SECTION 6: ALTERNATIVES TO REIMBURSE HOSPITALS AND OTHER HEALTH CARE PROVIDERS FOR UNREIMBURSED AND TRAUMA COSTS

Overview

In the previous section, we provided background financial information on Wyoming hospitals, including a discussion of charity care and bad debt, and described the estimated costs of the uninsured and unreimbursed trauma care and catastrophic care.

This section describes three main options that the Commission may want to consider to increase reimbursement to hospitals to support the provision of trauma and catastrophic care. We review potential benefits and challenges of these approaches and describe possible funding sources. Each of these options address different facets of the issues facing Wyoming hospitals today (e.g., targeting funds to the uninsured versus targeting funds to hospitals with the largest proportion of trauma care patients), and as the Commission decides to prioritize its options, it may choose to adjust one of these options, or blend features of multiple options. The State could make payments on a periodic basis for each of these options (i.e., annually or quarterly), and would need to dedicate additional resources for program administration.

All of these options assume a fixed pool of funding, which could be based on a combination of State budget priorities and the identification of specific levels of uncompensated care. For example, the State could consider setting the funding pool equal to one of the following:

- Unreimbursed trauma care costs statewide, which totaled approximately $5.4 million in SFY 2004.[1] Our study indicated, however, that hospitals have not consistently reported trauma care cases in the State's Trauma Registry, therefore, the number of trauma care cases may be significantly understated. Assuming that we have only one-fourth of the total trauma care discharges, we project that unreimbursed SFY 2004 trauma care costs could be $21.6 million.

- Unreimbursed catastrophic care costs, which totaled approximately $4 million in SFY 2003[2]

- Total costs associated with uninsured inpatient hospital discharges with costs over $10,000, which totaled approximately $3.1 million annually between SFY 2002 and 2003.[3] Total costs for all uninsured inpatient hospital discharges totaled approximately $15.8 million in SFY 2003.[4]

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[1] As described in Section 5 and calculated using data from the Trauma Program Registry.
[2] As described in Section 5 and based on Hospital Survey results.
[3] Based on total estimated costs from the Wyoming Hospital Discharge Database for discharges with a primary payor of "self-pay" or "medically indigent."
[4] Ibid.

Due to restrictions on the use of the Wyoming Hospital Discharge Database, we are providing only aggregate budget impact results and describing generally how these options may impact hospitals.

These options must be considered in light of Wyoming's Constitutional requirement that state or local governments may not "loan or give its credit or make donations to or in aid of any individual, association or corporation, except for necessary support of the poor…"[5] This statute has different implications for each of these options.

Discussion of Options

We describe each option below.

Option 1: Pay for Unreimbursed Costs of Discharges Exceeding a Predetermined Cost Threshold

Under this option, Wyoming would pay the costs of inpatient hospital stays related to trauma and catastrophic care that exceed a predetermined threshold (e.g., three standard deviations from the hospital's average costs). Wyoming could develop a specific fund amount, and make payments quarterly (or biannually) based on a percentage of all hospitals' costs exceeding a specific threshold, as does Pennsylvania, or it could pay claims on a "first-in" basis, as does the Federal Indian Catastrophic Health Emergency Fund.

The benefits of this option follow:

- All hospitals that provide trauma and uncompensated care can potentially be eligible for some payments.

- The payment of a particular hospital's cost recognizes the different cost structures in different hospitals.

The challenges of this option follow:

- It is apparent that the most detailed of cost data would be beneficial. This would require that the agency responsible for administering the program conduct detailed analyses of hospital data to determine hospital costs, or use the detailed cost estimates provided by Solucient.[6] In addition, if Trauma Care Program Registry data are used, efforts should be made to standardize reporting.

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[5]State of Wyoming Constitution, *Title 97, Section 16-006*

[6] In developing our cost estimates, we learned, for example, that Wyoming Medical Center has a unique approach for reporting costs for certain items, such as medical supplies. The use of Solucient cost-to-charge ratios does not

- The policy does not target the uncompensated costs from the uninsured, and an adjustment of the policy may be necessary to meet Wyoming's Constitutional Amendment to provide public funding only in support of the poor.

Option 1, in general, benefits Area Trauma Hospitals the most, and the benefit to Trauma Receiving Facilities and Community Trauma Hospitals varies widely. This Option does not specifically benefit critical access hospitals.

