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THE VIRGINIA GENERAL ASSEMBLY

INPATIENT CARE IN VIRGINIA

A report in a series focusing on medical assistance programs in the Commonwealth of Virginia

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INPATIENT CARE IN VIRGINIA

January 2, 1979

Joint Legislative Audit and Review Commission

Virginia exerts little direct control over hospital costs, primarily because public funding comprises just a small portion of total hospital revenues (Figure 1). Nevertheless, four key actions could help stem hospital costs and result in some medical assistance program savings:

- use of health planning and regulatory functions to reduce surplus hospital beds and services;
- formation of an interagency task force to coordinate and monitor indigent care program administration, fund distribution, and client access;
- adoption by medicaid of a prospective method of payment for hospitals and establishment of minimum reimbursable hospital occupancy levels; and
- amendment of the appropriations act to earmark indigent care funds for State teaching hospitals, with appropriate requirements for recordkeeping and eligibility determination.

In FY 1976, approximately $118 million was spent for care of the poor in hospitals. Government programs and State subsidized care at teaching hospitals accounted for $84.8 million. Of this amount, $47.2 million was funded by the State. Private sector hospitals provided another $33.1 million in the form of charity or bad debt accounts for patients unable to pay.

A JLARC REPORT SUMMARY

Hospital care for the poor is provided through a complex network of nine government programs, two State teaching hospitals, and 109 private sector hospitals. There has been no comprehensive assessment by State health agencies of the availability of care provided through these public and private sources.

AVAILABILITY AND COST OF HOSPITAL CARE

Most decisions regarding the cost and location of hospital services are made by the private sector. These decisions impact on government because services for indigents are generally purchased from hospitals in the community.

Availability of Care (pp. 6-11)

Most Virginians appear to have reasonable access to hospital services. Each of the five Health Service Areas in the Commonwealth contains at least one large hospital with the potential for providing specialized services on a regional basis. However, many hospitals, particularly in rural areas, are smaller than health economists believe necessary for efficient service provision.

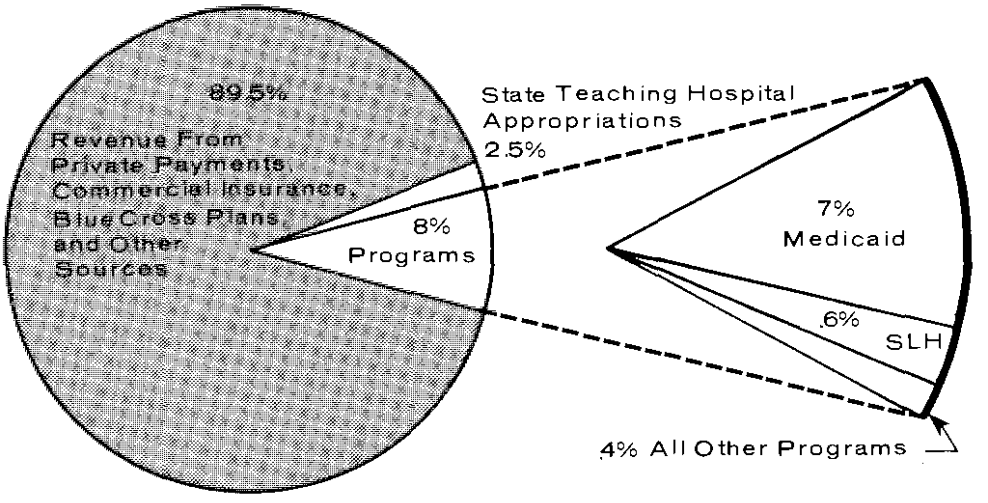
A high priority in the preparation of the State Health Plan should be placed on regionalization of services with teaching hospitals continuing to serve the entire State, minimization of small limited-service hospitals, and development of alternatives to inpatient care.

Cost of Care (pp. 11-16)

Indigent program expenditures are affected by increases in the cost of hospital care and by third-party reimbursement methods. Between 1970 and 1976, the daily cost of hospital care (exclusive of physician fees) more than doubled, increasing from $58 in 1970 to $123 in 1976.

The normal economic forces of supply and demand do not seem to have much impact in the hospital field. Most patients are covered by commercial insurance or government programs. Therefore, medical services are demanded without much concern for cost. Hospitals are assured of payment for almost all patient-related expenditures regardless of operating efficiency or service utilization.

FIGURE 1
PORTION OF HOSPITAL REVENUES IN VIRGINIA
FINANCED BY GOVERNMENT PROGRAMS (FY 1976)



Includes 94 hospitals with total revenues of $783.4 million.
Source: Hospital financial statements, program expenditures, FY 1976.

Most third party payors reimburse hospitals retrospectively. That is, hospitals are reimbursed for patient costs at the end of the year. Reimbursements are on the basis of cost (actual expenses incurred by the hospital) rather than charges (the price a hospital places on services). An interim per diem rate is paid throughout the year. Final settlement allows hospitals to pass on costs above the interim rate.

Surplus Beds (pp. 16-25)

Excessive numbers of beds and underutilized services are a major reason for high hospital rates. By 1980, the cost of maintaining a projected 2,632 surplus hospital beds in Virginia may be as high as $63.2 million. Surplus beds result in low hospital occupancy. Therefore, the total cost of operating hospitals is borne by fewer patients.

Reduction of Surplus Beds. Empty beds beyond the number determined necessary for emergency needs are considered surplus. Operating and capital costs are associated with surplus beds because much of a hospital's total cost will be incurred whether a bed is full or empty. According to current planning norms, there are surplus beds in every Health Service Area in the State.

The State Department of Health should evaluate methods of: reducing the number of beds licensed; decertifying beds and services; acquiring and disposing of unnecessary facilities; and encouraging conversion of facilities to other uses.

Effect on Rates. Excess beds add appreciably to public expenditures for indigent care. When medicaid pays a portion of a hospital's total operating expenditures, this includes costs associated with excess beds. Program expenditures for excess capacity could be reduced by establishing a minimum occupancy level for reimbursement. If an 80 percent minimum occupancy level had been in effect for FY 1976, expenditures could have been reduced by $1.5 million in just 25 hospitals that are major recipients of medicaid funds.

The State Medicaid Plan could be amended to base reimbursement on an acceptable occupancy rate (80 percent to 85 percent) when actual occupancy is below that level in any hospital. Per diem rates for other indigent care programs could be similarly calculated by SDH.

INDIGENT HOSPITAL CARE

Delivery of hospital care to indigent patients could be improved through development of a State policy regarding such care and greater coordination of public and private sources of care.

Need for Coordination (pp. 26-30)

Persons in need of care and health practitioners are confronted with a bewildering array of programs, eligibility criteria, and access points. Individuals not covered by medicaid, primarily two parent families, must depend upon the teaching hospitals for medical care or on funding from smaller programs such as maternal and child health when they are available.

To some extent, lack of coordination has also resulted in uneven distribution of indigent care funds among Health Service Areas. Expenditures in urban areas reflect higher hospital costs and a greater portion of program-eligible patients. Particularly striking are differences in expenditures per poor between Southwest Virginia ($98) and Northern Virginia ($270).

The Secretary of Human Resources should form an interagency task force, including representatives of the teaching hospitals, for the following

purposes: (1) coordinating the planning and administration of indigent care programs; (2) obtaining federal waivers where necessary to facilitate client access through means such as centralized eligibility determination, a single application form, and a well-defined referral system; (3) monitoring the individual and collective contributions of public and private sources to the availability of indigent hospital care; and (4) defining the particular costs incident to treatment of indigent patients and to medical education at teaching hospitals.

Private Sector Effort (pp. 30-33, 37-44)

Little comprehensive or reliable information has been assembled on the extent or impact of private sector indigent care. Reporting of free care (charity and bad debt care) is not standardized among hospitals. Free care offered under requirements of the federal Hill-Burton construction assistance program is not adequately monitored.

During FY 1976, hospitals in Virginia were able to provide indigent care without a significant negative impact on overall finances. Hospitals generally recovered their costs and achieved acceptable operating margins or surpluses. This indicates that in most cases hospitals had sufficient numbers of commercially insured, Blue Cross, and private pay patients to absorb indigent care costs. The appropriate degree to which shifting of free care costs adds to rates for other payors should be evaluated.

The State Department of Health should develop a standardized format for reporting of comparative data on the total indigent care effort of individual hospitals and develop procedures for data verification. This data should form the basis of Hill-Burton monitoring and general indigent care program surveillance. The data should also be available for use in the review of hospital budgets by the Virginia Health Services Cost Review Commission and the coordination activities of the proposed interagency task force.

STATE SUPPORTED INDIGENT HOSPITAL CARE

The State does not consistently require accountability for indigent care funds. Numerous federal-State regulations specify validation procedures for medicaid expenditures. In contrast, the State imposes few administrative restrictions on indigent care funds appropriated to State teaching hospitals and to the State-Local Hospitalization (SLH) program.

Medicaid (pp. 45-63)

The State Department of Health (SDH) has established a sound management base for the medicaid reimbursement process. Nevertheless, greater savings could result from development of an alternative reimbursement system and improvements in audit and utilization review functions.

Reimbursement Method. The current medicaid reimbursement system is retrospective. The method provides little incentive for hospitals to control spending or to operate efficiently since almost all costs are reimbursed. An appropriately safeguarded, prospective reimbursement system could contain program expenditures and encourage improved hospital budgeting. The major feature of a prospective system is that hospitals cannot, through year-end settlements, recover costs that exceed preestablished rates.

The value of a prospective system was recognized when the appropriations act was amended, during the last session of the General Assembly, to require SDH to adopt a prospective method of payment to nursing homes. The appropriations act could be further amended to require that a prospective method of payment for hospitals be adopted by SDH for medicaid. SDH should also explore with the U.S. Department of Health, Education and Welfare and other third-party payors development of a coordinated approach to prospective reimbursement.

Audit Process. Significant reimbursement adjustments result from SDH desk audits of hospital cost reports and field audits purchased from medicare. However, the process appears to consume excessive amounts of time; hospital data reporting is deficient; and medicare audits are too irregularly purchased and limited in scope to fully serve medicaid needs.

SDH should take steps to improve hospital cost reporting, including: (1) promoting the training of hospital administrative staff in medicaid reporting procedures; (2) reduction of interim settlements; and (3) imposition of sanctions for failure to submit cost reports in a timely and accurate fashion. In addition, SDH should arrange for regular audits of major providers and for supplementation of medicare audits.

Utilization Review. Utilization review is intended to ensure that medicaid payments are for medically necessary services. SDH is now responsible for medicaid cost reimbursement and utilization review for most hospitals. SDH has not regularly reviewed hospital staff activities nor followed up recorded deficiencies.

By 1980, the utilization review function will be assumed for all hospitals by independent Professional Standard Review Organizations (PSROs). It is essential that the separation of SDH cost reimbursement and the PSRO utilization review activities not result in increased medicaid expenditures.

SDH should regularly monitor hospital and PSRO activities. Comparative data on length of stay and treatment costs associated with the same diagnosis should be developed to reveal irregularities among hospitals and to monitor the effect of PSRO utilization review. Furthermore, any increases in medicaid expenditures that occur after PSROs assume utilization review should be immediately investigated by SDH.

Teaching Hospitals (pp. 64-80)

The teaching hospitals receive approximately $20 million in indigent care funds — an amount second only to medicaid. As a result of minimal State oversight, the Medical College of Virginia Hospital (MCVH) and the University of Virginia Hospital (UVAH) employ different and uneven procedures for the processing and documenting of patient accounts. At MCVH, procedures have been inadequate to determine indigence and to document patient accounts. At UVAH, inpatient accounting procedures appeared to be effective, but outpatient billing procedures have been inadequate.

During the current biennium, the State will not require expenditures for indigents at either hospital to be directly traceable to the appropriation. Expenditures for other indigent care programs are in the form of reimbursement for the care of specific patients, thereby creating a direct audit trail. At teaching hospitals, State funds are regarded as a general subsidy. The aggregate amount used for indigent care is retrospectively determined at the end of the fiscal year.

Accountability of indigent care funds could be improved by requiring both hospitals to develop and implement adequate procedures for determining patient eligibility and for processing of patient accounts.

The General Assembly should also consider amending the appropriations act to earmark indigent care funds for teaching hospitals, with appropriate requirements for record keeping, eligibility determination, and oversight.

State-Local Hospitalization Program (pp. 81-89)

Access to care is not provided on an equitable basis through the State-Local Hospitalization (SLH) program. SLH is a program of last resort for many low income persons excluded from medicaid.

Program Use. The local option nature of the program has resulted in considerable variation in local eligibility practices and program use. Urban areas use most of the SLH funds. Rural areas, which contain over half of the State's poor, make relatively limited use of the program.

The General Assembly should clearly define the purpose of the SLH program and determine the appropriate format for achieving that purpose. Adjustments to the program could include establishment of mandatory eligibility standards or centralized administration at the State level.

Teaching Hospital Payments. Limited use of the SLH program by localities in the vicinity of teaching hospitals results in increased demands on State subsidized indigent care at these institutions. Section 63.1-138 of the *Code of Virginia,* which is also cited in the appropriations act, appears to guarantee SLH payments to teaching hospitals for indigent health care. The hospitals are required to bill the locality and notify the State Comptroller if payment is not received. The Comptroller is authorized to transfer nonearmarked local funds to the hospital.

The provisions of Section 63.1-138 of the *Code of Virginia* have not been implemented in recent years by the hospitals or the Department of Accounts. This section should be reviewed by the teaching hospitals, the Department of Welfare, the Department of Accounts, and the appropriate committees of the General Assembly. Legislative intent should be clarified. If the provision is affirmed, appropriate accounting procedures should be implemented.

CONCLUSION

Improved accountability and reimbursement limits for indigent care programs can have only a limited impact on costs. Rates paid by public indigent care programs are influenced by factors such as surplus beds and the reimbursement policies of other payors. Moreover, reductions in the amounts reimbursed by indigent care programs may be shifted by hospitals to other payors. Effective cost containment in the hospital industry will require coordination of government program restrictions with rate review or regulation, certificate of need, licensure, and insurance regulation.

The Commission to Study the Containment of Health Care Costs should be requested to specifically address appropriate redistribution of indigent care costs and the extent to which State regulatory functions can be coordinated with rate review or regulation.

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Preface

The Joint Legislative Audit and Review Commission has been assigned statutory responsibility to carry out operational and performance reviews of State agencies and programs. Each review is designed to report on the extent to which legislative intent is being met as well as to assess the efficiency and effectiveness of program activity. This review of inpatient health care is the third in a series of reports that focus on medical assistance programs in the Commonwealth.

In FY 1976 approximately $85 million was used to provide hospital care to the poor through at least nine programs and the State teaching hospitals. Much of the care is delivered in private sector hospitals that are reimbursed by government programs such as medicaid. Thus, indigent care expenditures reflect increases in the overall cost of hospital care. Accordingly, this report discusses factors that influence hospital rates as well as the adequacy of financial controls over State funds used to support indigent care.

Most Virginians have reasonable access to hospital care. Nevertheless, delivery of services could be enhanced by greater administrative coordination. Some change in the way rates are established also appears to be needed in order to avoid expenditures resulting from under or over utilization of hospital services. Specific recommendations for improving the administration of inpatient care programs were adopted by the Commission on November 14 and are referred to generally in the legislative summary.

Each agency involved in the study was provided an opportunity to review the exposure draft and suggested recommendations. The Departments of Health and Welfare, the University of Virginia, and Virginia Commonwealth University were invited to comment on this report. A number of helpful suggestions were made and appropriate revisions have been incorporated.

On behalf of the Commission staff, I wish to acknowledge the cooperation and assistance provided during the study by each State agency, many hospital officials, and the Virginia Rate Review Program.

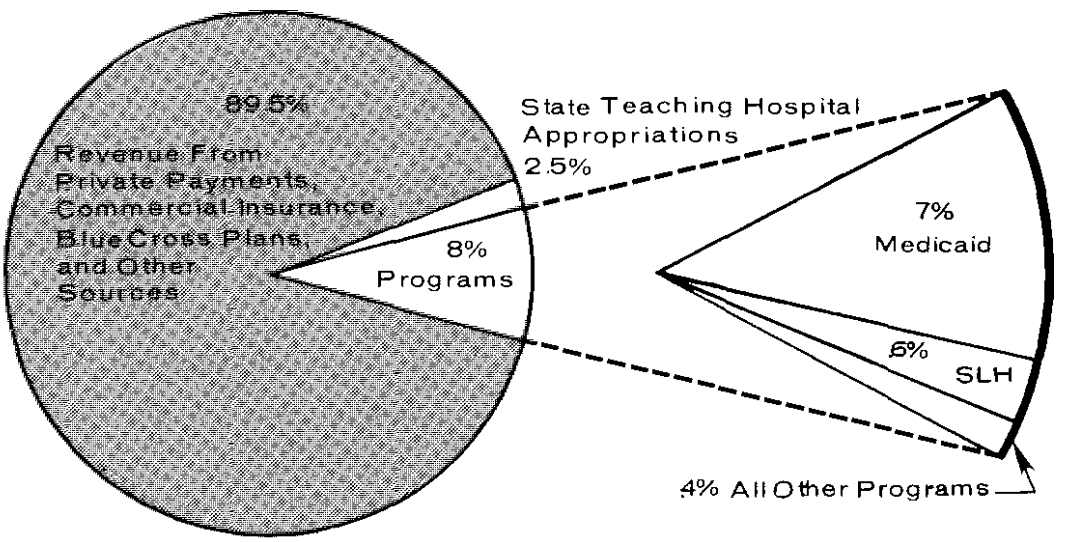
Ray D. Pethtel
Director

January 2, 1979

I. Introduction

The high cost of hospital care is a major public concern. Between 1970 and 1976 the daily cost of hospitalization in Virginia increased from $58 to $123.[1] Government has had little influence over hospital costs, primarily because public funding comprises just a small portion of overall hospital revenues. For example, in FY 1976 federal and State payments for indigent hospital care (exclusive of appropriations to teaching hospitals) amounted to $64.9 million about 8% of total hospital revenues (Figure 1).

Figure 1
PORTION OF HOSPITAL REVENUES IN VIRGINIA
FINANCED BY GOVERNMENT PROGRAMS (1976)



Includes 94 hospitals with total revenues of $783.4 million.

Source: Hospital financial statements, program expenditures, FY 1976.

State efforts to contain hospital costs have centered on medicaid, the most expensive program for financing indigent care. The State Department of Health administers numerous medicaid regulations designed to validate hospital claims for funds.

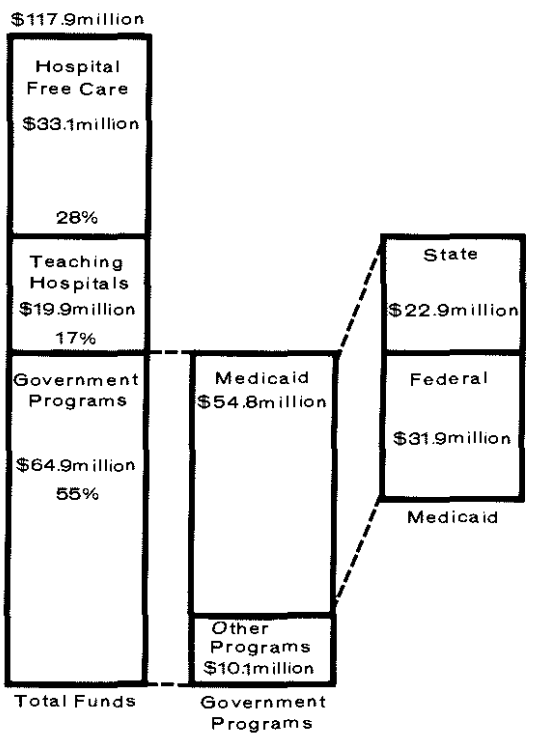
In contrast to the medicaid program, there are few administrative restrictions on indigent care funds appropriated to State teaching hospitals or to the State-Local Hospitalization program. These two sources of hospital care for the poor represent approximately $23 million in General Fund expenditures annually.

Expenditures for Indigent Hospital Care

In FY 1976, approximately $118 million was spent for the care of medical indigents in Virginia hospitals including State teaching hospitals (Figure 2). Government programs and State subsidized care at teaching hospitals accounted for $84.8 million. Of this amount, 56 percent was funded by the State. Private sector hospital free care accounted for another $33.1 million in the form of charity or bad debt accounts.

Figure 2

SPENDING FOR INDIGENT CARE
FY 1976



Source: Compiled from financial statements from 94 Virginia hospitals, and reported expenditures of programs and teaching hospitals.

Government Programs. There are two general types of government programs which provide hospital care to the poor: (1) programs jointly funded by the federal and State governments; and (2) programs jointly funded by the State and local governments (Table 1).

Teaching Hospitals. Despite receiving approximately $20 million to provide hospital care to the poor, teaching hospitals are not formally recognized as indigent care programs. Table 1

Table 1

GOVERNMENT PROGRAMS AND TEACHING HOSPITALS:
EXPENDITURES FOR INDIGENT CARE - FY 1976
(Millions of Dollars)

Government Programs	Total	Percent[a] State Share	Amount State
State/Federal Programs			
Medicaid	$54.8	41.7%	$22.9
Maternal Health	.6	50.0	.3
Child Health	1.1	50.0	.5
Crippled Children	1.7	48.6	.8
Vocational Rehabilitation	1.6	20.0	.3
Visually Handicapped	.2	20.0	.04
Family Planning and Title XX	.04	NA	NA
State-Local Programs			
State-Local Hospitalization Program	4.9	50.0	2.5
Teaching Hospitals			
Medical College of Virginia	12.7	100.0	12.7
University of Virginia	7.2[b]	100.0	7.2
TOTAL	$84.8	55.6%	$47.2

[a]Percentages supplied by program officials.
[b]Estimated expenditures.

Source: Expenditure data reported to JLARC by program officials and medicaid cost reports.

shows that in FY 1976 combined expenditures of the two teaching hospitals amounted to nearly as much as the State share for medicaid.

Indigent care appropriations to medical schools were significantly increased by action of the 1978 session of the General Assembly. The Eastern Virginia Medical Authority received a biennial appropriation of $4.5 million for indigent care. The Authority will allocate these funds to the 21 private sector hospitals affiliated with the Eastern Virginia Medical School.

Purpose and Scope

This study of inpatient care is part of a comprehensive JLARC review of State programs which provide health care to the medically indigent.

Purpose. The study has three main objectives:

- to assess the availability of hospital care to the poor;
- to describe factors that influence all payor rates--and, therefore, public costs; and
- to evaluate the adequacy of financial controls over State funds used to support indigent hospital care.

Scope. This report is primarily concerned with the availability of funds and services for the provision of indigent care in Virginia hospitals and with adequate accountability for State expenditures. Discussion focuses on general hospitals and several State, federal and local agencies with responsibility for planning, program administration and cost containment. The State Department of Health has the broadest program and oversight responsibilities. Other State agencies and institutions playing a prominent role include the Department of Welfare, the University of Virginia and Virginia Commonwealth University.

Methods. In order to carry out this study, JLARC staff obtained data from a number of sources. Interviews were conducted with State personnel involved in planning and program management and with hospital administrators. Field work included visits to hospitals in various areas of the State. Statistical data were gathered from the following sources:

- 1976 Medicaid Cost Reports;
- 1976 Hospital Financial Statements;
- Virginia Center for Health Statistics Hospital Survey;
- FY 1976 Expenditure Reports of Indigent Care Programs; and
- Sampled patient files at the Medical College of Virginia Hospital and the University of Virginia Hospital.

A computer model has been devised by JLARC to illustrate the effect on rates of third-party reimbursement policies, occupancy levels and amounts of indigent care. The model has been validated with actual data from Virginia hospitals.

A technical appendix has been prepared to explain, in detail, the methodology and research techniques used in this report. Basically, data are for the 1976 program fiscal year and for the fiscal year ending in 1976 of each facility. Complete data were available for 94 hospitals.

Organization

The remainder of this report reviews the availability of hospital care Statewide and the role of the Commonwealth in providing hospital care to indigents. Chapters Two and Three discuss the service delivery system from which indigent care is purchased and the availability of major sources of funds--government programs, teaching hospital appropriations, and hospital provided free care. The next three chapters focus individually on the adequacy of administrative procedures and financial controls for medicaid, appropriations to State teaching hospitals, and the State-Local Hospitalization program.

II. Availability and Cost of Hospital Care

With the exception of the teaching hospitals, the State does not directly provide hospital care to indigent patients. Therefore, the availability and cost of hospitalization for indigents is determined to a great extent by: (1) the distribution of services throughout the State; and (2) economic conditions, such as the growth of third-party coverage and increased demand, that have inflated the overall cost of hospital care.

Most Virginians have reasonable access to hospital services. In fact, in 1976 there were approximately 5,400 empty beds Statewide. Excess capacity is a cause for serious concern since the annual cost of an empty bed can be as high as $24,000.

Government control over the availability and cost of hospital care has been limited by the dominant position of the private sector in providing hospital services. State options for reducing hospital costs and influencing the distribution of services include the State Health Plan, the Certificate of Need program, and modification of third-party reimbursement policies.

AVAILABILITY OF CARE

Hospital care for indigents is heavily influenced by local conditions including the existence of facilities and the admission policies of hospitals and physicians. Historically, the State has exerted little control over the distribution of hospital services. However, the State role is expanding due to the cost and quality implications of maldistributed services.

Hospitals in Virginia

There are 129 hospitals in Virginia: (1) 109 State licensed, short-term hospitals; (2) 9 State licensed, extended care facilities for chronic ailments such as tuberculosis; and (3) 11 operated by the federal government primarily for military personnel.

The hospitals most relevant to this study are the short-term hospitals, sometimes referred to as general hospitals. These hospitals provide a broad range of acute patient care with a usual duration of less than 30 days. In Virginia, general hospitals are predominantly nonprofit and relatively small.

Ownership. Of the 109 hospitals, 78 are community nonprofit, 24 are proprietary, 2 are State teaching hospitals and 5 are authority nonprofit (Table 2).

Table 2

SHORT-TERM HOSPITALS IN VIRGINIA

Type of Hospital	Number of Facilities	Percent of Total	Number of Beds	Percent of Total
Community Nonprofit	78	72%	15,185	72%
Proprietary	24	22	3,626	17
State Teaching	2	2	1,582	7
Authority	5	4	800	4
Total	109	100%	21,193	100%

Source: State Department of Health, Center for Health Statistics, *1976 Annual Survey of Virginia Hospitals and Nursing Homes*, June, 1977.

Size. Not unlike the national picture, the majority of Virginia hospitals are smaller than health economists believe necessary for efficient service provision. The ideal size appears to be within the 200 to 500 bed range. Nationally 73% of all hospitals have fewer than 200 beds. In Virginia two-thirds of all hospitals have fewer than 200 beds (Table 3).

Table 3

BED SIZE OF SHORT-TERM HOSPITALS IN VIRGINIA

Size	Number	Percent of Total
Under 100	38	35%
101-200	36	33
201-300	13	12
301-400	11	10
401-499	4	4
Over 500	7	6
Total	109	100%

Source: State Department of Health, Center for Health Statistics, *1976 Annual Survey of Virginia Hospitals and Nursing Homes*, June, 1977.

Location and Distribution of Hospital Services

Hospitals tend to be concentrated in major urban areas, but beds and services are generally accessible throughout the Commonwealth (Figure 3). This does not mean that every locality has a hospital within its borders. About half of the counties do not. However, every one of the twenty-two State planning districts has at least one hospital.

The major difference between urban and predominantly rural hospitals is size. The average size of an urban hospital is 280 beds compared with 140 beds in a rural hospital.

