Joint Legislative Audit and Review Commission

The Virginia General Assembly

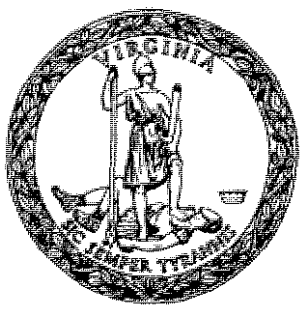
Funding of Indigent Hospital Care in Virginia

A Report in a Series on the Virginia Medicaid Program

REPORT OF THE
JOINT LEGISLATIVE
AUDIT AND REVIEW COMMISSION

Funding of Indigent Hospital Care in Virginia

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA



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Preface

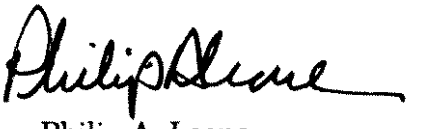
Senate Joint Resolution (SJR) 180 of the 1991 Session of the General Assembly directed the Joint Legislative Audit and Review Commission to study the Virginia Medicaid program and the indigent care appropriations to the State teaching hospitals and the Medical College of Hampton Roads. SJR 180 outlined 11 specific issues to be included in the study. This report examines issues related to the indigent care appropriations as well as options for optimizing the use of State funds for indigent hospital care.

The review found that the State teaching hospitals receive more than half of all State general fund expenditures for indigent hospital care. The institutions have been accountable for the use of State funds, and they have taken necessary steps to remain financially sound during a period of State budget difficulties. In the short term, the General Assembly's guidance is needed on policy issues such as the use of State indigent care funds to finance the care of non-Virginians. Looking to the future, the State needs to develop a more comprehensive approach to funding indigent care and medical education in recognition of significant changes in the academic medical center environment.

The review also found that the State is already taking advantage of most of the opportunities to leverage State funds with federal funds through the Medicaid program. The remaining opportunities are limited by legal and regulatory constraints.

The major findings and recommendations from this study have been provided to the Joint Legislative Audit and Review Commission and the Joint Commission on Health Care. The Joint Commission on Health Care will play the lead role in deciding how the recommendations in this report should be acted upon.

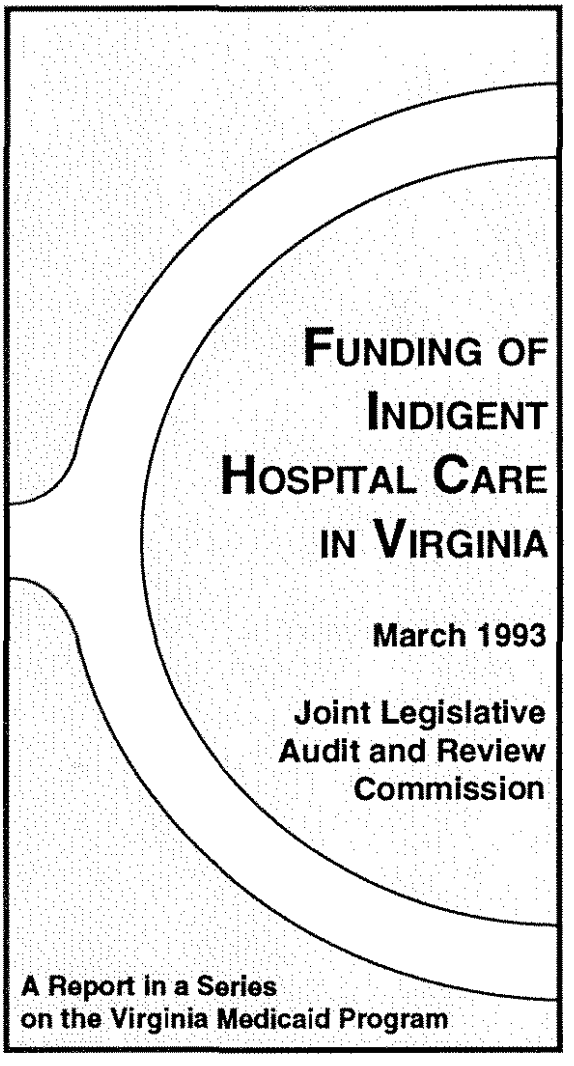
On behalf of JLARC staff, I would like to thank the Presidents and staff of the Medical College of Hampton Roads, the University of Virginia, and Virginia Commonwealth University. In addition, I would like to thank the staff of the Department of Medical Assistance Services, the Health Services Cost Review Council, and the Department of Health.



Philip A. Leone
Director

March 15, 1993

JLARC Report Summary



Large numbers of poor Virginians are without health insurance, and the cost of insurance and health care services is increasing. As a result, the State's indigent care programs have experienced significant growth, which is expected to continue into the future. In response to this concern, the General Assembly directed the Joint Legislative Audit and Review Commission (JLARC) to study the Commonwealth's Medicaid program and the indigent care appropriations to the State teaching hospitals and the Medical College of Hampton Roads (MCHR).

This report is one in a series completed in response to SJR 180 (1991). The report addresses three of 11 specific directives contained in SJR 180, in the context of hospital care:

- Review of eligibility, scope of services, and reimbursement rates for indigent care at the University of Virginia Medical Center (UVAMC), the Medical College of Virginia Hospitals of Virginia Commonwealth University (VCU/MCVH), and MCHR; and a determination of the appropriateness of general fund and Medicaid allocation methodologies.

- Examination of the relationship between Medicaid and other State programs to promote optimal utilization of State funds.

- Identification of options for using Medicaid funds for services currently supported with general funds.

The results of the review show that the State is the largest single source of indigent hospital care funding in Virginia. Furthermore, the two State teaching hospitals are the major providers of this care.

The review found that the State teaching hospitals are accountable for the use of State funds. However, the General Assembly should clarify its position on certain reimbursement, eligibility and service practices at the State teaching hospitals, such as the use of indigent care funding for out-of-state patients. The State should also develop a more comprehensive method for deciding indigent care funding levels at the State

teaching hospitals. In addition, MCHR should be required to revise its methods for requesting indigent care appropriations.

The review also found that there are limited opportunities for optimizing State funds through the Medicaid program. The State is already achieving major savings by using federal Medicaid funds to subsidize a portion of the non-Medicaid indigent care provided at the State teaching hospitals. New federal regulations and other factors may make it difficult to expand this policy. However, several options are presented for consideration by the General Assembly.

The State Is the Largest Payor for Indigent Hospital Care

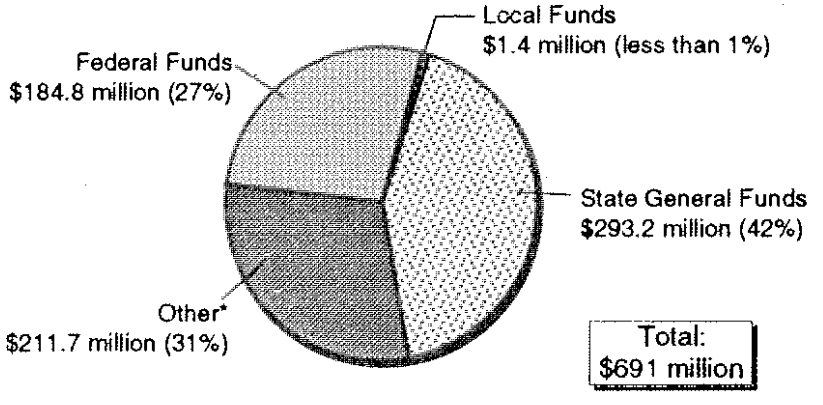
The State oversees four major financing mechanisms for indigent hospital care:

- The Virginia Medicaid program,
- The State and Local Hospitalization (SLH) program,
- The Indigent Health Care Trust Fund (Trust Fund), and
- Indigent care appropriations to UVAMC, VCU/MCVH, and MCHR.

An additional source of funding for indigent hospital care is unsponsored care provided by hospitals. Unsponsored care includes charity care and bad debt for which a hospital receives no payment.

Because of a lack of comprehensive, statewide spending data for indigent hospital care, an estimate of the total amount was developed. This JLARC estimate indicates that in FY 1991, approximately $691 million was spent on indigent hospital care in Virginia. More than $293 million (42 percent) of this spending came from State general funds (see figure below). Federal funds accounted for nearly $185 million (27 percent) of total spending, and local funds accounted for $1.4 million, or less than one percent of total spending. Hospital unsponsored care accounted for nearly $212 million, or 31 percent of total spending for indigent hospital care.

Spending for Indigent Hospital Care by Funding Source, FY 1991



* Includes hospital charity care, bad debts, and hospital share of Trust Fund payments.

VCU/MCVH and UVAMC Are Major Providers of Indigent Hospital Care In the State

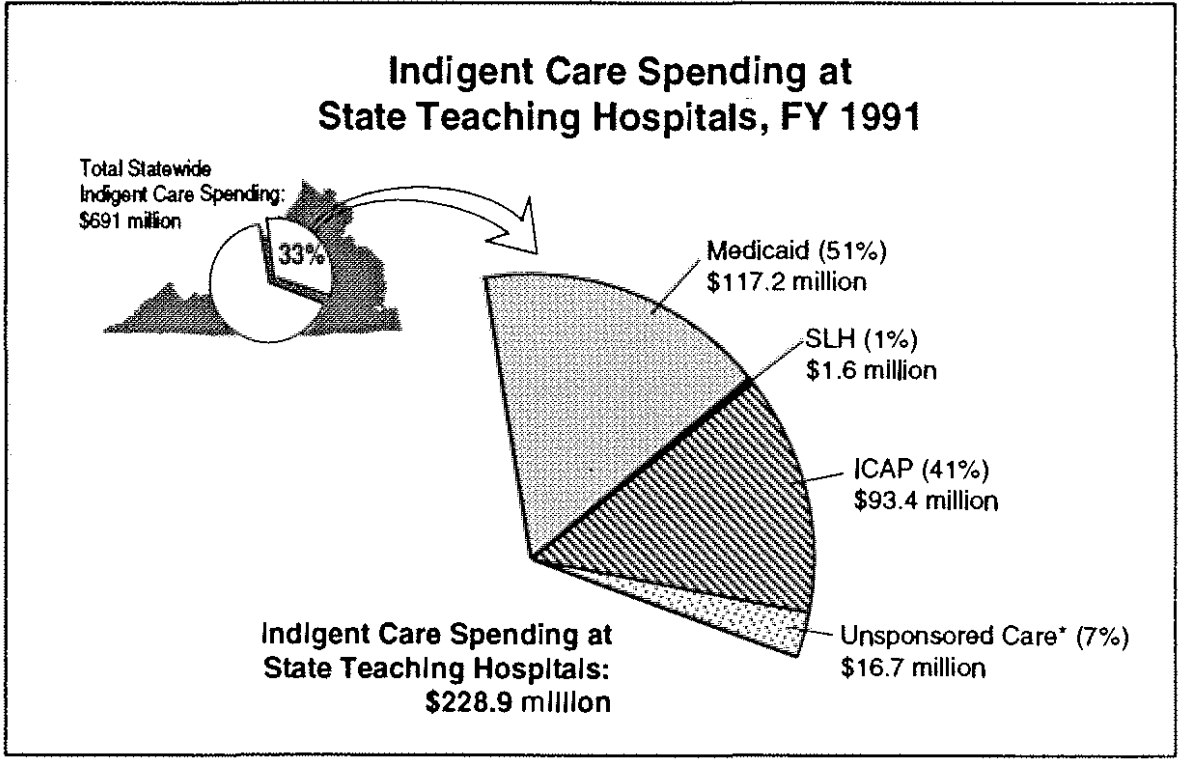
Of the estimated $691 million spent on indigent hospital care in FY 1991, VCU/MCVH and UVAMC accounted for about one-third (see figure below). Virginia Medicaid reimbursement and the indigent care appropriations comprised more than 90 percent of these funds. Together the State teaching hospitals received $154 million of the $293 million in State general funds spent on indigent hospital care.

There are several reasons why the State teaching hospitals accounted for this level of spending. Both VCU/MCVH and UVAMC serve a high volume of indigent patients compared to most other hospitals in the State. In addition, the teaching mission of these institutions makes them more expensive than most other hospitals in the State. Also, the State funds a greater share of costs at these institutions than at other hospitals.

Indigent Care Reimbursement Rates Are Reasonable at the State Teaching Hospitals, But Legislative Intent Should Be Clarified for Several Other Issues

To determine the reasonableness of the eligibility, scope of services, and reimbursement rates for the indigent care appropriations at VCU/MCVH and UVAMC, a comparison was made between these elements and those in place for other State indigent hospital programs. Although a comparative analysis of reimbursement rates found the indigent care rates to be reasonable, three concerns were identified.

First, the two State teaching hospitals currently receive general funds for their unreimbursed Medicaid costs. This may conflict with federal and State Medicaid policies of accepting Medicaid reimbursement as payment in full. The two teaching hospitals received more than $2.7 million in general funds for these costs in FY 1992.



Second, the State teaching hospitals have used their general fund appropriations to subsidize the indigent care of non-Virginians, which cost the State about $2.6 million in FY 1992. Most of this care has been provided to West Virginians at UVAMC. Of the states bordering Virginia, only North Carolina provides indigent care funding that can be used to provide care to Virginians, but only under certain limited circumstances.

Third, the indigent care appropriations have been used to reimburse the teaching hospitals for services they provided to indigent patients that would not be reimbursable under Virginia Medicaid. One costly example is certain types of transplants — liver, heart, and bone marrow. In FY 1992, UVAMC and VCU/MCVH were reimbursed more than $2.7 million in general funds for 38 of these transplants.

The issue of transplants is complicated by the fact that 12 of the 30 transplant recipients at UVAMC in FY 1992 were Medicaid eligible. If Virginia Medicaid had covered these services, $1.2 million in general funds could have been saved on these transplants. It is not clear at this point whether Virginia Medicaid should revise its transplant policy. More information is needed on the hidden demand for transplants, as well as alternative means of financing transplants through Medicaid.

The following recommendations are made in response to these findings:

- *The General Assembly should clarify its intent concerning the funding of unreimbursed Medicaid costs through the indigent care appropriations.*

- *The General Assembly should clarify its intent concerning whether the indigent care appropriations should be used to reimburse the State teaching hospitals for services provided to non-Virginians.*

- *The Secretary of Health and Human Resources, with support from the Secretary of Education, should study the current Medicaid limits on transplant services.*

- *The General Assembly should clarify its intent concerning the scope of services reimbursable through the indigent care appropriations.*

A More Comprehensive Approach Is Needed to Determine Appropriate Funding Levels at the State Teaching Hospitals

In the past, the indigent care appropriations to the State teaching hospitals have been based on a decision to fund a certain percentage of their reported indigent care costs. Despite receiving a reduced percentage of costs in recent years, the institutions have taken steps to remain financially sound.

There is no guarantee, however, that this will continue in the future because the health care and medical education environments are in a state of flux. To ensure that State general funds are used as cost effectively as possible, the State needs to adopt a multi-faceted approach to indigent care funding. This approach should be focused on institutional performance with respect to State policy goals for indigent care and medical education.

The following recommendation is made:

- *The Department of Planning and Budget should consider the following factors as it considers the State teaching hospitals' budget requests for general fund support of indigent care and medical education: (1) the volume of indigent care each institution will be expected to provide, (2) the medical education programs each institution will be expected to provide, (3) the cost effectiveness of each institution,*

(4) the impact of federal and State Medicaid policy changes as well as State hospital cost containment policies, (5) other providers' perceptions of payment equity, (6) each hospital's overall payor mix, financial position, capital needs, and bond rating.

Joint Budget Review Should Be Conducted

The State teaching hospitals pursue a dual mission of health care and education. Currently, recommendations for indigent care funding at the State teaching hospitals are overseen by the education secretariat, while Medicaid funding is overseen by the health and human services secretariat. There is no formal mechanism to ensure that the Secretary of Education has an opportunity to comment on Virginia Medicaid policy changes which could significantly impact the State teaching hospitals. Similarly, there is no formal mechanism to allow the Secretary of Health and Human Resources to comment on the cost effectiveness of the indigent care appropriations to the teaching hospitals.

As the health care and medical education environments grow increasingly complex, it will be important to ensure that health care policies do not compromise the education mission of the State teaching hospitals, and vice versa. Therefore, the following recommendation is made:

- *The Secretary of Education and the Secretary of Health and Human resources should develop a memorandum of agreement to implement joint budget development and associated program review for the State teaching hospitals and the Medical College of Hampton Roads. This agreement should exclude dual oversight of budget execution.*

Method for Determining Indigent Care Losses Should Be Revised at the Medical College of Hampton Roads

MCHR participates in the provision of a substantial amount of indigent care through its faculty practice plans and educational programs at various area hospitals. The State has provided indigent care funds to MCHR since 1978, including an annual appropriation of more than $4 million.

In its budget addenda for the FY 1992-94 biennium, MCHR requested additional funding of $2.8 million. There are three concerns about this budget request which should be addressed. First, MCHR's estimate of indigent care losses was based on charges rather than costs. Second, the estimate of indigent care losses included Medicaid contractual adjustments (the difference between Medicaid charges and reimbursement), which may be inconsistent with State Medicaid policy. Third, MCHR's estimate did not consider the financial impact of the Trust Fund on the affiliated teaching hospitals.

MCHR's indigent care losses appear to be significantly less when they are determined on the basis of costs excluding Medicaid contractual adjustments. Under this approach, the adequacy of indigent care reimbursement rates appears more favorable than previously reported. In order to move toward a more appropriate basis for determining indigent care funding levels for MCHR, the following recommendations are made:

- *The Medical College of Hampton Roads should use costs rather than charges as the basis for requesting indigent care appropriations and reporting indigent care losses, and should subtract net positive payments from the Indigent Health Care Trust*

Fund when determining indigent care losses.

- *The General Assembly should clarify its intent for the inclusion of unreimbursed Medicaid costs in the determination of indigent care losses at the Medical College of Hampton Roads.*

- *Because of the presence of the Indigent Health Care Trust Fund, the General Assembly should clarify its intent to use the indigent care appropriation to subsidize charity care provided by the Medical College of Hampton Roads affiliated hospitals;*

- *The Medical College of Hampton Roads should modify its plan for apportioning the State indigent care appropriations to reflect the actual apportionment between the Medical College and the affiliated hospitals.*

There Are Limited Options for Using Medicaid Funds for Hospital Services Currently Supported with General Funds

Because of the availability of federal matching dollars, it is often more cost effective to finance a service through the Medicaid program rather than through a program which is entirely State funded. There are three general ways in which to optimize State general funds through Medicaid: (1) expand Medicaid eligibility to include recipients covered under other State funding mechanisms, (2) expand Medicaid services to include those covered under other programs, and (3) use Medicaid funds to cross-subsidize other programs without changing eligibility or services.

Medicaid Eligibility Expansions Would Not Be Cost Effective. It would not be cost effective to expand Medicaid eligibility to enroll people covered by the SLH program or the Trust Fund. The primary reason is that because of Medicaid's status as an entitlement program, the new demand created by expanded eligibility would exceed any general fund cost savings.

Medicaid Service Expansions Would Not Be Cost Effective At This Time, But the 21-day Limit on Hospital Stays Should Be Reevaluated. Earlier it was noted that further research is necessary to determine whether it might be cost effective to expand Medicaid services to include certain transplants. Another important Medicaid service limitation is the 21-day limit on adult lengths of stay. In FY 1991, the 21-day limit appears to have cost the State $2.3 million in general funds at the State teaching hospitals. Limited information on the impact of this restriction at non-State hospitals indicates that it would not be cost effective for the State to lift the 21-day limit at this time.

However, the 21-day limit should be subjected to further study based on more comprehensive information. The following recommendations are made:

- *The Department of Medical Assistance Services should develop reporting mechanisms for Virginia Medicaid, the State and Local Hospitalization program, and the Indigent Health Care Trust Fund which will allow monitoring of the 21-day length of stay Medicaid limit to occur.*

- *The Joint Commission on Health Care should ensure that the current 21-day length of stay limit on adult inpatient hospital stays is reconsidered during the work conducted by the 1995 task force on Medicaid inpatient reimbursement.*

Expanded Use of Medicaid to Cross-Subsidize the Indigent Care Appropriations Depends on Federal Regulations. During FY 1992, the general fund appropriations to VCU/MCVH and UVAMC were reduced by $40.8 million. This funding was replaced with enhanced Medicaid payments of approximately $36 million, of which $18 million was general funds. For the 1992-94 biennium, $210.7 million in indigent care appropriations were made to the State teaching hospitals, with $65.8 million being federal Medicaid funds.

Beginning in FY 1993, the federal government placed interim limits on the amount of enhanced Medicaid payments that can be made. These limits indicate that there is potential for increasing federal funding of the indigent care appropriations at VCU/MCVH and UVAMC. However, a final federal policy will have to be enacted before final decisions can be made.

It may also be possible to implement an enhanced Medicaid disproportionate share adjustment policy for MCHR. However, the unique status of MCHR as a non-State agency adds to the complexity of this option. Therefore, the following recommendation is made:

- *The Joint Commission on Health Care should request the Secretary of Health and Human Resources and the Secretary of Education to examine the feasibility of using Medicaid funds to cross-subsidize the indigent care appropriations at the Medical College of Hampton Roads and its affiliated hospitals.*

Using Medicaid Funds to Cross-Subsidize the SLH Program or Trust Fund Would Be Difficult. JLARC staff examined whether the State could also reduce general fund expenditures by using federal Medicaid dollars to cross-subsidize the SLH program or the Trust Fund. The objective would be to change the funding sources to obtain federal funds without compromising the mission of either program. However, federal Medicaid regulations in conjunction with complex legal and administrative requirements would make it difficult to cross-subsidize these programs without compromising their current missions. There are other options for maximizing federal funds, but these would require significant changes to the SLH program and the Trust Fund as they currently exist.

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I. Introduction

Lack of health insurance is a major problem for the nation and Virginia. In 1990, the Commission on Health Care for All Virginians reported that up to 880,000 Virginians (or 13 percent of non-elderly residents) were uninsured. The uninsured are a diverse group in terms of age, employment status, and income. Often the uninsured are unable to pay for hospital care.

The State sponsors or co-sponsors four major financing mechanisms for indigent hospital care. The Virginia Medicaid program is a federal-State program which provides comprehensive health care services for certain groups of poor people. The State and Local Hospitalization (SLH) program is a State-local program which provides hospital-based services for poor people who do not qualify for Medicaid but meet certain eligibility guidelines. The Indigent Health Care Trust Fund (Trust Fund) is sponsored by the State and Virginia hospitals and is designed to provide financial relief to hospitals which provide large amounts of charity care. Finally, the State's medical teaching institutions receive general fund appropriations for their provision of both indigent health care and medical education.

These four funding mechanisms are not intended to serve all the needs of the uninsured. As a result, hospitals have traditionally provided a significant amount of uncompensated care. Uncompensated care includes the cost of services for which no payment is received from the patient, an insurer, or the government, and is comprised of charity care and bad debt. Charity care refers to the cost of care provided to people with incomes below 100 percent of poverty. Bad debt refers to the cost of uncompensated care provided to people with incomes above 100 percent of poverty.

Substantial sums of money are spent on indigent hospital care in Virginia. However, there is no single source of information on spending. For this review, JLARC staff developed an estimate of indigent hospital care spending for FY 1991. The estimate includes actual spending for Virginia Medicaid, the SLH program, the Trust Fund, and the indigent care appropriations (ICAP). Also included are the costs of hospital charity care and bad debt, adjusted for the impact of the Trust Fund and the ICAP. The methodology for the estimate is explained in Appendix B.

The JLARC estimate indicates that in FY 1991, about $691 million was spent on hospital services for people without the means to pay. The major providers of these services were the two State teaching hospitals — the Medical College of Virginia Hospitals of Virginia Commonwealth University (VCU/MCVH) and the University of Virginia Medical Center (UVAMC).

STUDY MANDATE

Senate Joint Resolution (SJR) 180 (1991) directed JLARC to study the Commonwealth's Medicaid program and the indigent care appropriations to the State teaching hospitals and the Medical College of Hampton Roads (MCHR). SJR 180 identified 11 specific issues to be addressed (Appendix A). This study addresses SJR 180 items 9 and 10 as they relate to indigent hospital care, as well as item 11:

- examination of the relationship [between Medicaid and] other State programs to promote optimal utilization of State funds;
- identification of options for using Medicaid funds for services currently supported with general funds; and
- review of eligibility, scope of services, and reimbursement rates for indigent care at UVAMC, MCVH, and MCHR; and a determination of the appropriateness of general fund and Medicaid allocation methodologies.

The first two items from SJR 180 focus on the relationship between Medicaid and the State's other indigent hospital care funding mechanisms — the SLH program, the Trust Fund, and the ICAP. This study focuses on these four funding mechanisms, while also acknowledging the important role of uncompensated hospital care.

SJR 180 also requests an examination of options for optimizing the use of general funds for indigent care, and specifically requests identification of options for using Medicaid funds for services currently supported with general funds alone. The cost of care provided through Medicaid is shared with the federal government, thus allowing the conservation of State funds. To address these items, research was aimed at determining whether indigent hospital care now financed through the SLH program, the Trust Fund, or the ICAP could be financed through Medicaid instead.

In addition, SJR 180 requests an evaluation of the indigent care appropriations to VCU/MCVH, UVAMC, and to MCHR. The eligibility, scope of services, and reimbursement rates for indigent care at these institutions were evaluated in comparison with those for Medicaid, the SLH program, and the Trust Fund to identify apparent differences.

Also requested was an evaluation of the appropriateness of general fund and Medicaid allocation methodologies at these institutions. This issue is especially important at VCU/MCVH and UVAMC because Medicaid reimbursement and the indigent care appropriations are intertwined. Prior to FY 1992, the non-Medicaid indigent care provided by VCU/MCVH and UVAMC was funded through general fund appropriations. With the implementation of a new funding policy in FY 1992, a large portion of the non-Medicaid indigent care at these institutions is now reimbursed indirectly through enhanced Medicaid payments.

RESEARCH ACTIVITIES

A variety of research activities were conducted to complete this study. Numerous documents were reviewed to identify the purpose and characteristics of the various funding mechanisms. State policymakers and hospital industry representatives were interviewed to obtain their perspectives on the issues. Also, information collected during the 1992 JLARC study, *Medicaid-Financed Hospital Services in Virginia*, is included in this report. In addition, a number of State databases and other records were analyzed to identify trends in the cost and utilization of indigent hospital care.

Document Reviews

To identify the purpose and structure of the various funding mechanisms, JLARC staff reviewed the *Code of Virginia*, Appropriation Acts, previous legislative studies and reports, and documents provided by the Department of Medical Assistance Services (DMAS), the Department of Planning and Budget (DPB), MCHR, VCU/MCVH, UVAMC, and the Virginia Hospital Association (VHA). JLARC staff also reviewed a number of research articles from academic and professional literature in order to identify key issues relating to the funding of indigent hospital care, particularly in the teaching hospital setting.

In addition, past JLARC reports were reviewed. These include:

- *Inpatient Care in Virginia*, 1979;
- *Outpatient Care in Virginia*, 1979;
- *Funding the State and Local Hospitalization Program*, 1988;
- *Review of the Virginia Medicaid Program*, 1992; and
- *Medicaid-Financed Hospital Services in Virginia*, 1992.

Interviews

Staff from DMAS and the medical teaching institutions were interviewed to confirm understandings about the indigent hospital care funding mechanisms and the various data sources used in the study. VHA staff were interviewed about the hospital industry's perspective on indigent care funding.

The DPB director and the deputy director for budget operations were also interviewed. In addition, interviews were conducted with DPB staff who have budget oversight responsibilities for indigent care funding. Finally, input was obtained from staff of the Joint Commission on Health Care and the House Appropriations and Senate Finance committees.

Analysis of Spending and Utilization Data

The study required analysis of total spending for indigent hospital care, as well as utilization of indigent hospital care services. Because there is no single source containing this information, JLARC staff developed a database utilizing a variety of different sources. Data on hospital revenues, expenses, charity care, bad debt, and payor mix were provided by the Health Services Cost Review Council (HSCRC). Data on spending and utilization for Virginia Medicaid, the SLH program, and the Trust Fund were obtained from DMAS. Data on the indigent care appropriations were obtained from MCHR, VCU/MCVH, and UVAMC. Data on the distribution of poverty in Virginia were provided by the Department of Health (DOH).

Finally, data on indigent care spending and utilization at individual hospitals were collected as part of the research activities for the 1992 JLARC report, *Medicaid-Financed Hospital Services in Virginia*. For example, during site visits with ten hospitals, information was collected concerning the impact of Medicaid service restrictions on other hospital indigent health care programs.

DIFFERENCES BETWEEN STATE FUNDING MECHANISMS

The Virginia Medicaid program is a joint federal-State program targeted at certain categories of poor individuals. The Medicaid program has been operational in Virginia since 1969 and is administered by DMAS. Virginia Medicaid is an entitlement program, meaning that necessary services provided to eligible persons must be financed according to an established payment rate. Currently, the State shares the cost of these services with the federal government on a 50 percent basis.

The SLH program is a joint State-local program which is designed to pay for hospital services for poor individuals who are not eligible for Virginia Medicaid. In FY 1991, the State financed approximately 90 percent of the paid hospital claims, while localities paid the remaining 10 percent. Unlike Virginia Medicaid, the SLH program is not an entitlement program. A finite amount of State and local funds is allotted to the program each year, and once those funds are exhausted, hospitals must either collect payment from patients or pursue other sources of funding.

The Trust Fund is designed to provide relief to those in-State hospitals which provide a disproportionately large volume of charity care. The Trust Fund is supported by general fund appropriations (60 percent) and hospital contributions (40 percent). Those hospitals with relatively high charity care loads are compensated for a portion of their charity care through the Trust Fund. The Trust Fund, in effect, is a payor of last resort for patients whose care cannot be financed by Medicaid or the SLH program.

Although the State teaching hospitals (VCU/MCVH and UVAMC) are the largest providers of charity care, they do not participate in the Trust Fund. Instead, the State appropriates general funds to these institutions in recognition of their mission to

provide indigent health care as well as medical education. The State also provides indigent care appropriations to MCHR for the indigent health care and education provided through its affiliated hospitals and faculty physicians. These appropriations are administered in accordance with plans submitted by the institutions and approved by the DPB director.

These four funding mechanisms differ by whom they cover, what they cover, and how they pay for services. Each has its own income limits, and all but the Trust Fund have recipient asset limits. While service limitations are placed on Medicaid, the SLH program, and the charity care reported to the Trust Fund, no service limitations are placed on the use of the ICAP by the State. Also, Medicaid and SLH reimburse hospitals based on prospectively determined rates, while the Trust Fund and the ICAP are based on different payment principles.

Covered Individuals

Coverage of individuals varies according to entitlement status and eligibility criteria. Of the four funding mechanisms, only Virginia Medicaid is an entitlement program. This means that the State must pay for approved services provided to persons deemed eligible for Medicaid. Unlike Medicaid, once SLH funds are exhausted, the SLH program clients are liable for their hospital bill (although they do not typically pay this bill). Individuals eligible for financing under the Trust Fund or the ICAP must also demonstrate that they cannot pay their bill before their accounts may be written off as charity care.

