

Chapter 7: State Funding for New Jersey Hospitals

Key Points

- **Medicaid and Disproportionate Share Payments (DSH) will combine to provide hospitals with nearly \$3 billion in annual payments in State fiscal year 2008 (62% Medicaid service payments, 38% additional subsidies).**
- **New Jersey's ability to tap additional federal funding is limited. The State can only do so by committing additional State funds. Complex federal regulations limit the flexibility of states to consolidate funding streams.**
- **Certain subsidy funds (Hospital Relief Subsidy Fund and Graduate Medical Education fund) should be consolidated into the Medicaid payment rates to ensure optimal distribution and to facilitate appropriate annual increases in funding levels.**
- **A small portion of current subsidies from the Hospital Relief Subsidy Fund should be shifted to the Hospital Relief Subsidy Fund for Mental Health to address shortages of acute and intermediate care mental health beds for community-dwelling individuals.**
- **An ongoing study of the efficiency of all New Jersey hospitals should be commissioned to guide the development of Charity Care and Medicaid payment reforms that would reward efficiency. In addition, the State should move toward a Charity Care payment methodology that is either an insurance or institutional grant model as opposed to the current mixed approach.**

The previous chapter examined the basic economics underlying the hospital market in New Jersey and elsewhere. It highlighted the fact that public payers are generally reimbursing providers at lower rates than private payers and in some cases far below the cost of providing care. This problem is not unique to New Jersey but appears to be more pronounced here with respect to payment levels. This leads to intense efforts on the part of hospitals to shift costs on to other payers.

Public funds flowing to hospitals on behalf of the State represent a complex relationship between New Jersey and the federal government. In nearly all cases, extensive regulatory requirements exist that provide fairly strict regulations on how funding can be distributed. While it is tempting to weigh policy options that could simplify the distribution of public funds,

some changes would threaten the current level of federal matching funds for such programs.

This chapter examines the various sources of public funding for hospitals from the State of New Jersey and makes recommendations intended to improve the returns on investment of those funds.

I. Medicaid Hospital Payments

The Medicaid Program, which consists of 50 distinct state-level programs,⁵⁵ comprises the bulk of states' funding for hospital services. In accordance with broad federal guidelines, each state develops its own administrative structure for its Medicaid program;

⁵⁵ There are six additional Medicaid Programs in the District of Columbia, Puerto Rico, and each United States territory.

establishes its own eligibility criteria; determines the type, amount, duration and scope of covered services and sets provider payment rates. States share the funding for their Medicaid expenditures with the federal government. Under this shared funding arrangement, the federal government matches state expenditures according to a formula based on each state’s per capita income, whereby lower income states have higher federal matching rates. In federal fiscal year (FFY) 2008, the federal government’s share can range from 50 percent to approximately 76 percent of a state’s total Medicaid spending.⁵⁶ Because of New Jersey’s relatively high per capita income, its Medicaid federal match rate is equal to the minimum 50 percent.

The State Children’s Health Insurance Program (SCHIP) is designed to provide low-cost health insurance coverage to uninsured children who are not eligible for Medicaid

and cannot afford to purchase private coverage. Within broad federal guidelines, each State determines the design of its SCHIP plan, eligibility groups, benefit packages, payment levels for coverage and administrative and operating procedures. New Jersey’s SCHIP, known as NJ FamilyCare, is combined with its Medicaid program. The federal government and states share in the funding of SCHIP, but the amount of federal funding is capped at an allotted amount nationwide and by state. States receive an enhanced federal matching rate under the SCHIP, based on their Medicaid matching rate.⁵⁷ For FFY 2007, the SCHIP enhanced rate ranged from 65 percent to approximately 83 percent. New Jersey’s SCHIP enhanced rate is 65 percent.

Table 7.1 shows New Jersey’s estimated Medicaid (including NJ FamilyCare) payments in 2008 to acute care hospitals, followed by a description and discussion of each type of payment.

Table 7.1:
Estimated Payments to Acute Care Hospitals under New Jersey Medicaid and DSH Programs (SFY 2008)

Type of Payment	Amount (in 000s) ⁵⁸
Medicaid	
Service Payments for Fee-For- Service	\$970,400
Service Payments by Medicaid HMOs	888,900
Graduate Medical Education (GME) Payments	60,000
Supplemental Payments - Hospital Relief Subsidy Payments	183,000
Supplemental Payments – Mental Health Subsidy Payments	20,000
Disproportionate Share Hospital (DSH)	
Charity Care Subsidy Payments	\$715,000
State Agency other than Division of Medical Assistance and Health Services (DMAHS) Contract Payments	153,900
Total Medicaid and DSH Payments to Acute Care Hospitals	\$2,991,200

⁵⁶ National Conference of State Legislatures, “HHS Release FY 2008 FMAP Figures.” Available online: <http://www.ncsl.org/statefed/health/FY08FMAP.htm>.

⁵⁷ Legislation passed by Congress to reauthorize SCHIP and increase its funding was vetoed by President Bush on October 3, 2007 because it provided more funding and included higher family income eligibility limits than his proposal. As a temporary measure until compromise

reauthorization legislation is enacted, Congress has passed a continuing resolution that extends current funding levels, but the levels are not sufficient to allow states to maintain coverage for current enrollment.

⁵⁸ **Source:** Expenditure estimates and budget appropriations provided by Division of Medical Assistance and Health Services.

A. Service Payments

For Medicaid recipients in the fee-for-service delivery system, New Jersey's Medicaid Program pays for most inpatient hospital services under a diagnosis-related groupings (DRG) system. The DRG system is designed to group together cases with clinically similar conditions that require similar amounts of hospital resources. New Jersey, like some other states, uses a DRG grouper developed for all patients, not just Medicare patients. New Jersey uses hospital-specific base rates derived from cost reports, with many adjustments, to reflect geographic variation in wages and variations in capital structure. For outpatient services, New Jersey Medicaid pays hospitals on a cost basis less a 5.8 percent discount. The Division of Medical Assistance and Health Services (DMAHS), the agency that administers New Jersey's Medicaid Program, estimates that in State Fiscal Year (SFY) 2008 its service payments to acute care hospitals for fee-for-service Medicaid recipients will total \$970.4 million, as shown in Table 7.1.

For Medicaid recipients enrolled in managed care, New Jersey's Medicaid Program pays HMOs capitation amounts intended to cover all the health care services their enrollees need. HMOs contract with hospitals in their networks and negotiate payment rates for services the hospitals provide to their Medicaid members. Medicaid HMOs generally pay contracting hospitals per diem or per case rates, depending on the services. All 80 acute care hospitals in New Jersey contract with at least one Medicaid HMO. If a Medicaid HMO member receives services at a hospital that is not in his or her HMO's network, the HMO must pay the hospital that provides the out-of-network care the Medicaid fee-for-service rate. Medicaid HMOs pay for outpatient hospital services based on individually negotiated contracts with each hospital. DMAHS estimates that Medicaid HMOs' payments to acute care hospitals for Medicaid managed care enrollees will total \$888.9 million in SFY 2008, as shown in Table 7.1.

B. Graduate Medical Education

Teaching hospitals have long been a critical part of healthcare delivery, often serving as safety-net hospitals and providing uncompensated care for the most vulnerable populations. Because of their education and research missions, teaching hospitals typically offer the

newest and most advanced services and equipment and more highly specialized services. They also care for a higher proportion of severely ill patients who require a greater amount of resources.

The federal government supports medical education through two kinds of Medicare payments – Direct Graduate Medical Education and Indirect Medical Education. Direct Graduate Medical Education payments compensate teaching hospitals for some of the costs directly related to the graduate training of physicians, including stipends and fringe benefits of residents; salaries and fringe benefits of faculty who supervise the residents; other direct costs and allocated institutional overhead costs. Indirect medical education payments to hospitals are, as stated in a 1983 House Ways and Means Committee report as part of the legislation that enacted the Medicare DRG payment system, “only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals.” These factors may include teaching hospitals' typical location in low-income inner city areas, where patients often have more co-morbid conditions and fewer social support networks, both of which can make them costly to treat; teaching hospitals' breadth of specialized services and programs; as well as the additional costs associated with the residents' learning process.⁵⁹