Services. Basic and specialized hospital services are generally available throughout the State. Basic medical, surgical, and diagnostic care is provided in such hospital departments as medicine, surgery, obstetrics and pediatrics with several support services or facilities including:

- Operating Room
- Recovery Room
- Intensive Care Unit
- Clinical Laboratory
- Blood Bank
- Pharmacy
- Respiratory Therapy
- Physical Therapy

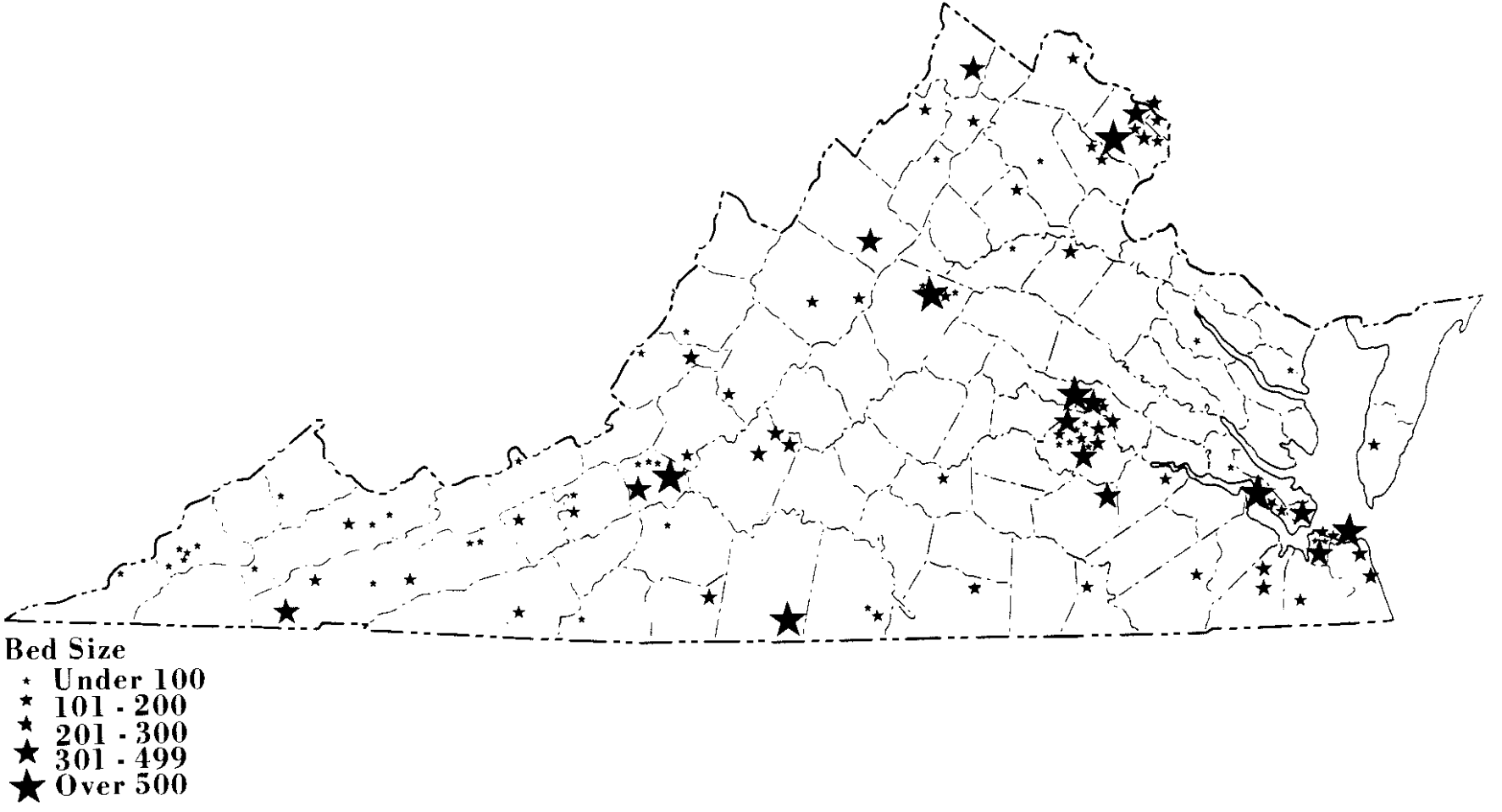
Specialized services are necessary for more complex and less frequently required types of care. These services include units for renal dialysis, organ banks, cardiac care and specialized services such as diagnostic x-ray, radium, or cobalt therapies. Most planning districts have available some specialized services (Figure 4). Districts with the highest number of services, 25 or more, tend to be urban and to have at least one large, multiservice hospital. These include districts encompassing Eastern Virginia, Northern Virginia and the greater Richmond, Charlottesville, and Roanoke areas.

Rural areas tend to have fewer specialized services. The small size of many rural hospitals prohibits the provision of these services. However, multi-service hospitals have the potential to serve as referral institutions for an entire region of the State. Figure 4 shows that several planning districts (LENOWISCO, Cumberland Plateau, New River) with few local services are within a 40 to 60 mile radius of large hospitals.

The extent to which multi-service hospitals such as Roanoke Memorial and Norfolk General serve rural areas is not readily determinable, because patient origin data are not available. There are indications, however, based upon interviews with hospital administrators that referral patterns to multi-service facilities exist and that specialized services tend to draw patients from throughout the State. For example, residents of Northern Neck make regular use of the Medical College of Virginia Hospital. Specialized units at the University of Virginia and Medical College of Virginia hospitals and the neonatal unit for premature infants at Children's

Figure 3

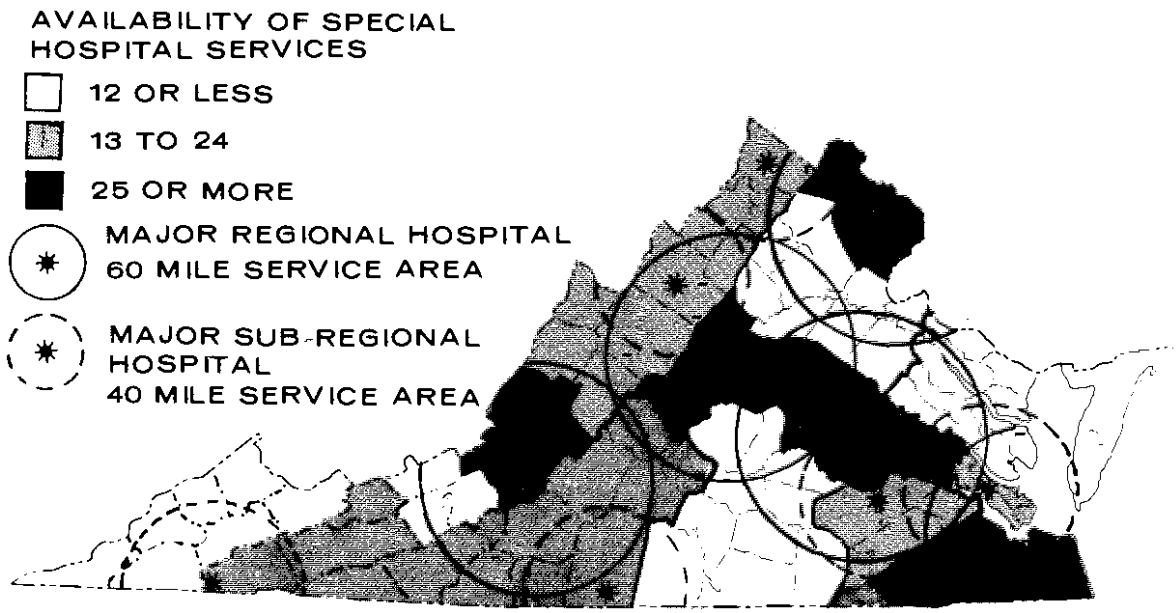
LOCATION AND SIZE OF GENERAL HOSPITALS IN VIRGINIA



Source: Based on State Department of Health, 1976 Annual Survey of Virginia Hospitals and Nursing Homes, June 1977. (Note: For statistical purposes, SDH classified the University of Virginia Children's Rehabilitation Center and the Self Care Unit as short term hospitals. For data consistency, JLARC has paralleled this SDH survey.)

Figure 4

DISTRIBUTION OF SPECIAL SERVICES



Source: Based on data compiled by the Virginia Center for Health Statistics, FY 1976.

Hospital of the Kings Daughters in Norfolk clearly attract patients from beyond their immediate geographic area.

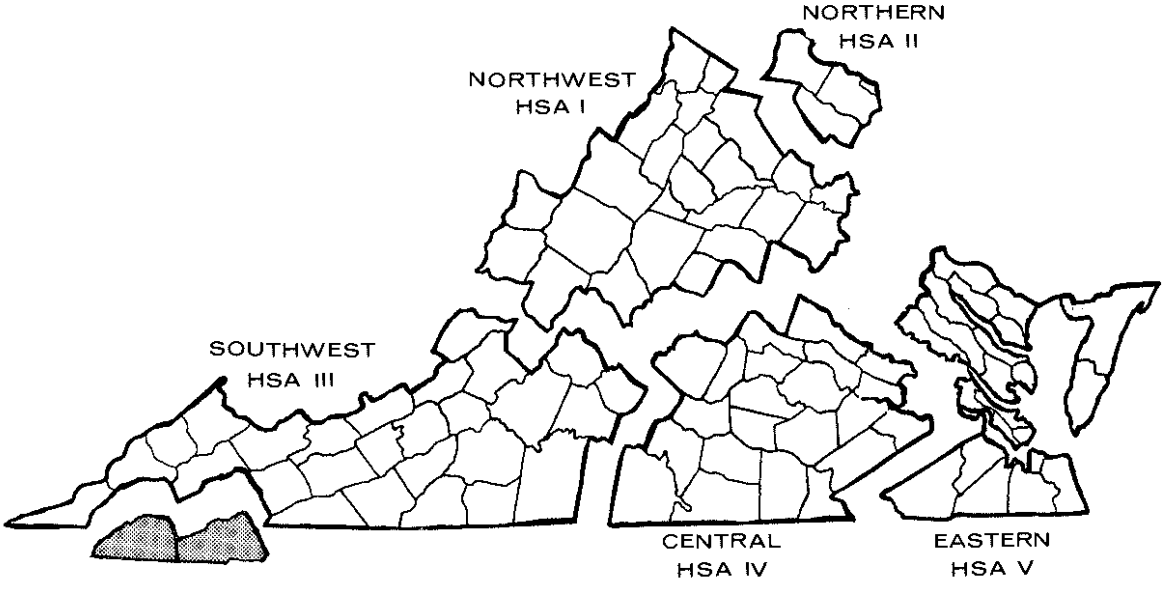
Planning for Services. A definite need exists for more thorough analysis of the quality, scope and accessibility of hospital services in Virginia. In accordance with federal law (PL 93-641), regional plans have been prepared by nonprofit Health Systems Agencies. These plans will form the basis for a State Health Plan to be prepared by the State Department of Health (SDH) and approved by the federally mandated State Health Coordinating Council.

For health planning purposes the State has been divided into five Health Service Areas (HSA). Each HSA encompasses one or more planning districts and about one-fifth of the State's population (Figure 5). These were areas designed to provide a sufficient population base to support an integrated range of basic and sophisticated inpatient, outpatient and emergency services.

As part of the planning effort, inventories of existing services and a household health status survey are being conducted. These will be crucial to determine how well the health needs of

Figure 5

HEALTH SERVICE AREAS IN VIRGINIA



Washington and Bristol are now part of a Tennessee HSA.

Source: JLARC.

Virginians are being met and to guide future efforts. SDH should place high priority on plan completion. Proliferation of small, limited service hospitals should be discouraged. Regional use of large multi-service hospitals should be encouraged through the State plan.

COST OF CARE

Individuals, insurance companies and government programs purchase medical care from hospitals. Each payor is affected by factors that account for cost differences among hospitals and by economic conditions that have caused health costs to soar. To a large extent, the growth of government health care programs for indigents and the elderly has contributed to these increased costs.

Costs in Virginia

Three questions can be asked about the cost of hospital care in Virginia: (1) What is the significance of differences between hospital charges and costs? (2) What have been the State-wide trends in hospital costs? and (3) What kind of hospital cost variations exist among regions of the State?

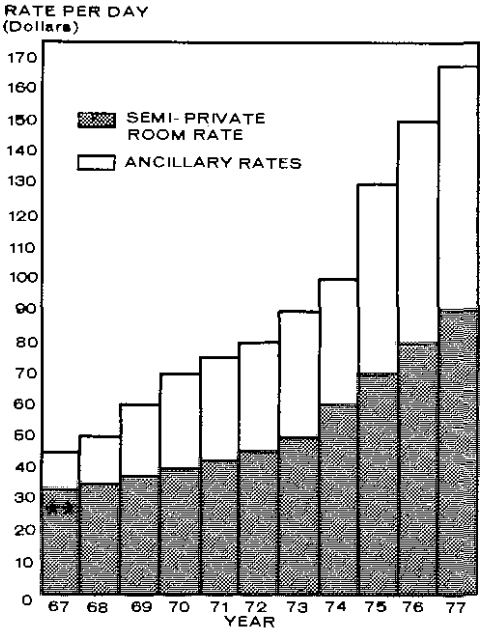
Cost and Charge. Hospitals usually charge more for a service than its actual cost. A cost is an expense incurred by the hospital in order to provide a service. A charge is the price a hospital places on the service. In Virginia charges are approximately 117% of total costs. However, for most payors hospital costs are more important than hospital charges, because only 25% of all patients are billed charges. Most patients are covered by private or public programs such as Blue Cross, medicaid, or medicare. These programs base reimbursement on the cost of the service and not the charge.

Trends. The trend in the cost of hospitalization has been steadily upward during the last decade. Nationally the cost of hospital care has more than tripled, outdistancing all other components of the consumer price index. Costs in Virginia have followed national patterns.

According to Blue Cross of Virginia (which covers two-thirds of the hospitals in the State, excluding Northern and Southwestern Virginia), per diem costs for hospital care have increased 271% since 1967 (Figure 6). Data recently compiled by the Department of Health indicate substantial cost increases for the entire State.

Figure 6

INCREASES IN VIRGINIA HOSPITAL RATES*
1967-1977



*Based on Blue Cross covered charges in member hospitals.
**1967 ancillary rates estimated.

Source: Blue Cross/Blue Shield of Virginia.

Most of the cost increase has been attributable to ancillary services, such as laboratory tests, use of operating rooms, drugs, and therapy. Over the years ancillary costs have increased more than basic room and board and have represented a growing share of the daily cost of care. Ancillaries increased from 33% of the total cost of hospital care in 1968 to half of the total cost in 1977. To some extent this growth represents greater use of new and more complex ancillary services.

Cost Variations. There are significant differences among hospitals and among regions of the State with regard to per diem costs. The Statewide average cost per day in 1976 was approximately $115. However, average costs ranged from $100 per day in Southwest Virginia to $178 in Northern Virginia (Table 4). Regional differences tend to reflect the fact that urban hospitals incur higher costs because they are generally larger, more complex and more labor intensive.

Table 4

REGIONAL COST VARIATIONS

Health Service Area	Total Inpatient Expenditures (millions)	Average Cost Per Day	Per Diem Range
I Northwest	$ 89.0	$105	$ 80-183
II Northern	113.1	178	148-206
III Southwest	148.4	100	49-127
IV Central	154.6	112	64-183
V Eastern	157.3	121	71-158
State	$662.4	$115	$ 49-206

Source: 1976 Virginia Medical Assistance Program Cost Analysis Forms for 94 Virginia, short-term, nonfederal hospitals.

The effect on cost per day of hospital size, number of services and personnel, and average length of patient stay can be seen in Table 5.

Industrywide Inflationary Factors

It is difficult to affix responsibility for cost increases in an industry which differs considerably from economic norms of supply and demand. Decision-making authority in the hospital tends to be decentralized, consumer choice is minimal, and payment is primarily from third-party sources. Individual physicians, not hospital boards or administrators, admit patients to hospitals. The patient, as consumer, has little control over the choice of hospital or the level of diagnostic testing or treatment prescribed by the physician.

Table 5

FACTORS AFFECTING COST IN HOSPITALS

Average Cost Per Day	Number of Hospitals	Bed Size	Average[a] Number of Services	Average[b] Personnel Per Average Daily Census	Average Length of Stay
$102	28	1-99	8.6	3.0	6.8
113	32	100-199	13.0	2.9	7.5
122	12	200-299	17.3	3.0	7.8
124	10	300-399	22.6	3.1	8.0
134	12	Over 400	28.8	3.7	8.4
State $114	94		15.3	3.3	7.9

[a]Total possible = 50.
[b]Average Daily Census = average daily number of inpatients.

Source: Compiled from JLARC sample data for 94 Virginia hospitals.

Decisions which lead to increased costs such as facility or service expansion are strongly influenced by community pride, medical necessity, physician preference and third party reimbursement policies. Nevertheless, leading economists primarily attribute the rise in hospital costs to two interrelated factors: (1) the impact of expanded insurance coverage and new government health care programs, and (2) the changing nature of the hospital product.

Impact of Insurance and Government Programs. When a large part of the cost of medical care is offset by government or insurance companies, patients and physicians frequently demand additional and more expensive services. The expansion of private insurance in the 1960s and the introduction of medicare and medicaid created an upward surge in demand and prices, while reducing consumer awareness of medical costs. Most persons in the United States now have some form of hospital coverage. Nearly 80% of the population under age 65[1] and all of the medicare eligible elderly are insured.

Between 1955 and 1975 increasing amounts of the cost of hospital care have been borne by government programs and insurance companies. The greatest shift has been in the share paid by government. In 1955 patients paid 35% of the cost of hospital care while government paid 20%. By 1975, government funds were used to finance 45% of the cost while consumers paid only 12%. The expanded role of government in financing health care largely reflects the impact of medicare and medicaid. These programs have made available medical services to previously uncovered groups, the welfare poor and the elderly (Table 6).

Table 6

EXPENDITURES FOR HOSPITAL CARE
BY SOURCE OF PAYMENT
(1955-1975)

	1955	1966	1975
Percentage of hospital costs paid by:			
Private Insurance	44.7	51.4	43.6
Government	19.9	25.5	44.5
Direct Consumer Spending	35.2	23.1	11.9

Source: Excerpted from Council on Wage and Price Stability Staff Report, "The Rapid Rise of Hospital Costs", January, 1977.

Insurers and government programs have provided access to medical care for more people. Cost no longer prohibits people from seeking care. As a result, consumers have been insulated from the impact of cost inflation. Inflated medical costs are reflected in higher taxes and insurance premiums. However, at the time of illness, cost is not a matter of real concern to the patient because the out-of-pocket cost is so small. Decisions by the patient and the physician reflect the out-of-pocket cost rather than the total cost of care. A recent report by the Council on Wage and Price Stability shows that direct consumer costs per day have increased only $6.91 since 1966, while total costs have increased $103.38 (Table 7).

Table 7

INCREASE IN TOTAL AND CONSUMER COSTS
PER PATIENT DAY
(1955-1975)

	1955	1966	1975
Average cost per patient day	$23.12	$48.15	$151.53
Net cost to consumer	8.14	11.12	18.03

Source: Council on Wage and Price Stability Staff Report, "The Rapid Rise of Hospital Costs", January, 1977.

Changed Product. The growth in third-party coverage has stimulated demand for hospital services. In turn, revenues received by hospitals from insurance companies and government programs have

been used to finance more expensive levels of care. Econometric studies have shown that approximately three-quarters of the cost increase for hospital care is attributable to the purchase of more sophisticated technology and to the employment of additional staff. Price and wage increases, frequently blamed for increased cost of hospital care, are less significant reasons. Increases in hospital prices have outstripped all other components of the consumer price index. Moreover, the rise of hospital wages in excess of the national average rate of wage increase can only account for about one-tenth of the rate of hospital-cost inflation.

The relationship between third-party coverage and hospital cost and service increases has serious implications for the future. If hospitals continue to generate excess revenues for reinvestment in new technology and additional staff, costs will most likely continue to rise. This process could be intensified by the introduction of national health insurance.

Health insurers and government programs must find ways to stem the rising cost of hospital care. Among the actions that could be taken are: (1) consumer awareness of costs could be enhanced by making patients pay a larger share of hospital costs; (2) third-party reimbursement methods could be designed to encourage cost containment by hospitals; and (3) government regulatory powers can be used more effectively to control capital expenditures by hospitals that result in a proliferation of surplus beds or services.

SURPLUS BEDS

One of the most serious issues facing government and the hospital industry is how to deal with excessive numbers of beds and underutilized services. Excess capacity is one reason for the striking increase in hospital costs since 1967. While beds may not be ideally distributed within Virginia, more beds exist than are needed to meet current and projected needs. In FY 1976, the cost of maintaining empty hospital beds totaled an estimated $129 million. This cost was distributed among all payors, including government programs, increasing rates paid for hospital care.

While there are substantial costs associated with each empty bed, it would not be desirable for all beds to be occupied at all times. Some number of empty beds must be retained to provide flexibility during seasonal peaks or emergencies. However, empty beds beyond the number determined necessary for emergency needs are considered surplus and associated costs should be reduced or eliminated. The Certificate of Need Law offers an opportunity to control the proliferation of hospital beds, but the law's implementation is laden with political and legal problems.

The Cost of Empty Beds

Hospitals can only appreciably reduce their fixed and variable costs when entire facilities, services, or sections are closed. Even when beds are empty, hospitals continue to incur fixed costs for interest and depreciation. Other types of costs can also be considered relatively fixed because they are not easily adjusted when hospital occupancy declines. These relatively fixed costs are for administration of the hospital, utilities, basic maintenance, and for support services such as radiology, laboratories, and pharmacies. Variable costs include expenditures for staff, food and supplies.

On a national basis, one frequently used estimate is that each empty bed costs the public two-thirds as much to maintain as a full bed.[2] This is based on the assumption that, on the average, two-thirds of the total costs of hospitals remain relatively fixed regardless of occupancy. The hospitals with least flexibility and the highest portion of fixed costs are low occupancy, small hospitals and large hospitals with specialized departments.

When this basic two-thirds fixed cost assumption was applied to the expenditure data available for 94 Virginia hospitals, the average cost of an empty bed in FY 1976 was estimated to be approximately $24,000. According to the Virginia Center for Health Statistics data, approximately 5,368 staffed beds were empty in FY 1976. Applying the $24,000 cost estimate, the total cost of these empty beds was $128.8 million. (See Technical Appendix.)

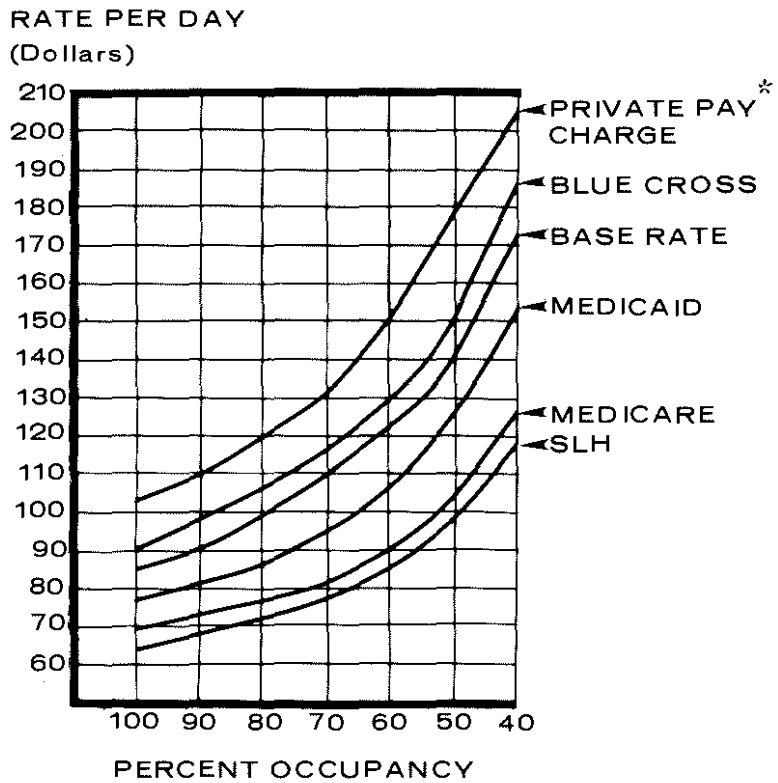
To date no hospital-by-hospital assessment of empty bed costs has been conducted in Virginia. However, there is general agreement among hospital spokesmen and third-party payors that costs of unoccupied beds are substantial, although there are significant differences among hospitals. The necessary data for assessment of the cost of empty beds within individual hospitals will become available to the newly created Virginia Health Services Cost Review Commission in the near future. Such data will be invaluable in the rate review and certificate of need decision-making processes.

Effect of Empty Beds on Rates

All payors share in the cost of empty beds, because the cost of an entire facility must be borne by fewer patients. JLARC has developed a computer model to demonstrate the effect of empty beds on rates for private pay and third-party payors (Figure 7). The model is not intended to be predictive of actual rates in a 100-bed hospital but to show relationships among different payors. Both the methodology employed by the model (see Technical Appendix) and the relationships indicated have been validated using data from actual Virginia hospitals.

Figure 7

EFFECT OF DECREASING OCCUPANCY
ON RATE PER DAY FOR ALL PAYORS



*The model assumes that the private pay charge can be set to recover bad debts and costs not assumed by other payors. However, at some point disproportionately high charges will generate additional bad debts and force hospitals to seek other remedies such as service reduction.

Source: JLARC model.

Per diem rates are appreciably higher for all payors when occupancy levels are low. The computer model simulates rate calculations for each type of payor in a hypothetical 100-bed nonprofit hospital with $3 million in expenditures and a 3% operating surplus or margin. The rate for each payor is calculated at each occupancy level from 100% to 40%.

The impact on rates paid by the medicaid program can be clearly seen. When the occupancy level is 80%, the medicaid rate is $92. When the occupancy rate is 60%, the medicaid rate increases to $114, an increase of $22 per day.

Medicaid and other third-party payors absorb the cost of low hospital occupancy because each pays a share of the total expenditures of a hospital commensurate with the proportion of program

covered patients. For example, if medicaid covers 10% of the patient days in the hospital, medicaid reimburses approximately 10% of the hospital's total operating costs including the costs associated with empty beds.

Reduction of Surplus Beds and Costs

The State currently has more empty beds than are needed to provide hospitals with sufficient flexibility to meet emergency situations. By 1980, the cost of surplus beds can be as high as $63.2 million based on the estimated cost of an empty bed in 1976.

Surplus Beds. The number of existing beds in each Health Service Area exceeds current planning norms. Based on recommendations of the Institute of Medicine, the Department of Health, Education and Welfare has established two criteria to be applied by health systems agencies. There should be no more than 4 beds/1000 population and an occupancy level of at least 80% within the HSA. In Virginia, the Statewide average occupancy rate is 73.4%, and no HSA has achieved the 80% level (Table 8).

Table 8

BEDS AND OCCUPANCY IN VIRGINIA, 1976

	Licensed Beds/ 1,000 Population 1976	Occupancy Rate	Occupancy Range
State	4.2	73.4	22.0 - 97.9
HSA I (Northwest)	4.6	73.2	45.4 - 86.8
HSA II (Northern)	2.9	68.6	22.0 - 81.2
HSA III (Southwest)	4.8	76.0	24.3 - 97.9
HSA IV (Central)	5.3	72.6	31.0 - 88.0
HSA V (Eastern)	3.7	74.2	42.8 - 87.9

Source: State Department of Health, Center for Health Statistics, *1976 Annual Survey of Virginia Hospitals and Nursing Homes*, June 1977.

Some aspects of the HEW guidelines have been controversial. However, most concerns relate to standards for special units within hospitals such as obstetrics, rather than to overall bed norms for Health Service Areas. HEW has recently proposed regulations that will allow planning agencies wider latitude in determining the need for hospital facilities and services, particularly in rural areas.

But, the desire for some degree of local flexibility should not obscure the necessity for an objective measure of the need for beds.

According to the 1976 Interim Virginia Medical Facilities Plan prepared by the State Department of Health, the State will have 2,632 surplus beds by 1980. The Department projects baseline needs for beds in the State on the basis of 85% desired occupancy. Each Health Service Area and planning district will have a surplus, including predominately rural Southwest Virginia (Table 9). The department is in the process of developing a new facilities plan that will project bed needs and define surpluses in terms of specific categories of beds (i.e., medical-surgical, obstetric, pediatric, psychiatric).

Table 9

BED REQUIREMENTS FOR GENERAL HOSPITALS IN VIRGINIA, 1980

	1980 Bed Requirements	1976 Beds Licensed, Exempt, Under Construction, or Approved	Excess Beds
State	18,029	20,661	2,632
HSA I (Northwest)	2,410	2,841	431
HSA II (Northern)	2,538	2,920	382
HSA III (Southwest)	4,755	5,271	516
HSA IV (Central)	4,020	4,683	663
HSA V (Eastern)	4,306	4,946	640

Source: Virginia State Department of Health, Interim Virginia Medical Facilities Plan, 1976.

Reducing Surplus Beds. There are several options for reducing surplus beds that merit serious consideration by the General Assembly and the Department of Health. Some options are directed at reducing indigent care program expenditures for surplus beds through adjustments to the reimbursement process. Others focus on outright elimination of such beds using the regulatory powers of the State for licensure, planning, and certificate of need.

The State Department of Health could minimize the effect of low occupancy on medicaid rates by adjusting the reimbursement formula. A minimum acceptable occupancy rate of 80% could be established. Hospitals with higher occupancy would be reimbursed at actual levels. Any hospital with lower occupancy would be reimbursed

as if it had 80% occupancy. Exceptions could be permitted in extraordinary situations where low occupancy hospitals were heavily dependent upon medicaid funds and provided the only essential services within a remote geographic area.

