Free Care:
A Compendium of State Laws

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Community Catalyst, Inc.
30 Winter Street, 10th Fl.
Boston, MA 02108
617-338-6035
Fax: 617-451-5838
www.communitycatalyst.org

FORWARD

Community Catalyst has compiled this overview of Free Care Laws to assist advocates in understanding the array of approaches taken on the state level. Health care is a changing environment, however, and laws and regulations are continually affected by the dominance of local issues and interests. Therefore, we welcome your input on the information provided so that we can ensure the accuracy and timeliness of this compendium. Please send your comments to: Stoll@communitycatalyst.org.

EXPLANATION OF HEADINGS FOR STATE SUMMARIES AND TABLE

Terminology: Does the state refer to free care, indigent care, charity care, etc.?

Regulatory Oversight: Which regulator or entity is charged with overseeing the state's free care program?

Definitions and Distinctions: Are the terms free care, charity care, bad debt, and/or uncompensated care defined? Are free care and bad debt distinguished?

Free Care as a Community Benefit: Does the state consider free care to be a community benefit?

Eligibility Requirements: What requirements (e.g. income guidelines) does the state have for free care?

Financing Source: How is the free care program supported financially?

Services Covered: What medical services are covered by the free care program (both inpatient and outpatient)?

Notification Requirements: How are hospitals required to inform patients of their free care policies?

Application Process: How can an individual apply for free care?

Grievance/Appeal Process: Are there any ways a free care applicant can appeal a decision denying free care?

Reporting Requirements: Are hospitals or regulators required to submit reports on the free care policy?

Penalties for Noncompliance: Are hospitals subject to any penalties if they do not adhere to the state's free care policy?

Other: Any additional interesting or pertinent information.

N/A: Not applicable. There is no pertinent information available.

EXPLANATION OF STATE COMPARISONS

Lien States: States that allow a hospital or county to attach a lien to the property of someone receiving free care.

CON States: States where the free care requirements are part of the certificate of need process.

Free Care v. Bad Debt States: States which distinguish free care and bad debt.

County States: States where counties run the free care system.

Community Benefit States: States which consider free care to be a community benefit.

Non-Community Benefit States: States which clearly distinguish free care and community benefits.

Expired States: States whose free care legislation seems to have expired (see summaries).

Conversion States: States where the free care laws are part of the conversion laws.

States with Nothing: States with no free care laws or regulations

Medicaid States: States where it was difficult for me to distinguish between Medicaid and free care.

Tobacco States: States where the financing source is tied to tobacco settlement funds.

FREE CARE TABLE:
A COMPARISON OF STATE FREE CARE LAWS AND REGULATIONS

	AL	AK	AZ	AR	CA	CO	CT	DE	D.C.	FL	GA	HI	ID	IL
Reg. Oversight	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	N/A
Def. & Dist.	N/A	✓	N/A	N/A	N/A	N/A	✓	N/A	N/A	N/A	N/A	N/A	N/A	✓
Free Care = Comm. Ben.?	N/A	N/A	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Eligibility Reqs	✓	N/A	N/A	N/A	✓	✓	✓	N/A	✓	✓	✓	N/A	✓	N/A
Fin. Source	✓	✓	✓	✓	✓	✓	✓	✓	N/A	✓	✓	N/A	N/A	N/A
Servs. Cov.	N/A	N/A	N/A	N/A	✓	✓	N/A	N/A	✓	N/A	N/A	N/A	✓	N/A
Not. Reqs.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	✓	N/A	N/A	N/A	N/A	N/A
Appl. Proc.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	✓	N/A	N/A	N/A	✓	N/A
Griev./Appeal Process	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	✓	N/A	N/A	N/A	✓	N/A
Rep. Reqs.	N/A	✓	✓	N/A	✓	✓	✓	✓	✓	✓	✓	N/A	✓	✓
Penals. For Hosp. Nocompl	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	✓	N/A	N/A	N/A	N/A	N/A

	IN	IA	KS	KY	LA	ME	MD	MA	MI	MN	MS	MO	MT	NE
Reg. Oversight	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Def. & Dist.	N/A	N/A	N/A	N/A	N/A	✓	✓	✓	N/A	✓	N/A	✓	N/A	N/A
Free Care = Comm. Ben.?	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Eligibility Reqs	✓	✓	✓	✓	✓	✓	N/A	✓	N/A	N/A	N/A	N/A	✓	✓
Fin. Source	✓	N/A	N/A	✓	✓	N/A	N/A	✓	✓	✓	✓	✓	✓	✓
Servs. Cov.	N/A	✓	N/A	N/A	✓	✓	N/A	N/A	N/A	N/A	N/A	N/A	✓	✓
Not. Reqs.	✓	N/A	N/A	✓	N/A	✓	N/A	✓	N/A	N/A	N/A	N/A	N/A	✓
Appl. Proc.	✓	N/A	N/A	✓	N/A	✓	N/A	✓	N/A	N/A	N/A	N/A	N/A	N/A
Griev./Appeal Process	✓	N/A	N/A	N/A	N/A	✓	N/A	✓	N/A	N/A	N/A	N/A	N/A	N/A
Rep. Reqs.	✓	N/A	✓	✓	N/A	✓	N/A	✓	N/A	✓	✓	✓	N/A	✓
Penals. For Hosp. Nocompl	N/A	N/A	N/A	N/A	N/A	N/A	✓	✓	N/A	N/A	N/A	N/A	N/A	N/A

	NV	NH	NJ	NM	NY	NC	ND	OH	OK	OR	PA	RI	SC	SD
Reg. Oversight	✓	✓	✓	✓	✓	✓	✓	✓	✓	N/A	✓	✓	✓	✓
Def. & Dist.	N/A	✓	N/A	✓	✓	N/A	N/A	N/A	N/A	N/A	✓	✓	✓	N/A
Free Care = Comm. Ben.?	N/A	✓	N/A	N/A	✓	N/A	N/A	N/A	N/A	N/A	N/A	✓	N/A	N/A
Eligibility Reqs	✓	N/A	✓	✓	N/A	N/A	✓	✓	✓	N/A	✓	N/A	N/A	✓
Fin. Source	✓	N/A	✓	✓	✓	N/A	N/A	✓	✓	N/A	✓	N/A	N/A	✓
Servs. Cov.	✓	N/A	✓	N/A	N/A	N/A	N/A	✓	N/A	N/A	N/A	N/A	N/A	✓
Not. Reqs.	N/A	✓	✓	N/A	N/A	N/A	✓	✓	N/A	N/A	✓	N/A	N/A	N/A
Appl. Proc.	✓	N/A	✓	✓	N/A	N/A	✓	N/A	N/A	N/A	N/A	N/A	N/A	✓
Griev./Appeal Process	✓	N/A	✓	✓	N/A	N/A	✓	N/A	N/A	N/A	N/A	N/A	N/A	✓
Rep. Reqs.	✓	✓	✓	✓	✓	N/A	N/A	✓	✓	N/A	✓	✓	N/A	N/A
Penals. For Hosp. Nocompl	N/A	N/A	N/A	N/A	✓	N/A	N/A	N/A	N/A	N/A	✓	N/A	N/A	N/A

	TN	TX	UT	VT	VA	WA	WV	WI	WY					
Reg. Oversight	✓	✓	✓	N/A	✓	✓	✓	✓	N/A					
Def. & Dist.	N/A	✓	N/A	N/A	✓	✓	N/A	✓	N/A					
Free Care = Comm. Ben.?	N/A	✓	N/A	N/A	N/A	N/A	N/A	N/A	N/A					
Eligibility Reqs	N/A	✓	✓	N/A	✓	✓	✓	✓	N/A					
Fin. Source	✓	✓	✓	N/A	✓	N/A	✓	N/A	N/A					
Servs. Cov.	N/A	✓	N/A	N/A	✓	✓	✓	N/A	N/A					
Not. Reqs.	N/A	✓	N/A	N/A	N/A	✓	✓	✓	N/A					
Appl. Proc.	N/A	✓	N/A	N/A	N/A	✓	✓	✓	N/A					
Griev./Appeal Process	N/A	✓	N/A	N/A	N/A	✓	N/A	N/A	N/A					
Rep. Reqs.	N/A	✓	N/A	N/A	✓	✓	N/A	✓	N/A					
Penals. For Hosp. Nocompl	N/A	✓	N/A	N/A	N/A	✓	N/A	N/A	N/A					

STATE COMPARISONS

LIEN STATES
Arizona
Idaho
Nevada
New Mexico

CON STATES
District of Columbia
Florida
Mississippi
South Carolina
Virginia

CONSUMER FRIENDLY STATES
District of Columbia
Maine
Massachusetts
New Jersey
Washington

FREE CARE V. BAD DEBT STATES
Connecticut
Illinois
Maine
Massachusetts
Minnesota
Missouri
New Hampshire
New Mexico
New York
Pennsylvania
Rhode Island
Texas
Washington
Wisconsin

COUNTY STATES
Alabama
Arizona
California
Florida
Georgia
Idaho
Indiana
Iowa
Michigan
Missouri
Montana
Nevada
New Mexico
North Carolina
North Dakota
South Dakota
Texas

COMMUNITY BENEFIT STATES
Arizona
New Hampshire
New York
Rhode Island
Texas
Utah

NON-COMMUNITY BENEFIT STATES
Illinois
Minnesota

EXPIRED STATES
Indiana (7/1/02)
New Jersey (12/21/04)
Ohio (10/16/03)
Tennessee (1992)
Utah (7/1/04)
Vermont?
West Virginia (1992)

CONVERSION STATES
Arizona
North Carolina (when a public hospital)
Rhode Island

STATES WITH NO FREE CARE PROVISIONS

Hawaii
Nebraska
Oregon
Vermont
Wyoming

MEDICAID STATES

Alaska
Arizona
Indiana
Kentucky
Missouri
Pennsylvania
South Carolina
Utah

STATES WITH A POOL OR FUND

Arizona
Arkansas
California
Georgia?
Indiana
Maryland
Massachusetts
Nebraska?
Nevada
New Mexico
New York
Ohio
Oklahoma
Tennessee (but expired)
Virginia
West Virginia

TOBACCO STATES

Arizona
New Jersey
Pennsylvania

STATES THAT USE THE TERM "FREE CARE"

Iowa
Maine
Massachusetts

STATES WITH INCOME GUIDELINES

Connecticut
District of Columbia
Florida
Kansas
Kentucky
Louisiana
Maine
Massachusetts
Nevada
New Jersey
New Mexico
Oklahoma
Texas
Virginia
Washington
West Virginia

STATES W/INCOME GUIDELINES >= 100% FPL

Connecticut (200%)
District of Columbia (100% or double)
Florida (100%)
Kansas (200%)
Kentucky (100%)
Louisiana (150%)
Maine (100%)
Massachusetts (200%; 201-400%)
New Jersey (200%; 200-300%)
Oklahoma (≤100%)
Texas (21%-200%)
Virginia (≤100%)
Washington (≤100%; 100-200%; ≥200%)
West Virginia (≤200%)

STATES W/SLIDING SCALE

District of Columbia
Florida (100-150%)

Massachusetts
New Jersey
Washington

FREE CARE COMPENDIUM:
A SUMMARY OF STATE FREE CARE LAWS AND REGULATIONS

ALABAMA

FREE CARE CITATION:
Alabama Code § 22-21-210, et. seq.
Hospital Service Program for Indigents

Alabama Code § 22-21-290, et. seq.
Alabama Health Care Responsibility Act

TERMINOLOGY:
Indigent Care

REGULATORY OVERSIGHT:
State Board of Health through the State Health Department oversees funding.
Ala. Code § 22-21-212.

Department of Pensions and Security oversees indigency status when patients are admitted to hospitals outside the county in which they reside.
Ala. Code § 22-21-294.

Each county chooses whether or not to participate in the Hospital Service Program for Indigents.
Ala. Code §§ 22-21-210(5); 22-21-291.

DEFINITIONS AND DISTINCTIONS: N/A

FREE CARE AS A COMMUNITY BENEFIT: N/A

ELIGIBILITY REQUIREMENTS:
Any person who has continuously resided in Alabama for at least one year and is acutely ill or injured and can be "helped markedly by treatment in a hospital," but is unable to pay the cost of hospitalization.
Ala. Code § 22-21-210(2); 22-21-292(2).

Indigency is determined by the Admissions Committee. Each county has its own Admissions Committee and is appointed by various county officials.
Ala. Code §§ 22-21-214, 22-21-215.

FINANCING SOURCE:
The State Board of Health appropriates funds each year for the Hospital Service Program for Indigents. The funds are apportioned as follows:

- 25% equally among all the participating counties
- 75% among the counties in proportion to which the population of each county bears to the total population of the state

Ala. Code § 22-21-220.

If the county expends all the funding before the end of the fiscal year, the county is not obligated to continue providing indigent care for the remainder of the year????
Ala. Code § 22-21-220(c).

County taxes for the maintenance of public hospitals may be applied to the Hospital Service Program for Indigents.
Ala. Code § 22-21-223.

SERVICES COVERED: N/A

NOTIFICATION REQUIREMENTS: N/A

APPLICATION PROCESS: N/A

GRIEVANCE/APPEAL PROCESS: N/A

REPORTING REQUIREMENTS: N/A

PENALTIES FOR NONCOMPLIANCE: N/A

OTHER: N/A

ALASKA

FREE CARE CITATION:
Alaska Statutes § 47.25.120, et. seq.
General Relief Assistance

TERMINOLOGY:
General Relief Assistance

REGULATORY OVERSIGHT:
Department of Health and Social Services

DEFINITIONS AND DISTINCTIONS:
There is a definition for "charity care" in the Medicaid regulations:
"Charity care" means health care services that
(A) a facility does not expect to result in cash payments; and
(B) result from a facility's policy to provide health care services free of charge to an individual who meets certain financial criteria"
7 Alaska Admin. Code 43.709.

FREE CARE AS A COMMUNITY BENEFIT: N/A

ELIGIBILITY REQUIREMENTS: N/A

FINANCING SOURCE:
The Department makes payments to hospitals to cover the costs of treating "needy" patients.
Alaska Stat. § 47.25.195(a).

In determining the amount of money that is paid to hospitals, the Department must follow the same rules and procedures that govern the administration of Medicaid.
Alaska Stat. § 47.25.195(b).

The Department sets the prospective rate of payment to a hospital based on a fair rate for the facility's reasonable costs. It must hold a public hearing before the Medicaid Advisory Commission before adopting the rate.
Alaska Stat. § 47.07.070.

If not enough money was appropriated to fund medical assistance in a given year, the Department may establish, by regulation, a prospective pro rata reduction of the hospitals' established payment rates.
Alaska Stat. § 47.25.195(c).

The Department may also negotiate with hospitals for individual payment rates that are even lower. Alaska Stat. § 47.25.195(d).

Hospitals may appeal the payment rate set by the Department.
Alaska Stat. § 47.07.075.

SERVICES COVERED:
Lists services that will not be covered if the Department does not have enough money to pay for them.
Alaska Stat. § 47.25.205.

NOTIFICATION REQUIREMENTS: N/A

APPLICATION PROCESS: N/A

GRIEVANCE/APPEAL PROCESS: N/A

REPORTING REQUIREMENTS:
Each hospital must submit an annual report on its financial performance to the Department.
Alaska Stat. § 47.07.071.

As a condition for receiving payment from the Department, hospitals must allow the Department reasonable access to their financial records for medical assistance beneficiaries and also allow audits and inspections of financial records by state and federal agencies.
Alaska Stat. § 47.07.074.

PENALTIES FOR NONCOMPLIANCE: N/A

OTHER:
See also 7 Alaska Admin. Code 47.010, et. seq. for provisions about General Relief Assistance. This does not appear to be free care, but is a program where Alaska residents can apply for state funds to help pay for daily expenses, including medical.

ARIZONA

FREE CARE CITATION:
Arizona Revised Statutes § 11-291, et. seq.
Medical Facilities and Care of Indigents

Arizona Revised Statutes § 10-11251
Hospital and Community Health Center Mergers and Other Transactions.

TERMINOLOGY:
Indigent Care

REGULATORY OVERSIGHT:
Board of County Supervisors

DEFINITIONS AND DISTINCTIONS: N/A

FREE CARE AS A COMMUNITY BENEFIT:
Yes. "Community benefit activity means any activity furthering community benefit purposes including any health care activity that includes education, prevention, promotion of community health, **indigent care** or any other charitable purpose."
A.R.S. § 10-11251, emphasis added.

ELIGIBILITY REQUIREMENTS: N/A

FINANCING SOURCE:
Beginning October 1, 2001, a portion of the Tobacco Settlement Agreement is used to fund indigent health care services. A.R.S. § 11-300(B). If the annual payments ever equals less than 66% of the original payment, the counties must contribute 33% of the difference.
A.R.S. § 11-300(A).

Also established the Tobacco Tax and Health Care Fund. Seventy cents of each dollar in this fund is placed in the "medically needy account to provide health care services to persons who are determined to be eligible for services pursuant to section 36-2901.1 or 36-2901.04 (Medicaid)... or any expansion of that program or any substantially equivalent or expanded successor program established by the legislature providing health care services to persons who cannot afford those services and for whom there would otherwise be no coverage."
A.R.S. § 36-774.

SERVICES COVERED: N/A

NOTIFICATION REQUIREMENTS: N/A

APPLICATION PROCESS: N/A

GRIEVANCE/APPEAL PROCESS: N/A

REPORTING REQUIREMENTS:
Hospital administrator shall keep a record of the names, dates of admission and discharge or death, and disease of anyone receiving indigent care. This record shall be filed with the Board of County Supervisors quarterly. A.R.S. § 11-296.

PENALTIES FOR NONCOMPLIANCE: N/A

OTHER:
The county is entitled to a lien to cover the expenses of the care. The lien may be taken against the patient or against the legal representative of the patient. A.R..S. § 11-291(E).

ARKANSAS

FREE CARE CITATION:
Arkansas Code § 20-77-107
Program for Indigent Medical Care

Arkansas Code § 19-5-306(12).
Department of Human Services Indigent Care Fund

TERMINOLOGY:
Indigent Care

REGULATORY OVERSIGHT:
Department of Human Services

DEFINITIONS AND DISTINCTIONS: N/A

FREE CARE AS A COMMUNITY BENEFIT: N/A

ELIGIBILITY REQUIREMENTS: N/A

FINANCING SOURCE:
The Department of Human Services administers money through a variety of funds to support various services. One of these funds is the Department of Human Services Indigent Care Fund Account which is used to partially defray the cost of uncompensated indigent care provided at the Arkansas Children's Hospital and the University of Arkansas for Medical Sciences. A.C.A. § 19-5-306(12).

SERVICES COVERED: N/A

NOTIFICATION REQUIREMENTS: N/A

APPLICATION PROCESS: N/A

GRIEVANCE/APPEAL PROCESS: N/A

REPORTING REQUIREMENTS: N/A

PENALTIES FOR NONCOMPLIANCE: N/A

OTHER:
A.C.A. § 20-77-107 states "The appropriate division of the Department of Human Services is authorized to establish and maintain an indigent medical care program." This is one of the only references to indigent care in the Arkansas statutes or administrative code.

The only other useful reference is found in the Code of Arkansas Rules and Regulations and is a reference in the Hospital Provider Manual to an "indigent care allowance" when explaining reimbursement rates for out-of-state hospitals. The indigent care allowance is defined as 20% or more Medicaid days as compared to total number of patient days. 016 06 CARR 028. There was no further explanation of indigent care or the indigent care allowance.

CALIFORNIA

California allows hospitals to set their own free care requirements. There is also a separate program called CHIP (California Healthcare for Indigents Program) which is administered by the counties.

FREE CARE CITATION:
Cal Welfare & Institutions Code § 16900, et. seq.
Health Care for Indigents

TERMINOLOGY:
Indigent Care

REGULATORY OVERSIGHT:
Counties administer a program of care to indigent persons in each county. Health services may be provided at county and non-county hospitals. Cal Wel & Inst Code § 17000. Counties report to the State Department of Health Services, as does the Office of Statewide Health Planning and Development.

DEFINITIONS AND DISTINCTIONS: N/A

FREE CARE AS A COMMUNITY BENEFIT: N/A

ELIGIBILITY REQUIREMENTS:
Must be a resident of the county in which the application is filed. Cal Wel & Inst Code § 17100. If the free care applicant is a recent immigrant (past three years), then the income of that person's sponsor is considered in determining eligibility. Cal Wel & Inst Code § 17001.7.

There is a reference which charges the Office of Statewide Health Planning and Development with adopting regulations for the "identification, assessment, and reporting of charity care services." It does not appear that such regulations have been adopted. References to charity care in the regulations imply that hospitals may set their own charity care policies. See 11 CCR 999.5; 22 CCR 97232. Tthe term "charity care"frequently is used in definition sections, but is never itself defined. See Cal Health & Saf Code § 127345(c)(1).

FINANCING SOURCE:
Counties receive funding and must deposit the funding in a special fund. Cal Wel & Inst Code §§ 16909(a); 16936.

SERVICES COVERED:
In addition to hospital services, certain physician services are also covered. Also emphasis on improving rural health care. Cal Wel & Inst Code § 16930, et. seq.

NOTIFICATION REQUIREMENTS: N/A

APPLICATION PROCESS: N/A

GRIEVANCE/APPEAL PROCESS: N/A

REPORTING REQUIREMENTS:
Counties must submit reports on the cost and utilization of the money in their special accounts for indigent care. The reports are submitted to the Department on a semiannual, preliminary annual, and final annual basis on forms prescribed by the county. Cal Wel & Inst Code § 16909(d); § 16915.

Each year, the Office computes data on the cost of uncompensated care[1] for all hospitals and counties (based on quarterly reports) and transmits this data to the Department within 30 days of April 15. Cal Wel & Inst Code § 16945.

PENALTIES FOR NONCOMPLIANCE: N/A

OTHER:

- Any hospital that receives funds under the CHIP program, may not attempt to collect payment from patients who received services under this program. Cal Wel & Inst Code § 16947.

- The San Francisco Board of Supervisors has adopted an ordinance that requires all general acute care hospitals (except for hospitals operated by federal, state, or local governments or by HMOs) operating in the City of San Francisco and the County of San Francisco to notify patients of their charity care policies and to file annual reports with the department of health on a range of data include the amount of charity care they provide. (Ordinance No. 163-01)

[1] Uncompensated Care Costs are based on a cost-to-charge ration, "calculated by dividing gross operating expenses less other operating revenue by gross inpatient and outpatient revenue." Cal Wel & Inst Code §§ 16945(b)(4)(D)(ii); 16920(d).

