

**REPORT OF THE  
JOINT COMMISSION ON HEALTH CARE**

**Indigent and Charity Care  
Provided by Hospitals  
(HJR 27, 2010)**

**TO THE GOVERNOR AND  
THE GENERAL ASSEMBLY OF VIRGINIA**



**HOUSE DOCUMENT NO. 2**

**COMMONWEALTH OF VIRGINIA  
RICHMOND  
2011**





COMMONWEALTH of VIRGINIA  
Joint Commission on Health Care

Delegate Benjamin L. Cline  
Chairman

Kim Snead  
Executive Director

900 E. Main Street, 1<sup>st</sup> Floor  
P.O. Box 1322  
Richmond, Virginia 23218  
804.786.5445  
804.786.5538 (facsimile)

April 25, 2011

The Honorable Robert F. McDonnell  
Governor of Virginia  
Patrick Henry Building, 3<sup>rd</sup> Floor  
1111 East Broad Street  
Richmond, Virginia 23219

Members of the Virginia General Assembly  
General Assembly Building  
Richmond, Virginia 23219

Dear Governor McDonnell and Members of the General Assembly:

The 2010 General Assembly in House Joint Resolution 27 (Delegate Purkey) requested a study by the Joint Commission on Health Care to determine the volume and cost of indigent health care provided by hospitals and to consider incentives to encourage the provision of health care to indigent individuals.

The Joint Commission report, completed in response to HJR 27, is enclosed for your review and consideration.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "B. Cline", written over a horizontal line.

Benjamin L. Cline



# Joint Commission on Health Care Members

## **Chair**

The Honorable Benjamin L. Cline

## **Vice-Chair**

The Honorable Linda T. Puller

## **Virginia House of Delegates**

The Honorable Robert H. Brink

The Honorable David L. Bulova

The Honorable Rosalyn R. Dance

The Honorable T. Scott Garrett

The Honorable Algie T. Howell, Jr.

The Honorable Harvey B. Morgan

The Honorable David A. Nutter

The Honorable John M. O'Bannon, III

The Honorable Christopher K. Peace

## **Senate of Virginia**

The Honorable George L. Barker

The Honorable Harry B. Blevins

The Honorable R. Edward Houck

The Honorable L. Louise Lucas

The Honorable Ralph S. Northam

The Honorable Patricia S. Ticer

The Honorable William C. Wampler, Jr.

The Honorable William A. Hazel, Jr.

Secretary of Health and Human Resources

## **Commission Staff**

Kim Snead

Executive Director

Stephen W. Bowman

Senior Staff Attorney/Methodologist

Michele L. Chesser, PhD

Senior Health Policy Analyst

Jaime H. Hoyle

Senior Staff Attorney/Health Policy Analyst

Sylvia A. Reid

Publication/Operations Manager

---

**Code of Virginia § 30-168.**

The Joint Commission on Health Care (the Commission) is established in the legislative branch of state government. The purpose of the Commission is to study, report and make recommendations on all areas of health care provision, regulation, insurance, liability, licensing, and delivery of services. In so doing, the Commission shall endeavor to ensure that the Commonwealth as provider, financier, and regulator adopts the most cost-effective and efficacious means of delivery of health care services so that the greatest number of Virginians receive quality health care. Further, the Commission shall encourage the development of uniform policies and services to ensure the availability of quality, affordable and accessible health services and provide a forum for continuing the review and study of programs and services.

The Commission may make recommendations and coordinate the proposals and recommendations of all commissions and agencies as to legislation affecting the provision and delivery of health care.

## Preface

House Joint Resolution 27 introduced by Delegate Harry R. Purkey (2010) requested that the Joint Commission on Health Care determine the volume and cost of indigent health care provided by hospitals in the Commonwealth as well as analyze incentives to encourage the provision of health care to indigent individuals.

In 2008, Virginia hospitals provided the equivalent in \$400 million in charity care; generally, not-for-profit hospitals provided more charity care than for-profit hospitals as a percentage of revenues. Charity care policies are set by each hospital and there is no state standard defining the calculation of charity care. Recent federal changes will provide for greater federal oversight of tax-exempt hospitals: the Internal Revenue Service (IRS) revised Form 990 to standardize how hospitals report charity care expenses and the U.S. Treasury was mandated to review hospitals' tax-exempt status every three years.

Furthermore in 2014, the Patient Protection and Affordable Care Act (PPACA) requirement for individual insurance coverage, if enacted, is expected to decrease significantly the number of uninsured Virginians and concomitantly decrease the need for hospital-provided charity care. However, before considering new policies regarding hospital charity care, additional review of the actual impact of federal health reform should be undertaken. By 2016, specific assessments of PPACA's impact on charity care could be gauged and multiple years of hospital charity care data from the revised IRS Form 990 will be available. If PPACA changes decrease the need for charity care, there may be justification for lowering Virginia's Certificate of Public Need charity care conditions.

Based on the study findings, the Joint Commission on Health Care approved two policy options:

- By letter of the Chairman, request that the Virginia Department of Health report to JCHC by August 30, 2012 regarding the impact of federal health reform on existing COPN charity care conditions and recommendations to address any program, regulatory or statutory changes that may be needed.
- Include in the JCHC 2011 work plan, a staff review of ways to define hospital-offered charity care to include determining the availability of data to support any charity-care definitions being considered. The purpose of the review would be to further future State-level charity care discussions and analyses.

On behalf of the Joint Commission and staff, I would like to thank the numerous individuals who assisted in this study, including representatives from the Department of Medical Assistance Services, Virginia Department of Health, Virginia Department of Taxation, and Virginia Hospital and Healthcare Association and its member hospitals.





## **Table of Contents**

Background.....1

Policy Options.....8

### Attachments

November 3, 2010 Slide Presentation

House Joint Resolution 27 (2010)



## Indigent and Charity Care Provided by Hospitals

House Joint Resolution 27 introduced by Delegate Harry R. Purkey (2010) requested that the Joint Commission on Health Care determine the volume and cost of indigent health care provided by hospitals in the Commonwealth as well as analyze incentives to encourage the provision of health care to indigent individuals.

### Background

Estimates for the number of uninsured Virginians in 2008 ranged from 600,000 to 1 million. Many low-income uninsured individuals do not have the financial means to afford needed medical care and hospitals have created specific charity care programs involving free or discounted care to assist them in accessing care. Each hospital determines the income qualifications for its charity care program. In general, hospitals provide financial assistance to individuals with incomes at or below 100% of the federal poverty level who need medical care. Many hospitals provide financial assistance to individuals at higher-income levels.

### Hospital-Offered Charity Care in Virginia

The General Assembly has defined indigent care as care for individuals at or below 100% of the federal poverty level for which the hospital receives no payment. Using that statutory definition, Virginia Health Information (VHI) standardized ways for hospitals to report indigent care data.<sup>1</sup> However, there is no standard definition or calculation for determining hospital charity care which exceeds the indigent care standard. This lack of standardization limits the extent to which hospital-sponsored charity care can be measured and compared.<sup>2</sup> Using non-standardized definitions, Virginia’s hospitals reported providing the equivalent of \$400 million in charity care costs and \$756 million in indigent care charges.<sup>3</sup>

Figure 1 highlights charity care charges and costs as reported by Virginia’s not-for-profit and for-profit hospitals in 2008. Generally, not-for-profit hospitals provided more charity care (2.4%) than for-profit hospitals (1.0%) as a percentage of their revenues.

**Figure 1: Indigent and Charity Care Charges and Costs as Reported by Virginia Hospitals in 2008**

	Not-for-Profit	For Profit
Number of hospitals <sup>4</sup>	67	19
Indigent care charges <sup>5</sup>	\$676 million	\$80 million
Indigent care charges as a percentage of gross revenues <sup>6</sup>	2.4%	1.0%
Charity care costs incurred <sup>7</sup>	\$372 million	\$28 million

<sup>1</sup> *Code of Virginia* §32.1-322 defined an indigent care standard for hospitals until repeal of the Indigent Health Care Trust Fund in 2009.

<sup>2</sup> These differences limit the types of analyses conducted during this study.

<sup>3</sup> When determining the value of hospital charity or indigent care using hospital costs is better than using charge data.

<sup>4</sup> VHI data collected from hospitals.

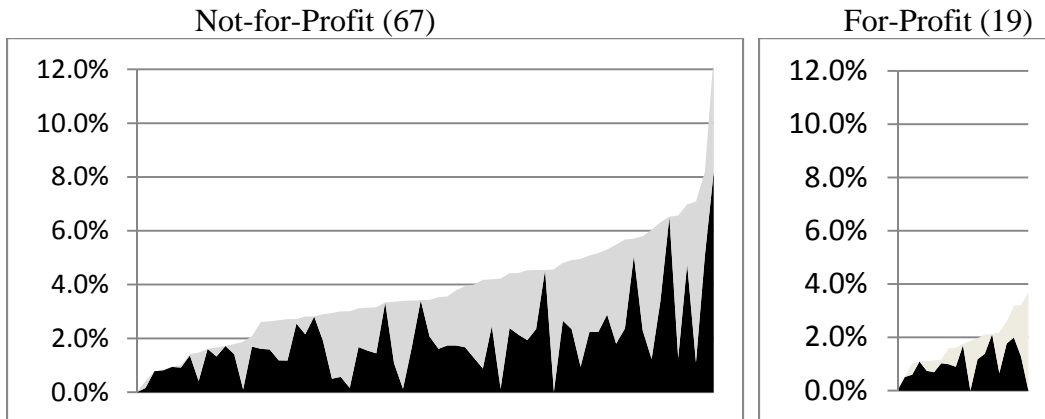
<sup>5</sup> JCHC staff analysis of VHI data collected from hospitals. Excludes Pioneer Community Hospital of Patrick County information and includes reimbursements from the Indigent Care Trust Fund.

