Analysis of Nationwide Uncompensated & Other Related Care Models

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The research and conclusions in this report are the sole responsibility of the authors and do not imply endorsement by the NJDOH.

Executive Summary

Promoting and ensuring access to medically necessary health care services is an important component of maintaining the health and wellbeing of a community. Equally important is for that health care to be accessible to and equitable for all populations, without barriers or limitations lack of due to ability to pay. As such, this report explores the various existing state programs and initiatives designed to ease the financial burden of health care and help promote access. The report also includes a series of policy recommendations to inform future policy development efforts relative to New Jersey's Charity Care program.

In New Jersey, the Department of Health (NJDOH), administers and oversees the Hospital Care Payment Assistance Program (also known as the Charity Care program), and works in close partnership with the Department of Human Services to process claims submitted as part of the program. The Charity Care program mandates that all acute care hospitals in the state of New Jersey provide free or reduced cost inpatient and outpatient care to eligible individuals who receive medically necessary care within specified income ranges.

NJDOH partnered with Master of Public Policy students at Rutgers to identify innovative approaches to inform the development and implementation of systemic changes and quality improvement initiatives for the Charity Care program. Further, the partnership also sought to better understand how New Jersey compares to other states in providing financial assistance to low-income individuals.

To accomplish this, a survey titled, *Uncompensated Care and Other Related Care Models,* was developed and disseminated to all 50 states, as well as the District of Columbia, to obtain information on existing programs and initiatives designed to provide financial assistance for individuals who require medically necessary health care services. In addition to the initial survey outreach, several case studies were completed to gather additional, more granular and detailed information on the nuances of the state's respective program/initiative components. Based on a review of relevant literature, creation of case studies, survey responses, and stakeholder interviews, the following recommendations were developed:

- **Recommendation 1: Prospective Reimbursement Model**
  Currently, reimbursement for New Jersey Charity Care is retrospective, meaning hospitals are reimbursed on a percentage of Medicaid payment rates based on operating margins and total Charity Care services rendered and adjudicated (referred to as Documented Charity Care (DCC) in a prior year. The model should be shifted to a prospective model in which, instead of hospitals getting reimbursed for prior year Charity Care treatment, hospitals could instead be allotted funds based on the prospective model.

- **Recommendation 2: Area Deprivation Index (ADI) to Further Address Equity**
  New Jersey's Charity Care program should incorporate the ADI to help further promote equity and ensure hospitals that operate in the most disadvantaged areas are able to receive the highest amount of funds from NJDOH. To complete this recommendation, legislation and regulation changes would be required.

- **Recommendation 3: Simplified & Standardized Application Process**
  We recommend that in the short-term, NJDOH seek to create a uniform and universal application for charity care across all hospitals in the State. We also recommend modernizing this process with a digital application and approval system. This would allow for simpler determination of eligibility and easier data collection for the State. We recommend that in the medium-term, NJDOH support efforts to create a streamlined application for health care services. In the long-term, we recommend that the State, with input from NJDOH, create a single, streamlined and universal application approach for health care coverage and other social service benefits.

- **Recommendation 4: Updating Affordability Standards**
  To further improve the affordability standards and to reduce the financial burden of costs on un- and under-insured individuals, it would be helpful to extend reduced-cost care to a higher percentage of the Federal Poverty Limit (FPL) than currently offered. Additionally, it would also be beneficial to mandate a lower price ceiling for uninsured individuals. To complete this recommendation, legislation and regulation changes would be required.

- **Recommendation 5: Expanding Scope of Coverage**
  Expanding the scope of coverage of the Charity Care program to include preventive care and prescription drug costs has the potential to vastly improve health outcomes among low-income individuals. It is recommended that New Jersey explore options to provide increased preventive care benefits within the Charity Care program. Though this care would typically be referred to Federally Qualified Health Centers (FQHCs) and other community-based providers, we recommend that NJDOH allow or require NJ hospitals to use a portion of charity care funding to reimburse FHQC or other community-based providers for ambulatory care management for patients who are frequent users of emergency department or inpatient care. The program could be structured as a pay-for-performance program where additional charity care funding is allocated to reducing avoidable hospital emergency visits or readmissions.

- **Recommendation 6: Connecting Preventive Care with Charity Care through Incentives and Data Sharing**

The State should increase funding to FQHCs and other community-based providers to bolster their ability to share data with hospitals and other providers to create a functional health information exchange. Additionally, to promote sustained partnership with community providers and hospitals, New Jersey should seek to tie in incentives into the Charity Care formula/methodology that includes increased funding for FQHCs/ community-based providers and Hospitals that work to increase primary care and preventive services. This could be implemented in conjunction with recommendation five, allowing or requiring NJ hospitals to use a portion of charity care funding to reimburse FQHC or other community-based providers for ambulatory care management for patients who are frequent users of emergency department or inpatient care.

Introduction

In 1986, Congress passed the Emergency Medical Treatment and Labor Act (EMTALA) to ensure public access to emergency services regardless of the individual's ability to pay (Centers for Medicare and Medicaid Services (CMS), 2021). Failure to comply with EMTALA may result in penalties such as fines, restriction of Medicare reimbursement, and federal prosecution (NCBI, 2021). Under the law, hospitals receiving funds from Medicare:

1. Cannot reject or restrict treatment to patients based on their insurance status or ability to pay or relocate them to other facilities under emergency situations.
2. Must provide medical screening examinations and stabilizing treatment for patients with emergency medical services (EMCs).
3. Should facilitate the transference of patients to other facilities, either due to their inability to stabilize the patient or at the patient's request.

New Jersey expanded on EMTALA and has been administering its state-mandated Hospital Care Payment Assistance Program, known simply as Charity Care. Charity Care in New Jersey reimburses NJ acute care hospitals for medically necessary inpatient and outpatient services they provide to low-income individuals at zero or reduced charge. Eligibility criteria are established by NJDOH and administered by all acute care hospitals, whose staff must supply the patients with and assist the patient with completing an application package. Charity Care is available to NJ residents who lack health insurance or whose coverage leaves them with out-of-pocket cost liability, who are not eligible for any government-sponsored coverage (such as Medicaid), and who meet certain income and asset criteria. Payment assistance is also available to non-NJ residents, subject to specific provisions. Funding for Charity Care comes from federal Medicaid matching funds state general revenue taxes.

This report, completed at the request of the NJDOH and conducted by graduate students in the Master of Public Policy program at Rutgers, analyzes the NJ Charity Care program relative to similar uncompensated care programs implemented in other states, particularly those exceeding the requirements stipulated by EMTALA. We aim to provide a thorough discussion of the design/care delivery model, eligibility, application process, covered services, and reimbursement and funding mechanisms of states' respective uncompensated care programs. The results will serve to inform the NJDOH of potential structural modifications of its Charity Care program and/or assist in identifying alternatives to improve efficiency in its program.

The remaining sections of the report briefly discuss our data collection methodology, findings from states (including a condensed comparative table), a brief discussion, and some recommendations.

Methods

This report uses data collected via an online survey distributed to the Medicaid Directors of all 50 states in the US. The survey on *Uncompensated Care and Other Related Care Models* was conducted in consultation with NJDOH and by Master of Public Policy students at Rutgers using Qualtrics survey software. The survey was fielded in March 2022.

The purpose of the survey was to collect information regarding key dimensions of states' program(s) that cover hospital-based services for the uninsured and underinsured populations. These dimensions included funding mechanisms and guidelines, application requirements, program(s) model, design, eligibility requirements, and states' laws and regulations. The questionnaire was characterized by a mix of open and closed-ended questions. Appendix A contains a copy of the survey. We obtained a total of five responses including three states providing program information and two states indicating that the state did not have a program that fund medically necessary care to uninsured or underinsured people, regardless of their ability to pay.

To supplement the survey, we conducted a virtual meeting with the Maryland Health Services Cost Review Commission staff and requested additional information via email to the Massachusetts Department of Health. Further, to augment survey responses, we conducted internet searches about programs and initiatives in California, New York, Oregon, and Texas, which were of particular interest to NJDOH.

Comparison Table

Based upon all research completed and survey response received, as well as independent analysis as to what is going on in other states versus what is happening currently in NJ, we have created an easy-to-understand comparison chart.

		Program / Initiative Design				
State	***Name of program or initiative***	***Design/delivery models – statewide, regional, county-based, etc.***	***Eligibility***	***Authority – state law/regulation***	***Funding mechanisms***	***Oversight/audits***
New Jersey (NJ)	The New Jersey Hospital Care Payment Assistance Program (Charity Care)	Statewide - all acute care hospitals	A person or family whose income is less than 200% of the FPL Guidelines is eligible for 100% Charity Care coverage. Persons or families whose annual income falls between 200 to 300% of FPL guidelines are eligible for partial Charity Care coverage, on a sliding scale percentage basis.	Regulations N.J.A.C. 10:52, Subchapters 11, 12, 13 *Charity Care* *Public Notices* State Fiscal Year (SFY) 2018 Public Notice - Healthcare Subsidy Fund - Charity Care *Hospital Notices* Calendar Year (CY) 2016 Medicaid Cost Report Revision Deadline	Funding for the Charity Care program comes from multiple tax sources and assessments.	NJDOH audits facilities annually in partnership with a contracted vendor
California (CA)	Hospital Fair Pricing Act	Statewide - all general acute care hospitals	Uninsured patient or patients with high medical costs who are at or below 400% of the FPL be eligible for charity care or discount payments from a hospital in California.	Assembly Bill (AB) 1020 (Chapter 473, Statutes of 2021) Calif. Health & Safety Code § 127401	California use Medicaid 1115 demonstration waivers to fund their Uncompensated Care.	Department of Health Care Access and Information (HCAI) responsible for: collecting copies of hospital charity care

			Uninsured patients whose medical costs exceed 10% of the family income from the previous year.	Calif. Health & Safety Code § 128740		policies, discount payment policies, eligibility procedures, review processes, and application forms, and making this information available to the public, adopting guidelines, identifying, assessing, and reporting charity care services; and performing onsite assessments as necessary to ensure that reported data is collected in compliance with the guidelines it sets.
Colorado (CO)	Colorado Indigent Care Program	Hospitals/clinics that choose to participate for Colorado Indigent Care Program (CICP) General, critical access hospital, and freestanding emergency department participation is mandatory for Hospital	For both programs participating providers are required to provide discounted care to patients with income up to 250% FPL on a sliding scale fee. The University of Colorado Hospital system must provide care to the medically indigent.	Colorado Revised Statutes §§ 25.5-3-101 to 25.5-3-112; 10 CCR 2505- 10 8.900 Colo. Rev. Stat. §§ 23-21-503 Colo. Rev. Stat. § 25.5-3-104(1) House Bill (H.B.) 21-1198	CICP and Hospital Discounted Care are funded through federal and state dollars.	Providers submit an audit statement and a Corrective Action Plan, when required, to the Department of Health Care and Policy and Finance. Public Consulting Group, Inc., (PCG) is contracted to review audits. The Department of Health Care and

		Discounted Care starting June 1, 2022.				Policy and Finance submits an annual report on CICP to the Health and Human Services committees of both Houses in the General Assembly and to the special Financing Division.
Maryland (MD)	Charity Care	Statewide - all acute care hospitals	Hospitals are legally required to provide free care to patients with a household income at or below 200% of the FPL Hospitals are required to provide a discount to patients with household income between 200% and 300% of the FPL Hospitals are also required to provide reduced-cost care to patients that have financial hardship and have a household income below 500% of the FPL.	Health General § 19-214, Maryland Code. Health General § 19-214.1 , Maryland Code. Health General § 19-214.2, Maryland Code Code of Maryland Regulations (COMAR) Sec. 10.37.10.26	Hospital uncompensated care is funded through the State's unique all-payer hospital rate-setting system, which distributes the burden of funding uncompensated care between healthcare payers.	Hospitals have strict reporting requirements. Health Services Cost Review Commission (HSCRC) also requires independent Certified Public Accountants (CPAs) to perform auditing on an annual basis to review each hospital's financial assistance and debt collection policies and procedures.
Massachusetts (MA)	Health Safety Net MassLimited	Statewide - all acute care hospitals	A person or family whose income is less than 200% of FPL Guidelines is eligible for 100% Health Safety Net Program (HSNP) coverage. Persons or families whose annual income falls between 200 to	101 CMR 613.00: Health Safety Net Eligible Services 101 CMR 614.00: Health Safety Net Payments and Funding	The HSNP Net is funded by state general funds and the Hospital and Commercial Payer Assessment.	HSNP Office All providers must establish a provider affiliate list that clearly indicates which providers are eligible for

			400% of FPL guidelines are eligible for partial Health Safety Net coverage, on a sliding scale percentage basis. A person or family can be eligible for HSNP based on medical hardship due to medical bills more than a threshold of their income.			reimbursement under the HSNP.
New York (NY)	Hospital Indigent Care Pool	Statewide - all hospitals	All hospitals are reimbursed for providing charity care from the Hospital Indigent Care Pool (ICP). Residents with incomes below 300% FPL get discounts. Those at 100% FPL or lower, get charged only a capped nominal amount. Individuals or families between 100% and 250% FPL are assessed on a sliding scale percentage basis. Cannot charge uninsured patients whose income is under 300% FPL more than what third party insurance pays.	N.Y. Pub. Health Law §§ 2803-l, 2805-a, 2807-c, 2807-k N.Y. Pub. Health § 2807-k(9) N.Y. Pub. Health Law § 2807-k(9-a)(b)(i) N.Y. Pub. Health Law § 2807-k(9-a)(b)(iii)	Hospitals are funded through the Hospital Indigent Care Pool (ICP), which is 50% federal Medicaid Disproportionate Share Hospital (DSH) payments and 50% by state tax mechanisms General hospital assessments determine the amount for hospitals.	The NY State Department of Health contracted hospital audits for compliance with the Hospital Financial Assistance Law (HFAL) to accounting firm KPMG The audit consists of a desk and field component. The desk audit is a questionnaire that each hospital completes using the audit tool to self-report compliance with the Hospital Financial Assistance Law (HFAL). KPMG conducts the field audit.

Oregon (OR)	Charity Care	Hospitals design their own charity implementation	State mandates that they must at least provide charity care following the FPL.	Reporting requirements are regulated by the Oregon Health Authority (OHA)	Hospitals must pay out of their own operations costs.	OHA
Texas (TX)	Indigent Care Program	Statewide - all public hospitals and nonprofit hospitals (as a requirement of non-profit status)	Hospitals establish their own eligibility, indexed to FPL. Income no lower than 21% of FPL and no higher than 200% of FPL. Excludes anyone who is already eligible for and receiving Medicaid benefits.		Hospital districts may collect taxes and issue bonds, in which case they assume full responsibility for charity care. Counties may supplement with state funds after spending 8% of general revenue levy on health care services, state funds cover at least 90% of payments after that.	Hospitals submit financial and utilization data to the TX Department of State Health Services (DSHS), including charity care, bad debt expenses, and total charity care admissions. Nonprofit hospitals must file a statement with the Bureau of State Health Data and Policy Analysis at the DSHS and the chief appraiser of the local appraisal district which explains how they are meeting the charity care requirements.

Findings from States

This section describes the different uncompensated care programs/initiatives and other related care models implemented by other states. For purposes of this report, emphasis is placed on those states that have programs/initiatives that exceed the requirements stipulated by EMTALA. The analysis covers various aspects such as states' regulatory authorities regarding the design and delivery models, eligibility, application requirements, covered services, and funding and reimbursement mechanisms. Besides the information obtained from the survey responses for MD, MA, and CO, we also conducted independent research using publicly available sources of information and data from states such as CA, NY, OR, and TX, which were considered priorities for NJDOH.

1. California (CA)

In 2006, CA passed the Hospital Fair Pricing Act. Since then, it has been considered one of the most comprehensive state-level hospital pricing laws to:

a. Limit prices hospitals may charge uninsured low-to-moderate-income patients;
b. Require licensed general acute care hospitals, psychiatric acute hospitals, and special hospitals to standardize their billing and collection procedures and increase public awareness of the availability of charity care, payment discounts, and government-sponsored health insurance; and
c. Require licensed general acute hospitals to provide free or discounted care to financially qualified patients. (Bai, 2015)

The CA Department of Public Health (CDPH), in partnership with other state agencies, is charged with enforcing charity care compliance and the Hospital Fair Pricing Act, respectively (Calif. Health & Safety Code § 127401). The Department of Health Care Access and Information (HCAI) is responsible for:

a. Collecting hospital charity care and discounted payment policies, including their eligibility, review, and application procedures, and making them publicly available. The information must be updated whenever major changes are adopted, or at least biennially;
b. Adopting guidelines for identifying, assessing, and reporting charity care services; and
c. Performing onsite assessments as necessary to ensure compliance with data reporting guidelines. (Calif. Health & Safety Code § 128740(d))

Any uninsured patient or patient with high medical costs whose income is at or below 400% FPL is eligible for charity care or discount payments (AB 1020, Chapter 473, Statutes of 2021). Eligibility also extends to patients (or families) who have spent more than 10% of their income on medical expenses in the prior 12 months (Cal. Health & Safety Code §§ 127400(c), (f), (g), and 127405(a)).

Hospitals may establish their own application process, and procedures. They must provide patients, in addition to posting in observation units, with comprehensible written

information concerning cost estimates and charity care, financial aid, and discount payment opportunities. They must also inform patients about organizations that aid with understanding billing and payment processes, including a web address for Health Consumer Alliance. If a hospital participates in Covered California (health care exchange) and Medi-Cal (CA's Medicaid program), it should notify patients of their presumptive eligibility.

Hospitals can determine a patient's charity care or discounted payment eligibility using:

a. Documentation of income, either recent pay stubs or income tax returns;
b. Health insurance which may fully or partially cover expenses of care, if any; and
c. All monetary assets (excluding the first $10,000 and 50% of the amount above that threshold), excluding retirement or deferred-compensation plans.

In addition to Medi-Cal, California takes advantage of several Medicaid 1115 demonstration waivers provisions to fund charity care. Hospitals may only consider expected payments from Medicare or Medi-Cal, whichever is greater, or determine an appropriate discounted payment in case the service provided has no established Medicare or Medi-Cal payment. Eligible patients cannot be required to go undergo independent dispute resolution (CDPH, 2021).

Regarding the Medicaid 1115 demonstration waiver, Section 1115 of the Social Security Act permits states to waive some federal statutory Medicaid program requirements or gain federal matching funds for costs or investments that would not otherwise be granted under the Medicaid program. In California, the most recent renewal of the Section 1115 Medicaid Waiver, known as Medi-Cal 2020, is expected to grant California approximately $7.1 billion in federal funding through programs aimed at modifying the emphasis on hospital-based and inpatient care to outpatient, primary and preventive care (CAPH, n.d.). In particular, the waiver includes four new programs focused on improving care for California's Medi-Cal and the remaining uninsured patients. These programs are:

- *Public Hospital Redesign and Incentives in Medi-Cal (Prime):* includes a pay-for-performance delivery system for California's public health care systems and district and municipal hospitals.
- *Global Payment Program:* includes a payment reform for services to the uninsured in California's public health care systems.
- *Whole Person Care:* this is a pilot program at the county level to provide more integrated care to the highest-risk and most vulnerable patients in local communities.
- *Dental Transformation Initiative:* this program includes incentives to increase the frequency and quality of dental care provided to children.

Funding for hospital-related medical services provided by Designated Public Hospitals (DPHs) to Medicaid recipients and the uninsured generally comes from:

a. General state revenues;
b. Local expenditures funded by non-state government sources that are reported as Certified Public Expenditures (CPEs);
c. Intergovernmental Transfers (IGT) funding from local government sources.
d. Revenue from healthcare-related provider taxes; and

e. Federal matching funds provided through the CMS.

2. Colorado (CO)

CO only requires the University of Colorado Hospital System to provide care to those eligible for partial reimbursement from the state. These facilities spread across the state and provide medical care to individuals qualified for payment assistance through any program that benefits the individuals without health insurance and who are not eligible for other health care such as Medicaid, Medicare, or private health insurance (Community Catalyst, 2022).

Other hospitals and providers that want reimbursements must participate in the CICP, overseen by the Department of Health Care Policy and Financing. "The Colorado Indigent Care Program (CICP) was created in 1983 under the "Reform Act for the Provision of Health Care for the Medically Indigent" and is currently located at 25.5-3-101, C.R.S" (Bimestefer, n.d). Providers decide which services to cover under the program, but priority goes to "medically necessary" treatment (Community Catalyst, 2022). Due to the flexibility across healthcare providers, policies are different depending on the hospital or organization providing care. The program reimburses free or discounted health care services delivered to eligible patients using a uniform rating system managed by the state's Department of Health Care Policy and Financing. The program grants aid to the uninsured and underinsured state residents, migrant workers, and individuals not eligible for Medicaid or Children's Health Insurance Program (CHIP).

Similarly, Hospital Discounted Care was designed for low-income patients to receive discounted care. General, critical access hospital and freestanding emergency department participation are mandatory for Hospital Discounted Care. This program is new and will be effective starting June 1, 2022, and July 1, 2022, for freestanding emergency departments (CO Department of Health Care Policy & Financing, 2016).

During 2017-2018 the Department of Health Care Policy and Financing gave providers the ability to be more flexible with income when determining CICP eligibility and their internal charity care programs as long as they fit the guidelines; the flexibility allows providers to establish income regulations to best help their communities. The Department also modified its methodology for CICP clinics to include a quality metric component in their reimbursement methodology. The new reimbursement method required 75% to be based on write-off costs, while the other 25% on quality metrics. Calculations for quality metrics use body mass index screening and follow-up; screening for clinical depression and follow-up plan; controlling high blood pressure and diabetes (Bimestefer, n.d).

CO does not provide enough resources to pay for all medical services for impoverished persons; therefore, the General Assembly prioritizes serious threats to the health of patients. The prioritization list ensures that those eligible with the lowest income have emergency care throughout the year. The order of prioritization follows:

a. Emergency care for the full year;
b. Additional medical care for those conditions determined to be the most serious threat to the health of indigent persons; and
c. Any other medical care.

The Department of Health Care Policy and Financing is working on implementing Hospital Discounted Care, but screenings for eligibility for public health coverage, CICP, and discounted health care (CO Department of Health Care Policy & Financing, 2016).

An individual's eligibility is determined by criteria approved by the department and whether they meet the requirements of the individual provider. A general rule for CICP is that families with a net income and assets at or below 250% of FPL pay on a sliding scale (Community Catalyst, 2022). While there is no actual asset dollar limit, a Liquid Asset Spend Down Provision allows individuals whose combined income and liquid resources prevent eligibility for the CICP. It determines the discounted amount using the difference between the CICP eligibility standard at 250% of the FPL and the applicant's income. These families must be residents of Colorado, including legal immigrants. Uninsured children and pregnant women that cannot afford private insurance but do not qualify for Health First Colorado are covered by Colorado's CHIP (called Child Health Plan Plus (CHP+)). If clients have third-party insurance, that insurance must be billed before using CICP (Bimestefer, n.d).

Providers are responsible for assigning a maximum allowable copayment based on the individual's eligibility on the sliding fee scale, and co-payments cannot exceed ten percent of a family's income and assets. The eligibility ratings are valid for one year unless significant income changes, the number of dependent changes, calculation errors, inaccurate information, or a second provider not accepting the initial rating due to differing income determination can cause ratings to change.

Hospital Discounted Care determines eligibility based on the Hospital Discounted Care Maximum Payment Calculator. If an individual is eligible for a rate, the calculator will determine the maximum amount for the patient. The Department of Health Care Policy and Financing sets Eligibility for Hospital Discounted Care includes the number of people in the household and the annual gross household income at or below 250% of the FPL (CO Department of Health Care Policy & Financing, 2016).

Providers are encouraged to meet with clients to complete the application within 45 days, but patients have 90 days from the service day to complete and sign an application, provide all documentation, and submit it to the provider. Required documentation includes copies of health insurance information and proof of citizenship and residential status. Providers then have 15 days to decide from the day the complicated application is submitted. If approved, decisions must include the date when eligibility began. If denied, the reason for denial must be included, along with the written right to an appeal process (Community Catalyst, 2022). If clients have a CICP card from another facility, they must report this to their new provider, failure to do so may result in a discount denial. Individuals unable to provide documentation can request a waiver from the state Department of Revenue. In some cases, emergency applications apply to individuals in the emergency room if they do not appear to qualify for Medicaid. The emergency application is for a one-time occurrence in an emergency room or concurrent service related to the emergency room episode; one-time use does not apply to homeless individuals (CO Department of Health Care Policy and Financing, 2016). Hospital Discounted Care is available in English and Spanish. The form is provided when they receive care at a hospital (CO Department of Health Care Policy & Financing, 2016).

The Executive Director at the Department of Health Care and Policy and Finance submits an annual report on CICP to the Health and Human Services committees of both Houses in the General Assembly. This report includes the condition of the program and offers suggestions for improving the delivery of care (Community Catalyst, 2022). The Department of Health Care and Policy and Finance completes a second report for the Special Financing Division, including summary data, physical data, pharmacy data, and ambulance data. A clinic's annual data is due with the application in May, and hospitals submit data in June (Bimestefer, n.d).

Providers must submit a provider compliance audit statement and a Corrective Action Plan, when required, to the Department of Health Care and Policy and Finance. The public accounting firm, PCG reviews the providers receiving funding from the CICP once every three years to test compliance with eligibility and billing criteria. Audits are completed for approximately one third of providers each year.

Due to limited resources, providers must prioritize emergency and urgent care services. Prioritized services for both the Colorado Indigent Care Program and the Discounted Hospital Care include ambulatory surgery, inpatient facility, hospital physician, emergency room, emergency transportation, outpatient hospital services, clinic services, specialty outpatient, prescriptions, laboratory, basic radiology and imaging, and high-level radiology and imaging (Bimestefer, n.d). Providers may also offer discounts for emergency mental health services rendered simultaneously with other medically necessary services, pharmaceutical services, and prenatal benefits with a predetermined co-payment. Abortion is covered if the pregnancy threatens the mother's life (Community Catalyst, 2022).

The CO General Assembly allocates money to the Department of Health Care Policy and Financing, which finances the Indigent Care Program and Hospital Discounted Care. The money comes from state and federal dollars and provider fees. The Primary Care Fund Program is supported by taxes on cigarettes and other tobacco products. The fund designates a portion of the money to healthcare providers that provide outpatient services to residents requiring financial assistance. The number of patients who receive services from a provider in proportion to the total number of patients receiving care by providers who qualify for the award determines the amount provided (Bimestefer, n.d). Reimbursement is based on allocation, not the services provided.

Medical services covered under the Medicaid program are matched with federal funds at the state's Federal Medical Assistance Percentage (FMAP) rate. Rates determine how much will be covered using federal funds and how much from the General Fund or other state dollars. DSH Payments also contribute to hospitals that provide services to Medicaid and low-income patients but cap the amount of DSH payments the state can utilize (Bimestefer, n.d). "The University of Colorado Hospital system must provide $4 worth of care to the medically indigent for every $3 it receives for that purpose from the General Assembly" (Community Catalyst, 2022).

3. Maryland (MD)

MD has a unique model through which it finances health care delivery in the state. Since the 1970s, hospitals rates in Maryland have been regulated by the Health Service Cost Review Commission (HSCRC). Through this model, the HSCRC sets the rates that hospitals can charge all payers (private, commercial, Medicare, Medicaid, and self-pay) in which the cost for

uncompensated care is built into the rates. As such, the payment methodology is known as the "all-payer system" (Community Catalyst, n.d.). In 2014, under CMS waivers, MD expanded its role in controlling costs by adopting a global budget for hospitals that guaranteed a set amount of revenue to healthcare providers for the year regardless of the number of services they provide (CMS, n.d.).

All hospitals in MD are required to provide financial assistance in the form of free and reduced-cost care to certain low-income patients. In MD, hospital uncompensated care is funded through the State's unique all-payer hospital rate-setting system, which distributes the burden of funding uncompensated care among healthcare payers. In MD, uncompensated care includes charity care and bad debt. The HSCRC is responsible for setting reimbursement rates for care provided by MD's acute care facilities, including to patients who otherwise could not afford it. Each hospital determines patient eligibility for financial assistance according to its own financial assistance policy, which must conform to the minimum standards outlined in law. The HSCRC audits financial assistance and debt collection policies and procedures annually to ensure compliance.

The following laws govern the program:

- Health General § 19-214, Maryland Code;
- Health General § 19-214.1, Maryland Code;
- Health General § 19-214.2, Maryland Code; and
- Code of Maryland Regulations (COMAR) Sec. 10.37.10.26.

MD hospitals are legally required to provide free care to patients with a household income at or below 200% of FPL. For patients with a household income between 200% and 300% FPL, hospitals are required to offer reduced-cost care (Md. Code Ann. Health-Gen. §19-214.1(b); COMAR 10.37.10.26(A2)(2)(a)). Hospitals are also required to provide reduced-cost care to patients who have a financial hardship (Md. Code, § 19-214.1(a)(2) of the Health General Article) and have a household income below 500% of the FPL. MD defines financial hardship as medical debt incurred by a household over a 12-month period that exceeds 25% of household income (Md. Code, § 19-214.1(b)(4) of the Health General Article).

A hospital may consider household monetary assets in determining eligibility for free and reduced-cost care under the hospital's financial assistance policy in addition to income-based criteria. Notably, this varies by hospital/hospital system. As such, household income and assets are both considered for specific individual-level eligibility criteria. If a hospital does consider household monetary assets, MD requires certain types of monetary assets that are convertible to cash to be excluded (Md. Code, Health-Gen. § 19-214.1). These include:

a. At a minimum, the first $10,000 of monetary assets;
b. A safe harbor equity of $150,000 in a primary residence;
c. Retirement assets that the Internal Revenue Service has granted preferential tax treatment as a retirement account, including deferred-compensation plans qualified under the Internal Revenue Code or nonqualified deferred-compensation plans;
d. One motor vehicle used for the transportation needs of the patient or any family member of the patient;

e. Any resources excluded in determining financial eligibility under the Medical Assistance Program under the Social Security Act; and
f. Prepaid higher education funds in a Maryland 529 Program account (a tax-advantaged investment plan designed to allow adults or children save for higher education expenses).

Additionally, hospitals are prohibited from using a patient's citizenship or immigration status as an eligibility requirement for financial assistance; or considering a patient's race, color, religion, ancestry or national origin, sex, age, marital status, sexual orientation, gender identity, genetic information, or disability in making a financial assistance determination.

Individuals apply for financial assistance using a uniform financial assistance application (Health General § 19-214.1(d)). Hospitals are responsible for informing patients of their right to apply for financial assistance through a variety of means including posting notices and providing information sheets. Under MD's program, inpatient care, hospital outpatient care, emergency services, and mental health services are all covered.

The HSCRC builds funding for uncompensated care into all-payer rates for all hospital facilities in MD. Thus, financing comes from health care payers, who subsidize a share of uncompensated care that is equal to each payer's share of the market. The HSCRC establishes rates for all hospital facilities in MD. Funding for uncompensated care is provided through a markup to hospital rates which is approximately 4% of the $19 billion industry.
HSCRC ensures that uncompensated care funding is distributed equitably among hospitals through an uncompensated care pool so that hospitals with proportionally higher levels of uncompensated care are not at a financial disadvantage. The HSCRC prospectively calculates the amount of uncompensated care provided in hospital rates at each regulated MD hospital using a five-step process.

1. *Statewide Uncompensated Care*: HSCRC determines the statewide actual uncompensated care based on the prior year's charity care and bad debt as a percentage of gross patient revenue as reported on the Hospitals' Revenue and Expense (RE) Schedules (e.g., Rate year (RY) 2022 uncompensated care rates are based on the uncompensated care percentage from the RY 2020 RE Schedules).
2. *Hospital-Specific Uncompensated Care*: HSCRC determines the hospital-specific actual uncompensated care for each hospital based on the prior year's charity care and bad debt as a percentage of gross patient revenue as reported on the RE Schedules. (e.g., RY 2022 uncompensated care uses the uncompensated care percentage from the RY 2020 RE Schedules).
3. *Predicted Future Uncompensated Care*: The third step uses a logistic regression model to predict the uncompensated care for RY 2022.
4. *Blended Actual and Predicted Uncompensated Care*: The HSCRC calculates a 50/50 blend between the hospital-specific actual uncompensated care and the predicted uncompensated care. This calculation serves to balance policy goals of reimbursing hospitals for uncompensated care provided to low-income patients through the hospital's financial assistance policy while also incentivizing hospitals to minimize bad debt by encouraging reasonable activities to collect debt from patients who can afford to pay.

5. *Hospital Payments or Contributions to the UCC fund*: The 50/50 blend for each hospital is subtracted from the amount of UCC funding provided in rates and multiplied by the hospital's global budget revenue (GBR) to determine how much each hospital will either withdraw from or pay into a statewide UCC Fund.

Hospitals must report their RE schedule aggregate hospital financial data including amounts incurred as charity care and bad debt to the Commission 120 days after the end of the hospital's fiscal year. Hospitals also have 9 months after the end of the fiscal year to report to the Commission patient-level charity care and bad debt write-off data. If a hospital needs to revise of update any of the required documentation, revisions must be submitted in accordance with the guidelines with the revised data only (HSCRC, 2018). Additionally, if a hospital requires an extension on any of these reports, a written request must be submitted to HSCRC prior to the due date (HSCRC, 2020). Hospitals must report aggregate data on the cost of providing financial assistance, the number of individuals who received financial assistance, and demographic information on those individuals (including race, ethnicity and gender) on an annual basis starting in FY 2021. HSCRC also requires independent CPAs to perform auditing on an annual basis to review each hospital's financial assistance and debt collection policies and procedures.

4. Massachusetts

MA operates the HSNP, covering health care services for underinsured, uninsured, and undocumented individuals with income below 300% FPL. The HSNP pays acute care hospitals and community health centers for certain essential health care services provided to qualified uninsured and underinsured MA residents. There are varying levels of care provided under the HSNP based on patient income level and total medical expenses. The HSNP can serve as the primary benefit for uninsured individuals or as the secondary benefit for insured individuals including those with private insurance or Medicare. This program is paid for through the Health Safety Net Trust Fund, which is funded by state general funds, Medicaid DSH matching funds, and their Hospital and Commercial Payer Assessment. Due to the implementation of MassHealth, MA maintains the lowest uninsured rate in the country at 2.9 percent which vastly reduces the burden of uncompensated care on the hospital system. MA statute (101 CMR 614.00 and 614.00) set the standard service eligibility and reimbursement rates for acute care facilities at current Medicare rates. This program is paid for through the Health Safety Net Trust Fund. All acute care facilities providing services receive reimbursement.

Individuals can qualify for the HSNP by having an income below 400% FPL or experiencing medical hardship. There are different levels of HSNP assistance, dependent on income. For individuals who have health insurance, the HSNP serves as a secondary benefit that can reduce copayments and deductibles. Under medical hardship, families receive medical expense waivers when their medical expenses exceed set thresholds of debt in comparison to total household income.

Eligibility requirements to qualify based on low-income patient status (101 CMR 613.00):

a. Must be a resident of MA;

b. Must have a household income below 400% FPL (individuals with an income between 201-400% FPL have a deductible);
c. Must not be eligible for MassHealth (Medicaid or CHIP); and
d. Asset information is required for individuals age 65 and older.

Eligibility requirements to qualify based on medical hardship status (101 CMR 613.00):

a. There are no income limits to qualify for the HSNP based on medical hardship
b. Assets are not counted towards eligibility
c. Medical hardship eligibility is based on the total amount of medical debt accumulated as a percentage of gross household income
d. Income and medical debt thresholds.

Incurred Medical Debt Compared to Income Level	
Income Level (% of FPL)	Percentage of Gross Income
0-200%	10%
201-300%	15%
301-400%	20%
401-600%	30%
601%+	40%

MA operates an online application system where residents are screened for MassHealth, the HSNP, and the Children's Medical Security Plan. This application may also be completed on paper, via telephone, or in person at a MassHealth Enrollment Center. This application is administered by the MA Office of Medicaid. Income verification is completed via paper verification or electronic data matches. Proof of income can include a recent pay stub, a signed statement from an employer, or the most recent federal tax return. Two forms of identification are required to be submitted with the application. Applicants eligible for the HSNP are enrolled in the program for one-year from the tenth day before the application date (130 CMR 516.003 and 130 CMR 516.006).

There is a separate application to determine eligibility for the HSNP based on medical hardship. This application is processed by the Health Safety Net Office. Applicants must provide documentation of countable income, residency documentation, proof of identity, and detailed, itemized documentation of medical expenses. An applicant may submit no more than two Medical Hardship applications within a 12-month period (101 CMR 613.05).

The HSNP reimburses the following services for those individuals eligible for the low-income HSNP (101 CMR 613.08):

a. Prescription drugs prescribed at a hospital or community health center. Prescriptions must be picked up at a hospital or community health center pharmacy. MA pairs with select retail pharmacies across the state that are also able to fill these prescriptions;
b. Acute hospital care;
c. Dental services;
d. Medical supplies for individuals with a chronic illness;
e. Inpatient and outpatient mental health services;

f. Substance use disorder services;
g. Vision; and
h. Care at a community health center including limited specialist care.

For individuals with incomes between 200% and 400% FPL, the same services are covered, but they must meet a deductible before the HSNP will pay for their care. The deductible is the equivalent of 40 percent of the difference between the lowest MassHealth eligible income and 200% of the FPL. Individuals are typically responsible for 20-80 percent copayment until their deductible is met. The deductible formula is: (Family Income – 200% FPL) X 40% = deductible.

For individuals where the HSNP serves as the secondary payer, the following services are covered:

a. Dental services not covered by current insurance;
b. Services not covered by private insurance or are subject to deductibles or coinsurance; and
c. Co-pays, coinsurance, and deductibles for individuals receiving Medicare.

For individuals receiving HSNP payment due to medical hardship, the HSNP covers a percentage of all medical bills from any health care provider that, if paid, would qualify as deductible medical expenses for federal income tax purposes. All paid and unpaid bills for services provided up to 12 months prior to the date of the medical hardship application can be covered. Each applicant is required to pay a specified percentage of income based on their FPL multiplied by gross income.

The HSNP is funded by state general funds and their Hospital and Commercial Payer Assessment. HSNP services are covered at Medicare rates and all hospitals and community health centers providing these services are reimbursed for them. If there is less funding in the Health Safety Net Trust than demand, a shortfall allocation is implemented which provides more funding for safety net hospitals. Hospitals may submit claims for emergency bad debt once they have made reasonable collection efforts to receive payments from patients.

For undocumented individuals, MA offers MassHealth Limited, covering all emergency medical services for acute care and care for medical conditions severe enough to cause harm to the individuals health, bodily functions, or organs. All undocumented individuals, except women and infants, are not eligible for MassHealth and are eligible to apply for MassHealth Limited (130 CMR 505.006).

MassHealth Limited covers the following services (130 C.M.R. § 450.105(G):

a. Emergent and urgent impatient hospital admissions;
b. Services provided by an outpatient hospital emergency department;
c. Outpatient ambulatory visits including services provided by community health centers or dialysis clinics;
d. Emergency dental treatment;
e. Transportation by ambulance for emergency services;
f. Oxygen Equipment and supplies;

g. Medically necessary drugs such as antibiotics and insulin;
h. Physician services provided within a hospital emergency department; and
i. Long term care and home health services on a case-by-case basis.

Eligibility Requirements (130 CMR 504.003(C):

a. Children <1 with an Adjusted Gross Income (AGI) less than 200% FPL
b. Children between the ages of 1 and 18 with an AGI less than 150% FPL
c. Adults with an AGI less than 133% FPL.

5. New York (NY)

In NY, the HFAL requires hospitals to provide charity care to uninsured patients (Gallipeau, 2011), establishing regulations regarding collection practices, eligibility, billing, and notification. Hospitals generally otherwise create their own uncompensated care program, and non-hospital private providers are not subject to the law.

Hospitals receive an allotted amount each year for charity care from the ICP, which is funded by a combination of federal and state revenues and overseen by the Commissioner of the Department of Public Health (Community Catalyst, 2022). Hospitals can limit financial assistance to patients not in their primary service area (PSA), except for emergency services, but may not alter their PSA to avoid medically underserved communities (Gallipeau, 201). Hospitals with 24-hour emergency departments must post information on financial assistance in waiting rooms, outpatient clinics, and billing and Medicaid offices. Whenever requested by any patient, hospitals must provide a summary of income eligibility for charity care, a description of their PSA, and information on applying for financial assistance (Gallipeau, 2011).

Charity care levels vary across hospitals and service providers, though the HFAL requires at least a sliding fee scale at or below 300% of the FPL. Eligibility is determined using current income levels, asset and other resources, and insurance status. Individuals in need must apply for a discount and their charge must be proportional to their income category, as outlined by the HFAL: (a) below 100% of FPL, (b) 100-150% of FPL, (c) 150-250% of FPL, and (d) 250-300% of FPL (Gallipeau, 2011). Individuals with significant assets may be eligible for discounts if their income is below 150% of FPL, subject to approval for hospitals from the New York State Department of Health (NYSDOH). Hospitals cannot deny discount benefits to individuals based on their immigration status or application for Medicaid or other public insurance (Gallipeau, 2011). The HFAL covers uninsured patients and insured patients who have used up their insurance benefits. NYSDOH provides nominal payment guidelines for inpatient services, ambulatory surgery, MRI testing, adult emergency room (ER)/clinic services, and prenatal and pediatric/ER clinical services (Gallipeau, 2011).

Although there is not a state-wide standardized application for medical financial assistance, the HFAL has general requirements for any hospital application process, including (Gallipeau, 2011):

a. Clearly informing patients of timeframes for application submission;
b. Immigration is not relevant to the patient's eligibility;

c. The appeal process in case an application is denied; and
d. Disregarding bills while an application is pending.

Applications must be made available in "primary languages" based upon the demographics of a hospital's PSA. Individuals are permitted to apply for assistance within at least 90 days of the date of discharge or of service and decisions are made within 30 days of the receipt of the complete application. General hospitals, when requested, must provide assistance to individuals in understanding their charity care policies and applying for discounted payments (Community Catalyst, 2022).

The NYSDOH contracted hospital audits for compliance with HFAL to accounting firm KPMG. The state can fine hospitals for each regulation they fail to enforce with penalties up to $10,000 based on the desk and field component. The desk audit is a questionnaire that each hospital completes using the audit tool to self-report compliance with HFAL. KPMG conducts the field audit; they are responsible for selecting a group of hospitals and verifying their answers to the desk audit (Tracy et al., 2018). Provider reporting requirements include an expense report, a written report, and an annual implementation report to the Commissioner of the Department of Public Health. Each report covers a range of topics about finances, community needs, and objectives (Community Catalyst, 2022).

Emergency services and medically necessary services for eligible residents of a hospital's PSA (Community Catalyst, 2022).

Funding for hospital charity care comes from the Hospital ICP, with 50% of reimbursements coming from federal Medicaid DSH payments and the other 50% from state revenues. Such state revenues, under the 1996 NY HCRA, are cigarette tax revenues, covered-lives assessment, NY City cigarette tax transfers, and Empire Blue Cross Blue Shield's for-profit conversion stock proceeds (Tikkanen et al., 2017). Allocations to each hospital are based on 7 factors in the state's methodology: uncompensated care, adjustment by the Statewide Adjustment Factor, net losses, targeted need, payment based on group cap, transition payment formula, and financial assistance compliance pool nonprofit and for-profit private hospitals may be granted a tax break so long as they provide community benefits which include charity care to uninsured patients (Tikkanen et al., 2017).

6. Oregon (OR)

OR defines charity care as "free or discounted health services provided to persons who cannot afford to pay and from whom a hospital has no expectation of payment" (Community Benefit Reporting Oregon Revised Statutes § 442.601 (2021)). One caveat is that charity care in OR excludes bad debt. While OR'S charity care implementation is not regulated by the state, reporting of charity care is regulated by the Oregon Health Authority (OHA).

Charity care in OR is considered a community benefit. In 2019, OR passed legislation that, starting in 2022, hospitals must meet a calculated community benefit spending floor. The calculation for 2022 and 2023 is as follows for each hospital:

FY22 spending floor = 3-year average of unreimbursed care spending + (Direct Spending Net Patient Revenue Percentage x 3-year average operating margin multiplier)

FY23 spending floor = FY22 spending floor + (FY22 spending floor 4-year average percent change in net patient revenue, capped at +/- 10%)*

Within the unreimbursed care spending is charity care, unreimbursed Medicaid net costs, and other reimbursed program costs. Each year, OHA updates their formulas to reflect trends in community care expenditures (Establishment of Community Benefit Spending Floor Oregon Revised Statutes § 442.624 (2021)). This legislation was passed to ensure nonprofit hospitals maintain a minimum level of community outreach necessary for nonprofit status.

While there is great variation in the implementation of charity care policies across for-profit hospitals and hospital systems, most for-profit hospitals set eligibility using federal poverty guidelines. OHA adopted a sliding scale for non-profit hospital charity care coverage based on the FPL. For example, individuals whose income is between 100% - 200% FPL are eligible for 100% cost coverage within the hospital (Requirements for Financial Assistance Policies Oregon Revised Statutes § 442.614 (2021)). This legislation impacted around 77% of hospitals given their nonprofit status (Kaiser Family Foundation 2022).

Because each hospital in OR oversees its own charity care program, the application process exists only within the hospital itself, and each hospital will have its own methodology for review of charity care applications. Since OR's legislature does not regulate charity care implementation, there is no state reimbursement structure in place. Hospitals must allocate funds from primarily their operating expenses to fund charity care. In 2017, between .2-4.0% of hospital operating expenses were spent on charity care (OR Legislature, 2019).

7. Texas (TX)

Charity care is considered a community benefit in the state of TX, which defines charity care as the "unreimbursed cost to a hospital of:

a. providing, funding, or otherwise financially supporting health care services on an inpatient or outpatient basis to a person classified by the hospital as "financially indigent" or "medically indigent"; and/or
b. providing, funding, or otherwise financially supporting health care services provided to financially indigent persons through other nonprofit or public outpatient clinics, hospitals, or health care organizations." (Tex. Health & Safety Code Ann. §311.031(2))

Under the state's Indigent Health Care and Treatment Act, all public hospitals are required to provide assistance to eligible patients who reside in their respective service area. For individuals who do not live within the service area of a public hospital, the responsibility of providing medical care regardless of their ability to pay falls on the counties (Tex. Health & Safety Code Ann. §61.023). In addition, nonprofit hospitals in TX are required to provide community benefits and charity care in order to maintain their nonprofit or charitable status (Tex Health & Safety Code Ann §311.043; Tex. Tax Code Ann. §11.1801(a)). The TX DSHS is charged with overseeing the community benefit and charity care program, known officially as

the Indigent Care Program. This oversight responsibility includes, but not limited to, (a) establishing application, documentation, and verification procedures for charity care cases - usually in accordance with, but never more restrictive than, those of the Temporary Assistance for Needy Families (TANF)-Medicaid program; (b) defining the services and establishing the payment standards for the categories of services (Tex. Health & Safety Code Ann. §61.006). Private, for-profit hospitals are not subjected to the charity care mandate.

In order to apply for charity care at public hospitals, individuals are required to submit a written application, furnished and assisted by the hospital staff (Tex. Health & Safety Code Ann. §61.053). Should a public hospital deny an application, it must notify the individual in writing and explain the reason, in which case the patient may resubmit their application if circumstances have changed (Tex. Health & Safety Code Ann. §61.053(h-k)). If there is a dispute between an individual and a hospital district administrator over the ability to pay, a county court will hear and determine the outcome of the case (Tex. Health & Safety Code Ann. §281.071(e-f)). Nonprofit hospitals establish and follow their own policies on charity care, though they must at least meet the state's requirements, and must notify every individual seeking care at their facilities of their respective charity care program. They must do so in a public and readily understandable manner (Tex. Health & Safety Code Ann. §311. 046). Individuals who do not reside within a public hospital's service area (i.e. hospital's district) are eligible to apply for charity care through the county and must provide the following information (Tex. Health & Safety Code Ann. §61.007):

a. Full name and address;
b. Social security number, if available;
c. The number of persons in the applicant's household;
d. County of residence;
e. Any insurance or hospital/health care benefits the applicant is eligible for;
f. Any transfer of title to real property the applicant has made in the past 24 months;
g. The applicant's annual household income; and
h. The amount of the applicant's liquid assets and the equity value of the applicant's car and real property.

In addition to establishing its own application procedures, each hospital may determine its own eligibility guidelines but must at least include income indexed to the FPL as a criterion. The state requires that the patient's income level may not be lower than 21% of FPL or higher than 200% of FPL, excluding anyone who is already eligible for and receiving Medicaid benefits (Tex. Health & Safety Code Ann. §311.031(11); §61.006(b); §61.052). Other items that public hospitals and the counties can use to determine eligibility include household resources, car equity level, real properties except for homesteads, and work-related and child care expenses (Tex. Health & Safety Code Ann.§ 61.008; §61.023).

In terms of reimbursement and funding mechanisms, hospital districts may collect taxes and issue bonds, on which date they assume full responsibility for providing care for indigent and needy individuals in their service area (Tex Health & Safety Code Ann. §281.046). Counties that provide care to patients outside of a public hospital district may supplement their program with state funds after spending at least 8% of their general revenue levy on health care services, after which state funds will make up at least 90% of actual payments (Texas Health & Safety

Code Ann. §61.037; §61.038). If the DSHS fails to provide a county with assistance, the county ceases to be liable for payments for services provided beyond the 8% threshold (Texas Health & Safety Code Ann. §61.039). DSH under Medicaid are exempt from charity care requirements (Tex. Health & Safety Code Ann. §311.045(b)(3)). Nonprofit hospitals have the option to choose between three standards on which to base their level of charity care (Tex. Health & Safety Code Ann. §311.045(b)(1); §11.1801(a)).

a. A level reasonable relative to the community needs (based on the community needs assessment), available resources, and the tax-exempt benefits the hospital receives;
b. An amount equal to at least 100% of the hospital's tax-exempt benefits (not including federal income tax);
c. At least 5% of the hospital's net patient revenue must be charity care and community benefits, with charity care making up at least 4%.

Though counties may provide additional services to charity care individuals, the minimum services that must be provided under charity care for public hospitals and counties include: primary and preventive services, inpatient and outpatient care, rural health clinics, laboratory and X-ray services, family planning, physician services, payment or no more than three prescription drugs a month, and skilled nursing (Tex. Health & Safety Code Ann. §61.028; §61.054; §61.055). Counties may fulfill these services via local health departments, publicly owned hospitals, private providers, or direct insurance purchases for eligible individuals (Tex. Health & Safety Code Ann. §61.029).

Discussion

The programs/initiatives described in the previous section play a significant role in each state in providing health care to uninsured and underinsured individuals. Given that these programs and initiatives vary in delivery model, scope of service, funding (including hospital reimbursement), and application requirements, broad comparisons are not straightforward. However, a summary of the most relevant aspects of such programs is as follows:

A. *Eligibility:* Income is almost always used as a benchmark for eligibility, ranging from 21% of FPL (i.e., TX) to below 500% of FPL (i.e., MD). None of the states in this report use U.S. citizenship as an eligibility criterion, although some states do require proof of residency.

B. *Funding and reimbursement:* Financing mechanisms vary across states. In general, funding comes from federal and state sources, though in some states (e.g., OR and TX), hospitals are responsible for funding their own charity care expenses.

C. *Covered services:* Most health providers in the states considered in this report prioritize emergency and urgent care services, inpatient and outpatient care, mental health services, and acute hospital care. However, states such as MA also reimburse prescription drugs, dental services, and vision, and in the case of CO, laboratory, radiology, and imaging.

As mentioned, there are noticeable variations in states' approaches to providing health care to uninsured and underinsured populations. Nonetheless, they offer valuable insights and lessons for improving Charity Care in New Jersey. In the following section, we provide a set of recommendations that go in that direction.

Recommendations

The NJ Charity Care program should consider the following recommendations. In making these recommendations, we do not address political feasibility, rather we focus on potential programmatic and policy changes that could be made to enhance and/or modify NJ's existing Charity Care program and discuss potential implementation strategies and challenges. We also address whether or not each recommendation would require new funding mechanisms.

Recommendation 1: Prospective Reimbursement Model

According to current NJDOH operations, reimbursement for charity care is retrospective - hospitals are reimbursed on a percentage of Medicaid payment rates based on operating margins and total charity care services rendered and adjudicated (referred to as DCC) in a prior year. This model could be shifted to a prospective payment model in a way that is similar to MD's model. Instead of hospitals getting reimbursed for prior year Charity Care treatment, hospitals could instead be allotted funds based on prospective models. Following MD's lead, this could be a 50/50 model used to determine payment to hospitals, 50% based on the prior year's hospital-specific Charity Care and 50% predicted Charity Care. As discussed above, MD bases their model on all uncompensated care, but New Jersey could adopt a model incorporating only care delivered to eligible individuals.

We believe that this recommendation would incentivize hospitals to collect a debt from individuals who are able to pay. Since hospitals are not able to make up for any lost revenue stream that is available in the retrospective reimbursement model, they are motivated to practice effective debt collection. There are two major benefits to debt collection - slowing the growth of uncompensated care and protecting the Charity Care funding pool. In taking a more proactive approach to debt collection, hospitals would require less Charity Care reimbursement, thus shrinking the Charity Care funding pool.

There are a few issues that would need to be addressed in thinking through strategies and challenges relative to implementing this recommendation. First, there is the potential for, whether on purpose or not, hospitals to engage in billing negligence (Cantor 2022). NJDOH should offer administrative guidance to ensure hospital faculty are charging individuals accurately. Enforcement of current legislation that protects individuals from predatory collection practices would need to be at the forefront of NJDOH's agenda to combat any mismanagement of individual charges.

- Pros:
    - Incentivize hospitals to collect from individuals who can pay.
        - Slows the growth of uncompensated care.
        - Protects Charity Care funding pool.
    - 50/50 Model
        - Minimize bad debt for hospitals and reimburse uncompensated care.
- Cons:
    - Potential for predatory collection practices.
    - Require hiring additional staff, or contracting for, expertise in predictive modeling.

Recommendation 2: ADI to Further Address Equity

The ADI can be used as a tool for more closely and directly addressing equity issues within NJ's Charity Care program (Knighton et al. 2016). In the proposed prospective reimbursement model, ADI can be utilized in a way similar to MD, to ensure that hospitals that operate in the most disadvantaged areas receive the highest amount of funds from the state. If NJ were to keep the retrospective reimbursement methodology/formula, they could incorporate the ADI into the calculation of the share of Medicaid rates a hospital is eligible to receive under Charity Care. NJDOH could calculate the hospital's ADI based on the hospital's market area. The market area would be defined as the area in which at least 80% of total admissions occurred (Zwanziger et al. 1990). From there, NJDOH would incorporate the ADI into the sliding scale Charity Care reimbursement rate. ADI would, at least in part, be incorporated into the hospital reimbursement formula. This could be considered a reimbursement ceiling and floor for each ADI quantile.

ADI could also be utilized to check the equitability of hospital performance metrics. By analyzing metrics such as 30-day readmission, NJDOH could test if individuals who receive charity care receive the same standard of treatment as their insured counterparts. This could be useful since evidence has shown higher readmission rates for patients residing in areas of high deprivation (Hu et al. 2018). Hospitals that fail to provide equal treatment to all individuals, or which show that Charity Care individuals from high ADI zip codes would be subject to payment deductions. It is important for the Charity Care program to not only consider payment and reimbursement but also closely monitor individual health outcomes and hospital performance broadly.

Ultimately, more closely and directly addressing equity in the Charity Care program should be a priority of NJDOH. ADI could be used as a tool to not only address the equitable distribution of Charity Care funds but also could be used to ensure equitable treatment of individuals who qualify for Charity Care. Under these recommendations, ADI could be used under either a retrospective or prospective reimbursement model. ADI's versatility as a proxy to measure the needs of zip codes or census blocks would be an essential part of equitable Charity Care implementation. Although applying a new factor to Charity Care reimbursement and analysis would have high up-front costs, including familiarization of the variable and data collection, its ability to address equity would be worth it.

- Pros
    - Ensure more equitable distribution of Charity Care funds.
    - Increased focus on equity issues relative to Charity Care treatment.
    - Can be implemented in a prospective or retrospective manner.
- Cons
    - May be complex and administratively burdensome to design predictive model.
    - May be up-front costs.
        - Expensive to introduce variables not previously studied by NJDOH.
    - Would require regular updating, likely on an annual basis.

Recommendation 3: Simplified & Standardized Application Process

Current Efforts: While there has been some movement towards streamlining applications relative to various NJ programs and initiatives, progress has historically been slow and there are still significant opportunities in this space. For example, current proposed legislation (A674) in NJ would create EZ enrollment for Medicaid and NJ marketplace insurance by determining eligibility based on State income tax returns. Though this bill would simplify the process exponentially and could tie in Charity Care eligibility as well, it is likely that many low-income individuals eligible for the program would not be required to file an income tax return.

Intro: A simplified and standardized application process can reduce administrative burden, help to ensure there is no ambiguity or confusion when it comes to the process, and ensure those individuals eligible for the Charity Care program receive appropriate and timely eligibility determinations. For example, MA currently combines their application with their application for MassHealth and the Children's Medical Security Plan. These applications are processed online, and applicants are screened for all three programs at the same time. Additionally, once applicants are approved for the MA's HSNP, they maintain their eligibility for an entire year, which reduces administrative burdens on both hospitals and the State. We have seen that many states have sought to reduce their administrative burden within a variety of health care and social service programs by reducing reliance on paper applications and digitizing processes. Additionally, within this simplified application process, we would highlight that most state programs seem to only ask for proof of income and identification, and otherwise truncate documentation required into a short list, which further helps to ensure appropriate and timely eligible determinations.

Short-Term Recommendation: We recommend that the NJDOH create a single, streamlined application and approval process for charity care in NJ. Currently, each hospital has their own application. Digitalizing this process would allow for simpler determination of eligibility and easier data collection for the state. Creating an eligibility process such as MAs that combines Medicaid, marketplace subsidy, and charity care eligibility into one online application process would reduce administrative burden on the State and reduce the burden of applying for multiple health care coverage options with different agencies on individuals.

In the short-term, NJDOH should create a single online application to be used for eligibility determinations by hospitals. Additionally, NJDOH can support efforts within the legislature to create a streamlined process for health care coverage, including bill A674 which would create a streamlined application for Medicaid and marketplace subsidies.

Long-Term Recommendation: We recommend that NJDOH supports efforts to create a single, streamlined and universal application approach for health care coverage and other social service benefits. For example, NY has created an application system where applicants can be screened for public assistance, SNAP, Medicaid, and emergency assistance within one application. Many of these programs require the same information to be submitted- proof of income, identification, etc. and allowing for one simplified application that is screened for multiple programs and distributed across agencies would reduce administrative burden on both the State and eligible applicants. Though this would be a large investment across multiple State agencies, this would simplify the application process for individuals in need of assistance and reduce administrative burden in the long-run across multiple social service programs.

- Pros
    - Reduces burden on individuals in need of medical assistance.
    - Streamlines, standardizes and simplifies the application process.
    - Reduces administrative burden and costs.
    - Reduces the potential for ambiguity or confusion when it comes to the application process, which will likely help to ensure timely and appropriate eligibility determinations.
- Cons
    - May be difficult to implement a single, streamlined and universal application that would be applicable and/or appropriate for all state programs across multiple State departments and other partner agencies.
    - Would require legislative and regulatory changes.

Recommendation 4: Updating Affordability Standards for Uninsured Individuals

Currently, under NJ law, hospitals are only allowed to charge an individual whose gross family income is less than 500% of FPL, an amount that is no greater than 115% of the applicable payment rate under the Medicare program for any health care services provided (NJ P.L. 2008 c. 60). Though this is codified into NJ statute, in practice this is a suggested guideline and not enforced. To further improve these affordability standards and to reduce the financial burden of costs on un-and under-insured individuals, it would be beneficial to extend reduced-cost care to a higher percentage of FPL than currently offered because many of these individuals fall in a gap where they are not eligible for Medicaid or traditional charity care, and remain uninsured or underinsured due to high costs of health insurance premiums, despite increased marketplace subsidies under NJ Health Plan Savings and increased subsidies through the CARES Act.

This concept was additionally proposed last legislative session as A4218/S081, establishing a cap on the amount hospitals could charge for laboratory services at 150% of Medicare rates. Furthermore, it would also be beneficial to mandate a lower price ceiling for uninsured individuals. For instance, following CA's Hospital Fair Pricing Act, the discounted charges to eligible uninsured and underinsured individuals could be no more than the highest amount paid by any government-sponsored health program. In other words, lawmakers could cap the price at what Medicare and/or Medicaid would pay. The latter would provide better protection to the uninsured because the new price ceiling would be lower than the highest amount paid by any commercial plan. Generally, commercial health plans pay hospitals higher rates than Medicare or Medicaid does.

Medicare specific research shows that lower Medicare rates lead to lower commercial rates as well, despite common misconceptions of the cost-shifting theory. For example, in a study by the Center for Studying Health System Change, researchers identified that a ten percent reduction in Medicare payment rates led to a reduction in commercial rates between 3-8 percent (White, 2013).

- Pros
    - Expands access to health care.
    - Reduces OOP costs for uninsured and underinsured individuals.

- Cons
    - Would require legislative and regulatory changes.
    - Competing interests will fight reductions in payment rates.

Recommendation 5: Expanding Scope of Coverage

Expanding the scope of coverage of the Charity Care program to include preventive care and prescription drug costs has the potential to vastly improve health outcomes among low-income individuals. With the rise of chronic health conditions such as diabetes and the large percentage of US deaths related to behavioral causes such as obesity and tobacco smoking, it is imperative that individuals have access to routine preventive health care servings and screenings. Primary [LJM[1]] preventive services, including but not limited to, alcohol and tobacco use screenings, mammograms, medication management, behavioral health (including mental health and substance use disorder) screenings, and chronic disease management, among others, have been shown to produce overall healthcare system savings upwards of $2 billion per year (Roundtable on Evidence-Based Medicine, 2010). For example, managing chronic health conditions and preventing conditions, such as cardiovascular disease, diabetes, and obesity, can help to reduce future medical expenses and costs to hospitals relative to high-cost services such as inpatient hospitalization, surgeries, etc.. We recommend that NJ explore options to provide increased preventive care benefits within the Charity Care program. Though this care has historically been provided through partnerships and/or referrals with FQHCs and other community-based providers.

We recommend that NJDOH allows or requires NJ hospitals to use a portion of charity care funding to reimburse FQHC or other community-based providers for ambulatory care management for patients who are frequent users of emergency department or inpatient care. The program could be structured as a pay-for-performance program where additional charity care funding is allocated to reducing avoidable hospital emergency visits or readmissions, consistent with DSRIP and QIP initiatives (Lloyd, Chakravarty, Brownless, Farnham, and Cantor, 2020). This could begin as a demonstration or pilot program before expanding it statewide.

We recommend that NJ implement a program similar to MA Health Safety Net prescription drug coverage where they have created partnerships with local retail pharmacies across the State to allow for easier management of monthly prescriptions. In MA, all prescriptions written by a hospital provider or community health center provider can be filled through local retail pharmacies. This allows for convenient pick up of medications and can increase medication compliance of Charity Care patients therefore reducing hospital costs for uncompensated care.

Funding sources for expanded Charity Care benefits and initiatives can include, but are not limited to, increased tax on tobacco and nicotine products, earmarked funding from cannabis revenue, and further assessments on private health care providers.

- Pros
    - May improve chronic disease management and the long-term health of patients eligible for Charity Care.
    - May reduce long-term costs of the Charity Care program by increasing access to preventive services and prescription drugs to manage chronic illnesses and reduce long-term health care costs.

- Cons
    - Would either require more funding for the Charity Care program or reduced hospital payments under the existing Charity Care program.
    - Could be administratively burdensome to implement and would require legislative and regulatory changes.

Recommendation 6: Connecting Preventive Care with Charity Care through Incentives and Data Sharing

Many individuals discharged from the hospital after receiving hospital-based acute care services require a follow-up visit and ongoing maintenance in a setting other than a hospital. Historically, these follow up visits oftentimes occur through FQHCs and community-based partners / CHCs. Through our research, we have anecdotally heard that there is oftentimes a disconnect between hospitals and FQHCs / community-based providers/CHCs providing these services, where FQHCs and community-based providers/CHCs often do not have access to necessary medical records from the hospital. Both CA and WA State have created health information exchanges and provided FQHCs with additional funding to be able to update their technology infrastructure to make health information exchanges possible. When providers are part of health information exchanges it improves health outcomes and helps to reduce readmissions among uninsured individuals.

Additionally, we recommend that NJ foster and encourage stronger relationships between Hospitals and FQHCs/community-based providers/CHCs with a focus on preventive care and follow-up care. We recommend that NJ explore options to tie an incentive into the Charity Care methodology/formula that includes increased funding for FQHCs/community-based providers/CHCs and hospitals that work to increase primary care and preventative services while reducing readmissions for those receiving Charity Care at hospitals. This recommendation could be implemented in conjunction with recommendation five, allowing or requiring hospitals to use a portion of charity care funding to reimburse FQHC or other community-based providers for ambulatory care management for patients who are frequent users of emergency department or inpatient care.

- Pros
    - Increased coordination of care for uninsured and underinsured individuals.
    - May reduce readmissions at hospitals.
- Cons
    - Establishing the infrastructure for data sharing is complicated due to state and federal privacy requirements.
    - Hospitals and other health care facilities may not have the appropriate infrastructure or technology systems to support exchanges, which can be costly.
    - Could be administratively burdensome to implement and would require legislative and regulatory changes.

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Appendix A

New Jersey Department of Health's 2022 Survey on Uncompensated & Other Related Care Models

Purpose/Background:
The state of New Jersey (NJ) created the Hospital Care Payment Assistance Program, also known commonly as Charity Care. NJ Charity Care provides free or reduced charge medically necessary inpatient and outpatient care to eligible individuals at acute care hospitals throughout NJ. NJ is interested in learning from similar initiatives in other states. This survey asks about your state's initiatives, programs, and policies that provide or fund health care services to uninsured or underinsured individuals, regardless of their ability to pay. The NJ Department of Health (NJDOH) is partnering with a group of students from the Master of Public Policy program at Rutgers Edward J. Bloustein School for Planning and Public to assist with this project. Your assistance with providing the requested information will be tremendously useful and greatly appreciated. Should you have any questions about the survey or wish to receive a summary of the findings following its conclusion, please do not hesitate to reach out to NJDOH directly via email at _____@doh.nj.gov or via phone at _____.

Instructions:
For purposes of this survey, NJDOH is broadly defining 'charity care' or uncompensated care programs (referred to throughout the survey simply as "program" or "programs") as those that provide or fund medically necessary inpatient or outpatient health care services to uninsured or underinsured individuals, regardless of their ability to pay. This does not include services covered or compensated by other government insurance (Medicare and Medicaid), third party private insurance, or direct payment form the patients' available funds. This also does not include services that are written off as bad debt that is not eventually reimbursed and considered a loss to the provider, or care provided at federally qualified health centers (FQHCs). While NJDOH recognizes that some states may utilize different definitions or approaches to providing health care services in this space, we encourage you to provide information on the broadest program(s) applicable to your state. For example, some states' programs only apply to health care services provided at hospitals, while others might include health care services rendered by different types of providers. Many of the questions below are open-ended to allow you as much flexibility as possible, including the option to upload documents or provide website links with relevant information. Should you wish you clarify any questions prior to submitting your responses, please reach out to the Rutgers' team representative, Tristan Gibson, via email at twg30@scarletmail.rutgers.edu.

Q1 Please provide the name of your state, territory, or district.

_____

Q2 Please provide the following information for the main individual responsible for responding to the survey:
Name

Agency/department/office
Title
Email
Direct phone

Q3 Does your state have a program that provides medically necessary care to individuals who are uninsured or underinsured, regardless of their ability to pay? Please refer to the definition in the instructions.

- o Yes (1)
- o No, and no plans to implement such a program (2)
- o No, but we have plans and/or have contemplated plans to implement such a program (3)

Skip To: End of Survey If Does your state have a program that provides medically necessary care to individuals who are unin... = No, and no plans to implement such a program

Skip To: Q5 If Does your state have a program that provides medically necessary care to individuals who are unin... = No, but we have plans and/or have contemplated plans to implement such a program

Display This Question:
If Does your state have a program that provides medically necessary care to individuals who are unin... = Yes

Q4 If you answered Yes to Q3, does your state have more than one program? Please provide a list of the applicable program(s), populations(s) served by that program(s) (inclusive of Indigenous Individuals/Native Americans), if applicable, and the agency/entity responsible for each (if different than your agency).

Q5 If your state has considered implementing a program to reimburse care for uninsured or underinsured individuals regardless of their ability to pay, but has not fully implemented it, please discuss the program details, why it has not been implemented (or fully implemented), and whether implementation is planned for the future.

Q6 What local, state, or federal law(s), govern(s) your state's program(s)? Please provide website links, if possible.

Q7 Does you state require that a certain class of facilities/providers participate in your program(s) or is participation voluntary? Please specify.

Q8 If your state has an established program, what services are covered? Please select all that apply and refer to the definition in the instructions.

- ☐ Preventive Care (in any setting) (1)
- ☐ Inpatient Care (2)
- ☐ Hospital Outpatient Care (3)
- ☐ Non-hospital based ambulatory care (4)
- ☐ Emergency Services (5)
- ☐ Outpatient prescription drugs (6)
- ☐ Medical equipment and supplies (7)
- ☐ Mental health services (8)
- ☐ Non-emergency medical transportation (9)
- ☐ Others. Please specify: (10)

_____

Q9 In addition to providing medically necessary health care service, does your state's program include other provisions to connect eligible individuals with additional services and supports if/whenever applicable? Please select all that apply.

- ☐ Housing Assistance (1)
- ☐ Food and Nutrition Assistance (2)
- ☐ Domestic Violence Intervention (including Shelters) and Services (3)
- ☐ Employment Services (4)
- ☐ Education Assistance (5)
- ☐ None (7)
- ☐ Other(s). Please Specify: (6)

_____

Q10 Does your state consider whether an individual is undocumented or lawfully present in the United States relative to determining program eligibility?

- o Yes (1)
- o No (2)
- o Other. Please explain: (3) _____

Q11 What demographic information does your state collect as part of your program(s) application process or program administration? For example, this could include items such as age, immigration status, race, ethnicity, income, insurance status, education, primary diagnosis, type of health care service/procedure, etc. Please be as detailed and comprehensive in your response as possible.

_____

Q12 How is demographic information collected as part of the application process? For example, when the individual is medically stabilized, do hospital financial counselors or medical staff manually retrieve the information? Is the information automatically linked when the individual is admitted to emergency room/hospital?

_____

Q13 Do you generate public dashboards or reports?

- oYes, please provide more detail and, if possible, website links below: (1)
- o No (2)

Q14 How are applications for your program(s), including supporting documentation, submitted? Please select all that apply.

- ☐ In-person. Please specify location of collection. (1) _____
- ☐ Mail (2)
- ☐ Electronic (Online Portal, or other) (3)
- ☐ Others. Please specify: (4) _____

Q15 Does your state have specific eligibility criteria that are captured at the individual patient level for program(s) reimbursement?

- o Yes (1)
- o No (2)
- o Other. Please explain: (3) _____

Display This Question:

If Does your state have specific eligibility criteria that are captured at the individual patient le... = Yes

Q16 What are the specific individual-level eligibility criteria for your program(s)? Please select all that apply

- ☐ Household income (1)
- ☐ Assets (2)
- ☐ Residency Requirements (3)
- ☐ Other(s). Please specify: (4) _____

Display This Question:

If What are the specific individual-level eligibility criteria for your program(s)? Please select al... = Household income

Q17 Please describe your program(s) household income requirements and/or provide any applicable website links.

_____

Display This Question:

If What are the specific individual-level eligibility criteria for your program(s)? Please select al... = Household income

Q18 Please upload any income requirement documentation.

Display This Question:

If What are the specific individual-level eligibility criteria for your program(s)? Please select al... = Assets

Q20 What documents are acceptable as proof of assets? Please provide any applicable website links.

_____

Display This Question:
If What are the specific individual-level eligibility criteria for your program(s)? Please select al... = Assets

Q21 Please upload any asset requirement documentation.

Display This Question:
If What are the specific individual-level eligibility criteria for your program(s)? Please select al... = Residency Requirements

Q57 What are your residency requirements and which documents are accepted as proof of residency? Provide applicable website links.

_____

Display This Question:
If What are the specific individual-level eligibility criteria for your program(s)? Please select al... = Residency Requirements

Q56 Please upload any residency requirement documentation.

Q22 Which state entity is charged with reviewing (approving, denying, etc.) and performing any necessary follow-up relative to program applications?

_____

Q23 In case an individual application is denied, does your state's program have an appeal or administration resolution process?

- o Yes. Please specify: (1) _____
- o No (2)

Q24 How is/are your program(s) funded in your state. Please select all that apply.

- ☐ Federal Medicaid Disproportionate Hospital Share (DSH) funds (1)
- ☐ State General funds (if there are specifically earmarked funds, please specify) (2)

_____

- ☐ Other federal funds, including grants. Please specify: (3)

_____

- ☐ Other funds. Please specify: (4)

_____

Q25 Please upload any files applicable to program funding such as a program budget.

Q26 Do you believe that your program is sustainable year-over-year as currently funded and/or reimbursed? If yes, what factors affect its sustainability? If no, please describe some of the

difficulties and/or challenges (internal and/or external) your state has experienced historically, Please be as detailed and comprehensive as possible.

_____

Q27 What is your state's formula or methodology for the program's reimbursement rate and how is it codified? For example, your program allows for participating facilities/providers to receive up to a certain percentage of reimbursement rate for covered health care services and it is codified in state statute. Please provide any helpful links.

_____

Q28 Please upload any files or supporting documentation, or provide website links, related to your state's uncompensated care program's formula for reimbursement rate.

Q29 What is your state's formula or methodology for distributing allotments to participating facilities/providers? For example, your state decides which facilities/providers are eligible to receive program reimbursement and which are not based upon state statute. Please link supporting documentation as necessary.

_____

Q30 Please upload any supporting documentation related to your state's formula for distributing allotments to participating facilities/providers.

Q31 Does your state's program(s) formula or methodology make any special considerations for safety-net facility/provider status, facilities/providers in low-income areas, and other facility/provider characteristics?

- o Yes, Please provide further details: (4) _____
- o No (5)
- o Other, Please Specify: (6) _____

Display This Question:

If Does your state's program(s) formula or methodology make any special considerations for safety-ne... = Yes, Please provide further details:

Or Does your state's program(s) formula or methodology make any special considerations for safety-ne... = Other, Please Specify:

Q32 Please upload any supporting documentation regarding your states considerations for safety-net facility/provider status.

Q33 Does your state’s program(s) align with or coordinate with existing community-based care programs such as Federally Qualified Health Centers or other outpatient ambulatory care services?

- o Yes. Please specify whether there is a formal requirement or whether this is at the discretion of participating providers. (1) _____
- o No (2)
- o Other. Please specify: (3) _____

Q34 Which agencies) are responsible for reimbursing facilities/providers under your state's program(s)? If more than one agency is responsible, please select all that apply.

- ☐ County/local government (1)
- ☐ State government (2)
- ☐ Regional authority (3)
- ☐ Other. Please specify: (4) _____

Q35 How is the general application process and application approval process managed in your state's program(s)?

- o Centralized system through government agency(ies) (1)
- o Managed directly by participating facilities/providers (2)
- o Managed by regional and/or county offices (3)
- o Other. Please specify: (4) _____

Q36 What obligations do participating facilities/providers have for making potentially eligible uninsured or underinsured individuals aware of the availability of the program(s) in your state? Please provide any website links as necessary.

_____

Q37 What are the reporting and audit requirements for participating facilities/providers to stay in compliance with applicable state statutes/regulations as well as agency program policies or guidance? If applicable, please name the agency/identity conducting the audit.

_____

Q38 Are there quality of care and/or other performance incentives or requirements linked to payments to participating facilities/providers under your state’s program(s)?

- o Yes (4)
- o No (5)
- o Don't know (7)

Display This Question:

If Are there quality of care and/or other performance incentives or requirements linked to payments... = Yes

Q39 Please describe these performance-based incentives or requirements. Have these performance-based efforts been successful? Why or why not?

_____

Display This Question:

If Are there quality of care and/or other performance incentives or requirements linked to payments... = Yes

Q40 Please upload any supporting documentation for these incentives/requirements as necessary.

Q41 Did your state take part in Medicaid expansion through the Affordable Care Act(ACA)?

- o Yes (4)

o No (5)

Display This Question:
If Did your state take part in Medicaid expansion through the Affordable Care Act(ACA)? = Yes

Q42 How has ACA expansion impacted your uncompensated care program(s)? What key differences are there between your program before and after the ACA was enacted, and what are some important lessons learned that you would like to impart on other states?

_____

Q43 How did the program(s) caseloads or claim volume in your state changed due to the COVID-19 pandemic? Please provide website links as necessary, particularly if your state created a COVID-19 dashboard or other public reporting platform.

_____

Q44 Did your state modify its program(s) to adjust to the COVID-19 pandemic? Please explain in detail.

_____

Q45 Please upload any supporting documentation on program caseloads or claim volume during the COVID-19 pandemic.

Q46 How has the availability of expanded COVID-19 pandemic and Health Resources and Services Administration (HRSA) funding impacted your program(s) and related processes and/or practices in your state, if at all?

_____

Q47 If there are other important features of your state's program(s) that this survey did not capture and/or address, please provide that information here.

_____

Q48 Please provide any applicable documentation of resources that you believe may be helpful as we analyze the results of this survey.

_____

Q49 If there was any information you were unable to provide and believe there is an additional person we should contact for more information on your State's uncompensated care program such as a hospital association or additional state agency, please provide their information below:
Name:
Agency/Dept:
Phone:
Email:

Q50 Please enter an email if you would like to receive a copy of your survey responses.