Because relatively high payments from private payors result in aggregate inpatient hospital cost coverage of more than 100 percent for selected hospitals (based on data submitted for the hospital survey), the optimal way to implement this option (assuming payment to all hospitals is a priority) would be to make payments on a claim-by-claim basis. Using that approach, even hospitals that receive in the aggregate payments that exceed costs could receive additional payments. Because some of the hospitals with greater than 100 percent cost coverage (in the aggregate) are Wyoming's Regional Trauma Centers, applying this option on a claim-specific basis would be necessary to cover the unreimbursed costs of these hospitals' care.

Option 2: Pay hospitals an amount equal to a percentage of a hospital's uncompensated care costs (bad debt and charity care), with adjustments to recognize those hospitals with a high proportion of trauma care.

This option recognizes the interrelationship of uncompensated care and hospital financial well-being, as well as the important role of hospitals that provide a significant portion of the State's trauma care. This option would pay hospitals an amount equal to a predetermined percentage of the hospital's uncompensated care costs (bad debt and charity care), with adjustments to recognize hospitals with a higher proportion of trauma care. This approach is similar to Illinois' distribution of funding according to each hospital's number of trauma care patients and Washington's distribution of funding based on an injury index system. In Option 2, we present three variations of this option:

- *Option 2A:* The fund pays hospitals a predetermined percentage of uncompensated care costs, calculated by multiplying the amount of bad debt and charity care costs the hospital reports annually by a predetermined percentage (equal to the desired funding pool amount).

- *Option 2B:* This option adjusts the predetermined percentage of uncompensated care costs by a trauma care adjustment factor. This trauma care adjustment factor reflects

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recognize that method. If the Legislature determines it is appropriate to allow hospitals to provide their own variations to Medicare's cost allocation process, significant additional effort will be required to gather and validate that information.

the number of trauma care discharges a hospital provides as a percentage of its total discharges, as follows:[7]

$$\text{Trauma Care Adjustment Factor} = \frac{\text{Hospital Trauma Care Discharges/Total Hospital Discharges}}{\text{Total Trauma Care Discharges for Wyoming Hospitals/Total Discharges for Wyoming Hospitals}}$$

- *Option 2C:* This option is similar to Option 2B, except that it bases the trauma care adjustment factor on estimated trauma care costs as opposed to trauma care discharges.[8]

As in Option 1, the State could establish a fund of any amount. Setting the funding pool at $5.4 million dollars,[9] for example, would result in payments equaling approximately 8.1 percent of hospitals' bad debt and charity care amounts. As in Option 1, the fund could make periodic payments.

By applying the trauma care adjustment factors, the fund could pay hospitals that provide more trauma care discharges (or have higher estimated trauma care costs) slightly more than 9.25 percent of their bad debt and charity care. Both Options 2B and 2C yield similar results.

The benefits of this option follow:

- The policy provides all hospitals, regardless of their trauma designation, additional funding to support unreimbursed care, which would include trauma and catastrophic care.

- Distributing funding in this manner is responsive to a particular hospital's provision of trauma care in relationship to its total discharges. In addition, if Trauma Care Program Registry data are used, efforts should be made to standardize reporting.

The challenges of this option follow:

- It is apparent that the most detailed of cost data would be beneficial. This would require that the agency responsible for administering the program conduct detailed analyses of hospital data to determine hospital costs, or use the detailed cost

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[7] We have assigned any hospitals that do not have data in the Wyoming Hospital Discharge Database a Trauma Care Adjustment Factor equal to the lowest calculated trauma care adjustment factor.

[8] We have assigned any hospitals that do not have data in the Wyoming Hospital Discharge Database a Trauma Care Adjustment Factor equal to the lowest calculated trauma care adjustment factor.

[9] SFY 2003 unreimbursed trauma care costs, as estimated in Section 5 using the State of Wyoming's Trauma Registry data.

estimates provided by Solucient. In addition, if Trauma Care Program Registry data are used, efforts should be made to standardize reporting.

- This policy does not target the uncompensated costs from the uninsured, and an adjustment of the policy may be necessary to meet Wyoming's Constitutional Amendment to provide public funding only in support of the poor.

- This policy does not specifically address catastrophic care discharges although the hospital could use the funding to cover the costs of those discharges.