Although Virginia Medicaid is the largest source of funding for indigent hospital care, it does not cover all poor people. As shown in Figure 1, Medicaid eligibility may be described in terms of eight eligibility groups. The income limit for each group ranges from 133 percent of the federal poverty level for pregnant women and certain groups of children, to about 35 percent of poverty for Aid to Dependent Children (ADC) recipients. Other poor people who do not fall into one of these eight eligibility categories are not eligible for Medicaid. (The February 1992 JLARC report, *Review of the Virginia Medicaid Program*, provides a more detailed description of Medicaid eligibility guidelines.)

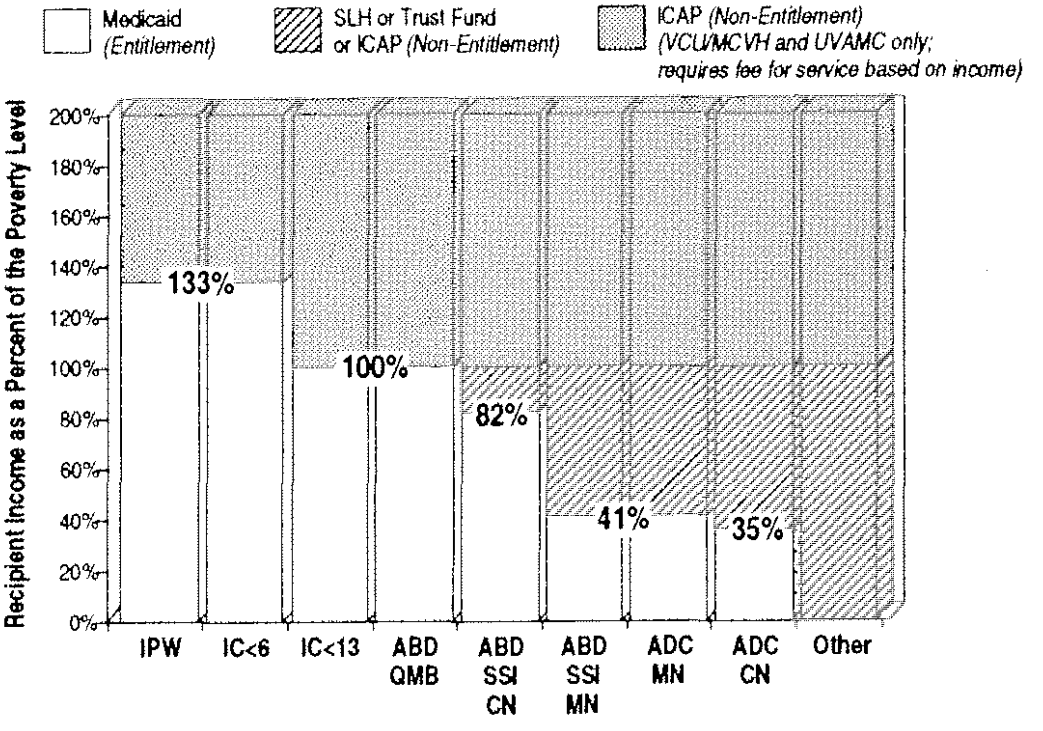
Indigent people who are not eligible for Medicaid have several limited options. People with incomes between 100 and 200 percent of the poverty level may benefit from partial financing of their hospital care through the ICAP if they receive care at VCU/MCVH or UVAMC. In these cases, indigent patients are asked to pay a fee-for-service based on their income level. If they do not receive care at VCU/MCVH or UVAMC, the unpaid charges for their care will be accounted for as hospital bad debt.

Indigent people who are not eligible for Medicaid but whose incomes are equal to or below the federal poverty level may have their care financed from one of several sources. If they receive their care at VCU/MCVH or UVAMC, their care can be financed through the SLH program or the ICAP. If they receive their care at another hospital, it may be financed by the SLH program, subject to availability of funds. If SLH program

Figure 1

Income Limits on the State Funding of Indigent Hospital Care, FY 1993

(Chart shows how recipients qualify for various kinds of funding according to their income levels and eligibility categories)



KEY:
- IPW = Indigent Pregnant Women
- IC<6 = Indigent Children younger than age 6 and born after September 1983
- IC<13 = Indigent Children under age 13
- ABD = Aged, Blind, or Disabled
- QMB = Qualified Medicare Beneficiary
- SSI = Supplemental Security Income
- CN = Categorically Needy
- MN = Medically Needy
- ADC = Aid to Dependent Children

Source: JLARC staff analysis of DMAS and DPB documents.

funds are exhausted, then the unpaid cost of care will be written off as charity care. The hospital may be compensated for a portion of this care through the Trust Fund, depending on the hospital's entire charity care load.

In addition to income, assets are considered in determining eligibility for Medicaid (except for indigent pregnant women), the SLH program, and the ICAP (except

MCHR). This means some people with incomes below the income cap for the individual funding mechanisms may not qualify if they have excessive assets. There are no asset limits for the Trust Fund.

Covered Services

Each of the State's funding mechanisms covers basic inpatient and outpatient hospital services (Table 1). Medicaid places a number of restrictions on the scope and duration of services. For example, kidney transplants may be provided only with prior approval from DMAS. A number of other transplants and experimental procedures are not covered at all. In addition, Virginia Medicaid will only pay for the first 21 days of a hospital stay for adults.

By statute, the SLH program and the Trust Fund impose the same restrictions on covered services as Virginia Medicaid. There is one exception: the Trust Fund will cover adult inpatient days in excess of 21, while Medicaid and the SLH program will not. As a result, the cost of adult patient days beyond 21 is typically accounted for as charity care and may be partially subsidized through the Trust Fund or, in the case of the State teaching hospitals, through the ICAP.

There are no State restrictions on the services which may be financed through the ICAP. MCHR, VCU/MCVH, and UVAMC are allowed to determine the scope and duration of services which may be financed through the ICAP. VCU/MCVH has stated that they follow Medicaid restrictions on services in most cases. MCHR limits its ICAP services to those approved by Medicaid or Medicare. UVAMC does not expressly limit services to those approved by Medicaid or Medicare.

Payment Principles

Virginia Medicaid uses a prospective payment system to reimburse hospitals for inpatient services and a cost-based system to pay for most outpatient services. SLH program payments are determined using Medicaid's prospective per diem rates, within available funds. The Trust Fund reimburses some hospitals for a portion of their charity care based on a redistributive formula designed to direct funds to those hospitals with the highest charity care loads. The ICAPs are lump sum appropriations based on the institutions' reported cost of providing indigent care during the previous fiscal year.

Virginia Medicaid and the SLH Program. The Medicaid inpatient reimbursement system, which has been in place since 1982, has six components:

- Hospitals are categorized into peer groups with established payment limits or "ceilings" for operating costs.

- An inflation factor is used to update peer group ceilings each year.

Table 1

Scope of Services for Indigent Health Care Funding Mechanisms

✔ - service is reimbursable ✘ - service is not reimbursable

	Funding Mechanism			
Service	Medicaid	Trust Fund	SLH[1]	ICAP[1]
Basic Inpatient	✔	✔	✔	✔
Basic Outpatient	✔	✔	✔	✔
Adult Inpatient Days Beyond 21	✘	✔	✘	✔
Kidney Transplant[2]	✔	✔	✔	✔
Liver Transplant	✘	✘	✘	✔
Bone Marrow Transplant	✘	✘	✘	✔
Heart Transplant	✘	✘	✘	✔
Experimental Procedures	✘	✘	✘	✔
Cosmetic Surgery	✘	✘	✘	✔
Drug and Alcohol Rehabilitation	✘	✘	✘	✔
Elective Procedures[2]	✔	✔	✔	✔
Inpatient Psychiatric Services for Children	✘	✘	✘	✔

[1]SLH = State and Local Hospitalization Program; ICAP = Indigent Care Appropriations.

[2]For Medicaid, SLH Program, and the Trust Fund these services can be performed with prior approval.

Source: JLARC staff analysis of the *Code of Virginia* and DMAS, VCU/MCVH, and UVAMC data.

- Hospitals are paid a per diem rate for their operating costs which is equal to the lower of the hospital's reported operating costs, charges, or payment ceiling.

- Hospitals may receive an efficiency incentive payment if their operating costs are below the peer group ceiling.

- Hospitals which carry a heavy Medicaid patient load are given additional payments called "disproportionate share adjustments.

- Hospitals are paid for the reasonable cost of capital expenditures and medical education.

The vast majority of inpatient hospital payments are for operating costs.

Virginia Medicaid's outpatient reimbursement system is distinctly different from the inpatient reimbursement system. While inpatient reimbursement rates are subject to a predetermined payment ceiling, in most instances outpatient services are reimbursed on the basis of charges or reported costs, whichever is lower. This payment policy is based on Medicare principles of reimbursement. (For more details on Medicaid hospital reimbursement systems, see the 1992 JLARC report, *Medicaid-Financed Hospital Services in Virginia.*)

SLH program payments are based on the same payment principles as Medicaid. For inpatient services, hospitals receive payments that equal their Medicaid per diem rate as of June 30 each year. For most outpatient services, hospitals receive their reported cost for the service. However, unlike Medicaid, the SLH program is not an entitlement program, which means that once the appropriated funds are exhausted, the SLH program claims go unpaid. For example, in FY 1991 more than $19.3 million in SLH program inpatient claims were not reimbursed. Also, the SLH program does not provide disproportionate share payments.

Trust Fund. The Trust Fund is a funding mechanism which receives contributions from the State and individual hospitals, and annually distributes funds to hospitals with high charity care loads. The *Code of Virginia* defines the formulas used in deciding: (a) which hospitals contribute to the Trust Fund, (b) how much each hospital contributes, (c) how much the State contributes, (d) which hospitals receive Trust Fund monies, and (e) how much each hospital receives from the Trust Fund.

The amount a hospital contributes to the Trust Fund is based on the amount of charity care it provides in relation to its operating margin and the median amount of charity care provided by all participating hospitals in the State. Whether a hospital receives a payment from the Trust Fund depends on the amount of charity care it provides that is above the median amount provided by all hospitals in the State. The greater the amount of charity care the hospital provides above the median, the greater the amount the hospital will receive from the Trust Fund.

Indigent Care Appropriations to VCU/MCVH and UVAMC. VCU/MCVH and UVAMC do not file claims for reimbursement from the ICAP. Instead, a lump sum appropriation is made to each institution at the start of the fiscal year. The starting point for determining the ICAP amount is an annual indigent care cost report. Indigent care costs include uncompensated care provided to individuals with incomes below 200 percent of the poverty level, and who meet the specified asset test. Unreimbursed Medicaid costs are also included as indigent care costs.

A guideline appropriation for each fiscal year is determined in a two-step process. First, a calculation is made to determine indigent care costs as a percentage of total costs in the current year. This percentage is multiplied by the institution's base appropriation for the budget year to determine the projected indigent care cost for the budget year. According to DPB staff, it has been the executive branch's intent to fund 100 percent of the projected indigent care costs through general fund appropriations. This policy has been articulated in the executive budget documents for the 1986-1988, 1988-1990, and 1990-1992 biennia. However, in recent years the institutions have been appropriated less than 100 percent of the forecasted cost (this trend is analyzed in detail in Chapter II).

Because the ICAP is intended to support both patient care and education, it is logical to ask what portion of the ICAP is allocated to each activity. However, it is difficult to separate patient care costs from medical education costs. Particularly in the case of clinical teaching, it is difficult to allocate the costs of faculty and residents between patient care and teaching. Thus, it is only possible to roughly estimate the portion of the ICAP which is used to support medical education.

JLARC staff developed such an estimate based on the assumption that the proportion of medical education costs incurred in the treatment of indigent patients is about the same as that incurred in the treatment of all patients at each institution. In FY 1991, UVAMC reported direct medical education costs of approximately $31 million, or more than ten percent of total expenses. Applying this percentage to the hospital's reported indigent care costs of $49 million, it is estimated that about $5.1 million of these costs can be attributed to direct medical education. Teaching hospitals also have indirect medical education costs. UVAMC staff reported that, in FY 1991, indirect medical education costs were approximately $53.2 million or 17 percent of total expenses. Applying this percentage to $49 million in indigent care costs, JLARC staff estimate that indirect medical education costs of $8.3 million could be attributed to indigent care in FY 1991. Therefore, a total of $13.4 million of the $49 million in indigent care costs could be attributed to medical education at UVAMC.

VCU/MCVH reported a total $60.6 million in medical education costs in FY 1991. Of this amount, $31.1 million or 10 percent of total expenses for VCU/MCVH were for direct medical education. Indirect medical education expenses were reported at $29.5 million in FY 1991. These direct and indirect costs accounted for about 20 percent of total expenses at the institution. Applying this percentage to reported indigent care costs of $67 million, an estimated $13.5 million can be attributed to medical education in FY 1991.

Indigent Care Appropriations to MCHR. The indigent care appropriations to MCHR are not based on an indigent care cost report. Instead, MCHR requests funds based on its own analysis of need. Since FY 1986, the appropriation to MCHR has been level at $4,036,945. Beginning in FY 1991, MCHR decided to use this funding to support its educational activities and indigent care provided by its faculty physicians. Therefore, since FY 1990, none of the appropriation has been allocated to the affiliated hospitals.

SPENDING FOR INDIGENT HOSPITAL CARE

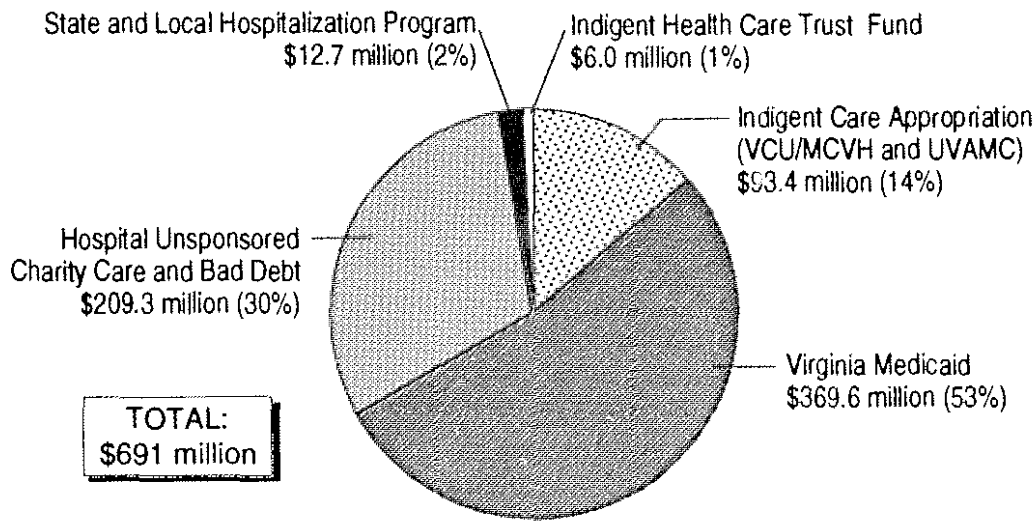
Virginia Medicaid is the largest source of State funding for indigent hospital care, followed by the ICAP. Through its various funding mechanisms, the State accounts for more than 40 percent of total spending for indigent hospital care. The statewide distribution of spending does not match the statewide distribution of poverty. Although there may be a number of reasons for this phenomenon, one important factor is that the State teaching hospitals are the major providers of indigent hospital care.

Overall Spending For Indigent Hospital Care

In FY 1991, an estimated $691 million was spent on indigent hospital care in Virginia (Figure 2). Most of this spending came from the Virginia Medicaid program. The ICAP was the second greatest source of State funding, followed by the SLH program and the Trust Fund. Unsponsored care accounted for 30 percent of total spending for indigent hospital care. Between Virginia Medicaid, the SLH program, and the Trust Fund, the State general fund provided 42 percent of total spending for indigent hospital care in FY 1991.

Figure 2

Spending for Indigent Hospital Care by Funding Mechanism, FY 1991



Note: Derivation of figures is explained in Appendix B.

Source: JLARC staff analysis of DMAS, Health Services Cost Review Council, VCU/MCVH, and UVAMC data.

Virginia Medicaid. Virginia Medicaid accounted for an estimated $369.6 million, or 53 percent of total spending for indigent hospital care. Of this amount, the State paid roughly half, or $184.8 million. In FY 1991, an estimated 87,256 people benefited from inpatient services reimbursed through Virginia Medicaid and more than 596,000 outpatient visits were reimbursed. All of Virginia's acute care hospitals participated in the program.

Indigent Care Appropriations to State Teaching Hospitals. According to the 1990-92 Appropriation Act (Chapter 723), the ICAP is provided for the "care, treatment, health related services and education activities associated with patients, including indigent and medically indigent ones." Indigent care appropriations to the State teaching hospitals totaled $93.4 million in FY 1991 (Appendix C). The appropriations represented about 14 percent of total spending for indigent hospital care in FY 1991.

In FY 1991, the ICAP was used to finance approximately 17,200 inpatient admissions and more than 208,000 outpatient visits. MCHR received more than $4 million in indigent care appropriations in FY 1991, but for reasons to be explained in Chapter IV, none of this money was used to subsidize indigent hospital care.

SLH Program. The SLH program spent $12.7 million on hospital services in FY 1991, or about two percent of the total spent on indigent care. The State share of the SLH program expenditures was approximately $11.4 million, while the local share was more than $1.3 million. There are no centralized data on the number of individuals served by this program. However, there are data which show that the program sponsored 8,023 hospital admissions and 13,345 outpatient visits in FY 1991. One hundred and four individual hospitals received reimbursement from the program.

Trust Fund. The Trust Fund had expenditures of slightly less than $6 million in FY 1991, or one percent of the total. In FY 1991, the State contributed $6 million to the Trust Fund, while individual hospitals contributed $3.9 million. Forty-seven of the 90 hospitals or systems contributing to the Trust Fund received more from the Trust Fund than they contributed. There are no centralized data on the number of individuals whose care was financed through the Trust Fund.

Unsponsored Care. While not commonly thought of as a funding mechanism, unsponsored care is an important source of indigent hospital care. Unsponsored care is defined as the cost of hospital charity care and bad debt adjusted for the impact of the ICAP and the Trust Fund (Appendix B). Bad debt has not been traditionally categorized as indigent care. However, bad debt is included in the calculation for two reasons.

First, the eligibility criteria for indigent care at VCU/MCVH and UVAMC do include people with incomes between 100 and 200 percent of poverty. Unpaid bills for people in this income category would be classified as bad debt in other hospitals. Second, in its 1990 report, the Joint Commission on Health Care reported that an estimated two-thirds of the State's uninsured had incomes below 200 percent of poverty. This indicates that there may be a significant number of uninsured people with incomes between 100 and 200 percent of poverty whose unpaid hospital bills may be classified as bad debt.

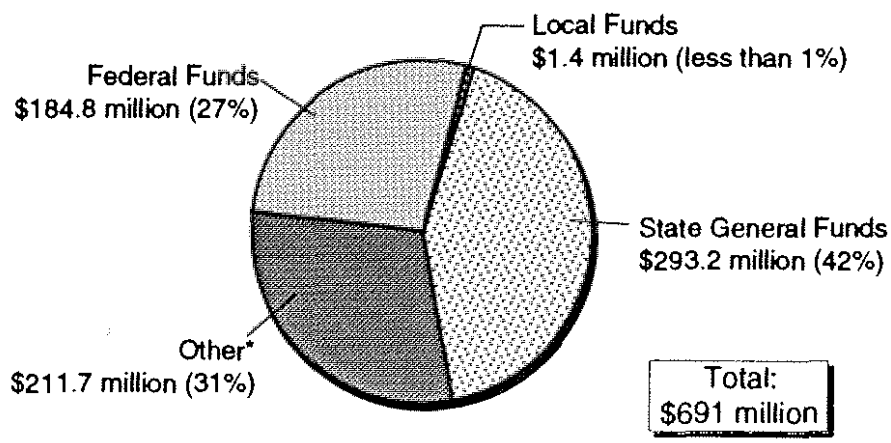
It is important to remember that bad debt is an overstatement of indigent care because the bad debt figures reported by hospitals include services provided to people whose incomes are above 200 percent of poverty. However, there are no data available to estimate the proportion of statewide bad debt which is attributable to people with incomes above 200 percent of poverty. As a result, bad debt is a rough measure which overstates the value of care provided to people at or below 200 percent of poverty.

Furthermore, the inclusion of bad debt in this calculation should not be construed as a recommendation for the State to expand any of its indigent care funding mechanisms to include people with incomes above 100 percent of poverty. Keeping these qualifications in mind, JLARC staff estimated that hospitals provided an estimated $209.3 million in unsponsored care during FY 1991. Unsponsored care accounted for about 30 percent of total spending for indigent hospital care. There are no centralized data on the number of individuals who received unsponsored care during FY 1991.

State Share of Overall Spending. The State share of total spending for indigent hospital care was an estimated $293.2 million, or about 42 percent of the total (Figure 3). The federal share was $184.8 million, or about 27 percent of the total. Hospital charity care, bad debt, and the hospital share of Trust Fund payments accounted for about 31 percent of the total. Local governments provided less than one percent of the total.

Figure 3

Spending for Indigent Hospital Care by Funding Source, FY 1991



*Includes hospital charity care, bad debts, and hospital share of Trust Fund payments.

Note: Derivation of figures is explained in Appendix B.

Source: JLARC staff analysis of DMAS, Health Services Cost Review Council, VCU/MCVH, and UVAMC data.

Uneven Distribution of Poverty Population and Spending

The Department of Health estimates that, in 1989, there were 1,564,836 Virginians with incomes below 200 percent of poverty. The majority of these individuals resided in health service areas (HSAs) III and V, which include the southwestern and southeastern parts of the State, respectively. Specifically, 58 percent of those below 200 percent of poverty resided in one of these areas. However, together these areas accounted for only 39 percent of total spending for indigent hospital care in FY 1991 (Figure 4).

By contrast, in the other HSAs, the proportional distribution of spending outstripped the proportional distribution of the poverty population. HSA I (northwestern region) accounted for 14 percent of the population below 200 percent of poverty, but accounted for 18 percent of total spending. HSA II (northern region) accounted for ten percent of the population below 200 percent of poverty, while accounting for 13 percent of total spending. HSA IV (central region) accounted for 18 percent of the population below 200 percent of poverty, while accounting for 30 percent of total spending.

There are a number of possible reasons for the uneven distribution of the indigent population and spending. Patients are not bound by the HSA in which they reside, and may choose a hospital in another HSA out of convenience. There may be differences in demographics and health status which result in different utilization patterns across the State. Differences in the availability and cost of services may also influence spending patterns.

An additional reason is that the two State teaching hospitals are the major providers of indigent hospital care in the State. Together, these institutions account for about one third of statewide spending for indigent hospital care (including all spending for Medicaid, ICAP, SLH program, Trust Fund, charity care and bad debt). This is reflected in the disproportionate share of spending which goes to HSAs I and IV. The reasons for this situation, as well as the implications for funding policy, are discussed in detail in Chapter II.

REPORT OUTLINE

This chapter has provided an overview of the study mandate, the basic research methods used to complete the study, and an overview of indigent hospital care and spending in Virginia. Chapter II discusses policy considerations for the appropriateness of indigent care funding at VCU/MCVH and UVAMC. Chapter III reviews the scope of services, eligibility, and reimbursement rates for the indigent care appropriations at the State teaching hospitals. Chapter IV reviews the indigent care appropriations at MCHR. Chapter V provides analysis of various options for optimizing the use of general funds for indigent hospital care.

Figure 4

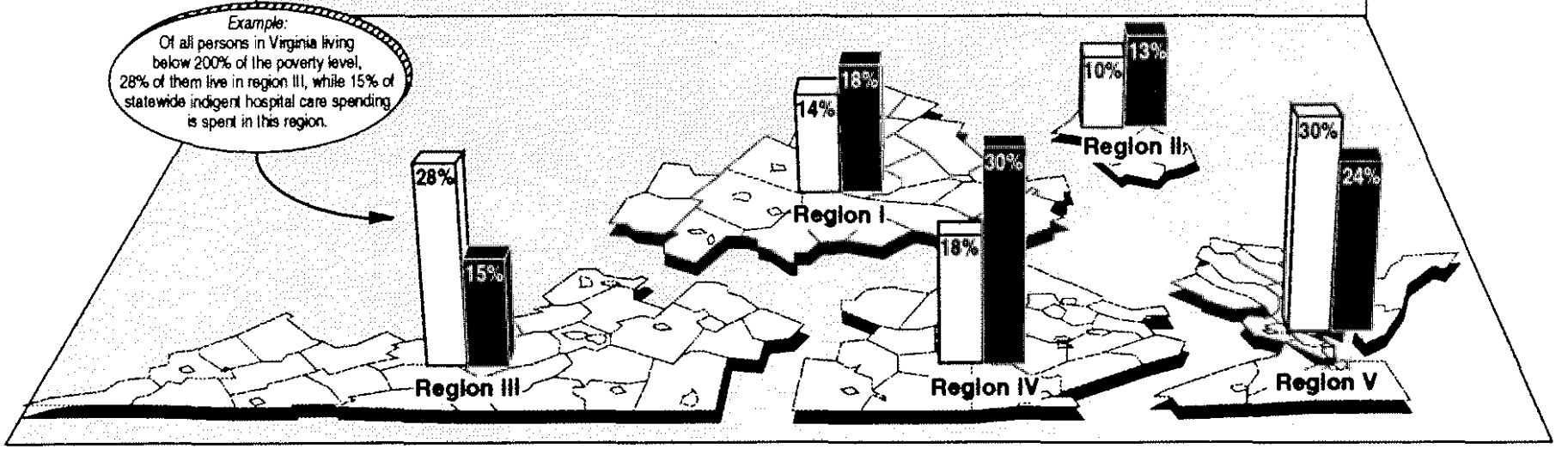
Distribution of Indigent Population Compared to Spending for Indigent Hospital Care, by Health Service Area, FY 1991

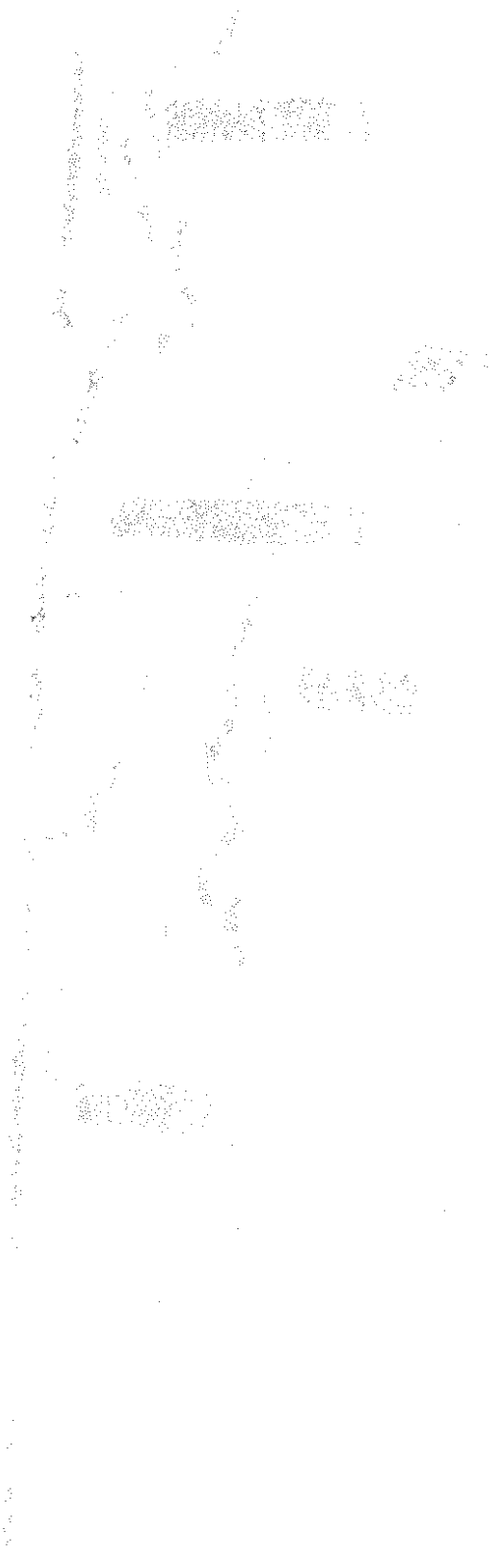
Portion of the statewide population living below 200% of the poverty level who reside in the service area

Portion of total statewide spending for indigent hospital care which is spent in the service area

Note: Derivation of spending figures is explained in Appendix B.

Source: JLARC staff analysis of DMAS, Health Services Cost Review Council, VCU/MCVH, UVAMC, and Department of Health data.





II. Appropriateness of Indigent Care Funding at the State Teaching Hospitals

Senate Joint Resolution 180 (1991) requested a determination of the appropriateness of general fund and Medicaid allocation methodologies to the Medical College of Virginia Hospitals of Virginia Commonwealth University (VCU/MCVH) and the University of Virginia Medical Center (UVAMC). These two hospitals play a major role in the provision of indigent hospital care in Virginia.

In FY 1991, the two hospitals accounted for almost $229 million of the $691 million spent on indigent care. Of the $229 million, VCU/MCVH and UVAMC received approximately $210 million for the services they provided to Virginia Medicaid or indigent care appropriation (ICAP) recipients. This revenue comprised 35 percent of the two hospitals' allotted operating revenues for FY 1991. Of the $210 million, almost $152 million were State general funds.

The role of the State teaching hospitals in indigent care creates a number of complex health policy concerns. To varying degrees, VCU/MCVH and UVAMC rely on State general funds to support their patient care and teaching missions. In the past, the State has taken actions through its Medicaid and ICAP payment policies to provide this financial support. These actions raise concerns about Medicaid cost containment and perceptions of payment inequity among hospital providers. In addition, this financial dependence creates concerns about future funding changes because they could impact access to indigent health care as well as the teaching mission of the institutions.

The General Assembly may wish to consider these key policy issues as it decides the future of indigent care funding at the State teaching hospitals. To aid the General Assembly in its decision-making, four illustrative funding options and their policy impact are described. These options indicate the complexity of indigent care funding policy at the State teaching hospitals. Therefore, the Department of Planning and Budget (DPB) should use a multi-faceted approach when evaluating and recommending indigent care funding levels at the State teaching hospitals.

STATE TEACHING HOSPITALS ARE MAJOR PROVIDERS OF INDIGENT HOSPITAL CARE

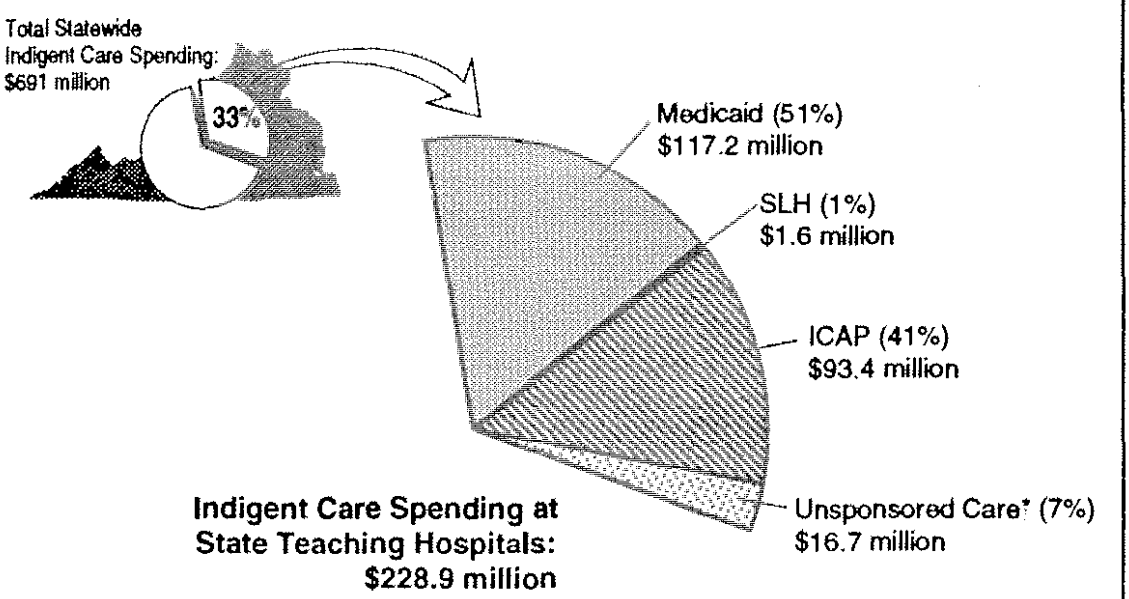
The State teaching hospitals account for almost one-third of statewide spending for indigent hospital care. This situation is explained by several factors. First, the State teaching hospitals serve a large number of indigent patients. Second, this care is delivered at a relatively high cost. Third, the State has implemented payment policies which recognize most of these costs.

State Teaching Hospitals Account for a Significant Portion of Indigent Care Spending

Together, the State teaching hospitals accounted for an estimated one-third of all statewide spending for indigent hospital care in FY 1991 (Figure 5). Further, the two State teaching hospitals received approximately $154 million of the State general fund expenditures for indigent hospital care, or more than half of the total general fund expenditures of $293.2 million (Figure 6). Virginia Medicaid and the ICAP accounted for 92 percent of the total spending for indigent hospital care at these institutions. While unsponsored care accounted for seven percent of the spending, payments from the State and Local Hospitalization (SLH) program accounted for one percent of the spending.

Figure 5

Indigent Care Spending at State Teaching Hospitals, FY 1991



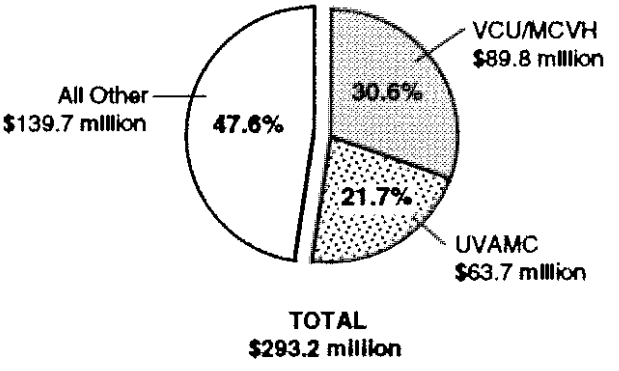
*Includes unsponsored charity care and bad debt.

Source: JLARC staff analysis of data from the Health Services Cost Review Council, Department of Medical Assistance Services, VCU/MCVH, and UVAMC.

Of the $156 million spent on charity care in the State during FY 1991, UVAMC and VCU/MCVH accounted for more than $101 million, or 65 percent of the spending. As shown in Figure 7, the State teaching hospitals carried most of the charity care load (in terms of cost) in their respective health service areas (HSAs). For HSA I, which is the

Figure 6

Distribution of State General Funds for Indigent Hospital Care, FY 1991

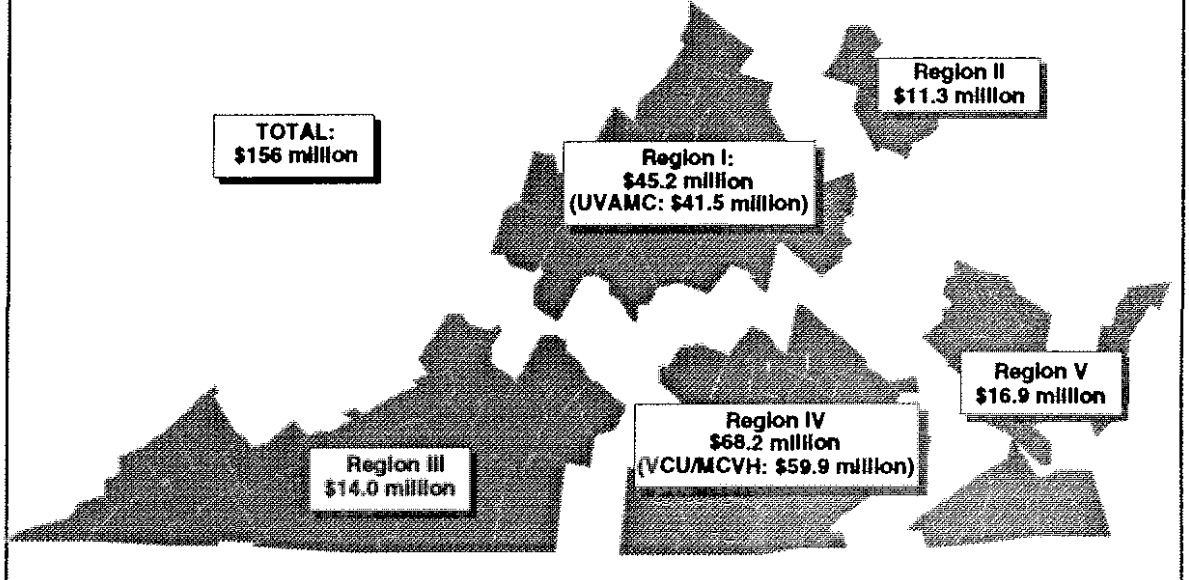


*Includes unsponsored charity care and bad debt.

Source: JLARC staff analysis of data from the Health Services Cost Review Council, Department of Medical Assistance Services, VCU/MCVH, and UVAMC.

Figure 7

Quality Care Costs, by Health Service Area, FY 1991



Source: JLARC staff analysis of DMAS, Health Services Cost Review Council, VCU/MCVH, and UVAMC data, FY 1991.

Northwest area of the State, more than $45.2 million in charity care costs were incurred by the 15 acute care hospitals in the area. UVAMC had more than $41.5 million of those costs.

A similar pattern also existed in HSA IV which is the central area of the State. VCU/MCVH incurred more than $59.9 million of the $68.2 million in charity care costs among the 19 hospitals in HSA IV.

State Teaching Hospitals Serve a High Volume of Indigent Patients

The State teaching hospitals provide a large proportion of indigent patient days. As shown in Table 2, in FY 1991, VCU/MCVH accounted for almost 11 percent of all Medicaid inpatient hospital days in the State, and approximately 45 percent of Medicaid days in its HSA. UVAMC accounted for almost five percent of Medicaid patient days statewide and slightly more than 43 percent of Medicaid patient days in HSA I.

Table 2

Comparison of Days of Care Provided to Medicaid Recipients at the State Teaching Hospitals, Statewide and HSA, FY 1991

Patient Days	VCU/MCVH	UVAMC
Total Medicaid Days	55,762	25,225
Percent of HSA Total	44.6%	43.1%
Percent of Statewide Total	10.7%	4.8%

Source: JLARC staff analysis of the Health Services Cost Review Council 1992 Annual Report.

While there is no central source of statewide data on charity care days, it can be assumed from the available data that the State teaching hospitals provide a significant amount of the total charity care days in the State. In addition, both institutions serve a significant number of patients from outside their service areas. In FY 1991, 16.9 percent of the ICAP patients at VCU/MCVH came from outside HSA IV. In this same year, 19.3 percent of ICAP patients at UVAMC were from outside HSA I.

State Teaching Hospitals Are Costly in Part Because of their Mission

According to literature in the field, major teaching hospitals are typically more expensive than other acute care hospitals. A major reason for this is their dual mission of patient care and education. Teaching hospitals tend to have higher costs because of

their urban location; treatment of sicker patients; broader range of services; higher salary and benefit costs because of interns, residents, and other health professionals in training; and provision of more ancillary services. However, while VCU/MCVH and UVAMC are two of the most expensive acute care hospitals in the State, when compared to other major teaching hospitals around the country, their costs are more comparable to those of their peers.

State Teaching Hospitals Cost More Than Most Other Virginia Hospitals. Each year, the Health Services Cost Review Council (HSCRC) collects information from Virginia's acute care hospitals. This information allows for comparisons of the cost of care among hospitals (Table 3). For example, in FY 1991, UVAMC, with $1,272 in cost per adjusted patient day, had the highest cost among acute care hospitals, while VCU/MCVH was sixth with $1,028. UVAMC had the second highest cost per adjusted admission ($9,764), while VCU/MCVH had the fourth highest cost per adjusted admission ($7,699).

Table 3

Comparison of UVAMC and VCU/MCVH to All Acute Care Hospitals in the State (FY 1991 except as noted)

	UVAMC		VCU/MCVH	
	Value	Rank	Value	Rank
Average Cost Per Adjusted Patient Day	$1,272	1	$1,028	6
Average Cost Per Adjusted Admission	$9,764	2	$7,699	4
Medicare Case Mix Index (1990)	1.5788	3	1.5489	4
Average Length of Stay	7.7	2	7.5	3

Source: JLARC staff analysis of the Health Services Cost Review Council 1992 Annual Report.

Both hospitals also tend to serve patients who on average require more complex treatment than patients in most other Virginia hospitals. One common measure of the level of treatment is the Medicare case mix index. In FY 1990, UVAMC had the third highest Medicare case mix index in the State, while VCU/MCVH had the fourth highest.

Higher acuity levels may lead to longer lengths of stay which can also increase costs. As shown in Table 3, in FY 1991, UVAMC had the second highest average length of stay among acute care hospitals at 7.7 days, while VCU/MCVH had the third highest, at 7.5 days.

Inherent in both UVAMC's and VCU/MCVH's costs is their teaching mission. In FY 1991, UVAMC reported more than $31 million in direct medical education costs. These costs accounted for about 10 percent of total hospital expenses in that year. UVAMC staff also reported another $53 million in indirect medical education costs for FY 1991. UVAMC trains more than 1,800 health professionals a year, including medical students, nursing students, residents, and allied health professionals. In FY 1991, UVAMC had 555 residents and fellows.

VCU/MCVH reported more than $31 million in direct medical education costs in FY 1991. These costs were 10 percent of total hospital expenses. VCU/MCVH reported an additional $29.5 million in indirect medical education costs. VCU/MCVH provides the clinical teaching environment for more than 2,900 students enrolled in VCU's six health sciences schools. These schools are allied health professionals, basic health sciences, dentistry, medicine, nursing, and pharmacy. In addition to the 2,900 students, VCU/MCVH had 462 interns and residents in FY 1992.

State Teaching Hospitals Are Comparable to their Peers. While a comparison of the two State teaching hospitals' costs to those of other acute care hospitals in the State is important for understanding why they consume a large share of indigent care spending, it does not necessarily indicate that the costs at these institutions are unduly high. To develop a clearer picture of the relative costs of VCU/MCVH and UVAMC, they were compared to other major teaching hospitals across the nation.

Table 4 shows selected performance indicators for VCU/MCVH and UVAMC compared to median measures for academic medical hospitals around the country. Comparison of these medians indicate that both UVAMC and VCU/MCVH are similar to their peers in terms of cost. For example, UVAMC's expense per adjusted discharge ($7,327) was the national median for a group of 31 academic medical hospitals for which data were available. VCU/MCVH's amount was higher than the median at $7,848, but was in the middle third of the hospitals in the group.

State Indigent Care Funding Policies Have Been Supportive of State Teaching Hospitals

Since 1914, when general funds were first appropriated to the State teaching hospitals, UVAMC and VCU/MCVH have had a formal role in indigent hospital care. Over the years, this role has grown more significant as have the costs of providing indigent care. As a result, the State has become highly dependent on the State teaching hospitals for the provision of indigent hospital care. Likewise, the State teaching hospitals have become dependent on State general funds and the provision of indigent care for their financial strength.

Table 4

Virginia State Teaching Hospitals Compared to Other Academic Medical Hospitals

	National Median	VCU/MCVH	UVAMC
Total Expenses Per Adjusted Discharge* (n=31)	$7,327	$7,848	$7,327
Medicare Case Mix Index (n=57)	1.62	1.55	1.65
Average Length of Stay (n=31)	7.57	7.63	7.68

*Total expenses have been adjusted for differences in wages and case mix.

Note: UVAMC and VCU/MCVH are included in the national median. Data encompass both State FY 1990 and FY 1991 because they are based on hospital fiscal year.

Source: JLARC staff analysis of Survey of Academic Medical Center/Hospitals data, Council of Teaching Hospitals, FY 1990 and FY 1991.

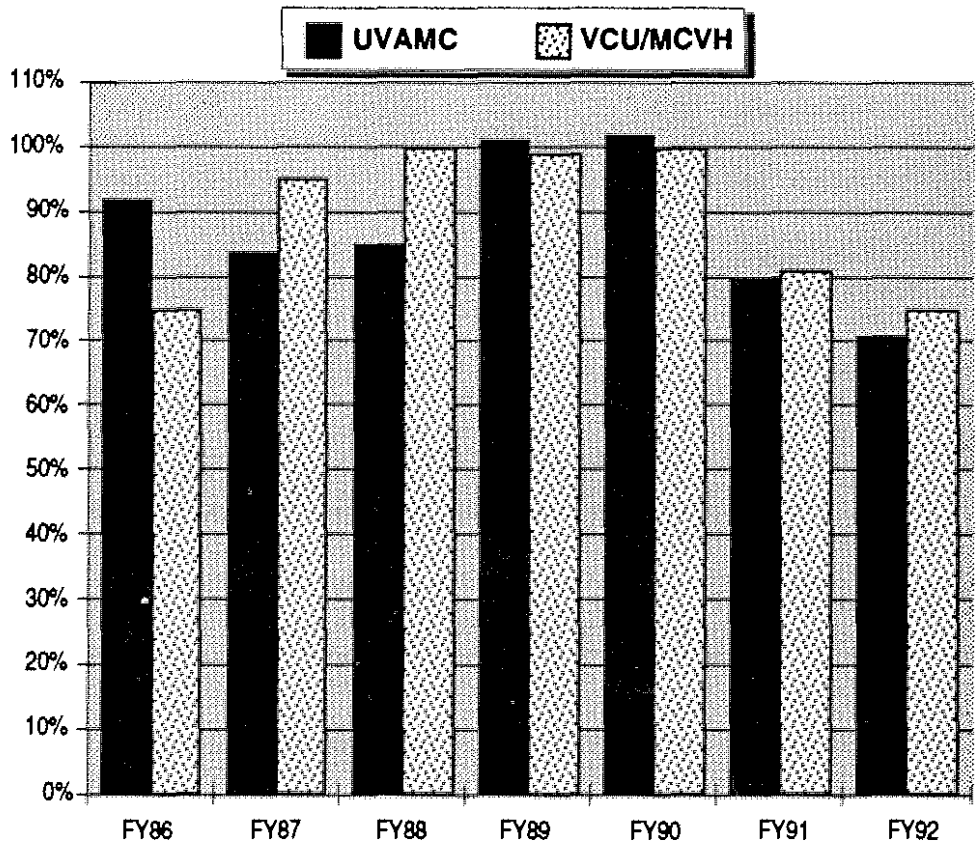
Since 1988, three actions in particular have exemplified this relationship. First, the State has made a commitment to fund all of the teaching hospitals' indigent care costs. Second, the two teaching hospitals were placed into their own peer group for Medicaid reimbursement which resulted in significantly higher Medicaid payments to these institutions. Third, to save State general funds in 1992, the State formally linked these two funding mechanisms by enhancing Medicaid payments to cover a portion of the teaching hospitals' indigent care costs.

Funding of 100 Percent of Indigent Care Costs. Between FY 1988 and FY 1992, the executive branch made a commitment to reimburse VCU/MCVH and UVAMC for all of their reported indigent care costs. For FY 1993, this commitment was 90 percent and for FY 1994, 95 percent. This policy has been articulated in all executive budget documents since the 1986-88 biennium.

As shown in Figure 8, the objective of 100 percent funding has not been achieved since FY 1990. Based on the indigent care cost reports submitted by the State teaching hospitals at the end of each fiscal year, UVAMC was reimbursed for 80 percent of indigent care costs in FY 1991, and 71 percent in FY 1992. VCU/MCVH received funding for 81 percent of indigent care costs in FY 1991, and 75 percent in FY 1992. (Dollar amounts appropriated are shown in Appendix C.)

Figure 8

Percentage of Indigent Care Costs Reimbursed by Indigent Care Appropriations, FY 1986 - FY 1992



Source: JLARC staff analysis of VCU/MCVH and UVAMC indigent care summary data.

There are two primary reasons why the institutions did not receive 100 percent funding in these years. First, beginning in FY 1990, the State experienced revenue shortfalls which resulted in reductions in most State programs' budgets. Second, the ICAPs are based on the costs incurred by the teaching hospitals in the previous year. For example, the FY 1992 ICAPs were based on the FY 1991 cost reports. Costs can increase unexpectedly from year to year for a variety of reasons including a change in the number of patients served and/or in the services provided.

Separate Medicaid Peer Grouping for State Teaching Hospitals. As discussed in detail in the 1992 JLARC report, *Medicaid-Financed Hospital Services in Virginia*, Virginia Medicaid reimburses hospitals based on their peer group median or allowable operating cost, whichever is lower. In 1988, the General Assembly authorized the segregation of VCU/MCVH and UVAMC into a separate peer group for Medicaid

reimbursement. At the same time, a new peer group median was established for these two hospitals based on their 1987 costs. Other acute care hospitals' peer group medians are based on 1982 costs.

This separate peer grouping resulted in the two hospitals being reimbursed, on average, for approximately 90 percent of their Medicaid allowable costs in FY 1989 — the year the change was enacted. In the two years prior, VCU/MCVH and UVAMC were reimbursed an average of 68 percent of their allowable operating costs by Virginia Medicaid. Therefore, placing the two hospitals in their own peer group allowed more of their operating costs to be covered through Medicaid reimbursement, compared to most other hospitals.

Enhanced Medicaid Payments to State Teaching Hospitals. In addition to their reimbursement for allowable operating costs, the State teaching hospitals also receive disproportionate share adjustment (DSA) payments from Virginia Medicaid because the hospitals serve a "disproportionate" number of Medicaid recipients. In FY 1990, these adjustments resulted in an additional $546,000 in reimbursement for UVAMC and $1.7 million for VCU/MCVH. (Thirty-nine other in-state acute care hospitals also received these enhanced payments in FY 1990.)

Prior to the 1992 General Assembly Session, it was determined that Medicaid DSA payments could be used to reduce the cost of indigent care to the general fund by "enhancing" the DSA payments to the State teaching hospitals. Therefore, for FY 1992, the ICAPs were reduced by $40.8 million. Of this amount, $18.1 million was appropriated to Virginia Medicaid while the remainder was used to support other State programs. The $18.1 million was then to be matched dollar for dollar with federal funding and paid back to the teaching hospitals through enhanced DSA Medicaid payments.

Exhibit 1 shows how these payments were made to the two teaching hospitals. The DSA Medicaid payment methodology was amended so that VCU/MCVH and UVAMC received more money for each day of care through the enhanced DSA payments. For example, at VCU/MCVH, the Medicaid payment for a day of care in November 1992 cost $1,034.83, with the DSA payment being $144.83 of the total. As of December 1, 1992 when the enhanced DSA payment went into effect, this same day of care cost $2,483.12. Of this amount, the DSA payment was $1,593.12.

It is important to note the General Assembly limited the total amount of funds that could be appropriated to the teaching hospitals through these enhanced payments to $36.2 million. VCU/MCVH received more than $23.1 million in enhanced DSA payments while UVAMC received more than $11.9 million.

As noted earlier, for the 1992-94 biennium, the intent was to fund the teaching hospitals for 90 percent of their indigent care costs in FY 1993 and for 95 percent of their costs in FY 1994. This level of funding amounted to more than $216 million for the biennium. The General Assembly actually appropriated $210.7 million, with $65.8 million of this amount to be federal Medicaid funds.

Exhibit 1

DSA Payment Adjustments for State Teaching Hospitals, FY 1992 (Until Cap Is Reached)

RATE COMPONENT	VCU/MCVH		UVAMC	
	Prior to DSA Change	After DSA Change	Prior to DSA Change	After DSA Change
Allowable Operating Cost Ceiling	$728.15	$728.15	$728.15	$728.15
Disproportionate Share	*144.83*	*1,593.12*	*62.98*	*692.83*
Capital Costs	62.93	62.93	140.84	140.84
Direct Education Costs	98.92	98.92	96.17	96.17
Total Reimbursement Rate Per Day	**$1,034.83**	**$2,483.12**	**$1,028.14**	**$1,657.99**

Note: Prior to DSA change, FY 1992 days are those patient days between July 1, 1991, and November 30, 1991. After DSA change, FY 1992 days are those patient days between December 1, 1991, and June 30, 1992.

Source: JLARC staff analysis of UVAMC and VCU/MCVH notices of program reimbursement, dated March 26, 1992.

CONSIDERATIONS FOR INDIGENT CARE FUNDING POLICY

The status of the State teaching hospitals as the major providers of indigent hospital care raises five concerns about future funding policy. First, because of the level of State funding at these institutions, changes in funding policy could have a significant impact on their financial positions as health care centers and teaching institutions. Second, the institutions may be affected by various Medicaid cost containment strategies. Third, funding policies for the State teaching hospitals may create a perception among other providers of payment inequity. Fourth, changes in funding policy could impact access to indigent care. These four policy concerns should be weighed against a fifth consideration: the cost to the State of funding indigent hospital care.

Financial Position of State Teaching Hospitals

According to literature in the field, three factors can directly affect the financial position of teaching hospitals. The first factor is the mix of patients that they serve. The second factor is the amount of education conducted in the hospital and the hospital's relationship to the medical school. The third factor is the hospital's sources of revenue

and its subsequent ability to maintain a positive operating margin each year. A strong financial position is important for providing quality services as well as for securing a favorable bond rating.

Influence of Payor Mix at the Two Hospitals. A common characteristic among public teaching hospitals is that they tend to provide care for "less profitable" patients, including indigent patients. These patients typically require more complex services because they have not received routine health care services, such as vaccinations.

Based on the mix of patient days in FY 1991 (Table 5), UVAMC provided more patient days to Blue Cross/Blue Shield patients than most hospitals in the State and in its HSA. However, UVAMC provided a lower percent of its patient days to Medicare patients while providing more days to Medicaid patients than most other hospitals. In addition, UVAMC served a larger proportion of other patients, including indigents. Although this category does include some insured and other paying patients, 44 percent of the patient days attributed to this category were consumed by indigent patients.

Table 5

Percentage of Patient Days by Payor at University of Virginia Medical Center Compared to Statewide and HSA Medians, FY 1991

Payor	UVAMC	Statewide	HSA I
Blue Cross/Blue Shield	17.7%	12.0%	15.8%
Medicare	33.5	51.0	53.1
Medicaid	12.3	7.1	4.6
Other, including indigents, self-pay, and commercial insurers	36.5	22.4	25.0

Source: JLARC staff analysis of the Health Services Cost Review Council 1992 Annual Report.

At VCU/MCVH, indigent patients comprise an even larger percentage of patient care days than they do at UVAMC (Table 6). While VCU/MCVH had the statewide median percentage of Blue Cross/Blue Shield patient days, it had a significantly lower percentage of Medicare patient days. Further, its mix of both Medicaid and other patient days were more than the statewide and HSA medians. For example, the statewide median for Medicaid patient days was 7.1 percent of total patient days. At VCU/MCVH,

Table 6

Percentage of Patient Days by Payor at Medical College of Virginia Hospitals Compared to Statewide and HSA Medians, FY 1991

Payor	UVAMC	Statewide	HSA I
Blue Cross/Blue Shield	12.0%	12.0%	12.1%
Medicare	25.7	51.0	52.0
Medicaid	23.4	7.1	9.7
Other, including indigents, self-pay, and commercial insurers	38.9	22.4	22.8

Source: JLARC staff analysis of the Health Services Cost Review Council 1992 Annual Report.

this number was 23.4 percent. In terms of other patients, 71 percent of the days were consumed by indigent patients.

Over the next several years, both the teaching hospitals and the Department of Medical Assistance Services (DMAS) predict that the number of Medicaid and indigent patient days will increase. For example, for FY 1994, these sources forecast that more than 117,000 days in inpatient care will be provided to Medicaid or ICAP patients at VCU/MCVH. At UVAMC, more than 66,000 days are projected.

Impact of Medical Education. Both UVAMC and VCU/MCVH are considered major teaching hospitals and appear to have strong ties to their medical schools. Medical education and research activities combine to impact the hospitals' costs. For example, studies have shown that costs are higher in major teaching hospitals because residents perform more diagnostic tests to gain experience, teaching hospital physicians perform more tests because of a "need to know" philosophy, state-of-the-art testing facilities are readily available, and severely ill patients are treated more aggressively.

As noted earlier, medical education costs at the two teaching hospitals are significant. In FY 1991, UVAMC reported medical education costs of close to $84.2 million. JLARC staff estimate that about $13.5 million of this can be attributed to indigent care. For VCU/MCVH, medical education costs were reported as more than $60.6 million, of which $13.6 million could be attributed to indigent care.

Dependence on State General Funds. As a result of their growing role in indigent care, as well as State funding policies which support this role, the State teaching hospitals are becoming more dependent on State general funds (the State share of Medicaid and the ICAP) for their financial position. As shown in Table 7, in FY 1991,

Table 7

Change in General Fund Component* of Total Allotted Operating Revenue FY 1982 - FY 1991

Fiscal Year	Total Allotted Operating Revenue	General Fund Component	General Funds as Percent of Total Revenue
1991 Total	$597,215,693	$141,959,805	23.8
VCU/MCVH	306,425,640	84,823,725	27.7
UVAMC	290,790,053	57,136,080	19.7
1982 Total	$248,534,136	$ 54,364,210	21.8
VCU/MCVH	138,534,136	33,976,439	24.5
UVAMC	110,000,000	20,387,771	18.5

*General fund component includes ICAP and State share of Medicaid reimbursement.

Source: JLARC staff analysis of Commonwealth Accounting and Reporting System 1408 reports, FY 1982 and FY 1991 reports; UVAMC and VCU/MCVH indigent care cost reports; and DMAS

almost 24 percent or $142 million of the two hospital's allotted operating revenues were general funds. Ten years earlier, in FY 1982, this amount was less than 22 percent, or $54 million.

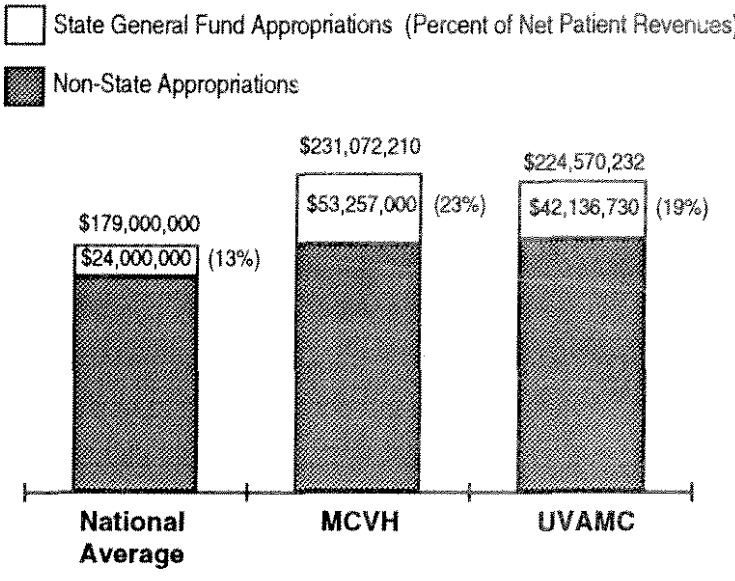
VCU/MCVH has become particularly dependent on State funds, with 27.7 percent of its revenue being general funds in FY 1991 compared to 24.5 percent in FY 1982. At UVAMC, general funds as a percent of total allotted operating revenue increased from 18.5 percent in FY 1982 to 19.7 percent in FY 1991.

In comparison to other academic medical centers around the United States, the State's funding of the two teaching hospitals is significant. According to a 1989 Council of Teaching Hospitals survey of 37 state-owned academic medical center hospitals, the average general fund appropriation was $24 million or 13 percent of total net revenue. The ICAP comprised about 20 and 24 percent of UVAMC's and VCU/MCVH's net patient revenues, respectively, in FY 1989 (Figure 9).

There are many possible reasons why this measure of general fund support would be higher at Virginia's teaching hospitals. For example, more acute patients can cost more and there could be a higher volume of indigent patients at Virginia's hospitals. Therefore, this measure, by itself, is an incomplete indicator of the adequacy of general fund support to the teaching hospitals. However, it does provide evidence that Virginia has had a major commitment to the support of these institutions.

Figure 9

Comparison of State General Fund Appropriations to Total Net Patient Revenue, FY 1990



Source: JLARC staff analysis of Council of Teaching Hospitals 1989 survey and Health Services Cost Review Council 1990 Annual Report.

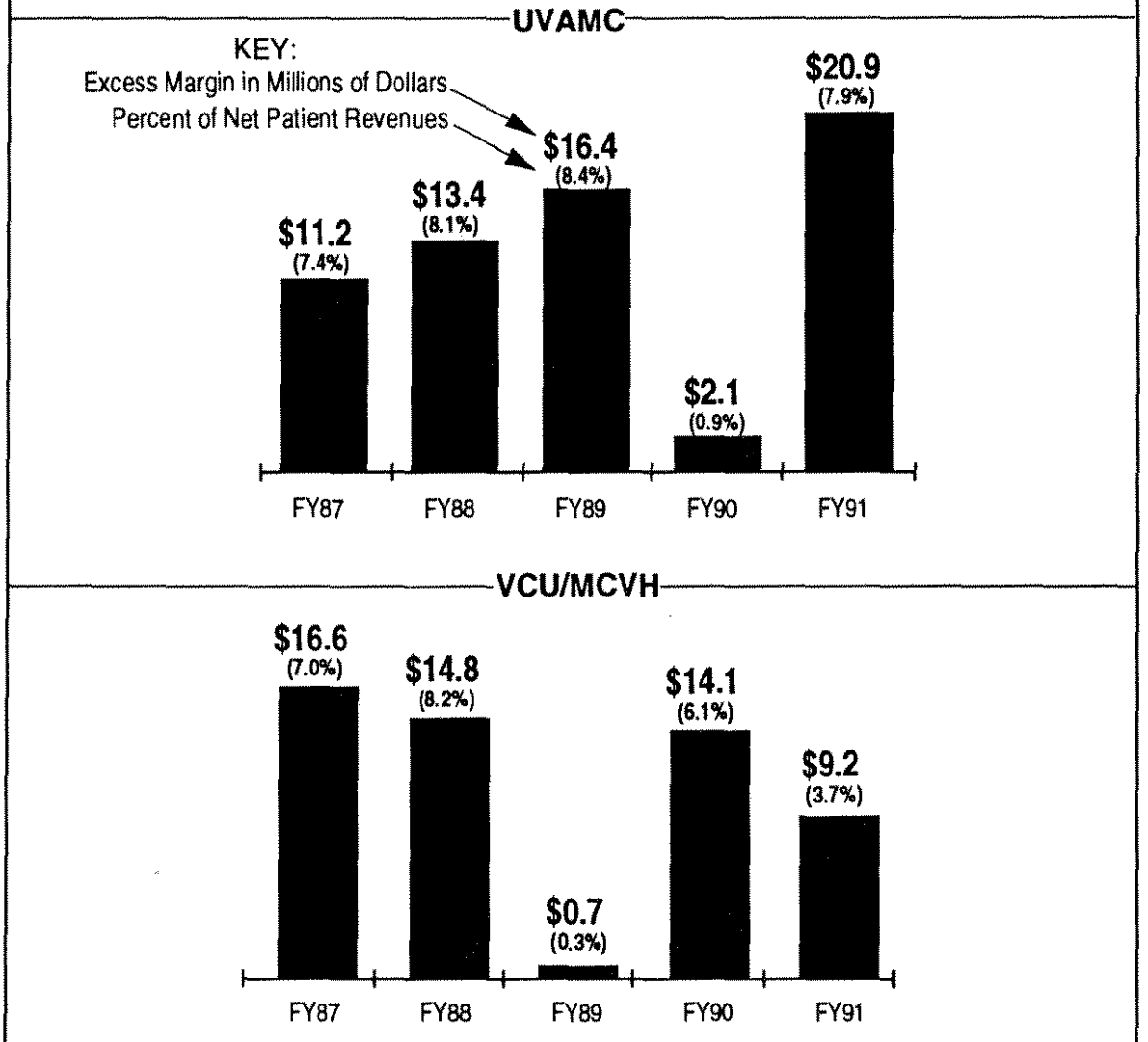
Maintenance of Positive Margins. State general funds appear to have an important role in the hospitals' ability to maintain positive margins. For comparison purposes within Virginia, the HSCRC calculates each hospital's excess margin as a percent of net patient revenues. This excess margin is derived by subtracting operating expenses from the sum of operating and non-operating revenues, and then dividing by net patient revenues. According to literature in the field, these excess revenues or margins are necessary to develop capital for future expansions, to update or replace equipment, and to make debt service payments. In FY 1991, the median excess margin as a percent of net patient revenues for Virginia hospitals was 4.1 percent.

As shown in Figure 10, VCU/MCVH's and UVAMC's excess margins as a percent of net patient revenues have varied during the last five years. In FY 1987, both hospitals had margins that were more than seven percent of net patient revenues. In FY 1991, VCU/MCVH had an excess margin of approximately $9.2 million, or 3.7 percent of net patient revenues. According to VCU/MCVH staff, approximately $6 million of the $9.2 million was used for debt service. The remaining $3.2 million was used to update or replace equipment.

UVAMC's FY 1991 excess margin was $20.9 million, or 7.9 percent of net patient revenues. According to UVAMC staff, $5 million was used to fund construction of the

Figure 10

UVAMC and VCU/MCVH Excess Margins as a Percent of Net Patient Revenues FY 1987 - FY 1991



Source: JLARC staff analysis of Health Services Cost Review Council data.

replacement hospital. The remaining $15.9 million was used for equipment purchases and replacement.

Maintenance of Favorable Bond Ratings. The State teaching hospitals sometimes issue bonds to finance capital projects. The cost of this debt is largely

determined on the basis of credit ratings, also commonly referred to as bond ratings, assigned by financial rating organizations such as Moody's. Bond ratings are important because they determine the interest rate that the hospitals must pay on bonds they issue. A high bond rating means that the financial rating organization believes that the hospital will have stable and sufficient income to pay the debt. Thus, the hospital will pay a lower interest rate on its outstanding debt.

Bond ratings range from "Aaa" (the highest rating) to "C" (the lowest rating). In assigning a bond rating, Moody's compares a variety of performance measures for the State teaching hospitals to industry norms. Both excess margins and operating margins are considered in addition to State general fund support for indigent care. Moody's defines the percent operating margin as the difference between operating expenses and operating revenues, divided by operating revenues. The percent excess margin is defined as operating expenses subtracted from total non-operating and operating revenues, divided by the total of non-operating and operating revenues.

In October 1992, Moody's raised UVAMC's bond rating from "A1" to "Aa," meaning that bonds issued by UVAMC are of high quality and of limited investment risk. Therefore, bonds issued by UVAMC in the future should garner a lower interest rate at the time of issuance. One reason for this favorable bond rating was UVAMC's FY 1992 operating margin of 6.8 percent (as measured by Moody's definition). This margin exceeded the FY 1992 median of 5.0 percent for all hospitals with "Aa" ratings. Another reason was UVAMC's excess margin of 7.3 percent, in comparison to a national "Aa" median of 6.5 percent.

As already noted, the ICAP is an important factor in the maintenance of positive margins. In assigning the "Aa" rating to UVAMC, Moody's did consider that in recent years, State general funds have covered a declining percentage of indigent care costs. However, Moody's also noted that UVAMC has taken actions to reduce its reliance on these funds. In its 1992 report, Moody's stated that:

> The relative importance of the teaching hospital and its strong medical staff, as well as ongoing investment in its facilities, help to ensure the institution's long-term viability. These factors mitigate concerns with respect to the reliance on State support.

VCU/MCVH has a Moody's credit rating of "A1." In part because of a concern about the hospital's vulnerability to the area's indigent population, VCU/MCVH's rating has not been changed by Moody's since 1983. In 1991, Moody's financial analysis of VCU/MCVH stated:

> Large other operating revenue represents the significant state appropriation for free care provided by the hospital. The appropriation is increasing but not in proportion to the services rendered, thereby increasing the hospital's vulnerability to the area's indigent population. Overall performance remains satisfactory.

The FY 1992 median operating margin for institutions with "A1" bond ratings was 3.6 percent of total operating revenues. For FY 1992, VCU/MCVH's operating margin was 3.4 percent of total operating revenues. The median excess margin for this bond rating was 6.2 percent. VCU/MCVH's excess margin was 4.4 percent.

Medicaid Cost Containment Efforts

Medicaid cost containment efforts should be considered when determining indigent care funding policy for four reasons. First, the State teaching hospitals may have difficulty competing in a managed care environment. Second, federal policy changes may impact Medicaid disproportionate share payments to the State teaching hospitals. Third, the Medicaid inpatient reimbursement system is scheduled to be reevaluated beginning in 1995. Fourth, a separate JLARC report has recommended that overall hospital cost containment should be a component piece of State attempts to control Medicaid hospital spending.

Virginia Medicaid Cost Containment Efforts Have Expanded. When the federal government changed Medicare reimbursement from a cost-based to a prospective payment system for hospitals in the early 1980s, it marked the beginning of a major effort to contain health care costs. Virginia also chose to implement prospective payment for Medicaid inpatient hospital reimbursement. In addition, DMAS increased its utilization review activities and reduced the percentage of costs covered for certain aspects of hospital activities, including capital.

In recent years, cost containment efforts have expanded to include a focus on preventive health care and managed care. In 1991, the Commission on Health Care for All Virginians recommended that DMAS implement a managed care program for Virginia Medicaid patients. The Commission cited enhanced quality of care through continuity of care, patient's access to primary care and appropriate services, and cost savings as the primary advantages of this program.

While this program is still being piloted, plans are underway to have a Medicaid managed care program implemented statewide by the end of 1993. This type of program may have significant implications for the teaching hospitals. This is because of the large Medicaid population that they have historically served, the high cost of that care, and the revenue the provision of this care provided. One aim of managed care is to direct patients to the most cost-effective setting. Literature in the field suggests that teaching hospitals will have difficulty adapting to managed health care because of their relatively high costs which are in part caused by their teaching mission. In addition, these hospitals typically have focused their resources on inpatient services.

Federal Medicaid Cost Containment Efforts Could Also Have an Impact. In recent years, the federal government has taken additional actions to contain Medicaid costs. In November 1991, the U.S. Congress passed the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, which could impact Virginia's ability to share its indigent care costs with the federal government.

This legislation placed a "cap" on the amount of matching federal DSA funds that a state will receive in each succeeding fiscal year. The U.S. Health Care Financing Administration (HCFA) has set this cap at $104 million for federal fiscal year 1993. This $104 million cap is an interim amount. It will be updated again in April 1993 and finalized in December of 1993. However, the implementation of this cap does limit the State's ability to use Medicaid funds to subsidize other indigent hospital care programs.

The Act also required the U.S. Prospective Payment Assessment Commission (ProPAC) to conduct a study of the DSA payment policies. ProPAC was established to advise the U.S. Congress on matters related to Medicare and Medicaid hospital reimbursement. This study, to be reported to the U.S. Congress by January 1, 1994, may also impact DSA payments to the teaching hospitals in the future.

Virginia Medicaid Hospital Payment Reform Will Begin in 1995. In 1986, the Virginia Hospital Association (VHA) filed suit against the State concerning Medicaid reimbursement rates for inpatient hospital services. This lawsuit was settled in December 1990 and dismissed in February 1991 when an agreement was reached between the VHA and the State. This agreement provided for additional payments to non-State hospitals, and required that a task force address Medicaid reimbursement reform beginning in January 1995. Changes to Medicaid reimbursement could greatly affect the costs of the Medicaid program and reimbursement to the State teaching hospitals.

Evaluation of Hospital Performance Has Been Recommended. In the 1992 JLARC report, *Medicaid-Financed Hospital Services in Virginia*, it was found that Medicaid hospital spending cannot be controlled through Medicaid policy alone. Because Medicaid hospital spending is largely a function of the cost of hospital care, hospital costs must be contained if the growth in Medicaid hospital spending is to be controlled.

The report concluded that the General Assembly, through the Joint Commission on Health Care, should focus on hospital cost containment as one way to control Medicaid spending. Specifically, it was recommended that the Joint Commission on Health Care may wish to:

- direct a study to identify the full range of factors driving hospital costs in Virginia, as well as public policies which might help to control these factors;
- establish a technical advisory group on hospital data collection to ensure the availability of adequate data for policy analysis;
- ensure that legislative direction is given to the Department of Medical Assistance Services and the Health Services Cost Review Council in their efforts to develop hospital efficiency indicators; and
- continue to promote the development of a patient-level database which could be used to educate providers about overutilization of services.

These recommendations were designed to affirm the importance of developing the capacity to evaluate hospital performance in terms of both costs and patient outcomes. As explained in Medicaid-Financed Hospital Services in Virginia, such performance information could aid the State in negotiating Medicaid payment rates with providers. Better performance information could also aid decisionmakers in determining the ICAPs to the State teaching hospitals.

Provider Equity

Considering the recent VHA lawsuit over Medicaid payment rates, provider equity is a concern in indigent care funding policy. During interviews, health care officials and providers expressed concerns about the differences in Medicaid reimbursement payments and methodologies. In addition, questions were raised about the different definitions of charity care used.

Equity among providers can be viewed from two perspectives. The first perspective is that the teaching hospitals are being reimbursed for a higher percentage of their costs by Virginia Medicaid. Therefore, the "financial burden" of treating Medicaid patients is lessened for them. In addition, the teaching hospitals are receiving financial support for a large portion of their charity care load through the ICAP, while the other hospitals are not.

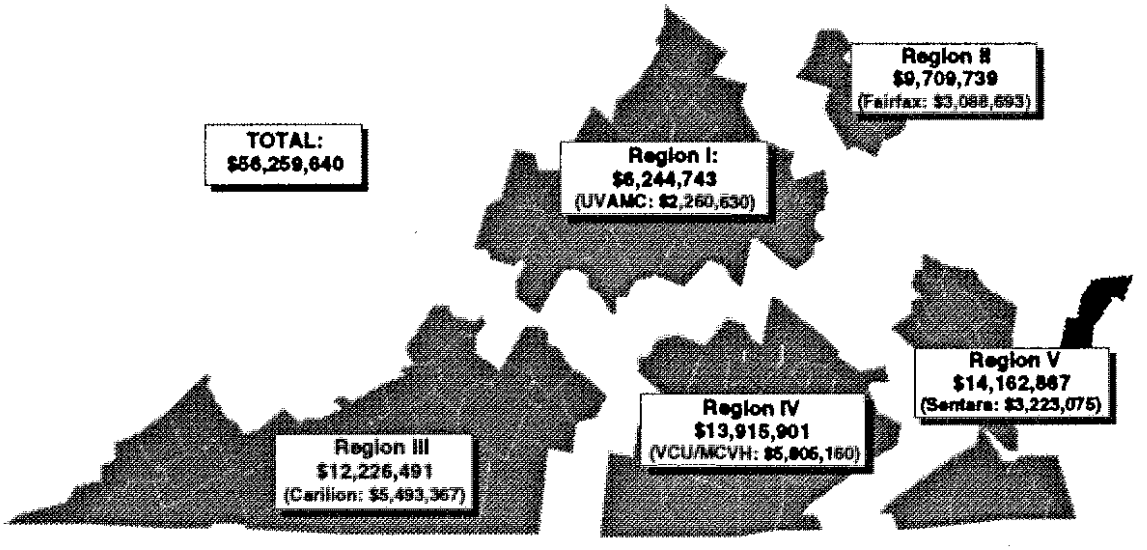
A second perspective is that the State teaching hospitals should be treated preferentially because of their high indigent care load and their teaching mission. Earlier analysis showed that the State teaching hospitals serve a disproportionately large share of Medicaid patients and provide almost two-thirds of the charity care in the State. In addition, the State benefits from the medical education provided at these institutions.

It appears that even after allowing for the ICAP, VCU/MCVH and UVAMC still carry a relatively large indigent care load for which they receive no compensation. As a result of the ICAP, VCU/MCVH's FY 1991 unsponsored charity care load was reduced from $59.9 million to slightly more than $5.8 million. UVAMC's charity care load fell from $41.5 million to an unsponsored charity care load of $2.3 million.

These amounts were more similar to the unsponsored charity care costs found around the State. However, VCU/MCVH still had the largest unsponsored charity care cost, with the Carilion Health System in the Southwest region of the State having the second largest (Figure 11). (Carilion Health System is comprised of seven hospitals in the Southwest area of the State and other health care-related organizations.) Sentara Health System in the Tidewater area followed with the third highest unsponsored charity care load. UVAMC ranked fifth in this comparison. However, hospital systems are comprised of several hospitals. For example, Carilion Health System is comprised of seven hospitals. UVAMC and VCU/MCVH, on the other hand, are single entities.

Figure 11

Unsponsored Charity Care Costs by Health Service Area*, FY 1991



*Hospitals shown in parentheses have highest unsponsored charity care costs in their HSAs and State.

Source: JLARC staff analysis of DMAS, Health Services Cost Review Council, VCU/MCVH, and UVAMC data, FY 1991.

Access to Indigent Care

As was discussed earlier, the State teaching hospitals provide a significant amount of the hospital services to indigent patients. If the teaching hospitals were no longer the primary providers of this care, a decision would have to be made on where this care would be provided. Federal Medicaid laws require that Medicaid recipients have access to medical care.

It would not be a simple task to redistribute the indigent care load at VCU/MCVH and UVAMC to other health care locations. If a larger percentage of the indigent care was to be assumed by other providers, it could mean that increases in Medicaid's or another indigent care program's reimbursement would be necessary because these costs would no longer be covered by the ICAP. In addition, statutory or regulatory changes may be necessary. For example, indigent care could be made a criteria for maintaining non-profit status. Even if such policies were adopted, it may be difficult to change the utilization patterns of indigent patients who have been conditioned to use UVAMC or VCU/MCVH for their medical care.

General Fund Savings

Because of the level of indigent care spending at the State teaching hospitals, opportunities to save State general funds are an obvious policy consideration. However, the General Assembly must first determine the appropriate level of indigent care funding at the State teaching hospitals. Then, the mechanisms and strategies that are available to fund this level can be designed.

There are three basic ways in which State general funds may be saved in the short term. One is to leverage general fund spending with federal matching dollars. This has been done using the enhanced DSA Medicaid payments. The federal share of these Medicaid payments are used to pay for a portion of the teaching hospitals' indigent care costs.

A second way to save general funds is to reduce Medicaid reimbursement rates at the State teaching hospitals. For example, this could be done by reducing the Medicaid payment rate for inpatient operating costs to what it would have been if the payment rate had not been rebased in 1988. This could be done without necessarily reducing Medicaid DSA payments providing that HCFA would approve a change in the State's current Medicaid DSA policy. A third way to save general funds is to reduce the indigent care appropriations to these institutions. This could be done by reducing the percentage of allowable costs covered by the ICAP.

APPROPRIATENESS OF FUNDING DEPENDS ON POLICY GOALS

There are a number of options which could be used to fund indigent health care provided by the State teaching hospitals. To illustrate the variety of funding options, four are outlined in this section. These options are:

- *Option One*: Maintain the current level of funding and funding mechanisms.
- *Option Two*: Maintain the current level of funding but increase enhanced DSA payment funding.
- *Option Three*: Reduce Medicaid reimbursement rates for inpatient services.
- *Option Four*: Reduce the indigent care appropriations.

All four options, which are neither exhaustive nor mutually exclusive, have varying implications for the five policy considerations identified in the previous section. These implications are summarized in Exhibit 2 and discussed in the following pages.

Exhibit 2

Impact of Future Funding Options on Indigent Care Health Policy Considerations

	Funding Option	General Fund Savings	Financial Position	Medicaid Cost Containment Efforts	Provider Equity	Patient Access
		POLICY CONSIDERATIONS				
ONE:	Maintain Current Level of Funding and Funding Mechanisms	$33 million FY 93	✇	●	●	○
TWO:	Maintain the Current Level of Funding but increase Enhanced DSA Payment Funding	>$33 million FY 93	✇	●	●	○
THREE:	Reduce Medicaid Reimbursement Rates for Inpatient Services	Up to $7.6 million FY 91	✇	○	○	✇
FOUR:	Reduce Funding for the Indigent Care Appropriations by 10%	Up to $12 million FY 91	✇	✇	✇	✇

KEY: ○ = Option has positive impact on policy consideration.

✇ = Option has mixed or questionable impact on policy consideration.

● = Option has negative impact on policy consideration.

Source: JLARC staff analysis.

Option One: Maintain the Current Level of Funding and Funding Mechanisms

For FY 1993, the funding policy for the two State teaching hospitals is continuation of existing Medicaid reimbursement policies and funding of 90 percent of non-Medicaid indigent care costs. A portion of the indigent care costs are being federally funded through the enhanced Medicaid DSA payments. The ICAP to the two hospitals totalled more than $102 million for FY 1993. Of this amount, approximately $69 million was State general funds. The remaining amount, $33 million, were federal matching funds to be paid to VCU/MCVH and UVAMC through enhanced DSA payments. These federal matching funds represent general fund savings.

The current funding policy has raised some concerns. First, according to State teaching hospital staff, the 90 percent funding of indigent care costs could negatively impact the State teaching hospitals' financial position. While it is too early to determine the full impact of this funding policy on FY 1993 operations, some insights can be gained from examining the impact of the FY 1991 indigent care funding policy.

In FY 1991, the ICAPs covered about 80 percent of indigent care costs at the two institutions. Under this funding policy, both hospitals maintained positive excess margins. VCU/MCVH's margin was $9 million or 3.7 percent of net patient revenues. UVAMC achieved a $21 million margin or 7.9 percent of net patient revenues. As noted earlier, the statewide median excess margin as a percent of net patient revenues was 4.1 percent.

Second, the use of enhanced Medicaid DSA payments has the effect of placing a greater share of the teaching hospitals' revenues under federal controls. If federal rules on enhanced DSA payments were to change, the General Assembly might have to decide whether to replace these funds with State general funds or require the hospitals to absorb some portion using their excess revenues. The amount of general funds that would be required could be significant. For example, DMAS has projected that enhanced DSA payments to VCU/MCVH and UVAMC will total close to $65 million in FY 1994, with the federal share being about $32 million.

Third, while the current policy does maintain access to indigent care, it does not promote Medicaid cost containment. In order to maximize federal matching funds, VCU/MCVH and UVAMC must continue to serve large numbers of Medicaid inpatients. For reasons cited earlier, it can cost more to treat these patients at VCU/MCVH and UVAMC than at most other Virginia hospitals.

Finally, the current policy may create a perception of payment inequity among other providers. This perception influences providers' attitudes about the adequacy of Medicaid reimbursement rates.

Option Two: Maintain the Current Level of Funding But Increase Enhanced DSA Payment Funding

A second option would be to maintain the current level of funding but obtain a greater portion of that funding from the federal government. There is potential to increase the amount of the ICAP that is funded through enhanced DSA payments. For instance, if all the indigent care appropriations had been funded through enhanced DSA payments for FY 1993, an additional $18.6 million in general funds could have been saved. However, the amount that can be shifted is limited by the federal cap on these payments.

From a funding standpoint, this policy would maintain the current financial position of the State teaching hospitals because overall funding levels would not change. However, under this policy, some of the indigent care funding to the State teaching hospitals would be under federal control. If federal matching funds were subsequently reduced or eliminated, the General Assembly might have to decide whether to appropriate additional general funds to cover the lost federal funds or require the hospitals to absorb the loss.

The effects of this funding option on the other policy considerations would be similar to option one (Exhibit 2). While this option would maintain current levels of access, it would not reduce Medicaid costs, nor would it decrease payment equity concerns.

Option Three: Reduce Medicaid Reimbursement Rates for Inpatient Services

A third option is to reduce Medicaid reimbursement rates for inpatient services at the State teaching hospitals. This option would have the benefit of increased general fund savings as well as reduction of concerns about Medicaid payment equity, although leveraged federal funds would be lost as well. However, the financial position of the institutions would be a concern under this option. This can be illustrated by examining what might have happened if the State teaching hospitals' Medicaid payment rates had not been rebased in 1988.

If the two teaching hospitals had not been rebased in 1988, their current Medicaid payment rate for inpatient operating costs would be significantly lower. The two hospitals were paid $695.81 per day in FY 1991 for operating expenses. Had they not been segregated into their own peer group, UVAMC would have been reimbursed $491.24 per day and VCU/MCVH would have received $464.66 for these same expenses. Therefore, inpatient reimbursement would have been reduced by $204.57 per day for UVAMC and $231.15 for VCU/MCVH.

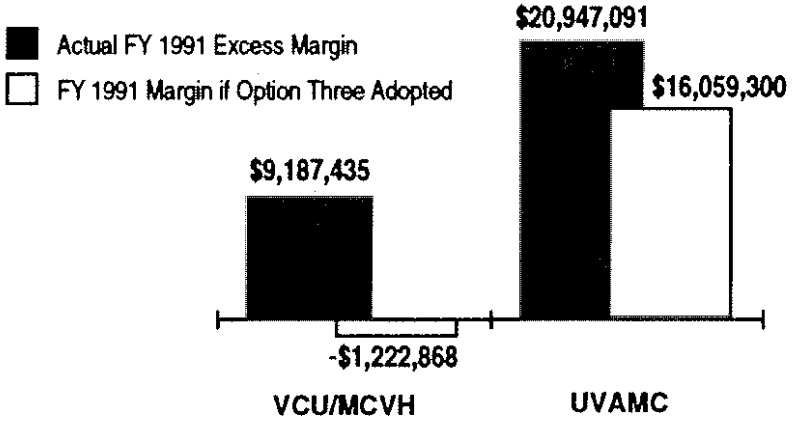
The impact of this funding option would be different for each hospital. If the lower per diem rate had been paid in FY 1991, VCU/MCVH's Medicaid revenue would

have been reduced by approximately $10.4 million. Holding all other factors equal (including the indigent care appropriations) this reduction in Medicaid revenues would have resulted in VCU/MCVH having a negative margin of more than $1.2 million, or a negative one-half of one percent of net patient revenues in FY 1991 (Figure 12).

Figure 12

Option Three: Treat the Teaching Hospitals the Same as Other Hospitals for Medicaid Reimbursement

(Chart shows impact on excess margins based on FY 1991)



Source: JLARC staff analysis of the 1992 Health Services Cost Review Council Annual Report and UVAMC and VCU/MCVH Medicaid cost settlement files, FY 1991.

At UVAMC, a reduction in the Medicaid payment rate would have resulted in a loss of more than $4.8 million in patient revenues. This reduction would have lowered the hospital's excess margin to $16.1 million, or to 6.1 percent of net patient revenues.

Therefore, in FY 1991, more than $7.6 million in general funds could have been saved because of reduced Medicaid payments. However, this option would have to be evaluated for its impact on the medical education programs at the hospitals. An additional concern would be access to care because the State teaching hospitals would have a reduced incentive to serve Medicaid patients even though federal laws guarantee access. Finally, this option would support Medicaid cost containment efforts by virtue of reducing reimbursement rates.

Option Four: Reduce Funding for the Indigent Care Appropriations

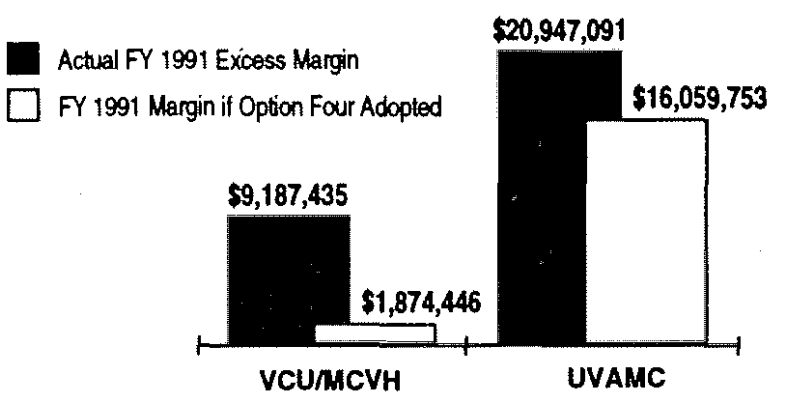
In FY 1991, UVAMC and VCU/MCVH reported that approximately 80 percent of their indigent care costs were reimbursed by the ICAP. Under this funding policy, both hospitals still achieved positive margins, although the excess margin as a percent of net revenues at VCU/MCVH was below the statewide median.

The impact of further reductions in funding can be illustrated by estimating the effect on the FY 1991 excess margins. For example, if the percentage of indigent care costs reimbursed by the ICAP had been 70 percent instead of 80 percent, UVAMC would have been appropriated $34.4 million instead of $39.3 million. VCU/MCVH would have been appropriated $46.8 million instead of $54.1 million. Holding all other factors equal, UVAMC's excess margin would have decreased to slightly more than $16 million, or six percent of net patient revenues (Figure 13). VCU/MCVH's excess margin would have dropped to $1.9 million, or to less than one percent of net patient revenues. The general fund savings would have been approximately $12.2 million.

Figure 13

Option Four: Reduce ICAP from 80% to 70% of Indigent Care Costs

(Chart shows impact on excess margins based on FY 1991)



Source: JLARC staff analysis of the 1992 Health Services Cost Review Council Annual Report, UVAMC data, and VCU/MCVH data, FY 1991.

Depending on how it was implemented, the option could reduce Medicaid DSA costs. It would not necessarily address provider equity concerns related to base payment rates. However, access to care and teaching programs could be negatively impacted if the hospitals took cost saving actions such as shortening clinic hours or reducing personnel.

Conclusion

The options just described illustrate that funding of indigent care at the State teaching hospitals is a complex and dynamic issue. It is complex because access to indigent care must be weighed against several important factors, including the competing demands on State funds, the financial position of the State teaching hospitals, and the need for medical education in the State. It is dynamic because the needs of the State teaching hospitals will change as health care and medical education environments continue to evolve in response to advances in medical practice, changing service needs, and increasing demands for cost containment.

In this environment, the State's indigent care funding policy should be based on more than a decision to fund a fixed percentage of indigent care costs. Instead, the policy should be based on a forward-looking, multi-faceted evaluation of State teaching hospital needs. The essential questions are: (1) What role should the State teaching hospitals play in the delivery of indigent hospital care and medical education? and (2) What level of State funding is necessary for the institutions to fulfill their roles while remaining financially sound? The State teaching hospitals currently play a major role in both the delivery of indigent hospital care and the provision of medical education. As long as they continue in this dual role, which is probable in the absence of broader health care reform, the institutions will likely require some level of general fund support.

The evaluation and determination of indigent care funding at these hospitals should consider the key policy factors identified in this chapter. At a minimum, the following questions should be asked by the Department of Planning and Budget as it considers indigent care funding at VCU/MCVH and UVAMC:

- What volume of indigent care will the institution be expected to provide?
- What medical education programs will the institution be expected to provide in the hospital setting, and how do these meet the needs of the Commonwealth?
- Has the institution achieved acceptable levels of cost effectiveness in delivering its health care and education services?
- How will State Medicaid initiatives such as managed care and inpatient reimbursement reform impact the financial position of the institution?
- How might federal policy changes affect current funding policies such as the use of Medicaid disproportionate share payments to subsidize non-Medicaid indigent care?
- How will other providers interpret payment policies for the State teaching hospitals?

- Considering the institution's overall payor mix, what level of State support will be necessary for the institution to fulfill its responsibilities and maintain a sound financial position?

- Considering the institution's capital needs, what level of State support will be necessary for the institution to maintain a desirable bond rating?

The answers to these questions may change from year to year as the institutions evolve. Thus, in a given year, each institution may or may not require funding of 100 percent of reported indigent care costs in order to maintain a strong financial position. Furthermore, although VCU/MCVH and UVAMC do share a common mission of serving indigent patients and providing medical education, they operate in different environments, and should be evaluated separately for the purpose of determining the ICAP.

Recommendation (1). **In considering the budget requests for general fund support of indigent care and medical education at the Medical College of Virginia Hospitals of Virginia Commonwealth University and the University of Virginia Medical Center, the Department of Planning and Budget should consider the following factors for each institution: (1) the volume of indigent care it will be expected to provide, (2) the medical education programs it will be expected to provide in the hospital setting, (3) the cost effectiveness of the institution, (4) the impact of federal Medicaid policy changes, (5) the impact of State Medicaid and hospital cost containment policies, (6) the impact of funding policy on other providers' perceptions of payment equity, (7) the institution's overall payor mix and financial position, and (8) the institution's capital needs and bond rating. After consideration of these factors, recommended funding levels should be based on the amount projected to be required to allow each institution to maintain a sound financial position.**

III. Eligibility, Scope of Services, and Reimbursement Rates for Indigent Care at the State Teaching Hospitals

In addition to an examination of the appropriateness of indigent care funding at the Medical College of Virginia Hospitals of Virginia Commonwealth University (VCU/MCVH) and the University of Virginia Medical Center (UVAMC), Senate Joint Resolution 180 (1991) directed JLARC to examine the "eligibility, scope of services, and reimbursement rates" in place for the indigent care appropriations (ICAPs) at the two hospitals. This chapter discusses the results of that examination.

This is not the first time JLARC staff have reviewed the provision of indigent care or its funding at the State teaching hospitals. The 1979 JLARC report, *Inpatient Care in Virginia*, provided an in-depth review of the indigent care appropriations. At that time, JLARC recommended that there be more accountability for the general funds appropriated to the teaching hospitals for indigent care. In the current review, JLARC staff found that accountability has been improved at both teaching hospitals.

In order to determine the reasonableness of the eligibility, scope of services, and reimbursement rates for the indigent care appropriations, JLARC staff compared each of these items to those in place for other State indigent health care programs. This comparison was made because the General Assembly, through statute, has required that program guidelines be consistent across programs. The assumption is that the General Assembly may want the policies for the indigent care appropriations to be consistent with those for Virginia Medicaid, the State and Local Hospitalization (SLH) program, and the Indigent Health Care Trust Fund (Trust Fund) unless there is a compelling reason to do otherwise.

This review found that the General Assembly may need to clarify its intent to subsidize the indigent care of non-Virginians, which cost about $2.6 million in State general funds in FY 1992. The General Assembly should also clarify its intent to subsidize services which are not reimbursable through the State's other indigent care financing mechanisms. In addition, the Secretary of Health and Human Resources should conduct an in-depth examination of Virginia Medicaid's current transplant limits because they appear to have cost the State more than $1.2 million in general funds in FY 1992.

In addition, although the reimbursement rates for indigent care appear to be reasonable, the General Assembly should clarify its intent to subsidize unreimbursed Medicaid costs through the ICAPs. The two teaching hospitals received more than $2.7 million in general funds for these costs in FY 1992.

Finally, because Medicaid reimbursement is a component of indigent care at the teaching hospitals, a memorandum of agreement concerning joint budgetary and program review of the two teaching hospitals should be established between the Secretary of Education and the Secretary of Health and Human Resources. The amount of enhanced Medicaid payments made to the State teaching hospitals should also be reported as part of the executive budget process.

1979 Accountability Concerns Appear to Have Been Addressed

In 1979, JLARC examined the indigent care appropriations to the State teaching hospitals as part of the review of inpatient hospital care. The review found that the two hospitals used different procedures for processing and documenting patient accounts. Also, the appropriations were not directly traceable to those accounts. These findings raised serious accountability concerns given that the ICAP was the largest single program for indigent health care under full State control at that time.

As a result of the 1979 JLARC review, the 1980 Appropriation Act required the hospitals to report their expenditures for indigent and medically indigent patients using generally accepted accounting procedures. The Auditor of Public Accounts (APA) and the State Comptroller were charged with monitoring the implementation of these procedures.

In 1984, the General Assembly requested that the APA develop a uniform methodology for reporting and analyzing indigent care costs at UVAMC and VCU/MCVH. The resulting cost report was based on the federal Medicare cost report and its payment principles. This cost report remains in place today.

Also in 1984, the Governor was given the responsibility of annually approving a common criterion and methodology for determining free care attributable to the ICAP. This requirement has since been modified to charge the director of the Department of Planning and Budget (DPB) with this responsibility.

According to the APA staff who conducted the financial audits of the two teaching hospitals in the last few years, both UVAMC and VCU/MCVH have significantly improved their ICAP accountability. APA staff have not found any internal control violations that are specifically related to the ICAP. Rather, audit concerns that have been raised have focused on such issues as payroll, petty cash, and disaster recovery plans, which are common State agency internal control problems. Further, both Virginia Commonwealth University and the University of Virginia have installed automated data processing systems which provide a wealth of information concerning their provision of indigent care.

ICAP Eligibility Guidelines Should Be Clarified

Through the indigent care appropriations, VCU/MCVH and UVAMC receive reimbursement for services provided to a broader base of indigents than other State

indigent hospital care programs. For example, the ICAP can be used to fund hospital services for those adult citizens between 133 and 200 percent of poverty. No other State indigent hospital care program reimburses hospitals for services provided to this segment of the population.

In addition, the ICAP provides reimbursement to hospitals for services provided to out-of-state patients. In 1954, the Appropriation Act specifically tied the ICAP to the care of indigent Virginia citizens. However, this restriction is no longer contained in the Act. According to information supplied by both hospitals, they have used the appropriations to cover the cost of services provided to patients from other states.

UVAMC reported the cost of services for out-of-state indigent patients in both FY 1991 and FY 1992. In FY 1992, the cost of inpatient services was more than $3.0 million (Exhibit 3). The cost of outpatient hospital services was more than $451,000. Therefore for UVAMC, the total indigent care cost for services provided to out-of-state indigents was more than $3.4 million. UVAMC received general funds for 71 percent of these costs, or nearly $2.5 million.

VCU/MCVH reported that it did not include any services provided to out-of-state indigents as part of its indigent care costs in FY 1991. In FY 1992, less than one percent of the people served by the appropriations were from other states or countries. The services provided to these patients cost approximately $196,000. VCU/MCVH received general funds for 76 percent of these costs, or $150,000. Therefore, the two teaching hospitals received approximately $2.6 million in general funds for providing care to out-of-state indigent patients.

The use of the ICAP to finance care for non-Virginians raises a concern because funds used to subsidize out-of-state patients could be used to support in-State patients through the SLH program or another State indigent health care program. In FY 1992, according to Department of Medical Assistance Services (DMAS) records, more than $36 million in SLH program inpatient claims could not be paid because program funds were exhausted.

UVAMC staff have argued in favor of using the ICAP to support the care of non-Virginians for two major reasons. First, UVAMC staff stated that serving out-of-state patients builds goodwill with institutions in neighboring states which may be asked to serve Virginia indigents. Second, UVAMC staff stated that it is important to serve indigent patients from West Virginia so that West Virginia physicians will continue to refer paying patients to the teaching hospital. Charges for services provided to West Virginia inpatients were almost $22 million, or 6.4 percent of UVAMC's FY 1992 gross inpatient revenues. Of the $22 million, services provided to West Virginia indigents comprised $2.5 million.

During this review, JLARC staff contacted officials in the surrounding states — West Virginia, Maryland, Tennessee, Kentucky, and North Carolina — regarding their funding for indigent hospital care. Washington, D.C. officials were also contacted. Kentucky, North Carolina, and Washington, D.C. appropriate general funds for indigent

Exhibit 3

Indigent Inpatients From Other States, UVAMC, FY 1992

State	Number of Patients	Cost of Care
West Virginia	383	$1,508,141
North Carolina	25	428,897
Maryland	18	239,645
Tennessee	17	202,899
New York	13	26,671
Washington, D.C.	13	262,904
Kentucky	10	64,605
Pennsylvania	9	15,550
New Jersey	7	31,570
Georgia	4	14,422
South Carolina	3	108,404
Indiana	3	31,322
Maine	2	7,968
Florida	2	2,310
Oklahoma	1	43,104
Rhode Island	1	8,384
Delaware	1	4,550
South Dakota	1	3,532
Ohio	1	3,095
California	1	1,208
TOTAL	515	$3,009,181
TOTAL REIMBURSED		$2,136,51

Source: JLARC staff analysis of UVAMC indigent care patient data.

care while the other states do not. However, only North Carolina allows this funding to be used for hospital care provided to Virginia citizens. Further, there are restrictions on this use:

> *North Carolina reimbursed the University of North Carolina (UNC) $1 million in costs for services its hospital provided to out-of-state indigents. However, the use of this funding for out-of-state indigents is limited to three circumstances. First, the funding can be used to reimburse the cost of care to Virginia patients referred to the hospital by UNC medical residents receiving training in Southwest Virginia hospitals. Second, the funding can be used for car accident victims. Third,*

use the funding when it needs out-of-state patients to meet patient loads that are necessary for certification or accreditation.

A decision against using the ICAPs to finance the care of out-of-state patients would mean that the teaching hospitals could have to make up the cost of treating these patients through other available revenue sources, or curtail the level of services provided to out-of-state indigent patients.

Recommendation (2). **The General Assembly should clarify its intent concerning whether the indigent care appropriations should be used to reimburse the State teaching hospitals for services provided to non-Virginians.**

ICAP Scope of Services Should Be Clarified

As described in Chapter I, Virginia Medicaid places a number of restrictions on the services it will reimburse. Furthermore, the *Code of Virginia* expressly limits services reimbursable by the SLH program and the Trust Fund to those covered by Virginia Medicaid. The only exception is that the Trust Fund can be used to reimburse hospitals for Medicaid hospital stays that exceed 21 days. The indigent care appropriations to VCU/MCVH and UVAMC have no service limitations imposed on them by the State.

Because there are no limits, the ICAP has been used to reimburse hospital services not covered by Virginia Medicaid. Two examples are inpatient drug and alcohol rehabilitation and transplants. According to information supplied by the two State teaching hospitals, more than $970,000 in costs were reimbursed by the ICAP for drug and alcohol rehabilitation services to 288 indigents. UVAMC received $265,000 in reimbursement for services provided to 116 patients, while VCU/MCVH received $705,000 for services to 172 patients.

However, UVAMC staff have reported that as of FY 1993, the Medical Center has eliminated inpatient drug and alcohol rehabilitation services. In addition, because of the methods used to report this information, some components of these rehabilitation services may have been reimbursable under Virginia Medicaid. Therefore, it cannot be assumed that all of the $970,000 in costs would not have been covered by Virginia Medicaid.

Legislative intent in this area has been mixed. During the 1990 Session, the General Assembly included language in the 1990-92 Appropriation Act to have substance abuse services provided by the community service boards as a covered Medicaid service. However, a 1991 joint study by DMAS and the Department of Mental Health, Mental Retardation, and Substance Abuse Services found that coverage of these services by Virginia Medicaid would be difficult. In addition, the program costs would be prohibitive considering the State's current financial outlook. As a result, during the 1991 General Assembly Session, the language to cover substance abuse services was stricken from the Appropriation Act.

Focusing on transplants, Virginia Medicaid only covers kidney and cornea transplants. VCU/MCVH and UVAMC have used the ICAP to provide other types of transplants, including bone marrow, liver, and heart, which are not reimbursable Medicaid services. For example, in FY 1992, UVAMC reported 30 of these transplants on their indigent care cost report at a cost of approximately $1.9 million (Table 8). Through the ICAP, UVAMC was reimbursed more than $1.3 million for these transplants. VCU/MCVH wrote off eight transplants at a reported cost of more than $1.8 million, and was reimbursed more than $1.4 million by the ICAP. Thus, the cost of transplants to indigent patients was more than $3.7 million in FY 1992. The teaching hospitals received more than $2.7 million in general funds for these transplants.

Table 8

Total Transplants Provided and Transplants Written Off to ICAP by UVAMC and VCU/MCVH, FY 1992

	VCU/MCVH		UVAMC	
Service	Number of Patients	Cost of Service*	Number of Patients	Cost of Service
Liver Transplant				
Total patients	40	$7,126,800	37	$6,520,136
Indigent patients	5	1,686,972	17	977,581
Bone Marrow Transplant				
Total patients	43	2,702,550	22	2,622,174
Indigent patients	2	86,200	6	269,864
Heart Transplant				
Total patients	21	11,564,097	20	1,595,821
Indigent patients	1	77,853	7	651,800
TOTAL COST FOR HOSPITAL	104	21,393,447	79	10,738,131
Total Cost for Indigents	8	$1,851,025	30	$1,899,245
Total Reimbursement for Indigents		$1,417,885		$1,348,464

*Cost of service for total patients is based on average cost times the number of patients.

Source: JLARC staff analysis of UVAMC and VCU/MCVH transplant data.

In light of the differences between the types of transplants covered by other State indigent care programs, as well as the lack of any explicit service guidelines, the General Assembly should clarify its intent concerning the ICAP. As the General Assembly considers this issue in relation to transplants, five key points should be considered: (1) indigent care program consistency, (2) the medical education mission of the teaching hospitals, (3) the institutions' certification as transplant centers, (4) the financial position of the institutions, and (5) the transplant policy of Virginia Medicaid.

Program Consistency. Currently, only kidney and cornea transplants are reimbursable services under Virginia Medicaid. Therefore, Virginia Medicaid will not reimburse any hospital, including the State teaching hospitals, for heart, liver, or bone marrow transplants. By statute, the SLH program and Trust Fund must follow Virginia Medicaid's reimbursement policy. Therefore, the ICAP is the only program which will reimburse hospitals for these services. If reimbursement for these types of transplants were eliminated from the ICAP, then the scope of transplant services would be the same for all State indigent care programs.

Medical Education Mission. Transplant services provide an opportunity for education of medical students and other health care professionals. In FY 1992, bone marrow, liver, and heart transplants to indigent people were 38 percent of all transplants performed at UVAMC (Table 8). At VCU/MCVH, approximately 16 percent of the liver, heart, and bone marrow transplants were performed on indigent patients. A reduction in transplants for indigent people would represent a loss of educational opportunities for medical students, residents, and other health care professionals.

Certification. In order to receive reimbursement for these transplants from Medicare or other third party payors, hospitals must be certified transplant centers. Each third party payor may have different certification requirements. For example, Medicare requires that 12 liver and 12 heart transplants be performed annually for a hospital to be certified. Based on FY 1992 data, even if all indigent transplants had been eliminated, it appears that both hospitals would have maintained their certification.

However, because the volume of transplants can change from year to year, certification should be considered when deciding the level of State funding for these transplant services. For example, at UVAMC, certification for heart transplants could have been in question if the six transplants performed for indigent people during FY 1992 had not occurred. This is because only 20 transplants were performed in total.

Financial Position of Hospitals. If coverage of transplants were to be eliminated from the ICAP, the teaching hospitals would have to decide to either reduce the number of transplants for indigent patients or subsidize them through other sources of revenue. According to staff of both hospitals, opportunities to fund transplants through private fund-raising are pursued. For example, in FY 1992, more than $180,000 was raised from other sources for two liver transplants performed on indigent patients at UVAMC.

Virginia Medicaid's Transplant Policy. Virginia Medicaid's transplant policy has a direct impact on ICAP spending for transplants. For example, while VCU/MCVH staff reported that none of the indigent transplant recipients were Medicaid eligible, UVAMC staff reported that 12 of the 30 indigent transplant recipients were Medicaid eligible. Therefore, general fund dollars could have been saved if these services had been covered by Virginia Medicaid. Specifically, the federal match could have allowed a general fund savings of $1.2 million in FY 1992.

The potential to optimize State funds through Medicaid raises the question of whether the program's scope of services should be expanded to include additional transplant services. However, there are two concerns which make the impact of this policy uncertain.

First, there could be a hidden demand for transplant services among indigent people. DMAS does not collect information on the demand for transplant services among indigents who have already enrolled in Virginia Medicaid. Further, if Virginia Medicaid's scope of services was broadened to include heart, liver, and bone marrow transplants, then the General Assembly would have to decide whether to broaden the scope of services for the SLH program and Trust Fund. Currently, there is not a systematic method for assessing what demand exists among all indigents for transplant services.

Second, inclusion of these transplants as reimbursable services could affect hospitals other than VCU/MCVH and UVAMC. Currently, four other non-federal hospitals — Fairfax, Henrico Doctor's, Sentara Norfolk General, and Children's Hospital of the King's Daughters — perform liver and heart transplants (Table 9). As transplants become more routine, the number of hospitals performing these procedures is likely to grow.

Comprehensive Study is Required. The issues just described indicate the need for a comprehensive study of Virginia Medicaid's transplant policy. Such a study should include an assessment of the potential demand for heart, liver, and bone marrow transplants among Medicaid patients. Further, the study should take into consideration the impact of a Medicaid policy change on the other State indigent care programs, including the ICAP.

The study should also evaluate implementation options such as prior authorization, limiting coverage to children, limiting reimbursement to in-State hospitals only, selective contracting, or paying hospitals a set fee for each type of transplant. For example, Virginia Medicaid currently negotiates a fee for kidney transplants. West Virginia Medicaid reimburses UVAMC $75,000 per liver transplant. This is in comparison to the average ICAP cost of more than $201,000 for five Virginia Medicaid recipients whose liver transplants were written off as indigent care in FY 1992. UVAMC received approximately $143,000 in reimbursement from the ICAP for each of these transplants.

In the interim, the General Assembly should clarify its intent concerning whether the ICAP should be used to fund the State teaching hospitals for transplants provided to indigent patients. In doing so, the General Assembly may wish to consider

Table 9

Acute Care Hospitals Providing Transplant Services and Number of Transplants Provided, Calendar Year 1991

Hospital	Type of Transplant		
	Bone Marrow*	Heart	Liver
Children's Hospital of the King's Daughters		3	
Fairfax		10	
Henrico Doctor's		11	5
Medical College of Virginia	43	25	26
Sentara Norfolk General		21	
University of Virginia Medical Center	22	25	51
TOTAL	65	95	82

*Number of bone marrow transplants is for July 1, 1991, through June 30, 1992.

Source: JLARC staff analysis of 1991 Virginia Transplant Council, VCU/MCVH, and UVAMC transplant data.

the issues of program consistency, medical education, certification, the financial position of the hospitals, and potential changes to Medicaid transplant policy. In addition, the General Assembly should clarify its intent concerning whether the ICAP should have the same service limitations as other State indigent hospital care programs.

Recommendation (3). **The Secretary of Health and Human Resources, with support from the Secretary of Education, should study the current Medicaid limits on transplant services. This study should include a detailed analysis of the demand for transplant services among indigent people in the State; the impact of the current limits and potential changes on other indigent care programs and the State teaching hospitals; and implementation options which would optimize State funds. The study should be presented to the Joint Commission on Health Care before July 1, 1993.**

Recommendation (4). **The General Assembly should clarify its intent concerning the scope of hospital services reimbursable through the indigent care appropriations to the State teaching hospitals. At a minimum, the General Assembly should clarify its intent on whether the indigent care appropriations should be used to reimburse the State teaching hospitals for bone marrow, liver, and heart transplants provided to indigent patients.**

ICAP Reimbursement Rates Appear to Be in Line with those of Virginia Medicaid

To determine if the reimbursement rates for inpatient hospital services covered by the indigent care appropriations are reasonable, they were compared to those of Virginia Medicaid. This comparison was used because Virginia Medicaid's inpatient reimbursement system has generally been cost effective for the State (as explained in the 1992 JLARC report *Medicaid-Financed Hospital Services in Virginia*). The comparison suggests that the ICAP reimbursement rates are reasonable and are, for the most part, in line with those paid to VCU/MCVH and UVAMC by Virginia Medicaid for inpatient hospital services. However, the current policy of allowing the teaching hospitals to include uncompensated Medicaid costs as indigent care costs should be reconsidered.

ICAP Allowable Costs Have Been Typically Less than those for Medicaid. A three-year comparison of reimbursement rates between the ICAP and Virginia Medicaid was conducted. As shown in Table 10, columns 1 and 2, an ICAP per diem for inpatient allowable costs was calculated for VCU/MCVH and UVAMC for FY 1989 through FY 1991 from the indigent care cost reports. Similar information was gathered from the Virginia Medicaid cost settlement reports for the same fiscal years (column 3). The same procedure was followed to calculate and compare the reimbursed costs for the ICAP (column 4) and Virginia Medicaid (column 5). These calculations are based on what UVAMC and VCU/MCVH were actually reimbursed by each funding mechanism. The table also shows the percentage increase between FY 1989 and FY 1991 for each column.

The data for VCU/MCVH indicate that allowable costs for indigent care have typically been less than those for Virginia Medicaid. For example, in FY 1991, allowable costs on a per diem basis were $774 for indigent inpatient care. In comparison, Medicaid allowable costs were $994. In addition, the percent increase in allowable costs for the period FY 1989 to FY 1991 was lower. For the ICAP, the increase was approximately 17 percent. For Virginia Medicaid, the increase was approximately 26 percent.

The comparison of reimbursed costs at VCU/MCVH indicates that the hospital was reimbursed less for an indigent inpatient day of care than a Medicaid day. In addition, the percentage increase was lower over the three-year period — seven percent in comparison to Medicaid's 14 percent.

As also shown in Table 10, allowable costs for indigent care for UVAMC were in line with those of Virginia Medicaid. Increases in these costs have also been similar to increases in allowable costs for Virginia Medicaid. In terms of actual reimbursement rates, the ICAP reimbursement rates were higher than Medicaid reimbursement rates for FY 1989 and FY 1990. However, the ICAP reimbursement rate in FY 1991 ($819) was lower than that of Virginia Medicaid ($933). In addition, actual reimbursement of inpatient hospital costs on a per diem basis has decreased for the ICAP since FY 1989 while Medicaid reimbursement has increased.

Table 10

Comparison of Reported Allowable and Reimbursed Inpatient Costs Indigent Care Appropriations and Virginia Medicaid Fiscal Years 1989, 1990, and 1991

(1) Hospital/FY	ALLOWABLE COSTS (2) ICAP Per Diem	ALLOWABLE COSTS (3) Medicaid Per Diem*	REIMBURSED COSTS (4) ICAP Per Diem	REIMBURSED COSTS (5) Medicaid Per Diem*
VCU/MCVH				
FY 1989	$659.03	$791.95	$573.43	$754.49
FY 1990	712.87	833.44	628.28	841.91
FY 1991	774.15	993.96	614.68	859.66
Percent Change	17%	26%	7%	14%
UVAMC				
FY 1989	$825.40	$886.87	$855.87	$793.58
FY 1990	962.85	1,018.45	986.81	894.16
FY 1991	1,042.27	1,140.24	819.33	932.82
Percent Change	26%	29%	-4%	18%

*Medicaid per diem was determined by adding the inpatient operating, medical education, and capital per diems. It does not include the disproportionate share adjustment per diem.

Source: JLARC staff analysis of UVAMC and VCU/MCVH indigent and Medicaid cost reports, FY 1989 through 1991.

Unreimbursed Medicaid Costs Are Currently Included as Indigent Care Costs. For the preceding analysis, the allowable costs that the teaching hospitals specifically attribute to inpatient hospital services were used. However, for the cost reports on which the ICAP are based, unreimbursed Medicaid costs are included as indigent care costs. These costs were more than $5.1 million in FY 1991 and $3.9 million in FY 1992. In FY 1992, the hospitals were reimbursed more than $2.7 million in State general funds for these costs, while in FY 1991, they received $4.1 million.

In FY 1991, VCU/MCVH reported close to $1.7 million in unreimbursed Medicaid costs and received close to $1.4 million in State general funds as reimbursement. In FY 1992, VCU/MCVH's unreimbursed costs were $178,000, with $136,000 being reimbursed by State general funds. At UVAMC, unreimbursed Medicaid costs that were written off to the ICAP totalled close to $3.5 million in FY 1991 and $3.8 million in FY 1992. Of these amounts, UVAMC received approximately general fund payments of $2.8 million in FY 1991 and $2.7 million in FY 1992.

VCU/MCVH and UVAMC define unreimbursed Medicaid costs differently. UVAMC determines unreimbursed costs by calculating the difference between allowable costs and reimbursed costs for all Medicaid hospital services, including inpatient, outpatient, and rehabilitation. In addition, Medicaid cost settlement adjustments from previous fiscal years are included, as are independent lab service costs and late charges. VCU/MCVH only includes the difference between Medicaid allowable costs and reimbursed costs. Staff of both hospitals state that inclusion of unreimbursed Medicaid costs as indigent care costs gives a truer picture of total indigent care costs.

However, federal laws and State policy concerning Medicaid reimbursement require that hospitals accept Medicaid payment as payment in full. As stated in Title 42, part 447, section 15 of the *Code of Federal Regulations*:

> [The] State plan must provide that the Medicaid agency must limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency.....

This regulation could be interpreted as disallowing the allocation of unreimbursed Medicaid costs to the indigent care cost report. The General Assembly may wish to exclude unreimbursed Medicaid costs from funding consideration.

Recommendation (5). **The General Assembly should clarify its intent concerning the funding of unreimbursed Medicaid costs as part of the indigent care appropriations to the State teaching hospitals.**

Joint Budget and Program Review for VCU/MCVH and UVAMC Should Be Formally Initiated

During this review, concerns were expressed that the two teaching hospitals' indigent health care programs and budgets are overseen and developed in a separate secretariat than that of Virginia Medicaid and other indigent health care programs. One concern is that the education secretariat may not have the expertise to decide budgetary changes for VCU/MCVH and UVAMC's health care services. While UVAMC and VCU/MCVH are appropriately considered components of Virginia's higher education system because of their medical education mission, they are clearly health care institutions as well.

From a health and human resources perspective, the greatest opportunities for general fund cost savings appear to be tied to the provision of health care. For example:

> *During the 1990-92 biennium, the Virginia Treatment Center for Children (a mental health facility) was transferred to VCU/MCVH through a memorandum of agreement. This transfer was completed so that Medicaid funds could replace State general funds and higher Medicaid reimbursement could be received by the Treatment Center. The Department of Medical Assistance Services (DMAS) estimated that $500,000 in general funds were saved through this transfer.*

Further, the two teaching hospitals' indigent care activities have a significant impact on the costs of the Virginia Medicaid program. This impact has been exacerbated by the shift of ICAP funding through enhanced Medicaid disproportionate share adjustment (DSA) payments. Therefore, from an operational standpoint, forecasts of spending and budgetary needs for both the ICAP and Virginia Medicaid must be simultaneously monitored to contain total spending as much as possible. It is also important to ensure that ICAP reimbursement rates are in keeping with those of other State indigent care programs.

From an education secretariat perspective, the health and human resources secretariat may recommend and implement Medicaid cost containment actions which substantially impact the State teaching hospitals' financial position. Two examples are (1) the $100 co-payment requirement for Virginia Medicaid, and (2) the non-emergency room payment policy.

> *Beginning in FY 1993, Medicaid inpatients were required to pay a $100 co-payment for each admission. The Secretary of Health and Human Resources and DMAS estimated that this requirement would save $2 million for the 1992-1994 biennium.*
>
> *During interviews, both UVAMC and VCU/MCVH staff indicated that the loss of revenue from this action will be substantial. VCU/MCVH reported that in FY 1991 it collected only $250,000 of the $4.3 million in co-payments it was owed.*
>
> * * *
>
> *Beginning in FY 1992, DMAS enacted a non-emergency fee reduction program for hospital emergency departments. This program reduces Medicaid payments to hospitals if a Medicaid recipient inappropriately uses the emergency room for non-emergency treatment. As of June 30, 1992, DMAS attributed close to $6.5 million in savings to the program.*
>
> *Of the $6.5 million, reduced payments to VCU/MCVH and UVAMC accounted for more than $1.6 million, or 25 percent, of the amount saved. The loss in revenue created by this program change was included in the cost report prepared for the ICAP.*

To address such policy issues, a memorandum of agreement for joint budget and associated program review by the Secretary of Education and Secretary of Health and Human Resources should be implemented. This agreement should ensure that during the budget development process both secretaries have an opportunity to comment on the indigent care appropriations to the State teaching hospitals, as well as on health policy changes which impact the State teaching hospitals. In addition, the agreement should ensure that evaluations of indigent health care policy and programs or of the State teaching hospitals involve both secretariats. However, involvement in budget execution at the State teaching hospitals by the Secretary of Health and Human Resources does not appear necessary at this time.

Recommendation (6). **The Secretary of Health and Human Resources and the Secretary of Education should develop a memorandum of agreement to implement joint budget development and associated program review for the Medical College of Virginia Hospitals of Virginia Commonwealth University and the University of Virginia Medical Center. This agreement should exclude budget execution activities from joint review.**

Formal Reporting of Enhanced DSA Payments Should Be Initiated

In addition to implementing joint budget and program review, the Secretary of Education and the Secretary of Health and Human Resources should formally report the amount of enhanced DSA payments made to the State teaching hospitals as part of the executive budget process. This action should be taken for two reasons.

First, as was noted in Chapter II, DMAS projects that these payments will total approximately $65 million in FY 1994. Routine Medicaid expenditures are forecasted to be $111.3 million for the two State teaching hospitals during the same year. Therefore, the enhanced payments will comprise a significant amount of Medicaid hospital expenditures in future years.

Second, if the federal government changes its current DSA policies, use of these payments to fund non-Medicaid program costs could be stopped. If that were to occur, the General Assembly would have to decide whether to appropriate general funds to cover the loss of federal funds. In FY 1994, $32.5 million in federal funds will be used to cover indigent care costs. Therefore, the General Assembly should be informed of the amount of general fund commitment that could be necessary if federal funding were eliminated.

Recommendation (7). **The Secretary of Education and the Secretary of Health and Human Resources, as part of the executive budget process, should report the total amount of enhanced Medicaid disproportionate share adjustment payments and general fund appropriations for indigent care to the State teaching hospitals. This report should also indicate the federal fund component of the enhanced Medicaid DSA payments.**

IV. Indigent Care Appropriations to the Medical College of Hampton Roads

The Medical College of Hampton Roads (MCHR) is one of three medical schools in the State, along with the University of Virginia Medical School (UVAMS) and the Medical College of Virginia of Virginia Commonwealth University (VCU/MCV). However, MCHR is very different from UVAMS and VCU/MCV in two important respects. First, while VCU/MCV and UVAMS are State agencies, MCHR is a non-State agency which receives State funds. Second, VCU/MCV and UVAMS are attached to State-owned teaching hospitals which also receive State support. MCHR is not associated with a State-owned teaching hospital. Instead, MCHR is affiliated with private hospitals within its health service area (HSA).

There are also fundamental differences in the indigent care appropriation (ICAP) to MCHR as compared to the appropriations to the Medical College of Virginia Hospitals of Virginia Commonwealth University (VCU/MCVH), and the University of Virginia Medical Center (UVAMC). The appropriation to MCHR is intended to support the indigent care provided in conjunction with its medical education programs by faculty physicians and by the affiliated teaching hospitals. The appropriations to VCU/MCVH and UVAMC are intended to provide direct financial support to these State-owned teaching hospitals.

In addition, the ICAP to VCU/MCVH and UVAMC are determined based on formalized cost reports as established by the Auditor of Public Accounts (APA). MCHR requests its ICAP based on its own analysis of need, although in recent years it has taken steps to align this analysis with the cost reports used by VCU/MCVH and UVAMC.

It is because of these differences that the ICAP to MCHR was evaluated separately during this review. A key difference in the evaluation approach was the assumption about the importance of State funding to the survival of the MCHR affiliated hospitals. The State has a historical commitment of subsidizing most of the indigent care provided at VCU/MCVH and UVAMC. This magnitude of commitment has not existed for the MCHR affiliated hospitals. Therefore, it was not assumed that the ICAP to the MCHR affiliated hospitals should be at the same level as the appropriations to VCU/MCVH and UVAMC.

These prefatory statements are not intended to minimize the contributions of MCHR and its affiliated hospitals to the provision of indigent care and medical education in Eastern Virginia. There is a heavy demand for indigent health care in Eastern Virginia, and MCHR physicians and the affiliated hospitals play an important role in providing this care. The affiliated hospitals account for a major share of regional spending for indigent hospital care. MCHR physicians are also an important source of indigent care in the region.

It is in this context that the mandate was addressed. Senate Joint Resolution (SJR) 180 (1991) requested a review of eligibility, scope of services, and reimbursement rates for indigent care at MCHR. There are four major findings from this review:

- MCHR should revise its indigent care cost methodology to provide a more accurate assessment of its indigent care losses.

- Reimbursement rates for physicians have been reasonable.

- The adequacy of reimbursement rates for hospitals depends on legislative intent to subsidize indigent care at these institutions above and beyond what the affiliated hospitals receive from the Indigent Health Care Trust Fund (Trust Fund).

- Eligibility guidelines and service limitations appear to be reasonable in light of the level of funding received.

SJR 180 also requested identification of options for using Medicaid funds for services currently supported with State general funds. Potentially, Medicaid funds could be used to cross-subsidize the ICAP to MCHR. In FY 1992, this option could have allowed the State to save up to $2 million in general funds. Or, the option could have allowed the State to generate $4 million in additional federal funds. However, because of several implementation concerns, the feasibility of this option is uncertain, and will require further study.

MCHR AND INDIGENT CARE

MCHR is a unique higher education institution in Virginia. Although it is not a State agency, MCHR operates under State charter as a public instrumentality and receives approximately 11 percent of its funding from the State. This funding is used for a variety of purposes, including indigent care and education. Historically, the indigent care funds have been allocated between MCHR and the affiliated hospitals.

MCHR Is A Unique Institution in Virginia

MCHR was created as the Norfolk Area Medical Authority in 1964. Chapter 471, Acts of Assembly (1964) created MCHR as a "public instrumentality, exercising public and essential governmental functions to provide for the public health and welfare of Eastern Virginia." This Act also designated MCHR as an institution of higher education. However, MCHR is considered a non-State agency.

The stated mission of MCHR is to be a "community-based academic institution dedicated to medical and health education, biomedical research and the enhancement of health care in the Hampton Roads region." MCHR is governed by a 17-member board of

visitors which oversees undergraduate and graduate education at the Eastern Virginia Medical School, a research institute, and two faculty practice plans. The faculty practice plans are made up of MCHR faculty who are also practicing physicians.

Unlike UVAMS and MCV, there is no State-owned teaching hospital affiliated with MCHR. Instead, MCHR contracts with private hospitals to provide clinical education programs. Currently, there are two federal institutions and seven non-federal institutions which contract with MCHR to provide clinical education services. The seven non-federal institutions include Chesapeake General Hospital, Children's Hospital of the King's Daughters, Depaul Hospital, Sentara Medical Center Hospitals, Maryview Hospital, Portsmouth General Hospital, and Virginia Beach General Hospital.

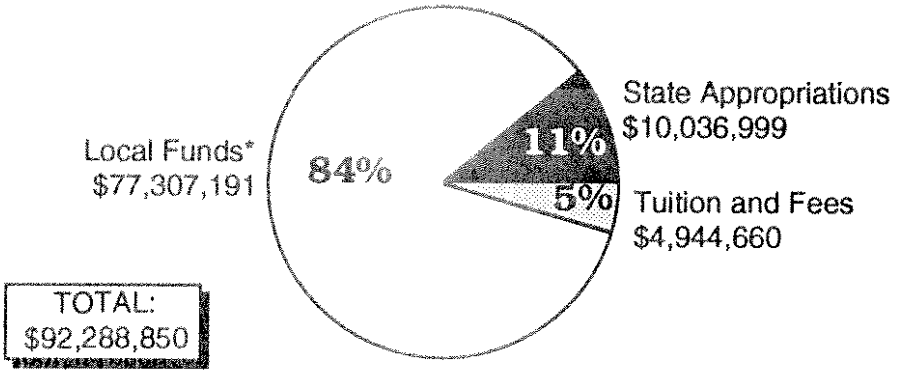
These seven institutions pay affiliation costs to MCHR. These fees help to finance resident education costs, undergraduate education costs, and shared physician costs. In FY 1991, these institutions paid a total of $11.3 million in affiliations costs to MCHR.

The Commonwealth Funds Various Activities

MCHR's activities are financed through multiple funding sources including patient revenues, tuition, grants, contracts, gifts, and local and State appropriations. In FY 1991, the State appropriation of more than $10 million represented about 11 percent of the institution's funding (Figure 14).

Figure 14

Medical College of Hampton Roads
Sources of Support, FY 1991



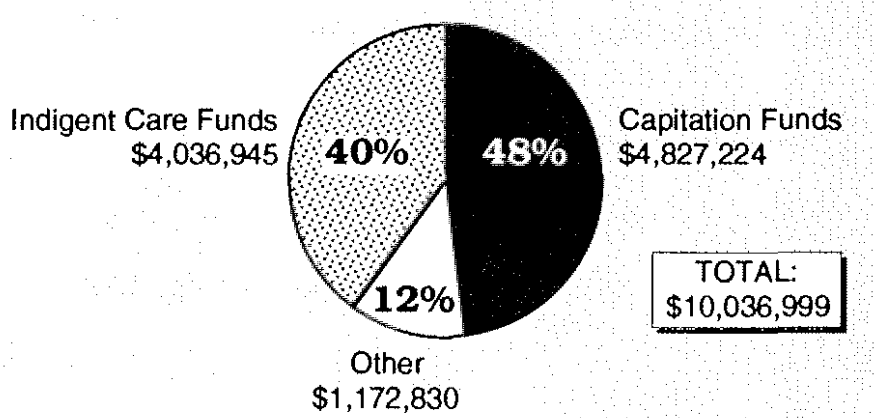
*Local funds include patient care revenues, gifts, grants, contracts, local government appropriations, and other revenues.

Source: JLARC staff analysis of MCHR data.

The General Assembly appropriates general funds to MCHR for various purposes (Figure 15). In FY 1991, the General Assembly appropriated $4.8 million in capitation funds to support medical instruction costs for undergraduate students. An additional $4 million was appropriated for the provision of indigent care. Most of the remaining $1.2 million in State appropriations was used to support family practice services and training.

Figure 15

Medical College of Hampton Roads
State General Fund Appropriations, FY 1991



Source: JLARC staff analysis of MCHR data.

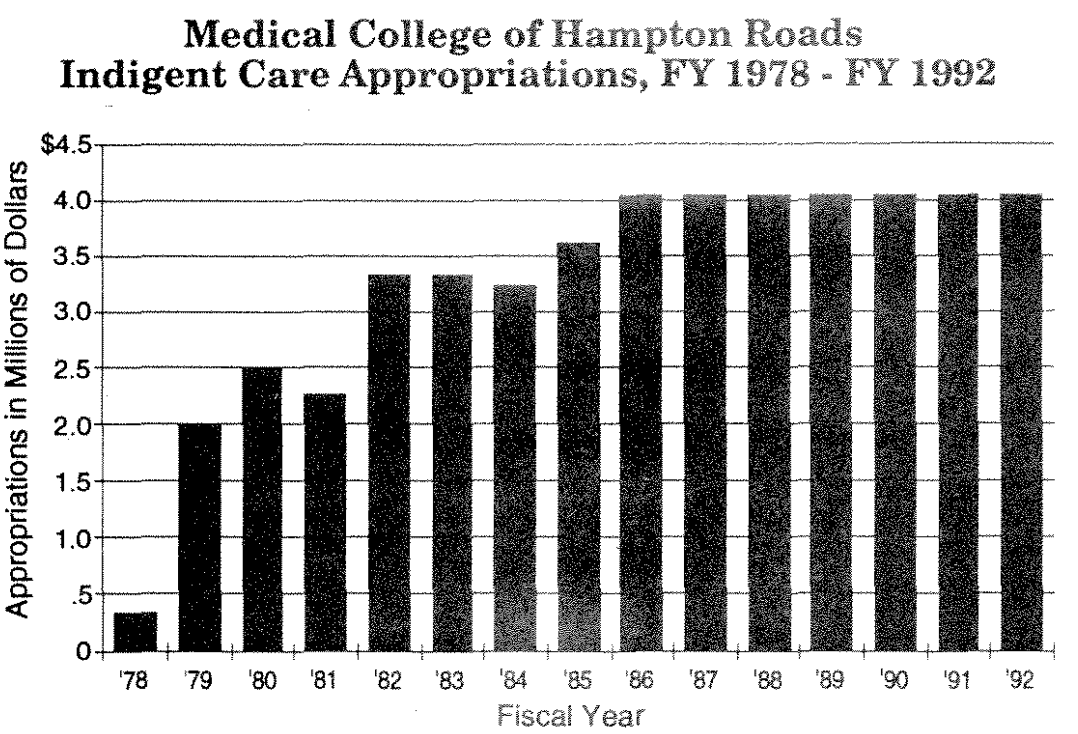
The State appropriation for indigent care is subject to the following provisions, as stated in the 1992 Appropriation Act (Chapter 893):

> The appropriation provides State aid for treatment, care and maintenance of indigent Virginia patients in hospital and other programs affiliated with the educational programs of the college; the aid is to be apportioned on the basis of a plan having the prior written approval of the director, Department of Planning and Budget (DPB).

MCHR received its first State ICAP of $350,000 in FY 1978 (Figure 16). In that same year, a legislative commission was established to study the funding of medical and hospital care for the medically indigent in Virginia. In its report to the Governor and the General Assembly (Senate Document No. 20, 1978), the commission stated:

> It is the view of this Commission that the evidence presented at public hearings has documented and provided the need and the equitable and legal justification for appropriate financial support by the Common-

Figure 16



Source: JLARC staff analysis of MCHR data.

> wealth of Virginia for the treatment, care and maintenance of indigent Virginia patients in hospitals and programs affiliated with the medical schools under the aegis of (MCHR); and it hereby recommends to the Governor of Virginia that a substantial appropriation be included in his budget for such purpose.

Although there was an increase in funding for FY 1978 and for most years until FY 1986, since FY 1986 the appropriation has remained level at $4,036,945. In its budget addendum for the 1992-94 biennium, MCHR requested an increase of $1,463,035 in its annual ICAP to support its indigent care and related educational activities. This request was not funded.

MCHR Plays an Important Role in Indigent Care

There is a relatively high rate of poverty in Eastern Virginia (HSA V), which is the primary service area for MCHR. The Department of Health (DOH) estimates that 31 percent of the population in HSA V is below 200 percent of poverty. Poverty rates are especially high in several cities directly served by MCHR. In Norfolk, an estimated 44

percent of the population is below 200 percent of poverty. Portsmouth, Newport News, and Suffolk all have more than 30 percent of their population living below 200 percent of poverty.

These poverty rates are reflected in high levels of spending for indigent hospital care in HSA V. In FY 1991, JLARC staff estimate that HSA V accounted for 24 percent of statewide spending for indigent hospital care. High poverty levels are also reflected in high demand for indigent primary care. A 1991 DOH report on primary care needs noted a number of concerns about access to primary care in Eastern Virginia for people below 200 percent of poverty.

MCHR participates in the provision of a substantial amount of unsponsored indigent care through its educational programs that are conducted through the faculty practice plans and the hospital-based clinics operated as part of the residency training programs. The Eastern Virginia Medical School has an enrollment of more than 380 students. In addition, the graduate school has more than 330 medical residents in various specialties. Medical residents and students observe and assist MCHR faculty in treating indigent patients, whether it be in a physician's office, a clinic, or a hospital.

JLARC staff estimate that in FY 1991, the affiliated hospitals accounted for 66 percent of charity care costs and 58 percent of bad debt costs in HSA V. The MCHR physician practice plans also provide a substantial amount of indigent care. MCHR reports that, in FY 1991, charity patients represented six percent of gross charges. Charity care costs for the two physician practice plans exceeded $3 million dollars, and represented about eight percent of total costs.

Indigent Care Funds Are Allocated to MCHR and Affiliated Hospitals

Historically, MCHR has allocated its ICAP between the medical school and the affiliated hospitals according to a plan which is approved by the DPB director. The plan defines medical indigency for the purpose of the appropriation, specifies the types of costs that may be accounted for as indigent losses, and explains how the funds are to be allocated between the affiliated hospitals and MCHR.

Definition of Medical Indigency. The plan stipulates that a medically indigent patient is one who is unable to pay for required medical services and whose spouse, parent, or guardian is unable to meet this need. The patient must meet a means and/or income level test to determine the ability to pay for required medical care. The patient must also be a Virginia resident. In addition, services provided must be medically necessary, as determined by consistency with Medicare or Medicaid guidelines.

Determination of Indigent Care Losses. The MCHR plan stipulates that in determining indigent care losses, hospitals and physicians may include: (1) bad debt costs, (2) charity care costs, (3) unreimbursed State and Local Hospitalization (SLH) program costs, (4) the cost of adult inpatient days beyond the Medicaid limit of 21, and

(5) the difference between reported costs and reimbursement for Medicaid patients. Hospitals may not include contractual adjustments (the difference between reimbursement and charges).

The plan also stipulates that the ICAP is to be the payor of last resort. The affiliated teaching hospital or physician is expected to determine the availability of payment from Medicare, Blue Cross/Blue Shield, Medicaid, SLH program, and other sources prior to classifying the claim as eligible for indigent care funding. Appropriated funds are not to be used to provide reimbursement in cases where other reimbursement is available.

Allocation of Indigent Care Funds. Since FY 1990, the MCHR allocation plan has called for 30 percent of the ICAP to be allocated to the affiliated hospitals, and 70 percent to be allocated to MCHR. However, since FY 1991, the teaching hospitals have agreed to increase their affiliation support in an amount equal to their share of the ICAP. The net effect is that all of the ICAP funds are used to support MCHR educational activities and physician services. MCHR staff reported that this internal reallocation was required to offset the Medical College's increasing costs, the lack of other funding for these essential programs, and the lack of increase in State support since 1986.

Thus, in FY 1991, an amount equal to the total appropriation of $4,036,945 was allocated to MCHR (Table 11). A total of $60,555 was used to cover administrative costs. Another $40,369 was used to fund a cooperative research and demonstration program with the region's health departments and hospitals to improve perinatal care for indigent people. The remaining $3,936,021 was used to support medical education and indigent care provided through the faculty practice plans. In addition, interest earnings of $9,883 were also allocated to MCHR.

As explained earlier, MCHR is required to submit an ICAP apportionment plan for the approval of the director of DPB. As long as MCHR continues its policy of no net allocation of ICAP funds to the affiliated hospitals, this policy should be reflected in the indigent care apportionment plan.

Recommendation (8). **The Medical College of Hampton Roads should modify its plan for apportioning State indigent care appropriations to reflect actual apportionment of funds between the Medical College and the affiliated hospitals.**

ELIGIBILITY, SCOPE OF SERVICES, AND REIMBURSEMENT RATES

In its budget addendum for the 1992-94 biennium, MCHR requested an increase of more than $1.4 million per year for indigent care. This request would have increased the annual appropriation to $5.5 million, or roughly half of the indigent care losses reported by MCHR physicians in FY 1991.

Table 11

Medical College of Hampton Roads Net Allocation of ICAP

	1987	1988	1989	1990	1991
Medical Education/Indigent Care Appropriation	$4,036,945	$4,036,945	$4,036,945	$4,036,945	$4,036,945
Less: 1 1/2 % Adminstration Costs	($60,555)	($60,555)	($60,555)	($60,555)	($60,555)
1% Research and Demonstration Program	$0	$0	$0	($40,369)	($40,369)
Funds Available for Allocation	$3,976,390	$3,976,390	$3,976,390	$3,936,021	$3,936,021
Allocation for Physician Services	$1,988,195	$1,988,195	$2,187,015	$2,755,474	$3,936,021
Plus: Interest Earned	$50,271	$78,861	$11,183	$8,976	$9,883
Allocation for Hospital Services	$2,038,466	$2,067,056	$1,800,559	$1,189,523	$0

Source: JLARC staff analysis of Medical College of Hampton Roads data, FY 1987 through FY 1991.

However, JLARC staff identified three concerns with MCHR's estimate of indigent care losses. First, this estimate was based on charges rather than costs. Second, the estimate included Medicaid contractual adjustments (the difference between Medicaid charges and reimbursement), which may be inconsistent with State Medicaid policy. Third, the estimate did not consider the financial impact of the Trust Fund on the affiliated teaching hospitals.

When these concerns are taken into account, indigent care losses at MCHR and its affiliated hospitals are still substantial but considerably less than what was indicated by the 1992-94 budget addendum. As a result, ICAP reimbursement rates appears to be more adequate than indicated in the budget addendum. When requesting indigent care appropriations in the future, MCHR should report indigent care losses on the basis of costs rather than charges. In addition, the General Assembly should clarify its intent to: (1) include Medicaid contractual adjustments in the determination of indigent care losses, and (2) allow the ICAP to be used to supplement the Trust Fund as a source of charity care financing.

There are no major concerns about eligibility and scope of services. Although the eligibility guidelines for indigent care at MCHR are different from those at VCU/MCVH and UVAMC, these differences do not have a major impact at current levels of funding. MCHR limits the scope of services for indigent care to those covered by Medicaid or Medicare. This limitation also appears reasonable considering the current level of funding.

Method for Determining Indigent Care Losses Should Be Revised

In its 1992-94 budget addendum, MCHR reported its indigent care losses on the basis of charges. This practice is inconsistent with that used at VCU/MCVH and UVAMC, which are required by the APA to report their indigent care losses on the basis of costs for the purpose of their appropriation. This decision was made because costs are a more accurate indicator of the actual outlay of resources than charges. Charges are the starting point for negotiations with private insurers and other payors. Charges may or may not be reflective of the actual cost of producing a service.

The 1992-94 budget addendum also included Medicaid contractual adjustments in its calculation of indigent care losses. Contractual adjustments are the difference between charges for Medicaid services and actual reimbursement. This policy could be interpreted as conflicting with a State policy which holds that providers are to accept Medicaid reimbursement as payment in full. By including Medicaid contractuals in the assessment of indigent care losses, MCHR and its affiliated hospitals were in effect requesting reimbursement from the State for unrecovered Medicaid charges.

While MCHR has included Medicaid contractuals in the determination of indigent care losses for its budget request, it has not actually reimbursed providers for Medicaid contractuals, according to MCHR staff. However, beginning with the FY 1992-94 biennium, MCHR is reimbursing providers for unreimbursed Medicaid *costs* (as

opposed to unreimbursed *charges*), within the limits of available funding. This policy is similar to the policy followed by VCU/MCVH and UVAMC, as reviewed in Chapter III. According to MCHR staff, this policy was adopted in an effort to make MCHR's determination of indigent care losses more consistent with that of VCU/MCVH and UVAMC.

These cost accounting methods have a major impact on the determination of indigent care losses, and therefore the assessment of the adequacy of indigent care reimbursement rates. If physician reimbursement rates were assessed on the basis of costs exclusive of Medicaid contractuals, it appears that the ICAP would have more than covered costs in FY 1990 and FY 1991. Reimbursement rates for hospitals would also appear more favorable.

Reimbursement Rates for Physicians. Table 12 compares indigent care funding to indigent care losses for both MCHR physicians and affiliated hospitals between FY 1987 and FY 1991. During this timeframe, indigent care charges for physicians increased from $6.3 million to nearly $11 million (column 2). Indigent care allocations to the faculty practice plan increased from nearly $2 million in FY 1987 to more than $3.9 million in FY 1991. The percentage of physician losses covered by the ICAP increased from 32 percent in FY 1987 to 36 percent in FY 1991 (column 4).

The percentage of indigent care losses covered by the ICAP appears larger when losses are calculated based on costs rather than charges. As shown in column 5, indigent care costs were significantly less than charges (column 1), ranging from just over $4 million in FY 1987 to $7.1 million in FY 1991. Under this cost accounting method, it appears that the proportion of indigent care losses covered by the ICAP ranged from 42 percent in FY 1989 to 55 percent in FY 1991 (column 6). This is an increase of 19 percent in FY 1991.

The indigent care reimbursement rates for physicians appear more favorable when Medicaid contractual adjustments are removed from the calculation of indigent care losses. Column 7 shows indigent care costs after removing Medicaid contractual adjustments. Under this method, physician indigent care losses are further reduced, ranging from less than $2.3 million in FY 1987 to just over $3 million in FY 1991. As shown in column 8, under this method it appears that the indigent care allocations actually exceeded indigent care losses by eight percent in FY 1990 and 29 percent in FY 1991.

Reimbursement Rates for Hospitals. As is the case with reimbursement rates for physicians, the adequacy of reimbursement rates for the affiliated hospitals also depends on how indigent losses are defined. As shown in column 2 of Table 12, total indigent care charges at the affiliated hospitals increased from $37.9 million in FY 1987 to $92.5 million in FY 1991. As shown in column 3, the portion of these charges covered by the indigent care allocations declined from five percent in FY 1987 to zero in FY 1991 (when no funds were allocated to the hospitals).

When total charges are reduced to costs (column 5), the proportion of losses covered by the indigent care funds appears to increase (column 6). When indigent care

Table 12

Indigent Care Appropriations Compared to Indigent Care Costs
Medical College of Hampton Roads
FY 1987 - FY 1991

(1)	(2) Total Indigent Care Charges	(3) ICAP Allocation	(4) % of Losses Reimbursed	(5) Total Charges Reduced to Costs	(6) Adjusted % of Losses Reimbursed	(7) Charges Less Medicaid Contractuals Reduced to Costs	(8) Adjusted % of Losses Reimbursed
Physicians							
FY 1987	$6,300,000	$1,988,195	32%	$4,095,000	49%	$2,268,712	88%
FY 1988	$7,200,000	$1,988,195	28%	$4,680,000	42%	$2,801,673	71%
FY 1989	$8,100,000	$2,187,015	27%	$5,265,000	42%	$2,577,985	85%
FY 1990	$8,904,611	$2,755,474	31%	$5,787,997	48%	$2,545,772	109%
FY 1991	$10,981,497	$3,945,904*	36%	$7,137,973	55%	$3,066,446	129%
Hospitals							
FY 1987	$37,900,879	$2,038,466*	5%	$25,338,889	8%	$11,769,218	17%
FY 1988	$46,871,166	$2,067,056*	4%	$28,644,710	7%	$11,263,313	18%
FY 1989	$60,507,137	$1,800,559*	3%	$39,090,874	5%	$12,430,392	14%
FY 1990	$73,595,482	$1,189,523*	2%	$46,808,616	3%	$15,894,341	7%
FY 1991	$92,508,384	$0	0%	$59,324,720	0%	$17,937,936	0%

*Includes interest earnings resulting from lags between the receipt of funds from the State and quarterly disbursement of funds.

Source: JLARC staff analysis of Medical College of Hampton Roads data, FY 1987 through FY 1991.

losses are determined on the basis of Medicaid costs exclusive of Medicaid contractuals (column 7), the proportion of losses covered by the indigent care funds increases further. Under this cost accounting method, it appears that the indigent care funds covered as much as 18 percent of hospital indigent care losses in FY 1988 before declining to zero percent in FY 1991 (column 8).

Cost Accounting Should Be Revised. Reporting of indigent care losses on the basis of charges overstates the cost of indigent care and understates the sufficiency of the ICAP. The APA requires VCU/MCVH and UVAMC to report their indigent care losses on the basis of costs. When submitting budget requests and other materials to DPB and the General Assembly, MCHR should calculate the value of its indigent care contributions on the basis of costs rather than charges.

The policy implications of including unreimbursed Medicaid costs in the calculation of indigent care losses are less straightforward. From the perspective of providers, it may appear justifiable to include unreimbursed Medicaid costs in the determination of indigent care losses because Medicaid payments are perceived to be insufficient. The 1992 JLARC report, *Medicaid-Financed Physician and Pharmacy Services in Virginia*, found that Medicaid physician reimbursement is generally lower than that of other payors, and that some physicians limit the number of Medicaid patients in their practices because of low reimbursement. The 1992 JLARC report, *Medicaid-Financed Hospital Services in Virginia*, found that hospital providers are also dissatisfied with Medicaid reimbursement rates. From the perspective of the Department of Medical Assistance Services (DMAS), Medicaid reimbursement rates are sufficient for efficient providers.

The General Assembly could decide to exclude unreimbursed Medicaid costs from the determination of indigent care costs at MCHR. Such a policy would be consistent with the principle of accepting Medicaid reimbursement as payment in full. However, it could also adversely affect the ability of MCHR physicians and affiliated hospitals to serve Medicaid patients.

Recommendation (9). **The Medical College of Hampton Roads should use costs rather than charges as the basis for requesting indigent care appropriations and reporting indigent care losses.**

Recommendation (10). **The General Assembly should clarify its intent for the inclusion of unreimbursed Medicaid costs in the determination of indigent care losses at the Medical College of Hampton Roads.**

Legislative Intent Should Be Clarified for Hospital Reimbursement

As explained earlier, the affiliated hospitals have agreed to forego their share of the ICAP since FY 1991. However, this policy has not left the institutions without any support for charity care. Beginning in FY 1991, the Trust Fund reimbursed hospitals for a portion of their charity care. In fact, in FY 1991, the affiliated hospitals, as a group, received more from the Trust Fund than they would have received from the ICAP.

Table 13 shows the net Trust Fund payments for each of the MCHR affiliated hospitals in FY 1991. The data indicate that four of the seven hospitals received payments from the Trust Fund, while three hospitals made payments to the Trust Fund. Overall, the affiliated hospitals received a net benefit of more than $2.3 million from the Trust Fund, or 13% of their indigent care costs less Medicaid contractuals. State general funds comprised more than $1.9 million of the $2.3 million. By comparison, the affiliated hospitals would have received only $1.2 million from the ICAP according to the MCHR plan.

Table 13

Net Trust Fund Contributions at MCHR Affiliated Hospitals, FY 1991

Hospital	Net Contribution	State Share of Net Contribution
Chesapeake General	($66,769)	$0
Childrens'-King's Daughters	($60,359)	$24,624
Depaul	$1,206,448	$957,617
Maryview	$187,008	$130,678
Portsmouth General	$305,975	$189,316
Sentara Health Systems	$948,637	$607,004
Virginia Beach General	($174,203)	$0
TOTAL	$2,346,737	$1,909,059

Source: JLARC staff analysis of DMAS data.

Given the presence of the Trust Fund, the General Assembly may wish to clarify its intent to use the ICAP to support charity care at the affiliated hospitals. The General Assembly could decide to disallow the use of the ICAP for hospital charity care. This decision could be based on the premise that the Trust Fund is the preferred method of subsidizing charity care at non-State hospitals. Under this approach, use of the ICAP for hospital charity care would be considered unnecessarily duplicative of the Trust Fund payments. However, the ICAP could still be used to finance hospital care for indigent patients with incomes above 100 percent of poverty.

Alternatively, the General Assembly could decide that the ICAP should be used to supplement the Trust Fund, subject to the availability of funds. Such a decision could be based on the view that the teaching hospitals incur additional costs because of their teaching activities.

In any case, MCHR should appropriately account for the impact of Trust Fund payments to hospitals when determining indigent care costs. This will provide a more accurate estimation of the unsponsored indigent care costs at the institutions.

Recommendation (11). **Due to the presence of the Indigent Health Care Trust Fund, the General Assembly should clarify its intent to use the indigent care appropriation to subsidize charity care provided by the teaching hospitals affiliated with the Medical College of Hampton Roads.**

Recommendation (12). **The Medical College of Hampton Roads should subtract net positive payments from the Indigent Health Care Trust Fund when determining indigent care losses at its affiliated teaching hospitals.**

Eligibility and Scope of Services Are Reasonable

The eligibility guidelines for MCHR are much like those for VCU/MCVH and UVAMC, with two exceptions: (1) only Virginia indigents are eligible for funding, and (2) hospitals are allowed to include all bad debt in the determination of their indigent care losses, as opposed to only the portion of bad debt for people with incomes up to 200 percent of poverty. At current levels of funding, MCHR's bad debt policy would appear to have a minimal fiscal impact. If indigent care funding levels were to be significantly increased in future years, it may become necessary to place limits similar to those at VCU/MCVH and UVAMC on the determination of eligibility at MCHR.

The scope of services for indigent care at MCHR is similar to that of VCU/MCVH. Current service limitations for indigent care are more restrictive than at UVAMC. While there are no service restrictions at UVAMC, MCHR limits the services which can be accounted for as indigent care losses to those allowable under Medicare or Medicaid. This policy appears to be reasonable compared to those of other state indigent health care programs.

OPTIMIZING GENERAL FUNDS

SJR 180 requested JLARC to identify options for using Medicaid funds to pay for services which are solely financed with general funds. Such options are often desirable because State general funds can be matched dollar for dollar with federal funds. As described in Chapter II, Virginia has already implemented a policy for sharing the cost of the ICAP to VCU/MCVH and UVAMC with the federal government through the Medicaid program. This section examines whether it might be possible to implement a similar approach for the ICAP to MCHR.

The policy at VCU/MCVH and UVAMC involves the use of Medicaid disproportionate share adjustment (DSA) payments. DSA payments are special Medicaid payments for hospitals which serve a disproportionate share of indigent patients. Beginning in FY 1992, a portion of UVAMC's and VCU/MCVH's ICAP was reallocated to the Virginia Medicaid program, with the remainder being used by the State for other purposes. These funds and the matching federal dollars are being returned to the two

hospitals in the form of enhanced Medicaid DSA payments. Thus, State general funds are saved while the institutions do not experience a loss in funding.

There is a possibility of implementing an enhanced Medicaid DSA policy through MCHR's affiliated hospitals. This option would involve assigning a special DSA designation to one or more of the affiliated hospitals for Medicaid reimbursement. All or a portion of the ICAP to MCHR could then be reallocated to Virginia Medicaid in order to draw federal matching funds. The leveraged funds could then be returned to the MCHR teaching hospitals in the form of enhanced Medicaid DSA payments. A portion of those funds could be returned to MCHR in the form of enhanced affiliation payments, much in the manner that the ICAP allocation is currently handled.

The feasibility of this option is uncertain for a number of reasons. A new disproportionate share payment policy would have to be approved by the U.S. Health Care Financing Administration (HCFA). Agreements would have to be made between the State, MCHR, and the affiliated hospitals on the amount and distribution of funds involved. Also, implications for Medicaid payment reform would have to be carefully scrutinized.

For these reasons, the Joint Commission on Health Care should request the Secretary of Health and Human Resources and the Secretary of Education to examine the feasibility of using Medicaid funds to support indigent care by the Medical College of Hampton Roads. In addition, the memorandum of agreement developed for joint budget and program review of VCU/MCVH and UVAMC between these two secretaries should include MCHR.

Uncertain Factors Affect Feasibility

There are a number of contingencies which would determine the feasibility of an enhanced Medicaid DSA strategy at the affiliated hospitals. At a minimum, the feasibility of the option would be highly dependent on federal requirements, the cooperation of the designated hospitals, and Medicaid reimbursement reform.

Federal Requirements. Federal requirements are a concern because HCFA would have to approve a Medicaid State Plan amendment to enact a special DSA policy for the designated hospitals. Federal regulations do not appear to rule out this possibility. Also, HCFA has approved a special DSA designation for VCU/MCVH and UVAMC. Ultimately, however, HCFA would have the final ruling over a new DSA proposal to obtain additional federal matching funds.

In addition, as explained in Chapter II, in future years there will be federal limits on the extent to which states can increase their Medicaid DSA payments. The extent to which Virginia will be able to increase its Medicaid DSA payments in the next fiscal year is still uncertain.

Cooperation of Hospitals. The identified teaching hospitals would also have to agree to participate in an enhanced DSA policy. Special agreements would have to be developed to specify obligations and administrative processes for each institution. Estimates would have to be developed for the amount of enhanced DSA payments to be received by each hospital. Affiliation costs would have to be increased by a specified amount in order to return a portion of the DSA funds to MCHR.

Medicaid Payment Reform. The feasibility of the option would have to be considered in the context of Medicaid payment reform. Under the settlement terms of the Virginia Hospital Association (VHA) lawsuit against the State, the Commonwealth has limited flexibility to implement Medicaid reimbursement reform prior to FY 1997. In the interim, implementation of a special DSA policy for the affiliated hospitals may require the approval of the VHA. Furthermore, a special task force on Medicaid inpatient reimbursement is scheduled to begin meeting in 1995 in order to revise the reimbursement system for implementation in FY 1997. Revisions implemented at that time may also affect the feasibility of a special Medicaid DSA policy.

Enhanced Medicaid DSA Payments to MCHR Teaching Hospitals

An essential requirement of this option is the ability to increase Medicaid payments only to those hospitals which are designated as teaching hospitals by MCHR. This would facilitate the transfer of Medicaid DSA dollars to MCHR in the form of affiliation payments. Thus, the focus is on those hospitals which are both Medicaid DSA hospitals and MCHR teaching hospitals which pay for their affiliation status. As of FY 1991, there were three hospitals which met these requirements: Children's Hospital of the King's Daughters, Depaul Hospital, and Sentara Norfolk Hospital (part of Sentara Health Systems).

Step 1: Separate Medicaid DSA Status. The three identified hospitals would have to be given a separate Medicaid DSA status in order to receive enhanced DSA payments. This would be necessary in order to target the enhanced disproportionate share payments to these hospitals only. The criterion for special designation could be each hospital's status as a MCHR affiliated teaching hospital. Once the hospitals obtained a special DSA status, an enhanced DSA payment policy could be developed for each hospital by DMAS.

Step 2: Establish Enhanced Medicaid DSA Payment Rate. The DSA payment rate would be based on the amount of the ICAP the State was willing to reallocate to Virginia Medicaid. For example, if the State were to allocate to Virginia Medicaid all of the current MCHR ICAP of more than $4 million, then an equal amount of federal matching funds could be obtained, and a total of more than $8 million could be distributed to the hospitals in the form of enhanced DSA payments. Or, if the State wanted to save general funds, an amount less than $4 million could be allocated to Virginia Medicaid, and the resulting total of federal and State funds could be distributed to the teaching hospitals through enhanced Medicaid DSA payments.

Step 3: Payments to MCHR. If State and federal matching funds could be successfully distributed to the teaching hospitals through enhanced DSA, then the next step would be to channel a portion of the funds to MCHR. One available mechanism for doing so is the affiliation costs paid by the hospitals to MCHR. These payments for affiliation could be enhanced by an appropriate amount in order to transfer an agreed-upon portion of the enhanced DSA to MCHR. MCHR could then use these funds to finance indigent physician care and educational costs of the institution.

Further Study is Necessary

Given the uncertain feasibility of this option, it will require further study before a definitive course of action may be taken. Considering that the option involves both education and health care policy, the Secretary of Education and Secretary of Health and Human Resources should be involved in the review.

In addition, because the potential for optimizing general funds exists at the Medical College of Hampton Roads, a formal mechanism for joint budget and program review by the Secretary of Education and Secretary of Health and Human Resources should be implemented. As was discussed in Chapter III, the relationships between indigent care funding and Medicaid and between medical education and indigent care are intertwined. Therefore, both secretaries should have the opportunity to comment on and review budgetary decisions affecting State support to a medical education entity which also provides significant levels of indigent care.

Recommendation (13). **The Joint Commission on Health Care should request the Secretary of Health and Human Resources and the Secretary of Education to examine the feasibility of using Medicaid funds to cross-subsidize indigent care at the Medical College of Hampton Roads and its affiliated hospitals.**

Recommendation (14). **The memorandum of agreement between the Secretary of Education and Secretary of Health and Human Resources implementing joint budget and program review for the State teaching hospitals should also include the Medical College of Hampton Roads.**

V. Optimizing General Funds for Indigent Hospital Care

In Virginia, as in most other states, hospital costs have continued to grow rapidly. At the same time, the number of uninsured people has increased. Together, these factors have increased the cost of hospital-based indigent health care programs. Consequently, Virginia has continued to search for ways to control indigent health care spending while providing reasonable access to care.

To control indigent health care spending, the states are attempting to maximize their use of the Medicaid program. Because the federal government matches a percentage of each state's Medicaid expenditures, it can be more cost effective for a state to cover indigent care costs through Medicaid, rather than through other State-supported programs. In light of this fact, Senate Joint Resolution (SJR) 180 (1991) directed JLARC to "examine the relationship [of Medicaid] with other State programs to promote optimal utilization of State funds," and to "identify options for using Medicaid funds for services currently supported with general funds."

As discussed in previous chapters, Virginia has already transferred a portion of the State teaching hospital indigent care appropriations (ICAP) to Medicaid to draw federal matching funds. JLARC staff examined additional ways that could maximize the use of Medicaid funds for indigent hospital care. Specifically, possibilities were examined for: (1) expanding Medicaid eligibility to include people covered under other State indigent care programs, (2) expanding Medicaid services to include those covered under other programs, and (3) using Medicaid funds to cross-subsidize other programs.

First, with regard to eligibility, analysis was conducted to assess the potential for expanding Medicaid eligibility to reduce demand for the State and Local Hospitalization (SLH) program and the Indigent Health Care Trust Fund (Trust Fund). Findings indicate that expanding Medicaid eligibility would cost the State more than it would save in either the SLH program or the Trust Fund.

Second, with regard to services, analysis was performed to assess the financial impact of the Medicaid 21-day length of stay limit. Although a lack of data prohibits definitive conclusions, the 21-day length of stay limit appears to be cost effective for the State. However, this limit should be reevaluated based upon more systematic data collection by the Department of Medical Assistance Services (DMAS) prior to the convening of the 1995 task force on Medicaid inpatient reimbursement.

Another major Medicaid service restriction is non-coverage of certain transplants. In Chapter III, it was recommended that the Secretary of Health and Human Resources conduct an in-depth examination of these limits. This recommendation was made because some transplants for Medicaid patients are now being financed entirely

with State general funds through the ICAP. Additional research by JLARC staff indicates that no transplants have been financed through either the SLH program or the Trust Fund.

Finally, JLARC staff examined the possibility of using Medicaid to cross-subsidize the SLH program and the Trust Fund in ways similar to what has been done with the ICAP. The purpose was to identify methods to increase federal funding for indigent care without compromising the current mission of these programs. Although the SLH program currently covers some services provided outside of the inpatient hospital setting, the largest portion of SLH funding supports inpatient hospital care. Therefore, options to cross-subsidize the SLH program through Medicaid were analyzed based on inpatient reimbursement.

In this context, JLARC staff identified options for using Medicaid funds to cross-subsidize the SLH program and the Trust Fund. However, analysis indicates that it would be difficult to implement these options due to federal regulations, administrative obstacles, and the requirements of the Virginia Hospital Association (VHA) lawsuit settlement agreement. There are other options available to the State which could be simpler to implement, but which would change the nature of the SLH program and the Trust Fund.

MEDICAID ELIGIBILITY EXPANSIONS NOT COST EFFECTIVE

One way to maximize State funding for indigent hospital care is to cover more of the indigent population under Medicaid, for which a significant proportion of costs are shared with the federal government. However, analysis indicates that the cost of expanding Medicaid would likely outweigh what the State could save in the SLH program or the Trust Fund, for five reasons.

First, new eligibles would have to be covered for all Medicaid services, not just hospital care. Second, Medicaid is an entitlement program which requires payment for all recipients, but SLH and the Trust Fund are not. Third, in most cases expansion of Medicaid eligibility would require expansion of other federal/State programs such as Aid to Dependent Children (ADC). Fourth, because of federal eligibility restrictions, only a portion of those eligible for the SLH program or the Trust Fund could be made eligible for Medicaid. Fifth, expanded eligibility could tap hidden demand because eligibility would not be limited to just those people who would have received services under the SLH program or the Trust Fund.

Eligibility Expansion Would Mean Coverage for Services beyond Hospital Care

Medicaid coverage entitles recipients to medical care in a variety of settings. Not only may a Medicaid recipient receive care in a hospital, but the recipient also is entitled to a wide range of other services, including long-term care and ambulatory care.

If the State were to expand Medicaid eligibility for the sole purpose of including some patients from the SLH program or the Trust Fund, the State would have to expect to cover Medicaid hospital expenses as well as services provided in other settings. For example, in FY 1991, the average SLH claim paid was $2,439, while the average Medicaid inpatient claim was $2,982. In addition, the average cost per Medicaid recipient of long-term care was $14,838 and the average cost per Medicaid recipient of ambulatory care was $688 in FY 1991. Thus, even with the benefit of federal matching funds, the State could expect to spend more on a Medicaid recipient than a SLH recipient over time.

Medicaid is an Entitlement Program Requiring Reimbursement for Each Recipient

All individuals who are Medicaid-eligible and who have received hospital care are entitled to have those services paid for by the Medicaid program. In contrast, the SLH program only pays for an individual's hospital care, if funds are available. SLH funds are appropriated yearly, and are distributed on a first come first serve basis. There is more demand for the funds than there are funds appropriated. Consequently, there is a considerable amount of care provided to SLH program eligibles which goes unfunded each year. For example, in FY 1992, more than $36 million in inpatient hospital claims were unfunded because SLH program funds were exhausted. Similarly, the Trust Fund does not reimburse hospitals for all charity care.

As a result, if some SLH program or Trust Fund recipients were instead made eligible for Medicaid, the State would be required to pay for their care. This could actually increase State outlays rather than save general funds.

Most Options for Expansion Would Require Increased Spending for Other federal/State Programs

Medicaid eligibility in most cases is tied to eligibility for ADC or the Supplemental Security Income (SSI) programs. Therefore, changes to expand Medicaid eligibility would require either increasing ADC or SSI income standards, or choosing to cover some other non-covered optional group that is tied to ADC or SSI. Such a policy would require a greater State financial commitment in terms of overall outlay for ADC or SSI payments, as well as additional Medicaid payments.

For example, during the 1991 Session of the Virginia General Assembly, the Senate budget proposal included a clause to increase the State ADC income limits and payment standards by four percent (it was ultimately rejected). This increase would have resulted in an estimated 4,000 persons becoming eligible for Medicaid. The projected cost of providing Medicaid services to these individuals was $3.3 million in State general funds. The total State outlay for the change would have been higher, since changes to the ADC program would also require an additional $4 million in State payments. Therefore, the increase in State financial commitment through a combination of increased ADC or SSI costs and increased Medicaid costs would appear to outweigh any financial gains that

could be achieved through expanding Medicaid eligibility to accommodate SLH program or Trust Fund recipients.

Shift in Recipients from SLH or the Trust Fund to Medicaid Could be Small

If Medicaid eligibility were expanded, it is likely that few of these new eligibles would have been covered by the SLH program. According to DMAS and Department of Social Services (DSS) staff, most people who are covered through the SLH program would not qualify for Medicaid even if the eligibility standards were changed, because these individuals would not meet the federal categorical requirements for ADC or SSI. Analysis of limited SLH claims data appears to confirm that there is a potentially large SLH population — nondisabled males between the ages of 22 and 65 — that could not be eligible for Medicaid if income standards were changed.

Based on federal Medicaid eligibility rules, most males between the ages of 22 and 65 who are not disabled cannot be insured under Medicaid regardless of their level of income and resources. By federal design, this group is broadly denied Medicaid coverage. In FY 1992, most SLH program recipients were male (Table 14). Also, most

Table 14

SLH Dollars Expended for Hospital Care* According to Sex and Age, FY 1992

Sex	Percent of SLH Population	Age in Years	Percent of SLH Population
Male	56%	0-22	7%
Female	44	23-65	91
		over 65	2

*Includes inpatient and outpatient care

Source: JLARC staff analysis of Department of Medical Assistance Services' SLH claims data, FY 1992.

SLH recipients were between the ages of 23 and 65. This suggests that the SLH program covers a large group of males that Medicaid does not cover. The Trust Fund population, on the other hand, is unknown. Very limited data exist on the recipient population, so it is unclear what the impact of expanded Medicaid eligibility would have on the Trust Fund.

Expanded Eligibility Could Tap Hidden Demand

In the attempt to draw individuals from the SLH program or the Trust Fund into Medicaid by expanding eligibility, it is possible that more individuals would be covered

under Medicaid than would otherwise be covered under the SLH program or the Trust Fund. Currently only people in need of hospital care benefit from the SLH program or the Trust Fund. If Medicaid eligibility were expanded, all citizens meeting the eligibility criteria would become eligible for Medicaid. Therefore, it is likely that more individuals would be brought into the Medicaid program than the number of individuals who otherwise would be covered through SLH or the Trust Fund.

MEDICAID 21-DAY LENGTH OF STAY LIMIT APPEARS COST EFFECTIVE

At non-State hospitals, Medicaid adult inpatient hospital stays that exceed 21 days may be reimbursed through the Trust Fund. At the State teaching hospitals, Medicaid stays beyond 21 days can be reimbursed through the ICAP. A limited assessment of the impact of the 21-day limit on the Trust Fund and the ICAP indicates that the limit is most likely cost effective for the State. However, a more comprehensive assessment should be conducted. If this assessment indicates a potential for optimizing general funds, then the 1995 task force on Medicaid inpatient reimbursement should examine modifications to this limit.

Limited Assessment Indicates 21-Day Limit Is Cost Effective

To determine the impact of the Medicaid 21-day length of stay limit on the Trust Fund, JLARC staff attempted to identify individual patients whose inpatient stays beyond 21 were written off to the Trust Fund. However, there was insufficient data to complete this analysis on a statewide basis.

A limited review based on FY 1991 information from 12 non-State hospitals indicates that Medicaid recipients stayed a total of 6,364 days beyond the 21-day limit (Table 15). Because of data limitations, it was possible to track only individual patients whose days beyond 21 were written off to the Trust Fund at three of the 12 hospitals. At these hospitals, it would have cost the State $2.2 million ($1.1 million in general funds) to cover the days in excess of 21 through the Medicaid program. These hospitals received in total approximately $998,000 from the Trust Fund, with $640,000 of the reimbursement being State general funds. Thus, it would not have been cost effective for the State to cover these days under the Medicaid program.

For the two State teaching hospitals, it would have cost the Virginia Medicaid program approximately $11.7 million ($5.9 million in general funds) to cover the more than 12,000 days in excess of 21 during FY 1991 (Table 16). However, because of the 21-day limit, the two hospitals reported approximately $10.5 million as indigent care costs on their ICAP cost reports. The hospitals received approximately $8.2 million in State general funds for these costs through the ICAP. Therefore, at the State teaching hospitals, elimination of the 21-day limit would have saved the State general funds because the ICAP reimbursement was approximately $2.3 million more than what the general fund component of Medicaid reimbursement would have been.

Table 15

Number of Patient Days Exceeding 21* and Their Cost at Selected Non-State Hospitals, FY 1991

Hospital	Days Beyond First 21	Medicaid Per Diem	Total Cost
Community Memorial Healthcenter	186	$325.39	$60,523
HCA Lewis Gale	80	402.55	32,204
Loudoun Memorial	78	501.50	39,117
Metropolitan	445	427.41	190,197
Mount Vernon	964	481.99	464,638
Page Memorial	0	341.87	0
Prince William	91	467.27	42,522
Riverside-Middle Peninsula	58	523.98	30,391
Sentara Leigh	168	380.41	63,909
Sentara Norfolk General	3,884	521.34	2,024,885
Southside Regional	289	401.12	115,924
Winchester Medical Center	121	404.61	48,958
Program Total	6,364		$3,113,267

*These days of care were written off to the Trust Fund by the hospitals.

Source: JLARC staff analysis of hospital reported 21-day length of stay data, hospital charity care logs, and DMAS cost settlement files.

Table 16

Number of Patient Days Exceeding 21 and Their Cost at State Teaching Hospitals, FY 1991

Hospital	Days Beyond First 21	Medicaid Per Diem	Total Cost
University of Virginia Medical Center	3,411	$970.67	$3,310,955
Medical College of Virginia	8,899	$942.81	$8,390,066
Program Total	12,310		$11,701,021
Amount Written Off to Indigent Care Cost Report			$10,482,199
Amount of General Fund Reimbursement			$8,186,258

Source: JLARC staff analysis of hospital reported 21-day length of stay data and DMAS cost settlement files.

Based on this finding, JLARC staff questioned whether the 21-day length of stay limit could be rescinded for only the State teaching hospitals. According to DMAS staff, current federal laws and regulations do not allow states to exempt certain hospitals from inpatient service restrictions. Therefore, the only way that State funds could be optimized was if non-State acute care hospitals had less than $2.3 million in unreimbursed Medicaid days (or the difference between the ICAP and the general fund component of Medicaid at the State teaching hospitals). As noted earlier, 12 hospitals had more than $3.1 million in unreimbursed Medicaid days.

Current Reporting For Indigent Care Programs Impedes Comprehensive Analysis

Because of current reporting requirements, there is no comprehensive method of determining the extent to which the State is paying for adult Medicaid days beyond 21 through the Trust Fund. Hospitals are required to maintain a charity care log for the Trust Fund. Program guidelines require that this log include the patient's principal diagnosis, admission and discharge dates, gross family income, family income, and total charges related to the stay. There is no requirement to include information concerning the patient's eligibility for other indigent care programs. The hospital is not required to report if the patient's account was attributed to the Trust Fund because the 21-day length of stay for Medicaid had been exceeded by the patient.

To ensure that the State is not expending more general funds than necessary because of the 21-day length of stay limit, DMAS should implement reporting mechanisms that will allow systematic analysis. Further, as noted earlier, a task force will begin to examine potential methods of revising the Medicaid inpatient reimbursement system in 1995. If DMAS's collection of complete 21-day information indicates potential for optimizing State funds, this task force should address the issue as part of reimbursement reform.

Recommendation (15). **The Department of Medical Assistance Services should develop reporting mechanisms for Virginia Medicaid, the State and Local Hospitalization program, and the Indigent Health Care Trust Fund that will allow the agency to monitor the impact of the 21-day length of stay Medicaid limit on these indigent hospital care programs.**

Recommendation (16). **The Joint Commission on Health Care may wish to consider ensuring that the current 21-day length of stay limit on adult inpatient hospital stays is reconsidered during the work conducted by the 1995 task force on Medicaid inpatient reimbursement if systematic data collection indicates that reimbursement of these days through other indigent care programs is costing the State more general funds than what would be required through Virginia Medicaid.**

OPTIMIZING GENERAL FUNDS THROUGH CROSS-SUBSIDIZING SLH AND THE TRUST FUND

One potential way to optimize general fund dollars for indigent health care could be to cross-subsidize the SLH program or the Trust Fund with Medicaid funds. The objective would be to change the funding sources for these programs to garner additional federal financial assistance, without compromising the mission of either program.

However, in practice this objective appears difficult to achieve. Federal Medicaid regulations in conjunction with a complex SLH program structure appear to make it difficult to fund SLH through Medicaid without changing the current program characteristics. While combining Trust Fund monies with Medicaid may be possible, further research is needed. For example, newly issued interim federal regulations could prohibit the feasibility of this option. Until the regulations are final and their impact on the Trust Fund understood, this option remains uncertain.

There are other options for maximizing federal matching funds, but these options would require significant changes to the SLH program and the Trust Fund. These possibilities are not examined in this report because they appear to be beyond the scope of SJR 180. Items nine and ten from SJR 180 specifically requested that indigent health care programs, such as SLH and the Trust Fund, be examined with respect to their relationship to Virginia Medicaid. Accordingly, the objective of this study was to determine whether State funds could be optimized by maximizing the use of federal matching funds through Medicaid.

In any case, although the VHA lawsuit settlement agreement could allow for changes to be made to SLH or the Trust Fund prior to FY 1997, the State may first need approval from the participating hospitals. In addition, the settlement agreement calls for discussions to begin in FY 1995 to revise Medicaid inpatient reimbursement methodologies. Linking the Trust Fund or SLH funding to Medicaid inpatient reimbursement prior to a change in the Medicaid reimbursement methodologies could have uncertain and potentially negative consequences.

VHA Lawsuit Settlement Agreement Constrains Cross-Subsidization of SLH or the Trust Fund

As discussed in the 1992 JLARC report, *Medicaid-Financed Hospital Services in Virginia*, Virginia was the defendant to a VHA lawsuit over Medicaid inpatient hospital reimbursement for approximately six years. In early 1992, the Commonwealth and the VHA settled out of court, with an agreement binding both parties through State FY 1996. As part of that agreement, restrictions were placed on other indigent care programs used to reimburse hospitals for State-defined charity care. According to paragraph 4a of the agreement:

> The Commonwealth...agrees not to reduce general fund appropriations to the State and Local Hospitalization program or the Indigent Health Care Trust Fund program in a manner which will circumvent this Agreement; provided however, the Commonwealth may restructure either such program and thereafter restructure the manner in which such funds are applied.

Thus, it is possible that changes to the SLH program or the Trust Fund could be interpreted by the hospitals as circumventing the settlement agreement. Also, in accordance with the settlement agreement, a joint task force must begin meeting in January 1995 to discuss revising Medicaid inpatient reimbursement methods. Because Medicaid inpatient reimbursement methods could change in FY 1997 as a result of the work of this task force, any changes made to the SLH program or the Trust Fund which would link their funding to the current Medicaid inpatient reimbursement processes may have to be changed as well.

Option One: Cross-Subsidize SLH Program through Virginia Medicaid

One option to maximize State indigent care funds is to channel SLH program funding through the Medicaid program. There are two mechanisms which could be used to pay hospitals for their SLH program costs through Medicaid. One mechanism is the Medicaid disproportionate share adjustment, or DSA. DSA payments are special payments made to hospitals which serve a disproportionate share of Medicaid or indigent patients. The second mechanism is the Medicaid per diem rate. The per diem rate is the basic rate which Medicaid pays to each hospital for a day of care.

Use of these mechanisms could allow the State to capture federal matching funds in the amount appropriated for the SLH program. The intent would be to keep the structure and integrity of the SLH program intact — changing only the funding stream. This would mean that all current program processes would continue.

The potential financial benefits of transferring SLH program funds to Medicaid are significant. The State could either: (1) cut in half its SLH program appropriation and continue to fund hospitals at the same level they are currently funded under the SLH program, or (2) use the federal match to double the level of funding currently appropriated for hospitals as a means to cover more unfunded SLH program costs.

To illustrate, in FY 1991, SLH program payments for inpatient care totalled $12.5 million. This amount included approximately $11.2 million in State funds and $1.3 million in local funds. If one-half of these combined funds ($6.25 million) were instead shifted to the Medicaid program, an additional $6.25 million in non-general funds could have been raised through the federal match. The original total of $12.5 million could have been returned to providers in the form of higher Medicaid payments. The State could have saved $5.6 million, while the local governments could have saved $.65 million.

Alternatively, if all of the $12.5 million were shifted to the Medicaid program, the State could have obtained federal matching funds of $12.5 million, resulting in a total of $25 million to be reimbursed to hospitals. Since SLH program funding levels currently do not cover all program costs (more than $19.3 million in FY 1991), this additional reimbursement could have been used to cover those costs.

However, a policy to cross-subsidize the SLH program would have to meet four objectives in order to avoid compromising the mission of the program. First, the policy would have to guarantee that local contributions would be used to support the care of local citizens. Second, the policy would have to limit spending for SLH patients to the amounts allocated to localities at the start of the year. Third, the policy would have to allow clients to maintain their connections with the SLH program, and to carry program benefits across local borders. Fourth, the policy would have to allow all participating hospitals to be reimbursed for SLH program costs.

With these policy objectives in mind, JLARC staff analysis indicates that it would not be feasible to use the Medicaid DSA mechanism because it would exclude certain hospitals. Also, although the Medicaid per diem mechanism could include all providers, it could be too impractical to implement.

Medicaid DSA Would Exclude Hospitals. Many hospitals which receive SLH funding do not receive Medicaid DSA payments (Appendix D). For example, in FY 1991, of the 104 hospitals which participated in the SLH program, only 58 received a Medicaid DSA payment. (These numbers include out-of-state and non-acute care hospitals.) Furthermore, under federal regulations it is not possible to make all hospitals Medicaid DSA recipients. Therefore, under this reimbursement option, a number of hospitals could not be reimbursed for their SLH program costs. Because not all hospitals are DSA hospitals, localities could not be guaranteed that their local contributions to the SLH program would be used to support their local citizens.

Medicaid Per Diem Would be Administratively Complex. All of Virginia's hospitals receive Medicaid per diem payments and thus all could be reimbursed for their SLH program costs under this mechanism. However, the local nature of the SLH program would make implementation of this option complex. The SLH program is funded through local contributions and matching State contributions. These funds are allocated annually to the localities. Hospitals bill against the locality allotments for SLH program reimbursement. Hospitals must bill the locality where the recipient resides, which may not necessarily be where the hospital is located.

Some localities run out of funding before others, depending upon recipient usage. Recipients are protected from hospital liability, so long as there is SLH program funding available. Once their locality's funds are depleted, recipients are no longer covered by SLH and are liable for all hospital bills.

These characteristics of the program would make it difficult to set enhanced Medicaid per diem rates which reflect each hospital's SLH program costs. Traditionally, DMAS forecasts SLH program costs on the basis of locality need rather than the amount

of funds spent at each hospital. New systems would have to be developed that could accurately forecast SLH program costs at each hospital in order to determine the amount by which the Medicaid per diem would be increased. This process would have to be completed for more than 90 hospitals and could result in a different Medicaid payment rate for each hospital.

It also would be difficult to monitor SLH program costs in order to ensure that budget allocations are not exceeded. As is currently done for the SLH program, DMAS would have to monitor SLH program claims to ensure that localities were billed appropriately, and that local allocations were not exceeded. This process would be complicated by the need to reconcile SLH program costs against the enhanced Medicaid per diem. At the end of the fiscal year, an expanded cost settlement and audit process might be necessary to ensure that hospitals were not overpaid or underpaid. Again, this monitoring process could be difficult to implement for more than 90 hospitals.

In addition, even if an appropriate reimbursement mechanism could be developed, federal Medicaid regulations might limit the amount of SLH funds that could be shifted through Medicaid and paid back to hospitals. Federal law requires that Medicaid payment to a hospital must be in the aggregate lower than what Medicare would have paid. If baseline reimbursement rates were increased to a point higher than what Medicare would have paid, federal matching funds might be disallowed. Because in the past a few hospitals have received large amounts of SLH program payments relative to their Medicaid payment levels, this could put some hospitals over the federal limit.

Finally, this option could create additional administrative workloads for the Trust Fund. For example, unless appropriate monitoring systems were put in place, this option could make it more difficult to determine which indigent patients were actually covered under SLH and which were not. In turn, this could make it more difficult to determine which patient accounts should be written off as charity care for the purpose of the Trust Fund. Thus, this option may require new monitoring systems to ensure the integrity of the charity care logs submitted for the Trust Fund.

Option Two: Cross-Subsidize Trust Fund through Medicaid

Another potential option to maximize State indigent health care funds is to channel Trust Fund dollars through the Medicaid program to obtain the federal match. Like the SLH option previously discussed, the intent would be to keep the structure of the Trust Fund intact — changing only the funding stream. This would mean that all the current program processes would continue.

The benefits of restructuring the Trust Fund program to utilize the federal Medicaid match are also significant. The State and participating hospitals could either: (1) cut in half their planned contributions and continue to fund hospitals at the same level they are currently funded, or (2) use the federal match to double the level of funding currently appropriated for the Trust Fund, as a means to cover more charity care costs.

To illustrate, in FY 1992, $6 million dollars in general funds and $6 million in hospital contributions were appropriated to the Trust Fund for a total of $12 million. If one-half of these funds were transferred into the Medicaid program, as much as $6 million could have been raised in non-general funds through the federal match. As much as $12 million could have been returned to providers in the form of higher Medicaid payments. The State could have saved $3 million, and the hospitals $3 million. Or, if all of the $12 million were shifted to the Medicaid program, the State could have obtained federal matching funds for as much as $24 million to be reimbursed to hospitals.

There are four essential characteristics of the Trust Fund, which are important to the analysis of this option. First, the State as well as all acute care hospitals in Virginia (except the University of Virginia Medical Center (UVAMC) and the Medical College of Virginia Hospitals of Virginia Commonwealth University (VCU/MCVH)) contribute to the Trust Fund. Second, the Trust Fund is designed so that funds are redistributed from the hospitals which provide less charity care to those hospitals which provide more charity care. Third, hospital contributions and payments are calculated and implemented in the middle of the State fiscal year following the hospital fiscal year in which the charity care was actually provided. Fourth, a portion of the contributions to the Trust Fund are cumulative, meaning that not all of the contributions to the Trust Fund in a given year are spent in that year.

In light of this fourth characteristic, it should be noted that federal matching funds can only be obtained for that portion of contributions which are actually expended for hospital services. Therefore, the financial benefit of channeling Trust Fund monies through Medicaid is only as valuable as the amount of dollars that are actually expended for hospital services. Thus, if the State decided to set aside a portion of Trust Fund contributions to accumulate for future years, that portion would not be eligible for federal matching funds until it was actually expended.

Implementation of this option would require that hospitals be reimbursed for their Trust Fund costs just as they would have been paid under the Trust Fund. As with the previous option, this could be done by either: (1) raising Medicaid DSA payments by the amount determined by the Trust Fund formula, or (2) raising each hospital's baseline Medicaid per diem by the amount determined by the Trust Fund formula. As was the case with the SLH program option, the DSA option is not viable because it would exclude some hospitals. The Medicaid per diem option could be feasible, but further research will be necessary in order to draw definitive conclusions.

Use of DSA Mechanism Not Viable. The use of the DSA mechanism to reimburse hospitals for Trust Fund costs does not appear to be viable. While all hospitals (except UVAMC and VCU/MCVH) participate in the Trust Fund, not all hospitals receive Medicaid DSA payments. Currently this would mean that of the 94 in-state acute care hospitals which contribute to the Trust Fund, only about 40 would be eligible to receive from the Fund.

Increasing Baseline Per Diem May Be Viable. Increasing Medicaid baseline per diems could be a viable method to reimburse hospitals for their Trust Fund costs.

However, there are two federal regulatory restrictions which must be considered, as well as some implementation concerns.

First, under this method, it is possible that Medicaid reimbursement would be increased beyond the legal limit. By federal law, Medicaid payment to a hospital must be in the aggregate lower than what Medicare would have paid. If baseline reimbursement rates were increased to a point higher than what Medicare would have paid, then this option could be disallowed. Because historical data indicate some hospitals could receive large Trust Fund payments relative to their Medicaid reimbursement levels, Trust Fund payment increases to baseline Medicaid per diems could put some hospitals over the federal limit. DMAS staff would have to examine the potential impact on individual hospitals in order to determine the potential impact of federal payment limits.

Second, any attempt to use the Trust Fund for obtaining federal matching funds may have to comply with the federal law governing provider taxes and donations. Hospital contributions to the Trust Fund could be considered a provider tax by Medicaid. The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 disallow the general use of federal matching funds for State Medicaid funds raised through provider taxes or donations.

In the case of Virginia, there is an exception to this law which may apply. The 1991 federal law allows for a provider tax if the net impact of the tax and any payments made to the providers by the State is generally redistributive. This occurs if the funds are redistributed from hospitals with lower indigent care loads to hospitals with higher indigent care loads. The Trust Fund is generally redistributive through its formula for required contribution to and payment from the fund.

However, because interim final regulations to accompany the law have just been published, it is not certain whether the Trust Fund could be used to obtain federal matching funds. The law may be interpreted in a manner which could place the Trust Fund in jeopardy. Also, there is still potential for the regulations to change through the public comment process. Currently, DMAS staff are in the process of determining whether the Trust Fund is allowable under the new regulations. In addition, even if the plan meets the requirements of the law, the State would need to obtain approval of the U.S. Health Care Financing Administration.

Finally, there are several administrative concerns which could impact the effectiveness of this option. For example, because of the timing of contributions to and distributions from the Trust Fund, it is not possible to determine Trust Fund payments to hospitals until late in the State fiscal year. This would make it difficult to adjust Medicaid reimbursement in the same year. Therefore, to use this method it may be necessary to delay the implementation of the enhanced Medicaid per diem until the start of the following fiscal year. This would create delays in payment to hospitals. Also, under this process, it may be necessary to institute a reconciliation process for the 94 participating hospitals to ensure that hospitals were not overpaid or underpaid through the enhanced Medicaid per diem.

Other Options

The preceding analysis indicates that it would be difficult to use Virginia Medicaid to finance the SLH program or the Trust Fund. Essentially, the difficulty lies in revising the Medicaid reimbursement system to compensate hospitals for the services which are currently financed by one of these two programs. Specifically, the Medicaid hospital settlement agreement and federal regulations may limit the range of policy options available to the State. In addition, administrative problems could make implementation a costly and laborious process.

A key assumption of the options presented is that the SLH program and the Trust Fund should maintain their current missions. Thus, both options focus on changing the funding stream for these programs without changing their other characteristics. In developing the options, an attempt was made to maintain the interests of program funders, program recipients, and service providers. It is this objective which creates many of the identified administrative problems.

There are other options available to the State which would be administratively simpler. For example, the State has the option of reallocating the funds it spends on the SLH program and the Trust Fund to the Medicaid program without trying to maintain the essential characteristics of these programs. The reallocated general funds and matching federal funds could be used to increase Medicaid reimbursement without trying to link the enhanced reimbursement to SLH program costs or Trust Fund distributions. As much as $24.5 million in federal matching funds could be obtained for inpatient reimbursement under this type of approach (based on FY 1992 program estimates).

However, this type of policy could have the effect of diminishing or abolishing the SLH program and the Trust Fund as they currently exist. In this situation, it is uncertain whether local governments and providers would want to continue to contribute to the financing of indigent hospital care. It is also uncertain what would happen to SLH program clients, who would lose their current affiliation with the program.

There might also be options for consolidating the Trust Fund and the SLH program into one entity. Currently, both of these programs are targeted at the charity care population. Together, the programs represent a partnership between State government, local governments, and providers. However, a more in-depth analysis would be required in order to determine the operational feasibility of these types of options because the two programs are very different in the way they are structured and administered.

Appendixes

Appendix A

Senate Joint Resolution No. 180

Requesting the Joint Legislative Audit and Review Commission to study the Commonwealth's Medicaid program and the indigent care appropriations to the state teaching hospitals and the Medical College of Hampton Roads.

Agreed to by the Senate, February 19, 1991
Agreed to by the House of Delegates, February 15, 1991

WHEREAS, a goal of the Commission on Health Care for All Virginians is to provide access to basic health care for all Virginians; and

WHEREAS, approximately 330,000 persons in Virginia are eligible for the Medicaid program, but an estimated 300,000 additional Virginians in poverty have no health insurance; and

WHEREAS, the number of Virginians eligible for Medicaid has increased by only 10 percent during the last 10 years, but Medicaid expenditures in Virginia have tripled during that period; and

WHEREAS, costs in the 1990-92 biennium are expected to be more than 40 percent greater than the costs in the 1988-90 biennium; and

WHEREAS, the Medicaid program now represents about 12 percent of the Commonwealth's general fund budget, with an estimated $1.4 billion (general fund) cost for the 1990-92 biennium; and

WHEREAS, Medicaid costs will continue to escalate at a rapid rate as inflation in health care costs far surpasses other goods and services; and new federal mandates are likely to continue as Congress expands health insurance for the elderly, disabled, and poor through Medicare and Medicaid; and

WHEREAS, federal mandates establish the core of the Medicaid program, but states can partially shape the benefits and costs through policy adjustments in reimbursement rates for service providers; services offered to recipients; utilization review to ensure appropriate care; and eligibility for groups of persons, and to some extent, how much recipients pay for their own care; and

WHEREAS, University of Virginia Medical Center, Medical College of Virginia Hospitals, and the Medical College of Hampton Roads provide a significant amount of care to low=income persons and receive state support for this care through Medicaid and direct general fund appropriations; now therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Legislative Audit and Review Commission be requested to study the Virginia Medicaid program and the indigent care appropriations to the state teaching hospitals and the Medical College of Hampton Roads.

The study shall include, but not be limited to:

1. Assessment of the cost savings and health policy implications of limiting the scope or duration of optional services, or adjusting recipients' contributions to their care;

2. Examination of the interpretation of federal requirements to determine if they have been implemented in the most effective and least costly manner;

3. Determination of the effectiveness of current utilization review procedures in controlling costs and exploration of additional options;

4. Evaluation of reimbursement methods to determine if they adequately encourage cost effective delivery of services;

5. Determination of the sufficiency of reimbursement rates to provide quality care at the lowest required cost;

6. Review of budget and forecasting methods to ensure that they adequately identify and project the cost of policy changes, service utilization, and new mandates;

7. Determination of how the legislative branch could increase its capacity to more closely monitor Medicaid forecasts and expenditures;

8. Exploration of the costs of alternative administrative methods for implementing program requirements and options;

9. Examination of the relationship with other State programs to promote optimal utilization of State funds;

10. Identification of options for using Medicaid funds for services currently supported with general funds; and

11. Review of eligibility scope of services, and reimbursement rates for indigent care at University of Virginia Medical Center, Medical College of Virginia Hospitals, and the Medical College of Hampton Roads, and a determination of the appropriateness of general fund and Medicaid allocation methodologies.

All agencies of the Commonwealth shall provide assistance upon request to the study as appropriate.

The Joint Legislative Audit and Review Commission shall complete its work in time to submit its findings and recommendations to the Governor and to the 1993 Session of the General Assembly, and shall provide interim reports to the Commission on Health Care for All Virginians and to the 1992 Session of the General Assembly and at other times as appropriate, using the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

Appendix B

Estimating Total Spending for Indigent Hospital Care in FY 1991

This appendix explains the method used to estimate total spending for indigent hospital care in FY 1991. It also explains the method used to estimate hospital unsponsored care.

Total Spending for Indigent Care

The estimate of total spending for indigent hospital care in FY 1991 was developed from several sources. The Department of Medical Assistance Services (DMAS) provided data on Medicaid hospital claims, SLH program hospital claims, hospital payments to the Indigent Health Care Trust Fund (Trust Fund), and payments from the Trust Fund. Data on the indigent care appropriations were obtained from the Department of Planning and Budget (DPB), the Medical College of Hampton Roads (MCHR), the Medical College of Virginia Hospitals of Virginia Commonwealth University (VCU/MCVH), and the University of Virginia Medical Center (UVAMC). Data on hospital charity care and bad debt charges were obtained from the 1992 annual report of the Health Services Cost Review Council (HSCRC).

Total spending for indigent care at each hospital was calculated as follows:

	FY 1991 Medicaid claims filed
plus	FY 1991 SLH claims paid (full and partial)
plus	FY 1991 charity care charges reduced to costs
plus	FY 1991 bad debt charges reduced to costs

Each hospital was assigned to a health service area (HSA) based on data from the HSCRC and the Virginia Department of Health (DOH). The total indigent care spending figure for each hospital was summed to produce a measure of total indigent care spending for each HSA and the State.

Medicaid claims filed is not a completely accurate indicator of actual Medicaid spending because these figures do not include additions to and subtractions from payments which occur during the cost settlement and audit process at the end of the fiscal year. Cost-settled data were not available for inclusion in this report.

Charity care and bad debt charges were reduced to costs based on FY 1991 cost-to-charge ratios for each institution as maintained by the DMAS. Costs were used instead of charges because costs are a more accurate indicator of actual outlays for indigent care.

It should be noted that hospital bad debt is a rough measure of indigent care. The bad debt figures reported by hospitals do include services provided to people whose incomes are well above poverty. However, there is general agreement in the hospital industry that uninsured people with incomes between 100 and 200 percent of the poverty level represent a large portion of hospital bad debt.

Although there is a lack of definitive data on the issue, the use of bad debt as a proxy is not inconsistent with recent findings of the Joint Commission on Health Care (Joint Commission). In its 1990 report to the Governor and the General Assembly, the Joint Commission reported that an estimated 880,000 Virginians were uninsured. The Joint Commission further reported that an estimated one-third of the uninsured had incomes below the federal poverty line, and an estimated two-thirds had incomes below 200 percent of the federal poverty line. This indicates that there may be a significant number of uninsured people with incomes between 100 and 200 percent of federal poverty whose unpaid hospital bills may be classified as bad debt.

Also, the eligibility criteria for indigent care at MCVH and UVAMC include people with incomes between 100 and 200 percent of poverty. Unpaid bills for people in this income category would be classified as bad debt in other hospitals. Therefore, for the purpose of this study, the bad debt portion of uncompensated care was used as a rough measure of indigent care.

Unsponsored Care

The term uncompensated care is commonly used in reference to the charity care and bad debt provided by a hospital. Hospitals report their uncompensated care to the HSCRC. However, the uncompensated care data reported to the Council do not account for the impact of the Trust Fund or the indigent care appropriations. In effect, the Trust Fund and the indigent care appropriations pay for a portion of the uncompensated care reported by hospitals.

In order to develop a more accurate measure of unsponsored hospital care, the following formula was used:

	FY 1991 charity care charges reduced to costs
plus	FY 1991 bad debt charges reduced to costs
less	FY 1991 net Trust Fund contributions
less	FY 1991 indigent care appropriations

Net Trust Fund contributions include the net difference between payments to the Trust Fund and payments from the Trust Fund for each hospital. If a hospital made a net payment to the Trust Fund, this payment was counted as charity care subsidized by the hospital. If a hospital received a net payment from the Trust Fund, this payment was counted as sponsored care, and subtracted from the hospital's charity care costs.

The indigent care appropriations include funds appropriated to MCVH and UVAMC for FY 1991. The appropriations to MCHR were not included in this analysis because none of those funds were allocated to the MCHR affiliated hospitals in FY 1991. The indigent care appropriations were subtracted from the charity care and bad debt costs at MCVH and UVAMC in order to develop a measure of unsponsored care at these institutions.

Appendix C

Indigent Care Appropriations to State Teaching Hospitals

Fiscal Year	Medical College of Virginia Hospitals	University of Virginia Medical Center	Total
1985	$39,631,000	$26,402,624	$66,033,624
1986	$44,890,000	$30,847,261	$75,737,261
1987	$59,123,000	$30,079,313	$89,202,313
1988	$65,423,000	$34,851,042	$100,274,042
1989	$49,452,000	$38,769,806	$88,221,806
1990	$53,257,000	$42,136,730	$95,393,730
1991	$54,117,000	$39,258,482	$93,375,482
1992	$52,374,000	$34,939,820	$87,313,820
State	40,794,000	28,952,389	69,746,389
Federal	11,580,000	5,987,431	17,567,431
1993	$59,863,589	$42,536,833	$102,400,422
State	37,073,589	32,756,833	69,830,422
Federal	22,790,000	9,780,000	32,570,000
1994	$63,388,858	$44,943,348	$108,332,206
State	40,188,858	34,933,348	75,122,206
Federal	23,200,000	10,010,000	33,210,000

Note: Amounts shown for FY 1993 and FY 1994 are based on Chapter 893 and are subject to change by the 1993 and 1994 General Assembly.

Appendix D

Providers Ranked According to Total SLH Inpatient Claims* With Medicaid DSA Status Noted, FY 1991

Provider	DSA Status**	SLH Inpatient Dollars Claimed*
SENTARA NORFOLK GENERAL	1	$4,062,621.09
ROANOKE MEMORIAL	1	$2,334,629.54
UVA MEDICAL CENTER	1	$1,854,226.48
DEPAUL	1	$1,640,330.53
FAIRFAX	1	$1,457,202.22
ALEXANDRIA		$1,179,036.20
LOUISE OBICI MEMORIAL	1	$1,104,282.77
RIVERSIDE REGIONAL	1	$994,936.19
MARYVIEW		$885,098.60
MEDICAL COLLEGE OF VA	1	$870,910.22
PORTSMOUTH GENERAL	1	$680,655.53
MARY WASHINGTON		$661,543.20
ARLINGTON		$648,172.73
LYNCHBURG GENERAL		$548,675.59
MOUNT VERNON		$546,910.05
SOUTHSIDE REGIONAL	1	$540,008.32
CHESAPEAKE GENERAL		$504,695.43
SENTARA HAMPTON GENERAL	1	$501,728.86
VIRGINIA BEACH GENERAL		$476,917.52
NORTHAMPTON-ACCOMACK	1	$454,139.21
MEM HOSP/DANVILLE	1	$440,577.61
HUMANA CLINCH VALLEY	1	$427,246.27
COMM HOSP ROANOKE VALLEY		$369,491.37
POTOMAC	1	$347,632.19
BRISTOL REG MEDICAL	1	$335,738.96
FAUQUIER		$326,894.52
LOUDOUN		$318,601.94
JEFFERSON		$298,937.98
HUMANA BAYSIDE	1	$276,246.85
HOLSTON VALLEY	1	$250,878.68
VIRGINIA BAPTIST	1	$247,727.07
HALIFAX-SOUTH BOSTON	1	$235,652.93
GREENSVILLE MEMORIAL	1	$228,095.57
PULASKI COMMUNITY	1	$227,929.85
PRINCE WILLIAM	1	$220,620.32
COMMUNITY MEM HEALTH CENT	1	$206,923.47
JOHNSTON MEMORIAL	1	$198,795.63
RADFORD COMMUNITY	1	$191,900.96
WINCHESTER MEDICAL CENTER		$172,891.12
CHIPPENHAM		$153,381.18
WARREN MEMORIAL	1	$148,542.48

* In cases where SLH payment was not made to a provider, claims data did not exist; billed charges were used.

**A "1" indicates that the hospital received a Medicaid DSA payment in FY 1991.

Provider	DSA Status**	SLH Inpatient Dollars Claimed*
NORTH CAROLINA BAPTIST	1	$136,254.52
BUCHANAN GENERAL	1	$135,806.42
FAIR OAKS		$132,885.87
RICHMOND MEMORIAL	1	$132,368.86
RUSSELL COUNTY MEDICAL	1	$131,139.48
MEM -- MARTINSVILLE/HENRY		$130,026.23
ROCKINGHAM MEMORIAL		$128,825.86
METROPOLITAN	1	$127,047.75
SOUTHSIDE COMMUNITY	1	$125,532.71
WYTHE COUNTY COMMUNITY	1	$115,828.73
NORFOLK COMMUNITY	1	$115,440.72
SENTARA LEIGH		$114,896.80
TWIN COUNTY COMMUNITY	1	$110,506.72
NEWPORT NEWS GENERAL	1	$108,762.98
NATIONAL ORTHO		$105,398.21
JOHN RANDOLPH	1	$102,183.77
TAZEWELL COMMUNITY	1	$95,110.46
SMYTH COUNTY COMMUNITY	1	$94,399.12
RETREAT		$85,787.55
RESTON		$80,286.25
JOHNSTON-WILLIS		$80,164.92
ST MARY'S NORTON	1	$77,292.80
WILLIAMSBURG COMMUNITY		$74,610.96
ST MARY'S RICHMOND		$72,339.92
MONTGOMERY REGIONAL		$60,495.60
RICHMOND COMMUNITY	1	$58,482.66
KING'S DAUGHTERS		$57,331.91
ALLEGHANY REGIONAL		$57,213.72
MARY IMMACULATE		$55,522.27
RIVERSIDE TAPPAHANNOCK		$55,333.95
LONESOME PINE	1	$52,927.21
WAYNESBORO COMMUNITY		$50,881.88
MARTHA JEFFERSON		$50,496.41
RAPPAHANOCK GENERAL	1	$49,002.13
NORTON COMMUNITY	1	$48,967.88
HENRICO DOCTORS'		$48,575.41
LEWIS GALE		$48,477.65
WASHINGTON HOSPITAL CENTE		$46,955.33
RIVERSIDE MIDDLE PENINSUL		$45,943.96
SOUTHAMPTON MEMORIAL	1	$43,816.55
SHENANDOAH CO MEMORIAL	1	$42,161.52
NORTHERN VA DOCTORS		$40,595.68
CULPEPER MEMORIAL		$38,810.63
DICKENSON COUNTY MEDICAL	1	$38,413.04
DUKE UNIVERSITY	1	$37,510.96

* In cases where SLH payment was not made to a provider, claims data did not exist; billed charges were used.

**A "1" indicates that the hospital received a Medicaid DSA payment in FY 1991.

Provider	DSA Status**	SLH Inpatient Dollars Claimed*
PENINSULA GENERAL		$33,316.87
LEE COUNTY COMMUNITY	1	$31,541.97
BEDFORD COUNTY MEMORIAL	1	$29,624.74
SHELTERING ARMS REHAB	1	$28,933.87
WISE APPALACHIAN REGIONAL	1	$24,460.40
STONEWALL JACKSON	1	$23,098.84
FRANKLIN MEMORIAL	1	$18,129.97
GILES MEMORIAL	1	$12,793.32
CHILDREN'S HOSP/KING DAUG	1	$10,636.51
CHILDREN'S HOSPITAL	1	$8,133.38
STUART CIRCLE		$6,706.60
PRINCE GEORGE'S		$5,964.69
INDIAN PATH MEDICAL		$4,512.43
R J REYNOLDS-PATRICK COUN	1	$4,360.65
GEORGE WASHINGTON UNIV		$4,025.68
D C GENERAL		$3,126.61
PAGE MEMORIAL		$2,745.44
MIDDLESBORO APPALACH REG		$450.00
Total		$31,464,803.66

* In cases where SLH payment was not made to a provider, claims data did not exist; billed charges were used.

**A "1" indicates that the hospital received a Medicaid DSA payment in FY 1991.

Appendix E

Agency Responses

As part of JLARC's data validation process, the Governor's Secretaries and State agencies involved in a study effort are given the opportunity to comment on an exposure draft of the report. Appropriate technical corrections resulting from the comments have been made in this version of the report. This appendix contains the responses of the following agencies:

- Medical College of Hampton Roads,
- University of Virginia, and
- Virginia Commonwealth University.

MEDICAL COLLEGE OF HAMPTON ROADS
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NORFOLK, VIRGINIA 23501-1980

OFFICE OF THE VICE-PRESIDENT
FOR INSTITUTIONAL ADVANCEMENT

TELEPHONE (804) 446-6090
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January 6, 1992

Mr. Philip A. Leone, Director
Commonwealth of Virginia
Joint Legislative Audit and Review Commission
Suite 1100, General Assembly Building, Capitol Square
Richmond, VA 23219

Dear Mr. Leone:

Thank you for the opportunity to comment on the draft report, Funding of Indigent Hospital Care in Virginia.

The analysis of the history of the indigent care appropriation to the Medical College of Hampton Roads, the uses of the appropriation, and current policy issues is accurate. Indeed, the analysis would have been even more enlightening if space had permitted a fuller description of the magnitude of poverty, medical indigency and the associated costs that are borne by the physicians and hospitals affiliated with the Medical College. However, the conclusions about the situation would have been the same: the indigent population in eastern Virginia is substantial and the physicians and hospitals of the Medical College of Hampton Roads are essential providers of medical care to that population.

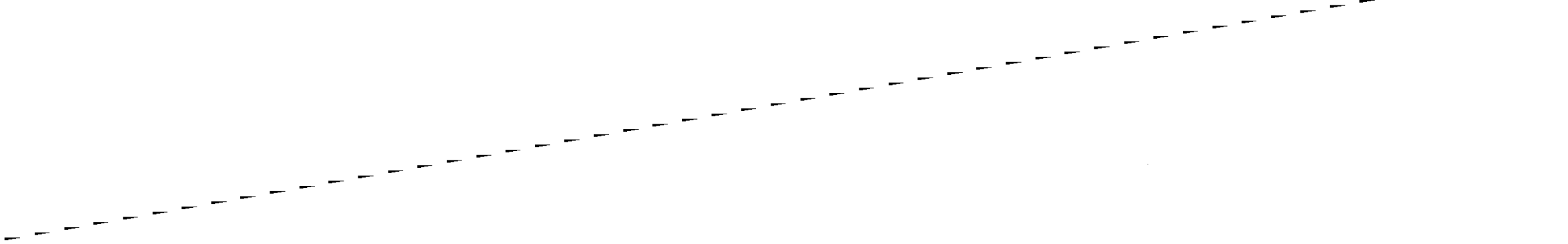
The staff recommendations are reasonable and we agree with them. Especially important are the recommendations that support a cost-based formula for the indigent care appropriation, the joint review of funding requests by the Secretary of Education and Health and Human Resources, and the exploration of the disproportionate share funding mechanism. We hope that the General Assembly will support the expeditious implementation of the latter recommendation because of the potential for increased support for the indigent care provided through the medical education programs of the Medical College of Hampton Roads. This increased support is critical if we are to maintain the College's capacity to respond to the needs of eastern Virginia and the Commonwealth-at-large.

Again, I appreciate the opportunity to comment on the draft report and to respond to the study during the Commission's January 12 meeting.

Sincerely,

C. Donald Combs, Ph. D.
Vice President for Institutional Advancement

CDC/adc



UNIVERSITY OF VIRGINIA
HEALTH SCIENCES CENTER
OFFICE OF THE VICE PRESIDENT

January 11, 1993

Mr. Philip A. Leone
Director
Joint Legislative Audit and Review Commission
Suite 1100, General Assembly Building
Richmond, Virginia 23219

RE: Exposure Draft - Funding Indigent Hospital Care in Virginia

Dear Mr. Leone:

Thank you for providing us the opportunity to review and comment on your above titled report.

We appreciate the open communication between the JLARC staff and our Health Sciences Center staff which has produced an informative, insightful report. Overall, we consider the report to be an objective representation of the complex issues surrounding the funding of indigent care and medical education in the two State teaching hospitals. Our specific comments are attached.

While recognizing that our Medical Center delivers a lower percent of indigent care in the State than the Medical College of Virginia Hospitals (4.8% vs 10.7% in FY 1991), our volume of indigent care is sufficiently large to threaten our financial viability. We recommend formation of a group, related to the Commission on Healthcare, to study the feasibility of developing a cost effective, comprehensive network for care in central Virginia surrounding the University of Virginia, particularly since our planning region has the lowest cost per citizen according to the Virginia Health Service Cost Review Council. As a part of the study, the group would also examine the policy questions raised in your report, as well as remedies for the need of greater flexibility for the clinical activities of our Medical Center as a State Agency. This group should include legislators, health professionals, insurers, business leaders, citizens, other regional care administrators, as well as representatives from the University of Virginia. The group should present its report to the Commission prior to the 1994 legislative session.

We appreciate the opportunity to comment on your report and look forward to attending the presentation of the report to the Commission on January 12, 1993.

Sincerely,

Don E. Detmer, M.D.
Vice President for Health Sciences

as

cc: President John T. Casteen
Michael J. Halseth
Leonard W. Sandridge, Jr.

UNIVERSITY OF VIRGINIA

COMMENTS ON EXPOSURE DRAFT OF JOINT LEGISLATIVE AND AUDIT REVIEW COMMITTEE

FUNDING INDIGENT HOSPITAL CARE IN VIRGINIA

Options for Funding Indigent Care

We are pleased with the JLARC report's recognition that the State consider, in its level of appropriation support, an amount that will allow each of the State teaching hospitals to fill the dual roles of providing indigent care and medical education while maintaining a strong financial position. We believe that the Commonwealth's stated objective of funding 100 percent of the cost of indigent care services is consistent with that recommendation. Maintaining a strong financial position is critical for our Medical Center in order to meet our current bond obligations and maintain our "AA" bond rating. Financing large capital projects to improve and meet the growing demand for our clinical programs is more feasible when we can demonstrate a strong financial position.

Indigent Care Eligibility Guidelines

In Recommendation # 2, the report suggests the General Assembly clarify its intent concerning whether indigent care appropriations should be used to reimburse the State teaching hospitals for services provided to non-Virginians. We believe that our Medical Center's provision of indigent care to non-Virginians sustains goodwill with institutions in neighboring states that are often asked to care for Virginians. It builds strong relationships with referring physicians for our providing the tertiary needs of all of their patients regardless of their ability to pay. Also, out-of-state indigent transplantation patients have contributed to the case volumes necessary for certification by Medicare and other third parties for reimbursement purposes. These patients require clinical procedures which also provide high quality educational opportunities for medical students and other health care professionals.

Indigent Care Scope of Services

In Recommendation #4, the report suggests that, at least for transplantations, the General Assembly clarify its intent concerning scope of hospital services reimbursable through the indigent care appropriations to the State teaching hospitals. In this regard, the report raises the question of whether the use of indigent care appropriations should have the same service limitations as other State indigent hospital care programs. Bone marrow, heart and liver transplantations are not currently covered under the Medicaid

program; whereas, Medicare does cover them as acceptable clinical therapy. In our opinion, the appropriation funding of transplantations for indigent patients has been important, both in supporting the academic and patient care missions of the Medical Center and, in adding to the case volumes necessary for certification by Medicare and other third party payors for reimbursement purposes. We are pleased that the Board of Medical Assistance Services is currently reconsidering Medicaid coverage of bone marrow, heart, liver, and pancreas transplantations based on the outcome success rates and the economic consequences for each type of transplant. The Board expects to issue a study report during 1993.

In addition to the above referenced transplantations, Recommendation #4 calls into question the indigent care funding of adult patient stays beyond 21 days. Medicaid and the State and Local Hospital Program do not cover patient stays beyond 21 days but the Trust Fund does. We believe that our Medical Center would be disproportionately impacted by not reimbursing the portion of the stay over 21 days, based upon our estimate that indigent inpatients incurred approximately $9.2 million in charges for the portion of their stays exceeding 21 days in FY 1991-92. The continuation of indigent care coverage is critical to our tertiary care programs which involve many patient stays of greater than 21 days and for which we receive many patient referrals from throughout Virginia. Frequently, at the time such tertiary care referrals are made to our Medical Center, a portion of the 21 authorized Medicaid days has already been utilized at another hospital.

Unreimbursed Medicaid Costs

In Recommendation #5, the report suggests the General Assembly clarify its intent concerning the funding of unreimbursed Medicaid costs as indigent care costs for the two State teaching hospitals. Since all Medicaid patients qualify within the indigent patient eligibility guidelines, State funding of the unreimbursed Medicaid costs is consistent with the State's objective of paying 100% of the indigent care costs. Inasmuch as Medicaid utilization is quite large at University of Virginia Medical Center (43.1% of Health Service Area Region 1 and 4.8% of State in FY 1991) and at Medical College of Virginia Hospitals (44.6% of Health Service Area Region 4 and 10.7% of State), a disproportionate burden would be placed upon the two State teaching hospitals if unreimbursed Medicaid cost is disallowed as an indigent care cost.

Joint Budget and Program Reviews

In Recommendation #6, the report suggests that the Secretary of Education and the Secretary of Health and Human Services (H&HS) develop a memorandum of agreement to implement joint budget

development and associated program review of the two State teaching hospitals. It is our understanding that the Secretary of Education will consult with the Secretary of H&HS regarding such budget and program matters and will continue to be responsible for making recommendations to the Governor on such matters for the two State teaching hospitals. In a dynamically changing health care field, such administrative clarity is critical to accomplishing our Medical Center's medical education and indigent care missions and making progress on decentralization issues.

Virginia Commonwealth University

January 8, 1993

Mr. Philip A. Leone, Director
Joint Legislative Audit and
Review Commission
Suite 1100, General Assembly Building
Capitol Square
Richmond, Virginia 23219

Dear Mr. Leone:

I appreciate the opportunity to review and comment on the JLARC report entitled, "Funding of Indigent Hospital Care in Virginia." Your staff has demonstrated a good understanding of the issues and has provided a very informative document.

As the report points out on pages 66-69, the funding of Indigent Care at the State's teaching hospitals is a complex and dynamic issue. In making a decision regarding funding, several factors must be considered, including the impact on access to Indigent Care, changing healthcare and the medical educational environment, the role of the teaching hospitals, and the importance of maintaining a sound financial position for these hospitals.

Virginia Commonwealth University's Medical College of Virginia Hospitals has over the years assumed increasing responsibility for the provision of Indigent Care throughout the Commonwealth. As noted in the report, in 1991 MCV Hospitals provided 38% of the charity care in the entire Commonwealth and 88% in its region of 18 other hospitals. Nearly 11% of the total Medicaid care in the Commonwealth was also provided.

MCV Hospitals has in recent years experienced decreasing reimbursement in Medicare. The combination of Indigent, Medicaid, and Medicare patient days has reached 70% of total volume, making our Hospitals' ability to continue to provide unlimited Indigent Care a very serious concern.

Although the current funding levels are at issue here, it is important as well to seek long-term solutions to preserve the mission and financial viability of our teaching hospital. I recommend the formation of a group under the aegies of the Commission on Healthcare to study the problems unique to MCV Hospitals and the provision of Indigent Care in the Richmond area in particular. Membership would consist of legislators, administrators, providers, insurers, citizens

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and representatives from MCV Hospitals. The committee's charge would be to address these problems as well as numerous policy questions raised in the JLARC document, with a final report presented at the 1994 legislative session.

I have appreciated the opportunity to participate in this process and look forward to attending the presentation of the report on January 12, 1993. I do not plan to speak but will be available to respond to questions.

Sincerely,

Eugene P. Trani
President

gmp

copy: Mr. Roger L. Gregory
Rector, Board of Visitors

Mr. F. Dixon Whitworth
Vice Rector, Board of Visitors

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● Barbara W. Reese

● *Indicates staff with primary assignments to this project*

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