COLORADO

FREE CARE CITATION:
Colorado Revised Statutes § 26-15-101, et. seq.
Reform Act for the Provision of Health Care for the Medically Indigent

TERMINOLOGY:
Indigent Care

REGULATORY OVERSIGHT:
Department of Health Care Policy and Financing. C.R.S. §§ 26-15-104; 26-15-106(1)(b).

DEFINITIONS AND DISTINCTIONS: N/A

FREE CARE AS A COMMUNITY BENEFIT: N/A

ELIGIBILITY REQUIREMENTS:
Every person seeking coverage under the program must provide proof of indigency, but the provider is responsible for determining eligibility. C.R.S. § 26-15-106(c)(3).

Legal immigrants who are residents of Colorado and meet all other requirements, are eligible to receive services. However, beginning July 1, 1997, a legal immigrant who is receiving care under this act, may not sponsor another immigrant while receiving care. C.R.S. § 26-15-104.3.

FINANCING SOURCE:
The General Assembly makes annual appropriations to the Department to accomplish the purposes of this Article. C.R.S. § 26-15-110(2). The Department is responsible for executing contracts with providers for payment of medical services for those eligible for the program. C.R.S. § 26-15-106(1)(a). The contracts must specify the aggregate level of funding available for the care of the medically indigent. Providers are not funded at a level exceeding actual costs. Funds are allocated to providers annually, based on the anticipated utilization of services. C.R.S. § 26-15-106(6). Providers receive monthly checks equal to 1/12 of their level of funding. C.R.S. § 26-15-106(7).

NOTIFICATION REQUIREMENTS: N/A

APPLICATION PROCESS: N/A

SERVICES COVERED:
Statute assigns care of medically indigent to different hospitals based on location. C.R.S. § 26-15-106(5).

Abortion will only be covered if the life of the mother or child is threatened. This provision will be repealed if section 50 of Article V of the Colorado Constitution is ever repealed. That Article prohibits the use of public funds for abortions. C.R.S. § 26-15-104.5.

GRIEVANCE/APPEAL PROCESS: N/A

REPORTING REQUIREMENTS:
The hospital's executive director must prepare an annual report on the medically indigent program. The report should assess the current state of the program and offer suggestions for improving the delivery of care in the future. It is submitted to the Health, Environment, Welfare, and Institutions Committees of the House of Representatives and Senate no later than February 1 of each year. C.R.S. § 26-15-105.

PENALTIES FOR NONCOMPLIANCE: N/A

OTHER:

CONNECTICUT

FREE CARE CITATION:
Connecticut General Statutes § 12-263a, et. seq.
Hospitals Tax

TERMINOLOGY:
Uncompensated Care

REGULATORY OVERSIGHT:
Office of Health Care Access

DEFINITIONS AND DISTINCTIONS:
"Uncompensated care means the cost of care that is written off as a bad debt or provided free under a free care policy that has been approved by the Office of Health Care Access." Conn. Gen. Stat. § 12-263a(4).

FREE CARE AS A COMMUNITY BENEFIT: N/A

ELIGIBILITY REQUIREMENTS:
Any individual whose income is at or below 200% of the poverty income guidelines and who has applied for and was denied health coverage under Medicaid or any other public general assistance program. Conn. Gen. Stat. § 19a-673(4).

FINANCING SOURCE:
Between 1996 and 2000 hospital gross earnings were taxed quarterly. The tax rate decreased each year (11% in 1996 and 4.5% between October, 1999 and April, 2000). After April 1, 2000, hospitals are no longer subject to this tax. Conn. Gen. Stat. § 12-263b.

SERVICES COVERED: N/A

NOTIFICATION REQUIREMENTS: N/A

APPLICATION PROCESS: N/A

GRIEVANCE/APPEAL PROCESS: N/A

REPORTING REQUIREMENTS:
Each hospital must annually file with the Office of Health Care Access its policies for free or reduced cost care and debt collection. Each hospital must also obtain and file with the Office an independent audit of the amount of uncompensated care it provides. (Must also obtain audit of charges payments, and discharges related to Medicare, medical assistance, CHAMPUS, and nongovernmental payers). Conn. Gen. Stat. § 19a-649.

PENALTIES FOR NONCOMPLIANCE: N/A

OTHER:
Connecticut had an uncompensated care pool, but it was repealed effective April 1, 1994. May have been enacted in 1991. See Conn. Gen. Stat. §19a-168, 168a; 19a-667. When the uncompensated care pool terminated, $10 million from the pool was transferred to a separate account of the General Fund to be used to pay debt service on any tax exempt state of Connecticut general obligation bond. Conn. Gen. Stat. § 19a-667(b).

The Connecticut legislature recently passed a law that addresses hospital debt collection practices in connection with uninsured individuals. It provides for the following:

- Hospitals must file a debt collection report with the Office of Health Care Access, which includes collection policy and process.
- Hospitals are only allowed to start collections on uninsured individuals (up to 250% fpl) who are not eligible for hospital "bed funds" (donated funds that are earmarked to assist low-income people with their hospital expenses).
- Hospitals can only collect charges at cost for services provided to those who are uninsured under 250% fpl.
- If the hospital determines at any time that the patient is eligible for hospital bed funds or free care, it will discontinue collections.
- Hospitals must reduce interest charged on debt from 10% to 5%.
- The homestead exemption increases to $125,000 from $75,000 for hospital debt.

DELAWARE

FREE CARE CITATION:
29 Delaware Code § 7201, et. seq.
Indigent Sick

TERMINOLOGY:
Indigent

REGULATORY OVERSIGHT:
Department of Health and Social Services

The Delaware Health Care Commission is charged with overseeing the implementation of the Governor's Indigent Health Care Task Force Report which was issued on May 31, 1990 by finding better alternatives to help the uninsured; unclear from statutes what it has done in this regard since its creation in 1990. 16 Del. C. § 9903.

DEFINITIONS AND DISTINCTIONS: N/A

FREE CARE AS A COMMUNITY BENEFIT: N/A

ELIGIBILITY REQUIREMENTS: N/A

FINANCING SOURCE:
Hospitals providing free care send a report (see reporting requirements below) to the Department of Health on a monthly basis. If the Department deems the report accurate, it will approve the hospital for reimbursement for its services. 29 Del. C. § 7203. The Secretary of Finance then pays each hospital at a rate per day that was determined by the Budget Director. 29 Del. C. § 7204.

SERVICES COVERED: N/A

NOTIFICATION REQUIREMENTS: N/A

APPLICATION PROCESS: N/A

GRIEVANCE/APPEAL PROCESS: N/A

REPORTING REQUIREMENTS:
"Every hospital… which furnishes medical or surgical care and attention to any indigent person shall keep record thereof… showing the number of such indigent sick receiving medical or surgical care and attention, the name and residence of each such person, the dates the person was admitted to and discharged from the hospital and an itemized list showing all expenses incurred

by the hospital for medical or surgical care and attention furnished such persons." 29 Del. C. § 7202. This record is sent to the Department on or before the fifteenth day of each month. 29 Del. C. § 7203.

PENALTIES FOR NONCOMPLIANCE: N/A

OTHER:

DISTRICT OF COLUMBIA

FREE CARE CITATION:
Code of D.C. Regulations § 22-4400, et. seq.
Provision of Uncompensated Care and Community Services

Tied in with certificate of need requirements: "Applicants for a Certificate of Need (CON) shall be subject to the statutory free care and community service requirements described in this chapter." CDCR § 22-4400.1.

TERMINOLOGY:
Uncompensated Care

REGULATORY OVERSIGHT:
State Health Planning and Development Agency (SHPDA)

DEFINITIONS AND DISTINCTIONS: N/A

FREE CARE AS A COMMUNITY BENEFIT: N/A

ELIGIBILITY REQUIREMENTS:
A person is eligible for uncompensated care if s/he:

(a) Is not covered by a third-party insurer or governmental program;
(b) Falls within one of the following categories:
    Category A – annual individual or family income is not greater than the current poverty line; or
    Category B – annual individual or family income is greater than, but not more than twice the current poverty line; and
(c) Requests services.

CDCR § 22-4406.1.

Individuals who fall into Category A shall receive services at no charge. CDCR § 22-4406.3. Individuals who fall into Category B shall receive services either at no charge or in accordance with a schedule of charges specified in the CON holder's allocation plan. CDCR § 22-4406.4. Individuals issued a D.C. Medical Charities Card are automatically deemed eligible for uncompensated care. CDCR § 22-4406.2.

FINANCING SOURCE: N/A

SERVICES COVERED:
Each CON holder must devise an allocation plan which explains which services are covered. The plan must be published in a newspaper of general circulation at least 60 days before it becomes effective. The SHPDA reviews each allocation plan to make sure that it meets

community needs. Any person may submit written comments to the SHPDA that pertain to its review of the allocation plan. CDCR § 22-4407.

CON holders must provide a "reasonable volume of uncompensated services." CDCR § 22-4404.1. Reasonable volume is defined as 3% of the CON holder's operating costs. CDCR § 22-4404.2. Once a CON holder has met its annual compliance level for a particular year, the CON holder, after receiving the SHPDA's approval, may cease providing uncompensated care for the remainder of that year. CDCR § 22-22-4409.1. There are less stringent requirements for CON holders with operating budgets of less than $500,000. *See* CDCR § 22-4414.

NOTIFICATION REQUIREMENTS:
Each CON holder must annually publish in a newspaper a notice of its uncompensated care services. The notice is also submitted to the SHPDA. At the hospital, the CON holder must also post a pre-written notice (found in the regulations) informing patients of the uncompensated care policy. It must be posted in appropriate areas, including admissions, business office, and ER, and in English, Spanish, and any other language which at least 10% of households in the service area speak. The CON holder must also provide individual written notice of the free care policy to each person who seeks services from the hospital. CDCR § 22-4405.

APPLICATION PROCESS:

GRIEVANCE/APPEAL PROCESS:
A determination or denial of eligibility shall be made in writing and promptly provided to the applicant (5 days for hospitals and ambulatory surgical facilities). In the case of denial, the CON holder shall provide a statement for the reasons for the denial. CDCR § 22-4408.

REPORTING REQUIREMENTS:
Each CON holder must submit an annual report to the SHPDA in order for the SHPDA to determine whether it is in compliance with its uncompensated care requirements. CDCR § 22-4410.

Each CON holder must also maintain records of the uncompensated care provided. These documents are available for public inspection. CDCR § 22-4411.

PENALTIES FOR NONCOMPLIANCE:
If a CON holder does not meet its annual compliance level, it must make up the deficit within the next three years. CDCR § 22-4404.3. If the CON holder exceeds its compliance level, it may use the excess to reduce its compliance level in a subsequent year. CDCR § 22-4404.15.

OTHER:
Any person may file a complaint with the SHPDA director that a CON holder is not complying with its uncompensated care requirements or that its allocation plan does not meet community needs. CDCR § 22-4412.1. If the Director finds that the CON holder is not in compliance, the Director may withdraw the CON. CDCR § 22-4413.1.

FLORIDA

FREE CARE CITATION:
Florida Statutes § 154.301, et. seq.
Florida Health Care Responsibility Act

Florida Statutes § 409.2673
Shared County and State Health Care Program for Low-Income Persons

TERMINOLOGY:
Charity Care/ Indigent patient

REGULATORY OVERSIGHT:
Agency for Health Care Administration

DEFINITIONS AND DISTINCTIONS: N/A

FREE CARE AS A COMMUNITY BENEFIT: N/A

ELIGIBILITY REQUIREMENTS:
Average family income, for the preceding 12 months, that is below 100% of the federal nonfarm poverty level; not eligible to participate in any other government program; has no private insurance or has inadequate private insurance; does not reside in a public institution. Fla. Stat. § 154.304(9).

Agency charged with adopting statewide eligibility rules; rules must be uniform statewide. Fla. Stat. § 154.308(1). But, counties may establish thresholds of financial eligibility which are less restrictive than 100% of the federal poverty line (may not establish more restrictive thresholds) Fla. Stat. § 154.308(5). Determination may be made either prior to or following admission to the hospital, but must be made within 60 days of the request. Fla. Stat. § 154.308(2), (3).

There is a spend down program for people who would otherwise qualify as indigent patients but whose average family income for the past twelve months is between 100% and 150% of the federal poverty level. Fla. Stat. § 154.308(6).

The Agency is also charged with adopting rules for determining residence. Fla. Stat. § 154.309.

FINANCING SOURCE:
Places the financial obligation of care for "qualified indigent patients" on the county where the patient resides. Counties must reimburse hospitals and provide indigent eligibility determination procedures and resident certification determination procedures. Fla. Stat. §§ 154.302; 154.306.

Each hospital has a "charity care obligation" which must be provided before the hospital is eligible to be reimbursed by a county. The amount is the ratio of uncompensated charity care

days compared to total acute care inpatient days, which shall be equal to or greater than 2%. Fla. Stat. § 154.304(4).

A county's financial obligation for each certified resident shall not exceed 45 days at a rate of payment equivalent to 100% of the per diem reimbursement rate currently in effect under Medicaid. Hospitals are permitted to negotiate a higher or lower per diem rate with the county. Fla. Stat. § 154.306(1).

By March 1 of each year, the Agency must calculate and notify each county of the maximum amount it may be required to pay (population of county multiplied by $4 per capita). The maximum amount a county may be required to pay to out-of-county hospitals may be reduced by up to one-half if the amount not paid is being spent on in-county hospital care for qualified indigent patients. Fla. Stat. §154.306(1).

There is also a state program, where both the state and the county reimburse the hospital for inpatient care and outpatient care, if the county chooses. Fla. Stat. § 409.2673(2). The state's portion of reimbursement comes from the Public Medical Assistance Trust Fund. Fla. Stat. § 409.2673(6)(c). This Fund is partly financed through annual assessment on hospitals. See Fla. Stat. § 395.701(2).

SERVICES COVERED:
No county is required to reimburse an out-of-county hospital for any elective or nonemergency care that the patient could have received at a hospital in the county. Fla. Stat. § 154.306(2).

NOTIFICATION REQUIREMENTS: N/A

APPLICATION PROCESS: N/A

GRIEVANCE/APPEAL PROCESS: N/A

REPORTING REQUIREMENTS:
Each county must certify to the Agency at the end of the fiscal year the amount of reimbursement it paid to all out-of-county hospitals. Fla. Stat. § 154.306(1).

PENALTIES FOR NONCOMPLIANCE: N/A

OTHER:
Fla. Statute §408.036, which was enacted in 2003, creates an exemption from the certificate of need process for certain hospitals that are establishing adult open-heart surgery programs. To qualify for the exemption, hospitals must satisfy certain criteria, including one that the applicant hospital's payor mix "at a minimum reflects the community average for Medicaid, charity care, and self-pay patients or the applicant must certify that it will provide a minimum of 5 percent of Medicaid, charity care, and self-pay to open-heart surgery patients."

GEORGIA

FREE CARE CITATION:
Official Code of Georgia § 31-8-1, et. seq.
Hospital Care for the Indigent Program

TERMINOLOGY:
Indigent

REGULATORY OVERSIGHT:
Department of Human Resources

DEFINITIONS AND DISTINCTIONS: N/A

FREE CARE AS A COMMUNITY BENEFIT: N/A

ELIGIBILITY REQUIREMENTS:
A person who is "financially unable to meet the full cost of hospital care as prescribed or ordered by a physician." A person must be certified as "indigent" by the governing authority of that person's county of residence. If the governing authority does not certify the person as indigent within five days after its next meeting, the person remains responsible for the care received at the hospital. O.C.G.A. § 31-8-2(1).

Person must have resided in Georgia for at least six months and hospital care is not available under any other program. The six months' residency requirement may be waived if a physician certifies that the illness is an emergency. O.C.G.A. §§ 31-8-2(6); 31-8-7.

The Commissioner of Human Resources must adopt a state-wide standard for determining indigency. Each county must designate a person as the Health Care Advisory Officer for the county. This person designates individuals as eligible for indigent hospital care based on the standards issued by the Commissioner and must maintain a file of these determinations. When a non-county resident patient claims indigency following hospital care, the Health Care Advisory Officer of the patient's county of residence makes the determination. If the Health Care Advisory Officer fails to respond within 30 days, the county of residence becomes responsible for payment.. O.C.G.A. § 31-8-32.

FINANCING SOURCE:
State funds are used to assist counties in providing hospital care for indigent residents. The Department is charged with creating a graduated matching formula for the disbursement of state funds. Under this formula, the state contribution cannot be more than $1 per capita based on the latest federal census data. The Department may also establish a set amount of state funds to cover indigent hospital care, as long as any unexpended state funds are reallocated by the Department according to the matching formula. O.C.G.A. § 31-8-3.

The Nonresident Indigent Health Care Fund is used for financing care provided outside the patient's county of residence. O.C.G.A. §§ 31-8-33; 31-8-35.

There is also an Indigent Care Trust Fund which is administered by the Department of Community Health. O.C.G.A. § 31-8-151. Monies in this fund may be appropriated for the following purposes: 1) to expand Medicaid eligibility and services; 2) for programs to support rural and health care providers, primarily hospitals, who serve the medically indigent; 3) for primary health care programs for medically indigent citizens; or 4) any combination of the above. O.C.G.A. § 31-8-154.

SERVICES COVERED: N/A

NOTIFICATION REQUIREMENTS: N/A

APPLICATION PROCESS: N/A

GRIEVANCE/APPEAL PROCESS: N/A

REPORTING REQUIREMENTS:
By April 1 of each year, the governing authority of each county participating in this program must submit a budget to the Department that contains an estimate and supporting data for the costs of indigent hospital care in that county. O.C.G.A. § 31-8-5.

Each hospital must maintain records of the cost of care for non-county resident indigent patients and report these costs to the Commissioner quarterly. O.C.G.A. § 31-8-34.

PENALTIES FOR NONCOMPLIANCE: N/A

OTHER:
Hospitals and counties elect to participate in the Indigent Care Program. O.C.G.A. §§ 31-8-2(2)(3); 31-8-4.

HAWAII

There is no reference to free care in statutes or regulations.

FREE CARE CITATION: N/A

TERMINOLOGY:
Indigent care

REGULATORY OVERSIGHT:
Department of Human Services charged with "assistance and care of the indigent and medically indigent." HRS § 26-14.

DEFINITIONS AND DISTINCTIONS: N/A

FREE CARE AS A COMMUNITY BENEFIT: N/A

ELIGIBILITY REQUIREMENTS: N/A

FINANCING SOURCE: N/A

NOTIFICATION REQUIREMENTS: N/A

APPLICATION PROCESS: N/A

SERVICES COVERED: N/A

GRIEVANCE/APPEAL PROCESS: N/A

REPORTING REQUIREMENTS: N/A

PENALTIES FOR NONCOMPLIANCE: N/A

OTHER:
There is a reference in an act relating to the 2001 budget to an appropriation of funds to the Department of Human Services "to finance the cost of outpatient, acute hospital, or long-term care of indigents or medical indigents in designated Hawaii health systems corporation critical access hospitals" when the Department has also obtained matching federal funds.

This same bill also provides that: The Department may provide outpatient, hospital, and skilled nursing home care of indigents or medical indigents and pay the Department of Health for such care. With the approval of the director of finance, the Department of Health may deposit part of

these payments into the appropriations referenced above, provided that the director of finance submit a report on the transactions twenty days prior to the 2002 and 2003 regular sessions.

2001 Hi.Act 259; approved by the Governor on June 22, 2001.

Indigent patients and medically indigent patients may be required to get treatment at Hawaii State Hospital. The regs. discuss a billing system for the hospital for these patients (last updated in 1986). Indigent is defined as "a person without adequate and proper means of subsistence." Medically indigent is defined as "a person otherwise able to subsist himself, but who in the emergency of sickness is not able to care for the extra expenses necessary to maintain or restore health." Both definitions refer to other sections for more detailed explanations; however, these later sections were repealed. *See* WCHR 11-174-2. Indigent patients who are eligible for public assistance do not have to pay for their care. A medically indigent patient whose income level and other assets would qualify him or her for medical assistance (as defined by the repealed section) is also not liable for any costs of hospitalization. WCHR 11-174-7.

This section of the regs. also contains a worksheet for calculating patient's financial obligation based on assets, income, and dependents, etc.

IDAHO

FREE CARE CITATION:
Idaho Code § 31-3501, et. seq.
Hospitals for Indigent Sick

TERMINOLOGY:
Indigent

REGULATORY OVERSIGHT:
Counties and state Catastrophic Health Care Costs Program (CHCCP). Idaho Code §§ 31-3501; 31-3503; 31-3517. The counties are responsible for the first $10,000 spent over a twelve month period. The remainder is paid by the CHCCP. Idaho Code §§ 31-3503(1); 31-3503A(1).

DEFINITIONS AND DISTINCTIONS: N/A

FREE CARE AS A COMMUNITY BENEFIT: N/A

ELIGIBILITY REQUIREMENTS:
"Medically indigent" means a person in need of "necessary medical services… who does not have income and other resources available to him from whatever source sufficient to pay for necessary medical services." Idaho Code § 31-3502(1).

"Resources means all property, whether tangible or intangible, real or personal, liquid or no liquid, including, but not limited to, all forms of public assistance, crime victim's compensation, worker's compensation, veterans benefits, Medicaid, Medicare and any other property from any source for which an applicant and/or obligated person may be eligible or in which he or she may have an interest. Resources shall include the ability of an applicant and obligated persons to pay for necessary medical services over a period of up to three years." Resources does not include the value of the homestead on the applicant's residence, a burial plot, and exemptions allowed by county resolution. Idaho Code § 31-3502(17).

FINANCING SOURCE: N/A

SERVICES COVERED:
"Necessary medical services" a medical service "required in order to identify or treat a medically indigent person's health condition, illness or injury and is:

(a) consistent with the symptoms, diagnosis or treatment of the medical indigent's condition, illness, or injury;
(b) in accordance with generally accepted standards of medical or surgical practice…
(c) furnished on an outpatient basis whenever it is safe.. to do so;
(d) not provided primarily for the convenience of the medically indigent person or the provider;

(e) the standard, most economical service or item that can safely, reasonably and ethically be provided."

Idaho Code § 31-3502(18).