Like many other states, New Jersey Medicaid also makes GME payments to qualifying teaching hospitals.⁶⁰ To qualify for a Medicaid GME payment, a hospital must have Medicaid fee-for-service inpatient days at or above the statewide median. The purpose of this qualifying test is to target GME payments to the teaching hospitals with high Medicaid utilization. Medicaid distributes GME payments among the qualifying hospitals based on hospitals' number of full-time-equivalent residents and their Medicaid fee-for-service inpatient days. Currently 20 hospitals qualify to

⁵⁹ The Centers for Medicare and Medicaid Services (CMS), the federal agency responsible for the Medicaid Program, issued proposed regulations that would deny states federal match for Medicaid GME payments to hospitals. Congress acted to prevent CMS from finalizing or implementing these proposed regulations until May 25, 2008.

⁶⁰ See Henderson, T. Medicaid Direct and Indirect Graduate Medical Education Payments: A 50 State Survey 2006. Association of American Medical Colleges. This survey found that 47 states provide GME funding in their Medicaid programs but did not quantify the amount.

receive Medicaid GME payments. For SFY 2008, the amount of funds allocated for Medicaid GME payments increased to \$60 million from the \$20 million level in many previous years.

C. Medicaid Supplemental Payments

Many states have Medicaid supplemental payment programs for hospitals. These payments are often referred to as upper payment limit (UPL) payments because they provide increased payments to hospitals up to the maximum limit federal regulations allow. The federal government has set the UPL as the amount that the Medicare Program would pay, and, currently, the UPL is an aggregate payment limit for three groups of hospitals – state-owned public, other public and private hospitals.⁶¹

Hospital eligibility criteria for these supplemental payment programs vary by state, but all the programs are similar in their intent to target Medicaid payments for particular hospitals in addition to the regular per DRG, per diem, etc. patient service-related payments. New Jersey has one such Medicaid supplemental payment program – the Hospital Relief Subsidy Fund.⁶²

New Jersey's Hospital Relief Subsidy Fund targets Medicaid supplemental payments for hospitals that provide high volumes of care in seven categories of services that are highly utilized by Medicaid and uninsured patients. To qualify to receive payments from this fund, hospitals must have Medicaid patient days at or above the statewide median, and total cases at or above the statewide median in at least one of the following seven service areas: AIDS as a primary diagnosis, AIDS as a secondary diagnosis, neonatal care, mental health, substance abuse, substance abuse for pregnant women and tuberculosis. In SFY 2008, 32 hospitals qualify to share \$183 million in payments from this fund. DMAHS distributes these payments monthly among the qualifying hospitals based on their share of cases in the special service categories.

⁶¹ On May 29, 2007, the Centers for Medicare and Medicaid Services published a final rule that makes the UPL for providers operated by units of government an individual facility limit rather than a group limit if the state uses intergovernmental transfers from these facilities or their certified public expenditures for purposes of claiming federal matching funds. Congress implemented a one-year moratorium on implementation of these rules.

⁶² New Jersey Medicaid previously counted this program as a DSH payment.

D. Disproportionate Share Hospital Payments/Charity Care Subsidy Program

The Medicaid disproportionate share hospital (DSH) payment program is the largest source of federal funding for hospital care for uninsured patients, and, similar to other Medicaid expenditures, state governments share in this funding. The Medicaid DSH payment program requires that states take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs.⁶³ There are two minimum federal criteria for hospitals to qualify for the DSH program: at least one percent of a hospital's total inpatient days must be attributable to Medicaid patients, and the hospital must have at least two obstetricians with staff privileges who have agreed to provide obstetric services to individuals eligible for Medicaid.⁶⁴ Federal law requires that states make DSH payments to DSH-eligible hospitals that meet the federal statutory mandatory eligibility criteria of having a Medicaid inpatient utilization rate that is one standard deviation above the statewide average, or a low-income utilization rate (i.e., Medicaid and charity care) of 25 percent or higher. Some states limit DSH payments to only those hospitals that meet one of these two mandatory criteria, while other states, including New Jersey, have criteria that are more expansive and make DSH payments to virtually all hospitals.

The Medicaid DSH program began in 1981, and initially, the federal government placed no limits on the amount of DSH payments for which states could receive federal matching funds. However, in 1991, the federal government capped states' federal share of DSH payments – known as federal DSH allotments – at each state's DSH expenditure level in 1991. Thus, states that made use of Medicaid DSH funding in the early years of the program have higher DSH allotments than states that did not. New Jersey is an example of such a state; its current federal Medicaid DSH allotment of \$606.4 million is the fifth highest in the nation.⁶⁵ In 1998, the federal government began cutting states' DSH

⁶³ Social Security Act 1902(a)(13)(A)(iv)

⁶⁴ This requirement does not apply to a hospital that did not offer non-emergency obstetric services as of December 21, 1987 or to a hospital that predominantly serves individuals under 18 years of age.

⁶⁵ Kaiser Family Foundation. New Jersey: Federal Medicaid DSH Allotments, FY 2007. <http://www.statehealthfacts.org/cgi-in/healthfacts.cgi?action=profile&area=New+Jersey&category=Medicaid+%26+CHIP&subcategory=Medicaid+Spending&topic=Federal+DSH+Allotments%2c+FY2007>

allotments, but the Medicare Modernization Act of 2003 restored states' allotments for 2004 with a 16 percent increase over 2003 levels. Most states' DSH allotments remain at the 2004 level until at least 2010, at which point they will increase annually by the rate of change in the Consumer Price Index.

The federal government also limits the amount of Medicaid DSH payments an individual hospital can receive. This hospital-specific DSH limit specifies that no hospital can receive Medicaid and DSH payments in excess of its total cost for caring for Medicaid recipients and uninsured patients.

The federal government is increasing its scrutiny of states' Medicaid DSH payments and, as required by the Medicare Modernization Act of 2003, the Centers for Medicare and Medicaid Services, the federal agency responsible for the Medicaid Program, issued proposed regulations in 2005 that specify new reporting and auditing requirements for hospital-reported information that states use to make DSH payments hospitals. CMS has not yet published final regulations on these DSH reporting and auditing requirements, but the regulations as proposed have significant implications for hospitals and states. For example, states must have independent audits to verify the accuracy of the hospital-reported data they use to make DSH payments. The audits must also verify that states collect and maintain appropriate documentation for calculating hospitals' costs in caring for uninsured patients and payments hospitals receive on behalf of uninsured patients.

As noted earlier, New Jersey's federal Medicaid DSH allotment of \$606.4 million, or \$1.2 billion in combined federal and state shares, is among the highest in the nation. New Jersey's Hospital Relief Subsidy Fund for Mental Health represents a small portion of DSH funds - \$20 million. It targets hospitals that provide short-term inpatient mental health services and inpatient children's crisis intervention services. The purpose of this fund is to support the State's efforts to move patients out of state mental health institutions, by encouraging community-based acute care hospitals to provide inpatient mental health services. In SFY 2008, 24 hospitals qualify to share \$20 million in payments from this fund. Medicaid distributes these funds quarterly among qualifying hospitals based on their number of short-term inpatient mental health beds and inpatient children's crisis intervention beds.

New Jersey's charity care subsidies to acute care hospitals comprise a large part of the State's Medicaid DSH payments. To be eligible for charity care in New Jersey, patients must have no or limited health insurance coverage, be ineligible for Medicaid or SCHIP, have limited assets excluding their primary residence and automobile or spend down below the asset limit to become eligible. Patients who meet these eligibility criteria pay a portion of their hospital bills based on their income; the portion of hospital bills patients are responsible for paying ranges from none for those with incomes below 200 percent of the Federal Poverty Level (FPL) to 80 percent for those with incomes between 270 and 300 percent of the FPL.

Under New Jersey's charity care program, hospitals apply for charity care by submitting claims for uninsured patients to the Medicaid fiscal agent and, in so doing, certify that these patients have sufficiently documented their eligibility for the program. The Medicaid fiscal agent "prices" the charity care claims at the Medicaid fee-for-service inpatient and outpatient rates, and the sum of all a hospital's charity care claims for the year "priced" in this way is its total amount of charity care for the year. The State uses this charity care information and follows a statutory formula in distributing charity care subsidy payments to hospitals.⁶⁶ New Jersey also counts payments to acute care hospitals by State agencies other than DMAHS of \$153.9 million in SFY 2008 as DSH payments and claims federal match on them. In addition, New Jersey, like most other states, also counts some expenditures for its state-owned psychiatric hospitals as DSH payments and claims federal match on these expenditures⁶⁷.

For SFY 2008, the New Jersey Legislature increased funding for the charity care subsidy payments to \$715 million from \$583.4 million, and eliminated discretionary hospital assistance grants that had been given to hospitals in the prior years. As a result of the increase in funding for charity care subsidy payments for SFY 2008, the DMAHS estimates its DSH payments to hospitals, when combined with the other State

⁶⁶ An Overview of Charity Care in New Jersey – Past, Present and Future. Forums Institute for Public Policy. September 29, 2004.

⁶⁷ The federal government limits states' Medicaid DSH expenditures for institutions for mental diseases and other mental health facilities to 33 percent of states' total federal DSH allotment.

expenditures claimed as DSH, will exceed New Jersey’s \$1.2 billion total DSH allotment. Thus, the State will have to fund some of the increased charity care subsidy payments with 100 percent state dollars.

The Charity Care program, like Medicaid, pays hospitals less than the full cost of care. The program is thus another example where state government pays less than full costs – hospitals and other payers are expected to make up the difference. If the State were to fully fund Charity Care to cover 100% of costs, an additional \$500 million above and beyond the approximately \$1 billion already spent on charity care would be needed to support the program. Instead, New Jersey, like other states, continues to rely on the good will and professional and legal obligations of hospitals and doctors to make up the difference and provide such care. Private payers offset the shortfall in part by paying a rate above costs as was highlighted in the previous chapter discussing the financial hydraulic system common to most hospitals.

II. Policy Options to Optimize Public Funding for Hospitals

Public funding for health care has two important goals. First, it should provide adequate financing to ensure equitable access to health care for all people. Second, public funds should support health care institutions (i.e. hospitals) that serve a high fraction of individuals from vulnerable populations (i.e. “essential” hospitals). The current public financing system for health care in New Jersey falls short on both goals. Medicaid payments are woefully inadequate such that access is compromised, particularly for physician services. And while the State provides important charity care payments to hospitals, it has not settled on whether it is an insurance program for low-income patients or a grant program for safety net hospitals. The mixed features of the program seem to have interfered with a rational disbursement of funds that would maximize gains toward either goal.

A. Consolidation of Public Funding into a Single Stream

Some have suggested that New Jersey Medicaid combine its various payments to hospitals to simplify the funding. However, federal regulations restrict the ability of states to combine Medicaid, DSH and SCHIP funds into a single unencumbered federal funding

stream. While it is possible to combine all Medicaid payments under a single distribution methodology, doing so could limit the State’s flexibility to target higher payment to safety net hospitals that are especially integral to the State’s Medicaid program and to teaching hospitals. In addition, as discussed below, Medicaid DSH funds that New Jersey uses for its charity care subsidy payments are designed to compensate hospitals for the care they provide to uninsured patients and are subject to specific federal limits. For this reason, these funds must be accounted for separately from other Medicaid payments. An exception to this is the “block grant” mechanism under an 1115 federal waiver of the Medicaid Program’s rules that enables states to combine Medicaid, DSH and SCHIP funds into a single unencumbered federal funding stream.⁶⁸ Florida and Massachusetts have recently implemented 1115 waiver block grants programs. Block grants provide states with greater flexibility in how to use Medicaid, SCHIP and DSH funds. However, these block grants are not a means to increase federal funding because, as a condition of approval of the grant, the federal government requires a state to agree to a cap on its federal funding.