<sup>6</sup> *Id.*

<sup>7</sup> *Cornerstones of Their Communities: The Impact of Virginia Hospitals*, VHHA, December 2009.

As displayed in Figure 2, the amount of charity care provided varied by hospital from zero to 12.5 percent of gross patient revenues.<sup>8</sup> This variation corresponds to national studies that also found substantial variation in the charity care provided by not-for-profit hospitals.

**Figure 2: Virginia Hospital Charity and Indigent Care Charges as a Percentage of Gross Patient Revenues**



To increase awareness of hospital charity care programs, the General Assembly enacted HB 2458 (Delegate O’Bannon) in 2009 to require hospitals to post their charity care policies in public areas of the hospital and on their websites.

**Federal Changes Impacting Hospital-Offered Charity Care**

Recent federal changes will affect hospital charity care offerings. Over the past few years, the Internal Revenue Service (IRS) and the U.S. Congress examined whether not-for-profit hospitals have been fulfilling their charitable missions and how to verify that hospitals that receive tax-exemptions deserve them.

For tax-year 2009, the IRS revised Form 990, which will standardize how hospitals report charity care expenses. This change will allow for better comparisons of the hospital costs incurred in providing charity care. In addition, the Patient Protection and Affordable Care Act (PPACA) directs the U.S. Treasury to review hospitals’ tax-exempt status every three years to exert greater oversight of hospitals receiving this tax advantage. PPACA also directs not-for-profit hospitals to fulfill new requirements including:

- Establishing a written financial assistance policy, including eligibility criteria for financial assistance to serve as a basis for calculating charges to patients.
- Limiting the amounts charged to patients eligible for financial assistance similar to the lowest amounts charged to insured patients.
- Undertaking reasonable efforts to determine whether a patient is eligible for financial assistance before engaging in extraordinary billing and collection actions.

In addition, PPACA provisions, mandating individual health insurance coverage and providing insurance premium assistance, are expected to decrease the amount of hospital charity care

<sup>8</sup> JCHC staff analysis of VHI data collected from hospitals.

needed.<sup>9</sup> It is expected that by 2014, more individuals will choose to have health insurance coverage as they will be assessed a fee if they are not insured. Moreover, subsidized health insurance premiums are expected to be available through health exchanges for individuals with incomes at or below 400 percent of the federal poverty guidelines. As the number of uninsured individuals decreases, the need for charity care is expected to decrease. However, some level of charity care will be needed even if PPACA provisions are fully implemented, as some individuals still will not have health insurance.

### **State Avenues to Encourage Hospital Charity Care**

Three avenues to encourage hospital-provided charity care were identified through reviews of other-state policies and discussions with hospital administrators. These avenues involve:

- Establishing a State fund to reimburse hospitals for charity care expenses.
- Increasing the Medicaid reimbursement rate to allow hospitals to provide more charity care.
- Requiring not-for-profit hospitals to meet charity care standards in order to receive the State tax-exemption.

***Reimburse for Charity Care Expenses.*** Two programs, State/Local Hospitalization and the Indigent Health Care Trust Fund, established by the Commonwealth to reimburse hospitals for the provision of charity and indigent care, had their funding discontinued in FY 2010.

State/Local Hospitalization, a program funded jointly by the State and by local governments, provided reimbursement for care provided by hospitals, ambulatory surgical centers, and local health departments to indigent patients who were not eligible for Medicaid. Due to funding limitations, requests for reimbursement always exceeded available funding. A total of \$12.9 million (in State and local funds) was appropriated for the program in FY 2009, but no funding was appropriated for FY 2010.

The Indigent Health Care Trust Fund (IHCTF) sought to equalize the burden of charity care among Virginia's hospitals. IHCTF was funded by contributions from hospitals whose provision of charity care was below the statewide median for hospital charity care;<sup>10</sup> these hospital contributions were matched by State general funds. Typically, IHCTF fell short of fully funding the amount of indigent care provided. In FY 2009, \$7.5 million was appropriated for IHCTF but no funding was appropriated for FY 2010.

***Increase Medicaid Payment Rate.*** An indirect method for increasing hospital-offered charity care is through increasing the Medicaid rates paid to hospitals. According to Virginia Hospital and Healthcare Association, Virginia's Medicaid program only reimburses hospitals for 76 percent of their inpatient and 80 percent of their outpatient care costs. To make up for low Medicaid reimbursement, other hospital operations must cross-subsidize Medicaid services. If the Medicaid reimbursement rates paid to hospitals were increased, hospitals would have smaller

---

<sup>9</sup> PPACA is undergoing legal challenges. One challenge centering on the individual mandate portion of the law is based on HB 10 (2010) which provides that no Virginia resident will be liable for a fee for not obtaining health insurance coverage. Analysis and implications described in this report are dependent on PPACA's current language being fully funded and sustaining all court challenges.

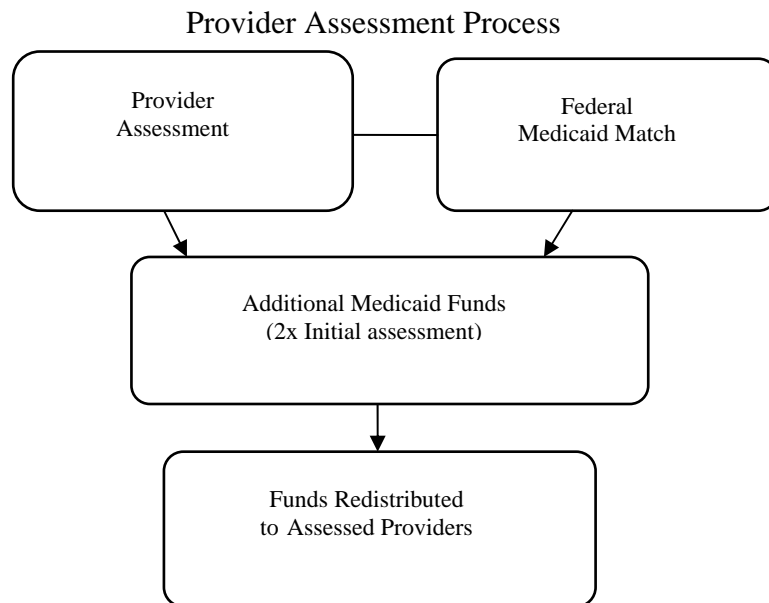
<sup>10</sup> Some, but not all, profitable hospitals contributed to the Trust Fund based on the amount of charity care they provided. Proprietary hospitals received a credit for the State corporate taxes they actually paid. Payments were made to each hospital based on the charity care the hospital provided in excess of the median amount of charity care for all hospitals, adjusted by the hospital's cost-to-charge ratio. The Trust Fund paid up to 60% of those charity care costs. Hospital contributions were matched by State general fund contributions. Source: *Virginia Indigent Health Care Trust Fund Program Guide - September 1999*.

per capita Medicaid losses and could chose to subsidize greater amounts of charity care due to improved financial condition.

Because Medicaid is a joint state and federal program, increasing Virginia’s Medicaid reimbursement rates would require additional State and federal funding. In FY 2010, Virginia’s Medicaid funding came from two State sources: the State general fund (\$2.7 billion) and the Virginia Health Care Fund (\$300 million) which includes funding from tobacco taxes and the Master Settlement Agreement. (Note that State funding for most Medicaid programs is matched dollar for dollar by federal funding. In FY 2010, federal funding of \$3.1 billion was appropriated.)

Imposing a provider assessment fee is one way to increase the funding available to draw down additional federal funding. As illustrated in Figure 3, two-times the amount of the collected provider fees could be draw down in federal funding to be redistributed to the providers, potentially by increasing the Medicaid reimbursement rates paid hospitals. Providing a significant increase in the reimbursement rates could reduce the need for hospitals to cost-shift to private payers.

**Figure 3: Provider Assessment Drawdown**



Twenty-nine states have instituted hospital assessments with 15 of those states establishing or increasing the assessments in 2009 or 2010.<sup>11</sup> States can base hospital assessments on a variety of factors such as annual net revenues, net patient operating revenue, inpatient and outpatient service revenues, gross revenue, and number of occupied beds or by levying a licensing fee. New assessments in other states indicate an estimated \$11 million to \$352 million per year in additional revenues is expected.

If Virginia adopted provider assessment fees with the fees going into the Medicaid program to drawdown additional federal funds, those funds could be allocated in a number of different ways

<sup>11</sup> National Conference of State Legislatures, Health Care Provider and Industry Taxes and Fees at <http://www.ncsl.org/default.aspx?tabid=14359>.

including: through supplemental Disproportionate Share Hospital payments, supplemental Medicaid payments, increased Medicaid rates, various combinations of these methods, or through other methodologies approved by the Centers for Medicare and Medicaid Services (CMS). The reimbursement method chosen would affect how much of the additional Medicaid funding each hospital would receive. However, it is likely that the assessment fee paid by some hospitals would be higher than the increase in Medicaid funding they would receive due to CMS' Medicaid regulations.

