which, as

previously described, serves as a source of provider financial data for IHCTF calculations. To the extent that providers of newly deregulated services do not prepare audited financial statements, that could reduce the amount of financial data available, and serve as a complicating factor in the development of a new or revised indigent care financing program.

Other differences between physicians and hospitals involve Medicare cost reporting. For example, while all hospitals are required to file a Medicare cost report, physicians are not required to submit such a report. This is a crucial difference since the Medicare hospital cost report serves as the basis of determining the Medicare cost to charge ratio. As previously discussed, this ratio is used to convert a hospital's charity care charges to costs. In the absence of a physician Medicare cost report, another means will be needed to convert their reported charity care charges to costs.

Another difference involves tax liability and payment of taxes. Proprietary hospitals pay state corporate income tax and receive IHCTF credit for payment of these taxes. However, it is possible, if not likely, that many providers of newly deregulated services will be investor-owned (including physician investors) institutions organized as proprietorships, partnerships or Subchapter S corporations with an entirely different set of tax liabilities. This difference will need to be incorporated into the design of any new or revised indigent care financing system.

Use of EPICS As a Model For Data Reporting by Newly Deregulated Service Providers. The Efficiency and Productivity Information Collection System (EPICS) for ambulatory surgical hospitals, administered by Virginia Health Information, could serve as a potential model for the type of data reporting system to be utilized by any new or revised IHCTF. Pursuant to §32.1-276.7 of the *Code of Virginia*, outpatient surgical hospitals (along with other specified health care providers) are required to submit financial and operational data to VHI as part of its statutory mandate to review the efficiency and productivity of health care providers. Major categories of the required data submission, which comprise nearly 100 data elements, include income statement, balance sheet, statement of changes in net assets, and statement of cash flows.

Ambulatory surgery centers (ASCs), which are licensed by the state as outpatient surgical hospitals, are one of the specialty service lines that would be deregulated under SB 1084/HB 2155 of the 2001 Session. EPICS,

therefore, constitutes a functioning data reporting system for providers similar, in some respects, to those that would be deregulated. During interviews with JCHC staff, stakeholder groups generally agreed that EPICS could serve as a basis for data reporting, even though, as VHHA noted, it is not as detailed as a Medicare cost report. The Medical Society of Virginia stated that the current principles for EPICS and IHCTF could be adopted so as to accommodate financial accounting practices commonly used by physician offices.

Individual EPICS data elements for ambulatory surgical hospitals include charity care and bad debt. Figure 9 provides trend data on charity care and bad debt for ambulatory surgical hospitals. The EPICS definition of charity care is the same as the IHCTF definition (i.e., care provided for which no payment is received). However, EPICS requires that charity care be reported separately at 100% of the federal poverty level, and also at 200 % of the federal poverty level.

Figure 9

Charity Care and Bad Debt Trends for Ambulatory Surgical Hospitals

Year	Charity Care Total	Charity Care as Percent of Gross Patient Revenue	Bad Debt Total	Bad Debt as Percent of Gross Patient Revenue
1996	$312,295	0.30%	$1,630,027	1.56%
1997	$681,226	0.52%	$2,416,170	1.85%
1998	$1,469,972	0.82%	$3,289,168	1.83%
1999	$1,208,254	0.58%	$4,489,829	2.15%
2000	$961,435	0.58%	$4,416,825	2.69%

Source: Virginia Health Information

Indigent Care Benchmark Measure Will Need to be Established

As was previously discussed, the IHCTF benchmark measure is the statewide median of all inpatient and outpatient hospital charity care services. Pursuant to the COPN deregulation plan, however, deregulated services would tend to be unique, stand-alone specialty services. While an aggregate benchmark charity care amount could be computed for all deregulated specialty service providers, individual, service-line specific benchmarks could also be calculated (e.g., for Magnetic Resonance Imaging, Radiation Oncology, Ambulatory Surgery Centers, etc.) This type of data collection, in addition to enabling charity care comparisons across specialties, would facilitate better monitoring of access to care, indigent care costs, and other issues in a deregulated environment. On the other hand, this type of approach presumes that a certain amount of data collection must occur prior to establishing the various benchmarks.