Medicaid expenditures could be considerably reduced by establishing a minimum occupancy rate. If an 80% minimum occupancy level had been applied in FY 1976, the program could have saved $1.5 million in just the 25 hospitals that receive over 70% of all medicaid funds. Further savings might result because hospitals would be provided with an incentive for eliminating excess capacity or cutting overall expenditures. Since medicaid represents only a small portion of total hospital revenues, the greatest effect from reimbursement adjustments would result if all payors were to establish a minimum occupancy level. A change in medicaid methodology may establish a precedent for other payors who would seek to avoid shifting of costs by hospitals.

Several methods of directly reducing surplus hospital capacity have been explored in recent national studies. Proposed options include delicensure of unused beds, decertification of beds and services, and acquisition and conversion of entire facilities. The intent is to reduce operating and capital costs as well as to reduce indirect costs, such as overutilization, generated by the existence of beds and services. Studies have shown that instead of the number of patients generating the need for beds, the number of beds and specialists seems to generate patients.

A recent authoritative study prepared for HEW has explored various bed reducing options. The major finding of the study was that "the savings produced by reducing excess hospital capacity could be substantial but depend crucially upon how it is done..." For example, minimal savings would be accrued through across the board general reductions of beds at each hospital. However, substantially more savings would be produced by retiring entire hospitals, and by consolidating and eliminating duplicative, underutilized departments among hospitals, such as obstetrics, pediatrics and special units.[3]

Bed reducing options for Virginia should be carefully evaluated by the General Assembly and the Department of Health in conjunction with the State's Health Plan and Certificate of Need Law.

Certificate of Need

The Certificate of Need Law has been viewed by many as a panacea to controlling surplus hospital facilities, but legal and political obstacles have limited the law's effectiveness. The 1974 National Health Planning and Resources Act (PL 93-641) consciously attempted to avoid problems inherent in previous health planning strategies. The legislation emphasizes Statewide planning on a regional level and regulation of health facilities through the Certificate of Need process.

Procedures. No new facility can be constructed nor can major service expansion take place unless the Commissioner of Health issues a Certificate of Need. Decisions of hospital boards on the location and service capacity of facilities must be tested in terms of the public interest. Section 32-211.17 of the *Code of Virginia* requires hospitals to obtain a certificate when a proposed project exceeds $150,000, changes the bed capacity of a facility, or substantially changes the services of a facility. The State Commissioner of Health is empowered to make the final decision on the advice of the health systems agency involved and the State Health Coordinating Council.

According to the Virginia law, the finding that a facility is in the public interest should be based upon the following criteria:

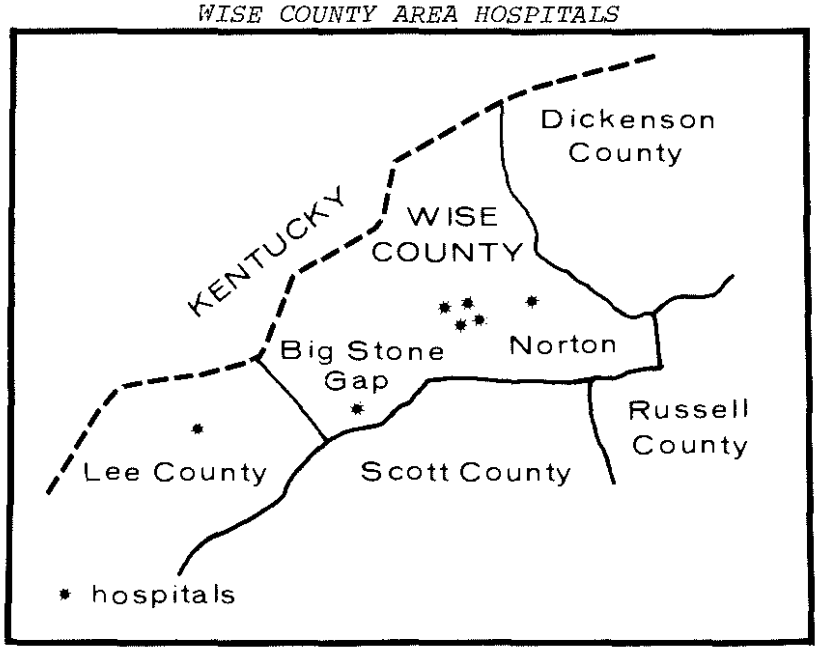
- The contribution of the proposed project to the orderly development and proper distribution of adequate and effective health services for the people residing in the area to be served.
- The size, composition, and growth of the population of the area to be served by the proposed project.
- The number of existing and planned facilities of types similar to the proposed project and the extent of utilization thereof.
- The availability of facilities or services, existing or proposed, which may serve as alternatives or substitutes to the proposed project.
- The compatibility of the proposed project with the State health plan and the State medical facilities plan.

Implementation Problems. There are some indications that problems regarding limited service hospitals and surplus beds are not being adequately addressed by recently issued certificates. One apparent reason is the absence of a State health plan to place bed needs within the context of an overall health care delivery system.

Another problem is an interpretation of the law which appears to restrict its application with regard to existing hospitals. The Department of Health takes the position that existing hospitals cannot be required to eliminate beds nor be prevented from relocating in the same general geographical area. The result is limited applicability of the public interest criteria spelled out in the law. The following case studies illustrate problems that have been encountered by the Department of Health in implementing the Certificate of Need Law.

Figure 8

WISE COUNTY AREA HOSPITALS



Source: JLARC.

Case Study - Wise County, Virginia

Recent Certificate of Need decisions in Wise County, Virginia indicate that limited capacity, small hospitals are being perpetuated in a rural area. Certificates were granted for rebuilding of two 60-bed hospitals after efforts to promote a merger failed. One of the hospitals was operated by a community board, the other by a religious order. Merger was opposed by both hospitals on the grounds that a parochial and public hospital would be incompatible in delivery of services, particularly in the areas of family planning and abortion.

Nonetheless, this action will maintain a status quo in which six small uneconomical hospitals exist within twenty miles of one another (Figure 8). The range of licensed beds for the six facilities is 60-75 and service capacity is very limited. Three of the hospitals suffered operating deficits in the 1976 fiscal year.

Future planning efforts will be impeded and possible development of a larger hospital with a broader range of services for the area may be precluded. Administrators of the newest facility

at Big Stone Gap have already decided that any increase in beds would be uneconomical despite the existence of a physical plant that could support a total of 200 beds.

Case Study - Eastern Virginia

A recent decision on an Eastern Virginia hospital indicates perpetuation of an over-bedded situation in an urban area. A hospital was granted a certificate to replace a facility found to be deficient by the State Bureau of Licensure. The hospital had 120 beds and was operating at 46% occupancy. If the facility were not replaced or renovated it would lose its license.

According to the 1978-79 Eastern Virginia Health Systems Plan, the existence of excess capacity in the region boosts costs $10 to $20 million per year. Moreover, duplicate surgical facilities in each of the area hospitals are currently underutilized.

Nevertheless, the Commissioner was advised by Department of Health counsel that denial of a certificate would constitute improper seizure of property. Therefore, a certificate was issued and the opportunity to reduce excess beds in the area was lost.

The impact of Virginia's Certificate of Need process is negatively affected by this interpretation of the law. It is unlikely that new hospitals will attempt to enter an already overbedded market. Existing hospitals are assured of perpetuation. Wisconsin and New York have made provision in their laws for recompense of owners of facilities required to close by denial of a certificate or whose beds are decertified. The federal government is considering provisions for delicensing or acquiring hospitals to reduce excess capacity.

There has also been an attempt to challenge Virginia's interpretation of the law in court. Blue Cross of Virginia sought an injunction against the Eastern Virginia hospital certificate. However, the court determined that Blue Cross did not have standing as an aggrieved party. The Department of Health is reluctant to seek a court ruling because precedent would be established for administrative decisions to be challenged in court. However, it seems that the intent of the law should be clarified through an official interpretation by the Office of the Attorney General, a court test, or legislative action. (Further information on Certificate of Need implementation will be available upon completion of a JLARC review mandated by the General Assembly.)

CONCLUSION

The State purchases health services for the indigent from a complex system of hospitals over which it has little control. Until recently, hospital decisions affecting availability, distribution, and cost of services have been immune from government scrutiny. However, a dramatic increase in hospital costs since 1967 and the substantial costs associated with maintaining excess beds and services have prompted the federal and State government to pay closer attention to the hospital industry.

Currently many industrywide factors that increase hospital costs are largely beyond the control of the State. Such factors include economic inflation, growth of federal health care programs, and expanded third-party insurance coverage. By providing greater numbers of people access to subsidized medical care, insurers and government programs have played a key part in insulating consumers from the real cost of health care. The relationship between consumer coverage and health costs has serious implications for the future. The State and federal government may need to take steps to increase consumer awareness of cost through cost sharing or institute some form of rate regulation.

A broad range of hospital services appears to be reasonably located throughout the State. But the Commonwealth has more hospital beds than needed. As an initial step to eliminate surplus beds, the Department of Health could adjust the medicaid formula to reduce the amounts paid by the program for excess hospital capacity. This would require establishing a minimum acceptable occupancy level. Hospitals would not be reimbursed for any empty beds below the minimum occupancy level. Furthermore, options such as delicensure of unused beds, decertification, or conversion of facilities to other uses should be evaluated as means of reducing surplus beds.

It would also appear advisable for the intent of the Certificate of Need Law and the authority of the Department of Health with regard to existing hospitals be clarified. The law as currently administered may not be realizing its full potential for controlling proliferation of beds and services.

III. Indigent Hospital Care

The State is strongly committed to providing hospital care for medical indigents. However, despite substantial expenditures, there is no policy for fund distribution or assessment of public and private impact on the availability of hospital care for indigents. Determination of how well the State's commitment to indigent hospital care is met requires: (1) identification of all sources of funds, including free care provided by private sector hospitals; (2) awareness of the Statewide distribution of all funds; and (3) analysis of the financial impact of indigent care on hospitals.

PUBLIC AND PRIVATE SOURCES OF INDIGENT HOSPITAL CARE

Both the public and private sectors provide hospital care to the poor. However, government programs are not well-coordinated and little is known about the extent of free care provided by private sector hospitals. The State could play a more active part in coordinating publicly financed hospital care programs and in developing a standardized format for reporting of the total indigent care effort of individual hospitals.

Public Programs

Virginia's approach to hospital care for the indigent is loosely defined and lacking central direction. Responsibility for delivery of indigent hospital care is fragmented among nine programs and two State teaching hospitals.

- Medicaid
- Maternal Health
- Child Health
- Crippled Children
- Family Planning
- Title XX
- Vocational Rehabilitation
- Visually Handicapped
- State-Local Hospitalization
- State Teaching Hospitals

Brief program descriptions will serve to illustrate the limitations on care available to most indigent Virginians. Persons in need of care and health practitioners are confronted with a confusing array of programs, eligibility criteria, and public and private access points.

Medicaid. Medicaid is administered by the State Department of Health in accordance with federal regulations. The intent of the program is to provide the welfare poor with the same access to medical services, including hospital care, as the general public. A comprehensive range of outpatient and inpatient services, up to a maximum of 21 days, is covered. Since eligibility is generally

determined prior to the onset of illness, medicaid acts as an insurance program under which providers must accept reimbursement as payment in full.

Eligibility determinations are made by local departments of welfare. Approximately 393,000 Virginians were enrolled in the program in 1976, representing only one segment of the State's poor. Two parent families are excluded, regardless of income or health status. Medicaid eligibility is generally restricted to recipients of the Aid to Dependent Children program or the Supplemental Security Income program for the aged, blind and disabled.

Income criteria established for medicaid eligibility are frequently regarded as bench marks for other programs. As shown in Table 10, allowance is made for family size and the cost of living in three areas of the State. Income levels are somewhat above the ADC level because the federal government permits coverage of an additional group of medically needy individuals with incomes a maximum of 33% above ADC. However, Virginia medicaid levels for the most part do not reach the federal maximum.

Table 10

INCOME LIMITS FOR ELIGIBILITY UNDER MEDICAID AND AID TO DEPENDENT CHILDREN PROGRAMS[1]
(Effective July 1, 1978)

Family Size	Cost of Living Differential[2]					
	Low		Medium		High	
	ADC	Medicaid	ADC	Medicaid	ADC	Medicaid
1	$1,428	*$2,300*	$1,704	*$2,500*	$2,388	*$2,900*
2	2,244	*2,700*	2,520	*3,100*	3,204	*3,500*
3	2,892	*3,100*	3,156	*3,400*	3,804	*3,900*
4	3,504	*3,500*	3,780	*3,800*	4,464	*4,300*
5	4,128	*3,900*	4,464	*4,200*	5,304	*4,800*
6	4,632	*4,300*	4,980	*4,600*	5,808	*5,300*
7	5,232	*4,800*	5,568	*5,100*	6,408	*5,800*
8	5,880	*5,300*	6,216	*5,600*	7,056	*6,400*
9	6,432	*5,800*	6,768	*6,100*	7,608	*6,900*
10	7,020	*6,400*	7,368	*6,700*	8,196	*7,400*
Each Additional	588	*600*	588	*600*	588	*600*

[1] Eligibility for medicaid is based on set of figures in italics. Adjacent set of figures represents income limits for qualifying for ADC cash assistance payments. Persons above the ADC levels but still eligible for medicaid are considered to be in the "medically needy" group.

[2] Differences reflect allowance for cost of living variations in different areas of the State.

Source: State Departments of Health and Welfare.

State-Federal Categorical Programs. Federally subsidized categorical programs provide less comprehensive services than medicaid. These programs have limited funds and provide only specialized types of health care. Often categorical programs have an outpatient orientation, but inpatient care is authorized by program managers when necessary.

Three programs are designed to serve primarily mothers and children:

- *Family Planning* covers counseling and appropriate forms of contraception. Federal funds are available under the family planning program or the Title XX social services program, which also pays for inpatient sterilizations.

- *Maternal Health* covers high risk deliveries.

- *Crippled Children* covers surgery and inpatient care for children under age 21 with specific crippling conditions and problems such as eye defects, facial deformities, burns or hemophilia.

The programs are administered by separate bureaus of the State Department of Health. Eligibility is not based upon income criteria, but the charge rate is determined according to income guidelines. Persons at medicaid income levels receive free service. Since each program has specifically defined clientele, children with other conditions, such as cancer, and mothers with normal pregnancies are not eligible for service.

Categorically restricted programs are also available for the *visually and vocationally handicapped.* The State Department of Vocational Rehabilitation provides medical care that will help disabled persons to obtain employment or resume some form of productive life. This may include services such as restorative surgery or training in the use of artificial limbs. Only persons for whom needed medical treatment would affect employability are eligible. Vocational and medical services are available for the blind and visually handicapped through the Virginia Commission for the Visually Handicapped.

State Programs. Programs initiated and funded by the State without federal match or guidelines are the *State-Local Hospitalization (SLH)* program and *indigent care provided by the State teaching hospitals.* A full range of hospital services is made available to persons not eligible for other federal and State programs.

The SLH program, is administered by the State Department of Welfare. However, the Department's role is limited to general

supervision and distribution of funds to participating localities. Participation in the SLH program is at the option of local communities. In 1976, inpatient care was provided by 107 localities and outpatient care was provided by 38 localities.

Income levels for the SLH program are higher than medicaid (Table 11). However, actual income levels as well as the type and availability of services are decided by each locality. This results in considerable variation across the State. Despite the role of SLH as a program of last resort, it is a small program. In FY 1976, 56,538 inpatient days were provided, which was about one-sixth of the days paid for by medicaid.

Table 11

MONTHLY INCOME SCALE FOR EVALUATING MEDICAL INDIGENCY

Number of Persons in Family	Areas Over 10,000 Population	Areas Under 10,000 Population
1	$225	$185
2	300	265
3	350	315
4	395	360
5 and over	$440 plus $45 per additional person	$400 plus $45 per additional person

Source: Department of Welfare.

The appropriations act contains authorization for State funded treatment of indigent and medically indigent patients at the hospitals of the University of Virginia and the Medical College of Virginia. Each hospital determines indigence on an individual basis.

Needed Improvements. The State has committed substantial financial and administrative resources to the delivery of indigent hospital services. However, indigents may remain unserved because of inadequately coordinated programs, confusing eligibility criteria, and obscure referral systems.

Persons least likely to receive funded care are those not qualified for medicaid, since other programs are so much less comprehensive and visible. In FY 1975, it was estimated by the State Departments of Health and Welfare that approximately 700,000 persons were in this category. To some extent these persons may be served by other programs, remain unserved, or rely on private sector charity.

The current fragmented approach to delivery of hospital care has resulted, in part, from federally subsidized programs that

must adhere to established guidelines. Nevertheless, client access to care could be facilitated by State action to coordinate program administration and simplify client application. The Secretary of Human Resources should form an interagency task force (with representatives from the teaching hospitals) for this purpose. Additionally, a pilot project consisting of pooled funds to provide care without categorical eligibility requirements should be considered. This would require appropriate federal waivers and redirection of some State funds.

Private Sector Free Care

In addition to publicly subsidized hospital care, many private sector hospitals provide free care to indigent patients. For example, under the federally financed Hill-Burton construction program, many hospitals are obligated to provide free care to the medically indigent. The extent to which individual hospitals fulfill this obligation is difficult to assess because of inadequate monitoring of the program by the Department of Health.

Types of Free Care. In FY 1976, private sector hospitals in Virginia incurred $33.1 million in costs of care for patients unable to pay. This constituted 28% of all funds expended for the care of indigent patients.

Most free care, approximately 90%, is provided in non-profit hospitals. There are three main categories of free care:

- *Hill-Burton Charity* care is provided in hospitals obligated by receipt of Hill-Burton construction aid to provide some level of free care for a period of 20 years. Patients must be determined eligible according to State guidelines based on medicaid income levels. Eligibility must be established prior to delivery of service or before collection efforts are begun.

- *Charity* care is provided to patients determined unable to pay by hospital business offices. There are no formal eligibility requirements.

- *Uncollectible Bad Debts* represent accounts for care of patients believed able to pay prior to service delivery, but for which collection efforts are unsuccessful.

Charity and bad debt accounts are often not fully distinguishable, because all or part of an uncollectible account may be due to the medical indigence of a patient. Moreover, hospital reporting is not standardized. Generally charity patients are known to be unable to pay prior to service delivery. Bad debts are recorded after the fact when bills cannot be collected. As reported

on financial statements for Virginia hospitals, 18% was charity and 82% was bad debt in 1976. The American Hospital Association is reportedly working to standardize reporting of charity care and bad debts.

Hill-Burton Charity Care. Most nonprofit hospitals have received Hill-Burton funds and are required to provide some amount of charity care. This is the only amount of charity care over which the State exercises a degree of control. However, the federal government does not provide funds to offset the cost of such care. It was assumed that community nonprofit hospitals would be able to absorb the cost, since they had tax exempt status as well as low debt service for construction costs.

The level of free care provided by a hospital is largely determined by factors such as ownership, location, or mission. However, Hill-Burton requirements may tend to stimulate higher levels of free care in obligated hospitals. Table 12 indicates the proportion of revenues earned and free care provided in 94 hospitals for which data were available in 1976.

Table 12

FREE CARE COSTS INCURRED BY
VIRGINIA HOSPITALS - 1976
(Millions of Dollars)

	Number of Hospitals	Total Net Revenues	% of State	Free Care Costs	% of State
Nonprofit Hill-Burton Obligated	57	$608.3	77%	$27.3	83%
Nonprofit Not Obligated	21	68.4	9	2.7	8
Proprietary[a]	16	106.6	14	3.0	9
Totals	94	$783.3	100%	$33.1	100%

[a]Includes one hospital obligated under Hill-Burton program.

Source: Compiled by JLARC from hospital financial statements, FY 1976.

Hill-Burton obligated nonprofit hospitals provided 83% of the free care in the State. This was somewhat higher than their proportion of total hospital revenues. Nonprofit nonobligated hospitals provided free care proportionate to their share of revenues. Proprietary hospitals provided a level of charity care somewhat lower than their share of revenues earned.

The Department of Health is responsible for monitoring the Hill-Burton program. However, surveillance is not adequate to determine whether hospitals are either complying with regulations or providing adequate amounts of charity care. The department employs only one person to audit construction aspects of Hill-Burton projects, collect charity care data, and investigate complaints. Most hospitals in Virginia have chosen to comply with Hill-Burton charity care requirements through an open door option, which does not require specific levels of expenditure. Nevertheless, accurate reporting is still necessary and patients must be certain of their rights.

JLARC staff comparison of amounts reported to the Department of Health as Hill-Burton charity care in 1976 with hospital writeoffs recorded on financial statements revealed serious inconsistencies (Table 13). Only in one case was it possible to verify the amount reported as Hill-Burton care. Hill-Burton amounts reported by 40% of the hospitals represented their total charity care deductions. However, sixty percent of the hospitals reported amounts that appeared to include sums identifiable as bad debts or third party contractual adjustments (difference between hospital charges and reimbursement) or amounts not determinable from the statement.

Table 13

REPORTED HILL BURTON-CHARITY CARE
COMPARED TO HOSPITAL FINANCIAL STATEMENTS

Hill-Burton Compared to Financial Statement	Number of Hospitals	Percent
Hill-Burton amount equal to charity deductions on financial statement	23	40%
Hill-Burton amount equal to other deductions from revenue on financial statement[a]	11	20
Hill-Burton amount not determinable from financial statement	23	40
	57	100%

[a]Includes bad debts, service discounts, contractual adjustments for third party payors.

Source: Compiled by JLARC from 1976 Financial Statements for hospitals reporting Hill-Burton charity expenditures.

Although hospital financial statements accompany Hill-Burton forms, they are not used by SDH to verify reported Hill-Burton amounts. Department procedures should be revised to include verification of submitted data and random sampling of hospital compliance with eligibility requirements. More aggressive monitoring might result in delivery of additional amounts of care. At the very least, it would result in a more accurate picture of the indigent care effort of private sector hospitals. Reporting requirements could easily be expanded to provide a complete accounting of the total amount of free care (charity and bad debts) and program funded care provided by each hospital. For this purpose, the department should require reporting of indigent care according to standardized definitions.

DISTRIBUTION OF INDIGENT CARE FUNDS

Government programs, teaching hospital appropriations, and private sector free care are the major sources of funds for indigent hospital care. The State, however, has limited ability to target or direct these monies. Distribution is largely dependent upon the ability of the poor to qualify for programs and the location and characteristics of the hospitals from which the poor seek care. As a result, significant disparities have occurred among hospitals across the State. Funds tend to be concentrated in urban areas and in large, high-cost hospitals.

Regional Differences

Indigent care expenditures per poor person vary significantly among the five Health Service Areas (Table 14). The range is

Table 14

INDIGENT CARE EXPENDITURES PER POOR PERSON AMONG HEALTH SERVICE AREAS IN FY 1976

	State	HSA I (Northwest)	HSA II (Northern)	HSA III (Southwest)	HSA IV (Central)	HSA V (Eastern)
Indigent Population	690,615	93,849	50,005	201,027	145,653	200,080
Total Expenditures[a] (in millions)	$116.2	$19.1	$13.5	$19.7	$33.0	$30.9
Per Capita Expenditures	$168	$223	$270	$98	$227	$155

[a]Includes government program, teaching hospital and private sector expenditures. Excludes $1.6 million for vocational rehabilitation programs and $200,000 for visually handicapped programs for which data were not available by hospital.

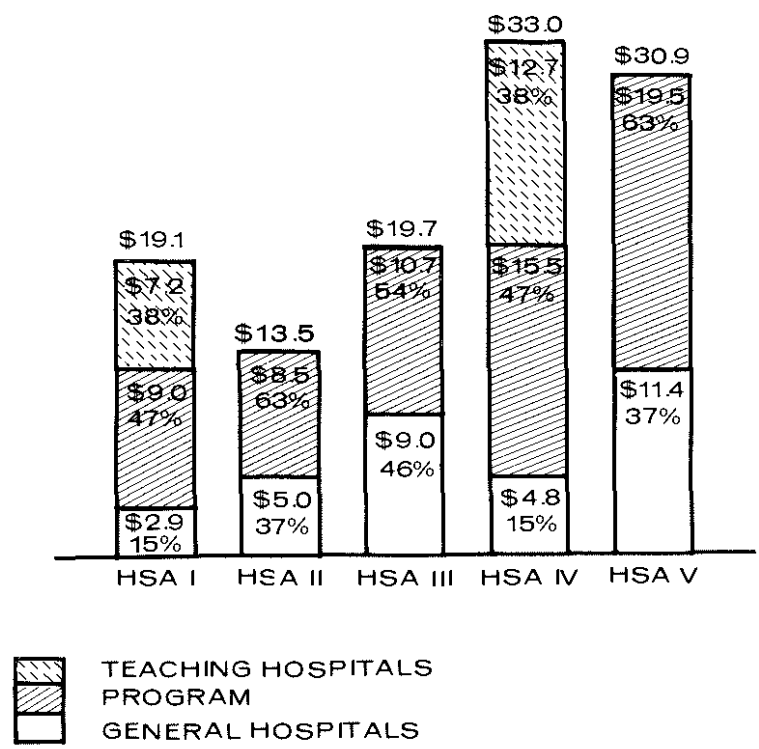
Source: Compiled by JLARC from reported expenditures and 1970 Census.

from a low of $98 in Southwest Virginia (HSA I) to a high of $270 in Northern Virginia (HSA II). Available data are for hospitals, not patients. Therefore, expenditures in one region may, to some extent, reflect services provided to residents of other areas. Nevertheless, differences among regions are striking. Major reasons appear to be the location of the two teaching hospitals and the urban or rural characteristics of the HSA.

Impact of State Teaching Hospitals. The University of Virginia Hospital (UVAH) is located in Northwest Virginia (HSA I) and the Medical College of Virginia Hospital (MCVH) is located in Central Virginia (HSA IV). State appropriations to these hospitals greatly increase the funds available for indigent care and affect the proportionate distribution of the three main sources of funds (Figure 9).

Figure 9

SOURCE OF FUNDS AMONG HEALTH SERVICE AREAS, 1976
(Millions of Dollars)



Source: Compiled by JLARC from reported expenditures.

Indigent care expenditures by teaching hospitals add $7.2 million to total expenditures in HSA I and $12.7 million in HSA IV. Teaching hospitals provide most of the indigent care in their respective HSAs. The portion of total expenditures represented by private sector free care is significantly lower in areas with a State hospital than it is in other areas.

The State will soon have the opportunity to assess the impact of teaching hospital-related appropriations in a new setting. During the 1978-80 biennium the Eastern Virginia Medical Authority will have available $4.5 million in State funds to offset indigent care costs in twenty-one hospitals affiliated with the Eastern Virginia Medical School. Despite the absence of special funds in 1976, total indigent care expenditures in the Eastern Virginia HSA were almost as high as Central Virginia. However, expenditures per poor person were significantly lower in Eastern Virginia due to the larger number of indigents residing in this section of the State.

The provision of State funds to Eastern Virginia may help equalize expenditures per poor person among the five Health Service Areas. It is also possible that private sector hospitals will use the funds to offset care currently being provided as free care. In this case, the hospitals, but not the poor, will benefit. Localities may also decide to limit their participation in the State-Local Hospitalization program. For these reasons, the Secretary of Human Resources should closely monitor the impact of State funds in Eastern Virginia. The results will be useful should it be determined necessary to take other steps to affect the distribution of indigent care funds across the State.

Urban-Rural Differences. As a general rule, urban areas attract more funds because services are more varied and costly, and the urban poor are more likely to qualify for medicaid and the State-Local Hospitalization (SLH) program. Only one-third of the rural poor meet medicaid requirements and the SLH program is only nominally used in rural areas.

The strongest example of the impact of providing indigent care in high cost urban hospitals can be seen in Northern Virginia. Indigent care expenditures per poor are $270, the highest in the State. This is partially attributable to the relatively low number of poor in the HSA. Nevertheless, indigent care expenditures reflect per diem hospital costs in Northern Virginia that are 55% higher than the Statewide average.

To some extent, eligibility and cost differences account for sharp differences in expenditures per poor person between Eastern Virginia (HSA V), which encompasses five inner cities, and rural Southwest Virginia (HSA III). Each of these HSAs has approximately 200,000 persons below the federal poverty level, the highest number in the State. However, program expenditures per poor person are $97 in Eastern Virginia and only half as much ($53) in Southwest Virginia (Table 15). The low level of expenditure in the rural Southwest, while to some extent reflecting lower costs, probably indicates that adequate care is less available.

Distribution By Hospital

Most indigent care is provided in a limited number of hospitals. One quarter of the hospitals with nearly half of the beds in the State are associated with over 70% of all indigent care.