Does not include the following: bone marrow transplants; organ transplants; elective, cosmetic and/or experimental procedures; services related to, or provided by, residential and/or shelter care facilities; normal, uncomplicated pregnancies, excluding caesarean section, and childbirth well-baby care; Medicare copayments and deductibles; and services provided by, or available to an applicant from state, federal and local health programs. Idaho Code § 31-3502(18).

Each county board may adopt additional services to be covered; however, the county (and not the CHCCP) will be responsible for payment of these extra services. Idaho Code § 31-3502(18).

NOTIFICATION REQUIREMENTS: N/A

APPLICATION PROCESS:

An applicant requesting assistance under this chapter must complete a written application. Upon application for financial assistance under this chapter, an automatic lien attaches to all real and personal property of the applicant, on insurance benefits to which the applicant may become entitled, and to any additional resources to which it may legally attach. Idaho Code §31-3504.

An application for non-emergency necessary services shall be filed at least ten days before receiving services from the provider. An application for emergency necessary services shall be made within 31 days beginning with the first day of the provision of necessary medical services from the provider or the first day of hospital admission. Idaho Code § 31-3505.

The clerk interviews the client and investigates the information on the application. The clerk has 20 days to complete the investigation in the case of non-emergency services, and 45 days in the case of emergency services. The clerk files his/her findings with the county board. Idaho Code § 31-3505A. The board approves an application if it determines that necessary medical services have been or will be provided to a medically indigent person in accordance with this chapter; provided, the amount paid by the county shall not exceed $10,000 per applicant for any consecutive twelve month period. Idaho Code § 31-3505B. The board must make an initial decision on an application within 15 days from receipt of the clerk's statement and within 5 days from receiving the clerk's statement on a request. Idaho Code § 31-3505C. If the board fails to act upon an application within the time periods required, the application is deemed approved. Idaho Code § 31-3511(4).

GRIEVANCE/APPEAL PROCESS:

An applicant or provider may appeal an adverse initial determination of the board by filing a written notice of appeal with the board within 28 days of the date of the initial determination. If no appeal is filed, the initial determination becomes final. Idaho Code § 31-3505D.

The board must hold a hearing on an appeal within 75 days of receiving notice of the appeal and the board must make a final determination within 30 days of the conclusion of the hearing.

Idaho Code § 31-3505E. If the board denies the application, the applicant may seek judicial review. Idaho Code § 31-3505G.

If a county determines that a service is not a necessary medical service, a provider may submit the issue to a panel for arbitration. The arbitration panel consists of three doctors with expertise in the condition treated (one appointed by the provider, one appointed by the board, and one appointed by the first two doctors). The panel must submit a decision within 30 days and there is no judicial review or other appeal of the decision. Idaho Code § 31-3505F.

REPORTING REQUIREMENTS:
The Catastrophic Health Care Costs Program may require annual reports from each county and each hospital and provider. The reports from counties may contain (but are not limited to) the following information: case number for each applicant and date services began, age, residence, sex, diagnosis, income, family size, amount of costs, approval or denial, and reasons for denial. The reports from hospitals may contain (but are not limited to) the following information: 990 tax forms, cost of charges for charitable care, and administrative and legal costs incurred while processing claims under this chapter. Idaho Code § 31-3503A(2).

PENALTIES FOR NONCOMPLIANCE: N/A

OTHER:
When an applicant receives assistance under the chapter, the applicant may become obligated to reimburse the county or the catastrophic health care costs program for a reasonable portion of the assistance over a reasonable period of time. If the applicant believes the reimbursement amount or rate is excessive, he/she may seek judicial review. Idaho Code § 31-3510A.

ILLINOIS

FREE CARE CITATION:
Illinois appears to recognize "free care" and "charity care," but there was no explicit policy in the statutes or the regulations other than what is listed below.

TERMINOLOGY:
Charity Care

REGULATORY OVERSIGHT: N/A

DEFINITIONS AND DISTINCTIONS:
Charity care deductions are defined as "the aggregate of the accounts written off when it is determined that a patient is unable to pay. Charity care results from the facility's policy to provide health care services free of charge to individuals who meet certain financial criteria."

It does not include costs associated with community benefits or other non-patient related services and is distinguished from bad debt.

See 77 Ill. Adm. Code 2510. Appx. A (2001); *see also* 77 Ill. Adm. Code 2550 Appx. A (2001) for a sample worksheet.

FREE CARE AS A COMMUNITY BENEFIT: No

ELIGIBILITY REQUIREMENTS: N/A

FINANCING SOURCE: N/A

SERVICES COVERED: N/A

NOTIFICATION REQUIREMENTS: N/A

APPLICATION PROCESS: N/A

GRIEVANCE/APPEAL PROCESS: N/A

REPORTING REQUIREMENTS:
The Illinois Health Care Cost Containment Council requires hospitals to submit annual financial data reports. Charity Care is listed as a deduction from revenue. See 77 Ill. Adm. Code 2510. Appx. A (2001); see also 77 Ill. Adm. Code 2550 Appx. A (2001) for a sample worksheet.

PENALTIES FOR NONCOMPLIANCE: N/A

OTHER:
A section in the statutes about the University of Illinois talks about "care to indigent patients." – "For each dollar of expense incurred by the University of Illinois in providing unreimbursed health care to indigent patients, the State shall reduce the amount of the University's repayment obligation to the State by one dollar." 110 ILCS 330/4.

INDIANA

Indiana's original program, Hospital Care for the Indigent was implemented in 1992. This year, it is being replaced by a new program called the Uninsured Parents Program, which is actually part of Medicaid. The Hospital Care for the Indigent program is being repealed on July 1, 2002, at which time the Uninsured Parents Program should be ready to be implemented. In the case that the new program is not or if it is terminated prior to July 1, 2003, the legislature also drafted alternate legislation governing the Hospital Care for the Indigent Program to then be implemented (although there are minimal changes from the original). See Ind. Code § 12-16.1-1-1. So, with the expiration of Hospital Care for the Indigent, it appears that Indiana's free care laws will also expire.

FREE CARE CITATION:

Ind. Code § 12-16-2-1, et. seq.
Hospital Care for the Indigent (expires July 1, 2002)

Ind. Code § 12-16.1-1-1, et seq.
Hospital Care for the Indigent (effective July 1, 2003)
Citations and changes are noted in **bold**.

TERMINOLOGY:

Indigent

REGULATORY OVERSIGHT:

The Division of Family and Children. Ind. Code § 12-16-2-1; see also § 12-7-2-69.

DEFINITIONS AND DISTINCTIONS: N/A

FREE CARE AS A COMMUNITY BENEFIT: N/A

ELIGIBILITY REQUIREMENTS:

The Division of Family and Children is charged with setting rules for income and eligibility requirements. The rules should be adjusted at least once every two years. Ind. Code § 12-16-3-3. **§ 12-16.1-3-3.**

Neither the Division of Family and Children nor the county is responsible for payment of care for illegal aliens. Ind. Code § 12-16-7-7; **12-16.1-7-7.**

FINANCING SOURCE:

Hospitals are reimbursed by the counties and the Division of Family and Children for the care they provide to indigent patients. In order to receive reimbursement, the hospital must file an application with the county in which it is located no more than 30 days after the patient has been admitted. Ind. Code §§ 12-16-4-1; 12-16-4-2; 12-16-6-5; 12-16-7-1; **12-16.1-4-1; 12-16.1-4-2; 12-16.1-6-5; 12-16.1-7-1.** The Division reimburses the

hospital for emergency care, while the county reimburses the hospital for care received at a county-owned health and hospital corporation. Ind. Code § 12-16-12-2; 12-16-12-5; **12-16.1-11-2; 12-16.1-11-5;** See also § 16-22-8-6 for definition of health and hospital corporation.

The Division of Family and Children pays 2/3 of each approved claim out of the state hospital care for the indigent fund. If there is not enough money in the fund to cover the payment, the Division and the county are limited to the sum of the following: (1) The amount transferred to the state hospital care for the indigent fund from county hospital care for the indigent funds in that year under IC 12-16-14. (2) Any contribution to the fund in that year. (3) Any amount that was appropriated to the state hospital care for the indigent fund for that year by the general assembly. (4) Any amount that was carried over to the state hospital care for the indigent fund from a preceding year. Ind. Code § 12-16-7-4; **12-16.1-7-4 (cite in part (1) changed to 12-16.1-13).**

Before the end of each state fiscal year, the Division shall, to the extent there is money in the state hospital care for the indigent fund, pay each provider a pro rata part of the 1/3 balance on each approved claim for patients admitted during the preceding year. Ind. Code § 12-16-7-5; **12-16.1-7-5.**

Disproportionate share hospitals receive a payment adjustment of 20% for each service. Ind. Code § 12-16-8-2.; 12-16-8-5. **This payment adjustment is not in the new statutes; however, patient days under the hospital care for the indigent program are included in calculating allowable disproportionate share additional payments under 42 U.S.C. 1395ww(d). Ind. Code § 12-16.1-2-4.**

Each county has a hospital care for the indigent fund, consisting of the following: (1) A tax levy on the property located in each county. (2) The financial institutions tax (IC 6-5.5), motor vehicle excise taxes (IC 6-6-5), and commercial vehicle excise taxes (IC 6-6-5.5) that are allocated to the fund. Ind. Code § 12-16-14-1. **Under the new statutes, the state board of tax commissioners will review and enforce each county's property tax levy as outlined above. Ind. Code § 12-16.1-13-1.** Before the fifth day of each month, all monies remaining in the county hospital care for the indigent funds, must be transferred to the state hospital care for the indigent fund. Ind. Code § 12-16-14-6; **12-16.1-13-3. If the state hospital care for the indigent fund is closed (see below), than a new fund will be created. Ind. Code § 12-16.1-13-3**.

On July 1, 2002, all funds remaining in a county hospital indigent care fund will be transferred to the state fund. Ind. Code § 12-16-14.1-1. The state fund will close upon the earlier of: the payment of all funds in the fund, or the payment of all claims for services before July 1, 2002. Ind. Code § 12-16-14.1-2.

SERVICES COVERED: N/A

NOTIFICATION REQUIREMENTS:

If the hospital has reason to believe that the patient is indigent, or if the patient requests information, the hospital must inform the patient of the eligibility and benefit standards for the Hospital Care For the Indigent program. Ind. Code § 12-16-3-4.; **§ 12-16.1-3-4.**

APPLICATION PROCESS:
A hospital or physician may assist a patient in completing an application for hospital indigent care. Ind. Code § 12-16-4-5; **12-16.1-4-5.**

GRIEVANCE/APPEAL PROCESS:
The Division may deny coverage if it cannot confirm eligibility. Ind. Code § 12-16-5-3; **12-16.1-5-3.** Upon making a decision, the Division must notify the patient and the hospital. If the decision is denied, the notice must contain the reason for the denial and information about appealing the decision. Ind. Code § 12-16-5-4; **12-16.1-5-4.** The patient has 90 days after the decision was mailed to appeal a denial. Ind. Code § 12-16-6-1; **12-16.1-6-1**. The appeal will consist of a hearing before a hearing officer. Ind. Code § 12-16-6-3; **12-16.1-6-3.** The Division is charged with developing rules for the hearing. Ind. Code § 12-16-6-7; **12-16.1-6-7.** If the Division fails to make a decision within 45 days of receiving an application, or if it refuses to reimburse the hospital, the applicant may appeal no more than 90 days after receipt of the application. Ind. Code § 12-16-6-2; **12-16.1-6-2.**

REPORTING REQUIREMENTS:
The Division is charged with adopting rules for establishing a statewide collection of data regarding the hospital care for the indigent program. The rules should include patient demographics; types of services; and costs. Ind. Code § 12-16-10-4; **12-16.1-9-4.**

PENALTIES FOR NONCOMPLIANCE: N/A

OTHER:

IOWA

FREE CARE CITATION:
Iowa Code § 347.16 – Treatment in County Hospitals

Iowa Code § 135.24 – Volunteer Health Care Provider Program

TERMINOLOGY:
Free care

REGULATORY OVERSIGHT:
None for county program – run by hospital board of trustees. Department of Public Health runs the Volunteer Health Care Provider Program. Iowa Code § 135.24(2).

DEFINITIONS AND DISTINCTIONS: N/A

FREE CARE AS A COMMUNITY BENEFIT: N/A

ELIGIBILITY REQUIREMENTS:
To be determined by the board of hospital trustees (of a county hospital) or the board may delegate the determination to the general assistance director or the office of the department of human services in the county. Iowa Code § 347.16(2).

Must be "indigent" for free care in a county hospital and reside in the county where the hospital is located. Iowa Code § 347.16(2).

FINANCING SOURCE:
If free care is provided to an indigent patient who does not live in the county where the hospital is located, the county in which that person has legal settlement shall pay to the board of hospital trustees the fair and reasonable cost of the care and treatment provided by the county public hospital. Iowa Code § 347.16(3).

SERVICES COVERED:
Volunteer Health Care Provider Program may include, but is not limited to, obstetrical and gynecological services and psychiatric services. Iowa Code § 135.24(2)(c); see 2001 Ia. HF 755 sec. 31.

NOTIFICATION REQUIREMENTS: N/A

APPLICATION PROCESS: N/A

GRIEVANCE/APPEAL PROCESS: N/A

REPORTING REQUIREMENTS: N/A

PENALTIES FOR NONCOMPLIANCE: N/A

OTHER:

Under the volunteer Health Care Provider Program, providers are encouraged to offer free medical and dental services on a voluntary basis. A health care provider participating in this program is treated as a state employee and afforded liability protection as an employee of the state, so long as the provider has registered with the Department of Public Health and provided services with an eligible hospital, clinic, etc. Iowa Code § 135.24

KANSAS

FREE CARE CITATION:
Kansas Administrative Regulations § 28-53-1, et. seq.
Charitable Health Care Providers

TERMINOLOGY:
Indigent

REGULATORY OVERSIGHT:
Department of Health and Environment

DEFINITIONS AND DISTINCTIONS: N/A

FREE CARE AS A COMMUNITY BENEFIT: N/A

ELIGIBILITY REQUIREMENTS:
Persons shall qualify as medically indigent if they are:

(a) determined to be a member of a family unit earning at or below 200% of poverty income guidelines…;
(b) not indemnified against costs arising from medical and hospital care by a policy of accident and sickness insurance, an employee benefits plan, a program administered by the state or federal government, or any such coverage; and
(c) seeking health care at: (1) an indigent health care clinic; (2) a federally qualified health center; or (3) a participating local health department.

K.A.R. § 28-53-3.

FINANCING SOURCE: N/A

SERVICES COVERED: N/A

NOTIFICATION REQUIREMENTS: N/A

APPLICATION PROCESS: N/A

GRIEVANCE/APPEAL PROCESS: N/A

REPORTING REQUIREMENTS:
Providers that participate in the program must maintain completed forms (signed by the patient) certifying that the patient is medically indigent. Providers must also submit quarterly activity reports to the Department. K.A.R. § 28-53-4.

PENALTIES FOR NONCOMPLIANCE: N/A

OTHER:
Medically indigent patients may receive referrals for care in other locations as long as the referral comes from a federally qualified health center, an indigent health care clinic, or a participating local health department. K.A.R. § 28-53-5.

Section seems only to apply to "charitable health care providers," yet they are never defined.

KENTUCKY

Statutory provisions related to free care are found in the Medicaid. It refers to a disproportionate share hospital program that is to be consistent with the requirements of Title XIX. It appears to provide for a free care program where hospitals are compensated for treating patients who are unable to pay for their own care and do not have insurance.

FREE CARE CITATION:

KRS § 205.40
Medical Assistance Revolving Trust Fund

TERMINOLOGY:

Indigent or uncompensated care

REGULATORY OVERSIGHT:

Department of Medicaid Services and Cabinet for Health Services

DEFINITIONS AND DISTINCTIONS: N/A

FREE CARE AS A COMMUNITY BENEFIT: N/A

ELIGIBILITY REQUIREMENTS:

Individuals and families with total annual incomes and resources up to 100% of the federal poverty level. KRS § 205.640(3)(b). Individuals who are eligible for medical assistance (Medicaid) or the Kentucky Children's Health Insurance Program do not qualify for reimbursement under these sections. K.R.S. § 205.640(5).

FINANCING SOURCE:

Beginning in fiscal year 2000-2001, provider tax revenues and state and federal matching funds are used to fund the disproportionate share program. The funds are divided into three pools for distribution:

1) 43.92% to acute care hospitals,
2) 37% to university hospitals, and
3) 19.08% to private psychiatric hospitals and state mental hospitals.

KRS § 205.640(3)(a).

The department must calculate an indigent care factor for each hospital annually – percentage of hospital's annual indigent care costs toward the sum of the total annual indigent care costs for all hospitals within each of the above pools. Indigent care costs are defined as the hospital's inpatient and outpatient care multiplied by the hospital's

Medicaid rate(or a rate determined by the department in regulations). K.R.S. § 205.640(3)(d)(1).

The hospital's indigent care factor is multiplied by the total fund allocated to all hospitals within the respective pool in order to determine the hospital's annual distribution. K.R.S. § 205.640(3)(d)(2).

By September 1 of each year, the department shall calculate a preliminary indigent care factor and preliminary annual payment for each hospital and notify the hospital of these figures. Any adjustments should be made by October 1. K.R.S. § 205.640(3)(d)(2)(c).

The Department issues one lump-sum payment on October 15, or later, as soon as federal financial participation becomes available for the disproportionate share funds available during the corresponding federal fiscal year. K.R.S. § 205.640(3)(e). Total annual disproportionate share payments shall be equal to the maximum amount of disproportionate share payments established under the Federal Balanced Budget Act of 1997. They shall also be subject to the availability of adequate state matching funds and not exceed total uncompensated costs. K.R.S. § 205.640(4).

NOTIFICATION REQUIREMENTS:
All hospitals receiving reimbursement under this section shall display a prominent sign which reads "This hospital will accept patients regardless of race, creed, ethnic background, or ability to pay." K.R.S. § 250.640(7).

APPLICATION PROCESS:
Hospitals shall determine whether an individual qualifies for any other state sponsored program. Hospitals may not bill for services provided to patients not eligible for medical assistance with family incomes up to 100% of the federal poverty level. K.R.S. § 250.640(5).

SERVICES COVERED: N/A

GRIEVANCE/APPEAL PROCESS: N/A

REPORTING REQUIREMENTS:
Hospitals must report quarterly the level of uncompensated care they are provided to eligible individuals. These figures are used to calculate the hospital's indigent care factor. K.R.S. § 205.640(3)(d)(2)(a),(b).

PENALTIES FOR NONCOMPLIANCE: N/A

OTHER:

LOUISIANA

FREE CARE CITATION:
Louisiana Revised Statutes 46:4 – 46:7
Charity Hospitals

Louisiana Revised Statutes 40:2196, et. seq.
Community Indigent Health Care Program

TERMINOLOGY:
Indigent

REGULATORY OVERSIGHT:
Department of Health and Hospitals. La. R.S. 46:6(C); La. R.S. 40:2196.2.

DEFINITIONS AND DISTINCTIONS: N/A

FREE CARE AS A COMMUNITY BENEFIT: N/A

ELIGIBILITY REQUIREMENTS:
A resident of Louisiana whose income is below 185% of the federal poverty level. La. R.S. 40:2196.1(4).

Any resident of Louisiana who is found to be medically indigent or medically needy is eligible for admittance to any state-owned hospital. Those patients who are found not to be medically indigent or needy are charged a minimum fee of $3.50 for any treatment or services; they are also charged on a sliding-scale according to the service provided and the financial status of the patient and the size of the family for which the person is responsible. La, R.S. 46:6(A).

FINANCING SOURCE:
"Police juries" may appropriate annually and use from parish funds no more than $1,000 to aid charity hospitals or other institutions who treat indigent patients without cost. La. R.S. 46:4.

Another section allows the police juries to appropriate up to $300 to aid charity hospitals or other similar institutions of adjoining states that treat indigent patients of the parish without cost. La. R.S. 46:5.

SERVICES COVERED:
The Community Indigent Health Care Program's purpose is to expand health and medical resources and to expand primary and preventive care services to low-income persons. It is implemented as a program of grants and contracts. La. R.S. 40:2196.2. The program

is not to be used to subsidize inpatient care. La. R.S. 40:2196.3(B). Grants will be awarded in amounts up to $50,000 annually. La. R.S. 40:2196.5.

Primary health care for the Community Indigent Health Care Program is defined as:

(a) Services of physicians and, where feasible, services of physician's assistants and nurse clinicians.
(b) Diagnostic laboratory and radiologic services.
(c) Preventive health services, including children's eye and ear examinations to determine the need for vision and hearing corrections, perinatal services, well child services, and family planning services.
(d) Emergency medical services.
(e) Transportation services as required for adequate patient care.
(f) Preventive dental services.
(g) Pharmaceutical services as may be appropriate for particular centers.
(h) Chiropractic services.
(i) Podiatric services.

La. R.S. 40:2196.1(5).

NOTIFICATION REQUIREMENTS: N/A

APPLICATION PROCESS: N/A

GRIEVANCE/APPEAL PROCESS: N/A

HOSPITAL REPORTING REQUIREMENTS: N/A

PENALTIES FOR NONCOMPLIANCE: N/A

OTHER:
The Community Indigent Health Care Program will become effective when funds are made available for it. No state funds may be used towards it. La. R.S. 40:2196.7. (Not clear whether it has ever been implemented).

MAINE

FREE CARE CITATION:
Code of Maine Regulations 10-144-150
Hospital Finance Rules

22 Maine Revised Statutes § 1716
Charity Care Guidelines
Enabling legislation

"No hospital shall deny services to any Maine resident solely because of the inability of the individual to pay for those services. Every hospital shall adopt and adhere to a free care policy that provides for a determination of inability to pay, defines the service to be provided as free care, and takes into account other sources of payment for care…" CMR 10-144-150(1.01)(A). Hospitals may implement free care policies that are broader in scope than those outlined in the regulations. CMR 10-144-150(1.01)(B).

TERMINOLOGY:
Free Care

REGULATORY OVERSIGHT:
Department of Human Services

DEFINITIONS AND DISTINCTIONS:
"Free care means service provided without expectation of payment from or on behalf of the individual receiving the hospital services." CMR 10-144-150(1.01)(C).

Definitions section distinguishes free care from bad debt:

"Bad debts is the amount of hospital revenue deduction, less any payments received for patient care, which is expected to be attributable to patients who, after reasonable collection efforts, are determined to have uncollectable accounts."

"Charity care is defined as the amount of revenue, less any payments received for patient care, which is expected to be written off as a result of a determination that the patient is unable to pay for the hospital services received."
CMR 10-144-150 Section 10: Definitions.