In order to establish a benchmark more quickly, the benchmark could be based either on existing EPICS data for hospitals or EPICS data for ambulatory surgery centers (ASC). As previously discussed, the statewide median charity care for hospitals is 2.55% of gross patient revenues and 0.58% for ASCs.

As was previously mentioned, the current IHCTF benchmark is a single, statewide benchmark. However, regional benchmarks could potentially be used. The Virginia Department of Health utilizes regional charity care benchmarks for monitoring compliance with charity care conditions attached to Certificates of Public Need. The costs and benefits of utilizing several regional benchmarks as opposed to a single benchmark would need to be evaluated.

The COPN deregulation plan stated clearly that indigent care should be measured as care provided to individuals with incomes up to 200% of the federal poverty level. Therefore, the benchmark measure should be based on that level of charity care.

Other Definitional Issues Concerning a Benchmark. During JCHC staff interviews with various stakeholder organizations, several issues were raised concerning the types of services that should be counted towards charity care. For example, some stakeholders contend that if a specialty service facility is owned by physicians, and those physicians provide non-specialty services to indigent patients in their offices, those

services should serve as a credit against the indigent care benchmark requirement of the specialty service license (e.g., if a practicing physician is the owner of an ambulatory surgery center, and he provides other types of medical services to indigent patients outside the ASC, those services should be used as a credit towards the ASC's indigent care benchmark requirement.)

As another example, some stakeholders contend that the state should furnish providers of deregulated specialty services with an indigent care "credit" equal to the amount of money they spent (e.g., in legal fees) in obtaining a COPN. The issue here is that some providers have "played by the rules" by going through the COPN application approval process, and are now being asked to get a new state license and comply with additional requirements. Another issue, however, is that some of those same providers may have a COPN charity care condition with which they have not complied. In addition, as VHHA noted, these same providers, in all likelihood, have long since recouped the initial investment of funds associated with acquiring the COPN.

Definitional Issues Involving Gross Patient Revenue (GPR)

Under the current IHCTF, as previously discussed, GPR is a key variable in the DMAS algorithm. The statewide median level of charity care is applied to each hospital's GPR to compute charity care standard charges, from which flows the determination of the hospital's excess charity care costs above the median, and then the trust fund payment to the hospital. One issue that was raised was, under a revised trust fund, should the GPR of the entire facility be utilized for trust fund calculations, or just the GPR of only those deregulated specialty services provided in the facility? While gross patient revenue specific to only deregulated services would appear to be the logical approach, the facility would then have to collect, maintain, and report data concerning revenue pertaining exclusively to those deregulated services. This could prove to be an administrative burden to the facility, and could be complicated by the facility's accounting and financial management systems.

During JCHC staff interviews, VHHA suggested that the applicable revenue source should be those to whom the specialty service license is attached. For example, a physician or group of physicians could choose to attach the specialty service license to the existing practice. In that case, the applicable GPR would be that of the entire practice. On the other hand,

the specialty service could be licensed on a stand-alone basis, in which case the GPR of only the stand-alone service would be counted.

There are other examples as well. For instance, in determining gross patient revenue for a free standing specialty-service facility, what should be counted – the time-based value of a physician's professional services or the procedure-based cost of the specific deregulated service? The issue here is how much physician's time should be valued in calculating the cost of indigent care. During JCHC staff interviews, many stakeholders contended that emphasis should be placed on procedure-based costs. However, some physicians have stated that there should be an official value assigned to a physician's time in the provision of indigent care, since the physician is the primary provider of that care.

A Key Design Element Is Whether the Existing IHCTF Should Be Revised and Expanded to Include Deregulated Specialty Service Providers, or Whether a New, Separate Indigent Health Care Financing Mechanism Should Be Established

Figure 10 provides some broad, illustrative examples of how a new or revised indigent health care financing mechanism could be structured. A key consideration is whether there should be one fund or two.