The issue of provider assessments to fund the Medicaid program has been considered by the General Assembly. In 1992, the Virginia Health Care Cost Containment and Shared Provider Participation Act (HB 1113/SB 422) was introduced, but did not receive legislative support. In 2010, the General Assembly approved an assessment fee for Intermediate Care Facilities for the Mentally Retarded (ICF/MR).<sup>12</sup> The 2010 assessment fees were not implemented; however, because PPACA forbids increasing local government contributions for Medicaid and some Virginia localities operate ICF/MRs.

JCHC staff interviewed representatives from the Virginia Hospital and Healthcare Association (VHHA) about the concept of hospital assessment fees. VHHA representatives raised a number of concerns including that Medicaid should be approached as a core service and funded with State general fund dollars. Furthermore, even with an initial increase in Medicaid funding, hospitals might not be better off over the long run; provider assessment fees might be used to supplant State general funds for Medicaid since initial agreements regarding the use of assessment funds might not be kept by future administrations.

JCHC staff conducted a simulation applying a 2.5 percent assessment fee on net hospital-inpatient revenue for 2008.<sup>13</sup> As shown in Figure 4, a 2.5 percent assessment fee would collect \$198 million from hospitals that could be used to drawdown an additional \$198 million in federal Medicaid funding. If the \$396 million were used to increase hospital reimbursement, the Medicaid rate could be increased to cover 99 percent of hospitals' inpatient operating costs (as compared to the current rate which covers 76 percent of hospitals' inpatient operating costs). While not all Virginia hospitals would realize a financial benefit, under the simulation 91 percent (78 of 86) of hospitals would receive new Medicaid revenue in excess of the assessment fees paid. When hospital systems were examined, 92 percent (34 of 37) would realize net gains.<sup>14</sup> Figure 4 illustrates graphically these gains and losses for hospitals and hospital systems.

Figure 5 highlights the demographics of hospitals and hospital systems with net gains and net losses under the simulation. (While this report describes one simulation, two additional staff simulations were described in the presentation made to JCHC in November 2010.)

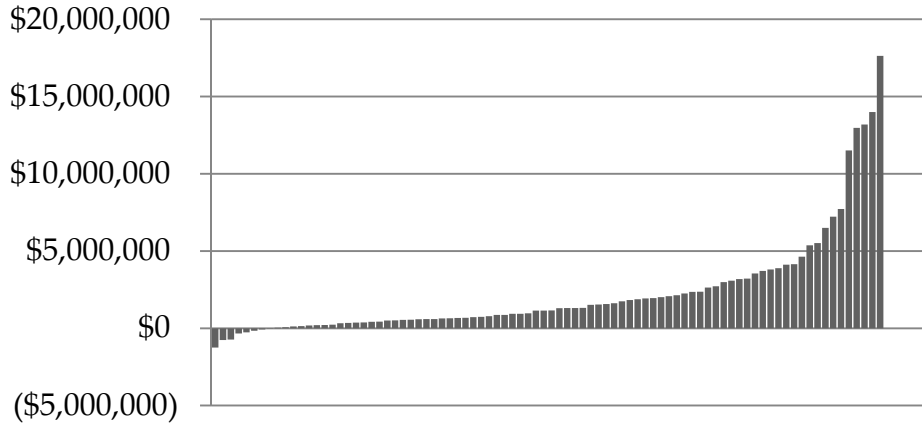
<sup>12</sup> *Virginia Acts of Assembly*, Chapter 874, Item 297.UU (2010).

<sup>13</sup> Analysis used VHI and DMAS 2008 data.

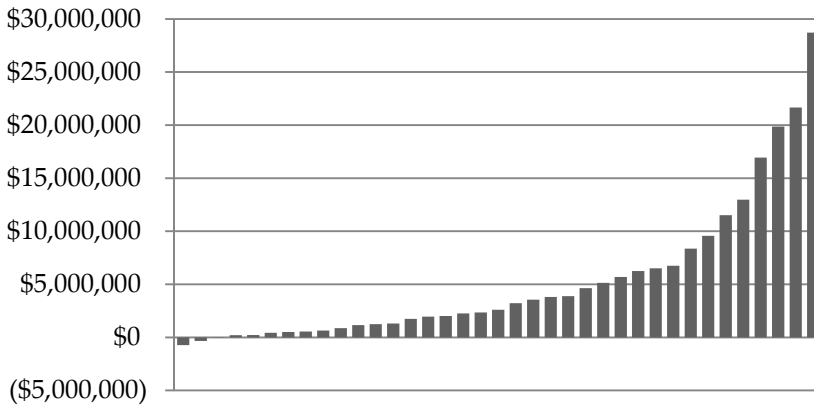
<sup>14</sup> Individual hospitals not owned by a hospital system in Virginia were counted as a hospital system for these analyses.

**Figure 4:**

Hospital Losses and Gains Based on Simulation of an Increase in Medicaid Inpatient Operating Rate Minus Assessment Fees Paid



Hospital System Losses and Gains Based on Simulation of an Increase in Medicaid Inpatient Operating Rate Minus Assessment Fees Paid



**Set Hospital Charity Care Standard.** Consideration could be given to ensuring that not-for-profit hospitals receiving a State tax-exemption deserve the favorable tax treatment. No bright-line federal standard exists for the amount of charity care that a hospital must provide in order to receive a federal tax exemption. Virginia follows federal treatment for hospital tax-exemption meaning that non-profit hospitals that receive a federal tax-exemption also receive a State tax-exemption. To encourage higher levels of charity care, Pennsylvania, Utah, and Texas have set specific charity care standards for hospitals to receive a state tax-exemption.



**Figure 5: Provider Assessment Impact on Hospitals and on Hospital Systems**

		Hospitals	Hospital Systems
Net Gains	Count	78	34
	Average Gain	\$2.6M	\$5.8M
	Range: High	\$17.6M	\$28.7M
	Range: Low	\$41K	\$206K
<hr/>			
Net Losses	Count	8	3
	Average Loss	-\$451K	-\$366K
	Range: High	-\$1.2M	-\$733K
	Range: Low	-\$29K	-\$28K

While the rationale for ensuring that not-for-profit hospitals provide an appropriate level of charity care, concerns were communicated that setting specific charity care standards might have unintended consequences, such as:

- Hospitals may forego offering preventive services which are not counted as charity care.
- Some hospitals may not be able to afford the required amount of charity care.
- The cost of offering charity care may outweigh the savings a hospital receives from its tax-exemption.

While setting specific charity care standards for not-for-profit hospitals may deserve review, recent and planned federal changes will affect charity care and the need for it. A reconsideration of hospital charity care may be called for in 2016. By 2016, an assessment of PPACA’s specific impacts on charity care could be gauged and multiple years of hospital charity care data from the revised IRS Form 990 will be available. This information would allow for a more data-driven assessment of hospital-offered charity care and the issue of State tax-exemptions for not-for-profit hospitals.

**Charity Care and Virginia’s Certificate of Public Need**

In completing this review, it was determined that charity care conditions included on Virginia’s Certificate of Public Need (COPN) certificates may be affected by provisions of PPACA. The COPN “program requires owners and sponsors of identified medical care facility projects to secure a certificate from the State Health Commissioner prior to initiating” most medical care construction and some medical equipment purchases.<sup>15</sup>

In 2010, 205 charity care conditions were included on approved COPN certificates. While there are no specific regulations defining how the charity care requirements should be determined, most conditions are based on a percentage of gross revenue and on regional charity care averages

<sup>15</sup> Virginia Department of Health website.

at the time the COPN certificate was approved.<sup>16</sup> If there is a decreasing need for charity care under PPACA, there may be justification for lowering Virginia's COPN charity care conditions after 2014. To determine more precisely the impact of federal health reform on COPN, the Virginia Department of Health (VDH) should review the issue and report to JCHC with recommendations for any needed program changes.

### **Policy Options and Public Comments**

Two policy options were presented for JCHC consideration in November 2010. A third option was added by the members of the Joint Commission and that option as well as Option 2 were approved.

**Option 1:** Take no action.

- Option 2:** By letter of the Chairman, request that the Virginia Department of Health report to JCHC by August 30, 2012 regarding the impact of federal health reform on existing COPN charity care conditions with recommendations to address any program, regulatory or statutory changes that may be needed.
- Option 3:** Include in the JCHC 2011 work plan, a staff review of ways to define hospital-offered charity care to include determining the availability of data to support any charity-care definitions being considered. The purpose of the review would be to further future State-level charity care discussions and analyses.

*No public comment was received regarding proposed policy options.*

### **JCHC Staff for this Report**

Stephen W. Bowman  
Senior Staff Attorney/Methodologist

---

<sup>16</sup> Virginia Department of Health, *Annual Report on the Status on the Virginia's Medical Care Facilities Certificate of Public Need Program*, 2009.



# INDIGENT AND CHARITY CARE PROVIDED BY HOSPITALS

Joint Commission on Health Care

November 3, 2010

Presenter: Stephen W. Bowman

Revised 11/17/10

## **HJR 27 – INDIGENT HEALTH CARE PROVIDED BY HOSPITALS (PURKEY - 2010)**

- Determine the volume of indigent health care provided by hospitals in the Commonwealth;
- Determine the financial cost of indigent health care to hospitals in the Commonwealth; and
- Identify and analyze incentives that may be offered to hospitals and other health care providers to encourage the provision of health care to indigent individuals.