Table 15

PROGRAM EXPENDITURES PER POOR PERSON AMONG
HEALTH SERVICE AREAS - 1976

	State	HSA I (Northwest)	HSA II (Northern)	HSA III (Southwest)	HSA IV (Central)	HSA V (Eastern)
Indigent Population	690,615	93,849	50,006	201,027	145,653	200,080
Program Funds[a] (millions)	$63.2	$9.0	$8.5	$10.7	$15.5	$19.5
Program Funds/ Poor	$92	$96	$170	$53	$106	$97

[a]Exclusive of teaching hospital appropriations and expenditures for vocational rehabilitation and visually handicapped.

Source: Compiled from program reported expenditures and 1970 Census.

The hospitals include the two teaching hospitals, which alone provide 30% of all care, and other hospitals that are generally urban, large and relatively high cost. The average cost per day is $134 compared with the State average cost of $115. Half of the hospitals in the State provide 90% of the care. The remaining 10% is incrementally distributed among about 50 hospitals.

Government funds, exclusive of private sector free care, are similarly concentrated in relatively few hospitals. This can be seen in the distribution of medicaid funds among hospitals. Approximately one-quarter of the hospitals with about half of the beds in the State received over 70% of all medicaid funds in FY 1976 (Table 16). This seems to be inconsistent with the medicaid goal of providing equal access to private sector hospitals for the poor.

About half of all medicaid payments were made to just thirteen hospitals. These hospitals contain less than one-third of the State's hospital beds. Per diem costs averaged $148 per day. Each hospital received over $1 million in medicaid payments. Moreover, these same hospitals received about 82% of payments from all other government programs. The Department of Health should examine the reasons for this pattern since some hospitals may be unwilling to admit patients who are eligible for public assistance.

Concerns about the ability of the State to equitably provide indigent care are raised by indications that funds are unevenly distributed across the State; care is concentrated in high cost hospitals; and, teaching hospital appropriations intensify imbalances. The proposed task force to be assembled by the Secretary of Human Resources should go beyond eligibility and client intake concerns to develop a comprehensive, coordinated policy for the Commonwealth. Data routinely generated by programs should be used

Table 16

CUMULATIVE DISTRIBUTION OF MEDICAID FUNDS

Number of Hospitals	Funds (Millions)	Percent	Number of Beds	Percent
3	$15.4	28%	2,305	11%
6	20.9	38	3,636	17
9	25.6	47	4,709	22
12	29.3	53	5,916	28
15	32.6	59	7,150	34
18	35.2	64	8,385	40
21	37.2	68	9,031	43
24	39.0	71	9,731	46
27	40.6	74	10,150	48
State Total				
109	$54.8	100%	21,193	100%

Source: Compiled by JLARC from medicaid cost reports and Virginia Center for Health Statistics 1976 Survey.

by the task force to assess the individual and collective impact of funding sources, identify problems, and guide the appropriation of State funds.

IMPACT ON PROVIDERS

The primary focus of government concern is the cost of indigent care programs. However, privately operated hospitals are the providers of care. They provide care that is reimbursed by government programs and free care to persons ineligible for programs. Hospital spokesmen, including the Virginia Hospital Association, have expressed considerable dissatisfaction with reimbursement policies that require complex cost reporting, result in differences among rates for each payor, and have a negative effect on hospital finances.

Reimbursement Rate Variations

Hospitals must contend with a complex and varied system of third-party reimbursement. Payment is not uniform among payors because of factors that are included or excluded from reimbursement calculations. Compensation for most patients is computed by third party payors on the basis of "reasonable" cost for providing patient services. Cost based rates differ among payors due to how "reasonable" cost is calculated. Hospitals term the difference between their charges and the reimbursement level for each third party payor as a contractual adjustment.

Table 17 shows variations in the level of reimbursement and contractual adjustments for most payors in an actual 200 bed, nonprofit Virginia hospital. In this hospital charges are about 8% above cost. Contractual adjustments vary from $4 to $24. There is no contractual adjustment shown for commerical or self-pay patients because they are billed charges. However, it should be noted that accounts in the latter category are the ones most likely to become bad debt accounts.

Table 17

RATE VARIATIONS AMONG THIRD PARTY PAYORS FOR INPATIENT CARE IN THE SAME HOSPITAL

Payor	Per Diem Rate	Contractual[a] Adjustment
Charge	$119	$ 0
Commercial & Self-Pay	119	0[b]
Blue Cross	115	4
Medicare	95	24
Medicaid	106	13
Vocational Rehab.	104	15
SLH	101	18
Maternal Child Health & Crippled Children	NA	NA

[a]Difference between charge per day and program reimbursement.

[b]Hospital may incur some bad debts, not referred to as contractual adjustments.

Source: Medicaid Bureau Cost Analysis Forms, 1976.

Most government programs, including medicaid and medicare, pay only for costs that are attributable to eligible patients. They exclude convenience items such as telephones, costs incurred by the hospital for free care to noneligible indigents and any allowance for a surplus or operating margin in nonprofit hospitals. Medicaid cost reports provide the basis for computation of per diem rates paid by the State-Local Hospitalization, Vocational Rehabilitation and Maternal and Child Health programs.

Per diem rates for other indigent care programs tend to be lower than medicaid rates. Medicaid pays an interim per diem rate based on costs during a facility's previous fiscal year. At the end of the year a cost settlement adjusts for additional costs incurred during the current year. Other programs do not have a final settlement procedure. Additionally, the State-Local Hospitalization program uses the same cost base as medicaid but then subtracts depreciation.

Payment rates for the three Blue Cross plans operating in Virginia include more than just "reasonable" cost for plan patients. Blue Cross of Virginia covers two-thirds of the hospitals in the State. At the end of the hospital's fiscal year, this plan calculates reimbursement for Blue Cross patients on an allowable cost basis similar to government programs. However, the plan also allows hospitals a 5% growth and development factor and absorbs a proportion of hospital costs attributable to charity, bad debts and contractual adjustments for medicare and the State-Local Hospitalization program. The latter is called a community service allowance. On a simplified basis, if 30% of the patients in a hospital are covered by Blue Cross of Virginia, the plan will reimburse 30% of these additional costs.

Effect of Indigent Care on Rates

To the extent possible, hospitals shift costs for which they are not directly compensated, such as free care to indigents, to other payors. From the hospital point of view there are three costs associated with indigent care:

- the cost of hospital provided free care;
- contractual adjustments for indigent care programs; and
- the failure of government programs to absorb part of free care costs.

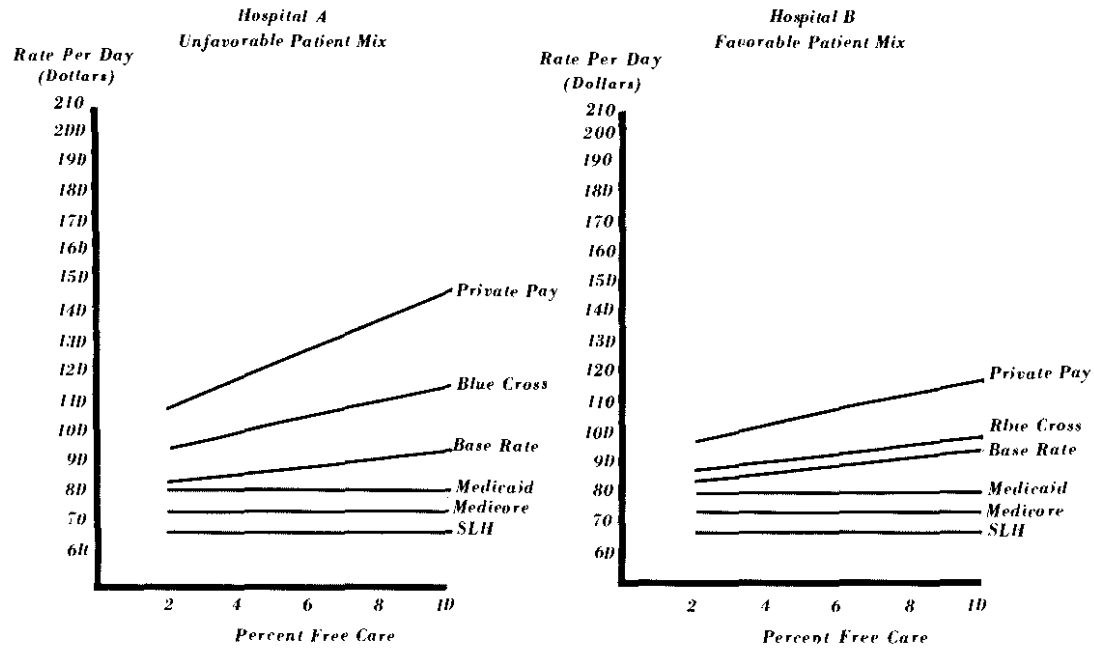
Patient mix and the hospital's occupancy level have a significant impact on the ability to shift costs and the amount of rate increase for other patients.

JLARC staff developed a simplified model to demonstrate the impact of indigent care on rates for various types of patients. The hospital in the model is a 100 bed nonprofit hospital with $3 million in expenditures. It is budgeted to achieve a 3% operating margin. The model is not intended to be predictive of actual rates in a 100 bed hospital, but to demonstrate relationships among payors. These relationships have been validated with data from Virginia hospitals.

Payment levels for each type of payor were determined in accordance with a simplified simulation of the appropriate reimbursement method (See Technical Appendix). Rates were computed for private pay patients, Blue Cross, medicare, medicaid and the State-Local Hospitalization program. In addition a base rate was computed. The base rate is the rate that would be paid if all payors paid the same rate. The American Hospital Association refers to this as the fair share rate. It would be higher than rates now paid by government programs and lower than the Blue Cross or private payor rates.

Figure 10

EFFECT OF FREE CARE ON PAYOR RATES IN HOSPITALS WITH 100% OCCUPANCY



Source: JLARC model.

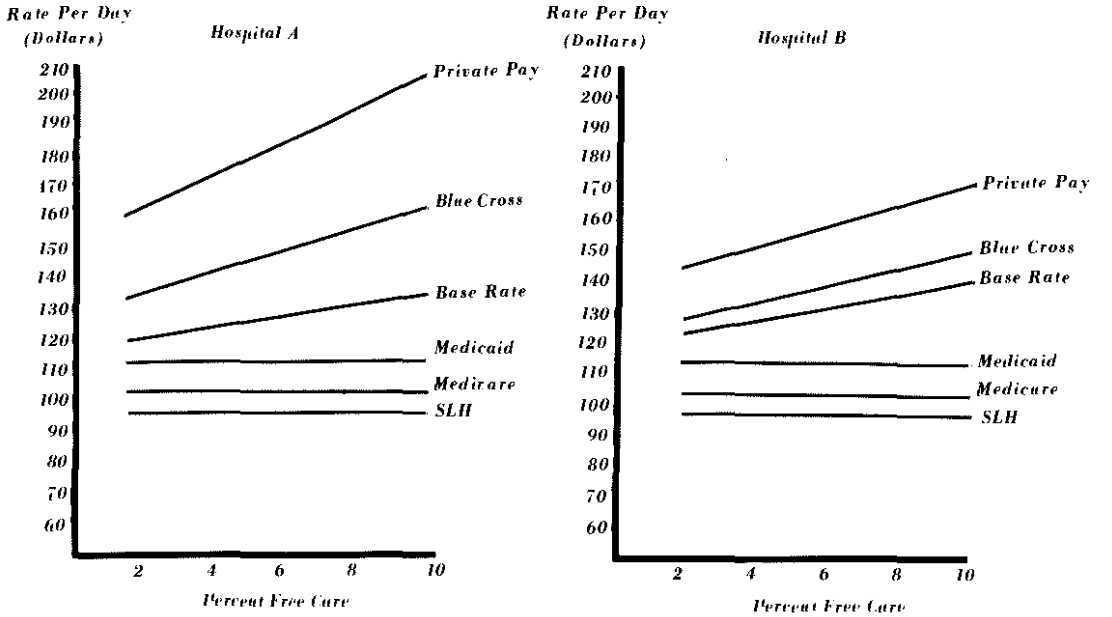
Effect of Patient Mix. Figure 10 shows the effect on payor rates of increasing levels of uncompensated care in two hospitals with different patient mixes. Hospital A has a patient mix usually associated with inner city or less affluent rural areas. The hospital has relatively high proportions of indigent patients receiving government assistance. Hospital B has a more favorable patient mix usually associated with suburban or more affluent urban or rural hospitals. This hospital has higher levels of commercially insured or Blue Cross patients. Occupancy levels in both hospitals have been established at 100% to simplify the comparison and eliminate the effect on rates of occupancy levels.

In both hospitals the charge rates paid by Blue Cross and private payors are increased when levels of free care are increased. This occurs because charge rates are established to recover all hospital costs not reimbursed by other payors and Blue Cross absorbs some portion of indigent care and contractual adjustments. Government rates stay the same because the programs only pay allowable costs for their own patients.

The increase in rates is less pronounced in the hospital with the more favorable patient mix. Charge rates increase $21 (23%) in Hospital A, and $12 (14%) in Hospital B. The cost of free care is distributed among a greater number of nonindigent and nongovernment patients in Hospital B.

Figure 11

EFFECT ON PAYOR RATES INTENSIFIED BY
LOW OCCUPANCY RATE



Source: JLARC model.

Effect of Low Occupancy. In hospitals with lower occupancy levels the cost of indigent care and hospital overhead must be borne by fewer patients. Figure 11 shows the same hospitals when occupancy is at 60% rather than 100%.

The effect of free care on charges and Blue Cross rates is exacerbated by lower occupancy. The private pay increase in each hospital is 40% higher than it had been at full occupancy. Government rates remain stable as uncompensated care increases but are initially higher than at 100% occupancy because allowable costs are shared by fewer patients.

This figure illustrates why it is easier for hospitals with a good patient mix to remain financially viable without enormous rate increases. Obviously a favorable patient mix and a high occupancy rate is the most desirable condition. Generally Virginia hospitals providing the greatest amounts of indigent care appear able to manage the related costs.

Effect of Indigent Care on Hospital Finances

During FY 1976, there is little indication that the provision of indigent care had a significantly negative impact on overall hospital finances in Virginia hospitals. The statistical relationship between hospital surpluses or deficits and the level of indigent

care provided is minimal (see Technical Appendix). Since hospitals do incur costs for indigents, this lack of relationship probably indicates an ability on the part of hospital managers to cope with the intricacies of third-party reimbursement and to budget accordingly.

Based on JLARC staff review of 1976 financial statements for 94 hospitals, the financial condition of most Virginia hospitals appeared to be good. Despite third party contractual adjustments, free care and other deductions, hospitals as a whole, recovered their costs and received 93% of what they charged. Operating margins or surpluses averaged 3% in nonprofit hospitals and 6.7% in proprietary hospitals. This was within the operating margins believed necessary for each type of hospital by the Virginia Hospital Rate Review program: 2 to 3% for nonprofit hospitals and about 8% for proprietary hospitals.

However, a considerable range existed among hospital operating margins (Table 18). Some of the nonprofit hospitals had surprisingly high margins considering their status; 58% had margins in excess of 4%. Over two-fifths of the proprietary hospitals had margins in excess of 8%. Nonetheless, approximately one-quarter of the total number of hospitals experienced operating deficits.

Table 18

OPERATING MARGINS* IN VIRGINIA HOSPITALS

Operating Profit/ Loss Margin %	Proprietary Hospitals Number of Facilities	Proprietary Hospitals % of Total	Nonprofit Hospitals Number of Facilities	Nonprofit Hospitals % of Total
12.1 to 14	3	18.7%	--	--
10.1 to 12	1	6.3	--	--
8.1 to 10	1	6.3	3	3.8%
6.1 to 8	2	12.5	12	15.4
4.1 to 6	1	6.3	16	20.5
2.1 to 4	3	18.7	14	18.0
0.1 to 2	2	12.5	12	15.4
-2.0 to -0	1	6.3	8	10.3
-4.0 to -2.1	1	6.2	3	3.8
-6.0 to -4.1	-	--	4	5.1
-6.1 and less	1	6.2	6	7.7
Totals	16	100.0%	78	100.0%

*Operating Margin = $\frac{\text{Total Operating Surplus or Loss}}{\text{Total Operating Revenue}}$

Source: 1976 Financial Statements for 94 Virginia Hospitals.

There are numerous factors that affect hospital finances including: patient mix, location, age, occupancy, efficiency of management, adequacy of charges and local competition. These factors can have a negative or a positive effect on operating margins. The negative impact is illustrated by the attributes of the deficit hospitals.

Generally, deficit hospitals have more than one condition associated with poor performance. Most are smaller than is generally believed to be economically efficient. Twelve of the 24 deficit hospitals have fewer than 110 beds and all but four have fewer than 200 beds. Nine of the hospitals have less than a 65% occupancy rate (range 24% to 65%).

Two of the hospitals are charitable institutions dedicated to serving indigents regardless of cost. Approximately six additional hospitals deliver substantial amounts of indigent care. Two are in the process of replacing inadequate facilities, and one is a new hospital in the process of developing a clientele.

Charges in the deficit hospitals may not have been appropriately established. In most hospitals charges are established high enough above costs to compensate for bad debts and other losses and to achieve a balance or surplus. Statewide charges average 17% above costs. The difference between costs and charges for all 24 hospitals was below the State average. In four of the hospitals, charges were actually below costs.

The State is concerned with providing care to indigents in existing hospitals. If deficits in 1976 are indications that some or all of these hospitals might ultimately close their doors, possible loss of hospitals may be of concern. However, each case would have to be thoroughly evaluated. One of the charity hospitals is already preparing to convert to another purpose because of limited need for free care since the advent of medicaid. Other hospitals are located in already overbedded areas where services will continue to be available should they close. Existing larger, multiservice hospitals might provide a better and more economical range of services than small hospitals in many areas of the State.

CONCLUSION

Indigent care in Virginia is not delivered in accordance with a coordinated plan or goal. Responsibility for delivery of care is fragmented among various State agencies and the private sector. There is no coordinated attempt to use available data to evaluate program impacts or the availability of care. Striking differences occur among regions in the amount expended for indigent care, and funds are primarily received by a relatively small number of high cost hospitals.

It appears that the Commonwealth requires a more comprehensive and coordinated approach to provision of hospital care to indigents. Such coordination might be accomplished by forming an interagency task force under the auspices of the Secretary of Human Resources. This task force should include the teaching hospitals, because they have a major role in the delivery of indigent care and receive substantial amounts of State funds. The purposes of the task force should include: facilitating client access to care through simplified application and referral procedures; monitoring the individual and collective impacts of public and private sources of care; and, developing administrative and planning linkages among programs.

The appropriate level of private sector indigent care effort should also be considered. There are indications that indigent care costs are absorbed by hospitals or passed on to other patients or insurers in the form of increased rates. Most hospitals appear able to support such care. However, more reliable information on the extent and impact of private sector indigent care costs needs to be developed. As a first step, the State Department of Health should expand Hill-Burton reporting requirements to include all forms of inpatient care for the poor. This information should be verified and made available to the Virginia Health Services Cost Review Commission for use in evaluating hospital rates.

IV. Medicaid Cost Controls

The medicaid program is the most costly and comprehensive indigent care program in Virginia. In FY 1976, medicaid expenditures for hospital care totaled $54.8 million, accounting for approximately half of all indigent care funds. Due to serious expenditure control and fraud and abuse problems nationally, the medicaid program has been subjected to increasingly stringent federal-State regulation.

The State Department of Health administers the medicaid program in accordance with federal regulations. Most regulations are intended to ensure that payments to hospitals are for necessary services and reflect the actual costs of providing care. Generally, reimbursement procedures are reasonably well executed by the department. However, greater attention should be given to monitoring the use of medical services by medicaid patients.

MEDICAID REIMBURSEMENT

The medicaid program reimburses hospitals retrospectively for costs incurred in providing care to eligible recipients. Since most costs are covered, hospitals have little incentive to control costs or promote efficiency. Nevertheless, overall rate setting and cost settlement procedures have a significant impact on encumbrance of medicaid funds and actual reimbursements received by hospitals.

Medicaid Rate Setting

Hospital officials contend that the data used to establish interim reimbursement rates are 18 months old and that interim rates do not keep pace with increases in cost. However, JLARC staff found that interim rates for 1976 accurately reflected facility expenditures for medicaid patients and prevented unnecessary encumbrance of program funds.

Under a retrospective reimbursement system, exact costs and reimbursement cannot be determined until after completion of the hospital's fiscal year. Therefore, the State Department of Health (SDH) calculates interim reimbursement rates for each provider. These are based on actual costs in the previous year plus an inflation factor. Hospitals may request rate adjustments during the year if unusual expenditures occur.

Accurate interim rates are necessary to prevent unnecessary encumbrance of State funds and excessive year-end settlements. If rates are set too low, hospitals may experience financial problems

and the program will have to make large lump sum payments at the end of the year. Rates which are too high unnecessarily encumber State funds and require providers to return excess reimbursement to VMAP (the Virginia Medical Assistance Program or medicaid--VMAP is administered by SDH).

Interim reimbursements to 99 institutions reviewed by JLARC staff totaled $49.9 million. Final reimbursement adjustments to these hospitals after the fiscal year were $4 million, or approximately 7% of the total reimbursement received. Of this amount, $500,000 represented overpayments to hospitals and $4.5 million were underpayments.

Eleven facilities accounted for 76% of the underpayments. Two of the underpaid facilities were the State teaching hospitals, which accounted for $2.5 million. For the majority of the facilities reviewed, final adjustments amounted to less than 10% of total interim reimbursement (Table 19).

Table 19

FINAL REIMBURSEMENT ADJUSTMENTS

Final Adjustment as a Percent of Total Interim Reimbursement[1]	Number of Facilities[2]
0-5%	23 (32%)
6-10	18 (25%)
11-15	15 (21%)
More than 15%	16 (22%)

[1]Based on unaudited cost reports.
[2]Includes 72 hospitals which were underpaid by VMAP.

Source: JLARC medicaid cost report analysis.

Although rates generally reflect actual costs, SDH should closely analyze hospitals with large year-end settlements. Some of these hospitals appear to present unique problems. For example, SDH had difficulty in identifying special revenues that offset charity care in one hospital. Teaching hospital cost reports are often late and incomplete. Nevertheless, interim rates should be adjusted where possible to reflect the financial needs of providers without excessive encumbrance of State funds.

Reimbursement Calculation

A complex method of calculating reimbursement has been established for most hospitals. However, a simpler method used by small hospitals may be less economical for the medicaid program. The basis for determining appropriate levels for medicaid reimbursement is a cost report which each hospital must submit within 90 days of the end of its fiscal year. The cost report contains statistical and financial data to support the hospital's reimbursement claim.

The basic reimbursement calculation involves relating charges to medicaid patients to charges for all patients. On a simplified basis, if 15% of total charges were made for medicaid patients, then 15% of the total allowable costs of operating the hospital would be reimbursed by medicaid:

$$\frac{\text{Total Charges to Medicaid Patients}}{\text{Total Charges to All Patients}} \times \text{Total Cost of Operating Hospital} = \text{Medicaid Reimbursement}$$

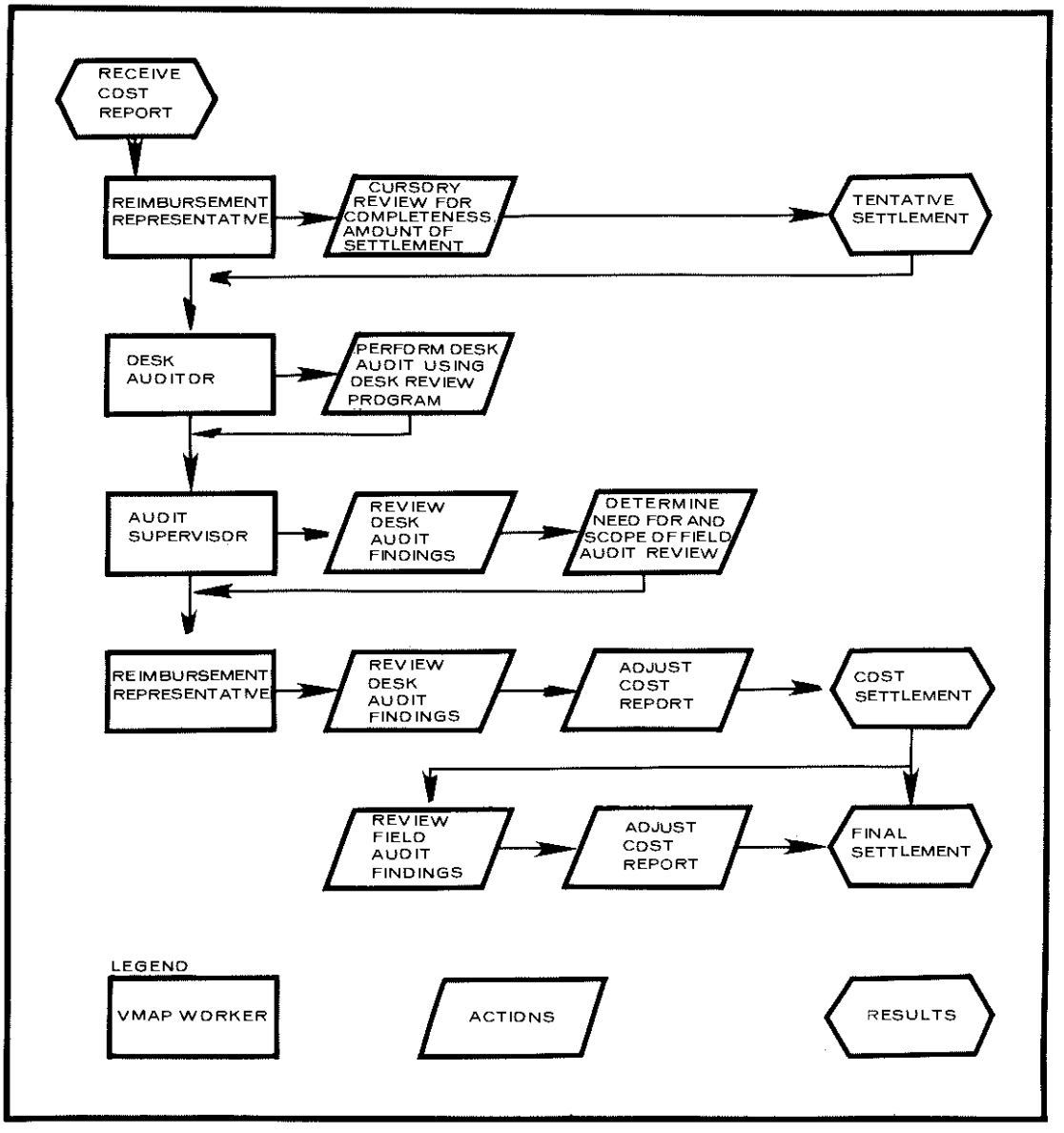
To ensure that the program will not absorb an inappropriate portion of the hospital's total costs, each hospital is required to establish charges that are the same for all patients. As a further control, the program reimburses the lower of cost or charges. Therefore, medicaid does not subsidize hospitals with inappropriately low charges.

Hospitals with over 100 beds must use a departmental method of cost reporting in which cost and reimbursement computations are made separately for each ancillary (e.g., x-ray, laboratory, operating room) department. Small hospitals, however, are allowed to use a simpler, combination method in which all ancillary departments are combined. One study has estimated that the combination method of cost reporting results in as much as 10% higher reimbursement for hospitals than the departmental method due to an averaging effect.[1]

In Virginia, if all 28 hospitals using the combination method during 1976 had been required to use the departmental method, medicaid expenditures may have been reduced by as much as $510,000. (These hospitals were reimbursed $5.1 million.) SDH should consider requiring all hospitals to use the departmental method. First, however, it will be necessary to determine whether net program savings will be sufficient to justify higher reimbursable accounting and clerical costs for hospitals.

Figure 12

VMAP REIMBURSEMENT SETTLEMENT PROCESS



Source: JLARC.

Cost Settlement Process

The performance of the State Department of Health (SDH) in administering the cost settlement process is generally favorable. SDH validates hospital data and determines a final sum for cost settlement. Figure 12 shows the steps in the process from receipt of the medicaid cost report to final settlement. The principal steps are: preliminary review to arrive at a tentative settlement, a detailed desk audit to verify hospital calculations, and a field audit, in some instances.

Preliminary Review. After SDH receives the cost report, a reimbursement representative conducts a preliminary review for completeness and accuracy. A tentative cost settlement is usually made after the preliminary review. In most cases, 80% to 90% of the final adjustment claimed by the provider is paid at this time. If the reimbursement representative uncovers substantial problems during the preliminary review, SDH will reduce the amount of the tentative settlement or make no adjustment until the desk audit is completed.