B. Medicaid Coverage Expansion

In addition, the federal government is taking steps to restrict the ability of states to cover additional uninsured populations through special Medicaid and SCHIP waiver programs as previously allowed.⁶⁹ For example, the Deficit Reduction Act prohibited states from using SCHIP funds to cover childless adults, which had previously been allowed through a special Medicaid and SCHIP “HIFA” waiver program. Many states have expanded coverage recently to the uninsured by expanding public coverage to higher income levels, and

⁶⁸ Section 1115 of the Social Security Act provides the Secretary of Health and Human Services broad authority to authorize experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid statute. Flexibility under Section 1115 is sufficiently broad to allow states to test substantially new ideas of policy merit. These projects are intended to demonstrate and evaluate a policy or approach that has not been demonstrated on a widespread basis. (http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/03_Research&DemonstrationProjects-Section1115.asp)

⁶⁹ Some states have used SCHIP funds to cover parents of children enrolled in SCHIP and pregnant women and on a limited basis, childless adults. New Jersey’s SCHIP, NJ FamilyCare, covers certain parents of enrolled children and pregnant women.

many other states are looking to do the same. However, this may be a limited option for New Jersey, given the already relatively generous nature of the State's public programs. New Jersey's SCHIP, NJ FamilyCare, has the highest family income limit in the nation, up to 350 percent of the FPL. The Bush Administration released new guidance in August that require states to demonstrate that they have enrolled at least 95 percent of children in the State below 200 percent of the FPL who are eligible for Medicaid or SCHIP before they will be able to expand SCHIP for children and families beyond 250 percent of the FPL. The federal government is also threatening to withhold federal funding for existing expansion programs beyond 200 percent FPL, and most states including New Jersey, have not achieved the 95 percent level. States are generally reluctant to expand Medicaid coverage through non-waiver programs (i.e., a State Plan Amendment) as this approach entails an open-ended financial commitment to the new "entitlement" population(s). However, this remains an option available to New Jersey if the State were willing to devote new funding to expanding coverage for the uninsured.

C. Partial Consolidation of Funds into Medicaid Direct Payments

While there is some appeal to consolidating funding into a single stream, the numerous regulatory issues described above would have a negative financial impact on the State. However, there are several more limited opportunities to streamline funding. Two good candidates for consolidation into Medicaid direct payments are the Hospital Relief Subsidy Fund (HRSF) and Graduate Medical Education (GME) payments. HRSF is a supplemental Medicaid payment to hospitals based on the volume of care for a range of conditions common among Medicaid and uninsured patients. GME payments are allocated to hospitals with residency training programs. Both of these programs implicitly and explicitly target hospitals with large numbers of Medicaid patients. Consolidation ensures that hospitals are subsidized in a fair and rational way that is directly linked to Medicaid volume rather than relying on fragmented sources based on different payment formulas. In addition, consolidation would ensure that funding grows each year commensurate with annual cost increases rather than remaining frozen at current appropriations levels.

Recommendation:

The Commission recommends consolidation of the Hospital Relief Subsidy Fund (with the exception noted below) and Graduate Medical Education funds into Medicaid direct payments.

D. Shifting Funds to Support Mental Health

A landmark Supreme Court case in 1999 ruled that the Americans with Disabilities Act may require states to provide community-based rather than institutional placements for individuals with disabilities.⁷⁰ New Jersey's Department of Human Services has responded by steadily moving more institutional patients back into the community. This new model of care requires an infrastructure to handle short-term emergencies through the provision of acute care hospital beds.⁷¹ The Hospital Relief Subsidy Fund for Mental Health (HRSF-MH) provides financial incentives to maintain such beds. The Commission heard from numerous sources that there are current shortages of these beds and that emergency rooms are now facing increased numbers of visits related to mental health issues. The current funding level for HRSF-MH is \$20 million – this funding is shared across the system and diminishes in per bed value as the total number of beds increases.

Recommendation

The Commission recommends shifting some funds from the Hospital Relief Subsidy Fund to the Hospital Relief Subsidy Fund for Mental Health to ensure existing beds are maintained and to provide financial incentives for the addition of new beds to address current shortages.

The Commission believes that a \$5 million transfer of funds from the HRSF to increase the HRSF-MH fund from \$20 to \$25 million is an appropriate amount to achieve the stated goal of enhancing the capacity for acute and immediate care mental health beds.

⁷⁰ *Olmstead vs. L.C.* (98-539) 527 U.S. (581) 1999 – See Cornell University Law School Legal Information Institute – available at <http://www.law.cornell.edu/supct/html/98-536.ZS.html> (accessed December 13, 2007)

⁷¹ Short-term care facility (STCF) and Children's Crisis Intervention Services (CCIS) beds

E. Should Efficiency and Profitability be Factored into Charity Care Payments?

Based on input from the Subcommittee on Reimbursements and Payers, the Commission identified a range of issues relevant to discussion of the current methodology for distributing charity care subsidies:

- 1) Subsidies do not consider efficiency and in some cases reward inefficient hospitals.
- 2) Subsidies do not consider profitability and in some cases subsidies are going to hospitals that do not need them to remain financially viable.
- 3) Lags in data collection and hold harmless provisions prevent the subsidies from truly following the patients and transform the charity care payments into quasi-grants.
- 4) The documentation requirements encourage hospitals to spend money on documenting charity care rather than pursuing collection procedures or public insurance enrollment.
- 5) Hospitals often have to use a portion of their subsidies to pay for physician services for charity care patients.
- 6) Charity care payments lack any type of care management program that would optimize health outcomes or the cost effectiveness of care.

There are two competing theories as to how the State should disburse Charity Care funds. First, the funds could be structured as an insurance program to cover hospital care for the uninsured. Funds would directly follow patients and be distributed in the same manner in which patients are distributed across hospitals in New Jersey. Second, the funds could be distributed as grants to the most “needy” hospitals caring for a disproportionately high number of patients from vulnerable populations and experiencing financial challenges. In this case, funds would be concentrated on a smaller number of hospitals that would generally be characterized as essential and in financial distress. New Jersey has generally pursued a mixed strategy that looks somewhat like insurance and somewhat like grants with some of the shortcomings identified above. Choosing a particular strategy would go a long way toward making the distribution of funds more objective and rational.

The Commission was unable to come to resolution as to which of the two strategies is better for New Jersey. On one hand, a fiscally constrained governmental environment combined with a substantial number of essential hospitals experiencing financial distress calls for more a focused strategy for disbursing funds. On the other hand, concentrating funds on a limited number of hospitals may penalize some hospitals that are more efficient and thus more profitable.

In weighing these options, it is important to consider the various reasons why one hospital might be more profitable than another. First, the hospital may be efficiently run with physicians practicing cost-effective medicine. Second, the hospital may be located in a relatively affluent area with a case mix consisting primarily of well insured or well paying patients. Third, the hospital may have greater bargaining power and thus able to obtain higher payment rates from private insurers. Efficiency is but one cause for better profitability; the others are external to the hospital and have little to do with the effectiveness of management.

Recommendations:

The State should further examine and resolve the issue of whether the Charity Care program should be based on an insurance model, under which State subsidies for charity care would travel with the patient regardless of what hospital the patient used, or on an institutional grant model under which State subsidies would not travel with the patient but be concentrated on essential hospitals in financial distress.

The State should develop a payment system for Medicaid and Charity Care that includes incentives for efficiency and high quality health care.

III. Conclusion

State funds supplemented by federal matching funds provide an important revenue source for New Jersey's hospitals. Current funding levels are generally inadequate as Medicaid underpays many hospitals for services provided, forcing the shifting of costs on to other payers. The Commission entertained proposals to consolidate funding sources into a single stream; however, the ability to do so is limited by current federal regulations. However, the Commission identified several opportunities to merge funds directly into Medicaid payment rates (i.e. GME payments, Hospital Relief Subsidy Fund). Such changes would ensure that funding increases annually commensurate with changes in health spending. It would also ensure that funding

flows to hospitals in a more equitable fashion based on need given that Medicaid burden is highly correlated with requirements for financial support. In addition, the Commission also put forth a recommendation for a modest shift of subsidies to support the capacity of acute care mental health beds – an area of great need. Finally, the Commission strongly urges the State to conduct an efficiency study of New Jersey hospitals that would help guide reform of the Charity Care and Medicaid payment system to reward efficiency. In addition, the State is urged to further examine the design of the Charity Care system and resolve whether an insurance or institutional grant model is preferred public policy.