Several State Budgetary and Administrative Issues Need to Be Resolved

During JCHC staff interviews with stakeholder organizations, one issue that was raised involved how large the fund should be, and whether existing constraints on the size of the fund are appropriate. As previously mentioned, two major constraints on the size of the fund are the state's $6 million general fund appropriation, and the fact that the hospital contribution cannot exceed 40 percent of the total amount. Some stakeholders expressed interest in allowing the fund to grow beyond $10 million using additional provider organizations alone. As an example, an alternative funding approach would be to determine the hospital contribution rate absent any constraint, and then go back and apply the 6.25% operating margin cap for each hospital. Such a method could result in a larger IHCTF with the increase coming solely from additional provider contributions. In this way, the fund size would be less affected by state financial constraints. However, other stakeholders, including the Virginia Hospital and Healthcare Association, expressed a preference for

the IHCTF to grow with equal additional contributions from both the state and providers.

Figure 10
Illustrative Examples of Potential Fund Structure for New Indigent Care Financing Mechanism

Number of Funds	Characteristics	Comments
One	Expand IHCTF to include specialty service providers	This would leave the IHCTF very much like it is today, and simply increase the number of participating entities
One	Restructure the IHCTF so that it is administered on a service-line basis (e.g., MRI, CT, ASC, etc.)	Indigent care is reported, tracked and credited by each specific type of specialty service Would require changes to existing IHCTF in order to separate deregulated specialty services performed by hospitals for indigent persons from regulated services provided to indigents
Two	Each fund has its own segregated account: one for hospitals only, based on both regulated and deregulated services, and one for non-hospital, freestanding specialty service providers	This attempts to leave the IHCTF "as is" for hospitals while establishing a new fund for freestanding specialty service providers
Two	One fund for hospital-based regulated services and one fund for all deregulated services regardless of the setting in which they are performed	This approach would require modified reporting requirements for hospitals, to reflect the fact that certain services are deregulated. Hospitals could form separate corporate entities to provide deregulated services

Source: JCHC staff analysis

Another budgetary issue to be resolved involves state matching funds to the new or revised indigent care financing mechanism. The state may need to implement mandatory reporting of charity care by physicians who provide deregulated specialty services, in advance of implementing a new indigent care funding mechanism with additional state matching funds. This may be needed in order to measure the total amount of indigent care provided, calculate the benchmark level of charity care provided, and estimate the fiscal impact of the state matching contribution. Alternatively, the state could simply match provider payments up to a specified dollar amount. Statutory language would have to be drafted concerning how newly-deregulated providers would report charity care and participate in a new indigent care financing mechanism.

The General Assembly, in establishing any new or revised indigent care financing mechanism, would need to designate an entity as being responsible for its administration. Likely candidates are DMAS, VHI and/or the Virginia Department of Health. In all likelihood, each of those three entities would have some degree of responsibility for administering the system.

The General Assembly, in designing any new or revised system, may wish to consider what is more valuable to Virginia's health care delivery system – a provider's financial contribution to support indigent care performed by other providers or the provider's direct provision of health care to indigent persons? There was general consensus during JCHC stakeholder interviews that direct provision of care was more valuable. However, stakeholders noted that it was not always practical for providers to actually provide a benchmark level of indigent care in their areas, usually due to the demographics of their service area.

Deregulated specialty service providers could be encouraged to obtain signed referral agreements with local primary care providers who treat significant numbers of indigent/uninsured, or it could be required as a condition of specialty service licensure. This would help to create new referral patterns for indigent specialty care, relieve backlog/waiting lists at certain hospitals, and help enable specialty service providers to meet indigent requirements, perhaps without having to make a mandatory financial contribution to the fund. To the extent that each service provider is actually providing the required level of indigent care, and not having to make a payment for redistribution to other providers, the issue of indigent

care cost vs. charge is mitigated. This approach could also provide corollary benefits for specialty service providers: If they are willing to accept a primary care provider's uninsured patients, perhaps they will also be more likely to obtain insured referrals from that provider.