Out of 30 representative cost reports that were reviewed by JLARC staff, VMAP made 18 tentative settlements averaging 82% of the final adjustment claimed by the provider (Table 20). The tentative settlements averaged $17,742 and ranged from $1,600 to $45,365. Four hospitals did not receive tentative settlements and eight providers owed balances to the medicaid program.

Table 20

MEDICAID TENTATIVE SETTLEMENTS

Amount	Number of Hospitals[1]
Less than $5,000	2
$5,001 to $10,000	5
$10,001 to $20,000	5
$20,001 to $40,000	4
More than $40,000	2

Range: $1,600 to $45,365
Average: $17,742

[1]Based on a sample size of 30.

Source: JLARC Cost Report Analysis.

Since tentative settlements are based on unaudited cost reports, it is possible for the settlement to exceed the total amount due to the provider after desk audit adjustments. In these cases, the provider must return the extra money to medicaid. Of the 16 cost-settled reports, six tentative settlements were too large despite the fact that only partial settlements were made. In one instance, a hospital had to return $14,567 to medicaid.

Since excessive tentative settlements unnecessarily encumber State monies, SDH should reduce tentative settlement to a smaller portion of the amount claimed by the provider.

Desk Audit. After the tentative settlement is made, a thorough desk audit is completed to check and verify the numerous calculations, allocations, and adjustments on the cost reports. The

purpose of the complex cost reporting system is to determine allowable medicaid costs, distribute overhead costs to revenue-producing departments, and to separate costs for inpatients and outpatients.

Desk and field audits often have a significant effect on the amount of reimbursement. Final reimbursement generally differs from the amount claimed by the provider due to errors found and adjustments made in the audit process. Hospitals frequently submit cost reports with numerous arithmetic errors, misallocations of cost, incomplete schedules, and missing and erroneous data. Table 21 shows the types of problems noted by VMAP desk auditors in the 30 cost reports reviewed by JLARC staff. In some cases new reports have to be completed by SDH staff using corrected data.

Table 21

COST REPORTING DEFICIENCIES

Type of Deficiency	Percent of Hospitals[1]
Missing data or forms	70%
Arithmetic errors	67%
Data could not be traced between schedules	47%
Misallocated costs	40%
Cross-referencing errors	20%
Erroneous data reported	17%
Improper adjustments	17%
Other	7%

[1]Based on a sample size of 30.

Source: JLARC Cost Report Analysis.

Desk auditors make adjustments to almost every cost report. JLARC analysis of 16 completed desk audits showed an average of five adjustments per provider ranging from zero to nine per cost report. Even more important than the number of adjustments, however, is the dollar change in reimbursement resulting from the desk audit. Nine out of 16 were adjusted in favor of SDH, five were changed to the benefit of the providers, and reimbursement for two remained unchanged.

Changes in reimbursement resulting from the desk audit were often significant. Table 22 shows the adjustments made to the reports reviewed by JLARC. In one instance, desk audit adjustments reduced medicaid reimbursement by $21,000. In another case, however, SDH found that the hospital was entitled to $32,000 more reimbursement.

Field Audit. Federal medicaid regulations require that on-site audits of providers be conducted regularly to recapture reimbursements made for unallowable costs not identifiable through

Table 22

DESK AUDIT ADJUSTMENTS
TO MEDICAID REIMBURSEMENT

Type of Adjustment	Number of Facilities
Reduction in Provider Reimbursement:	
Less than $1,000	2
$1,001 to $10,000	5
More than $10,000	2
Total savings to VMAP: $61,688 for nine facilities.	
Greater Reimbursement for Provider:	
Less than $1,000	1
$1,001 to $10,000	2
More than $10,000	1
Total extra reimbursement: $37,134 to four facilities.[1]	

[1] One hospital's cost report was adjusted in favor of the provider but was not sufficiently completed prior to the desk audit to determine the actual dollar adjustment.

Source: JLARC.

the desk audit. SDH purchases medicare field audits from Blue Cross, the fiscal intermediary. In 1976, 38 audits were purchased at a total cost of $26,652 or $700 per audit. On the average, each audit resulted in approximately $2,000 to $3,000 in adjustments to medicaid reimbursements.

According to SDH, annual audits of all hospitals would not be worthwhile because of the small amounts of money involved in most cases. Since 1972, audits have been purchased for about one-third of the hospitals each year. In addition, some audits are provided by hospitals (Table 23).

While it may be cost effective to audit a limited number of hospitals each year, a more systematic method of selection should be employed. At present, some hospitals are selected because they have not been audited before; others because of questions raised by the desk audit or because the hospital has a history of reporting unallowable costs. However, for no apparent reason, audits have not been purchased for approximately 13 hospitals.

Table 23

HOSPITAL FIELD AUDITS

Provider Fiscal Year	Number Purchased from Blue Cross	Number Provided by Hospital
1972	7	0
1973	30	7
1974	39	8
1975	35	3
1976[1]	4	1

[1]Since October, 1977, Blue Cross has not provided VMAP with its field audits due to a court injunction. However, FY 1976 audits have been requested for 36 hospitals although all of these were probably not field audited by Blue Cross.

Source: VMAP.

Large medicaid providers are not regularly audited, despite the possibility that adjustments might have a proportionately large impact on program expenditures. Of the 14 hospitals reimbursed more than $1 million by medicaid, only six have been field audited since 1974 (Table 24). Furthermore, eight of the 14 have been audited only once since 1972 (Table 25).

Table 24

MOST RECENT FIELD AUDITS OF THE 14 LARGEST MEDICAID PROVIDERS

Most Recent Field Audit	Number of Providers
FY 1973	3
FY 1974	4
FY 1975	6
Not field audited	1

Source: VMAP, Summary of Field Audits Conducted 1972-1978.

At the time of this review, another problem was presented by the limitations of relying exclusively on the purchased medicare field audit. Most medicare audits are of limited-scope, focusing on particular departments or services. Services heavily used by medicaid patients or problems noted in the medicaid desk audit were

Table 25

NUMBER OF FIELD AUDITS SINCE
1972 OR THE 14 LARGEST MEDICAID PROVIDERS

Number of Field Audits	Number of Providers
0	1
1	8
2	2
3	3

Source: VMAP Summary of Field Audits Conducted 1972-1978.

not always sufficiently covered. During FY 1978, medicaid was unable to obtain any medicare audits due to court action by a number of hospitals to have the audits declared private documents. SDH has recently entered into a contractual arrangement with Blue Cross to conduct medicaid field audits. The department will now have the opportunity to determine the content of the audit.

Timeliness of Cost Settlement

Both JLARC and the Audit Agency of the Department of Health, Education and Welfare (HEW) found the processing of cost settlements to be excessively long. Cost reports for fiscal year 1976 are still in the process of being settled. Of the 30 reports analyzed by JLARC staff, half had not been settled. Those that were settled took an average of 282 days (Table 26).

Table 26

TIME SPENT IN COST SETTLEMENT CYCLE[1]

Number of Days	Cost-Settled Hospitals	Open Cost Reports
Less than 150	2	0
151 to 200	1	0
201 to 300	8	0
301 to 400	2	8
More than 400	3	6
	16	14
Average:	282 days	401 days
Range:	129 to 431 days	322 to 433 days

[1]As of April 14, 1978.

Source: JLARC Cost Report Analysis.

SDH officials attribute time problems to the heavy workload of representatives. In addition, a one-year backlog of desk audits was inherited when SDH took over the desk audit function from Blue Cross in 1972.

Much of the problem appears to be related to delinquent filing of reports by hospitals. JLARC staff and the HEW Audit Agency found that many hospital reports were filed after the 90 day limit. Of the 30 cost reports analyzed by JLARC, 23 were filed an average of 48 days late. Delinquency periods ranged from 5 to 163 days.

HEW found that 93 hospitals, 79% of all Virginia hospitals, filed cost reports after the 90 day limit specified in federal regulations (Table 27). SDH took no action against 13 of the hospitals, threatened to suspend payments to 20 hospitals and granted 60 hospitals extensions. Of the 60 hospitals that were granted extensions, 22 exceeded the time limit, but no further action appears to have been taken.

Table 27

COST REPORT FILING

Submittal of Cost Report	Number of[1] Hospitals	
Timeliness:		
90 days or less (on time)	25	(21%)
91 to 120 days	34	(29%)
More than 120 days	59	(50%)
	118	
VMAP Action on Reports Submitted After 90 Days:		
Granted 30-day extensions	60	(64%)
Suspension of payments threat	20	(22%)
No action	13	(14%)
	93	

[1]Includes State mental institutions.

Source: HEW Audit Agency review of 1976 medicaid cost reports.

SDH does not appear to have a standard policy with regard to delinquent reports. In several cases SDH threatened to suspend medicaid payments to the provider until the cost report was filed. However, other hospitals were late by 90 days and received no suspension notice. In two instances, suspension of payments did not occur, although provider cost reports were not received until after the effective date of the payment suspension.

Although in most instances late filing has no financial impact on program funds, timely cost reporting enhances management planning and helps to prevent processing backlogs from occurring. SDH should make a greater effort to encourage providers to file cost reports on time and to apply sanctions against chronically delinquent hospitals.

Cost reports, which are submitted with incorrect or missing data and forms, cause considerable delay and contribute to a lack of continuity in the desk audit. Missing data that must be requested from the provider can stall cost report processing for two months or more. Hospitals generally have 60 days in which to comply with requests. By then the reimbursement representatives and desk auditors are involved with other hospitals. SDH should take steps to improve the quality of cost reports submitted by hospitals by promoting additional training of hospital personnel.

Hospitals that repeatedly submit delinquent or incomplete reports should be assessed financial penalties. As a first warning, the interim settlement could be reduced. Subsequent abuses could result in a service charge to be deducted from the final settlement. This would be justifiable, since lax hospitals benefit considerably from the thoroughness of SDH analysts who attempt to ensure appropriate levels of reimbursement.

Prospective Reimbursement Alternatives

A prospective reimbursement system has greater potential for limiting medicaid expenditures than the present retrospective system. Such a system can be established for the medicaid program alone by SDH, or for all or several payors (e.g., Blue Cross, private pay) under the auspices of a rate setting entity created by the General Assembly. The key feature of a prospective system is that hospitals cannot, through year-end settlements, recover costs that exceed established rates.

Rates are established prior to the beginning of each hospital's fiscal year. The basis for rate-setting may be through negotiation, budget review, or formula. At the end of the year, the hospital must absorb losses if total costs are higher than reimbursement received. If costs are lower, all or part of surplus payments may be retained.

Establishment of fixed reimbursement rates may serve to promote improved budgeting, planning, and cost control by hospitals. Different management decisions are necessary under a prospective system. Inefficient or expansionary hospitals cannot expect to have all their costs covered by year-end reimbursement adjustments.

Prospective Medicaid System. It would be advisable for SDH to develop a prospective system for medicaid reimbursement of hospitals. Conversion to a prospective system for medicaid was

recommended to SDH in 1973 by a management consultant.[2] To date no action appears to have been taken with regard to hospitals. Nevertheless, during the last session, the General Assembly directed SDH to adopt a prospective reimbursement method for nursing homes (1978 Appropriations Act, Item 407). In addition to cost-containment benefits, a prospective system for hospitals would maintain consistency in reimbursement for inpatient care.

The experiences of other states should be taken into account when developing a prospective method for Virginia. Several states have instituted HEW-approved prospective reimbursement systems (Table 28).

Table 28

STATE PROSPECTIVE REIMBURSEMENT SYSTEMS

State	Administrative Agency	Method of Rate Setting
California[1]	Department of Health	Formula
Colorado	Department of Social Services	Budget Review
Connecticut	Independent Commission	Budget Review
Maryland	Independent Commission	Budget Review
Massachusetts	Independent Commission	Budget Review
New Jersey	Department of Health	Budget Review
New York	Department of Health	Formula
Rhode Island	Budget Office	Negotiation
Washington	Independent Commission	Budget Review
Wisconsin	Independent Commission	Budget Review

[1]The California system is currently enjoined as the result of hospital law suits.

Source: Compiled by JLARC.

Problems have been encountered in developing prospective systems. Valid cost and productivity measures have been difficult to develop and implement. This problem was compounded by the absence of comparable hospital data due to variations in accounting and information systems among hospitals. In addition, medicaid agencies have found numerous rate appeals by hospitals to be time consuming and costly.

The biggest problem, however, appears to have been establishing a ceiling that will contain costs. A ceiling on per diem rates has, at least in one state, resulted in increases in the cost per case due to longer lengths of stay for patients. It appears to be more effective to establish a ceiling on total revenues that may be received by a hospital.

It is also difficult to affect overall hospital costs through changes in the reimbursement method of one payor, particularly medicaid. Reimbursement for medicaid patients accounts for only 7% of total hospital revenues. Therefore, changes in medicaid methods will provide little incentive for commensurate changes in hospital budgeting or cost control. While medicaid expenditures may be reduced, amounts foregone by hospitals from medicaid patients are likely to result in increased charges for other patients.

State Agency Rate Setting. The difficulties inherent in single-payor reimbursement changes have led to establishment of state regulatory agencies. To the extent possible, these agencies attempt to control hospital costs for all payors (e.g., medicaid, Blue Cross, commercially insured) through the mechanisms of rate review or rate setting. Rate review consists of review of hospital budgets or proposed rate increases. Agency recommendations are advisory, but compliance is sought through public disclosure of data and conclusions. Rate setting agencies actually establish mandatory rates for two or more payors.

Virginia has shown strong interest in a broader regulatory approach to cost containment. In 1972, the General Assembly directed the Virginia Hospital Association to establish a voluntary rate review program. The Virginia Hospital Rate Review program became operational in 1975. It functioned for one full year, through the fall of 1976, as a quasi-public agency. Then, due to possible conflict with the federal anti-trust laws, the program was converted to its present status as a private, nonprofit consulting organization for hospitals.

During the 1978 legislative session, the General Assembly passed a mandatory rate review statute authorizing creation of the Virginia Health Services Cost Review Commission. The new commission, functioning as a State agency, will not be subject to anti-trust prohibitions. All hospitals are required to submit their budgets for review.

In 1978, the General Assembly also created a study commission to study the desirability of mandatory rate regulation and the compatability of rate regulation with existing and anticipated federal law. It is unlikely that mandatory federal rate controls will be enacted in the near future. However, Congress is considering several proposals to establish mandatory controls over medicare and medicaid rates and to require voluntary review of hospital rates. The Virginia study commission has initiated a study of Blue Cross rates and premiums, which are currently not regulated by the State, and of the regulatory activities of other states. An interim report will be completed by December, 1978 and a final report by December, 1979.

To date, the overall impact of state regulatory agencies has not been fully evaluated on a national basis. Existing agencies claim to have reduced the rate of increase of hospital costs.

However, no comparative or comprehensive evaluation has been conducted. Most of the programs have been established within the last four years. Methodologies and number and type of payor differ considerably.

Nevertheless, it appears advisable to give serious consideration in Virginia to changes which would establish uniform payment policies and, perhaps, a uniform rate for all payors. Greater control over hospital rates could be achieved. It should be noted, however, that a uniform rate would be lower for payors such as private pay and Blue Cross, but higher for government programs, such as medicaid or the State-Local Hospitalization (SLH) program. These programs do not now reimburse all costs allowed by private payors. For example, both programs exclude bad debt and charity expenditures, and the SLH program excludes depreciation.

UTILIZATION CONTROL

Procedures to control unnecessary use of hospital services can contain medicaid expenditures. Federal medicaid regulations require that states establish utilization control programs to monitor the use of medical services by medicaid recipients. Most recently, Congress has established locally-controlled Professional Standards Review Organizations (PSROs) to ensure proper utilization of services under the medicare and medicaid programs.

JLARC review of medicaid utilization control activities indicates that SDH does not have adequate review procedures. Although PSROs are gradually assuming utilization review responsibilities for medicaid patients, SDH will still have a monitoring role to assure that the PSROs are controlling unnecessary utilization of hospital services. SDH review functions should be modified in order to provide adequate oversight.

SDH Utilization Control

SDH conducts prepayment review and approval of hospital stays longer than 14 days, and post-payment audits of hospital utilization review activities.

Prepayment Review. Hospital stays beyond the 14th day must receive prepayment approval from SDH. This control is required by the State Appropriations Act to protect the medicaid program from expenditures for excessive stays. Approximately 900 cases are reviewed monthly. However, use of the 14 day limit to define extended stays excludes from review stays of shorter duration that, nonetheless, exceed norms for the diagnosis involved. Approximately 86% of all patients stay fewer than 14 days, and claims submitted for their care are not subject to review.

The need for review by diagnosis was demonstrated in a 1975 study by the HEW Audit Agency. HEW used Virginia medicaid data to show considerable variation in the length of stay and the cost of ancillary services (e.g., tests, drugs, x-rays) associated with the same common surgical procedure, such as hernia or gall bladder operations.

Approximately 22% of medicaid patients exceeded norms for one of the eight common diagnoses at an estimated cost of $663,000 for 6,926 possibly excess days. Most hospitals in the State exceeded norms for one or more diagnosis (Table 29). There was a considerable range among hospitals in the cost of ancillary services. For example, the range for a normal delivery was from $105 to $789 (Table 30).

Table 29

HOSPITALS EXCEEDING LENGTH OF STAY NORMS

Number of Diagnoses in Which Hospital Exceeds Norm	Number of Hospitals	Percent of Hospitals
0	10	9%
1	18	16
2	14	13
3	20	18
4	14	13
5	10	9
6	12	11
7	5	5
8	6	6
	109	100%

Source: HEW Audit Agency, compiled from 1978 computer files.

Table 30

VARIATIONS IN ANCILLARY COSTS AMONG VIRGINIA HOSPITALS

	Cost Per Recipient			Cost Per Day		
Diagnosis	High Hospital	Low Hospital	Average	High Hospital	Low Hospital	Average
Hysterectomies	$1,405	$191	$666	$201	$38	$ 73
Tonsils	412	87	243	341	44	108
Normal Delivery	789	105	241	191	37	71
Peptic Ulcers	2,827	47	545	215	10	56
Abortions	743	112	278	308	40	98
Gall Bladder	1,671	65	667	145	7	64
Hernia	1,061	10	297	184	10	60
Hemorrhoids	1,101	51	354	157	12	51

Source: HEW Audit Agency, compiled from medicaid 1976 computer files.

It would be advisable for SDH to develop similar comparative profiles of service delivery and cost patterns in hospitals. A certain amount of deviation can be explained by differences in the patient and service mix among hospitals. Therefore, profiles should be developed to reveal discrepancies among hospitals of similar size and type. Broad discrepancies should prompt further investigation. SDH should develop procedures for review of stays by diagnosis, at least in hospitals in which repeated irregularities occur.

Post-Payment Review. SDH does not conduct timely review of hospital compliance with utilization review requirements. A committee composed of medical staff in each hospital is required to review all medicaid admissions, the anticipated length of stay and reasons for extended stays. It is SDH policy to conduct annual audits of review activities in each hospital by sampling files of medicaid patients. However, 15 hospitals have never been reviewed; 20 were last reviewed two years ago; and 32 were last reviewed over one year ago (Table 31).

Table 31

MOST RECENT UTILIZATION REVIEW AUDIT

Date	Number of Hospitals
Before December 31, 1975	11
January - March 1976	9
April - June 1976	20
July - September 1976	13
October - December 1976	10
January - March 1977	0
April - June 1977	9
July - September 1977	8
October - December 1977	9
Not Audited	15

Source: JLARC Utilization Review Analysis.

Additionally, SDH does not take adequate steps to correct deficiencies noted in post-payment audits. Most recorded deficiencies appear to be minor, but 15 hospitals have been rated unsatisfactory because of multiple problems. In most of these cases, the required six-month follow-up audit was not conducted. In no case were sanctions implemented. Possible sanctions include loss of current medicaid patients, moratorium on further medicaid admissions and suspension of payments.

SDH should put a high priority on developing adequate techniques for monitoring utilization review activities of hospitals. Although Professional Standards Review Organizations will ultimately be responsible for all hospitals, SDH still retains responsibility for a great many. Moreover, similar techniques will be necessary to monitor the effectiveness of PSRO activities.

Professional Standards Review Organizations

In 1972, Congress amended the Social Security Act to create Professional Standards Review Organizations (PSROs) to perform the utilization control functions that are now the responsibility of state medicaid programs. Eventually all review for medicare, medicaid and Title V will be a PSRO responsibility. The legislation defined the role of PSROs as:

- ensuring that all claims to federally-funded medical assistance programs are medically necessary;
- ensuring that health services meet recognized standards of care; and
- ensuring that these services are provided in the most economical manner.[3]

PSROs are independent, federally-funded local entities composed of area physicians. Professional staffs are usually hired with the responsibility for the day-to-day operations of the PSRO. Specific activities include admission reviews, utilization reviews, and medical care evaluation studies.

Five PSROs have been designated in Virginia corresponding to the Health Service Areas (Table 32). Three are currently operational and cover 47 hospitals. All five PSROs were to be operational by July 1978. It is anticipated that all hospitals in Virginia will be under PSRO review by 1980.

Table 32

VIRGINIA PSRO PROFILES

PSRO	Current Status	Effective Date for Reviews	Hospitals Under Review		Percent of Area Physicians in PSRO
			Number	Percent	
Shenandoah	Conditional	1/1/78	15	94%	50%
Northern Virginia	Conditional	8/1/77	12	100	60
Southwest Virginia	Planning	7/1/78	Phase-in by 7/1/80		45
South Central	Planning	7/1/78	Phase-in by 12/31/78		43
Colonial Virginia	Conditional	3/1/77	20	100	65

Source: JLARC telephone survey.

PSROs have three options for conducting review functions. First, the PSRO may choose to conduct all review activities itself. The PSRO hires medical personnel to conduct the on-site reviews. Second, the PSRO may delegate all review responsibilities to hospital utilization review committees. The PSRO monitors the committee to assure compliance with program requirements. The third option is to delegate only some of the review activities, such as admission certification, to the hospitals.

Utilization control under Virginia PSROs will be very similar to the current medicaid utilization control process. Among Virginia PSROs, the predominant method of review is to delegate review responsibilities to the hospital with the PSRO monitoring the providers. Approximately 90% of Virginia hospitals are or will be delegated review responsibilities.

Controversy has developed regarding the separation of responsibility for reimbursement and for utilization review. State medicaid agencies are required to pay for all services approved by the PSRO. However, nationally the PSRO commitment to cost containment has been questioned. A Congressional Budget Office study reported that preliminary evidence showed that reductions in costs have not resulted from PSRO activities. The report said that hospitals and physicians were primarily interested in using the review process to eliminate poor medical practices and improve the quality of care rather than reduce admissions or lengths of stay to control program costs.[4]

HEW has encouraged state medicaid agencies to monitor PSRO activities to ensure that utilization does not increase under the program. SDH has developed a monitoring plan. According to federal legislation, state medicaid agencies may appeal PSRO decisions if they increase program expenditures. SDH should be ready to act if costs should increase due to greater utilization of services or longer stays.

CONCLUSION

On the whole, SDH performance is creditable in review of hospital cost reports and claims for final settlement. Considerable procedural and financial adjustments are made to most cost reports. However, the process could be improved and expedited if selection of hospitals to be field audited was regularized, and hospital use of cost reporting was improved. Moreover, hospitals that regularly submit delinquent or inaccurate reports should be subjected to sanctions, such as reduction in interim settlement or a service charge levied against the final settlement.

SDH has not achieved the full potential of utilization or reimbursement controls. It will be imperative that SDH procedures be adequate to ensure the necessity for medicaid expenditures once the payment and review functions are separated. PSROs will assume

the review function by 1980. SDH should use data regularly stored in medicaid computers to reveal irregularities among hospitals with regard to length of stay by diagnosis and the number and cost of associated ancillary services. Irregularities should be investigated for possible fraud, abuse, erroneous reporting, or inadequate PSRO review activities.

Furthermore, constraints should be placed on the open-ended nature of medicaid reimbursement. The General Assembly has already directed SDH to adopt a prospective reimbursement system for nursing homes. A prospective system based on budget review would also be advisable for hospitals. Negative impacts, such as transfer of costs to non-medicaid patients, could be minimized if linked to broader State regulatory functions of rate review or rate regulation.

V. Accountability for Indigent Care at State Teaching Hospitals

Teaching hospitals represent the largest source of indigent care funded solely with State funds. Expenditures of the Medical College of Virginia Hospital (MCVH) of Virginia Commonwealth University and the University of Virginia Hospital (UVAH) were second only to medicaid in 1977. Nevertheless, appropriations to subsidize indigent care in this setting are not formally recognized as a government program. In contrast to medicaid, the Commonwealth requires limited accountability for the disposition of funds for indigent care purposes at teaching hospitals.

The appropriation appears to serve as a general subsidy for each hospital as well as a source of indigent care funding. In the absence of well-defined eligibility standards or reporting requirements, the hospitals have been free to individually interpret the intended use and required accounting for State funds. JLARC staff found administrative procedures for account processing to be different and unevenly applied at each institution.

Teaching Hospitals and Indigent Care

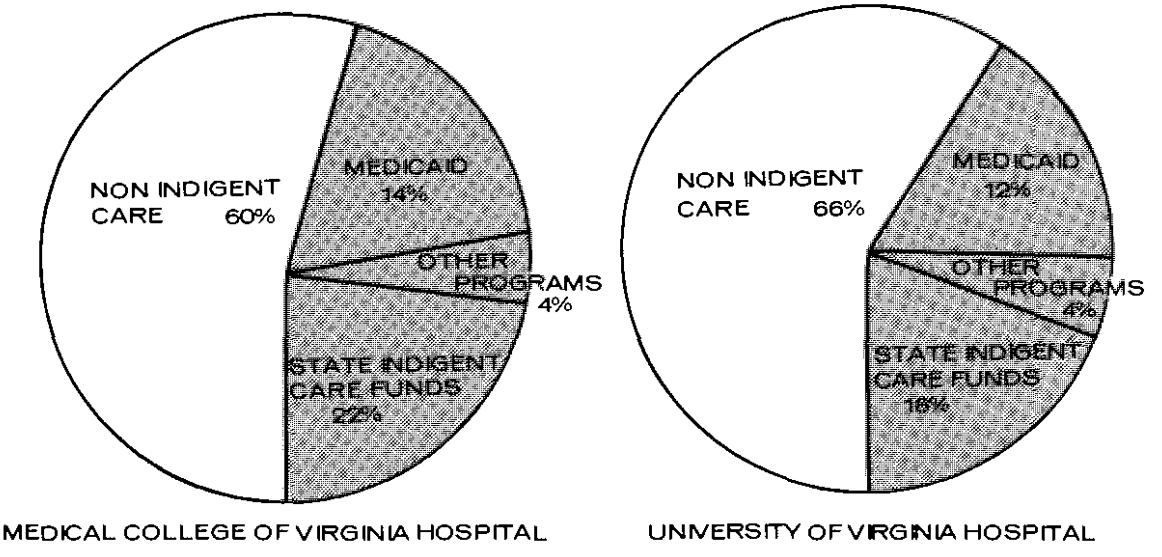
The university hospitals are the only State-owned general hospitals. Although committed to patient care, these hospitals strongly emphasize education of medical professionals and research as well. They are equipped to deliver complex levels of care, known as tertiary care, and to receive referrals of complicated cases from smaller, less specialized hospitals. Services are provided on a Statewide basis, but most patients reside in specific geographic areas easily accessible to the hospital.

Indigent patients are an integral part of the patient population at both teaching hospitals for two reasons. First, both MCVH and UVAH have an "open door" policy, which means medical care will be provided regardless of the patient's ability to pay. Second, indigent patients are used in training students. All patients are considered to be teaching cases. However, patients that do not have a private physician are usually treated by an intern or resident under the supervision of a member of the clinical faculty.

Indigent Care Revenues. In recent years the growth of government-financed health care has made indigent patients a major source of revenue at both MCVH and UVAH. In addition to direct State appropriations for indigent care, teaching hospitals receive a major share of medicaid and other program funds. Patient revenues attributable to indigents comprise approximately 40% of net patient revenues at the Medical College of Virginia Hospital and 34% at the University of Virginia Hospital (Figure 13).

Figure 13

SOURCES OF ESTIMATED NET PATIENT SERVICE REVENUES AT STATE TEACHING HOSPITALS



Source: Revenues reported by State teaching hospitals, FY 1976.

Indigent Accounts. Patient accounts that would be categorized as charity or bad debt write-offs in other hospitals are written off, in effect, against State funds at teaching hospitals. Credit and collections personnel at each hospital identify persons unable to pay and process accounts accordingly. For the 1978-80 biennium, appropriations for patient services, including indigent care, totaled $34.9 million at MCVH and $41.1 million at UVAH.