2

## STUDY SUMMARY

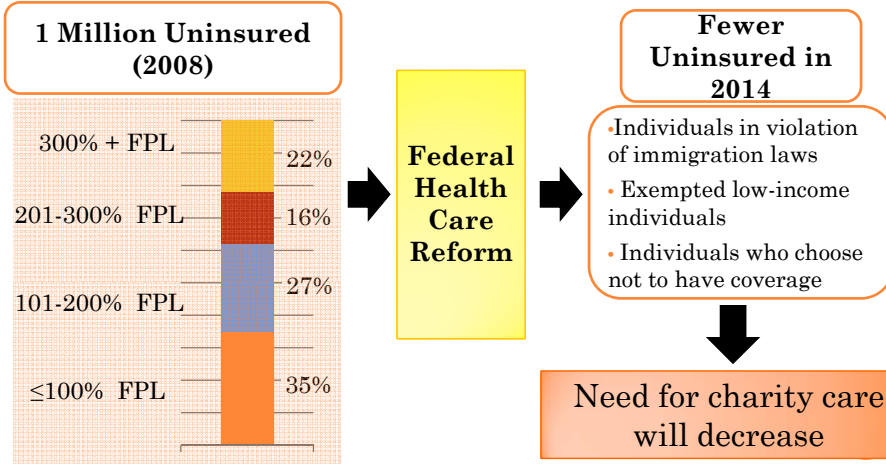
- In 2008, Virginia hospitals provided \$400 million in charity care
- Non-profit hospitals provide more charity care than for-profit hospitals as a percentage of revenues
- Federal health care reform is expected to decrease the need for charity care in 2014
- It is too soon to determine how federal changes will impact hospital charity care offerings
- VDH may need to reevaluate previously approved COPN charity care conditions, as less charity care will be needed in 2014

3

## FEDERAL HEALTH CARE REFORM IMPACT : LOWER-INCOME INDIVIDUALS AND UNINSURED

## Impact of Federal Health Care Reform

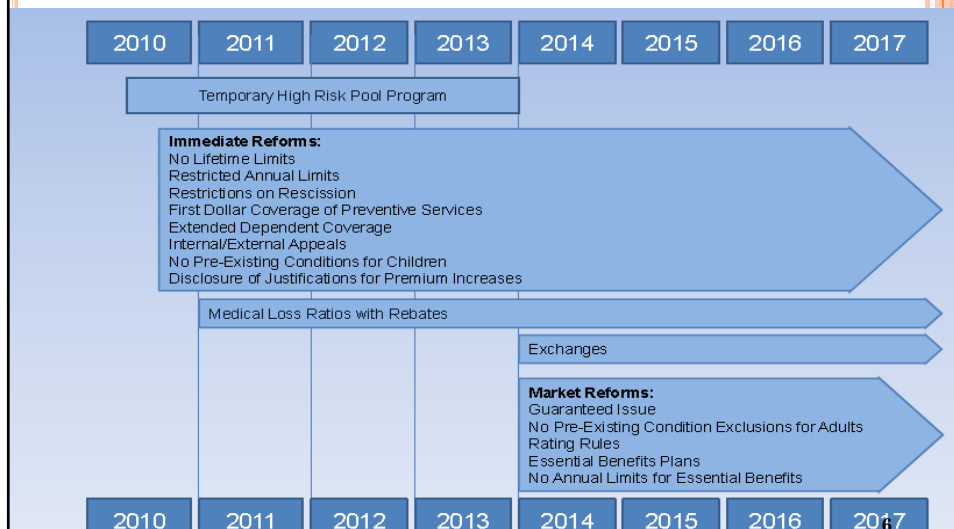
### NUMBER OF UNINSURED AND CHARITY CARE NEEDED WILL DECREASE



5

## Impact of Federal Health Care Reform

### HEALTH INSURANCE REFORM IMPLEMENTATION TIMELINE



## Impact of Federal Health Care Reform

### TEMPORARY HIGH-RISK POOLS

Begins in 2010

(AKA: PRE-EXISTING CONDITION INSURANCE PLANS)

- Eligibility Requirements:
  - Uninsured for six months
  - Pre-existing condition
  - U.S. citizen or legal immigrant
  - State resident
- Bans:
  - Pre-existing condition exclusions
  - Coverage waiting periods after enrollment
- Size of enrollment pool may be managed
- No premium assistance

Individuals are enrolled in VA's High-Risk Pool administered by HHS (\$113 million federal fund allocated for VA)

**Virginia Monthly Premiums**

Age	0-34	35-44	45-54	55+
	\$289	\$347	\$443	\$616

Source: Coverage of Uninsurable Pre-existing Conditions: State and Federal High-Risk Pools, NCSL website, [http://www.ncsl.org/?tabid=14329#2010\\_Pools](http://www.ncsl.org/?tabid=14329#2010_Pools) and PCIP website <https://www.pcip.gov/StatePlans.html>.

7

## Impact of Federal Health Care Reform

### OTHER AVENUES LEADING TO GREATER INSURANCE COVERAGE

- Provide small employers with tax credits to purchase health insurance Begins in 2010
  - No more than 25 employees
  - Average annual wages of less than \$50,000
- For individual and group policies Begins in 2010
  - Dependant coverage for children under age 26
  - Prohibit pre-existing condition exclusions for children
- Insurance coverage mandate Begins in 2014

8

Source: Summary of Health Reform Law, Kaiser Family Foundation website [www.kff.org/healthreform/upload/8061.pdf](http://www.kff.org/healthreform/upload/8061.pdf).

## Impact of Federal Health Care Reform

### EXCHANGES OFFER LOWER-INCOME INDIVIDUALS ASSISTANCE TO MAKE INSURANCE AFFORDABLE

#### Avenues Making Insurance More Affordable

- Premiums
  - Set premiums from 2 - 9.5% of income for those under 400% FPL through subsidies
- Medical Expenses
  - Limit out of pocket expenses to 1/3 - 2/3 of HSA limit for those up to 400% FPL
- Cost-sharing
  - Increase policy's value by setting policies' actuarial value from 70% to 94% for under 400% FPL through subsidies

See Appendix A (Slides 39) for details

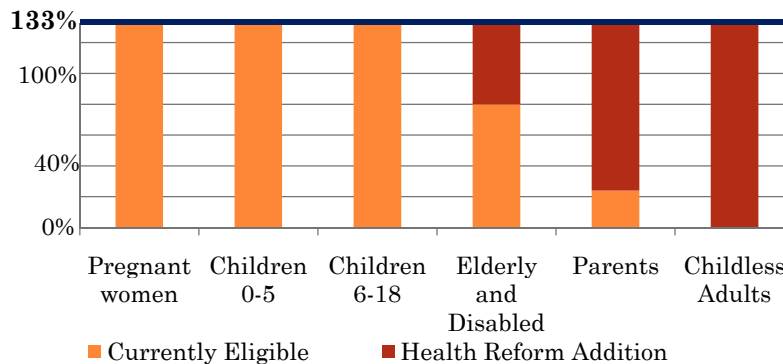
9

Source: Summary of Health Reform Law, Kaiser Family Foundation website [www.kff.org/healthreform/upload/8061.pdf](http://www.kff.org/healthreform/upload/8061.pdf).

Begins in 2014

## Impact of Federal Health Care Reform

### 270,000 – 425,000 NEW MEDICAID ENROLLEES WHEN ELIGIBILITY RAISED TO 133% FPL



Medicaid averages 863,672 monthly enrollees (2010)

10

Note: Virginia currently provides coverage up to 200% FPL for pregnant women and children  
 Source: DMAS presentation to Senate Finance Committee June 21, 2010

Begins in 2014



## INDIGENT AND CHARITY CARE PROVIDED BY HOSPITALS

### HOSPITALS' INDIGENT AND CHARITY CARE

Indigent Care - care for  
which no payment is  
received for individuals at  
100% FPL or lower

Charity Care - free or discounted  
care for individuals meeting a  
hospital's charity care income  
qualification

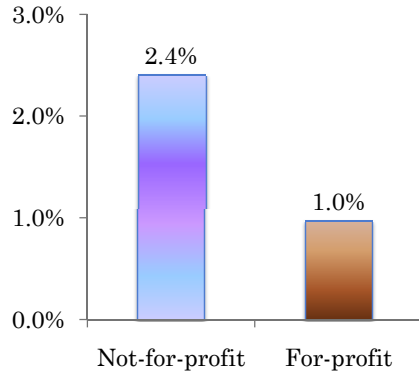
*(includes indigent care and can include care  
provided to underinsured )*

- Charity care policies are set by each hospital
- Policies posted in hospital's public areas and website (HB 2458 – 2009)

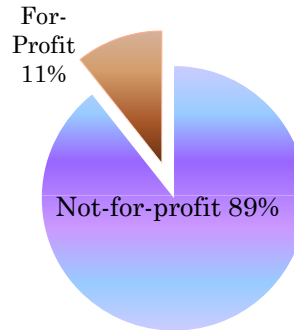


## VIRGINIA'S HOSPITALS PROVIDED \$856M IN CHARGES TOWARD INDIGENT CARE (2008)

**Indigent Care as % of Total Gross Patient Revenue**  
(2.0% for hospitals as a group)



**% of Total Indigent Care Provided by Hospital Type (Charges)**

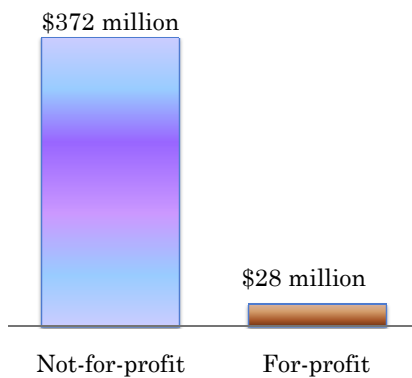


13

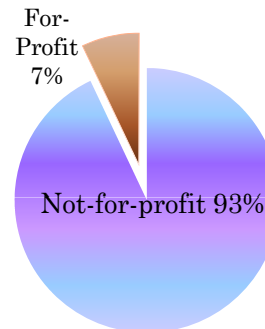
\* Source: JCHC staff analysis of VHI data collected from hospitals. Excludes Pioneer Community Hospital of Patrick County information and includes reimbursements from the Indigent Care Trust Fund.