Alternatively, an incentive arrangement could be established for deregulated specialty service providers to actually provide needed care to indigents as opposed to merely writing a check. Specifically, an incentive bonus payment could be made to those providers who exceed the benchmark by some specific amount. The Medical Society of Virginia found that type of approach preferable to penalizing providers who fail to meet the benchmark, but was not sure it would support such an incentive arrangement.

IV.
Review of Preliminary Design Proposals

Kemper Consulting Supports Establishing a New Fund to Replace the IHCTF in Which All Providers Would Participate

Kemper Consulting (Kemper), which represents several medical oncologists in Virginia, would like to see the state create an indigent care financing mechanism that holds all providers of deregulated services to the same requirements regardless of the site or institution in which the service is provided. According to Kemper's proposal, the benchmark measure would be the median of all the participants' indigent care charges as a percentage of gross patient revenues. However, indigent care is defined broadly as "uncompensated charges for care," which would include bad debt.

Contributions to the Fund. Under the proposal, providers whose indigent care percentage is more than 50 basis points below the benchmark would be contributors to the fund. The contribution would be calculated as follows:

- Each contributor would be assigned a contribution percentage calculated as the difference between 50 basis points under the benchmark and the contributor's indigent care percentage.

- Each contributor's individual contribution to the fund would be calculated as the lesser of 1) the product of the contributor's contribution percentage and GPR; or 2) ten percent of the contributor's positive operating margin.

- Each contributor's individual contribution would be reduced by the amount of the contributor's state corporate income tax payment (or other state income tax attributable to the contributor – such as a partners' individual state income tax payments in cases where the provider is legally structured as a partnership).

The Commonwealth of Virginia would continue to appropriate $6 million annually to the fund and would be encouraged to increase its

contribution as state finances allow, but no function of the fund should be dependent upon any state appropriation. Under the Kemper proposal, the only limit on the total size of the fund would be that no provider could be required to contribute more than 10 percent of its gross patient revenue. The fund could grow in size through additional provider contributions even if the state appropriation never increases beyond the current $6 million.

Distributions from the Fund. Participants whose indigent care percentage is greater than 50 basis points above the benchmark would be beneficiaries of the fund. Under Kemper's proposal, calculation of the distribution would be performed as follows:

- The sum of all indigent care charges in excess of 50 basis points above the benchmark for every beneficiary would be the aggregate distribution goal

- Each beneficiary would be assigned a distribution percentage equal to the percentage of the aggregate distribution goal attributable to that participant, so that the sum of all beneficiaries' distribution percentages equals 100 percent

- The total distribution amount would be calculated as the sum of all contributions to the fund

- Each beneficiary's individual distribution from the fund would be equal to the product of that beneficiary's distribution percentage and the total distribution amount (i.e., each beneficiary would receive a proportional share of the total funds available for distribution based on its amount of all indigent care in excess of 50 basis points above the benchmark.)

Virginia Hospital and Healthcare Association Favors Maintenance of IHCTF and Establishment of a New Health Access Improvement Fund

The VHHA proposes that deregulated service providers be incorporated into a modified IHCTF. Under the VHHA proposal, the IHCTF would be revised to update and broaden the definition of "qualified" charity care to include inpatient and outpatient services

provided to uninsured individuals with incomes up to 200% FPL. In addition, reporting standards and the data collection system would be updated to 1) include the new charity care definition, 2) apply equally to all providers, and 3) conform to new federal regulations concerning charity care revenue and expense.

The new federal rules referred to by VHHA are proposed Medicare hospital regulations. The new regulations provide the following definitions:

- uncompensated care – charity care and bad debt;
- charity care –the cost to the provider organization for rendering free or discounted care to persons who cannot afford to pay, who are not eligible for public programs, and for which the provider did not expect payment; and
- bad debt – the unpaid dollar amount for services rendered from a patient or third party payer, for which the provider expected payment.

This proposed definition of charity care is broader than the current definition in the *Code of Virginia*. Virginia does not currently have statutory definitions for either uncompensated care or bad debt. According to the VHHA proposal, all providers would be required to maintain a log of qualified charity care cases. This log would have to be independently verified in conjunction with an audit of financial statements.