At each hospital, a sample of patient accounts that had apparently been offset by State funds during FY 1977 was reviewed by JLARC staff. Files were analyzed for compliance with hospital policies, adequacy of data collection, and the reasonableness of procedures. (For detailed sample methodology, see Technical Appendix.)

Two primary indications of accountability were applied at each hospital:

- the ability to document and explain expenditures for indigent care; and
- the ability to relate expenditures for indigent care to State appropriations.

UNIVERSITY OF VIRGINIA HOSPITAL

During FY 1977, the University of Virginia Hospital wrote off an estimated $6.4 million for care of indigent patients--$2.9 million for inpatients and $3.5 million for outpatients. Inpatient accounts were well documented. In contrast, inadequate procedures for outpatient accounts make it impossible to accurately identify amounts appropriately expended for indigent care.

No direct link exists between individual patient accounts and State funds. The hospital regards State appropriations as a general subsidy to cover any expenditures not covered by other sources of revenue. For reporting purposes at the end of the fiscal year, it is assumed that deficit amounts are largely attributable to services provided for indigent patients.

Procedures to Document Expenditures for Indigent Inpatients

Account processing procedures developed by hospital administrators are effectively used to ascertain the ability of the patient to pay, identify third-party payors, and collect amounts due. When it is necessary to write off an uncollectible account, appropriate information is available for the review and approval of hospital managers.

Accounts Processing. Financial counselors are responsible for collection of basic financial data, determination of third-party coverage, and establishment of credit arrangements where applicable. JLARC review of patient accounts indicated that data collected on the UVAH admissions form, such as income, family size, assets, and liabilities, were adequate to determine the financial status of patients. In accordance with the written policy of the hospital, collection of this information was emphasized for patients without sufficient third-party coverage. However, some source of third-party coverage was identified for most patients, and in approximately 75% of the cases payment was received.

Once basic information has been collected, patient account representatives process authorizations for a variety of indigent care programs, and remain responsible for an account until it is either: (1) paid; (2) written off as free service; (3) forwarded for legal action; or (4) sent out for collection to the Attorney General's Office or a private collection agency. Legal actions which may include garnishment of wages or a lien against property are tempered by the University's unwillingness to inflict undue hardship on an individual.

Write-Off Procedures. Patient account representatives make the initial determination to write off bad debt or free service accounts. UVAH clearly distinguishes Free Service from Bad Debt:

> Generally speaking a patient (or those responsible for him) who was deemed able to pay at the time of admission and for whom no request for assistance was made, should be regarded as "Bad Debt" charge-off. Whereas a patient for whom assistance was requested from one or more of the various "indigent care" programs would be a "Free Service" charge-off.[1]

For each account recommended for write-off, a summary sheet placed in the patient's file contains patient identification data, charges, payments and the account balance (amount to be written off). For unusual accounts and for most accounts over $4,000, a short explanation of the write off may be given. For most cases, one of twenty-two possible reasons for the write-off is checked.

Table 33 shows the number of patient accounts and the dollar amounts associated with each type of write-off. A total of $2.8 million was written off. Bad debts account for 86% of the patient accounts, but for less than 22% of dollars written off. This difference occurs because bad debts are often not for the total cost of service provided. Nearly 20% were in the small or under $10 category and other categories, such as medicare deductible, which indicates that substantial payment was made. In contrast charity care constitutes only approximately 14% of total accounts, but 78% of the cost of services because generally no payment is made.

Each month an Accounts Committee, consisting of the Comptroller of UVAH, the Comptroller of the Medical School, and the Director of UVAH reviews accounts recommended for write-off. The Committee may ask for further elaboration on a write-off or they may eliminate an account completely. Revised reports are reviewed by the University of Virginia Board of Visitors at their regular meetings. Final approval by agency managers is required by Section 2.1-127 of the *Code of Virginia*.

JLARC staff's patient file review showed that the files contained all necessary data to document the amount of the write-off. In all but 13% of the files the amount of the write-off could be verified. The actual amount of money that could not be documented totaled only $131 or approximately one-half of 1% of the total dollars sampled. It is apparent that procedures operational at UVAH over a period of years have been used effectively by hospital personnel to document inpatient accounts and explain amounts written off.

Procedures to Document Outpatient Expenditures

A major portion of indigent health care at UVAH is provided in outpatient clinics. However, policies and procedures for the processing of patient accounts are vague and fragmented and

Table 33

INPATIENT WRITE-OFFS, CASES AND DOLLARS,
ACTUAL AND PERCENT OF TOTAL, FY 1976-77

Bad Debts	Cases Actual	Cases % of Total	Dollars Actual	Dollars % of Total
A. $10.00 or less	1,209	26.6%	$ 4,190	0.2%
B. Too Small	320	7.0	9,700	0.3
D. Bankrupt	32	0.7	31,630	1.1
E. Accounts in Judgement	220	4.9	213,550	7.4
G. Deceased	34	0.7	67,910	2.3
H. Medicare Deductible	436	9.6	69,990	2.4
I. Returned by Collection Agency	351	7.7	215,800	7.4
J. Finance Charges	670	14.7	12,740	0.4
L. Compromised Settlement	43	1.0	76,730	2.6
M. Other[1]	23	0.5	13,350	0.5
Total Bad Debts	3,338	73.4%	$ 715,590	24.6%
Free Service				
N. Insufficient SLH Funds	108	2.4%	$ 253,180	8.7%
O. SLH Funds Exhausted	147	3.2	235,660	8.1
P. No SLH Contract	174	3.8	278,070	9.6
Q. Medicaid Ineligible	101	2.2	207,140	7.1
R. No One Applied	90	2.0	87,980	3.0
S. Medically Indigent - Other	184	4.1	356,880	12.3
T. Teaching Case	50	1.1	121,040	4.2
V. House Staff and/or Dependents	33	0.7	11,030	0.4
W. Medicaid Non-covered Days	304	6.7	541,040	18.6
Z. Other[2]	19	0.4	99,270	3.4
Total Free Service	1,210	26.6%	$2,191,290	75.4%
Total Inpatient Write-Offs	4,548	100.0%	$2,906,880	100.0%

[1]Includes "whereabouts unknown", "attorney drops", "contested charges", and "other".
[2]Includes "prolonged illness", "indigent patients at Blue Ridge" and "other".

Source: UVAH Accounts Committee Reports, FY 1976-77.

documentation to support write offs is incomplete. In addition, the hospital does not comply with medicaid and medicare reimbursement requirements.

Account Processing. The amount of payment required from the patient is based on ability to pay, not the cost of treatment. The total cost, which hospital administrators estimate at $82 for an average clinic visit, appears to be high. It is attributed to expensive equipment and the high volume tests required in a teaching setting.

Financial screening of patients is based on criteria such as income and family size. Patients able to pay professional fees are given the opportunity for treatment in the Private Clinic Division of the Medical School. Those determined to be indigent receive care in the Outpatient Department (OPD) indigent care clinics. Medicaid patients are eligible for the private clinic. However, according to hospital personnel, medicaid patients often choose treatment in the OPD clinic. A major portion of OPD revenue is derived from medicaid reimbursements.

Screening is informal. There is no written sliding scale, and the fee is assigned on the basis of the financial interviewer's individual judgement. A written schedule has been proposed but has not been adopted. Moreover, the assigned fee only covers the cost of routine care. Ancillary services, such as x-rays, drugs, and therapy are billed separately at rates that are apparently not based on a sliding scale.

UVAH should establish a written sliding scale to be uniformly applied. The fee should be all inclusive and not subject indigent patients to additional billings. Moreover, the right of medicaid patients to treatment in the private clinic should be carefully safeguarded by UVAH and the State Department of Health.

Lack of a uniform billing system also results in incomplete accounting for OPD transactions. A manual, card file billing system is used for the basic clinic fee. Only cash collections are recorded and the hospital has no way of determining how much of the assessed fee was collected. Some services are billed through a computerized combined outpatient billing system, which also handles billing for the emergency room, renal dialyses and x-ray departments. Since UVAH has already developed a combined system for some outpatient departments, it appears feasible and advisable to completely integrate OPD billing into this system.

Collection efforts appear to be minimal in the outpatient setting. Patients who cannot pay at the time of treatment are given bills when they leave the clinic. A follow-up bill is sent after one month. A bill is sent to the patient for any unpaid balance. For accounts under $10 no further billing or collection effort is pursued. Monthly bills are sent for larger accounts. Twice a year these larger accounts are reviewed by OPD staff.

Those determined to be uncollectible are sent to the Account Committee to be written off.

Write-Off Procedures. It is difficult to ascertain the dollar amount of outpatient accounts that are accurately and appropriately written off against general funds. The hospital apparently considers the cost to the State for outpatient indigent care to be equal to the total operating loss for the entire outpatient department (cost less collections) plus free service and bad debt write-offs for services processed through the combined outpatient billing system.

For 1977, JLARC staff estimates the amount spent for outpatient care at $3.5 million (Table 34). This estimate may be under or over State actual indigent care expenditures, and provides only a limited accounting of amounts attributable to State funds. Current financial reports prepared by UVAH do not separate indigent and nonindigent care provided by the outpatient department. Moreover, account documents do not indicate how much of the assessed fee is paid by the patient nor reconcile manual and computer bills.

Table 34

ESTIMATE OF OUTPATIENT
INDIGENT CARE, FY 1976-77

Combined Outpatient Billing	
-Free Service Write-Offs	$ 44,443
-Bad Debt Write-Offs	118,866
Outpatient Department Loss	$3,383,458
Total Outpatient Indigent Care	$3,546,767

Source: UVAH Accounts Committee Reports and Operating Report, FY 1976-77.

A major problem is the lack of a standard against which to measure outpatient write-offs. For inpatient write-offs the charge for a given service is the same for all patients. Therefore, the charge is the standard against which indigent accounts are written off. However, UVAH has not established a system of charges for outpatient services.

It is understandable that indigent patients could not be expected to pay the full hospital charge. Nevertheless, a charge structure in the health care field is more an accounting than a pricing mechanism. It is used for financial reporting and/or allocation of costs among payors, including medicaid.

Medicaid Reimbursement. The absence of a charge structure has made it impossible for UVAH to comply with medicaid regulations regarding reimbursement practices. A temporary waiver has been obtained. Medicaid regulations require that the relationship between charges to medicaid patients and charges to all patients be used to apportion and identify the portion of hospital costs attributable to medicaid patients. This method is also used by other third-party payors such as medicare and Blue Cross.

In general terms, reimbursement calculations take the following form:

Step 1 $\frac{\text{Charges to Medicaid Recipients}}{\text{Charges to All Recipients}}$ = Percent of Charges Attributable to Medicaid

Step 2 (Percent of Charges Attributable to Medicaid) X (Total Outpatient Costs) = Outpatient Costs Attributable to Medicaid

Since UVAH does not have formal charges for its outpatient clinics, it is impossible to perform the first step. Instead, UVAH calculates the medicaid portion of its outpatient services by taking the average cost per unit of service (i.e., visits) in the outpatient department and multiplying that figure by the number of outpatient visits for medicaid patients. This approach does provide an estimate of expenses attributable to medicaid. However, it is based on the assumption that the cost of care received by every patient is the same.

There is no immediate way to verify this assumption or to determine if the service given medicaid patients differs in volume, type, or cost from that provided nonmedicaid outpatients. Additional data are needed to ascertain the amount of money affected by this departure from medicaid reimbursement procedures. However, there are possible financial implications. For example, if the cost of services to a nonmedicaid patient recipient exceeds the cost of services to a medicaid patient, the medicaid program could be subsidizing the care of other patients.

UVAH administrators are aware of the need for a charge structure in outpatient indigent clinics. Medicaid officials indicate that the hospital will have to comply with reimbursement regulations within a two year period. Hospital administrators anticipate development and utilization of charges for all clinic care by 1980. The hospital already uses charges for other outpatient units such as the emergency room.

UVAH could work to establish an appropriate charge structure for the outpatient department in conjunction with the Auditor of Public Accounts. A joint effort is already underway to establish an accrual accounting system for the hospital in place of the present cash-based system. If, in addition, the system were

designed to separate the cost of indigent care from other costs, a better basis for funding decisions by the State budget office and the General Assembly would be provided.

Relating Expenditures to General Funds

For both inpatients and outpatients there is no way of tracing individual patient accounts for indigent care to the State appropriation. The appropriation is not set aside in a fund against which accounts may be written off. At the end of the year, the hospital retroactively assigns this use to State funds on the assumption that no other source of funds was available to cover charity care or bad debt losses. However, the monies could actually have been expended for salaries, supplies, or any other purposes associated with operation of the hospital.

UVAH budgets and accounts for funds in this general way because State budget policies permit comingling of general and special funds. The reason generally given for permitting the comingling of funds is that certain activities, such as hospital services delivery, may not lend themselves to allocating costs for a variety of tasks to specific "earmarked" funds. The appropriation, therefore, serves as a general subsidy or operating fund.

However, the hospital claims to use almost all of the State funds for indigent care. In most other instances where the State provides funds for indigent care, amounts expended are related to specific patient accounts. This provides an audit trail and the basis for control on the part of the State and accountability on the part of the recipient. At the present time, UVAH can account for expenditures on an aggregate level and relate them to revenues after the fact. However, this is of little practical value in determining the use of and need for future appropriations.

The State could establish more direct accountability for indigent care appropriations in two key ways. First, the major portion of the appropriation could be earmarked for indigent care with specific eligibility and reporting requirements to be carried out by the hospital. Second, the State could appropriate funds to the Department of Health or another agency with the responsibility for administering indigent care funds as third-party payor. The hospital would bill this agency for care rendered to indigent patients.

MEDICAL COLLEGE OF VIRGINIA HOSPITAL

Administrative procedures at the Medical College of Virginia Hospital (MCVH) were also reviewed for FY 1977 to determine the ability of the hospital to document expenditures for indigent care and relate expenditures to State revenues. It was found that

for the fiscal year reviewed, MCVH had poorly administered patient accounting procedures which could not adequately justify indigent care charged to the State. During the course of the review, the hospital administration initiated a series of organizational and procedural changes. These changes may serve to somewhat improve account processing, but careful monitoring will be necessary and further changes may be warranted.

During the year reviewed, it was possible for MCVH to relate its claimed indigent care to specific State revenues. MCVH billed the Department of Health for services rendered to indigent patients. For the 1974 and 1976 biennia, indigent care appropriations for MCVH were in the form of a line item Health Services Fund appropriation to the Department of Health. The Department was to act as a fiscal intermediary.

The Health Services Fund (HSF) had not been established for purposes of indigent care. It was terminated in 1978, when it was not needed to facilitate the issuing of bonds to finance hospital construction. Appropriations are now made directly to the hospital as they had been prior to 1974. Nevertheless, the existence of the HSF during the year reviewed shows the strengths and weakness of account processing under an alternate appropriations and reimbursement mechanism to that traditionally used in Virginia for the teaching hospitals.

Procedures to Document Expenditures for Indigent Inpatients

During the four years that the Health Services Fund was in existence, the State Department of Health placed a limited interpretation on its role as fiscal intermediary. The department's position was stated in an internal memorandum:

> We should not get involved in the internal collection system and procedures used by MCV in collecting patient accounts. This is a MCV responsibility and, once they have certified the bill to this agency for payment, we can assume that they have utilized proper collection procedures on each patient account.[2]

Therefore, actual administration and oversight of the Health Service Fund was left to the hospital.

Account Processing. JLARC staff was not able to identify a written procedures manual, an integrated organization chart, or a flow chart for the processing of patient accounts. From a series of uncoordinated charts supplied by MCVH, it appeared that following admission it would be possible for an account to fall through the cracks of a confusing network of ill-defined and overlapping responsibilities. Generally, the phases of account processing seemed intended to include: a financial interview, referral for

financial assistance, billing, arrangement of a payment plan, or ultimate charge-off.

The admission form in use at the time of this review requested only minimal data relating to monthly income of the patient or guarantor and the number of dependents. No information was acquired on household income, assets or liabilities, which would more accurately indicate financial status. Moreover, according to MCVH personnel even this limited data was frequently inaccurately recorded or incomplete.

Although accuracy could not be checked, 37% of the accounts sampled by JLARC lacked all basic elements of financial data.* Generalizing to all accounts charged-off, this indicates that at least 3,000 cases and from $1 million to $3 million was charged to the Health Services Fund with no recorded financial data to support the decision.

MCVH is attempting to improve the quality of financial data collection by introducing a new admission form that will require additional information. Use of this form began in May, 1978. However, even the most comprehensive form will not be effective if data are not accurately and completely recorded.

Post admission follow-up of patient accounts appears to have been the responsibility of financial interviewers or patient resource counselors. Apparently a patient account might be processed by one, both or neither. Financial interviewers seemed to be responsible for data verification, credit arrangements, and identification of possible sources of medical assistance. The interviewer did not, however, assist patients in applying to programs. Patient resources personnel were apparently responsible for making program contacts for patients in some cases and for conducting financial interviews of patients not previously seen by a financial interviewer.

It is apparent, however, that some patients, whose accounts were written off against State funds, were not interviewed beyond admission. Routinely not seen by financial interviewers were patients admitted through the emergency room and those whose paperwork was done prior to actual admission. JLARC staff review of patient accounts charged to the Health Service Fund revealed that over 42% of the patients had not met with an interviewer. This is more than just a technical problem. Patients who did receive interviews were more likely to have made installment payment arrangements.

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*Five data elements considered essential are: total monthly income, number of persons employed, number of persons in household, number of children under 18, and number of children 18 and over.

MCVH administration has recognized the complexity of the accounts process. Some positions have been eliminated and organizational relationships have been simplified. It is hoped that this will result in more efficient processing of accounts. However, it is difficult to determine the effectiveness of these arrangements at this time. Adequate numbers of sufficiently trained personnel working with well-defined management information will be needed to process the large volume of accounts at MCVH.

Write-Off Procedures. MCVH classified all accounts written off against the Health Services Fund as deleted bad debts. Charity cases were not separately identified. In FY 1977 deleted bad debts totaled $11.8 million, approximately $1 million monthly (Table 35). However, MCVH patient files were not sufficient to verify amounts written off.

Table 35

WRITE-OFFS AGAINST THE
HEALTH SERVICES FUND - FY 1977

	Number of Accounts	Dollars Charged
July	3,329	$ 558,099.13
August	7,125	841,845.30
September	5,028	824,291.36
October	8,332	1,210,152.92
November	7,032	956,712.26
December	6,048	639,287.55
January	5,616	568,907.52
February	9,068	1,929,743.82
March	7,907	1,436,626.33
April	3,518	331,521.33
May	6,534	1,137,687.70
June	5,233	1,385,489.52
Total	74,770	$11,820,364.74

Source: Medical College of Virginia, "Deleted Bad Debt Report", Microfiche, FY 1976-77.

During most of the period under review, the MCVH Current Accounts Unit was primarily responsible for determining whether accounts were to be immediately determined uncollectible and charged against the Health Services Fund or subjected to further internal or external collection efforts. There were no guidelines as to what constituted an uncollectible account. Moreover, incomplete or inaccurate data collected earlier in the process were often inadequate for decision making. Thorough review of individual accounts was further complicated by the large volume of accounts, approximately 100,000 per month.

The inadequacies of this system were apparent in the patient file review. In 41% of the cases the amount of the write-off could not be verified on the basis of bills, statements, payment receipts, and other records contained in the files. Generalizing to total charges to the fund, from $1.5 million to $3.3 million were not accounted for.

In all but one case the HSF appeared to have been charged too little. Apparently, computerized transactions such as late bills or final payments may not have been entered in the file. However, the computerized and manual files were not easily reconciled. Hospital administrators agreed that manual files should be complete. An up-to-date summary form is now being required for each patient file.

Recent administrative changes at MCVH have relieved the Current Accounts Unit of some of its responsibilities. The unit no longer has complete authority to determine the collectibility of accounts or to make final decisions concerning write offs. MCVH now conforms to procedures established in 1977 by the Secretary of Administration and Finance that require all accounts to be sent for collection by private agencies or the Office of the Attorney General.

Allowing only the Current Accounts Unit to decide on accounts to be written off was also not in compliance with Section 2.1-127 of the *Code of Virginia*. This section requires the Attorney General or his assistant to settle accounts with the approval of the head of the agency and the approval of the Governor when amounts over $1,000 are involved. MCVH had no provision for internal review by the agency head or the Attorney General. Recently, procedural changes were made to comply with Section 2.1-127. These changes include requiring an Accounts Committee composed of hospital and university administrators to review accounts recommended for charge-off.

Review by the Accounts Committee would be facilitated if a brief reason for each write-off were provided. Less than one-quarter of the cases sampled by JLARC staff contained a specific written comment explaining the write-off. There did seem to be some effort to explain larger amounts. However, about 7,000 cases and between $2 million and $4 million were charged to the State without a formal explanation. MCVH administrators have indicated that they also plan to address this problem. Consideration should be given to using a patient account summary form similar to that used at the University of Virginia Hospital.

Account processing and write-off procedures at MCVH have been deficient. Administrators are to be commended for their awareness of problems and willingness to implement improvements. However, it is difficult at this time to assess the impact of planned changes. More comprehensive data collection and a simplified process with clearly defined reporting responsibilities are needed. Some changes appear to be moving in this direction. Nevertheless,

large amounts of State indigent care funds will be subject to procedures that have not yet been proven effective. It appears that it might be in the best interests of the State and of MCVH to establish a formal procedure for outside monitoring of efforts to improve account processing.

Procedures to Document Outpatient Expenditures

Approximately $3.2 million was charged to the HSF for outpatient care provided at the A. D. Williams Memorial Clinic during FY 1977. JLARC did not draw a separate sample of outpatient accounts. However, A. D. Williams accounts are handled by MCVH's Patient Accounting Department in the same manner as inpatient accounts. MCVH officials concede that data on outpatients is of inferior quality and less detailed than that collected for inpatients. An additional problem is posed by standards for determination of indigence which are far more liberal than guidelines established for outpatient care at local departments of health.

Data inadequacies are attributed by MCVH to a less detailed admission form and the short duration of patient stays in outpatient units. Nevertheless, inadequate data pose obstacles to ensuring proper indigency determinations and adequate bill collection efforts. More comprehensive information should be requested and follow-up verification procedures implemented.

Despite data limitations, MCVH does establish patient fees based on a sliding scale according to income. The scale, however, is significantly higher than that established by the State Department of Health for treatment in local health department clinics. Table 36 compares the lower end of both schedules (i.e., the income level which a patient may not exceed and receive free care). The MCVH standards consistently exceed Department of Health guidelines by more than 40%.

Table 36

COMPARISON BETWEEN FREE SERVICE INCOME LEVELS AT MCVH AND SDH GUIDELINES

Number of Dependents	Monthly Net Income		% MCVH Exceeds State Guidelines
	State Guidelines	MCVH Scale	
1	$178	$325	45%
2	256	433	41
3	321	542	41
4	383	650	41

Source: MCVH and SDH Administrative Procedures Manual for Local Health Services.

Hospital officials contend that the cost of living is higher in urban areas, such as Richmond, and that the cost of rendering care is higher at a teaching hospital than in other health care facilities. Nevertheless, the City of Richmond uses health department standards to determine eligibility for City-financed care provided at A. D. Williams night clinics. The City had concluded that MCVH standards were overly high.

MCVH is apparently considering sliding scale revisions in accordance with State Health Department eligibility standards. It appears that uniform eligibility standards might be desirable for all State supported care of a similar nature. Although there are differences among programs, greater uniformity would clarify eligibility for applicants at various facilities.

Relating Expenditures to Indigent Funds

During the two biennia in which the Health Services Fund existed, $55.6 million was expended for the care of indigent and medically indigent inpatients and outpatients (Table 37).

Table 37

APPROPRIATIONS TO HEALTH SERVICES FUND
FOR INDIGENT CARE AT MCVH
1974-76 and 1976-78 Biennia

1974-75	1975-76	1976-77	1977-78
$12,305,435	$12,783,160	$15,047,690	$15,506,760

Source: Acts of Assembly 1974, Ch. 681, Item 380 and
Acts of Assembly 1976, Ch. 779, Item 681.

This is the only four-year period for which it is possible to trace the accounts for specific indigent patients to State funds.

The HSF also presented the opportunity for external third party control of the funds. Technically the State may not have been a third party payor. However, practically that was the nature of the State's role since the Department of Health paid a health care provider for services rendered to a patient. Nevertheless, neither the hospital nor the State Department of Health interpreted the arrangement as more than a fiscal convenience.

Administration of the fund was to be in accordance with rules and regulations to be prescribed by the Governor. However, established reporting requirements were imprecise. Information specifically required included the name of the patient, account number, amount of debt, and date of service or admission.

MCVH provided the required information to the health department on microfiche. However, such data is not sufficient to verify the appropriateness of a particular charge against the HSF, ascertain the existence of other third-party payors, or certify the indigency of patients. The Health Department was aware of these short comings. Early in 1977 an internal memorandum documented the problem:

- The presentation of accounts...from MCV makes it almost impossible to derive the figures which MCVH has claimed on the monthly charge-off summary.

- This and the lack of internal control on the part of the Health Department prevents our control over the use and possible abuse of this charge-off fund.[2]

It is a debatable point whether the Department of Health should have exercised additional control over the HSF. SDH was not provided with additional administrative resources to carry out this function. Moreover, at the time the HSF was established, its purpose was to fulfill bonding requirements, rather than to establish additional control over indigent care funds.

The apparent ineffectiveness of administrative controls over the HSF should not preclude awareness of the potential that existed. The State could require explicit accounting for sizeable indigent care expenditures at MCVH under a similar procedure in the future. However, review responsibilities of the fiscal agent should require verification of data and establishment of adequate reimbursement procedures.

CONCLUSION

Direct State appropriations used for indigent care at the teaching hospitals of Virginia Commonwealth University and the University of Virginia account for an amount of State dollars nearly equal to general fund expenditures for medicaid. Monthly expenditures at MCVH alone are almost as high as total annual expenditures for several categorical programs. However, for the 1978-80 biennium, State appropriations to teaching hospitals will be in a form that precludes specific accountability for indigent care expenditures. Yet, these appropriations could be regarded as constituting the largest single program for indigent care that is totally under State control.

It is clear that the manner in which funds are appropriated defines the State's role and affects reporting requirements for State funds. General appropriations for purposes to include indigent care permit the hospitals to comingle revenues and make after-the-fact allocations for the use of State funds. This method of

appropriation has apparently resulted in provision of large amounts of care. However, there has been limited accountability for State funds and a lack of uniformity with regard to standards for determination of indigency.

JLARC's staff review has encountered administrative problems in processing of accounts and reporting of State expenditures at both teaching hospitals. At MCVH inadequate accounting and record keeping made it nearly impossible to document and explain how appropriations were used and indigency determined. For outpatient clinics, in particular, financial criteria for free care far exceed standard guidelines for care in Department of Health clinics. At UVAH inpatient accounting and record keeping procedures are well defined. However, outpatient procedures are clearly inadequate to document expenditures, establish patient fees, and allocate costs among payors, including medicaid and general fund appropriations.

During the course of this review, MCVH has begun instituting new procedures and UVAH has indicated steps will be taken in the outpatient clinics. Nevertheless, large amounts of State dollars are still being administered in accordance with unproven procedures. It appears that it would be in the best interests of the State to monitor proposed improvements and to establish regular and clearly defined auditing of general fund expenditures for indigent care.

The State should consider exerting a greater degree of control over indigent care expenditures by establishing teaching hospital appropriations as a recognized program for indigent care. Each hospital would be required to directly relate State funds to indigent expenditures and comply with State guidelines for determination of indigency. These objectives could be accomplished through establishment of a third-party mechanism similar to the Health Service Fund, but with adequate oversight provisions. A more limited method would require earmarking State funds for indigent care and requiring hospitals to develop and maintain records that would account for the use of the funds for this specific purpose.

VI. State-Local Hospitalization Program

The State-Local Hospitalization (SLH) program provides hospital care to the poor. Established in 1946, the program was once the primary source of funds for indigent hospital care. Since introduction of medicaid in 1969, it has become a program of last resort for the many low income persons excluded from medicaid coverage.

The SLH program may have the potential for supplementing other hospital care programs and equalizing access of indigents to medical care across the State. As presently funded and administered, SLH has limited impact. As a local option program, SLH is underutilized by many localities and subject to differing interpretations concerning eligibility and coverage.

ADMINISTRATION

SLH is primarily a locally controlled program. The State's role is limited to general supervision, establishment of guidelines, and distribution of funds to participating cities and counties. Since 1968, biennial appropriations for SLH have totaled approximately $35 million. Because all localities do not participate in the program, a portion of the biennial appropriation is usually returned to the State Treasury.