FREE CARE AS A COMMUNITY BENEFIT: N/A

ELIGIBILITY REQUIREMENTS:
A person is considered unable to pay for services when that person's family income is equal to or below 100% of the federal poverty guidelines. Family income is calculated as follows:

(1) multiplying by four the person's family income for the three month's preceding the determination of eligibility, or
(2) using the person's actual family income for the past 12 months.

CMR 10-144-150(1.02).

A hospital determines eligibility as follows:

(a) if the person meets the income guidelines specified above;
(b) if the person is not covered by any insurance or covered by state or federal medical assistance programs;
(c) the services received were medically necessary.

If the person meets the income guidelines, but is either covered by insurance or receives state or federal medical assistance, that person is eligible for any amount remaining due after payment by the insurer or medical assistance program.
CMR 10-144-150(1.05)(B).

FINANCING SOURCE: N/A

SERVICES COVERED:
All medically necessary inpatient and outpatient hospital services. CMR 10-144-150(1.03).

NOTIFICATION REQUIREMENTS:
"Each hospital shall post notices of the availability of free care in locations within the hospital at which members of the public generally transact business with the hospital or present themselves to receive or request hospital services, including admitting areas, waiting rooms, business offices, and outpatient reception areas." CMR 10-144-150(1.04)(A).

In the case of inpatient services, hospitals shall provide individual written notice to each patient upon admission. In the case of outpatient services, hospitals shall either include notice of the free care policy with the patient's bill or provide a copy of the individual notice at the time service is provided. CMR 10-144-150(1.04)(B).

The posted and individual notices must state the following:

NOTICE

FREE MEDICAL CARE FOR THOSE UNABLE TO PAY

We must give free care to Maine people with income less than:

Size of Family Unit	Income Guidelines
1	$ 7,890
2	$ 10,610
3	$ 13,330
4	$ 16,050
5	$ 18,770

6	$ 21,490
7	$ 24,210
8	$ 26,930

Add $ 2,720 for each additional person

You can apply for free care at ___ [specific location where individuals may apply].

You will be asked if you have insurance of any kind to help pay for your care. You may also be asked to show that insurance or a government program will not pay for your care.

Only necessary medical care is given as free care.

If you do not qualify for free hospital care, you are allowed to ask for a fair hearing. We will tell you how to apply for a fair hearing.
CMR 10-144-150(1.04)(C).

APPLICATION PROCESS:
Each hospital shall provide applications for persons seeking free care. CMR 10-144-150(1.05)(A).

GRIEVANCE/APPEAL PROCESS:
Each hospital shall provide each applicant who is denied free care a written and dated statement explaining the reasons for the denial. CMR 10-144-150(1.05)(E).

The Department must offer a hearing to anyone who has been denied free care. Requests for a hearing must be made within 60 days of receiving the initial denial. Any person who is dissatisfied with the hearing determination may seek judicial review. CMR 10-144-150(1.10).

REPORTING REQUIREMENTS:
Each hospital must maintain records of the amount of free care it provides. If a hospital provides free care beyond what is required by law, it must maintain separate records of the amount of such care it provides. CMR 10-144-150(1.08)(A).

Each hospital must annually report to the Department a summary of the amount of free care that it provided under law, the amount of free care it provided that was beyond what is required by law, and the number of patients who received free care. CMR 10-144-150(1.08)(B).

Each hospital must file and maintain with the Department a current copy of its free care policy and the notice of that policy. CMR 10-144-150(1.09).

PENALTIES FOR NONCOMPLIANCE: N/A

OTHER:

MARYLAND

FREE CARE CITATION:
Code of Maryland Regulations 10.37.09.01, et. seq.
Fee Assessment for Financing Hospital Uncompensated Care

TERMINOLOGY:
Uncompensated Care

REGULATORY OVERSIGHT:
Department of Health and Mental Hygiene and the Health Services Cost Review Commission within the Department.

DEFINITIONS AND DISTINCTIONS:
Uncompensated Care is defined as "care provided for which compensation is not received (that is, any combination of bad debts and charity care)… COMAR 10.37.10.01. *Note: This definition comes from a different chapter in the regulations. There is no definition of uncompensated care in the chapter relating to financing hospital uncompensated care.*

In other sections, charity care is defined as "hospital care for which the costs are not reimbursed through any patient or third party." COMAR 10.09.47.01(B)(1).

FREE CARE AS A COMMUNITY BENEFIT: N/A

ELIGIBILITY REQUIREMENTS: N/A

FINANCING SOURCE:
Hospital Uncompensated Care Fund.

All acute general hospitals are assessed a fee to pay for the financing of the reasonable costs of hospital uncompensated care. The fee is paid monthly and the Commission notifies the hospitals of their assessment each month. The fee may not exceed 1.25% of the total gross operating revenue from each hospital. COMAR 10.37.09.02.

Under the Uncompensated Care Reduction Program, the Commission may issue a request for proposals for hospital-sponsored programs designed to reduce hospital uncompensated care. COMAR 10.37.09.05.

SERVICES COVERED: N/A

NOTIFICATION REQUIREMENTS: N/A

APPLICATION PROCESS: N/A

GRIEVANCE/APPEAL PROCESS: N/A

REPORTING REQUIREMENTS: N/A

PENALTIES FOR NONCOMPLIANCE:
Hospitals that fail to make a required payment may be charged a penalty of up to 5% of the amount of an underpayment. COMAR 10.37.09.06.

OTHER:
The Health Services Cost Review Commission may issue a request for proposals for hospital-sponsored applications for programs designed to reduce uncompensated care. COMAR 10.37.09.05.

Hospital administrator is charged with developing and implementing "a description of the provision of complete and partial charity care for indigent and Medicaid patients to promote access to all services regardless of an individual's ability to pay." COMAR 10.05.01.06.

MASSACHUSETTS

FREE CARE CITATION:
114.6 CMR 10.01, et. seq.
Free Care and Uncompensated Care Pool

TERMINOLOGY:
Free Care/Uncompensated Care Pool

REGULATORY OVERSIGHT:
Division of Health Care Finance and Policy

DEFINITIONS AND DISTINCTIONS:
Free care is defined as "unpaid hospital or community health center charges for medically necessary services which are eligible for reimbursement from the [Uncompensated Care] Pool…" 114.6 CMR 10.02.

Bad debt is defined as "an account receivable based on services furnished to any patient which:

(a) is regarded as uncollectible, following reasonable collection efforts…;
(b) is charged as a credit loss;
(c) is not the obligation of any federal or state governmental unit; and
(d) is not free care."

114.6 CMR 10.02.

Uncompensated care is defined as "the sum of reported net free care and net emergency bad debt." 114.6 CMR 11.02.

FREE CARE AS A COMMUNITY BENEFIT: N/A

ELIGIBILITY REQUIREMENTS:
There are four types of care which providers can bill the Uncompensated Care Pool – Full Free Care, Partial Free Care, Medical Hardship, and Emergency Bad Debt. Eligibility requirements for each are explained below:

In order to be eligible for **Full Free Care**, a patient must be a Massachusetts resident whose family income is equal to or less than 200% of the federal poverty income guidelines. A non-Massachusetts resident is eligible for full free care it that person received emergency care and has a family income equal to or less than 200% of the federal poverty income guidelines. 114.6 CMR 10.03(1).

A patient is eligible for **Partial Free Care**, if that person is a Massachusetts resident and has a family income from 201% to 400% of the federal poverty income guidelines. A non-Massachusetts resident is eligible for partial free care if that person received

emergency care and has a family income from 201% to 400% of the federal poverty income guidelines. 114.6 CMR 10.03(2)(a).

In the case of partial free care, the patient is responsible for a deductible equaling 40% of the difference between the patient's family income and 200% of the federal poverty income guidelines. The following formula is used to determine the deductible: [Family Income – (2 x Federal Poverty Income Guidelines)] x 40% = Annual Patient Deductible.
There is only one partial free care deductible per family per eligibility period. 114.6 CMR 10.03(2)(b).

A Massachusetts resident (or a nonresident receiving emergency care) at any income level may qualify for **Medical Hardship** if the medical expenses related to care have so depleted the family's income and resources that s/he is unable to pay for the care. In order to be eligible for medical hardship, the patient's medical expenses must exceed 30% of his or her family income and the patient's available assets are insufficient to cover the cost of the expenses that exceeds 30% of the family income. Available assets do not include the primary residence, the first motor vehicle, and the first $4,000 of other assets for an individual, or $6,000 for a family of two, etc. The patient's medical hardship contribution is calculated by adding 30% of the patient's family income to the patient's available assets. There is one medical hardship contribution per family per eligibility period. The patient is responsible for all expenses up to this contribution. The patient is eligible for free care for all medically necessary services in excess of the medical hardship contribution. 114.6 CMR 10.03(3).

In order to be eligible for **Emergency Bad Debt**, the patient must be uninsured for the services provided and received emergency care. At the same time, the hospital must establish that appropriate collection action was taken. 114.6 CMR 10.03(4).

Family Income is defined as "the sum of annual earnings and cash benefits from all sources before taxes, less payments made for alimony and child support." 114.6 CMR 10.02.

Medicare Bad Debt is also eligible for payment from the Pool to the extent that:

1. such charges are related to Medicare co-payments and deductibles or to medically necessary services that are not covered by Medicare;
2. such charges are for a patient who otherwise qualifies for free care;
3. such charges were properly submitted for payment to Medicare and were rejected; and
4. the hospital establishes that reasonable collection efforts were made.

114.6 CMR 10.04(4)(b).

FINANCING SOURCE:

Uncompensated Care Pool – hospitals, private third-party payers, and the state pay into the Pool, and the funds are then redistributed to hospitals and community health centers

(hereafter "providers") based on the amount of free care provided and reported at each institution.

A hospital's liability to the Pool is the product of:
(a) the ratio of its private sector charges to all hospitals' private sector charges; and
(b) total hospital liability to the Uncompensated Care Pool as determined by the General Court for each fiscal year.

114.6 CMR 11.04(2).

The Uncompensated Care Pool's gross liability to a hospital is determined by the following calculation:
Total Free Care Charges x Cost to Charge Ratio = Allowable Free Care Costs – Shortfall Allocation Amount = **Pool Liability to Hospitals**. 114.6 CMR 11.04(3).

The Cost to Charge Ratio is the sum of each hospital's inpatient reasonable costs and actual outpatient costs, divided by the hospital's gross patient service revenues. 114.6 CMR 11.04(4).

"Surcharge payers[1]" must pay a distinct surcharge that is deposited in the Pool for services provided by a hospital or ambulatory surgical center. 114.6 CMR 11.05.

SERVICES COVERED: N/A

NOTIFICATION REQUIREMENTS:
Providers must post conspicuous, easy to read signs in designated areas: the inpatient, clinic, emergency admissions/registration areas and in business office areas that are customarily used by patients. The signs must also tell patients where to apply for free care. 114.6 CMR 10.08(1)(a). The signs must be translated into languages that are spoken by 10% or more of the residents in the provider's service area. 114.6 CMR 10.08(1)(c).

APPLICATION PROCESS:
Before approving a patient for free care, providers must screen the patient for other sources of coverage and potential eligibility in government programs. However, a patient who declines to apply for another government program may apply, and if eligible, be approved for free care. 114.6 CMR 10.04(2). Providers must use the standard application form provided by the Division to determine eligibility. 114.6 CMR 10.04(3). The provider must document the process used to determine free care eligibility by completing the Facility Use Only section of each application. 114.6 CMR 10.04(3).

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[1] Surcharge payers are defined as: an individual or entity that:
(a) makes payments for the purchase of health care hospital services and ambulatory surgical center services; and
(b) meets the criteria set forth in these regulations.

114.6 CMR 11.02.

Providers must give the patient written notice of an eligibility determination within 30 days of receipt of a complete application. 114.6 CMR 10.04(5)(c); 114.6 CMR 10.08(3).

The patient is eligible for free care for one year from the date of the eligibility determination, unless over the course of that year, the patient's family income or insurance status changes to such an extent that the patient becomes ineligible. 114.6 CMR 10.04(5)(d).

If the patient is denied free care, a denial letter must be sent to the patient within 30 days. The letter must explain (among other things) why the patient is not eligible, how to apply for medical hardship, explain how to file a grievance. 114.6 CMR 10.08(3)(d).

GRIEVANCE/APPEAL PROCESS:

Any person aggrieved by a providers denial of free care may petition the Division by filing a complaint. The complaint may contain supporting documentation. After receiving a complaint, the Division will send a copy to the provider and ask for additional information. The provider has 30 days to answer the complaint in writing. When the Division has received all necessary information, it will review the complaint and answer and must issue a written decision within 30 days of receiving all necessary information. 114.6 CMR 10.07.

REPORTING REQUIREMENTS:

Providers must file their credit and collection policies with the Division. 114.6 CMR 10.09(1). Providers must also maintain auditable records of their free care activities, including documentation of free care accounts and free care applications. Providers that do not comply with the auditing requirements may be denied Pool payment. 114.6 CMR 10.10.

In order to facilitate administration of the Uncompensated Care Pool, providers must make their Uncompensated Care Pool patient level data available to the Division upon request. 114.6 CMR 11.03(1)(b).

Providers must use electronic free care application software that is provided by the Division to collect free care application data. The data must be submitted to the Division, at least monthly. 114.6 CMR 11.03(6)(a).

PENALTIES FOR NONCOMPLIANCE:

If a hospital does not pay its liability to the Pool by the due date, the Division will assess a 1.5% penalty on the outstanding balance. 114.6 CMR 11.04(8)(a). If a surcharge payer does not pay its surcharge payment to the Pool, the Division may impose an additional 1.5% interest penalty on the outstanding balance. 114.6 CMR 11.05(7)(a).

OTHER:

MICHIGAN

There are no direct provisions about a free care policy in either the Michigan statutes or regulations. The one statutory reference related to public hospitals.

FREE CARE CITATION:
Michigan Compiled Laws § 331.167

TERMINOLOGY:
Charity Care

REGULATORY OVERSIGHT:
Public Hospital Board of Trustees has the power to determine whether or not patients at the public hospital are "subjects for charity" and shall determine the level of compensation for care of any of these patients. MCL § 331.167

DEFINITIONS AND DISTINCTIONS: N/A

FREE CARE AS A COMMUNITY BENEFIT: N/A

ELIGIBILITY REQUIREMENTS: N/A

FINANCING SOURCE:
Any unpaid hospital services (that have been determined to be charity cases) are directed to the county treasurer who credits the hospital fund for payment. MCL § 331.167.

SERVICES COVERED: N/A

NOTIFICATION REQUIREMENTS: N/A

APPLICATION PROCESS: N/A

GRIEVANCE/APPEAL PROCESS: N/A

REPORTING REQUIREMENTS: N/A

PENALTIES FOR NONCOMPLIANCE: N/A

OTHER:

MINNESOTA

FREE CARE CITATION:
Minnesota Administrative Code 4650.0102, et. seq.
Hospital and Surgical Center Reporting

Minnesota Administrative Code 4651.0100, et. seq.
Health Care Provider Reporting

TERMINOLOGY:
Charity Care

REGULATORY OVERSIGHT:
Department of Health

DEFINITIONS AND DISTINCTIONS:
In the case of hospital and surgical centers, charity care "means the dollar amount that would have been charged for health care services that were provided with no expectation of cash inflows. Charity care results from a provider's policy to provide health care services free of charge or at a charge below the reasonable cost of the service to individuals who meet the provider's established criteria of inability to pay… Charity care is included in gross revenue from patient care and in adjustments and uncollectibles." Minn. R. 4650.0102 Subp. 9.

In the case of providers [doctors], charity care is defined as "the total amount of dollars written off for uninsured or underinsured individuals who cannot pay for total charges billed because of limited income or unusual circumstances." Minn. R. 4651.0100.

Charity care does not include the following:
1) contractual allowances – the difference between gross charges and payments received under contractual arrangements with insurance companies and payers;
2) bad debt;
3) underpayments for operating public programs;
4) unreimbursed costs of basic or clinical research or professional education and training;
5) professional courtesy discounts;
6) community service or outreach activities;
7) services for patients against whom collection actions were taken that resulted in a financial obligation documented on a patient's credit report.

Minn. R. 4650.0115, as adopted in 26 Minn. Reg. 627 (November 13, 2001).

FREE CARE AS A COMMUNITY BENEFIT:
No. Charity care does not include community service or outreach activities.
Minn. R. 4650.0115, as adopted in 26 Minn. Reg. 627 (November 13, 2001).

ELIGIBILITY REQUIREMENTS: N/A

FINANCING SOURCE:
Individuals, groups, foundations, government entities, and corporate donors may make donations and grants toward charity care. Minn. R. 4650.0102 Subp. 12b.

SERVICES COVERED: N/A

NOTIFICATION REQUIREMENTS: N/A

APPLICATION PROCESS: N/A

GRIEVANCE/APPEAL PROCESS: N/A

REPORTING REQUIREMENTS:
Hospitals must submit annual reports that include financial, utilization, and services information. Financial information must include: a) a statement of adjustments and uncollectibles by type of payer for charity care (both for inpatient and outpatient care); b) public funding for operations and donations and grants for charity care with estimates of the percentage received from private and public sources; c) a description of charity care policies and services provided, and a description of other benefits provided to the community, including unpaid public programs, nonbilled services, and other community services. Minn. R. 4650.0112.

Outpatient surgical centers must also submit annual reports. These reports must include a statement about adjustments and uncollectibles by type of payer, and for charity care, a description of charity care policies, including income guidelines, asset guidelines, medical assistance status impact, and sliding fee schedules, and a general description of the change in the demand for charity care to be provided in the budget year, and a general estimate of the change in the amount of charity the surgical center expects to provide in the budget year. Minn. R. 4650.0113.

In order for a facility to report on its charity care, it must have a policy on the provision of charity care that contains specific eligibility criteria and is made available to the public. Minn. R. 4650.0115, as adopted in 26 Minn. Reg. 627 (November 13, 2001).

Providers must also file annual financial reports with the Commissioner of the Department of Health. Minn. R. 4651.0110. These reports must include a statement of charity care and bad debt. Minn. R. 4651.0120.

PENALTIES FOR NONCOMPLIANCE: N/A

OTHER:

St. Paul-Ramsey Medical Center or its successor or assignee must provide hospital and medical services for the indigent of Ramsey County. The services must equal those made available to nonindigent patients. Minn. Stat. § 383A.91.

MISSISSIPPI

FREE CARE CITATION:
Mississippi Code Annotated §§ 41-7-21; 41-7-35; 41-7-39; 41-7-45.
Indigent Care Law (*The majority of the sections in this chapter were repealed in 1986. What remains is not very comprehensive).*

Mississippi Code Annotated §§ 41-99-1, et. seq.
Qualified Health Center Grant Program

Code of Mississippi Rules 12-000-020
Certificate of Need Review Manual

TERMINOLOGY:
Indigent Care

REGULATORY OVERSIGHT:
Department of Health

DEFINITIONS AND DISTINCTIONS: N/A

FREE CARE AS A COMMUNITY BENEFIT: N/A

ELIGIBILITY REQUIREMENTS: N/A

FINANCING SOURCE:
Under the Qualified Health Center Grant Program, grants are administered to qualified health centers for providing care to uninsured or medically indigent patients. Miss. Code Ann. § 41-99-3. A qualified health center is a public or nonprofit entity which provides comprehensive primary care services that 1) has a community board of directors, the majority of whom are users of the center; 2) accepts all patients, despite their ability to pay and uses a sliding-fee schedule for payments; and 3) serves a designated medically underserved area or population. Miss. Code Ann. § 41-99-1(a).

Qualified health centers file applications with the Department of Health to participate in the grant program. The grants must be used to: 1) increase access to preventative and primary care services by uninsured or medically indigent patients; and 2) create new services (e.g. dental services, optometric services, in-house laboratory services, diagnostic services, pharmacy services, nutritional services, and social services) directed at uninsured or medically indigent patients. Grants may not be used 1) to supplant federal funds; 2) for land or real estate investment; or 3) to finance or satisfy any existing debt. Miss. Code Ann. § 41-99-5.

The total amount of grants issued shall be $4 million a year and no qualified health center may receive more than $200,000 in one year. Miss. Code Ann. § 41-99-5.

SERVICES COVERED: N/A

NOTIFICATION REQUIREMENTS: N/A

APPLICATION PROCESS: N/A

GRIEVANCE/APPEAL PROCESS: N/A

REPORTING REQUIREMENTS:
Qualified health centers that receive grants must provide yearly reports to the Department of Health detailing the number of additional uninsured and medically indigent patients that are treated and the services provided. Miss. Code Ann. § 41-99-5(5)(c).

When applicants apply for a CON, they must state in their application that they will record the following information, at a minimum, about charity care, care to the medically indigent, and Medicaid populations:

1) Utilization data (number of indigent, Medicaid, and charity admissions);
2) Age, race, sex, etc. of each patient
3) Cost/charges per patient day and /or cost/charges per procedure, if applicable, and
4) Any other data pertaining to the utilization of services.

CMSR 12-000-020.
Note: There is no distinction between charity care, care to medically indigent, and Medicaid.

PENALTIES FOR NONCOMPLIANCE: N/A

OTHER:
Hospitals may not try to obtain payment from patients previously determined to be indigent, unless the patient was mistakenly admitted as an indigent patient. Miss. Code Ann. § 41-7-35.

Any person who knowingly misrepresents themselves as an indigent patient is guilty of a misdemeanor. Miss. Code Ann. § 41-7-39.

There are several requirements for providing free care in the Certificate of Need Review Manual:

- Applications for certificates of need will be disapproved if the applicant does not provide a "reasonable amount of indigent care or has admission policies which deny access to care by indigent patients."
- Certificate of need applications will be denied if approval would have a "significant adverse effect on the ability of an existing facility or service to provide Medicaid/indigent care."

“Reasonable amount of indigent care” is determined by the State Health Officer. It should have a relationship to the “amount of care offered by other providers of the requested service within the same, or proximate, geographic area.” CMSR 12-000-020.

MISSOURI

FREE CARE CITATION:
There is no legislative mandate for free care, but there are several references to charity and indigent care in both the statutes and the regulations:

§ 96.230 Revised Statutes of Missouri
§ 205.060 Revised Statutes of Missouri
§ 205.770 Revised Statutes of Missouri

13 Missouri Code of State Regulations 70-15.010
19 Missouri Code of State Regulations 10-33.030

TERMINOLOGY:
Charity or Indigent Care

REGULATORY OVERSIGHT:
Cities of the third class and counties of the second class may establish Social Welfare Boards which oversee the care of the indigent, among other responsibilities. The board may receive donations to carry out its purposes and then disburse these donations. §§ 96.230 R.S.Mo; 205.770 R.S.Mo.