The unique aspect of the VHHA proposal involves how money would be contributed to and disbursed from the IHCTF. VHHA proposes that the IHCTF algorithm in effect be run twice – first for hospitals and then for the newly deregulated service providers (which could include some hospitals). The algorithm would be run the first time for hospitals providing regulated services in order to establish the statewide indigent care median (encompassing the broader definition of charity care), and to determine the amount of payments to hospitals and contributions from hospitals. As is the case currently, the various adjustment factors that are used to constrain hospital contributions and state appropriations would be applied. State matching funds would continue to be made.

The algorithm would then be run a second time to determine the required contributions from deregulated service providers. The previously-determined hospital-based indigent care benchmark would also serve as the benchmark measure for the deregulated specialty service providers. Contributions from these providers would be used to establish a Health Access Improvement Fund. This fund would be used to provide competitive grants for innovative efforts to extend coverage to the uninsured, or to otherwise rectify a health care access barrier. This fund would give preference to sustainable projects serving areas with the greatest proportion of the population that is uninsured.

Under this proposal, deregulated service providers who provide charity care in excess of the benchmark would not necessarily receive any payments from the trust fund. According to VHHA, however, most specialty service providers would be under the (hospital-based) benchmark anyway, and would not stand to receive any payment from the IHCTF. Grant conditions could be established to address those specialty service providers who do provide charity care in excess of the benchmark.

Under the VHHA proposal, contributions from the specialty service providers, along with state matching funds, would fund the Health Access Improvement Fund during Phase 1 of deregulation, pending completion of a broader study by JCHC on the impact of Phase 1 deregulation on essential services and access to care. The current system of allocating hospital contributions and the related state match would continue during Phase 1. Prior to Phase 2, JCHC would complete the study and make recommendations concerning the scope of the IHCTF and the best use of the full funds.

Central Virginia Health Planning Association (CVHPA) Supports a Single Fund For All Providers, Favors a Charity Care Benchmark Based on Hospital Charity Care Experience, and Supports Inclusion of Some Bad Debt in Charity Care Definition

The CVHPA's proposal contained a list of attributes that it believes should be incorporated into any design proposal for a revised IHCTF. First, the state should, at a minimum, match funds that are paid by private providers. The state should continue to contribute a majority of the funds in order to ensure appropriate and adequate coverage.

Second, there should be a single IHCTF, with redistribution of funds achieved using the existing formula or other appropriate methodology. The benchmark charity care measure should be the statewide mean amount of charity care provided by hospitals. There would not be any formal external constraint to the size of the fund, but CVHPA does envision state contributions rising in tandem with private contributions.

Third, each provider should have a standardized policy and procedure for free or reduced price care for persons with incomes up to 200% FPL, and actively utilize that procedure. In addition, all medical staff of a provider should agree to provide free or reduced price care for persons with incomes up to 200% FPL, and agreement to do so should be part of the provider's credentialing process. An alternative payment method should be available to those who, in spite of having an appropriate policy and procedure, fail to achieve an equitable level of charity care.

Fourth, no bad debt write offs should be allowed to count toward charity care, with one exception. CVHPA believes, as a general rule, that including bad debt in charity care submissions would 1) encourage escalating charges which has a proportionately much higher impact on the uninsured, and 2) billing for services and not properly screening patients for financial need discourages future use of the facility by those in financial need. However, because the emergency room is often used by those with limited financial resources for primary care and there is often little ability to get proper documentation to qualify these persons for free or reduced price care, bad debt acquired through emergency room visits (and associated diagnostic services) should be allowed, but only in cases where the patient is not subsequently admitted to the hospital.

Medical Society of Virginia Proposes That Consideration Be Given to Disbanding the IHCTF and Using the $6 Million State Appropriation to Increase Medicaid Hospital Reimbursement

Given that the IHCTF addresses such a small portion of existing charity care costs at hospitals, and given the unknowns associated with including new classes of providers in the IHCTF (i.e., record keeping, audits, and dollars to be generated by the new providers), the MSV stated that other types of approaches should be considered. In fact, according to the MSV proposal, consideration should be given to disbanding the IHCTF entirely. Under such a proposal, the current $6 million state general fund appropriation could be added to the general fund share of Medicaid

hospital reimbursement, thereby drawing down a non-general fund federal match of another $6 million. These funds would then be paid to hospitals in the form of increased reimbursement.

Furthermore, under the MSV proposal, a charity care requirement could be established as a condition of state licensure for all hospitals and deregulated specialty service providers. An appropriate level of charity care would be set as the benchmark. The benchmark could be met by either direct provision of services or monetary payments. Providers not meeting the benchmark would be required pay a contribution, in actual dollars, equal to the difference between the benchmark and the amount of care provided. The contribution would be made to the same Health Access Improvement Fund that was previously described as part of the VHHA's proposal. According to MSV, the Health Access Improvement Fund and the effects of increased Medicaid reimbursement to hospitals would be incorporated into any continuing studies of the outcomes of COPN deregulation.

Conclusion

Many stakeholders believe that incorporation of deregulated specialty service providers into some type of indigent care program is an important health policy goal. The four different preliminary design proposals received by JCHC staff are illustrative of the various types of approaches that can be taken to incorporating providers of newly deregulated services into an indigent care funding program. As was previously discussed, key components to a new or revised program are its stated objective, its definition of indigent care, the choice of a benchmark, data reporting infrastructure, and the size of the program. Moreover, these key components can be interrelated in terms of their affect on each other. Figure 11 compares and contrasts some of the key provisions of each of the four preliminary design proposals. Additional proposals could still be developed.

As noted by the MSV, there are still many unknowns associated with adding new types of providers to the IHCTF, including the dollars to be generated by the newly deregulated providers. Indeed, the number and type of specialty service providers who will take advantage of a deregulated market is still an unknown. For example, the extent to which hospital-based physicians, such as radiologists, decide to establish free standing facilities and license themselves as specialty service providers

Figure 11

Selected Characteristics of the Preliminary Design Proposals Received by JCHC Staff

Proposal	Definition of Charity Care	Benchmark	Contribution and Use of Funds	Size of Fund
Kemper Consulting	Broad, includes uncompensated charges (i.e., bad debt)	Blend of hospital and non-hospital based specialty service providers' indigent care charges	Reimburse providers for charity care rendered; Contributions required if charity care is more than 50 basis points below benchmark, Payments received only if charity care more than 50 basis points above benchmark	Only limit on size of fund is that no provider can contribute more than 10 percent of gross patient revenue
VHHA	Based on proposed Medicare hospital regulations, Cost for rendering free or discounted care to persons who can't afford to pay, who are not eligible for public programs, and for which the provider did not expect payment; Excludes bad debt	Hospital-based benchmark	Current system of allocating hospital contributions and related state match remains in place during phase 1 pending further study; New contributions from deregulated service providers used to establish Virginia Health Access Improvement Fund	Current constraints on size of fund ($6 million state general fund appropriation and 40 percent hospital contribution) remain in place

Figure 11

Selected Characteristics of the Preliminary Design Proposals Received by JCHC Staff (continued)

Proposal	Definition of Charity Care	Benchmark	Contribution and Use of Funds	Size of Fund
CVHPA	Includes bad debt for emergency room visits (and associated diagnostic services) in cases where patient is not subsequently admitted to the hospital	Hospital-based benchmark	Reimburse providers for charity care rendered	No outside constraint on size of fund, but envisions increasing state contributions
MSV	Not specified	Not specified, but benchmark should be "appropriate"	Consideration should be given to disbanding fund and using $6 million state general fund contribution to increase Medicaid hospital reimbursement; Establish charity care requirement as condition of hospital and specialty service licensure; Providers below the benchmark will be required to contribute to Virginia Health Access Improvement Fund.	

Source: JCHC staff analysis

remains to be seen. Hospital-based physicians currently benefit from a hospital's COPN protection, but do not participate in the IHCTF. The extent to which those types of physicians decide to become licensed as specialty service providers will affect overall participation in a new or revised IHCTF.