Program Appropriations and Costs

The SLH program is financed entirely by State and local funds. The General Assembly controls the total amount of State expenditure through the appropriations process. Prior to the 1976-78 biennium, appropriations for SLH were sum sufficient, but now they are fixed amounts. A procedure has been established in legislation for allocating funds to localities on the basis of population. However, the actual level of expenditure is determined by localities which may choose to match all, part, or none of the allocated State funds. Localities match State funds on a 50-50 basis.

Fund Reversions. Not all funds appropriated for the SLH program have been claimed by localities. In fact in some years, funds were used to subsidize Department of Welfare programs. During the 1970-72 biennium, approximately $2 million in SLH funds were transferred to other welfare programs. Now that appropriations are fixed, funds cannot be used for other purposes.

The Department of Welfare allocates funds to each locality in the State on the basis of population. Allocations are made for each six-month period in the biennium. Therefore, each locality has a predetermined amount which can be claimed when matching local funds are encumbered for patient care. Amounts unencumbered by localities revert to the reserve fund at the end of each six-month period.

Reserve funds may be claimed by localities that wish to match more than their original allotment. If the reserve were insufficient to match all claims, the fund would be prorated. However, this has not been necessary in recent years. Funds remaining in the reserve at the end of the biennium have reverted to the State Treasury. For the last three biennia, reversions totaled $1.5 million, but the percent of funds unexpended has been declining steadily (Table 38).

Table 38

UNEXPENDED SLH FUNDS
1970-1976
(Millions of Dollars)

			Total Unexpended		
	Appropriation	Expenditures	Net Transfers	Reversions	Percent Unexpended
1970-72	$6.3	$3.8	$2.0	$.5	40%
1972-74	4.7	3.8	.5	.5	20%
1974-76	5.5	4.9	.02	.5	10%

Source: Department of Welfare, Bureau of Fiscal Management, April, 1978.

Increasing Per Diem Cost. Although more SLH funds are being used by localities, fewer days of care are being purchased (Figures 14 and 15). This is due primarily to increases in hospital costs that have reduced the purchasing power of a fairly constant level of appropriation.

In 1977, almost the same combined State-local expenditure purchased one-quarter the number of days for half the number of patients served in 1969. Total expenditures of $4.3 million purchased 119,912 inpatient days for 11,463 patients in 1969. By 1977, expenditures of $4.9 million purchased 47,857 inpatient days for 6,135 patients. During the same time period, per diem hospital costs for the SLH program nearly tripled, increasing from $37 in 1969 to $103 in 1977.

Figure 14

SLH PATIENT DAYS

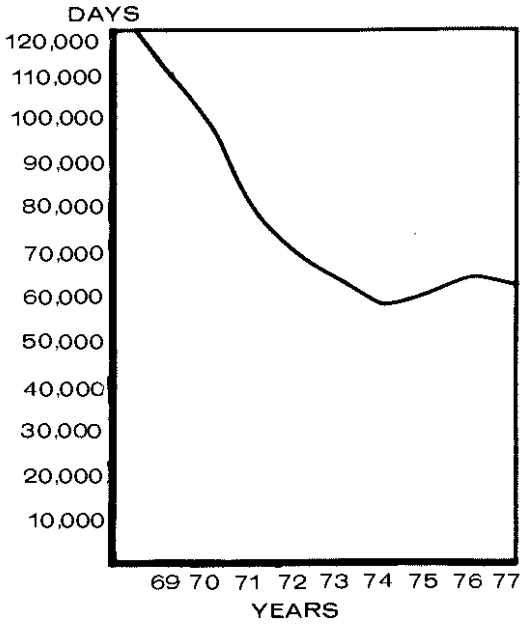
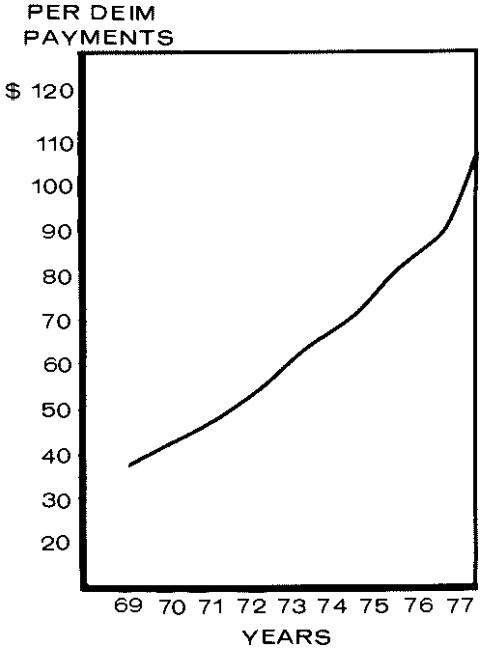


Figure 15

SLH PER DIEM HOSPITAL PAYMENTS



Source: Department of Welfare, State-Local Hospitalization Program for the Indigent, Annual Statistical Reports, 1970-1977.

Reimbursement Rates. Authorizing agents designated by the local government select hospitals and health clinics for participation subject to approval by the Department of Welfare. Most hospitals in Virginia are participants. The contract between the locality and the hospital or clinic specifies the minimum services to be provided, cost of care and other conditions.

The authorizing agent may agree to pay for all or part of the cost of treatment for an individual. The locality then makes a claim to the State for reimbursement for one-half of the cost of care up to a regional per diem ceiling.

The regional per diem ceiling is set at 115% of the weighted average cost of hospital care, exclusive of depreciation, in each of five State regions. In 1976 these rates ranged from $80 a day in Roanoke to $151 in Northern Virginia. Hospitals may be paid less than the maximum. The ceiling may also be exceeded with local funds, but the excess will not be matched by the State.

Eligibility

Eligibility for SLH is broadly defined and there are no categorical requirements. A medical indigent is defined as a person who:

> ...whether gainfully employed or not and who either by himself or by those upon whom he is dependent is unable to pay for the hospitalization required.[1]

The Department of Welfare is charged with establishing uniform guidelines for the evaluation of an applicant's medical indigency. The guidelines allow higher monthly income levels than medicaid standards. However, the guidelines are not binding on local agents.

As a result, eligibility standards and application procedures vary across the State. Eligibility is established prior to admission in some localities which have a referral system between authorizing agents and the hospitals and physicians in the area. Other localities only consider applications after the individual has received the medical services, but within a specific time limit (72 hours to 15 days) following hospitalization. Generally, application must be made in person and a claim may be denied if the application is delayed.

SLH inpatient services include routine medical/surgical conditions and psychological/emotional disorders. However, localities may choose not to cover certain types of cases. For example, several localities contacted by JLARC did not cover maternity. The explanation was that families had time in which to prepare for delivery expenses or that large numbers of cases would quickly expend funds. Some localities stressed emergency admissions and some excluded psychological disorders. The number of days covered also varied from a limit of three to the duration of the case.

UTILIZATION PATTERNS

The local option nature of the SLH program and the manner in which funds are appropriated and allocated accounts in some measure for uneven use of the program by localities. An increasing number of localities have opted out of the program. The number of participating localities dropped from 133 in 1970 to 108 in 1977. This occurred in part because localities chose not to supplement medicaid which became operational in 1970. In contrast, some localities have made substantial claims on the reserve fund in order to supplement original allocations. Two patterns of SLH use are discernible: (1) greater expenditures and admissions in urban areas and, (2) an apparent disincentive for use in counties near teaching hospitals.

Urban Emphasis

The greatest use of the program is made by urban areas, including Richmond, Petersburg, Northern Virginia, Roanoke, Lynchburg and the Eastern Virginia cities. These areas collectively accounted for 75% of all inpatient admissions in FY 1976.

Urban areas generally spend their total allocation of State funds. They are, therefore, able to draw upon the reserve fund. A small reserve is established for this purpose by the appropriations act. However, amounts unused by any locality are added to the reserve semiannually. This can significantly increase sums available to localities willing to appropriate the local match. During the 1974-76 biennium, major urban areas were allocated 45% of the biennial total. Nevertheless, these areas earned 85% of all State SLH inpatient monies by matching amounts in reserve (Table 39).

Table 39

SLH ALLOCATION AND ACTUAL RECEIPTS
INPATIENT CARE, 1974-1976 BIENNIUM

Locality	Biennial Allocation	Biennial Receipts	Receipts as a Percent of of Allocation
Alexandria	$ 54,460	$ 335,222	615%
Norfolk	142,572	869,261	610
Portsmouth	54,560	270,077	495
Richmond	119,144	582,521	489
Arlington	85,644	342,330	400
Hampton	62,568	218,334	349
Lynchburg	27,656	83,203	301
Newport News	68,064	199,459	293
Roanoke	45,644	118,893	261
Petersburg	22,216	55,864	251
Suffolk	23,224	57,801	248
Fairfax	240,712	499,993	208
Chesapeake	47,356	72,903	154
Virginia Beach	95,464	125,982	132
Subtotal	$1,089,284	$3,831,846	352%
State Total	$2,400,000	$4,531,552	
(Percent to Urban Areas)	(45%)	(85%)	

Source: Department of Welfare.

The concentration of SLH in urban areas does not reflect the distribution of the State's poor. According to the 1970 census, central cities and small urban areas contained only 36% of the State's population with income below the federal poverty level. Rural areas make more limited use of the program, but encompass 52% of the poor.

To some extent, local participation in the SLH program is influenced by factors such as fiscal capacity, local tradition, political climate and the presence or absence of provider pressure. Local tradition and concepts of indigence have often been cited to JLARC staff as explanations for high or low use of the program. For example, despite a generally low level of participation by rural counties, Accomack and Northampton counties are high users of SLH funds. This apparently stems from a local commitment to care of residents and support of Northampton-Accomack hospital.

Participation by cities may be affected by the existence of well-developed processes for delivery of social services to a defined population group. Additional impetus toward SLH participation may come from hospitals in poverty areas that make regular SLH referrals. The City of Norfolk, for example, has several hospitals that are heavily involved in indigent care. To some extent, the high level of Norfolk expenditures for SLH are a form of subsidy for these hospitals. It is possible that this level of participation will decrease due to State indigent care appropriations to the Eastern Virginia Medical Authority.

SLH and Teaching Hospitals

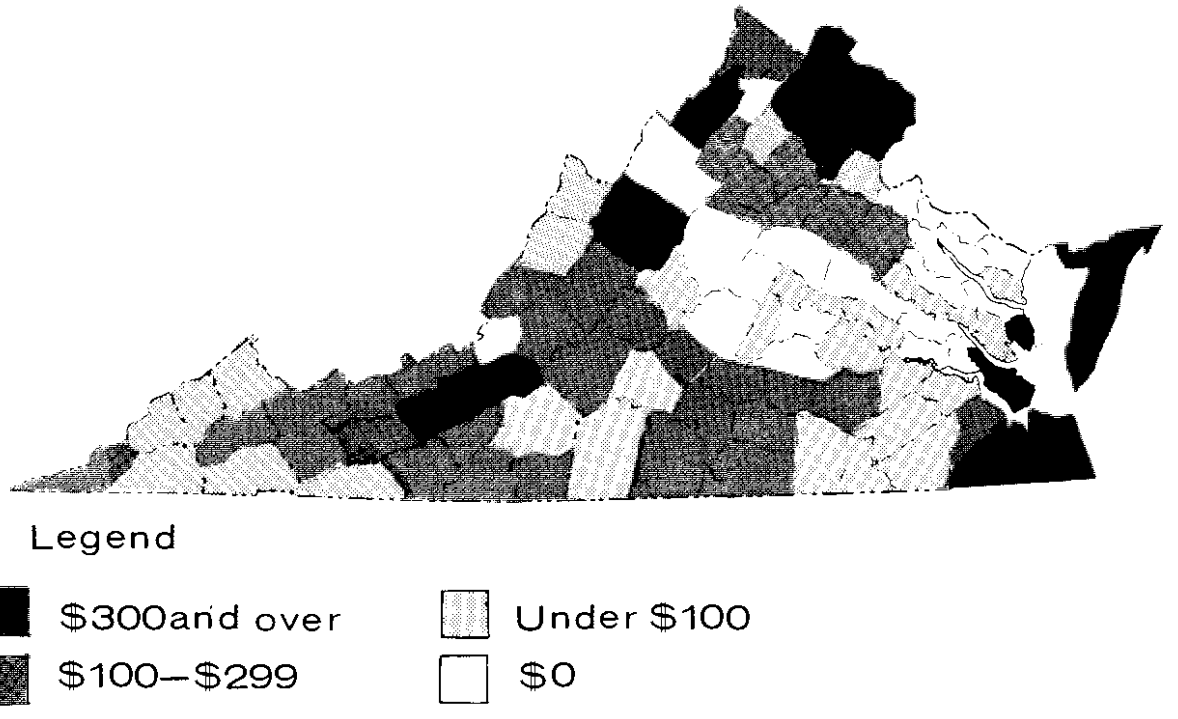
Limited use of the SLH program results in increased demands being placed on the limited financial resources of university operated hospitals. Cities and counties located near teaching hospitals make limited use of the SLH program. Local governments frequently do not reimburse teaching hospitals for care provided individuals eligible for SLH benefits.

Teaching Hospital Disincentive. With the notable exception of the cities of Charlottesville and Richmond, most localities in the immediate service area of State teaching hospitals either do not use or make limited use of the SLH program. This can be seen in Figure 16 which measures use in terms of local expenditures per poor person. One reason may be that State subsidized free care is available to residents of those localities. Therefore, there is less incentive for the SLH local match to be appropriated.

Limited information is available on the origin of indigent patients at the Medical College of Virginia hospital. However, more than half of the total number of patients at MCVH are from the Richmond or Northern Neck area. These localities make little or no use of the SLH program.

Figure 16

SLH DOLLARS PER 100 POOR
(FY 1976)



Source: State-Local Hospitalization program 1976 statistical report.

Similarly, localities that account for more than half of all admissions to the University of Virginia Hospital, make limited use of the SLH program. UVAH maintains detailed information on patients receiving free care, including patient origin and the reason each account was determined eligible for free care.

On the whole, counties make greater use of State subsidized free care at UVAH than cities. Nine counties in proximity to the hospital accounted for over 40% of total free care dollars and over 60% of free care provided to counties. These same counties made little or no use of the SLH program. They were considerably over the State average for use of free service at UVAH by counties and considerably under the State average for SLH use (Table 40). Moreover, several of the counties had not entered into SLH contracts with UVAH.

UVAH writes off substantial sums for patients that are apparently SLH eligible. According to UVAH records, the total written off due to deficiencies in SLH coverage was $766,906 in FY 1977. This represented 38% of all accounts and 36% of all dollars written off. According to UVAH records, these accounts were for patients certified as indigent by local authorizing agents.

Table 40

UVAH FREE CARE TO RESIDENTS OF COUNTIES
WITH LOW SLH USE
FY 1977

Locality	Free Service	Number of Free Service Admissions	Total SLH Expenditures	Total SLH Admissions
Greene	$ 72,110	49	$ 2,840	9
Fluvanna	103,232	57	--	-
Albemarle	235,598	164	--	-
Orange	100,145	57	6,011	9
Culpeper	101,697	36	8,085	8
Nelson	108,589	64	3,277	7
Louisa	88,436	52	--	-
Buckingham	58,357	51	--	-
Augusta	61,571	24	9,391	18
State Average	$ 15,623[a]	8.7	$19,332	26.8

[a]Excludes six counties for which data were not available.

Source: Compiled by JLARC from UVAH Free Care Summary and SLH Statistical Annual Report for FY 1977.

However, the patient accounts were not reimbursed or only partially reimbursed because the agency had insufficient funds, no funds or no contract with the hospital.

Teaching Hospital Reimbursement. Payment to teaching hospitals seems to be guaranteed by Section 63.1-138 of the *Code of Virginia*, but it has apparently not been used. The section states that if a county or city certifies that an indigent patient is eligible for SLH and is treated at one of the teaching hospitals, the locality is liable for the cost of the care even if a formal contract does not exist. Only 74 localities had contracts with UVAH in 1976. The hospital is required to bill the locality and notify the State Comptroller if payment is not received.

The State Comptroller is authorized to transfer to the hospital any nonearmarked monies otherwise distributable to such locality by any department or agency of the State. Nonearmarked funds are not defined. However, funds such as ABC profits or sales tax revenues are annually distributed to localities.

The law was apparently unknown to administrators at the hospitals and the procedure has reportedly not been used by the Comptroller's office. Nevertheless, the section was referenced in the appropriations act for at least the last two biennia. This appears to reaffirm the intent of the provision.

The Department of Welfare, the Comptroller's office and the Appropriations Committee of the House of Delegates should review Section 63.1-138. The intent should be clarified and implemented where applicable.

STATE-LOCAL HOSPITALIZATION PROGRAM OPTIONS

The State Hospitalization program is relatively small. State expenditures in 1976 were only 11% of expenditures for medicaid and 13% of expenditures at teaching hospitals. Even if fully matched by localities, the program would have a limited impact.

Nevertheless, the program costs the State close to $3 million annually. Its performance has been a recurring source of legislative concern. Since the program is completely State initiated and funded, it can be terminated or redesigned by the General Assembly. Serious attention should be given to modifying the SLH program.

Legislative Concern

Variations in local use have been recognized almost since the inception of the program. Reform proposals have included introduction of greater uniformity while maintaining the local option character of the program, total State administration and funding, and adjustment in the matching formula. Nonetheless, few changes have occurred.

The Virginia Advisory Legislative Council conducted a study of SLH in 1960. At that time, prior to medicaid, SLH was the major source of hospital care for medical indigents. Despite the current role of the program as last resort for persons not eligible for medicaid, three major problems identified in that study are still of concern today:

- differences in eligibility criteria among localities;
- failure of some localities to fully match allocations; and
- amount of cost for care of indigents and medical indigents absorbed by hospitals and passed onto other patients.

The Virginia Advisory Legislative Council considered, but rejected, the idea of a totally State controlled plan. The belief was that local tradition was strong in Virginia and that over time more localities would recognize the needs of the medically indigent.

The Council advocated increased State appropriations and establishment of State eligibility guidelines. These guidelines were not to be binding on localities, but were intended to promote uniformity.[2]

By 1975 SLH had assumed its current role. However, lack of uniformity, inequitable distribution of funds and service gaps were still recognized problems. Fewer localities participated than in 1960. The Virginia Advisory Legislative Commission was directed by the General Assembly to:

> ...conduct a study of the feasibility of and cost factors involved in the inclusion of the State Local Hospitalization Program in the Virginia Medical Assistance Program with comparable administrative and eligibility criteria for those formerly eligible for the State-Local Hospitalization program.[3]

Merger of SLH and medicaid would have resulted in a State administered and funded program with uniform policies and standards. The study group recommended enrollment of medical indigents between the ages of 21 and 64 in a nonfederally matched hospitalization program. Persons under 21 would be included in the federally matched medicaid program as an optional group.

It was estimated that the cost for a total of approximately 700,000 potential eligibles would be about $21.7 million annually. SLH expenditures at that time were $2.6 million. Since all medical indigents would be covered by the program, the study group indicated that the additional cost might be offset by using appropriations made to the University of Virginia and the Medical College of Virginia for indigent care.[4] This proposal was not enacted, apparently due to cost factors and teaching hospital objections.

The most recent proposal with regard to SLH affected only funding. Currently all participating localities must match State funds on a 50-50 basis. In 1977, the Commission on State Aid to Localities advocated that the local portion be established between a minimum of 20% and a maximum of 50%. The local share would be calculated according to a formula based on three factors: (1) relative incidence of need, (2) relative tax effort, and (3) relative fiscal ability.

Under the proposed formula, cities generally would be required to pay a smaller share than counties or rural areas. Since urban areas now make greater use of the SLH program, the cost to the State would be increased, but the availability of care statewide might not be appreciably supplemented. This proposal was rejected by the 1978 session of the General Assembly.

Program Options

The JLARC study has indicated that SLH-funded care is still not uniformly accessible to medical indigents across the

State. Problems that existed in 1960 still exist today. Moreover, they have been exacerbated by decreases in the number of localities and increases in hospital costs. A total of $6.9 million has been appropriated for the coming biennium. This is a sizeable sum for a program that is obviously not meeting its legislative purpose.

Apparently none of the recommendations of previous studies have been considered feasible at the time made. However, a broad range of options exists:

Option 1: Program Termination or Merger

Terminating the SLH program would save about $6 million per biennium for the general fund or would permit reallocation of the dollars to other health programs such as medicaid. It should be noted, however, that over 6,000 patients and 108 localities did receive some benefit from the program in FY 1976.

Option 2: Create Uniform State Program

Eliminating the local role would permit the State to create a uniform State-financed and administered hospitalization program of last resort. Hospitals would bill the State agency for services provided to eligible individuals as they do for medicaid and other programs.

Option 3: Subsidy to Hospitals

Using State funds to provide hospitals throughout the State with an indigent care subsidy similar to that received by teaching hospitals would assist both hospitals and indigents. Funds would be allocated on an equitable basis, such as the ratio of free care to total care provided.

Option 4: Mandating Eligibility Guidelines

Maintaining the current SLH local option program with mandatory eligibility guidelines would guarantee equal access to care in participating localities. However, funds would still not be available Statewide.

Option 5: Vary Local Match

Maintaining the current SLH program, but varying the local match might provide incentive to communities unable to raise the current dollar-for-dollar match for State funds. The matching formula would incorporate some indicator of ability to pay and provide additional incentive to rural areas.

The most radical option would be termination of the program. This may now be feasible because medicaid provides uniform coverage across the State for the welfare-eligible poor.

And some localities apparently believe that a supplement for the medically needy is unwarranted.

By eliminating the local role, other options would permit the State to control the distribution of funds at whatever appropriation level the General Assembly believes necessary. The most conservative options maintain the current program, but serve to encourage increased local participation and equalize eligibility across the State.

APPENDICES

Agency Responses

JLARC policy provides that each State agency involved in a program review be given the opportunity to comment on an exposure draft. This process is one part of an extensive data validation process.

Appropriate corrections resulting from the written comments have been made in the final report. It should be noted that page references in the responses relate to the draft report and do not necessarily correspond to page numbers in the final report.

END NOTES

Chapter I

1. State Department of Health, 1978 Draft Preliminary Health Plan. Cost figures are exclusive of physician fees.

Chapter II

1. Davis, Karen, National Health Insurance Benefits, Costs and Consequences, Brookings Institution, Washington, D.C., 1975, p. 34.

2. Schmidt, Ron, State Health News, Georgetown University Health Policy Center, Washington, D.C., August 1977.

3. McClure, Walter, Ph.D., "Reducing Excess Hospital Capacity", Department of Health, Education and Welfare, Interstudy, October 1976.

Chapter IV

1. R. J. Meyers, *Medicare*. (Homewood, Illinois: R. D. Irwin, Inc., 1970), pp. 141-142.

2. Ernst and Ernst, *Final Report on Consulting Services Rendered for the Cost Settlement/Audit Section of the State Health Department*, July 1973, p. 13.

3. Social Security Act, Section 1155(a)(1).

4. Congressional Budget Office, *Expenditures for Health Care: Federal Programs and Their Effects* (Washington, D.C.: U. S. Government Printing Office, August 1977), p. 38.

Chapter V

1. University of Virginia Hospital, Memo to Credit Office Personnel, April 30, 1970.

2. State Department of Health, Memorandum, March 11, 1977.

Chapter VI

1. *Code of Virginia*, Section 63.1-139.

2. Senate Document No. 11, Virginia Advisory Legislative Council, Hospitalization of the Indigent and Medically Indigent, Richmond, 1960.

3. Virginia Acts of Assembly, 1974, Senate Joint Resolution No. 22.

4. Report by the Directors of the Department of Welfare and Department of Health, August 1974.

Appendix 1

TECHNICAL APPENDIX
(Available on Request)

JLARC policy and sound research practice require a technical explanation of research methodology. A technical appendix was prepared for this report and was part of the exposure draft. The technical appendix is available on request from JLARC, 910 Capitol Street, Richmond, Virginia 23219.

The technical appendix includes an explanation of analytical procedures and relevant statistics in four areas:

1. Cost of Empty Beds. Operating expenditures of 94 hospitals with 19,827 beds were obtained from FY 1976 financial statements. The number of empty beds and patient days foregone was estimated based on the State-wide average occupancy rate of 73.4%. The cost of empty beds was determined based on the assumption that on the average the fixed costs associated with an empty bed are two-thirds the amount of a full bed. (3 pages)

2. JLARC Hospital Cost Reimbursement Model. The JLARC staff developed a simplified, descriptive computer model to demonstrate the reimbursement system under which hospitals operate. The model was designed to show the basic relationship between rates paid by different payors (medicare, medicaid, State-Local Hospitalization, Blue Cross, private pay). It also illustrates the effects of low occupancy and indigent care (charity and bad debts) on rates paid by each payor. The model is not intended to be an accurate predictor of actual rates. (10 pages)

3. Impact of Indigent Care on Hospital Finances. The data for this analysis were obtained from hospital financial statements and reported expenditures of medicaid and other indigent care programs. Operating margin was used as an indicator of hospital financial status. Chi-square tests and correlation analysis were used to evaluate the dependence of hospital financial status upon various indicators of indigent care. Three measures of indigent care, standardized as ratios, were used singly and in combination: (1) the amount of free care (bad debts and charity); (2) contractual adjustments (difference between charges and reimbursement received); and (3) the amount of reimbursement received by indigent care programs. (3 pages)

4. Teaching Hospital Accounts Sample. A random sample of indigent inpatient accounts charged to State funds during FY 1976-77 was drawn from patient files at the Medical College of Virginia Hospital (MCVH) and the University of Virginia Hospital (UVAH). The purpose was to determine the ability of each hospital to document indigent care expenditures and to establish a reasonable procedure for writing off patient accounts. At MCVH a total of 51 cases was selected from a sample large enough to permit statistical generalization. At UVAH a representative but not generalizable sample of 44 total cases was selected. Indications of patient accounting deficiencies and little available summary data required a more rigorous sampling procedure at MCVH. At UVAH complete, usable data were available and a pretest of write-offs during a recent month did not indicate problems with inpatient accounting procedures. (15 pages)

Appendix 2

HOSPITALS REVIEWED

Financial reports and statistical data for FY 1976 were reviewed for 94 Virginia hospitals:

Name of Facility	Bed Size	Location
Health Service Area I (Northwest Virginia)		
University of Virginia Hospital	638	Charlottesville
Winchester Memorial Hospital	469	Winchester
Rockingham Memorial Hospital	330	Harrisonburg
Mary Washington Hospital	286	Fredericksburg
King's Daughters Hospital	191	Staunton
Waynesboro Community Hospital	171	Waynesboro
Martha Jefferson Hospital	145	Charlottesville
Stonewall Jackson Hospital	134	Lexington
Shenandoah County Memorial Hospital	131	Woodstock
Warren Memorial Hospital	111	Front Royal
Culpeper Memorial Hospital	106	Culpeper
Fauquier Hospital	90	Warrenton
Page Memorial Hospital	54	Luray
Gordonsville Community Hospital	30	Gordonsville
Bath County Community Hospital	25	Hot Springs
Health Service Area II (Northern Virginia)		
The Fairfax Hospital	656	Falls Church
The Alexandria Hospital Association	414	Alexandria
Arlington Hospital	350	Arlington
Loudoun Memorial Hospital	192	Leesburg
Commonwealth Doctor's Hospital	160	Fairfax
Prince William Hospital	154	Manassas
Potomac Hospital	137	Woodbridge
Circle Terrace Hospital	127	Alexandria
Jefferson Memorial Hospital	120	Alexandria
Health Service Area III (Southwest Virginia)		
Roanoke Memorial Hospital and Roanoke Memorial Rehabilitation Center	725	Roanoke
The Memorial Hospital	506	Danville
Community Hospital of Roanoke Valley	400	Roanoke
Bristol Memorial Hospital*	351	Bristol, Tenn-Va.
Lewis-Gale Hospitals, Inc.	320	Salem
Lynchburg General-Marshall Lodge Hospitals	270	Lynchburg
Virginia Baptist Hospitals, Inc.	251	Lynchburg
Memorial Hospital of Martinsville and Henry County	223	Martinsville

*Bristol Memorial Hospital is licensed in Tennessee but was included in Virginia Health Service Area data during FY 1976.