While Option 2A treats all hospital equally (as each hospital would be paid the same percentage of its bad debt and charity care), Options 2B and 2C favor hospitals with the highest proportion of trauma discharges or costs out of their total discharges or costs (respectively), specifically:

- Those hospitals with a trauma care adjustment factor greater than 1 (based on estimated costs) are: West Park Hospital, Washakie Medical Center, Sweetwater County Memorial Hospital, Sheridan County Memorial Hospital and St. John's Hospital (all have Area Trauma Hospital or Community Trauma Hospital designations).

- Hospitals with some of the lowest trauma care adjustment factors are Weston County Memorial Hospital, Crook County Memorial Hospital and South Lincoln Memorial Hospital (all with Trauma Receiving Facility designations).

Regional Trauma Centers, such as Wyoming Medical Center and United Medical Center benefit the most from Option 2, whereas the Trauma Receiving Facilities benefit the least. Furthermore, non-critical access hospitals benefit from this option more so than critical access hospitals.

Option 3: Provide a catastrophic care pool for uninsured Wyoming residents.

This option pays the costs of all inpatient hospital discharges for uninsured individuals after a predetermined threshold (set at $10,000 in costs for this model). The State could limit eligibility to individuals below a certain federal poverty level (i.e., 250 percent of the federal poverty level). New Mexico and Idaho use a similar approach.

For budget impact purposes, we developed two options:

- *Option 3A*: The fund pays the costs of all inpatient hospital discharges with a primary payor of self-pay or charity care that exceed $10,000.

- *Option 3B*: The fund pays similar to Option 3A, but limits payments to discharges with a trauma care diagnosis.

An actuarial estimate would be necessary to determine how many of these discharges correspond to individuals with particular income levels, if the State chooses to tailor these options further.

The benefits of this option follow:

- The funding methodology targets the population that incurs the most uncompensated costs, and the State could identify participating individuals as "poor" if it chooses to use a specific income level as a cap.

- The payments address trauma and non-trauma discharges.

The challenges of this option follow:

- It is apparent that the most detailed of cost data would be beneficial. This would require that the agency responsible for administering the program conduct detailed analyses of hospital data to determine hospital costs, or use the detailed cost estimates provided by Solucient. In addition, if Trauma Care Program Registry data are used, efforts should be made to standardize reporting.

- This option may reduce employer incentives to offer basic health care insurance because it essentially provides a minimal level of health care insurance.

- The methodology does not tailor payments to each hospital's cost experience (i.e., a review of the Wyoming Hospital Discharge data indicates that a least eight small hospitals do not have inpatient discharges that reach this a $10,000 threshold).

Non-critical access hospitals gain the most under Option 3, whereas critical access hospitals and the majority of Community Trauma Hospitals and Trauma Receiving Hospitals see little or no benefit. On the other hand, Area Trauma Hospitals and Regional Trauma Centers seem to benefit largely from this option. The following hospitals would receive the majority of the funding: St. John's Hospital, Campbell County Memorial Hospital, Wyoming Medical Center and United Medical Center.

Potential Funding for Reimbursement Options

States have used a wide variety of sources to fund trauma and catastrophic care, as described in Section 4 of this Report. Illinois, for example uses traffic fines, Maryland uses vehicle registration fees and Pennsylvania uses criminal fines. Below we describe options for funding that Wyoming may want to consider.

Public Fines, Taxes or Fees

Wyoming could collect funding through a variety of public fines, taxes or fees; collecting funding through traffic violations and car and driver fees would require a constitutional amendment to allow for such funding to be distributed to other state agencies. Examples of this funding would be:

- *Traffic violation fines* – Some states increase or add fines for serious infractions, including Driving Under the Influence (DUI) violations, reckless driving, speeding and improper use of safety belts. Illinois, for example, adds $100 to each DUI violation, which funds the State's trauma system.

- *Car and driver fees* – Wyoming could choose to apply additional fees to driver and vehicle licenses. Oklahoma, for example, adds $5.50 per drivers license renewal for the State's indigent care fund and the State's emergency medical system and Trauma System administration.

- *Taxes* – Wyoming could use a variety of taxes, including taxes on employers and tobacco and alcohol taxes. Maryland, for example, increased the state alcoholic beverage tax to fund the Emergency Medical Services Operation Fund.

- *Civil and criminal fees*—Additional fines could be imposed on criminal and civil crimes which are likely to cause traumatic injury. Illinois, for example, assesses an additional $100 for the illegal discharge of a firearm.

Wyoming's ability to use county funding for a trauma and catastrophic care pool is limited due to the variation among counties' taxing structures and ability to levy additional taxes. Local governments use mills to calculate the amount of taxes a taxpayer pays for every $1,000 of property value (defined per the Wyoming Statute). County governments use the following two mechanisms to collect funding:[10]

- *Special district* – A hospital district is a type of special district that use taxes to fund a public heath center.[11] Each hospital district has a cap on the total taxes it may collect and only one of the 13 hospital districts in Wyoming is at the cap.

  Hospital districts can receive a three-mill levy annually; however, the hospital board can ask for more mills. The hospital board can vote to increase the mill levy to more than three mills; however, the levy in a hospital district may not exceed six mills for

[10] Wyoming Taxpayers Association, "Wyoming Property Taxation 2003." Available online: http://www.wyotax.org. Wyoming State Statute 35.2.401 and 35.2.414. Available online: http://legisweb.state.wy.us/statutes/titles/title35/c02a04.htm.
[11] Ibid.

operation and maintenance annually. If the hospital board does agree to increase the mill levy, the county commissioners must call an election within the special district. If the increased mill levy is approved, the proposition will appear on the ballot at the general election held every four years until defeated. Once the proposition is defeated, it cannot appear on a ballot for at least 23 months. The hospital board is responsible for the cost of any special elections to raise the mill levy. County residents may be unwilling to fund a pool dedicated to hospital care.

- *County operations* – County hospitals receive local funding through the county operations budget.[12] Each county can receive up to 12 mills for county operations. County hospitals can receive any portion of that levy. Other programs included in the county operations mill levies are civil defense, museums, public libraries, roads and bridges. Counties can guarantee a specific levy for certain programs as long as the total levy does not exceed 12 mills. The total county operating budget is capped, so to increase the county hospital budget, other budgets would need to be decreased.

Given Wyoming resident's current tax burden, it may be difficult to increase taxes to fund a pool dedicated to hospital care.

State General Revenue Funds

A number of states designate a portion of their state budgets specifically for the development, implementation and maintenance of their trauma programs. State funding ranges from $5 million to $25 million in California, Illinois, Pennsylvania, Texas and Washington, for example.

Federal Medicaid Payments

The State could fund hospital payments through Medicaid dollars eligible for federal match, currently at the rate of 57.9 percent. For example, the State could use an approach like Washington's, which distributes Medicaid supplemental payments to Level 1, 2 and 3 trauma hospitals based on the relative amount of trauma care they provide per quarter to Medicaid clients.[13]

Using Federal Medicaid payments requires coordinating funding with Medicaid disproportionate share hospital and qualified rate adjustment payments as these payments also fund unreimbursed care and receive federal Medicaid matching funds. Alternatively, the Commission could recommend additional funding to expand Medicaid coverage to additional

[12] Wyoming Taxpayers Association, "Wyoming Property Taxation 2003." Available online: http://www.wyotax.org. Wyoming State Statute 35.2.401 and 35.2.414. Available online: http://legisweb.state.wy.us/statutes/titles/title35/c02a04.htm.

[13] Department of Social and Health Services Medical Assistance Administration, "Memorandum 03-53 MAA – Reissued: Reinstatement of Supplemental Payments for Qualified Trauma Services," (July 1, 2003).

uninsured populations; the State could potentially limit this coverage to a reduced benefit package.

According to SFY 2004 estimates, there is approximately $9.2 million in unreimbursed inpatient and outpatient Medicaid costs. The State could choose to fund these remaining costs to increase cost coverage for these services through the development of peer groups for hospitals based on trauma level designation. This would require a general fund revenue to obtain the federal match, however, and would be targeted to certain providers. Any Medicaid changes would require careful coordination with existing programs and a State Plan amendment.

Summary

This section of the report has provided information on three main options that Wyoming may want to consider given key state-specific considerations. Because these options vary in regards to the impact they have on different groups of hospitals, Wyoming will want to consider funding priorities given state-specific goals regarding trauma and catastrophic funding.