The extent to which the indigent will continue to have access to needed health care in a deregulated health care marketplace is a valid public policy concern. A recent study published by the Center for Studying Health System Change found that the proportion of physicians providing charity care declined from 76 percent to 72 percent from 1997 to

1999. The HSC study noted that, in the short term, most medically indigent people are still getting care. However, according to HSC, policy makers should take note that reduced physician participation in charity care will hurt the poor if – as projected – growth in physician supply slows and the number of uninsured rises along with escalating health care costs.

This report has focused on an initial review of preliminary design proposals. Additional evaluation by the JCHC, in conjunction with the various stakeholder organizations, will be needed to arrive at a final design proposal for incorporating providers of newly deregulated specialty services into a new or revised indigent health care trust fund.

V.
Policy Options

I. Take no action

II. Introduce a budget amendment (language only) to revise Item 320 of the Appropriation Act such that the non-general fund hospital contribution is $4 million rather than $6 million so as to reflect the actual amount now contributed by hospitals

III. Introduce a budget amendment (language only) directing DMAS to conform the administration of the Indigent Health Care Trust Fund to the provisions of Item 320 or the Appropriation Act such that the non-general fund hospital contribution is $6 million rather than the current practice of the hospitals contributing $4 million

IV. Direct JCHC staff to continue working with interested parties on a new/revised IHCTF as part of a future COPN deregulation plan

APPENDIX A

JOINT COMMISSION ON HEALTH CARE

SUMMARY OF PUBLIC COMMENTS:
Revised/New Indigent Health Care Trust Fund

Organizations/Individuals Submitting Comments

Two organizations submitted comments in response to the revised/new indigent health care trust fund study.

- Virginia Hospital & Healthcare Association
- Virginia Association of Regional Health Planning Agencies

Policy Options Considered for the Revised/New Indigent Health Care Trust Fund

Option I: Take no action.

Option II: Introduce a budget amendment (language only) to revise Item 320 of the Appropriation Act such that the non-general fund hospital contribution is $4 million rather than $6 million so as to reflect the actual amount now contributed by hospitals.

Option III: Introduce a budget amendment (language only) directing DMAS to conform the administration of the IHCTF to the provisions of Item 320 of the Appropriation Act such that the non-general fund hospital contribution is $6 million rather than the current practice of hospitals contributing $4 million.

Option IV: Direct JCHC staff to continue working with interested parties on a new/revised IHCTF as part of a future COPN deregulation plan.

Overall Summary of Comments

The comments were generally positive, and made a number of suggestions for inclusion of additional clarifying information into the report.

Summary of Individual Comments

Virginia Hospital & Healthcare Association (VHHA)

Christopher Bailey, Senior Vice President, VHHA, offered clarification of certain aspects of the IHCTF and the administration of the program, including bad debt, amounts of charity care, and those hospitals that are both recipients and contributors to the IHCTF. He suggested clarifying the report to show that the total contribution of hospitals is $3.7 million. He also pointed out that thee has been a migration in percentage terms from charity care to bad debt because more of Virginia's uninsured population now have incomes between 100 and 200% of the federal poverty level. (Charity care for the IHCTF is defined as care provided to persons at or below 100% FPL.)

Virginia Association of Regional Health Planning Agencies (VARHPA)

Karen L. Cameron, CHE, Executive Director/CEO, VARHPA, stated that it would encourage use of an "average" or "mean" amount of charity care rather than the "median" in any methodology that is used "since it is evident that a few providers currently bear the burden of a majority of the charity care in the state which results in an inordinately low median that does little in raising the contributions of other providers." She also commented that "only bad debt from emergency department accounts on which no third party payment is received should be available for inclusion in the charity care definition." Further, she indicated that "any monies available for increased Medicaid reimbursement should include the expansion of Medicaid to persons living at or below 100% of the federal poverty level."

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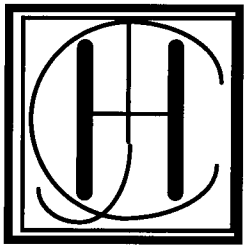

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