County commissions are also charged with overseeing the care of the indigent. § 205.060 R.S.Mo.

DEFINITIONS AND DISTINCTIONS:
Charity care is defined as "a provider's policy to provide health care services free of charge or a reduction in charges because of the indigence or medical indigence of the patient." 13 CSR 70-15.010.

Charity care must be included and is distinguished from bad debt in the annual financial report hospitals submit to the Department of Health (see Reporting Requirements below). 19 CSR 10-33.030.

ELIGIBILITY REQUIREMENTS: N/A

FREE CARE AS A COMMUNITY BENEFIT: N/A

FINANCING SOURCE:
As part of the regulations governing Missouri's Medicaid program, there is a provision allowing for hospital reimbursement for treatment of charity care patients. It is called "Uninsured Add-Ons." Hospitals receive 76% of the cost of care. If a hospital supports the state's poison control center and the Primary Care Resource Initiative for Missouri, it will receive 77% of the cost of care. The payment is based on a three-year average of the

fourth, fifth, and sixth prior base year cost reports. Cost of the uninsured is determined by multiplying the charges for charity care and allowable bad debts by the hospital's total cost-to-charge ratio for allowable hospital services from the base year cost report's desk review. The cost of the Uninsured is then trended to the current year using the trend indices reported elsewhere in this section. Allowable bad debts do not include the costs of caring for patients whose insurance covers the particular service, procedure or treatment.
13 CSR 70-15.010.

SERVICES COVERED: N/A

NOTIFICATION REQUIREMENTS: N/A

APPLICATION PROCESS: N/A

GRIEVANCE/APPEAL PROCESS: N/A

REPORTING REQUIREMENTS:
Hospitals are required to submit an annual financial report to the Department of Health. The submitted reports are public records. Charity care is one of the elements that must be included in the financial report and is distinguished from bad debt. It is not deducted when determining total gross patient revenue.
19 CSR 10-33.030.

PENALTIES FOR NONCOMPLIANCE: N/A

OTHER:

MONTANA

FREE CARE CITATION:
Montana does not have any legislation (statutes or regulations) mandating free care. It used to have a program called General Relief, but that was largely repealed in 1993. All that remains is one section:
Montana Code Annotated 53-3-116 – Indigent Assistance- Optional County Program.

TERMINOLOGY:
Indigent

REGULATORY OVERSIGHT:
Counties

FREE CARE AS A COMMUNITY BENEFIT: N/A

DEFINITIONS AND DISTINCTIONS: N/A

ELIGIBILITY REQUIREMENTS:
Counties may establish eligibility requirements. Mont. Code Anno. § 53-3-116(2).

FINANCING SOURCE:
May be funded with money derived from a county mill levy. Mont. Code Anno. § 53-3-116(4).

SERVICES COVERED:
Health care, preventive care, and wellness programs. Job search, job training, work-for assistance, and employment programs. Mont. Code Anno. § 53-3-116(1).

NOTIFICATION REQUIREMENTS: N/A

APPLICATION PROCESS: N/A

GRIEVANCE/APPEAL PROCESS: N/A

REPORTING REQUIREMENTS: N/A

PENALTIES FOR NONCOMPLIANCE: N/A

OTHER:

NEBRASKA

Nebraska has a Health Insurance Pool, but it is not like the Massachusetts Free Care Pool. It is primarily aimed at individual's who cannot receive health insurance coverage because of a pre-existing condition. Individuals who do not have health insurance and do not qualify for Medicare or Medicaid are also eligible. All individuals participating in the Pool pay an annual premium and deductible. Is this really free care? If not, there are NO provisions in the Nebraska statutes or regulations about free care.

FREE CARE CITATION:

Revised Statutes of Nebraska § 44-4201, et. seq.
Comprehensive Health Insurance Pool Act

TERMINOLOGY:

REGULATORY OVERSIGHT:

The Director of the Department of Insurance oversees the Pool.

The Pool also has a Board of Directors composed of seven individuals:

- Four representatives of domestic insurers,
- One representative of health agencies involved in advocating for individuals with special health care needs,
- One representative of individuals eligible for Pool coverage, and
- One representative of the general public.

R.R.S. Neb. § 44-4216(2)(b)(i).

The representative of individuals eligible for Pool coverage cannot be a member of the board of directors, an officer, or an employee of an insurer. S/he must be eligible for Pool coverage or would be eligible if not otherwise eligible for other health coverage, or the spouse, parent, adult child, or guardian of such an individual. R.R.S. Neb. 44-4216(2)(b)(ii)(B).

The representative of the general public cannot be a member of the board of directors, an officer, or an employee of an insurer or of a health agency which is involved in advocating for individuals with special health care needs. S/he cannot be an individual who is qualified for selection as the representative of individuals eligible for pool coverage. R.R.S. Neb. § 44-4216(2)(b)(ii)(C). *See also* Code of Nebraska Rules 210-43.

Domestic insurers, health agencies involved in advocating for individuals with special health care needs, individuals eligible for pool coverage, and organizations which are involved in advocating for individuals eligible for pool coverage (in the case of the representative of individuals eligible for pool coverage) may nominate board members to the Director of the Department of Insurance. R.R.S. Neb. § 44-4216(2)(b)(iii).

DEFINITIONS AND DISTINCTIONS: N/A

FREE CARE AS A COMMUNITY BENEFIT: N/A

ELIGIBILITY REQUIREMENTS:
The Pool is primarily aimed at individuals who do not have health insurance due to a pre-existing medical condition or whose COBRA coverage has expired. However, the Pool is also available to residents of Nebraska who are not eligible for coverage under a group health plan, Medicare or Medicaid, and who do not have any other health insurance coverage. R.R.S. Neb. § 44-4221(1)(b).

An individual is no longer eligible for Pool coverage after the Pool has paid $1 million in claims for that individual. R.R.S. Neb. § 44-4222(1)(d).

FINANCING SOURCE:
The Comprehensive Health Insurance Pool Distributive Fund is used to finance the Pool. It consists of monies from premium and related retaliatory taxes imposed on insurance companies doing business in Nebraska. R.R.S. Neb. §44-4225(2).

The Director of the Department of Insurance approves all withdrawals from the fund in order to maintain its financial stability. R.R.S. Neb. § 44-4225(4).

Individuals receiving coverage from the Pool must pay an annual premium which must be approved by the Director of Insurance following a public hearing. R.R.S. Neb. § 44-4227(2). *Does this not make it free care?*

SERVICES COVERED:
The Pool provides major medical expense coverage to every eligible individual. R.R.S. Neb. § 44-4226(1). Individuals are required to pay a deductible towards the coverage which ranges from $250 to $5,000. R.R.S. Neb. § 44-4226(3); Code of Nebraska Rules 210-44-004. *Does this not make it free care?*

See Code of Nebraska Rules 210-44-007 for a list of covered services.

NOTIFICATION REQUIREMENTS:
The Board of Directors is charged with developing and implementing a program to publicize the existence of the Pool and maintain public awareness of the Pool. This program should include information about eligibility requirements and the procedures for enrollment. R.R.S. Neb. § 44-4219(4).

Every insurer must include notice of the Pool when it rejects an application for health insurance coverage due to the health of the applicant or issues a restrictive health insurance rider. R.R.S. Neb. § 44-4235.

APPLICATION PROCESS: N/A

GRIEVANCE/APPEAL PROCESS: N/A

REPORTING REQUIREMENTS:
The Board must submit annual reports of the paid and incurred losses for the year to the Director of the Department of Insurance, the Governor, and each member of the Legislature. R.R.S. Neb. § 44-4225(1).

PENALTIES FOR NONCOMPLIANCE: N/A

OTHER:

NEVADA

FREE CARE CITATION:

Nevada Revised Statutes § 439B.300, et. seq.
Care of Indigent Patients
See also Nevada Administrative Code 439B.390, et. seq. for more details

Nevada Revised Statutes § 439B.010, et. seq.
Public Welfare, Indigent Persons
See also Nevada Administrative Code 439B.010, et. seq. for more details

Nevada Revised Statutes § 428.275, et. seq.
Fund for Medical Assistance
See also Nevada Administrative Code 428.010, et. seq. for more details

TERMINOLOGY:

Indigent Care

REGULATORY OVERSIGHT:

The Department of Human Resources and the Director of the Department oversee the Care Of Indigents Patients Program. In addition to the Care of Indigent Patients Program, individual counties are also charged with establishing policies for providing care to indigent patients. Nev. Rev. Stat. §§ 428.010(2); 244.160.

DEFINITIONS AND DISTINCTIONS: N/A

FREE CARE AS A COMMUNITY BENEFIT: N/A

ELIGIBILITY REQUIREMENTS:

An "indigent" person is defined as someone who:

1. Does not have health insurance,
2. Is ineligible for Medicare, Medicaid, the children's health insurance program, or any other state or federal medical assistance program,
3. Meets the county imposed asset and resources limitations, and
4. Has an income less than:
    - $438 for a single person,
    - $588 for two people,
    - $588 plus $150 for each person in the family in excess of two.

"Income" includes the entire income of a household and the amount which the county projects the person is able to earn.
Nev. Rev. Stat. §§ 439B.310; 428.015(2).

Counties may use a definition of "indigent" that is more inclusive than the definition provided in the statutes. Nev. Rev. Stat. § 439B.300(3)(b).

FINANCING SOURCE:

Under the **Care for Indigent Patients Program**, hospitals are required to annually provide care to indigent patients in an amount that represents 0.6% of its net revenue from the preceding fiscal year. They are not reimbursed for this baseline level of care and must submit their discharge forms to the Board of County Commissioners to ensure that they meet the 0.6% requirement. After a hospital has fulfilled this requirement, it is eligible for reimbursement by the County for the care it provides to indigent patients. The county may reimburse the hospital at any rate after the hospital has met the obligation. Nev. Rev. Stat. § 439B.320.

If the Board of County Commissioners determines that a hospital is serving a disproportionately large share of low-income patients, it may:

1. Pay a higher rate to the hospital for treatment of indigent patients,
2. Pay the hospital for treatment of indigent patients whom the hospital would otherwise be required to treat without receiving compensation from the county, or
3. Both, 1 & 2.

Nev. Rev. Stat. § 439B.330(2).

If the Director of the Department of Human Resources determines that a hospital has not met its minimum obligation for a fiscal year, the hospital is assessed the difference. When a hospital pays this difference, the money is used for paying other hospitals in the county for the treatment of indigent patients.
Nev. Rev. Stat. § 439B. 340(2), (5).

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Counties must also establish a **Fund for Medical Assistance to Indigent Persons**. Money in this fund is used for reimbursement for any unpaid medical care furnished to an indigent patient. Nev. Rev. Stat. § 428.275.

The Board of County Commissioners pays hospitals for the costs of treating indigent patients an amount which is not less than the payment required by Medicaid for the treatment. Nev. Rev. Stat. § 428.030(2). The Board of County Commissioners may levy an ad valorem tax to finance these payments. Nev. Rev. Stat. § 428.050(1).

Each year, when the Board of County Commissioners prepares its budget, it must allocate money for medical assistance to indigents. Nev. Rev. Stat. § 428.295(1). If the amount of money spent on medical assistance to indigents ends up being greater than the amount budgeted, the Board of County Commissioners may use money in the Fund for Medical Assistance to Indigent Persons to make up the difference. Nev. Rev. Stat. § 428.295(3). The Board of County Commissioners must apply to the Board of Trustees of the Fund for reimbursement. The County may receive reimbursement of unpaid charges for hospital care in excess of $25,000 per indigent patient. Nev. Rev. Stat. § 428.335(1). If reimbursement is approved, payment to the County is made from the supplemental account (see next paragraph). Nev. Rev. Stat. § 428.345(1). If the Board of Trustees reimburses the county, it is subrogated to the right of the County to recover unpaid

charges from the indigent person or from other persons responsible for his/her support, and it *has a lien on the proceeds of any recovery by the county from the indigent person or other person responsible for his/her support.* Nev. Rev. Stat. § 428.345(2).

Within the Fund for Medical Assistance to Indigent Persons, there is also a supplemental account. Nev. Rev. Stat. § 428.305(1). The Board of County Commissioners for each county imposes an additional ad valorem tax of between 6 and 10 cents on each $100 of assessed valuation. Each year, the Board then remits to the state controller 1 cent of every $100 of assessed valuation for credit to the supplemental fund. Nev. Rev. Stat. § 428.285. If the balance in the supplemental account exceeds $2 million on May 1, the excess is credited pro rata against the amounts due from the respective counties. Nev. Rev. Stat. § 428.305(2).

Immediate relatives (father, mother, children, brother, or sister) who have the financial ability to do so, must reimburse the county for payment of an indigent relative. Likewise, the recipient him/herself must also reimburse the county, if at a later date, he/she becomes financially able to do so. Nev. Rev. Stat. § 428.070.

SERVICES COVERED:
A county's program of medical assistance must provide for emergency medical care and all other medically necessary care rendered in a medical facility designated by the county. Nev. Rev. Stat. § 429.015(3).

NOTIFICATION REQUIREMENTS: N/A

APPLICATION PROCESS:
Indigent patients apply to the Board of County Commissioners for relief. The application should include information about the patient's county of residence and information to determine the financial condition of the patient. Nev. Rev. Stat. § 428.040.

After a hospital has treated an indigent patient, the hospital must submit a discharge form to the Board of County Commissioners. The County must then verify the status of the patient and the amount which the hospital is entitled to receive. Nev. Rev. Stat. § 439B.330(3), (4).

GRIEVANCE/APPEAL PROCESS:
An individual who is denied medical assistance by a county may appeal that decision under the county's rules of appeal. The person must receive adequate notice and an opportunity for a hearing. The individual may further appeal the county's second opinion to the district court. This decision may be appealed to the supreme court. Nev. Rev. Stat. § 428.093.

A hospital that is aggrieved by a decision of the Board of County Commissioners for reimbursement may appeal the determination to the Director. The Director's decision may be appealed to a court having general jurisdiction in the county. Nev. Rev. Stat. § 439B.330(4).

REPORTING REQUIREMENTS:
Before September 30 of each year, each county where there are hospitals subject to this law must report to the Department of Human Resources the following information:

1. The total number of indigent patients treated by each hospital,
2. The number of such patients for whom no reimbursement was provided because of the .6% limitation,
3. The total amount paid to each hospital, and
4. The amount the hospital would have received for patients for whom no reimbursement was provided.

The Director must verify this information.
Nev. Rev. Stat. § 439B.340(1), (2).

PENALTIES FOR NONCOMPLIANCE: N/A

OTHER:
Nev. Rev. Stat. §§ 439B.300, et. seq. applies to every hospital in the state that is located in a county where there are at least two licensed hospitals. The statute does not apply to hospitals with fewer than 100 beds. Nev. Rev. Stat. § 439B.300(2).

NEW HAMPSHIRE

FREE CARE CITATION:
New Hampshire Revised Statutes § 7:32-c, et. seq.
Community Benefits

TERMINOLOGY:
Charity Care

REGULATORY OVERSIGHT:
Attorney General

DEFINITIONS AND DISTINCTIONS:
Charity care does not include bad debt. RSA §§ 7:32-d(III)(a); 7:32-h(I).

"Charity Care means health care services provided by a health care charitable trust for which the trust does not expect and has not expected payment and which health care services are not recognized as either a receivable or as revenue in the trust's financial statements." RSA § 7:32-d(I).

FREE CARE AS A COMMUNITY BENEFIT:
Charity care is considered a community benefit so long as it does not include bad debt, a receivable, or revenue. RSA §§ 7:32-d(III)(a); 7:32-h(I).

ELIGIBILITY REQUIREMENTS: N/A

FINANCING SOURCE: N/A

SERVICES COVERED:

NOTIFICATION REQUIREMENTS:
In order for charity care to be included as a community benefit, there must be a written policy available to the public explaining the charity care policy of the institution. The policy should provide an application and allow for a prompt decision on eligibility. The notice must be prominently displayed in the institution's lobby, waiting rooms, or other areas of public access. RSA § 7:32-h(II).

APPLICATION PROCESS:

GRIEVANCE/APPEAL PROCESS:

REPORTING REQUIREMENTS:
Every health care charitable trust (see below for definition) must submit an annual community benefits plan. The plan must include an estimate of the cost of each activity

proposed in the plan and *a report on the unreimbursed cost of each activity undertaken in the previous year.* RSA § 7:32-e(V)(a). The plan should also include the ratio of gross receipts from operations to net operating costs.; RSA 7:32-e(V)(b).

PENALTIES FOR NONCOMPLIANCE: N/A

OTHER:

The charity care requirements in New Hampshire are included within the Community Benefits legislation. The community benefits laws apply to all "Health Care Charitable Trusts" which are defined as nonprofit corporations organized "to directly provide health care services." RSA § 7:32-d(V).

If the total value of the health care charitable trust is under $100,000, it is exempt from these requirements. Health care charitable trusts may also apply for a three-year exemption from the requirements in the case of financial hardship. RSA § 7:32-j.

NEW JERSEY

FREE CARE CITATION:
New Jersey Administrative Code § 10:52-11.1, et. seq.
Charity Care
Note: Appears to expire 12/21/04.

New Jersey Administrative Code §§ 8:31B-4.38; 8:31B-4.40.

New Jersey Statutes § 26:2H-18.58, et. seq.
Health Care Subsidy Fund

TERMINOLOGY:
Charity Care

REGULATORY OVERSIGHT:
Department of Health and Senior Services

DEFINITIONS AND DISTINCTIONS: N/A

FREE CARE AS A COMMUNITY BENEFIT: N/A

ELIGIBILITY REQUIREMENTS:
A person is eligible for complete charity care if his/her income (individual or family) is less than or equal to 200% of the federal poverty guidelines. If the income (individual or family) is between 200 and 300% of the federal poverty guidelines, the person is eligible for charity care at a reduced, sliding scale rate. N.J.A.C. § 10:52-11.8(b), (c). If the medical expenses for applicants eligible for reduced charge charity care exceeds 30% of the applicant's or family's annual gross income, the excess is eligible for 100% coverage under charity care. N.J.A.C. § 10:52-11.8(d).

Applicants must provide proof that their individual assets do not exceed $7,500 and that their family's assets do not exceed $15,000. N.J.A.C. § 10:52-11.10(a). Assets are defined as items which can be readily converted into cash (e.g. cash, savings and checking accounts, corporate stocks and bonds, Individual Retirement Accounts, equity in real estate (other than the primary residence)). N.J.A.C. § 10:52-11.10(c).

FINANCING SOURCE:
Disproportionate share hospitals are eligible for charity care reimbursement through the Health Care Subsidy Fund. The fund consists of revenues from various taxes, including tobacco. N.J. Stat. §§ 26:2H-18.58(a); 26:2H-18.58g. There is a special component within the Fund devoted solely to charity care reimbursement. N.J. Stat. § 26:2H-18.58(d). The total amount allocated for charity care is $320 million. N.J. Stat. § 26:2H-18.59(e).

SERVICES COVERED:

In addition to hospital services, persons eligible for charity care may also receive charity care for the following services:

- Advanced life support
- Outpatient dialysis

N.J.A.C. § 8:31B-4.38(a).

NOTIFICATION REQUIREMENTS:

Hospitals are required to provide patients with an individual written notice explaining the charity care policy. The notice must be consistent with the form provided by the Department of Health and Senior Services and must be given to the patient at the time or service or no later than the first billing statement. N.J.A.C. § 10:52-11.5(a).

APPLICATION PROCESS:

The Department of Health and Senior Services provides hospitals with a standardized application and determination form. N.J.A.C. § 10:52-11.13(a).

An applicant must apply for charity care within one year from the date of service. This time limit may be extended at the discretion of the hospital. The hospital must notify the applicant of its decision within 10 working days of the date the application was submitted. N.J.A.C. § 10:52-11.13(b).

Applicants must provide the hospital with a form of identification (e.g. driver's license, birth certificate, social security card, or passport) and a document containing his/her name and address (e.g. driver's license, voter registration card, tax form, unemployment benefits statement). N.J.A.C. § 10:52-11.6. Applicants must also provide proof of New Jersey residence. N.J.A.C. § 10:52-11.7[1].

Note: Slightly different application procedures if admitted through the emergency room. See N.J.A.C. § 10:52-11.16.

GRIEVANCE/APPEAL PROCESS:

When an application for charity care is denied, the hospital must provide the applicant with a written statement of the reasons for the denial. This notice must also inform the applicant that he/she may reapply if his or her financial circumstances have changes to make him or her eligible for charity care for future services. N.J.A.C. § 10:52-11.13(d).

REPORTING REQUIREMENTS:

Hospitals must submit quarterly information to the Department of Health and Senior Services for all patients who were screened for charity care in that quarter. The information should include demographics (e.g. age, sex, marital status, etc.). N.J.A.C. § 8:31B-4.40.

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[1] Non-New Jersey residents requiring immediate medical attention for an emergency may also apply for charity care. N.J.A.C. § 10:52-11.7(b).

PENALTIES FOR NONCOMPLIANCE: N/A

OTHER:
Persons deemed eligible for charity care may not receive a bill for services or be subject to collection procedures. N.J.A.C. § 10:52-11.14.

NEW MEXICO

New Mexico has a county-based system where the counties reimburse hospitals and other providers (including ambulances) for the care they provide to indigent patients. Hospitals are also responsible for implementing their own charity care policy and determining income eligibility levels independently.

FREE CARE CITATION:

New Mexico Statutes § 27-5-1, et. seq.
Indigent Hospital and County Health Care

New Mexico Administrative Code 7.1.24.1, et. seq.
Charity Care Data Reporting Requirements

TERMINOLOGY:

Indigent Patient
Charity Care

REGULATORY OVERSIGHT:

County Board of Commissioners and the County Indigent Hospital and County Health Care Board of each county (composed of members of the Board of County Commissioners for that county). N.M. Stat. § 27-5-5.

The New Mexico Health Policy Commission oversees the charity care data reporting requirements.

DEFINITIONS AND DISTINCTIONS:

Charity Care is defined as "the provision of medically necessary health care without any expectation of cash inflow and without classification as revenue or receivables in a financial statement, as determined by the criteria established in a formal policy by the facility providing the care." 7.1.24.7(C) NMAC.