Name of Facility	Bed Size	Location
Emmett Memorial Hospital	203	Clifton Forge
Radford Community Hospital	181	Radford
Smyth County Community Hospital, Inc.	156	Marion
Johnston Memorial Hospital	154	Abingdon
Pulaski Community Hospital	153	Pulaski
Twin County Community Hospital	104	Galax
Montgomery County Community Hospital	99	Blacksburg
Wythe County Community Hospital	99	Wytheville
Burrell Memorial Hospital	92	Roanoke
Bedford County Memorial Hospital, Inc.	90	Bedford
R. J. Reynolds-Patrick County Memorial Hospital	77	Stuart
Mattie Williams Hospital	76	Richlands
Norton Community Hospital, Inc.	75	Norton
Lee General Hospital	74	Pennington Gap
Wise Appalachian Regional Hospital	67	Wise
Giles Memorial Hospital, Inc.	65	Pearisburg
St. Mary's Hospital, Inc.	65	Norton
Franklin Memorial Hospital, Inc.	62	Rocky Mount
Lonesome Pine Hospital	60	Big Stone Gap
Park Avenue Hospital, Inc.	60	Norton
Alleghany Memorial Hospital	58	Covington
Wytheville Hospital Corporation	54	Wytheville
Tazewell Community Hospital, Inc.	50	Tazewell
Thomas McKee Hospital	38	Saltville
Health Service Area IV (Central Virginia)		
Medical College of Virginia	944	Richmond
Richmond Memorial Hospital	459	Richmond
Petersburg General Hospital	440	Petersburg
Johnston-Willis Hospital	360	Richmond
St. Mary's Hospital of Richmond, Inc.	352	Richmond
Chippenham Hospital	346	Richmond
Henrico Doctor's Hospital	236	Richmond
Retreat Hospital	230	Richmond
St. Luke's Hospital	200	Richmond
Stuart Circle Hospital	153	Richmond
John Randolph Hospital	150	Hopewell
Greensville Memorial Hospital	127	Emporia
Community Memorial Hospital	120	South Hill
Halifax Community Hospital	113	South Boston
Southside Community Hospital	105	Farmville
Crippled Children's Hospital	88	Richmond
South Boston General Hospital	86	South Boston
Sheltering Arms	53	Richmond
Richmond Community Hospital	25	Richmond
Health Service Area V (Eastern Virginia)		
Norfolk General Hospital	723	Norfolk
Riverside Hospital	641	Newport News

Name of Facility	Bed Size	Location
DePaul Hospital	393	Norfolk
Hampton General Hospital	369	Hampton
Portsmouth General Hospital, Inc.	311	Portsmouth
Maryview Hospital Corporation	289	Portsmouth
General Hospital of Virginia Beach	263	Virginia Beach
Bayside Hospital	250	Virginia Beach
Louise Obici Memorial Hospital	243	Suffolk
Norfolk Community Hospital	192	Norfolk
Leigh Memorial Hospital	167	Norfolk
Chesapeake General Hospital	141	Chesapeake
Northampton-Accomac Memorial Hospital	128	Nassawadox
Whittaker Memorial Hospital	126	Newport News
Mary Immaculate, Inc.	120	Newport News
Southampton Memorial Hospital	117	Franklin
Tidewater Memorial Hospital, Inc.	100	Tappahannock
Williamsburg Community Hospital, Inc.	96	Williamsburg
Children's Hospital of the King's Daughters	92	Norfolk

COMMONWEALTH of VIRGINIA

Office of the Governor

Richmond 23219

Jean L. Harris, M.D.
Secretary of Human Resources

December 15, 1978

Mr. Ray D. Pethtel, Director, Joint
Legislative Audit & Review Commission
823 East Main Street, Suite 200
Richmond, Virginia 23219

Dear Mr. Pethtel:

I have reviewed the draft report of the Commission entitled "In-Patient Care in Virginia". The report is well done. It identifies and delineates major problem areas associated with in-patient care, health care delivery and the attendant and associated costs.

I am in agreement with the responses to the draft report supplied by Dr. James B. Kenley, State Health Commissioner. I should therefore like to caution that proceeding immediately with some of the recommendations could compound the problems which the Commonwealth is now striving to address in the immediate and near future. We need an opportunity to further study and refine strategies toward cost containment.

To this end, I am encouraged by the appointment of the Virginia Health Services Cost Review Commission. For the first time the State has a real working tool in trying to get a handle on health care costs. The Commission, in mandating uniform reporting by all hospitals within the Commonwealth, will be accumulating comprehensive information which can provide the necessary data base with which we can begin to start addressing and resolving critical issues. Making changes to our system without the necessary comparative data can be disastrous. If we don't know from whence we have come, how do we know when we have arrived?

Thank you for the opportunity to review this report. Containment to health care costs through appropriate utilization of all of our physical and fiscal resources is of great personal interest and concern to me. I look forward to lending the support of my office to which ever strategies the State may adopt in the pursuit of the provision of adequate, quality care at a reasonable cost to all of its citizens.

Respectfully,

Jean L. Harris

Jean L. Harris, M.D.

JLH/jes

cc: Dr. J. B. Kenley

COMMONWEALTH of VIRGINIA

JAMES B. KENLEY, M.D.
COMMISSIONER

Department of Health
Richmond, Va. 23219

October 18, 1978

Mr. Ray D. Pethtel, Director
Joint Legislative Audit and Review Commission
Suite 200
823 East Main Street
Richmond, Virginia 23219

Dear Mr. Pethtel:

This letter and its attachment represent the State Health Department's response to the draft report of the Commission entitled "Inpatient Care in Virginia".

In the attached discussion and listing of comments, the order of the draft report is maintained. I hope that you will carefully consider these concerns and issues.

Sincerely,

James B. Kenley, M.D.
State Health Commissioner

STATE HEALTH DEPARTMENT COMMENTS ON THE DRAFT
JLARC REPORT: INPATIENT CARE IN VIRGINIA

I. Comments on Recommendations

1. Development of State Plan

A State Health Plan will be completed in early 1979 and will reference regionalization of services and alternatives to inpatient care.

2. Coordination of Indigent Care

In establishing uniform eligibility criteria and a single application form, it must be kept in mind that each State Health Department program which purchases hospital care does this on the basis of separate and distinct rules, regulations, and legislative purposes (from the federal government). It may not be possible to meet the mandate of these categorical programs through such uniform methods.

3. Assessment of Private Sector Effort

The development of a uniform cost accounting system is a necessary precursor to rate review activities. Virginia has adopted a "rate review" law and will be initiating a uniform hospital accounting/reporting system as a part of the implementation of the law. One can logically assume that care for indigents whether wholly reimbursed, partially reimbursed, or not reimbursed at all will be uniformly reported. The law provides the first mechanism available to the State for identification of hospital costs in a uniform manner.

The Health Department should review the content of hospital reporting relative to indigent care under the Hill-Burton program. It should be possible to obtain needed data in coordination with future activities of the Virginia Rate Review Commission.

4. Reduction of Surplus Beds

Under State law, there is no authorization for the State Health Department to force reduction in hospital beds. The Virginia Medical Care Facilities Certificate of Public Need law is effective in preventing the development of unneeded additional beds and, if used in conjunction with the hospital licensure law, could reduce surplus capacity over time. The Department will study the matter of licensing only the number of beds that are used or can be reasonably made available for care.

5. Limitation of Program Reimbursement for Surplus Beds

and

6. Medicaid Reimbursement Method

Recommendation #5 regarding an acceptable hospital occupancy of 80 to 85% and recommendation #6 proposing a prospective reimbursement

system for hospitals are both laudable ideals at first glance. The difficulty with both of these recommendations is that they propose that hospitals be subject to these requirements for their participation in Medicaid only. In other words, hospitals would be required to operate under one set of rules for Medicaid participation, which represents a fairly small proportion of their patient load, while being subject to different sets of rules for Medicare, Blue Cross, other insurance, and private pay patients. Such a system perpetuates the inequities to Blue Cross, other insurance, and private pay patients already occurring. Allowable cost limitations or, in the case of these recommendations, occupancy rates and reimbursement rates are and would continue to be more stringent for government programs than for non-government programs. Consequently, the non-government subsidized patient population subsidizes the government programs' patients.

Before recommending changes in the reimbursement system, which would affect only one program, JLARC must consider the interests of more than just the State's Medicaid budget. The effect of recommendations #5 and #6 would be to continue to shift costs from the government sector to the private sector. These recommendations will not, because of the relatively low volume of Medicaid hospital patients, produce any real cost reductions for hospitalization or any real savings for the State. The implementation of these recommendations would serve only to further frustrate hospital administrative and fiscal personnel in their efforts to recover the cost of maintaining operations.

The Virginia Medical Assistance Program has adopted both of these recommendations in the nursing home reimbursement formula, and we would be receptive to prospective reimbursement and minimum occupancy levels, if they were mandated to all payors of hospitalization and not just the Medicaid Program.

While a prospective method of payment for hospital care could be developed by Medicaid, its impact on hospital practices would seem to be minimal. Such actions should await Virginia's decisions on whether or not to establish rate-setting activities.

The primary purpose of Medicaid is to assist in making "mainstream" medical service available to poor people. Efforts to cut the amount of reimbursement for service provided to medicaid patients may very well further remove recipients from the mainstream of medical care.

7. Improvement of Medicaid Audit Process

The current system is time consuming and responsible for many adjustments, but these are due to a highly complex reimbursement system, which is not easily modified. The principles of Medicare reimbursement to which the Medicaid Program must comply are subject to constant revision and reinterpretation. The State Health Department is making efforts in enforcing sanctions (including fiscal sanction) for the submission of cost reports in a timely and accurate fashion and is negotiating a shared audit agreement with Blue Cross of Virginia, which would provide input from the Medicaid Program with regard to the scope of hospital audits.

However, with regard to training hospital personnel, there are numerous opportunities through Medicare and professional organizations for personnel to receive training in reporting procedures. As for a reduction in interim settlements, these are an inherent feature of the current reimbursement system. The purpose is to facilitate cash flow on a current basis and not restrict payments until the complete review process is completed.

8. Medicaid Utilization Review

The Health Department plans to monitor PSRO activities. The new Medicaid Management Information System will provide the data necessary for comparison of facilities based on diagnoses and lengths of stays.

The Medical Assistance Program has designated PSRO monitoring as a priority of the newly formed Surveillance and Utilization Review Section. To support the development of a monitoring system, the Program's PSRO Coordinator has met with the Department of Health, Education, and Welfare's Bureau of Health Standards and Quality and their consultants to review the State's proposals for a monitoring plan. The Program has received preliminary approval of the plan and is presently evaluating the process of tying the Plan into the Program's Medicaid Management Information System.

Federal regulations require that the Medical Assistance Program submit a draft of the plan to all PSROs for a thirty-day comment period. It is anticipated the Program can begin operation of the monitoring system by December 1, 1978.

The Plan sets standards of performance for the PSROs and provides for the review of PSRO decisions if the Medical Assistance Program finds that PSRO activities have adversely affected the norms of hospital care and Medicaid expenditures. If the State is unable to work with the PSRO to correct any adverse impact on the Program, the Medical Assistance Program may appeal to HEW to relieve the PSRO of its binding authority until corrective action can be taken.

9. Accountability for Teaching Hospital Expenditures

No comment.

10. State-Local Hospitalization Program Payments to Teaching Hospitals

No comment.

11. State-Local Hospitalization Program

No comment.

12. Coordination of Cost Containment Activities

No comment.

II. Comments on the Balance of the Text

JLARC NOTE

The Department of Health provided several clarifications of fact on the balance of the text. A number of these comments helped to clarify JLARC's interpretation of programs and procedures and were incorporated into this document. Comments 3, 4, 5, 9, and 10 resulted in changes and have been deleted to avoid confusion.

Other comments are included on pages 104 and 105. Text citations to these statements have been changed to represent page numbers in the printed text of the report.

1. Certificate of Need, Pages 21-25

In view of the fact that JLARC is currently involved in a detailed study of the Certificate of Need Program, the Department will reserve comment on this aspect of the report, until the study is completed.

2. Implementation Problems, Page 22

The State Health Department does have a State Medical Facility Plan. (The 1976 Interim Medical Facility Plan projects hospital bed need requirements through 1980. The 1977 State Medical Facility Plan - Part I projects Nursing home bed needs through 1982.) The 1978 State Medical Facility Plan, which will project both hospital and nursing home bed needs through 1983 and inventory other available medical care resources, is currently under development and should be operational around January 1, 1979.

6. Hill-Burton Charity Care, Pages 31-33

It should be noted that the Hill-Burton (federal construction assistance) was phased-out in September 1976, although the obligation of any facility which received assistance to provide "free" care to eligible patients continues for 20 years following receipt of the assistance.

In 1976, sixty-four hospitals were still within their 20-year obligation period. Of these, 58 hospitals chose the "open-door option" for fulfilling their obligation. In accordance with federal regulations governing the program such facilities are presumed to be fulfilling with their obligation. Selecting the "open door" option relieves the hospital of any set dollar amount of "free" care it must provide.

The State Health Department recognizes that many hospitals misreport the amount of Hill-Burton free care they provide, however, we are unaware of any hospital reporting any more uncompensated care than they actually deliver based upon their audited financial statements.

The Department does vigorously investigate complaints and takes affirmative action when violations of the Hill-Burton obligations of hospitals are detected.

It is difficult to believe that more detailed auditing and review will in any way increase the amount of services to the poor. It is probable that such activity would create additional burdens upon hospital fiscal officers and increase hospital operating costs.

7. Distribution of Indigent Care Funds, Pages 33-37

In regards to regional differences in the expenditure of indigent care funds, this section is somewhat confusing and too simplistic. No efforts have been made to standardize regional experience using the variables which are acknowledged to exist.

8. Distribution by Hospital, Pages 35-37

Admissions of poor persons to hospitals is a function of the hospitals' medical staffs. Physicians that practice in areas with high concentrations of poor people are most likely to have admitting privileges only at the large community non-profit hospital. Therefore, a large majority of poor persons requiring admission are concentrated in a "few" hospitals. Access to hospitals is clearly related to where the physician who serves the poor has privileges.

11. Reimbursement Calculation, Page 47

It seems inappropriate from the reference of one study to state that the averaging method for finding hospital costs in small facilities might have led to as much as $510,000 excess reimbursement as opposed to the Departmental cost finding approach.

12. Medicaid Reimbursement at UVAH, Pages 71-72

Medicaid reimbursement for outpatient services at the University of Virginia will be monitored to insure that an established system of charges for outpatient services is developed.

UNIVERSITY OF VIRGINIA
CHARLOTTESVILLE

OFFICE OF THE PRESIDENT

October 16, 1978

Mr. Ray D. Pethtel, Director
Joint Legislative Audit
and Review Commission
Commonwealth of Virginia
Suite 1100, 910 Capitol Street
Richmond, Virginia 23219

Dear Mr. Pethtel:

In response to your request of September 20, 1978, I enclose a memorandum given me by Dr. William H. Muller, Vice-President for Health Affairs. We would like to participate in any discussions pursuant to any possible change in the appropriation process.

Please let me know if you require further information.

Sincerely,

Frank L. Hereford, Jr.
President

FLH:lal

Enclosure

CC: Vice-President William H. Muller, Jr.
Vice-President Ray C. Hunt, Jr.

University of Virginia
BOX 179 MEDICAL CENTER
CHARLOTTESVILLE, VIRGINIA 22901

ASSISTANT VICE PRESIDENT
FOR HEALTH SERVICES

October 2, 1978

TELEPHONE: (804)-924-5259

MEMORANDUM

TO: Dr. William H. Muller, Jr.
Vice President for Health Affairs

FROM: Dr. Charles E. Hamner
Assistant Vice President for
Health Services

Mr. Robert Henderson
Assistant Vice President for Health Affairs
Finance, and Comptroller

SUBJECT: Joint Legislative Audit and Review Commission's Staff Report on Inpatient Care in Virginia

We have read the staff report from JLARC and find that they have two major concerns:

1. The lack of state control over hospital rates and health care costs.

2. The lack of specific accountability requirements such as, eligibility standards, utilization review, and claim verification for inpatient care programs.

There are twelve recommendations suggested to enhance delivery of care and to contain costs. Ten of these recommendations would directly affect our hospital operation. Five of the recommendations would affect our long term planning and coordination, but the other five would affect us almost immediately. As would be expected the State Health Department has been recommended as the principal organization for coordination and control at the State level.

Recommendations 4,5,6,7, and 9 would have an immediate impact. Recommendation number 9 would be the most significant since it requires more accountability for teaching hospital and uses of State appropriated funds for indigent care. JLARC recommends that the hospital be required to develop and implement adequate procedures for determining patient eligibility and for processing of patient accounts. They further recommend that the General Assembly should earmark indigent care funds for teaching hospitals with appropriate requirements for record keeping, eligibility, determination and oversight.

In Chapter 5 of this Report, the JLARC Staff looked at two primary indicators for accountability.

1. The ability to document charges and explain expenditures for indigent care.
2. The ability to relate expenditures to indigent care to state appropriations.

In reviewing the University of Virginia Hospital, they noted immediately that inpatient accounts were well documented. However, there were inadequate procedures for outpatient accounts, making it impossible to accurately identify amounts written off for indigent care. They simply stated that no direct link exists between individual outpatient accounts and state appropriations for indigent care. Further, they noted that the Hospital does not comply with Medicaid and Medicare reimbursement requirements because policies and procedures for processing outpatient accounts are vague and fragmented and documentation to support write offs is incomplete. Medicaid regulations require that the relationship between charges to Medicaid patients and charges to all patients be used to apportion and identify the portions of hospital cost attributable to Medicaid patients. Currently the hospital has a temporary waiver based on the assumption that the cost of the care received by every outpatient is the same. However, the hospital has no method to verify this assumption. The JLARC Staff recommended that:

1. The University should establish a written sliding scale based on that established by the State Department of Health for treatment in local health department clinics and that the scale be uniformly applied.

2. Because there is a lack of uniform billing systems for outpatients, that the University establish an appropriate charge structure for the outpatient department in conjunction with the Auditor of Public Accounts. This charge structure should include a system designed to separate the cost of indigent care from other costs.

3. They suggest two possible methods for funding the hospital for indigent care in the future.

    a. The appropriation could be earmarked for indigent care with specific eligibility and reporting requirements to be carried out by the hospital.

    b. The state could appropriate funds to the Department of Health or another agency with the responsibility for administering indigent care from the third party payors.

Mr. Don Bowers believes that we can develop an outpatient charge structure and billing system which can be combined with our current Combined Outpatient Billing System and meet some of the recommendations of JLARC. It would take 12 to 18 months to write the programs and implement the system. With this in mind as a realistic approach, it

would be much better to have the state appropriations come directly to the hospital with appropriate auditing and accounting stipulations. If the appropriations are funded through a third party, it would involve considerable additional paperwork and costs to bill a third party payor.

Recommendation 4 has to do with reduction of surplus beds similar to HSA requirements.

Recommendation 5 is related to Number 4 having to do with limitation of program reimbursements for surplus beds. They recommend that the state Medicaid plan be amended to base reimbursement on an acceptable occupancy rate (80-85%) when actual occupancy is below that level in any hospital.

Recommendation 7 has to do with improvement of the Medicaid audit process. This recommendation fits in with our plans to improve our overall documentation of Medicare and Medicaid cost reimbursements.

The remaining recommendations have to do with long term plans. Recommendation 1 suggests that the State Health Department develop a state plan which corrects maldistribution or surplus hospital service capacity and Recommendation 2 has to do with the State Health Department acting as a coordinator on indigent care funds and programs.

Recommendation 3 has to do with the State Health Department assessing private sector effort through the development of standardized formats for reporting of comparative data on the total indigent efforts.

Recommendation 8 has the State Health Department regularly monitoring hospital and PSRO activities.

Recommendation 12 considers coordination of cost containment activities and is actually related to Recommendation 2, in that it recommends that there be appropriate redistribution of indigent care costs and the extent to which state regulatory functions can be coordinated with rate review or regulations be addressed by the Commission on Health Care. All of these final recommendations will have interactions with Federal programs.

We feel that the report is generally accurate and their recommendation to develop a charge system for Hospital Outpatient Clinics is appropriate in light of our current accountability requirements for other third-party cost reporting and in light of good management practices.

CEH/RH:ba

VIRGINIA COMMONWEALTH UNIVERSITY
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Medicine
Nursing
Pharmacy

Mr. Ray D. Pethtel, Director
Joint Legislative Audit & Review Commission
Commonwealth of Virginia
Suite 200, 823 East Main Street
Richmond, Virginia 23219

Dear Mr. Pethtel:

I am enclosing information to clarify some areas of the JLARC Report as it applied to the Medical College of Virginia Hospital.

If further information is necessary, please feel free to give me a call.

Sincerely,

Edmund F. Ackell

Edmund F. Ackell, D.M.D., M.D.

October 18, 1978

EFA:mp
attachment

cc: Dr. Ronald E. Beller
Dr. Lauren A. Woods

JLARC STUDY ON INDIGENT CARE
MCV HOSPITAL RESPONSE
TO THE DRAFT OF SEPTEMBER 18, 1978

The purpose of this document is to offer some considerations and clarifications regarding the JLARC Report on Indigent Care as it relates to MCV Hospital. We believe that for the report to be properly understood and to serve the purpose for which it was intended that a number of the following factors must be considered.

1. Focus of the Report - In relation to MCV Hospital, the report focused on the period July 1, 1976 through June 30, 1977. At the time JLARC began its review, many management and procedural changes had been implemented and some were in the process of being implemented. The report in terms of its review of MCVH processing was outdated before the study began. The following is a chronological sequence of the events that should serve to demonstrate some of the positive steps taken by the Hospital in the past twenty-one months.

   Staff Changes - A complete reorganization of the management structure of the financial areas was begun in January of 1977. Prior to that time, there were no degreed accountants on the MCVH fiscal staff

   - A new Director of Fiscal Services took charge of the fiscal areas in January 1977
   - A Director of Patient Accounting Position was created and filled in March 1977
   - The position of Manager of Reimbursement was filled in June 1977
   - A position was re-allocated and an individual was promoted to Manager of A. D. Williams in February 1977
   - The position of Manager of Patient Billing was filled in February 1978
   - Twenty-one hourly positions were re-allocated to P-3 and a number of employees with poor attendance and work habits were released

   Organizational Changes - Organizational changes that were suggested by consultants and Alexander Grant and Company CPA's were implemented

   - Patient Accounting was organized to provide an adequate management structure and better control of processing flows

- The Admitting Department was transferred to Fiscal Services in, January 1978 to provide better control of data collection

- Clinic Registration started reporting to Fiscal Services for patient registration and billing purposes

Procedural Changes - As the new organization was established, new procedures were developed to control the flow of financial data

- An inactive filing system was established in the Magnolia Street Warehouse, enabling the Patient Accounting office to reduce the number of inhouse files from approximately 200,000 to 60,000. A system for microfilming closed accounts was devised that will eliminate the necessity to store physical documents

- Procedures were adopted that allowed the Hospital to write-off accounts in the hands of outside collectors thereby, increasing the likelihood of collecting delinquent accounts. Previously, written-off accounts were taken from collections and all collection activity ceased (Attachment I)

- The Hospital Accounts Committee was re-activated and started providing direction in terms of approving write-offs and establishing policies and procedures

- Methods were established to document all collection activity on accounts. The new documentation provides an audit trial that enables the Hospital to provide justification for account write-offs (Attachment II)

- Guidelines were issued regarding billing and collection practices in the Clinic. Accounts previously automatically written-off were sent to outside agencies for further collection effort. Reconciliation procedures were developed to ensure that Clinic accounts were properly billed

- ER billing procedures were modified to capture ER registration and ancillary charges that previously were unbilled

The purpose of documenting the above changes was to give a sense of the direction and progress that has been achieved in the MCVH fiscal areas. Without an awareness of these developments, the commission would not have a valid basis for any recommendations to be made.

2. Report Findings - MCVH Comments - the findings of the report are stated below as they pertain to MCVH. Each finding is followed by a Hospital response. In many instances, clarifications or corrections to the report findings are necessary.

1. Introduction

Page 102 states that MCVH could not adequately account for or justify indigent care charged to the State.

All accounts charged to the State were listed on one of two reports; the Deleted Bad Debt Report or the Cash Receipts and Adjustment Report. The correct statement would be that there was not a proper audit trail of action taken to collect indigent accounts. There is no question as to whether service was rendered or as to whether a bill was generated.

2. Account Processing

Page 103 states that the JLARC staff was unable to identify a written procedures manual, an organizational chart, or a flow chart for the processing of patient accounts.

Attached is a letter to Mr. Nahra in response to his request for an organizational chart pertaining to the period in question. (Attachment III)

Page 104 states that forms to collect additional financial information are not in use.

The Hospital implemented an automated admissions discharge and transfer system May 2, 1978. At that time, a new financial screening form was implemented. (Attachment IV)

Page 104 states that Financial Interviewers did not assist patients in applying for programs

The finding is correct in that more effort should be expended in attempting to qualify patients for financial aid. A new manager has been recruited for this area and procedural changes are being developed to strengthen the referral process

3. Write-Off Procedures

Page 106 states that inadequacies were apparent in the patient file review and that amounts written-off could not be verified on the basis of bills, statements payment receipts and other records contained in the file.

The Patient Accounting Department depends heavily on an automated system for record keeping and tracing of patient accounts. SMS (used prior to July 1, 1978) and Technicon (implemented July 1, 1978) produce paper and fiche reports which reflect the status of a patient's account during the stages of its life cycle. When records pertaining to a patient's account are produced on both paper and fiche, the fiche copy is preferred for retention. Retention of these records on fiche enables Patient Accounting to retain more information in the office for future reference as opposed to storing paper in a warehouse.

During the FY 1977, this methodology was being practiced. The full history of a patient account may not have been traceable using only the paper records contained in the folder. A combination of patient folder plus fiche provides a historical record. The folder holds the paper records that were not produced on fiche and the remaining records are retained within the Department on fiche. The total record thus retained permits the verification of the write-off.

3. Indigent Guidelines - The report compares the MCVH indigent guidelines to those used by the State Health Department. Correspondences in the MCVH files show that the State Health Department agreed with MCVH that there was justification for using a higher scale for the

Hospital and that the Hospital had the authority to establish its own scales for the Clinics. The SHD scales referred to in the report are primarily in use in Clinics that charge much lower registrations fees than the Hospital and that do not offer the expensive ancillary services provided to A. D. Williams patients. (Attachment V)

4. Summary - The JLARC Report on Indigent Care as it applies to MCV Hospital reflects a number of differences in interpretation of processes and guidelines that were in existence during the period examined, fiscal year 1977. The report does not however, deny the volume or cost of indigent care provided to residents of the State. The Hospital billed the State Health Department for accounts as they were deleted from the MCVH system regardless of the age of the account. On a fully accrued accounting system, the actual amount of bad debts incurred by the Hospital would exceed the amount reimbursed by the Health Services Fund.

JLARC NOTE

Relevant administrative changes implemented at the Medical College of Virginia Hospital during the course of this review have been noted by JLARC in the text of this report. Hospital personnel have attempted to address a number of complex issues. Nevertheless, large amounts of State indigent care funds are still being administered in accordance with unproven procedures and further improvements appear to be warranted.

COMMONWEALTH of VIRGINIA

Office of the Comptroller

'. J. Pross, Jr.
ıcting Comptroller

P. O. BOX 6–N
RICHMOND, VIRGINIA 23215

October 16, 1978

Mr. Ray D. Pethtel
Director
Joint Legislative Audit and
Review Commission
Suite 1100
910 Capitol Street
Richmond, Virginia 23219

Dear Ray:

Enclosed are Mr. Hairfield's comments of the JLARC exposure draft of Inpatient Care in Virginia per your request of September 19, 1978.

Should you need any additional comments or review, please call.

Very truly yours,

Vincent J. Pross, Jr.
Acting Comptroller

Enclosure

COMMONWEALTH of VIRGINIA

Office of the Comptroller

CHARLES B. WALKER, C.P.A.
COMPTROLLER

V. J. PROSS, JR.
DEPUTY COMPTROLLER

P. O. BOX 6-N
RICHMOND, VIRGINIA 23215

October 16, 1978

Mr. Ray D. Pethtel
Director
JLARC
910 Capitol Street
Richmond, Virginia 23219

RE: Exposure Draft - Inpatient Care in Virginia

Dear Mr. Pethtel:

The draft report, especially chapter five, points out just about the same things that I discovered in my survey of MCVH and UVH last fall.

I agree with your recommendation number 9 completely. Under the current system it is too easy for the hospitals to use the indigent fund in a way to simply correct a cash flow situation for the hospitals. Records are not documented sufficiently enough to justify writing-off an account without first evaluating the collection possibilities.

As a result of my survey, and a survey done by Peat, Marwick and Mitchell last fall, the hospital is in the process of revising and implementing some patient billing and collection procedures. Others are planned for the near future.

Recommendation number 10 is well taken. Up to now, the Department of Accounts acted only when requested to do so by the teaching hospitals.

I shall request the Comptroller to allow the Delinquent Accounts Coordinator to monitor the State-local hospitalization program payments. We will work with the two teaching hospitals

to implement procedures necessary to carry out the intent of the General Assembly for this program.

Very truly yours,

J. W. Hairfield
Delinquent Accounts Coordinator

JWH/au

JOINT LEGISLATIVE AUDIT AND REVIEW COMMISSION

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