## VIRGINIA'S HOSPITALS PROVIDED \$400M IN COSTS TOWARD CHARITY CARE (2008)

**Charity Care Provided by Hospital Type (Actual Costs)**



**% of Total Charity Care Costs by Hospital Type**

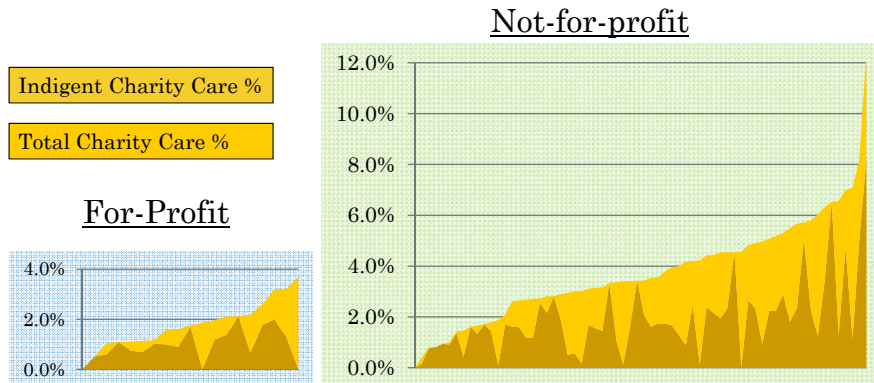


14

\* Source: Cornerstones of Their Communities: The Impact of Virginia Hospitals, VHHA, December 2009.

## CHARITY CARE VARIES BY HOSPITAL FROM 0% - 12.5% OF GROSS PATIENT REVENUES

### Charity Care Charges as a percentage of Gross Patient Revenues by Hospital (2008)



Note: There is no set amount of charity or indigent care that not-for-profit or for-profit hospitals are required to provide

15

Source: JCHC staff analysis of 2008 VHI data submitted by hospitals

## VIRGINIA HOSPITALS PROVIDE SEVERAL TYPES OF BENEFITS TO COMMUNITIES

### IRS-Defined Community Benefit (2008)

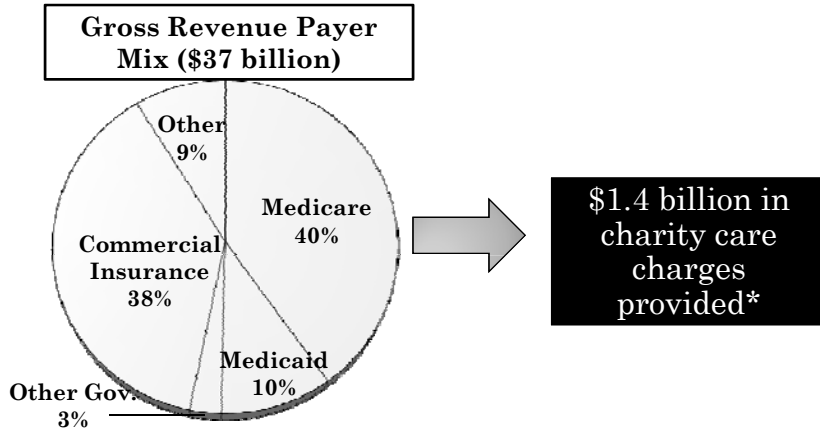
<b>Charity Care</b>	<b>\$400 million</b>
<b>Medicaid Shortfall</b>	<b>\$188 million</b>
<b>Other Means-Tested Government Programs</b> <i>(e.g. unreimbursed cost associated with the State Children's Health Insurance Program)</i>	<b>\$ 26 million</b>
<b>Subsidized Health Services</b> <i>(billed clinical services provided at a loss such as some trauma centers, neonatal units, behavioral health services, obstetrics services and burn centers)</i>	<b>\$ 42 million</b>
<b>Community Programs and Services</b> <i>(e.g. community health improvement services, health professions education, and research)</i>	<b>\$246 million</b>
<b>Total</b>	<b>\$902 million</b>

\* Source: Cornerstones of Their Communities: The Impact of Virginia Hospitals, VHHA, December 2009.

16

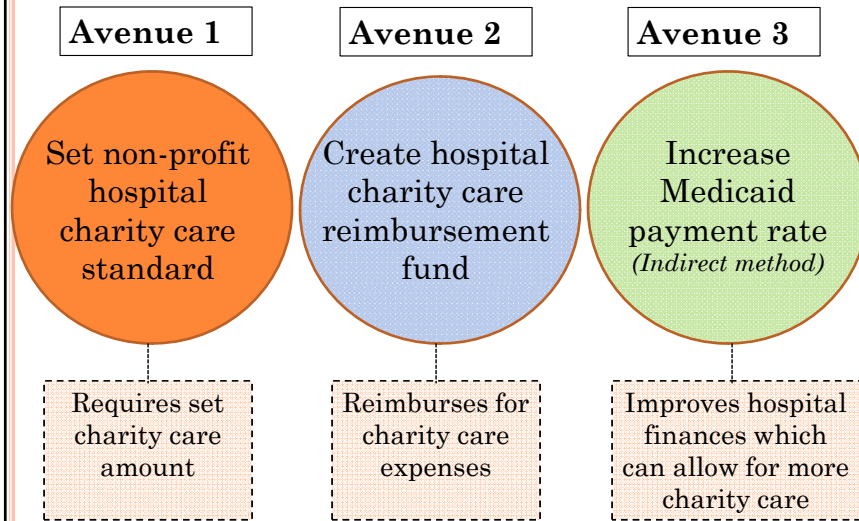
HOSPITALS CHOOSE HOW MUCH CHARITY CARE TO OFFER AND GOOD PAYER MIXES ALLOW HOSPITALS TO SUBSIDIZE CHARITY CARE

**Virginia Hospitals 2008**



Source: JCHC staff analysis with 2008 VHI data submitted by hospitals  
 \* Excludes any COPN conditioned charity care requirements

STATE AVENUES TO ENCOURAGE HOSPITAL CHARITY CARE



## Avenue 1: Set Hospital Charity Care Standard

### FEW STATES HAVE SET SPECIFIC CHARITY CARE STANDARDS FOR HOSPITALS TO RECEIVE TAX-EXEMPT STATUS

- Virginia follows federal tax treatment for not-for-profit hospitals
- Some states set specific charity care and community benefit standards for non-profit hospitals to receive tax-exemption
  - Pennsylvania, Utah and Texas
- Concerns regarding specific charity care standards
  - Does not incorporate hospitals' benefits to community
  - Hospitals may forego offering preventive services that are not counted as charity care
  - Some hospitals may not be able to afford the required amount of charity care
  - Value of charity care offering may outweigh tax-exemption

19

Sources: *Putting the Community Back in Community Benefit: Proposed State Tax Exemption Standards for Nonprofit Hospitals*, Michele Goodman, Indiana Law Journal Volume 84, 713 and Health Law Symposium: Federal and State Tax Exemption Policy, Medical Debt, and Healthcare for the Poor, John D. Columbo, 51 St. Louis L.J. 433.

## Avenue 1: Set Hospital Charity Care Standard

### NEW FEDERAL REQUIREMENTS TARGET NOT-FOR-PROFIT HOSPITALS FULFILLING THEIR CHARITABLE MISSIONS

- Revised IRS Form 990 standardizes how hospitals report charity care which have taken effect for tax year 2009
- U. S. Treasury Department reviews hospitals' tax-exempt status every three years
- Examples of new not-for-profit hospital requirements:
  - Establish a written financial assistance policy, including criteria for eligibility for financial assistance and basis for calculating amounts charged to patients
  - Limit the amounts charged to patients eligible for financial assistance similar to lowest amounts charged to insured patients
  - Refrain from engaging in extraordinary billing and collection actions until reasonable efforts have been made to determine whether a patient is eligible for financial assistance

20

Source: Patient Protection and Affordable Care Act, Section 9007 and Simpson, Thatcher and Bartlett LLP: Changes to 2008 IRS Form 990 and Instructions .

## Avenue 1: Set Hospital Charity Care Standard

### IMPACT OF FEDERAL CHANGES SHOULD BE UNDERSTOOD BEFORE MAKING CHANGES IN REGULATING HOSPITAL CHARITY CARE REQUIREMENTS

- Federal Impacts on Charity Care
  - Decrease in uninsured through health care reform
  - Standardizing non-profits hospitals charity care reporting
  - Review non-profit hospital status every three years

**Premature topic review:** Many federal level changes will impact the need for and the provision of charity care. It would be premature to establish new charity care policies before 2016.

21

## Avenue 2: Reimburse for Charity Care Expenses

### STATE PROGRAMS TO REIMBURSE CHARITY CARE HAVE BEEN SUSPENDED OR REPEALED

- State and Local Hospitalization Program
  - A venture between State and local governments to provide reimbursement for care provided by hospitals to indigent patients who are not eligible for Medicaid.
  - FY09 funding \$12.9 million.
    - Funds were capped and hospitals were not reimbursed for all eligible claims
  - Suspended in 2010
- Indigent Health Care Trust Fund (IHCTF)
  - Hospitals providing a certain amount of charity care received a payment to partially cover the cost of care.
  - Hospitals below charity care median contributed to the fund
  - FY09 funding \$7.5M (*state and hospital contribution*)
    - Funds capped and typically fell short of fully funding the amount of indigent care provided
  - Repealed in 2009

22

## Avenue 2: Reimburse for Charity Care Expenses

### VIRGINIA LAW PREVENTS AN UNINSURANCE FEE

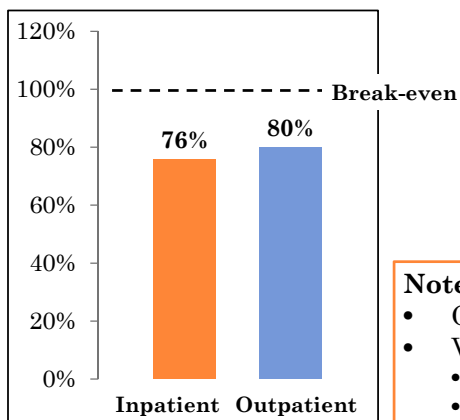
- Delegate Purkey (patron) discussed creating a charity care fund to reimburse hospitals for costs incurred during the Senate Rules Committee hearing for HJR 27
  - Uninsured individuals would be required to pay uninsured fee
- In 2014, Patient Protection and Affordable Care Act imposes mandate that most individuals be insured
  - If an required individual is not insured then a fee is assessed
- HB 10 (2010) states that no Virginia resident is liable for any fee for not obtaining health insurance coverage

23

## Avenue 3: Increase Medicaid Payment Rate

### VIRGINIA HOSPITALS HAD \$188 MILLION MEDICAID SHORTFALL IN 2008

**Medicaid Reimbursement Rates (2008)**



Increasing Medicaid reimbursement rate could provide hospitals increased finances to provide additional charity care

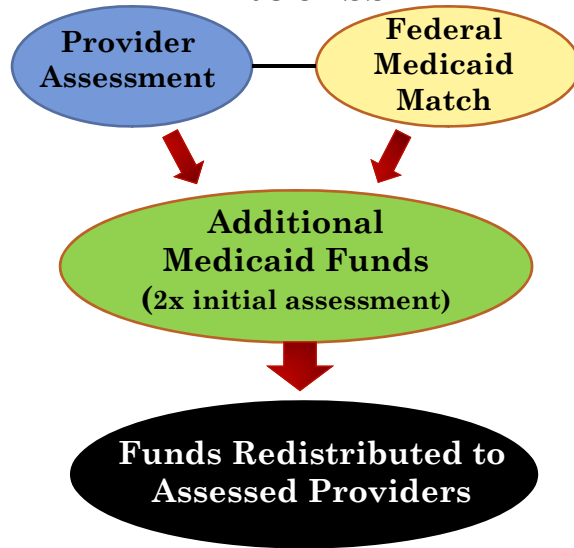
- Note:** State Medicaid funding (FY10)
- General Funds – \$2.7 billion
  - VA Health Care Fund – \$300 million
    - Tobacco taxes
    - Master Settlement Agreement

\* Sources: Cornerstones of Their Communities: The Impact of Virginia Hospitals, VHHA, December 2009 and 2010 Virginia Acts of Assembly: Chapter 874.

24

### Avenue 3: Increase Medicaid Payment Rate

#### PROVIDER ASSESSMENT PROCESS



**Provider group can receive funding significantly higher than assessment**

25

### Avenue 3: Increase Medicaid Payment Rate

#### PROVIDER ASSESSMENTS CAN BE USED TO INCREASE MEDICAID RATES

- Provider assessment fees can be used to drawdown additional Medicaid funds
  - Provider fee assessed can be doubled through Virginia's federal 50/50 Medicaid match
- Overall funding to the provider group can be increased in excess of the assessment
  - Provider group reimbursed through increased Medicaid rates
- Increasing Medicaid reimbursement rates promotes:
  - Better payer mix to subsidize additional charity care
  - Reductions in cost-shifting to private payers

26

See Appendix B1 (Slides 40-41) for Additional Provider Assessment Rules

## Avenue 3: Increase Medicaid Payment Rate

### 29 STATES HAVE HOSPITAL PROVIDER ASSESSMENTS

- 15 states created or increased hospital provider assessments in 2009 and 2010
  - Estimates from new state hospital assessments range \$11 million – \$352 million per year
- Examples of hospital assessments
  - 1.5% of annual net revenues (FL)
  - 1.83% of net patient operating revenue (KS)
  - 2.5% of inpatient and outpatient services (WV)
  - 2.5% of gross revenue (KY)
  - 3.14% licensing fee (RI)
  - \$238 per occupied bed (IL)

27

Source: Health Care Provider and Industry Taxes and Fees, NCSL, <http://www.ncsl.org/default.aspx?tabid=14359>

## Avenue 3: Increase Medicaid Payment Rate

### EXAMPLE: COLORADO PASSED A SIGNIFICANT HEALTH REFORM THAT INCLUDED A PROVIDER ASSESSMENT (2009)

#### Colorado Health Care Affordability Act

- Sustainable source of funding for hospital care for Medicaid and uninsured
- Secure new source of funding for health care reforms
- Improve the quality of health care services
- Reduce cost-shifting to private payers

Supported by Colorado Hospital Association

28

See Appendix B2 (Slides 42-44) for Colorado Provider Assessment detail

Source: Colorado Provider Fee Oversight and Advisory Board, *Colorado Health Care Affordability Act* presentation, June 23, 2009.



### Avenue 3: Increase Medicaid Payment Rate

#### HISTORY OF PROVIDER ASSESSMENTS IN VIRGINIA

- In 1992, Governor Wilder introduced provider assessment for non-profit hospitals
  - Did not leave committee
- ICF/MR Provider Assessment Passed in 2010
  - Not implemented as Affordable Care Act forbids increasing local government contribution for Medicaid
- Provider concerns
  - Philosophical – Medicaid should be approached as core service and funded with state general fund dollars
  - Short term financial – State might use provider assessment to supplant state Medicaid funding
  - Long-term
    - Political – Any promises for fund uses might not be kept by another administration
    - Financial - Will hospitals be better off in the long-term?

29

### Avenue 3: Virginia Simulation (2008 data)

**Assessment:** 2.5% of Hospital Net Inpatient Revenues  
**Reimbursement:** Medicaid Inpatient Operating Rate

	% of New Funds to Hospitals		
	100%	89%	75%
<b>Hospital Assessment</b>	<b>\$198M</b>	<b>\$198M</b>	<b>\$198M</b>
<b>Federal Match</b>	<b>\$198M</b>	<b>\$178M</b>	<b>\$158M</b>
<b>New Medicaid Funding</b>	<b>\$396M</b>	<b>\$356M</b>	<b>\$317M</b>
<b>Additional Hospital Revenue in Excess of Assessment</b>	<b>\$198M</b>	<b>\$158M</b>	<b>\$119M</b>
<b>Additional State Funds</b>	<b>\$0</b>	<b>\$20M*</b>	<b>\$40M*</b>
<b>% Medicaid pays of Inpatient Operating Expenses</b>	<b>99%</b>	<b>95%</b>	<b>91%</b>

\* The 89% and 75% simulations of new funds to hospitals assume that the additional State funding is not used towards the Medicaid program and thus does not receive the federal Medicaid 50/50 match.

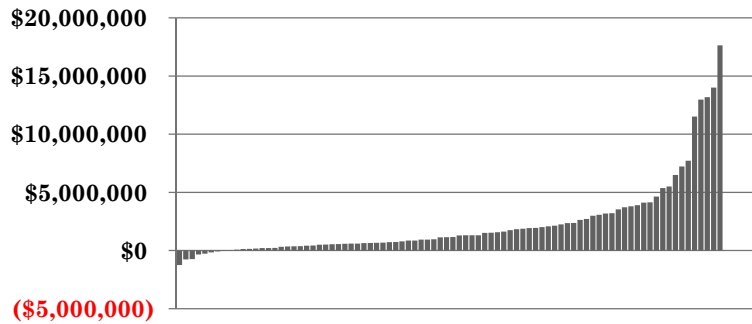
30

Individual hospital results for these three simulations are available behind this presentation

Avenue 3: Virginia Simulation (2008 data)

91% (78 OF 86) OF HOSPITALS WOULD BE FINANCIALLY BETTER OFF WHEN 100% OF NEW FUNDS ARE USED TO REIMBURSE HOSPITALS

Net of Assessment and Increased Medicaid Payments by Hospital



See Appendix B3 (Slides 45-46) for additional Virginia Hospital Simulation detail

Source: JCHC staff analysis with VHI and DMAS data.

31

Avenue 3: Virginia Simulation (2008 data)

PROVIDER ASSESSMENT IMPACT ON INDIVIDUAL HOSPITALS

		% of New Funds to Hospitals		
		100%	89%	75%
Hospitals with Net Gains	Count	78	75	68
	Average Gain	\$2.6M	\$2.2M	\$1.9M
	Range: High	\$17.6M	\$15.0M	\$12.3M
	Range: Low	\$41K	\$14K	\$50K
Hospitals with Net Losses	Count	8	11	18
	Average Loss	\$451K	\$411K	\$429K
	Range: High	\$1.2M	\$1.4M	\$1.6M
	Range: Low	\$29K	\$17K	\$4K

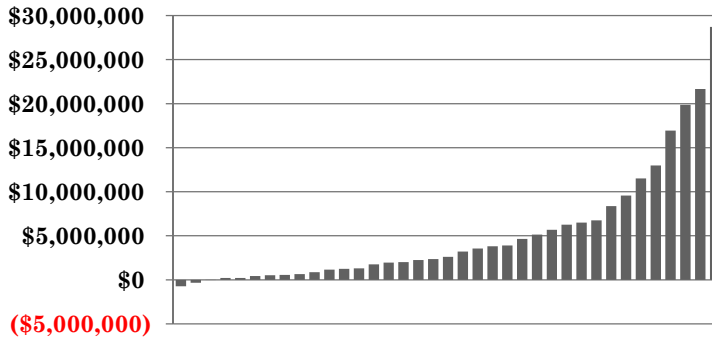
Source: JCHC staff analysis with VHI and DMAS data.

32

Avenue 3: Virginia Simulation (2008 data)

92% (34 OF 37) OF HOSPITAL SYSTEMS WOULD BE FINANCIALLY BETTER OFF WHEN 100% OF NEW FUNDS ARE USED TO REIMBURSE HOSPITALS

Net of Assessment and Increased Medicaid Payments by Hospital System



See Appendix B3 (Slides 47-48) for Virginia Hospital System Simulation detail

Source: JCHC staff analysis with VHI and DMAS data.

33

Avenue 3: Virginia Simulation (2008 data)

PROVIDER ASSESSMENT IMPACT ON 37 INDIVIDUAL HOSPITALS AND HOSPITAL SYSTEMS

		% of New Funds to Hospitals		
		100%	89%	75%
Hospitals and Systems with Net Gains	Count	34	33	32
	Average Gain	\$5.8M	\$4.8M	\$3.8M
	Range: High	\$28.7M	\$23.3M	\$18M
	Range: Low	\$206K	\$181K	\$68K
Hospitals and Systems with Net Losses	Count	3	4	5
	Average Loss	\$366K	\$355K	\$517K
	Range: High	\$733K	1.0M	\$1.3M
	Range: Low	\$28K	\$17K	\$42K

Source: JCHC staff analysis with VHI and DMAS data.

34

## Secondary Federal Reform Impact: Virginia COPN Program

### FEDERAL HEALTH REFORM MAY IMPACT VIRGINIA'S CERTIFICATE OF PUBLIC NEED PROGRAM

- In 2010, 205 charity care conditions were included on approved COPN certificates
  - Most conditions were based on a % of gross revenue
  - Based on regional averages at the time of COPN approval
  - No regulations define how the charity care requirements should be determined
- With a decreasing need for charity care, there may be a justification for lowering existing COPN charity care conditions

In 2012, VDH could report to JCHC regarding the impact of federal health reform on existing COPN charity care conditions and recommendations to address any program, regulatory or statutory changes that may be needed.

Source: Annual Report on the Status on the Virginia's Medical Care Facilities Certificate of Public Need Program, 2009 and discussion with VDH COPN staff.

35

### OPTIONS

- **Option 1:** Take no action
- **Option 2:** By letter of the Chairman, request that the Virginia Department of Health report to JCHC by August 30, 2012 regarding the impact of federal health reform on existing COPN charity care conditions and recommendations to address any program, regulatory or statutory changes that may be needed.

36

## PUBLIC COMMENTS

- Written public comments may be submitted to JCHC by close of business on November 22, 2010. Comments may be submitted via:
  - E-mail: [sreid@jchc.virginia.gov](mailto:sreid@jchc.virginia.gov)
  - Facsimile: 804-786-5538
  - Mail to: Joint Commission on Health Care  
P.O. Box 1322  
Richmond, Virginia 23218
- Comments will be summarized and reported at the next JCHC meeting.

37

## Appendices

### INSURANCE EXCHANGES

A: FINANCIAL ASSISTANCE

### PROVIDER ASSESSMENT

B1: RULES

B2: COLORADO EXAMPLE

B3: VIRGINIA SIMULATION

## Appendix A: Affordable Insurance Through Exchanges

### EXCHANGES OFFER LOWER-INCOME INDIVIDUALS ASSISTANCE TO MAKE INSURANCE AFFORDABLE\*

Premiums	Out of Pocket	Cost Sharing																																
<p>Credits making insurance more affordable: **</p> <table border="1"> <thead> <tr> <th>Income</th> <th>Credit</th> </tr> </thead> <tbody> <tr> <td>0 -133%</td> <td>2%</td> </tr> <tr> <td>133-150%</td> <td>3 - 4%</td> </tr> <tr> <td>150-200%</td> <td>4 - 6%</td> </tr> <tr> <td>200-250%</td> <td>6 - 8%</td> </tr> <tr> <td>250-300%</td> <td>8 - 9.5%</td> </tr> <tr> <td>300-400%</td> <td>9.5%</td> </tr> </tbody> </table>	Income	Credit	0 -133%	2%	133-150%	3 - 4%	150-200%	4 - 6%	200-250%	6 - 8%	250-300%	8 - 9.5%	300-400%	9.5%	<p>Limits out of pocket expenses:</p> <table border="1"> <thead> <tr> <th>Income</th> <th>% of HSA Limit</th> </tr> </thead> <tbody> <tr> <td>100-200%</td> <td>1/3</td> </tr> <tr> <td>200-300%</td> <td>1/2</td> </tr> <tr> <td>300-400%</td> <td>2/3</td> </tr> </tbody> </table>	Income	% of HSA Limit	100-200%	1/3	200-300%	1/2	300-400%	2/3	<p>Subsidies increasing policy actuarial value:</p> <table border="1"> <thead> <tr> <th>Income</th> <th>Value</th> </tr> </thead> <tbody> <tr> <td>100-150%</td> <td>94%</td> </tr> <tr> <td>150-200%</td> <td>87%</td> </tr> <tr> <td>200-250%</td> <td>73%</td> </tr> <tr> <td>250-400%</td> <td>70%</td> </tr> </tbody> </table>	Income	Value	100-150%	94%	150-200%	87%	200-250%	73%	250-400%	70%
Income	Credit																																	
0 -133%	2%																																	
133-150%	3 - 4%																																	
150-200%	4 - 6%																																	
200-250%	6 - 8%																																	
250-300%	8 - 9.5%																																	
300-400%	9.5%																																	
Income	% of HSA Limit																																	
100-200%	1/3																																	
200-300%	1/2																																	
300-400%	2/3																																	
Income	Value																																	
100-150%	94%																																	
150-200%	87%																																	
200-250%	73%																																	
250-400%	70%																																	

\*All income % reference Federal Poverty Level (FPL)

\*\* Percentages are rounded

Source: Summary of Health Reform Law, Kaiser Family Foundation website [www.kff.org/healthreform/upload/8061.pdf](http://www.kff.org/healthreform/upload/8061.pdf)

39

## Appendix B1: Provider Assessment Rules

### ASSESSMENTS TO DRAWDOWN MEDICAID FUNDS MUST MEET CERTAIN STANDARDS

- Provider assessment requirements
  - 1) Imposed on a permissible class of health care services
    - Such as inpatient or outpatient hospital services
  - 2) Broad-based fee imposed on all providers within a class
  - 3) Imposed uniformly in a jurisdiction such that all providers within a class are assessed at the same rate.
  - 4) Avoid hold harmless arrangements where amount reimbursed is correlated to assessment amount
- Centers for Medicare and Medicaid Services (CMS) may grant waiver of broad-based and uniform requirements
- Assessments may not exceed 5.5% of net-patient revenue for service class

Source: 2009 Annual Report, Colorado Hospital Provider Fee Oversight and Advisory Board.

40

## Appendix B1: Provider Assessment Rules

### ASSESSMENT PROCESS CAN BE STRUCTURED IN MANY WAYS

- Increased Medicaid reimbursements may be made through:
  - Supplemental DSH payments
  - Supplemental Medicaid payments
  - Medicaid rates
  - Combinations of the above methods
  - Other methodologies approved by CMS
  
- Some providers will be reimbursed more than assessed and some will be reimbursed less
  
- Provider assessment method and Medicaid reimbursements can be designed to support a range of policy goals

41

Source: 2009 Annual Report, Colorado Hospital Provider Fee Oversight and Advisory Board.

## Appendix B2: Colorado Provider Assessment

### COLORADO HEALTH CARE AFFORDABILITY ACT

- Imposes hospital provider assessment that generates additional federal Medicaid matching funds
  
- Provides selection criteria regarding exemption or reduction in provider assessment
  
- Improves Medicaid hospital reimbursement rates
  - Reimbursed 100% of costs
  
- Additional reforms financed by assessment:
  - Expand Medicaid coverage for children and adults without dependent children
  - Continuous eligibility for children
  - Buy-in program for disabled adults and children
  - Implement performance based incentive payments

42

Source: House Bill 09-1293 The Colorado Healthcare Affordability Act (2009).

## KEY ACT PROVISIONS FOR COLORADO HOSPITALS

- Provider Fee Oversight and Advisory Board
  - 13 members (6 hospital member-designated positions)
- Protect integrity of current hospital Medicaid payments
  - “Provider fee is to supplement, not supplant, General Fund appropriations to support hospital reimbursements” unless other Medicaid provider payments are reduced
- Cease collection of assessment if federal government no longer provides matching funds
- Short time between assessment to reimbursement
  - Mandated within 2 business days and often instantaneous

43

Source: House Bill 09-1293 The Colorado Healthcare Affordability Act (2009).

## KEY ASSUMPTIONS FOR COLORADO PROVIDER ASSESSMENT AND REDISTRIBUTION

- Exclude long-term care facilities, rehabilitation and free-standing psychiatric hospitals
- Design assessment and how funds are redistributed so that:
  - Rural hospitals net gains as possible
  - High-volume Medicaid providers will net gains
  - Low-volume Medicaid providers will net losses
  - Minimize the number of losing hospitals and size of losses

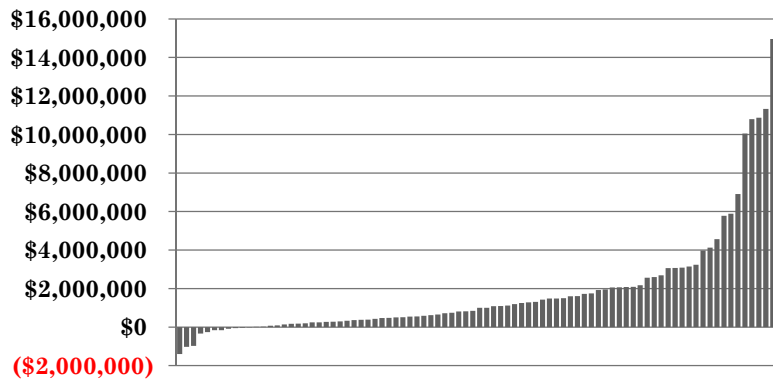
44



## Appendix B3 : Virginia Simulation (2008 data)

87% (75 OF 86) OF HOSPITALS WOULD BE FINANCIALLY BETTER OFF WHEN 89% OF NEW FUNDS ARE USED TO REIMBURSE HOSPITALS

### Net of Assessment and Increased Medicaid Payments by Hospital

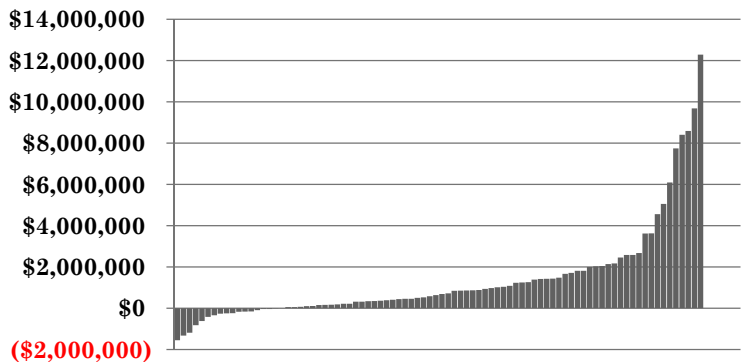


Source: JCHC staff analysis with VHI and DMAS data.

## Appendix B3 : Virginia Simulation (2008 data)

79% (68 OF 86) OF HOSPITALS WOULD BE FINANCIALLY BETTER OFF WHEN 75% OF NEW FUNDS ARE USED TO REIMBURSE HOSPITALS

### Net of Assessment and Increased Medicaid Payments by Hospital

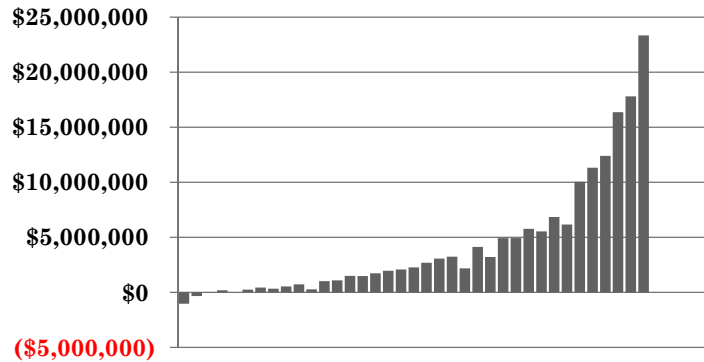


Source: JCHC staff analysis with VHI and DMAS data.

### Appendix B3: Virginia Simulation (2008 data)

89% (33 OF 37) OF HOSPITAL SYSTEMS WOULD BE FINANCIALLY BETTER OFF WHEN 89% OF NEW FUNDS ARE USED TO REIMBURSE HOSPITALS

#### Net of Assessment and Increased Medicaid Payments by Hospital System



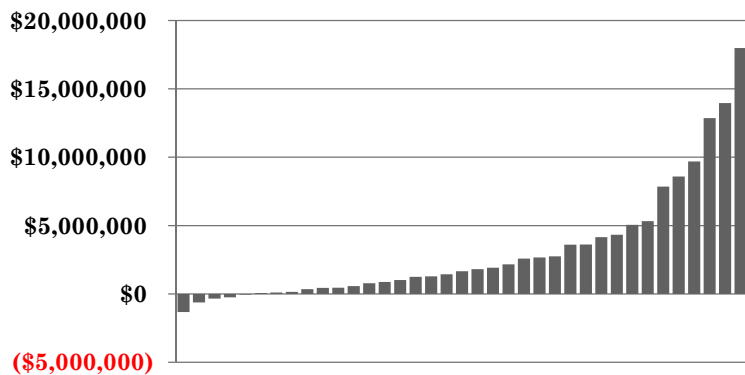
47

Source: JCHC staff analysis with VHI and DMAS data.

### Appendix B3 : Virginia Simulation (2008 data)

86% (32 OF 37) OF HOSPITAL SYSTEMS WOULD BE FINANCIALLY BETTER OFF WHEN 75% OF NEW FUNDS ARE USED TO REIMBURSE HOSPITALS

#### Net of Assessment and Increased Medicaid Payments by Hospital System



48

Source: JCHC staff analysis with VHI and DMAS data.

# 2010 SESSION

ENROLLED

## HOUSE JOINT RESOLUTION NO. 27

*Directing the Joint Commission on Health Care to study indigent health care in the Commonwealth. Report.*

Agreed to by the House of Delegates, February 15, 2010

Agreed to by the Senate, March 9, 2010

WHEREAS, indigent Virginians are among the most vulnerable populations in terms of access to affordable quality health care services; and

WHEREAS, research has shown that persons without access to affordable, quality health care services are less likely to receive medical services such as immunizations and routine check-ups, and, as a result, are more likely to develop conditions that could be prevented or more successfully treated with early intervention and primary care; and

WHEREAS, failure to prevent diseases and disorders, and to treat diseases and disorders in their early states, leads to increased cost of treatment; and

WHEREAS, research indicates that indigent persons without access to affordable health care are more likely to rely on the Commonwealth's hospitals and emergency rooms for basic health care services and medical treatment; and

WHEREAS, the provision and financing of health care services for the indigent pose important and complex issues for businesses, health care service providers, and the Commonwealth's academic health centers as well as for the state and local governments; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Commission on Health Care be directed to study indigent health care in the Commonwealth.

In conducting its study, the Joint Commission on Health Care shall (i) determine the volume of indigent health care provided by private, specialty and not-for-profit hospitals in the Commonwealth; (ii) determine the financial cost of indigent health care to private, specialty, and not-for-profit hospitals in the Commonwealth; and (iii) identify and analyze potential tax and other incentives that may be offered to private and specialty hospitals and other health care providers to encourage the provision of health care to indigent individuals.

Technical assistance shall be provided to the Joint Commission on Health Care by the Virginia Department of Health. All agencies of the Commonwealth shall provide assistance to the Joint Commission on Health Care for this study, upon request.

The Joint Commission on Health Care shall complete its meetings for the first year by November 30, 2010, and for the second year by November 30, 2011, and the chairman shall submit to the Division of Legislative Automated Systems an executive summary of its findings and recommendations no later than the first day of the next Regular Session of the General Assembly for each year. Each executive summary shall state whether the Joint Commission on Health Care intends to submit to the General Assembly and the Governor a report of its findings and recommendations for publication as a House or Senate document. The executive summaries and reports shall be submitted as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports and shall be posted on the General Assembly's website.

ENROLLED

HJ27ER

Joint Commission on Health Care  
900 East Main Street, 1st Floor West  
P. O. Box 1322  
Richmond, VA 23218  
804.786.5445  
804.786.5538 (fax)

Website: <http://jchc.virginia.gov>