Charity care is distinguished from bad debt.

FREE CARE AS A COMMUNITY BENEFIT: N/A

ELIGIBILITY REQUIREMENTS:

An indigent patient is defined as someone "who can normally support himself and his dependents on present income and liquid assets available to him but, taking into consideration this income and those assets and his requirement for other necessities of life for himself and his dependents, is unable to pay the cost of the ambulance transportation or medical care administered or both. If provided by resolution of a board, it shall not include any person whose annual income together with his spouse's annual income totals an amount that is fifty percent greater than the per capita personal income for New Mexico…. Every board that has a balance remaining in the fund at the end of a

given fiscal year shall consider and may adopt at the first meeting of the succeeding fiscal year a resolution increasing the standard for indigency." N.M. Stat. § 27-5-4.

Hospitals must also implement their own "charity care" programs and specify income eligibility levels. 7.1.24.8(C) NMAC.

FINANCING SOURCE:

The Indigent Hospital and County Health Care Program is funded by the County Indigent Hospital Claims Fund. N.M. Stat. § 27-5-7. A portion of the county property tax, determined by the Board of County Commissioners, is used to fund the County Indigent Hospital Claims Fund. N.M. Stat. § 27-5-9(A).

If there is not enough money in the Fund to cover all claims for a particular year, the claims shall be carried over to the next year. N.M. Stat. § 27-5-13.

After a claim has been paid, the Fund has a claim against the estate of the indigent patient and a lien against all real property later acquired by the patient. N.M. Stat. § 27-5-14. However, if the county has a sales tax for the support of indigent hospital patients, this provision will not apply. N.M. Stat. § 27-5-15.

SERVICES COVERED: N/A

NOTIFICATION REQUIREMENTS: N/A

APPLICATION PROCESS:

Rather than the patient applying to participate in the Indigent Hospital and County Health Care Program, the hospital or provider applies to the County Indigent Hospital and County Health Care Board for reimbursement of care. When filing a claim, the hospital or provider must:

- File the claim with the board of the county in which the patient is domiciled;
- File a separate claim for each patient; and
- File a verified statement signed by the patient stating that he or she qualifies as an indigent patient and is unable to pay for the care received. This statement should contain a list of all assets the patient owns.

N.M. Stat. § 27-5-12(A).

The County Indigent Hospital and County Health Care Board determines whether a particular patient is indigent and determines the allowable costs for the care provided. N.M. Stat. § 27-5-6(I).

GRIEVANCE/APPEAL PROCESS:

When the County Indigent Hospital and County Health Care Board disapproves a claim, it must notify the hospital or health care provider within 60 days of making its decision. N.M. Stat. § 27-6-6(J).

Any hospital or provider that is aggrieved by a decision of the County Indigent Hospital and County Health Care Board may appeal the decision to the district court. N.M. Stat. § 27-5-12.1.

REPORTING REQUIREMENTS:

Hospitals, ambulance services, and/or health care providers must keep on file with the County Indigent Hospital and County Health Care Board current data, statistics, schedules, and other information necessary to determine the cost for all patients being served; proof of licensure; and any other information deemed necessary by the Board. N.M. Stat. § 27-5-11(A).

All non-federal health care facilities must also submit their formal charity care policy to the New Mexico Health Policy Commission. The policy must specify the level of qualifying income as a percentage of the applicable federal poverty level. 7.1.24.8(C) NMAC. They must also report the following data for each fiscal year: bad debt, charity care charges, cost-to-charge ratio, county indigent fund revenue…. 7.1.24.12 NMAC. If these reporting requirements require unreasonable cost, a health care facility can apply for a temporary modification or exemption. 7.1.24.15(A) NMAC.

PENALTIES FOR NONCOMPLIANCE: N/A

OTHER:

The Indigent Hospital and County Health Care Program does not apply to any county which has a county sales tax in effect, unless that tax resolution provides for possible expanded use of the county indigent hospital claims fund. N.M. Stat. § 27-5-4.1.

NEW YORK

FREE CARE CITATION:
NY Pub. Health § 2807-c(16), (17), (18), (19).
NY Pub. Health § 2805-a.
NY Pub. Health § 2803-l.

TERMINOLOGY:
Charity care.

REGULATORY OVERSIGHT:
Commissioner of Health
State Hospital Review and Planning Council.

DEFINITIONS AND DISTINCTIONS:
Bad debt is defined as uncollectible monies. Charity care is defined as the reduction in charges for services provided to an indigent or medically indigent patient. 10 NY ADC 86-1.11.

FREE CARE AS A COMMUNITY BENEFIT:
Yes. *See* § 2803-l. Community Service Plans
Charity care is included as an element of the community service plan.

ELIGIBILITY REQUIREMENTS: N/A

FINANCING SOURCE:
The free care system is financed through a series of statewide and regional pools. NY Pub. Health § 2807-c(16), *et. seq.*

The regional pools are financed through an assessment on general hospitals of 5.48% of their total reimbursable inpatient costs, excluding Medicare but including bad debt. NY Pub. Health § 2807-c (14)(c). Funds in the statewide pool are also distributed to the regional pools. NY Pub. Health § 2807-c (16). Article 43 insurers (nonprofit medical indemnity and BCBS) may be required to contribute to the pools. § 2807-c (16)(c).

The funds in the regional pools are distributed to eligible major public general hospitals,[1] voluntary nonprofit hospitals, private proprietary hospitals, and public general hospitals. Funds are first distributed to major public general hospitals, who may receive 110% of their inpatient reimbursable costs, excluding Medicare. NY Pub. Health § 2807-c (17)(a).

[1] Major public general hospital is a state operated general hospital with an annual inpatient operating costs in excess of $25 million. (14)(a).

Any funds remaining are then distributed to the other hospitals listed above, on the basis of each hospital's targeted need share.[2]

To receive funds, a hospital must "implement collection policies and procedures approved by the commissioner and must be in compliance with bad debt and charity care reporting requirements established pursuant to this article." NY Pub. Health § 2807-c (16)(d). Hospitals that have an OB department must also provide prenatal care to the medically indigent. NY Pub. Health § 2807-c (16)(e). Any remaining funds are then placed in a special revenue-other fund and distributed as Medicaid payments. NY Pub. Health § 2807-c (17).

The statewide pool is funded through an assessment charged to general hospitals. The assessment is 1% of the hospital's gross revenue from inpatient services. It is not charged to voluntary nonprofit and private proprietary general hospitals which qualify for distributions under NY Pub. Health § 2807-c (19)(c). In the mid-'90s, the fund was also financed by the medical malpractice insurance association.

The monies in the statewide pool are distributed monthly as follows: NY Pub. Health § 2807-c (18).

1. Regional pools NY Pub. Health § 2807-c (19)(a)
2. Voluntary nonprofit and private proprietary general hospitals experiencing severe fiscal hardship due to losses from bad debts and charity care. NY Pub. Health § 2807-c (19)(c).

SERVICES COVERED: N/A

NOTIFICATION REQUIREMENTS: N/A

APPLICATION PROCESS: N/A

GRIEVANCE/APPEAL PROCESS: N/A

REPORTING REQUIREMENTS:
Every hospital must file an annual report with the Commissioner which shows its financial condition and all of its financial transactions for the previous fiscal year. The report must include information about bad debts and charity care. § 2805-a(2)(a).

PENALTIES FOR NONCOMPLIANCE:
If a hospital doesn't file a timely report on funds due a pool, the Commissioner may estimate the amount and charge the hospital for it. NY Pub. Health § 2807-c (16-a).

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[2] Targeted need share is defined as the relationship between each hospital's base year nominal payment amount to the base year nominal payment amounts for all hospitals statewide other than major public general hospitals. (17)(b)(ii).

Any hospital which does not make a timely payment to a pool is not eligible for receiving a distribution until the payment is made. NY Pub. Health § 2807-c (20)(a).

OTHER:

NORTH CAROLINA

FREE CARE CITATION:
N.C. Gen. Stat. §§ 108A-14; 153A-255.

TERMINOLOGY:
Indigent Care

REGULATORY OVERSIGHT:
Although there are no formal statutes or regulations governing free care in North Carolina, the counties (specifically the County Director of Social Services) are charged with overseeing care of indigent persons in each county. N.C. Gen. Stat. §§ 108A-14; 153A-255.

FREE CARE AS A COMMUNITY BENEFIT: N/A

DEFINITIONS AND DISTINCTIONS: N/A

ELIGIBILITY REQUIREMENTS: N/A

FINANCING SOURCE: N/A

SERVICES COVERED: N/A

NOTIFICATION REQUIREMENTS: N/A

APPLICATION PROCESS: N/A

GRIEVANCE/APPEAL PROCESS: N/A

REPORTING REQUIREMENTS: N/A

PENALTIES FOR NONCOMPLIANCE: N/A

OTHER:
When a municipality or hospital authority leases, sells, or otherwise conveys a hospital facility to a for-profit or nonprofit corporation, the new corporation must ensure that indigent care is available to the population of the municipality served by the hospital. The municipality must review the corporation's record on charges, services, and indigent care at similar facilities owned by the corporation before entering into an agreement. N.C. Gen. Stat. § 131E-13.

NORTH DAKOTA

FREE CARE CITATION:
North Dakota Century Code § 50-01-01, et. seq.
County Poor Relief

TERMINOLOGY:
Poor Relief/County General Assistance

REGULATORY OVERSIGHT:
County Social Service Board N.D. Cent. Code § 50-01-02.

DEFINITIONS AND DISTINCTIONS: N/A

FREE CARE AS A COMMUNITY BENEFIT: N/A

ELIGIBILITY REQUIREMENTS:
A person applying for county general assistance (or that person's spouse) may own property or a life insurance policy. However, the applicant may be required to transfer the property in trust as security for receiving assistance, unless the property is one of the following: a homestead, a life insurance policy having a value less than $300, personal property having a value less than $300, real or personal property held in trust for the applicant by the federal government, or real or personal property on which the taking of security is prohibited by Congress. N.D. Cent. Code § 50-01-01(2).

FINANCING SOURCE: N/A

NOTIFICATION REQUIREMENTS:
Each county social service board shall establish written eligibility standards for county general assistance which must be available upon request. N.D. Cent. Code § 50-01-01(2).

SERVICES COVERED: N/A

APPLICATION PROCESS:
The director of the county social service board is responsible for determining, within a reasonable time period, an applicant's eligibility for county general assistance. The applicant must be given written notice of the decision which includes the reasons for the determination and explains that the applicant has a right to appeal the decision. N.D. Cent. Code § 50-01-01.1.

GRIEVANCE/APPEAL PROCESS:
Applicants aggrieved by a decision of the county social service board may appeal the decision to the court. N.D. Cent. Code § 50-01-01.1.

REPORTING REQUIREMENTS: N/A

PENALTIES FOR NONCOMPLIANCE: N/A

OTHER:
County General Assistance includes medical attention and hospitalization. N.D. Cent. Code § 50-01-13.

Many of the sections in Chapter 50-01 (County Poor Relief) have been repealed.

OHIO

FREE CARE CITATION:
Ohio Revised Code § 5112.01, et. seq.
Hospital Care Assurance Program

Ohio Administrative Code § 5101:3-2-0717.

Note: The Program will expire on October 16, 2003.

TERMINOLOGY:
Indigent Care Pool

REGULATORY OVERSIGHT:
Department of Job and Family Services
ORC 5112.08.

DEFINITIONS AND DISTINCTIONS: N/A

FREE CARE AS A COMMUNITY BENEFIT: N/A

ELIGIBILITY REQUIREMENTS:
Each hospital that receives payment under this Program must provide, without charge, basic medically necessary hospital-level services to residents of Ohio who are not recipients of Medicaid and whose income is at or below the federal poverty line. Current recipients of the disability assistance program also qualify for free care. OAC 5101:3-2-0717.

Income is defined as total salaries, wages, and cash receipts before taxes. OAC 5101:3-2-0717(B).

FINANCING SOURCE:
The Indigent Care Pool equals the sum of the following:

(1) The total assessments paid by hospitals into the pool minus that portion of the assessments that are deposited into the legislative budget services fund;
(2) The total amount of intergovernmental transfers made by governmental hospitals minus the portion of those transfers that are deposited into the legislative budget fund;
(3) The total amount of federal matching funds that are available as a result of funds distributed by the Department of Job and Family Services to hospitals.

ORC 5112.01(E).

An assessment is imposed on all hospitals in Ohio. Each hospital's assessment is based on total facility costs. No hospital may be assessed more than 2% of its total facility costs. ORC 5112.06(A).

The Director of Job and Family Services is charged with establishing a methodology to pay hospitals that is sufficient to expend all money in the Indigent Care Pool. The amount to be allocated is based on any combination of the following indicators of indigent care:

(1) Total costs, volume, or proportion of services to recipients of Medicaid;
(2) Total costs, volume, or proportion of services to low-income patients in addition to recipients of Medicaid;
(3) The amount of uncompensated care provided by the hospital;
(4) Other factors that the Director deems appropriate.

ORC 5112.08(B).

However, precedence is given to those hospitals that provide a high proportion of indigent care in relation to the total care provided by the hospital or in relation to other hospitals. ORC 5112.08(C).

The Department of Job and Family Services will make a preliminary determination of the amount of the hospital's annual assessment. The hospital may request a reconsideration of this determination. When there is a reconsideration, the Department must hold a public hearing. A hospital may further appeal the Department's decision to the Court of Common Pleas in Franklin County. ORC 5112.09.

SERVICES COVERED:
A person may be eligible for outpatient services as well. When eligibility has been determined for outpatient services, it remains effective for 90 days. OAC 5101:3-2-0717(B)(3).

NOTIFICATION REQUIREMENTS:
Notice must be posted in appropriate areas of the hospital, including but not limited to the admissions area, the business office, and the emergency room. The notice must at least:

(1) State the rights of individuals to receive without charge, basic, medically necessary hospital-level services;
(2) Be clear and written in simple terms;
(3) Be printed in English and other languages that are common to the population of the area serviced;
(4) Be clearly readable at a distance of 20 feet.

The hospital must also make reasonable efforts to communicate the contents of the notice to those people it has reason to believe cannot read the notice.
OAC 5101:3-2-0717(D).

APPLICATION PROCESS: N/A

GRIEVANCE/APPEAL PROCESS: N/A

REPORTING REQUIREMENTS:

On or before July 1, each hospital must submit to the Department of Job and Family Services a financial statement for the preceding calendar year that accurately reflects the income, expenses, assets, liabilities, and net worth of the hospital. The financial statement must also show bad debt and charity care separately from courtesy care and contractual allowances.[1] ORC 5112.04(A).

Each hospital must submit a cost report to the Department of Job and Family Services within 180 days of the end of its cost reporting period. ORC 5112.04(B).

Each hospital must report to the Department information on the number and identity of patients receiving free care. ORC 5112.17(D).

Information filed under these sections may not include any patient-identifying material. ORC 5112.21.

See OAC 5101:3-2-0717(E) for more reporting requirements.

PENALTIES FOR NONCOMPLIANCE: N/A

OTHER:

Hospitals may send bills to patients if all of the following apply:

(1) The hospital has an established post-billing procedure for determining the patient's income and canceling the charges if the patient is found to qualify for services under the Hospital Care Assurance Program;
(2) The initial bill, and at least the first follow-up bill, is accompanied by a written statement that does all of the following:
    (a) Explains that individuals with income at or below the federal poverty guideline are eligible for services without charge;
    (b) Specifies the federal poverty guideline for individuals and families of various sizes at the time the bill is sent; and
    (c) Describes the procedure for determining a patient's income and canceling charges.
(3) If the written statement is printed on the back of the bill, the hospital must reference the statement on the front of the bill;
(4) A hospital providing care to an individual under this Program is subrogated to the rights of any individual to receive compensation or benefits from any person or governmental entity for the hospital goods and services rendered.

ORC 5112.17(C); OAC 5101:3-2-0717(C).

[1] Bad debt, charity care, courtesy care, and contractual allowances have the same meanings as in regulations adopted under Title XVIII of the Social Security Act. ORC 5112.01(B).

OKLAHOMA

FREE CARE CITATION:
56 Oklahoma Statutes § 57, et. seq.
Oklahoma Indigent Health Care Act

TERMINOLOGY:
Indigent Care/Charity Care

REGULATORY OVERSIGHT:
Department of Human Services
56 Okl. St. § 63.

DEFINITIONS AND DISTINCTIONS: N/A

FREE CARE AS A COMMUNITY BENEFIT: N/A

ELIGIBILITY REQUIREMENTS:
A person is deemed medically indigent if s/he:

(1) has an income less than or equal to the poverty level and insufficient personal resources to provide for needed medical care for himself/herself or his/her dependents, and
(2) requires medically necessary hospital or primary health care services for himself/herself or for his/her dependents for which no public or private third-party coverage is available, and
(3) has made no assignment, transfer, or encumbrance of property for the purpose of establishing eligibility for services at any time within the last two years.

A person is also eligible if there has been a catastrophic injury or illness which is not covered by medical insurance and the costs exceed 50% of the gross annual income of the person or health of household.
56 Okl. St. § 58(2).

A person seeking assistance under the Oklahoma Indigent Health Care Act must undergo a screening process where the Department of Human Services will determine eligibility.
56 Okl. St. § 65.

FINANCING SOURCE:
The Indigent Health Care Act is funded by the Indigent Health Care Revolving Fund. 56 Okl. St. § 59.1(B). Monies from the Indigent Health Care Revolving Fund are used to reimburse hospitals. The Department of Human Services determines reimbursement rates for each hospital after consulting with provider groups. The rate of reimbursement shall not exceed the Medicaid reimbursement rate. 56 Okl. St. § 66.

On each state income tax return, Oklahoma residents have the option of donating a portion of their refund to the Indigent Health Care Fund. 56 Okl. St. § 59.1(A); 2001 OK H.B. 1203, sec. 25; approved by the Governor June 4, 2001.

SERVICES COVERED: N/A

NOTIFICATION REQUIREMENTS: N/A

APPLICATION PROCESS: N/A

GRIEVANCE/APPEAL PROCESS: N/A

REPORTING REQUIREMENTS:
Hospitals participating in the Oklahoma Indigent Health Care Act must annually submit to the State Department of Health reports documenting:

(1) the total amount of health care costs incurred by the hospital for medical indigents;
(2) the total patient charges by the hospital for medical indigents;
(3) the patient mix including, but not limited to, the number of indigent persons served as measured by hospital patient days as appropriate, and
(4) such other information as may be required by the State Department of Health.

56 Okl. St. § 64(A)(2).

The State Department of Health forwards these reports to the Department of Human Services so that the latter Department may use them in determining reimbursement levels for the hospital. 56 Okl. St. § 64(C).

PENALTIES FOR NONCOMPLIANCE: N/A

OTHER:

OREGON

FREE CARE CITATION:
There are no formal statutes or regulations governing free care in Oregon.

TERMINOLOGY: N/A

REGULATORY OVERSIGHT: N/A

DEFINITIONS AND DISTINCTIONS: N/A

FREE CARE AS A COMMUNITY BENEFIT: N/A

ELIGIBILITY REQUIREMENTS: N/A

FINANCING SOURCE: N/A

SERVICES COVERED: N/A

NOTIFICATION REQUIREMENTS: N/A

APPLICATION PROCESS: N/A

GRIEVANCE/APPEAL PROCESS: N/A

REPORTING REQUIREMENTS: N/A

PENALTIES FOR NONCOMPLIANCE: N/A

OTHER:

PENNSYLVANIA

FREE CARE CITATION:
35 Pennsylvania Statutes § 5701.1101, et. seq.
Hospital Uncompensated Care

35 Pennsylvania Statutes § 449.1, et. seq.
Health Care Cost Containment Act
Expires June 30, 2003
Sets up system to collect and study data to determine ways to both reduce the cost of health care while increasing access.

TERMINOLOGY:
Charity Care, Uncompensated Care, Indigent Care

REGULATORY OVERSIGHT:
Department of Public Welfare 35 P.S. § 5701.1103(B).

Health Care Cost Containment Council (consists of 21 appointed members, one of whom is a consumer representative). 35 P.S. § 449.4.

DEFINITIONS AND DISTINCTIONS:
"Charity care expense" is defined as "the cost of care for which a hospital ordinarily charges a fee but which is provided free or at a reduced rate to patients who cannot afford to pay but who are not eligible for public programs and from whom the hospital did not expect payment in accordance with the hospital's charity care policy."

"Bad debt expense" is defined as "the cost of care for which a hospital expected payment from the patient or a third-party payor, but which the hospital subsequently determines to be uncollectible."

"Uncompensated care" is defined as "the cost of care provided to patients financially unable or unwilling to pay for services provided by a hospital. This cost shall be determined by the [Health Care Cost Containment] Council utilizing reported data and the hospital's cost-to-charge ratio and shall include charity care expense and bad debt expense."
35 P.S. § 5701.1102.

FREE CARE AS A COMMUNITY BENEFIT: N/A

ELIGIBILITY REQUIREMENTS:
"Indigent Care" is defined as "the actual costs… for the provision of appropriate health care, on an inpatient or outpatient basis, given to individuals who cannot pay for their care because they are above the medical assistance eligibility levels and have no health insurance or other financial resources which can cover their health care."

35 P.S. § 449.3.

FINANCING SOURCE:

Monies from the Tobacco Settlement Fund are used to support the Hospital Uncompensated Care Program. 35 P.S. § 5701.1103(A).

The Department of Public Welfare determines how much aid hospitals are eligible for based on the annual data the hospitals submit (see Hospital Reporting Requirements, below). 35 P.S. § 5701.1104(A). Each hospital is given an annual uncompensated care score which is based on the collected data. 35 P.S. § 5701.1104(C).

A hospital is eligible to receive aid from the Hospital Uncompensated Care Program if it has a plan in place to serve the uninsured and it:

1) Accepts all individuals regardless of the ability to pay for emergent medically necessary services;
2) Seeks collection of a claim;
3) Attempts to obtain health coverage for patients;
4) Ensures that an emergency admission or treatment is not delayed of denied pending determination of coverage or requirement for prepayment or deposit;
5) Posts adequate notice of the availability of medical services and the obligations of hospitals to provide free services;
6) Provides data to the Health Care Cost Containment Council (see Hospital Reporting Requirements, below).

35 P.S. § 5701.1104(B).

There is also a Hospital Extraordinary Expense Program which reimburses hospitals for extraordinary expenses in treating the uninsured on an inpatient hospital basis.[2] In order to receive payment from this Program, a hospital cannot be receiving payment from the Hospital Uncompensated Care Program. 35 P.S. § 5701.1105.

The Department of Public Welfare shall also seek to maximize any Federal funds, including Title XIX of the Social Security Act, available for the Hospital Uncompensated Care Program and the Hospital Extraordinary Expense Program. 35 P.S. § 5701.1107.

SERVICES COVERED: N/A

NOTIFICATION REQUIREMENTS:

In order to be eligible to receive aid, hospitals must post adequate notice of the availability of medical services and the obligations of hospitals to provide free services. 35 P.S. § 5701.1104(B)(5).

APPLICATION PROCESS: N/A

[2] Extraordinary expense is the cost of inpatient services provided to an uninsured patient which exceeds twice the hospital's average cost per stay for all patients. 35 P.S. § 5701.1102.

GRIEVANCE/APPEAL PROCESS:

The Health Care Cost Containment Council is authorized to establish procedures and requirements for the filing, hearing, and adjudication of grievances against it. 35 P.S. § 449.14(A).

REPORTING REQUIREMENTS:

The Department of Public Welfare must notify hospitals of the uniform reporting requirements for uncompensated care. The reporting requirements should address the following:

1) Patient eligibility for other public or private coverage;
2) Income eligibility threshold based on family size;
3) Consideration of other resources available to a patient or responsible party;
4) Patient or responsible party employment status and earning capacity;
5) Other financial obligations of the patient or responsible party;
6) Other sources of funds available to the hospital such as endowments or donations specified for charity care.

35 P.S. § 5701.1103(D)(2).

Beginning January 1, 2002, hospitals are required to report uncompensated care information to the Health Care Cost Containment Council in order to receive payments under the Hospital Uncompensated Care Program. 35 P.S. § 5701.1103(D)(3).

PENALTIES FOR NONCOMPLIANCE:

If a hospital knowingly violates any of the requirements for the Hospital Uncompensated Care Program or the Hospital Extraordinary Expense Program, it can be assessed a penalty of no more than $25,000 if it has less than 100 beds and no more than $50,000 if it has at least 100 beds. 35 P.S. § 5701.1108.

Any person who does not supply data to the Health Care Cost Containment Council is subject to a fine of $1,000 for each day the data is not submitted. After sentencing of this fine, if the person continues not to submit the data, s/he is subject to a fine of $10,000 or imprisonment for not more than five years. 35 P.S. § 449.12(B).

OTHER:

Under the Health Care Cost Containment Act, one of the duties of the Health Care Cost Containment Council is to study and analyze the medically indigent population, the magnitude of uncompensated care, the degree of access to and the result of any lack of access by the medically indigent to appropriate care, the types of providers and the settings in which they provide indigent care and the cost of the provision of that care. 35 P.S. § 449.8(B)(1).

RHODE ISLAND

FREE CARE CITATION:

Rhode Island General Laws § 23-17-43
Charity Care Requirements – "Any new hospital licensee shall meet the statewide community standard for the provision of charity care services as a condition of initial and continued licensure."

Rhode Island General Laws § 23-17.14-15
Hospital Conversions Act, Charity Care Requirements

Code of Rhode Island Rules 14-090-007
Rules and Regulations for Licensing of Hospitals

Code of Rhode Island Rules 14-090-028
Rules and Regulations Pertaining to Hospital Conversions

TERMINOLOGY:

Charity Care

REGULATORY OVERSIGHT:

Director of the Department of Health – Each year the Director must review each licensed hospital's level of performance in providing charity care and uncompensated care. R.I. Gen. Laws § 23-17.14-15(b); CRIR 14-090-028-11.1.

DEFINITIONS AND DISTINCTIONS:

Charity Care is defined as "health care services provided by a hospital without charge to a patient and for which the hospital does not and has not expected payment." R.I. Gen. Laws § 17.14-4(4).

"Under no circumstances shall bad debt be deemed to be charity care. Charity care shall be cost-adjusted by applying a ratio of cost to charges from the hospital's Medicare Cost Reports to charity care charges-foregone."
CRIR 14-090-007-1.5; CRIR 14-090-028-1.6

Uncompensated Care is defined as "a combination of free care, which the hospital provides at no cost to the patient, bad debt, which the hospital bills for but does not collect, and less than full Medicaid reimbursement amounts." R.I. Gen. Laws § 17.14-4(16).

FREE CARE AS A COMMUNITY BENEFIT:

Yes. Community benefit is defined as "the provision of hospital services that meet the ongoing needs of the community for primary and emergency care in a manner that enables families and members of the community to maintain relationships with person who are hospitalized or are receiving hospital services, and shall also include, but not be

limited to charity care and uncompensated care." R.I. Gen. Laws § 23-17.4-4(5); CRIR 14-090-028-1.7.

ELIGIBILITY REQUIREMENTS: N/A

FINANCING SOURCE: N/A

SERVICES COVERED: N/A

NOTIFICATION REQUIREMENTS: N/A

APPLICATION PROCESS: N/A

GRIEVANCE/APPEAL PROCESS: N/A

REPORTING REQUIREMENTS:
On or before March 1, each licensed hospital must provide the Director of the Department of Health with a report detailing the cost of charity care, bad debt, contracted Medicaid shortfalls, and any additional relevant information. R.I. Gen. Laws § 23-17.14-15(d). If the Director believes that the hospital is not providing an adequate amount of charity care, there will be a hearing with ten days notice to the hospital. R.I. Gen. Laws § 23-17.14-15(e).

PENALTIES FOR NONCOMPLIANCE: N/A

OTHER:
The Statewide Standard for the Provision of Charity Care Services is the annual average amount of charity care provided by the previously licensed hospital over the past five years. CRIR 14-090-028-11.3; CRIR 14-090-007-8.7, 8.8

Many of the charity care requirements are tied into the "Hospital Conversions Act" and apply when a nonprofit hospital is converted to for-profit.

- The parties to the conversion must submit a description of how the new hospital will provide community benefit and charity care during its first five years of operation and how the hospital will monitor and value charity care services and community benefit. R.I. Gen. Laws § 23-17.14-6(a)(24),(25).
- If a for-profit corporation applies to acquire a controlling interest greater than 20% in more than one hospital, the Department of Health must determine whether the for-profit provided an appropriate amount of charity care and it demonstrated a substantial linkage between the hospital and the affected community. R.I. Gen. Laws § 23-17.14-19(c)(6),(7).

SOUTH CAROLINA

FREE CARE CITATION:
South Carolina Code of Regulations 61-15
Certification of Need for Health Facilities and Services

TERMINOLOGY:
Indigent Care

REGULATORY OVERSIGHT:
Department of Health and Environmental Control

FREE CARE AS A COMMUNITY BENEFIT: N/A

DEFINITIONS AND DISTINCTIONS:
Indigent care does not include bad debt, contractual adjustments, or care which is reimbursed by a governmental program, church, or philanthropic organization. S.C. Code Regs. 61-15-202, Part C. Programmatic Documents.

ELIGIBILITY REQUIREMENTS: N/A

FINANCING SOURCE: N/A

SERVICES COVERED: N/A

NOTIFICATION REQUIREMENTS: N/A

APPLICATION PROCESS: N/A

GRIEVANCE/APPEAL PROCESS: N/A

REPORTING REQUIREMENTS: N/A

PENALTIES FOR NONCOMPLIANCE: N/A

OTHER:
As part of the CON application, hospitals must provide an indigent care plan that addresses the following:

- The existing and proposed admission and treatment policies with regard to ability to pay;
- The proposed admission and treatment policies with respect to care of indigent patients;
- The amount and percent of gross revenues that the facility provided in indigent care during the past three fiscal years;

- The proposed amount of indigent care the facility projects to provide during the existing and next fiscal year;
- A discussion of why the above figures are adequate or inadequate for the needs of the community; the need of indigent care within the proposed service area; and any solutions, remedial plans or proposals by the facility or agency to better address the indigent care problem in the service area;
- A description of any Advisory Board established to implement or control "the indigent problem" at the facility.

S.C. Code Regs. 61-15-202, Part C. Programmatic Documents.

Among the criteria for review of the CON application are the following:

- Consideration of the performance of the applicant in meeting its obligation *under any applicable Federal regulations requiring provision of uncompensated care, indigent care plan, community service, or access by minorities and handicapped persons to programs receiving Federal financial assistance.*
- *Consideration to the extent to which Medicare, Medicaid, and mecially indigent patients are serviced by the applicant.*

Not sure this is relevant to free care?

S.C. Code Regs. 61-15-802-31, Criteria for Review.

SOUTH DAKOTA

FREE CARE CITATION:
South Dakota Codified Laws § 28-13-1, et. seq.
County Poor Relief

TERMINOLOGY:
Indigent

REGULATORY OVERSIGHT:
Counties. S.D. Codified Laws § 28-13-1.

FREE CARE AS A COMMUNITY BENEFIT: N/A

DEFINITIONS AND DISTINCTIONS: N/A

ELIGIBILITY REQUIREMENTS:
A "medically indigent" person is defined as someone who:
1. Requires medically necessary hospital services and does not have public or private third-party insurance coverage;
2. Has no ability or only limited ability to pay a debt for hospitalization;
3. Has not voluntarily reduced or eliminated his/her assets for the purpose of establishing eligibility;
4. Is not indigent by design; and
5. Is not a veteran or a member of a Native American tribe who is eligible or would have been eligible for services through the Veterans' Administration or the Indian Health Service if the services had been applied for within 72 hours of the person's admission.

S.D. Codified Laws § 28-13-1.3.

The fact that an individual has filed for bankruptcy may not be considered in making a determination of indigency. S.D. Codified Laws § 28-13-44.

The county shall establish an annual income guideline which is derived as follows:
1. Determine the housing index[3] for the person's county of residence. Multiply the county index by $306, the median gross rent of residences in South Dakota in 1996;
2. Using the federal poverty guidelines, determine the federal poverty level for the household size and multiply that figure by 175%; and
3. Add the results of (1) and (2) and multiply by 12.

S.D. Codified Laws § 28-13-32.5.

[3] *See* S.D. Codified Laws §§ 28-13-32.6 – 28-13-32.8 for determination of housing index.

Hospitals and counties may enter into reasonable agreements for hospitalization of medically indigent persons at other rates than those provided here. S.D. Codified Laws § 28-13-36.

FINANCING SOURCE:
In order for a hospital to receive reimbursement from the county for treating a medically indigent person, it must file a detailed statement of costs with the Secretary of Social Services at least annually. The statement of costs must compute the ratios of costs to charges for the fiscal year covered by the statement. S.D. Codified Laws § 28-13-28. The Secretary must approve the statement of costs after determining that it is accurate, complete, and reliable. S.D. Codified Laws § 28-13-30.

The amount of reimbursement may not exceed the actual cost of hospitalization[4] or an amount determined by the Secretary of the Department of Social Services, whichever is less. S.D. Codified Laws § 28-13-29.

When a hospital submits a bill to a county for reimbursement, it must demonstrate that it has exhausted all avenues of payment including accepting reasonable monthly payments from the patient. S.D. Codified Laws § 28-13-33.2.

SERVICES COVERED:
"Medically necessary services:"
1. Consistent with the person's symptoms, diagnosis, condition, or injury;
2. Recognized as the prevailing standard and are consistent with generally accepted professional medical standards of the provider's peer group;
3. Provided in response to a life-threatening condition; to treat pain, injury, illness, or infection; to treat a condition which would result in physical or mental disability; or to achieve a level of physical or mental function consistent with prevailing standards for the diagnosis or condition;
4. Not furnished primarily for the convenience of the person or the provider; and
5. No other equally effective course of treatment available or suitable which is more conservative or substantially less costly.

The county relies on the physician's determination as to medical necessity.
S.D. Codified Laws § 28-13-27.1.

The county may adopt guidelines which define the amount, scope, and duration of medical and remedial services. S.D. Codified Laws § 28-13-27.2.

Counties are not liable for experimental procedures. S.D. Codified Laws § 28-13-33.1.

NOTIFICATION REQUIREMENTS: N/A

[4] "Actual cost of hospitalization" means "the actual cost to a hospital of providing hospital services to a medically indigent person, determined by applying the ratios of costs to charges appearing on the statement of costs… to charges at the hospital in effect at the time the hospital services are provided." S.D. Codified Laws § 28-13-27.

APPLICATION PROCESS:

In order to be eligible as a "medically indigent person," the person or someone acting on behalf of the person must apply to the person's county of residence for assistance within two years of the date of the hospital's discharge of the person. S.D. Codified Laws § 28-13-32.3; 2002 S.D. HB 1241, section 1, approved by the Governor February 11, 2002.

The hospital submits the person's application to the County Auditor within one year of discharge. The application must contain the following information:

1. The notice of hospitalization (see below);
2. The dates of hospitalization;
3. The final diagnosis;
4. The cost of hospital services; and
5. Any financial information in the possession of the hospital concerning the patient or the responsible party, including the availability of insurance coverage.

The county may not require the hospital to provide more information than the above. S.D. Codified Laws § 28-13-32.4.

The County is not liable for reimbursement unless the hospital furnishes notice of hospitalization to the County. Notice must be made within 15 days in the case of an emergency admission. S.D. Codified Laws § 28-13-34.1.

GRIEVANCE/APPEAL PROCESS:

A person may appeal the county's decision to the circuit court. The court may affirm or remand the case, or it may reverse or modify the decision if the county's findings are:

1. In violation of constitutional or statutory provisions;
2. In excess of the statutory authority of the county;
3. Made upon unlawful procedure;
4. Affected by other error of law;
5. Clearly erroneous in light of the entire evidence in the record; or
6. Clearly unwarranted exercise of discretion.

S.D. Codified Laws § 28-13-1.4.

REPORTING REQUIREMENTS: N/A

PENALTIES FOR NONCOMPLIANCE: N/A

OTHER:

TENNESSEE

The hospital licensing tax which is used to fund the Indigent Health Care Risk Fund was to terminate on September 30, 1992, unless extended by the general assembly through subsequent legislation. I couldn't find any extension but don't know why it's still in the statutes ten years later.

FREE CARE CITATION:
Tenn. Code Ann. § 68-11-1101, et. seq.
Indigent Health Care

TERMINOLOGY:
Indigent Care

REGULATORY OVERSIGHT:
Commissioner of Finance and Administration

DEFINITIONS AND DISTINCTIONS: N/A

FREE CARE AS A COMMUNITY BENEFIT: N/A

ELIGIBILITY REQUIREMENTS: N/A

FINANCING SOURCE:
Statutes create an Indigent Health Care Risk Fund from revenue received from a hospital licensing tax (see below). Money from the fund is allocated to hospitals to help cover the costs of treating "medically indigent patients." When the Commissioner of Finance and Administration allocates funds to hospitals, consideration should be given to:
1. The amount of bad debt, medically indigent and charity care provided by the hospitals;
2. The amount of government subsidies to the hospitals; and
3. Any other factor relating to indigent care as determined by the Commissioner.

Tenn. Code Ann. § 68-11-1102.

Whether a hospital is eligible for distribution of funds is determined as follows:
1. Each hospital gets a number representing the total bad debt, charity and indigent care provided by the hospital, divided by the hospital's total gross patient charges.
2. An average of the numbers computed in (1) is determined. Each hospital which either equals or exceeds the average shall then have another number determined based on the total government subsidies to the hospital divided by total gross patient charges of the hospital.
3. The mean of the numbers computed in (2) above is determined. Those hospitals that are two standard deviations or more above the mean are eligible for distribution of funds.

Tenn. Comp. R & Regs. R. 0620-3-4-.03(2)(a).

The individual amount a hospital receives is the product of:
1. an arithmetic quotient which results from dividing the total amount of funds to be distributed by the number of hospitals eligible to receive funds; and
2. An index value which is calculated by the arithmetic average ratio of government subsidies to charges for all hospitals eligible to receive funds.

Tenn. Comp. R & Regs. R. 0620-3-4-.03(2)(b).

Any hospital with less than 50 beds whose ratio of charges for bad debt, charity, and indigent care to gross patient charges is .25 or more shall receive $25,000. Tenn. Comp. R & Regs. R. 0620-3-4-.03(3).

The hospital licensing tax is directly proportional to the hospital's:
1. Medicaid utilization rate;
2. Low income utilization rate; or
3. Large volume of Medicaid days per year.

The fee cannot exceed the hospital's bad debt, charity care, and Medicare/Medicaid contractual adjustments adjusted to expense.
Tenn. Code Ann. § 68-11-216(c)(2).

The Commissioner must also report annually to the general assembly on the financial status of the fund. Tenn. Code Ann. §68-11-1103.

SERVICES COVERED: N/A

NOTIFICATION REQUIREMENTS: N/A

APPLICATION PROCESS: N/A

GRIEVANCE/APPEAL PROCESS: N/A

HOSPITAL REPORTING REQUIREMENTS: N/A

PENALTIES FOR NONCOMPLIANCE: N/A

OTHER:

TEXAS

Nonprofit hospitals are required to provide charity care in order to maintain their nonprofit/charitable status. TX Health & Safety Code § 311.043; TX Tax Code § 11.801(a). There is also an Indigent Care Program (which I think is separate from Medicaid). Under this program, public hospitals and counties are mandated to provide health care assistance to eligible county residents, as payors of last resort. TX Health & Safety Code § 61.022. (See Health and Human Services Code §32.001,et. seq. for Medicaid).

FREE CARE CITATION:

TX Health & Safety Code § 311.031, et. seq.
Hospital Data Reporting and Collection System

TX Health & Safety Code § 311.041, et. seq.
Duties of Nonprofit Hospitals

TX Tax Code § 11.801, et. seq.
Taxable Property and Exemptions

TX Health & Safety Code § 61.001, et. seq.
Indigent Health Care and Treatment Act

TERMINOLOGY:

Charity Care for nonprofit hospital program
Indigent Care for county program (TX Health & Safety Code § 61.001, et. seq.)

REGULATORY OVERSIGHT:

Department of Health

DEFINITIONS AND DISTINCTIONS:

Charity care is defined as "the unreimbursed cost to a hospital of:

(A) providing, funding, or otherwise financially supporting health care services on an inpatient or outpatient basis to a person classified by the hospital as "financially indigent" or "medically indigent"; and/or

(B) providing, funding, or otherwise financially supporting health care services provided to financially indigent persons through other nonprofit or public outpatient clinics, hospitals, or health care organizations."

TX Health & Safety Code § 311.031(2).

Both charity care and bad debt expenses must be reported separately to the Department of Health. TX Health Safety Code § 311.033(a). The Department of Health uses this data to publish an annual report regarding the amount of charity care, bad debt, and other uncompensated care hospitals provide; the use of hospital services by indigent patients; and the effect of indigent care services on hospitals. TX Health & Safety Code § 311.035.

FREE CARE AS A COMMUNITY BENEFIT:

Charity care is considered a community benefit. TX Health Safety Code §§ 311.041, 311.042.

ELIGIBILITY REQUIREMENTS:

Each hospital may establish its own system to determine eligibility for charity care, but the system must include income levels and means testing indexed to the federal poverty guidelines. The income level may not be lower than 21% or higher than 200% of the federal poverty guidelines. TX Health & Safety Code § 311.031(11).

Public hospitals are required to provide health care assistance to eligible patients who reside in the hospital's service area. Additionally, counties are responsible for the care of eligible patients who do not reside in the service area of a public hospital. In both cases, the patient must have a net income equal to 21% of the federal poverty level. (Public hospitals may adopt a less restrictive standard). People who are eligible for and receiving Medicaid benefits may not receive free care under this program. TX Health & Safety Code §§ 61.006; 61.052. When determining eligibility for patients who do not live in a public hospital's district, a county may not consider the value of the applicant's homestead, but may consider the equity value of a car, work-related and child care expenses, and real property other than a homestead. TX Health & Safety Code §§ 61.023, 61.008. Additionally, a county may require an applicant to register for work with the Texas Employment Commission. TX Health & Safety Code § 61.042.

FINANCING SOURCE:

Counties that are responsible for assistance to residents that do not live in a public hospital's district may receive state funds to supplement these payments. In order to receive this assistance, the county must spend at least 8% of the county general revenue levy on health care services and must notify the Department of Health. TX Health & Safety Code § 61.037. State funds must be equal to at least 90% of the actual payment for the health care services after the 8% expenditure level has been reached. TX Health & Safety Code § 61.038. If the Department of Health does not provide an eligible county with assistance, the county is not liable for payments for the services provided after the 8% level has been reached. TX Health & Safety Code § 61.039.

NOTIFICATION REQUIREMENTS:

Each nonprofit hospital must provide to every person seeking care at that hospital notice of its charity care requirements. The notice must be in appropriate languages, readily understandable by the average reader, and explain the eligibility policies and how to apply. The notice must be conspicuously posted in the general waiting area, the waiting area for emergency services, in the business office, and in other helpful locations. Each hospital must also publish notice of its charity care policy in local papers once a year. TX Health & Safety Code § 311.046(d).

For the County Indigent Care Program, each county must make a reasonable effort to notify the public of its standards at the beginning of the fiscal year. TX Health & Safety Code § 61.023.

APPLICATION PROCESS:

Public hospitals must adopt application procedures and furnish applicants with written application forms and provide assistance in completing these forms. TX Health & Safety Code § 61.053.

Applicants who do not reside in a public hospital's district and are applying to the county for care must provide the following:

1. The number of persons in the applicant's household,
2. Any insurance or hospital or health care benefits for which the applicant is eligibile,
3. Any transfer of title the applicant has made in the past 24 months,
4. The applicant's annual household income, and
5. The amount of the applicant's liquid assets and the equity value of the applicant's car and real property.

TX Health & Safety Code § 61.007.

SERVICES COVERED:

Both public hospitals and counties must provide and/or cover the following services: primary and preventative services, inpatient and outpatient care, rural health clinics, laboratory and X-ray services, family planning, payment for no more than three prescription drugs a month, and skilled nursing. The county may provide additional services. TX Health & Safety Code §§ 61.028; 61.054; 61.055.

A county may arrange to provide health care services through a local health department, a publicly owned hospital, contract with a private provider, or purchase insurance for eligible residents. TX Health & Safety Code § 61.029.

GRIEVANCE/APPEAL PROCESS:

Public hospitals must have procedures for reviewing applications and allowing applicants to appeal a denial for assistance. They must notify the patient in writing of their decision, and if there is a denial, explain the reason. Applicants who were denied a claim, may resubmit their application if circumstances have changed. Public hospitals must keep a record of all applications for at least three years. TX Health & Safety Code § 61.053.

HOSPITAL REPORTING REQUIREMENTS:

Each hospital must submit financial and utilization data to the Department of Health which includes charity care and bad debt expenses and the total charity care admissions. TX Health & Safety Code § 311.033.

All nonprofit hospitals must prepare an annual report on their community benefits plan. The report must include the amount of charity care provided. TX Health & Safety Code § 311.046.

Nonprofit hospitals must file a report with the Bureau of State Health Data and Policy Analysis at the Department of Health which explains how they are meeting the charity care requirements (See "Other" below). TX Health & Safety Code § 311.045(a).

Each year, the Department of Health must submit to the attorney general and comptroller a report which includes the amount of charity care each nonprofit hospital provided in that fiscal year. TX Health & Safety Code § 311.0455(b).

Each year, the Department of Health must publish a manual that lists each nonprofit hospital in the state with a brief summary of the charity care and community benefits it provides. TX Health & Safety Code § 311.0461.

Under the county indigent care program, public hospitals providing care must submit annual reports on the expenditures and nature of care provided to eligible residents, eligibility standards and procedures, and relevant characteristics of eligible residents. TX Health & Safety Code § 61.009.

PENALTIES FOR NONCOMPLIANCE:

If a nonprofit hospital unintentionally fails to meet any of the charity care requirements (see "Other" below), the hospital will not automatically lose its tax exemption without the opportunity to fix the problem. A hospital may apply this exemption only once every five years. TX Health & Safety Code § 311.045(e).

Each year, the Department of Health must submit a report to the attorney general and comptroller listing each hospital that did not meet the charity care requirements. TX Health & Safety Code § 311.0455(a).

OTHER:

Nonprofit hospitals are required to provide charity care in order to maintain their nonprofit/charitable status. TX Health & Safety Code § 311.043; TX Tax Code § 11.801(a). Hospitals may choose from the following three standards to determine the level of charity care they provide:

1. A level which is reasonable in relation to the community needs, as determined by the community needs assessment, the available resources, and the tax-exempt benefits the hospital receives;
2. An amount equal to at least 100% of the hospital's tax-exempt benefits, excluding federal income tax; or
3. Charity care and community benefits are provided in a combined amount equal to at least 5% of the hospital's net patient revenue, provided that charity care is provided in an amount equal to at least 4% of net patient revenue.

TX Health & Safety Code § 311.045(b)(1); TX Tax Code § 11.801(a).

Hospitals that have been designated disproportionate share hospitals under Medicaid are considered to have provided a reasonable amount of charity care and do not need to comply with the above standards. TX Health & Safety Code § 311.045(b)(3).

UTAH

Not clear if this is free care, and it is found in the Medicaid statutes. Chapter 18, of Title 26 is Medical Assistance (Medicaid). Chapter 18 will be repealed on July 1, 2004. Utah Code § 63-55-226.

FREE CARE CITATION:
Utah Code § 26-18-301, et. seq.
Access to Health Care

TERMINOLOGY:
Medically Underserved

REGULATORY OVERSIGHT:
Department of Health

DEFINITIONS AND DISTINCTIONS: N/A

FREE CARE AS A COMMUNITY BENEFIT: N/A

ELIGIBILITY REQUIREMENTS:
Medically underserved is defined as "the population of an urban or rural area or a population group designated by the department as having a shortage of primary health care services." Utah Code § 26-18-301(1).

FINANCING SOURCE:
The Department of Health awards grants to public and nonprofit entities providing primary health care services to medically underserved populations. Utah Code § 26-18-302. Grant applications must explain: the measurable objectives, the area to be served, an assessment of need, the personnel responsible, a list of services, a schedule of fees, and the number of medically underserved people to be treated. Utah Code § 26-18-303.

In awarding the grants, the Department of Health will consider the extent to which the applicant: demonstrates that the population being served as a shortage of primary health care; utilizes other sources of funding; demonstrates the ability and expertise to serve traditionally medically underserved populations; and demonstrates that it will assume a financial risk for a specified number of medically underserved persons. Utah Code § 26-18-304.

The Department of Health must report to the Health and Human Services Interim committee each year on the implementation of the grant program. Utah Code § 26-18-305.

NOTIFICATION REQUIREMENTS: N/A

APPLICATION PROCESS: N/A

SERVICES COVERED: N/A

GRIEVANCE/APPEAL PROCESS: N/A

HOSPITAL REPORTING REQUIREMENTS: N/A

PENALTIES FOR NONCOMPLIANCE: N/A

OTHER:

VERMONT

FREE CARE CITATION:
No specific references to free care in statutes. In the Code of Vermont Rules, there is a section entitled "Hospital Services for Low Income People." *See CVR 13-140-020 Action 1*. This section became effective in 1979 and seems to amend an earlier section, 3-1024A. It defines "persons unable to pay" and discusses income guidelines (without any specific information). I couldn't find § 3-1024A or any other reference to "Hospital Services for Low Income People" in the CVR. I wonder if it still exists?

The only other reference to free care is an annotation in the statutes. 32 V.S.A. § 3802 is about property tax exemptions. The notes cite a case which held that "there is no requirement that health care institution dispense any free care in order to be eligible for tax-exempt status… pertinent inquiry is whether health care was made available to all who needed it, regardless of their ability to pay." *Medical Center Hospital of Vermont, Inc. v. City of Burlington*, 152 Vt. 611, 566 A.2d 1352 (1989).

TERMINOLOGY: N/A

REGULATORY OVERSIGHT: N/A

DEFINITIONS AND DISTINCTIONS: N/A

FREE CARE AS A COMMUNITY BENEFIT: N/A

ELIGIBILITY REQUIREMENTS: N/A

FINANCING SOURCE: N/A

SERVICES COVERED: N/A

NOTIFICATION REQUIREMENTS: N/A

APPLICATION PROCESS: N/A

GRIEVANCE/APPEAL PROCESS: N/A

REPORTING REQUIREMENTS: N/A

PENALTIES FOR NONCOMPLIANCE: N/A

OTHER:

VIRGINIA

FREE CARE CITATION:
Virginia Code § 32.1-332, et. seq.
Virginia Indigent Health Care Trust Fund

TERMINOLOGY:
Indigent Care; Charity Care

REGULATORY OVERSIGHT:
Board and Department of Medical Assistance
While the Department also oversees Medicaid, the Indigent Health Care Trust Fund is to "be maintained and administered separately from any other program or fund of the Board and Department." Va. Code § 32.1-333(B).

There is also a Technical Advisory Panel which advises the Board and Department on administration of the Fund. The Panel consists of 15 members who are a combination of state health officials, corporate and insurance representatives, and medical professionals. There are no consumer representatives on the panel. Va. Code § 32.1-335.

DEFINITIONS AND DISTINCTIONS:
Charity care is defined as "hospital care for which no payment is received." Va. Code § 32.1.-332.

FREE CARE AS A COMMUNITY BENEFIT: N/A

ELIGIBILITY REQUIREMENTS:
Charity care is available "to any person whose gross annual family income is equal to or less than 100 percent of the federal nonfarm poverty level…" Va. Code § 32.1.-332.

FINANCING SOURCE:
Virginia Indigent Health Care Trust Fund.

The Fund consists of monies appropriated by the General Assembly and by contributions from hospitals. The fund may also receive voluntary contributions from hospitals and other entities. Va. Code § 32.1-334.

Hospital contributions are calculated as follows:
- Each year, a charity care standard is calculated. For each hospital, a percentage shall be calculated of which the numerator shall be the charity care charges and the denominator shall be the gross patient revenues. This percentage shall be the charity care percent. The median of the percentages for all such hospitals shall be the charity care standard.
- A disproportionate share level shall be established as a percentage above the charity care standard not to exceed three percent above the standard.

- The cost of charity care shall be each hospital's charity care charges multiplied by each hospital's cost-to-charge ratio.
- An annual contribution shall be established which shall be equal to the total sum required to support charity care costs of hospitals between the standard and the disproportionate share level. This sum shall be equally funded by hospital contributions and general fun appropriations.
- A charity and corporate tax credit shall be calculated, the numerator of which shall be each hospital's cost of charity care plus state corporate taxes and the denominator of which shall be each hospital's net patient revenues as defined by the Board of Medical Assistance Services.
- An annual hospital contribution rate shall be calculated, the numerator of which shall be the sum of one-half the contribution plus the sum of the product of the contributing hospitals' credits multiplied by the contributing hospitals' positive operating margins and the denominator of which shall be the sum of the positive operating margins for the contributing hospitals. The annual hospital contribution rate shall not exceed 6.25 percent of a hospital's positive operating margin.
- For each hospital, the contribution dollar amount shall be calculated as the difference between the rate and the credit multiplied by each hospital's operating margin. In addition to the required contribution, hospitals may make voluntary contributions or donations to the fund for the purpose of subsidizing pilot health care projects for the uninsured.

Va. Code § 32.1-337.

The Fund shall compensate a hospital for its charity care percent less the charity care standard as follows:

- The payment to each hospital shall be determined as the standard subtracted from each hospital's charity care percent, multiplied by each hospital's gross patient revenues, multiplied by each hospital's cost-to-charge ratio and multiplied by a percentage not to exceed sixty percent.
- That portion of a hospital's charity care percent which is below the disproportionate share shall be paid from the total amount of the contribution.
- That portion of a hospital's charity care percent which is above the disproportionate share shall be paid solely from general fund moneys as provided by the General Assembly in the appropriations act.

Va. Code § 32.1-338.

SERVICES COVERED:
Hospital inpatient and outpatient medical services covered under the Medical Assistance Program, excluding durational or newborn infant services. Va. Code § 32.1-333(C)(2).

NOTIFICATION REQUIREMENTS: N/A

APPLICATION PROCESS: N/A

GRIEVANCE/APPEAL PROCESS: N/A

REPORTING REQUIREMENTS:

Each hospital must annually file with the Department a statement of charity care. Va. Code § 32.1-336.

PENALTIES FOR NONCOMPLIANCE:

Anyone who knowingly or willfully makes misrepresentations in order to receive reimbursement, fails to provide reports, or fails to pay is guilty of a misdemeanor. Va. Code § 32.1-341.

OTHER:

WASHINGTON

FREE CARE CITATION:
Washington Administrative Code § 246-453-001, et. seq.
Hospital Charity Care

Revised Code of Washington §§ 70.170.060; 70.170.070
Health Data and Charity Care

TERMINOLOGY:
Charity Care

REGULATORY OVERSIGHT:
Department of Health

DEFINITIONS AND DISTINCTIONS:
"Charity care" is defined as "appropriate hospital-based medical services provided to indigent persons." WAC § 246-453-010(5).

"Bad debts" is defined as "uncollectible amounts, excluding contractual adjustments, arising from failure to pay by patients whose care has not been classified as charity care." WAC § 246-453-010(6).

FREE CARE AS A COMMUNITY BENEFIT: N/A

ELIGIBILITY REQUIREMENTS:
Individuals with family incomes equal to or below 100% of the federal poverty standard, adjusted for family size, are deemed indigent and qualify for the full amount of charity care. Those individuals with family incomes between 100 and 200% of the federal poverty standard, adjusted for family size, are deemed indigent and qualify for discounts from charges related to hospital based medical services. Hospitals may also classify individuals whose income exceeds 200% of the federal poverty standard, adjusted for family size, as indigent and eligible for a discount from charges. WAC § 246-453-040.

Each hospital shall implement a sliding fee schedule for determination of discounts. WAC § 246-453-050.

"Indigent Persons" is defined as "those patients who have exhausted any third-party sources, including Medicare and Medicaid, and whose income is equal to or below 200% of the federal poverty standards, adjusted for family size or is otherwise not sufficient to enable them to pay for the care or to pay deductibles or coinsurance amounts required by a third-party payor." WAC § 246-453-010(4).

"Income means total cash receipts before taxes derived from wages and salaries, welfare payments, Social Security payments, strike benefits, unemployment or disability benefits,

child support, alimony, and net earnings from business and investment activities paid to the individual." WAC § 246-453-010(17).

"Family means a group of two or more persons related by birth, marriage, or adoption who live together; all such related persons are considered as members of one family" WAC § 246-453-010(18).

FINANCING SOURCE: N/A

SERVICES COVERED:
"Appropriate hospital-based medical services" – meaning, "those hospital services which are reasonably calculated to diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective more conservative or substantially less costly course of treatment available or suitable for the person requesting the service." WAC § 246-453-010(7).

NOTIFICATION REQUIREMENTS:
Notice of the charity care policy must be made publicly available. WAC § 246-453-020(2). "Publicly available" means "posted or prominently displayed within public areas of the hospital, and provided to the individual in writing and explained… in any language spoken by more than ten percent of the population in the hospital's service area, and interpreted for other non-English speaking or limited-English speaking or other patients who can not read or understand the writing and explanation." WAC § 246-453-010(16).

APPLICATION PROCESS:
In determining eligibility, hospitals may rely upon information provided orally by the patient or responsible party. Hospitals may require applicants to use an application process attesting to the accuracy of the information provided to the hospital. WAC §§ 246-453-020(5); 246-453-030(1).

Any of the following documents are considered sufficient evidence for determining charity care status:
- W-2 withholding statement;
- Pay stubs;
- An income tax return;
- Forms approving or denying Medicaid eligibility;
- Forms approving or denying unemployment compensation; or
- Written statements from employers or welfare agencies.

WAC § 246-453-030(2).

If the individual cannot provide any of these forms, the hospital must rely on a written and signed statement. WAC § 246-453-030(4). If the person's identification as an indigent person is obvious, the hospital does not need to establish the exact income level or request the above documentation. WAC § 246-453-030(4).

GRIEVANCE/APPEAL PROCESS:

Hospitals must notify persons applying for charity care of their final determination within 14 calendar days of receiving an application. The notification must include a determination of the amount which the individual will be held financially accountable. WAC § 246-453-020(7).

If the hospital denies the application, it must notify the applicant of its decision and explain the reasons. WAC § 246-453-020(8). The applicant must be notified of the appeals procedure. WAC § 246-453-020(9). Under the appeals procedure, applicants have 30 calendar days to request an appeal. If the hospital's review under appeal affirms its decision, the case is sent to the Department of Health who will review it. If the Department determines that the denial of charity care was inappropriate, ti may seek penalties (see below). WAC § 246-453-020(9).

REPORTING REQUIREMENTS:

Each hospital must submit its charity care policies, procedures, and sliding fee schedules to the Department. They must also submit their bad debt policies and procedures, including reasonable and uniform standards for collection of the unpaid portions of hospital charges that are the patient's responsibility. The Department must review these policies and procedures and reject any that do not comply with these rules and regulations. WAC § 246-453-070.

Each hospital must also compile and report data to the Department with regard to the amount of charity care provided. WAC § 246-453-080.

The Department must also issue a report on charity care once a year. Rev. Code Wash. §70.170.060(8).

PENALTIES FOR NONCOMPLIANCE:

Failure to file any required information with the Department subjects the hsoptial to a civil penalty of $1,000 per day of violation. WAC § 246-453-090. *See also* Rev. Code Wash. § 70.170.070.

OTHER:

While the hospital is determining whether an individual is qualified for charity care, it may not begin collection efforts from that person. WAC § 246-453-020(1). If the hospital has denied charity care, a hospital may not begin collection proceedings until 14 days after notifying the applicant of its decision. If no appeal has been filed after 14 days, collection proceedings may begin. If an appeal is subsequently filed, the collection proceedings must stop until a final decision is made. WAC §246-453-020(9).

If an individual pays a portion or all of the charges and is then determined to be eligible for charity care, s/he may be refunded for the payments. WAC § 246-453-020(11).

WEST VIRGINIA

FREE CARE CITATION:
West Virginia Code § 5-16A-3
West Virginia Health Care Insurance Act
Note: The Health Care Insurance Act appears to have expired in 1992. The only reference to the expiration is § 5-16A-9, rather than writing "expired" before the entire Article. Despite the confusion, I summarized the key points of the Article.

TERMINOLOGY: N/A

REGULATORY OVERSIGHT:
Public Employees Insurance Agency
W. Va. Code § 5-16A-4(c).

DEFINITIONS AND DISTINCTIONS: N/A

FREE CARE AS A COMMUNITY BENEFIT: N/A

ELIGIBILITY REQUIREMENTS:
Creates an insurance pool that is available to employers and employees of small businesses (including nonprofit organization). Small businesses have less than nineteen employees. Individuals who have been without health insurance for at least six months are also eligible. W. Va. Code § 5- 16A-5.

The plan will limit enrollment to those individuals who have incomes at or below 200% of the federal poverty level. W. Va. Code § 5-16A-5(e).

FINANCING SOURCE:
West Virginia Health Care Insurance Fund.

The plan shall provide for differing premium and benefit structures based upon the enrollee's level of income. There is a minimum $250 annual deductible for inpatient care and a lifetime cap of $250,000, per individual, for all benefits provided under the plan. W. Va. Code § 5-16A-5(e).

There shall be a bidding process from qualified and licensed insurance companies or carriers who wish to offer plans or reinsurance for the insurance coverage desired. W. Va. Code § 5-16A-5(b).

SERVICES COVERED:
Members of the West Virginia Health Insurance Pool must receive health care through an exclusive provider organization consisting of acute care hospitals, primary care centers, clinics, physician groups, and physicians. Inpatient care is provided at a discounted rate at or below cost. Primary care and outpatient services is provided on a per capita basis.

A formulary prescription drug program shall also be included on a near cost basis. W. Va. Code § 5-16A-5.

NOTIFICATION REQUIREMENTS:
The Public Employees Insurance Agency shall ensure accurate and appropriate marketing of the health insurance coverage to small businesses throughout the state. W. Va. Code § 5-16A-5(b).

APPLICATION PROCESS:
The Public Employees Insurance Agency shall provide an application form for participation and procedures for application. W. Va. Code §5-16A-5(b).

GRIEVANCE/APPEAL PROCESS: N/A

REPORTING REQUIREMENTS:
For the years 1990-1992, the Public Employees Insurance Agency submitted annual reports to the legislature on the Health Care Insurance Plan. W. Va. Code § 5-16A-6.

PENALTIES FOR NONCOMPLIANCE: N/A

OTHER:
The Public Employees Insurance Agency shall establish criteria for monitoring the effectiveness of the insurance pool. W. Va. Code § 5-16A-5(b).

All participants are required to complete a medical screening exam. Those who do not pass the medical screen may be able to participate. Premiums for such individuals may be at a rate higher than those established for other participants. W. Va. Code § 5-16A-5(g).

WISCONSIN

FREE CARE CITATION:
Wisconsin Administrative Code
Department of Health and Family services 120.01, et. seq.

TERMINOLOGY:
Charity Care

REGULATORY OVERSIGHT:
Department of Health and Family Services

DEFINITIONS AND DISTINCTIONS:
Bad debts means "claims arising from rendering patient care services that the hospital, using a sound credit and collection policy, determines are uncollectible, but does not include charity care."
Wis. Adm. Code HFS 120.02(2).

Charity care means "health care a hospital provides to a patient who, after an investigation of the circumstances surrounding the patient's ability to pay, including nonqualification for a public program, is determined by the hospital to be unable to pay all or a portion of the hospital's normal billed charges. Charity care does not include any of the following:

(a) Care provided to patients for which a public program or public or private grant funds pay for any of the charges for the care.
(b) Contractual adjustment in the provision of health care services below normal billed charges.
(c) Differences between a hospital's charges and payments received for health care services provided to the hospital's employees, to public employees or to prisoners.
(d) Hospital charges associated with health care services for which a hospital reduces normal billed charges as a courtesy.
(e) Bad debts."

Wis. Adm. Code HFS 120.03(4).

"Uncompensated Health Care Services means charity care and bad debts." Wis. Adm. Code HFS 120.03(35).

FREE CARE AS A COMMUNITY BENEFIT: N/A

ELIGIBILITY REQUIREMENTS:
Although nothing is specifically required, hospitals must annually submit their procedures for determining eligibility to the Department of Health and Family Services. Wis. Adm. Code HFS 120.12(1)(a)(2).

FINANCING SOURCE: N/A

SERVICES COVERED: N/A

NOTIFICATION REQUIREMENTS:
Although nothing is specifically required, hospitals must annually submit their notification process to the Department of Health and Family Services. Wis. Adm. Code HFS 120.12(1)(a)(3).

APPLICATION PROCESS: N/A

GRIEVANCE/APPEAL PROCESS: N/A

REPORTING REQUIREMENTS:
Hospitals must provide the following data on their uncompensated health care plans annually to the Department of Health and Family Services:

(a) A set of definitions describing terms used by the hospital throughout the uncompensated health care plan.
(b) The procedures the hospital uses to determine a patient's ability to pay for health care services received and to verify financial information from the patient.
(c) The hospital's means of informing the public about charity care available at that hospital and a description of the procedure for obtaining the care.
(d) The amount of any state loan funds… outstanding with a continuing obligation during the previous year.

Wis. Adm. Code HFS 120.12(1)(a).

Hospitals must also annually submit a fiscal survey to the Department of Health and Family Services. Among the information which must be submitted as part of this survey is the prior year hospital uncompensated care charge data and the anticipated hospital uncompensated care charge data. Both of these categories require submitting data comparing the number and cost of charity care cases with bad debt cases for the previous and next year, respectively. Wis. Adm. Code HFS 120.12(2).

Hospitals must also submit an Uncompensated Health Care Services Report. This report must contain information on the dollar amount and proportion of cases of charity care and bad debt, respectively. This report shall be distributed to the Governor and the Legislature. It will also be available for purchase by individuals or free of charge at the Department's Web Site. Wis. Adm. Code HFS 120.25.

PENALTIES FOR NONCOMPLIANCE: N/A

OTHER:

WYOMING

Wyoming has no legislative mandate for free care.

FREE CARE CITATION: N/A

TERMINOLOGY: N/A

REGULATORY OVERSIGHT: N/A

DEFINITIONS AND DISTINCTIONS: N/A

FREE CARE AS A COMMUNITY BENEFIT: N/A

ELIGIBILITY REQUIREMENTS: N/A

FINANCING SOURCE: N/A

SERVICES COVERED: N/A

NOTIFICATION REQUIREMENTS: N/A

APPLICATION PROCESS: N/A

GRIEVANCE/APPEAL PROCESS: N/A

REPORTING REQUIREMENTS: N/A

PENALTIES FOR NONCOMPLIANCE: N/A

OTHER: