REPORT OF THE
JOINT SUBCOMMITTEE

Established to Study Alternatives for a Long-Term State Indigent Health Care Policy

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

House Document No. 29

COMMONWEALTH OF VIRGINIA
RICHMOND
1986

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SUMMARY OF RECOMMENDATIONS

- A Governor's Task Force representing the public and private sectors should be established to provide a focal point for broad consideration of indigent health care issues.

- The Code of Virginia should be modified to specify that the Health Services Cost Review Council shall develop, in consultation with the Auditor of Public Accounts, standard accounting definitions to be used by hospitals in reporting uncompensated balances as contractual allowances, bad debt or charity care.

- The teaching hospitals should be required to adopt the Auditor's proposed cost report format in data submissions to the legislative money committees.

- The Bureau of Insurance of the State Corporation Commission should conduct a comprehensive analysis of the degree of health insurance coverage of the general population.

- The Secretary of Human Resources should designate staff within the secretariat to conduct an on-going review and analysis of other states' actions in response to indigent health care issues.

- Administration of the SLH Program should be transferred from the Department of Social Services to the Department of Medical Assistance on July 1, 1987.

- An amount of $525,000 in general funds should be transferred from the SLH Program to the Department of Mental Health and Mental Retardation for the provision of inpatient mental health services. An additional $105,000 in general funds per year should be appropriated to DMHMR to compensate for the difference in local match rates for the SLH and Community Services Board programs.

- The Department of Medical Assistance should submit a report to the General Assembly by October 1986 which identifies a strategy for setting uniform eligiblity criteria under the SLH Program, offers recommendations concerning the SLH hospital reimbursement structure, and the value of applying Medicaid cost-containment features to the SLH Program. Concurrent with implementation of these recommendations, the State match for the SLH program should be increased from 75% to 80% in the second year of the 1986-88 biennium.

- The Joint Legislative Audit and Review Commission should be asked to conduct a study of formulas used in the SLH Program and the State/Local Cooperative Health Department Program, and make recommendations to improve both formulas.

- The State should appropriate $1.0 million in general funds for four model projects in FY 1988 in order to encourage localities to employ innovative techniques when addressing the health care needs of their low-income population.

- The Study Committee should support by resolution the Virginia Hospital Association's efforts to overcome market barriers that exist for small firms in the purchase of reasonably priced health insurance.

INTRODUCTION

The Joint Subcommittee studying alternatives for a long-term state indigent health care policy was authorized by House Joint Resolution No. 129 of the 1984 General Assembly and continued through House Joint Resolution No. 210 of the 1985 Session. The subcommittee was established to evaluate the effect of changes in the health care environment on the provision of indigent health care in the Commonwealth and to propose policy changes as deemed appropriate.

The Joint Subcommittee met three times during 1985, once in Norfolk at the Norfolk Community Hospital and twice in Richmond.

The Joint Subcommittee appreciates the assistance provided by the Auditor of Public Accounts in his report on indigent health care costs at the state teaching hospitals. Input from the following parties also was helpful to the subcommittee in its deliberations:

Department of Medical Assistance
Department of Health
Department of Social Services
Health Services Cost Review Commission
Medical College of Virginia
University of Virginia Hospital
Eastern Virginia Medical Authority
Virginia Hospital Association
Administrators of Virginia Hospitals

BACKGROUND

The question of how best to provide and finance delivery of necessary health care for those who do not have the resources to pay is not a new issue. Public policy has fostered the development of "safety net" programs like Medicaid which assists the poor elderly, disabled and one-parent families and has financed health care for other indigents through either public-operated general hospitals or the clinical education programs of public teaching hospitals.

Traditionally, care provided to indigents without access to one of these public programs has been financed through cost shifting. This was a recognized and accepted policy whereby hospital charges for self-pay patients and those covered by insurance were set above the actual cost of care in order to recoup the cost for indigents who did not have the financial means to pay.

While cost shifting was never an ideal solution to a recognized problem, it did allow the cost impact to be spread across a broad base, i.e., everyone who purchased health insurance, the self-insured and private pay patients, and, to a limited degree, public purchasers of health care services.

Changing Health Care Environment:

Numerous factors have converged in the last two years that undermine the means of financing health care for the indigent population without access to public programs.

These factors are an outgrowth of national concern over rapidly rising health care costs, particularly rising hospital costs. Over the past two decades, national expenditures for hospital care increased at an average of 14% per year.

Over half of the increase in hospital expenditures over the past ten years was due to general inflation and population growth, factors that are outside the control of the health care and hospital industries. However, the remaining 42% of growth related to hospital-specific inflation, increases in volume and sophistication of hospital services and increases in hospital utilization (increased admissions per capita). These factors are controllable to some degree.

Reaction to the continuing spiral of hospital costs and the realization that some cost factors are controllable has created a totally different health care environment. Public and private actions to limit cost exposure have made the marketplace far more price sensitive and have eroded the traditional sources of financing indigent health care. For the first time, hospitals are concerned about what their competitors charge for similar services.

The development of Medicare's diagnosis–specific fixed rate payment system and the emergence of preferred provider plans, negotiated rates, health maintenance organizations and similar approaches have called into question the old policy of cross–subsidization through cost–shifting.

In today's "buyer's market", major purchasers have the ability to demand that what they pay for health care services is less than or certainly no greater than the actual cost of care for the populations they represent. The elimination of cost shifting as an accepted practice combined with increases in the uninsured and underinsured populations have profound implications for indigent health care in the country and in Virginia.

As hospitals become less willing to deal with the financial problems that accompany the indigent population, the provision of care will become more concentrated among fewer providers and an already uneven provider burden will be exacerbated. The public teaching hospitals and many of the inner city hospitals with their high charity caseloads will be at an extreme price disadvantage with their suburban competitors and some "sole source" rural hospitals could face financial ruin.

Public Indigent Health Care Programs in Virginia:

The state's indigent health care expenditures are concentrated in two major programs. Eighty–five cents of every state dollar for indigent health care goes to Medicaid and the state teaching hospitals. The distribution of state dollars is shown on the following chart.

The State has appropriated approximately $815.0 million in general funds for indigent health care in the 1984–86 biennium.

STATE APPROPRIATIONS

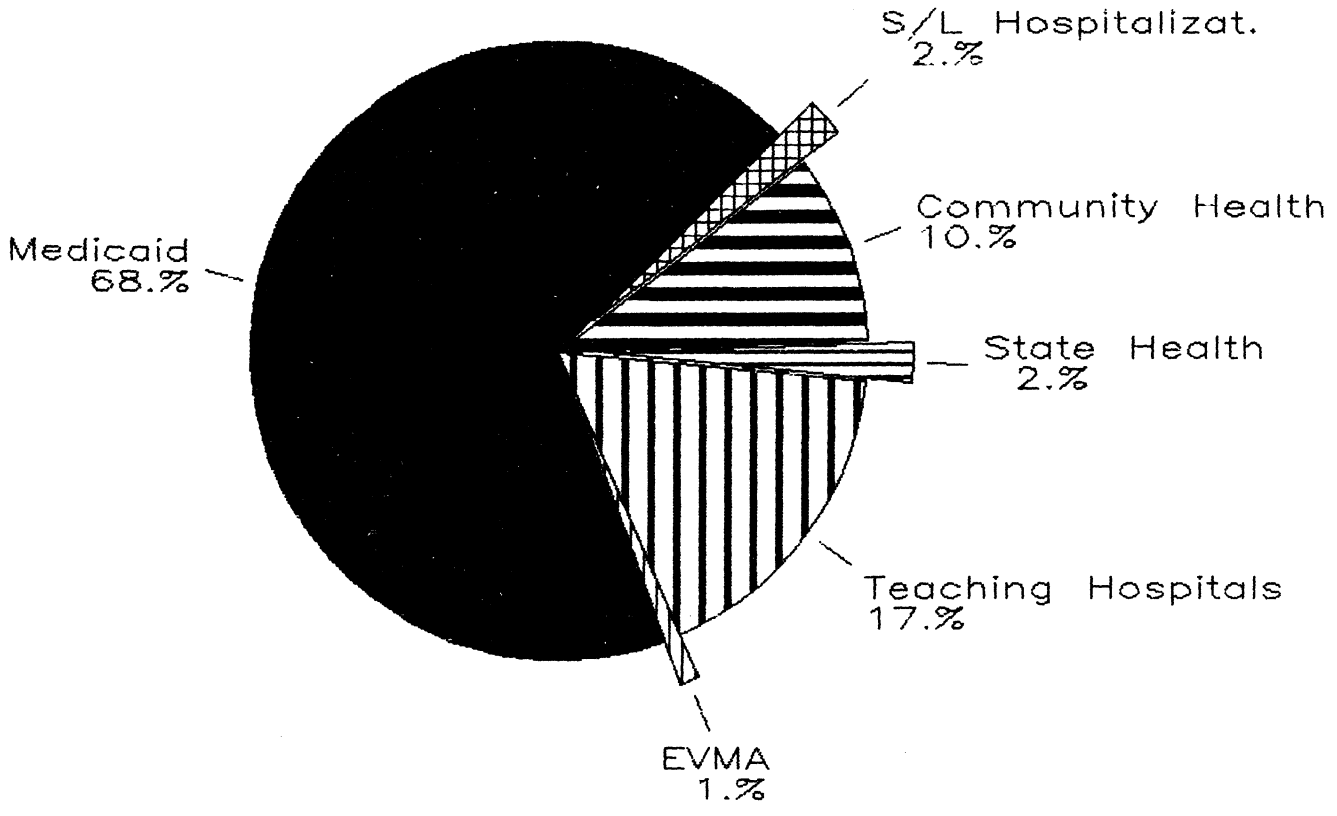
INDIGENT HEALTH CARE IN VIRGINIA

1984–86 BIENNIUM

(MILLIONS)

PROGRAM	GF	
MEDICAID	$555.0	68%
STATE TEACHING HOSPITALS (INDIGENT CARE APPROP.)	134.1	17%
COMMUNITY HEALTH (LOCAL HEALTH DEPTS)	83.2	10%
STATE HEALTH SERVICES (MCH, CRIPPLED CHILDREN, ETC.)	18.7	2%
STATE–LOCAL HOSPITALIZATION	16.6	2%
EVMA (INDIGENT CARE APPROP.)	7.7	1%
	$815.3	

STATE APPROPRIATIONS
INDIGENT HEALTH CARE IN VIRGINIA
1984-86 Biennium



Description of Programs

Medicaid

Provides comprehensive health care services to low-income aged, blind and disabled citizens and members of one-parent families. The number of Medicaid recipients ranges from 325,000 to 350,000 per year. The largest proportion of Medicaid's budget goes for hospital care (22%) and nursing home care (34%).

Teaching Hospitals

The teaching hospitals provide inpatient and outpatient services through an open-door policy to medically indigent citizens who do not meet the categorical requirements for Medicaid or whose health benefits have been exhausted.

Roughly 80% and 70% respectively of MCV and UVA indigent patients come from the communities immediately surrounding the hospitals.

Local Health

Local health clinics provide outpatient services through local health departments. The primary emphasis is on preventive health care including lab services, prenatal and postpartum care and screening, diagnostic and treatment services primarily for indigent women, infants and preschool children.

In addition to a preventive clinic program, eighteen local health clinics provide general medical services which include basically the same outpatient services that community physicians and hospitals would provide.

Local health clinics are funded cooperatively by the state and localities with an overall 58% state and 42% local share.

State Health Services

Indigent health care is provided primarily through the Maternal and Child Health hospitalization program for critically ill newborns and their mothers and through the crippled children program.

Description of Programs (cont.)

State–Local Hospitalization

SLH is an optional, locally–controlled program which reimburses hospitals for inpatient and outpatient care for low–income families who do not qualify for Medicaid.

The program is financed with 75% state and 25% local funding.

SLH is not an entitlement program. It is limited generally by funds budgeted and by local choice of services and scope of services. Hospital rates are negotiated by localities not to exceed a regional maximum rate set by the State Board of Social Services.

Three fourths of localities participate in the SLH inpatient program to some degree but seven localities receive 67% of total state funds.

Eastern Va. Medical Auth.

EVMA is a public entity created by the General Assembly which offers indigent care services through its Eastern Virginia Medical School, affiliated institutions, and health professionals.

Charity Care and Bad Debt of Virginia's Non–Public Hospitals:

Additional indigent health care is provided by Virginia's private non–profit and proprietary hospitals. Non–public hospitals reported to the Virginia Health Services Cost Review Commission that they experienced $171.3 million in charity care and bad debt in 1984.

It is difficult to determine exactly how much of this amount is true charity care since hospitals individually determine what to report in one category versus the other. The amount reported by non–public hospitals as charity care in 1984 was $38.3 million.

The lack of consistency in reporting is troublesome since bad debt does not represent the same type of public policy concern as charity care. Efforts should be made to distinguish between the two categories in the future.

A history of bad debt and charity care for Virginia hospitals since 1981 is attached as Appendix I.

VIRGINIA HOSPITALS
BAD DEBT AND CHARITY CARE
1984
(Excluding Public Hospitals)

$171.29 Million

6.2% Total Revenues

HSA I = 5.4%

HSA II = 5.6%

HSA III = 6.5%

HSA IV = 4.4%

HSA V = 7.9%

Expenditures by Health Region in Virginia:

Direct Public Expenditures

Analysis of indigent care provided through the major public health care programs and through the indigent care appropriations at the two state teaching hospitals shows an imbalance between program benefits and poverty population in four of Virginia's Health Services Areas (HSA's).

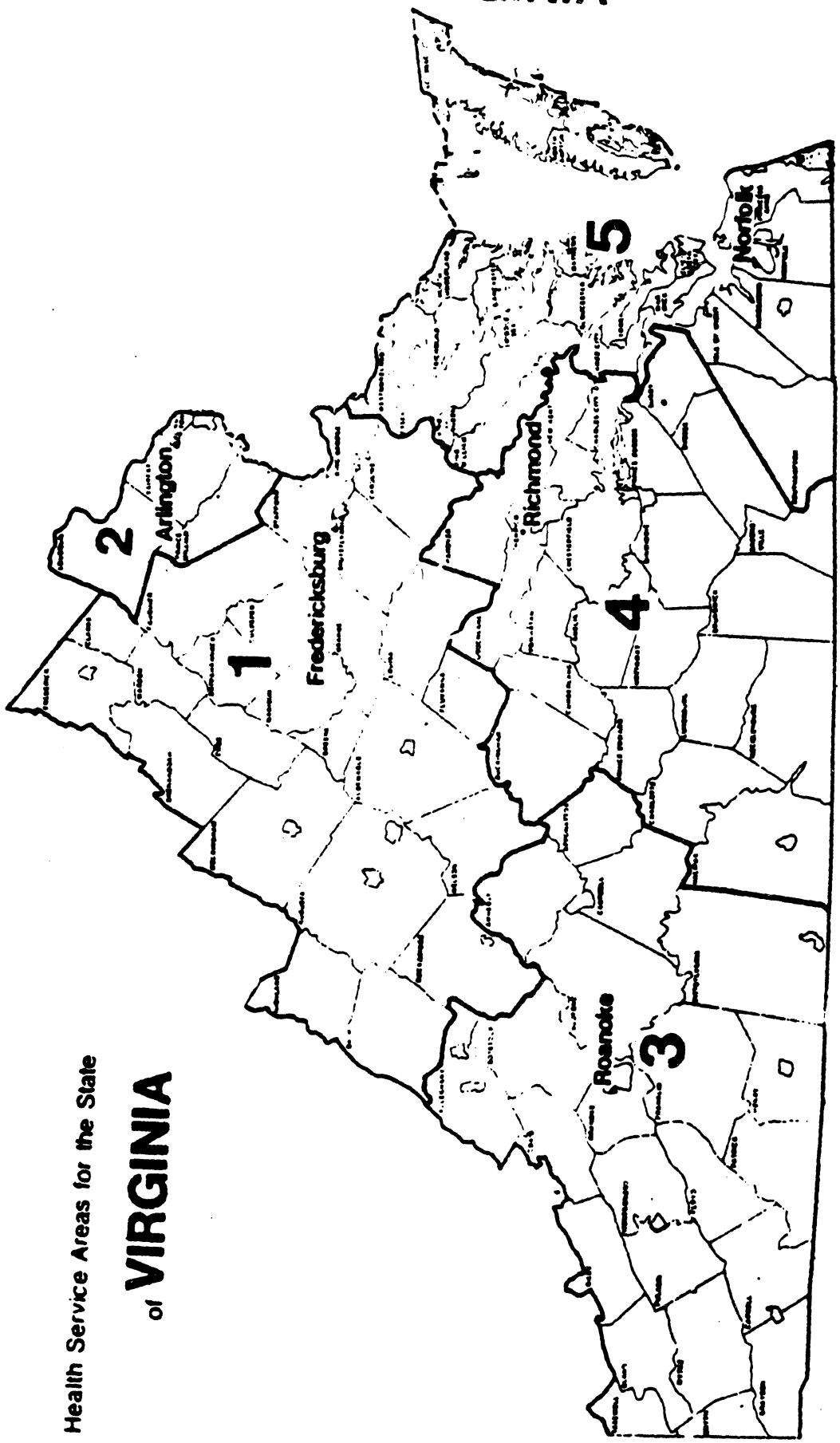
The Richmond area (HSA IV) shows a disproportionately high benefit pattern with 24.0% of the public indigent health services provided in fiscal year 1984 and 19.0% of the poverty population. Northern Virginia (HSA II) shows a benefit pattern of 12.5% of public expenditures against a 10.0% poverty population.

Part of the Northern Virginia difference relates to higher costs which are reflected in salary scales for local health department employees and in higher hospital charges.

In large part, the imbalance in the Richmond area relates to the existence of the Medical College of Virginia. Approximately 88% of this teaching facility's indigent care services in 1984 were provided to citizens of HSA IV.

Conversely, Southwest Virginia (HSA III) and Tidewater (HSA V) show disproportionately low benefit patterns. Southwest Virginia has a 26.0% poverty level but received 22.2% of public indigent health services in 1984 and Tidewater with 31.0% of the poverty population received 27.3% of public indigent health services.

Health Service Areas for the State of **VIRGINIA**



Health Service Areas for the State of **VIRGINIA**

FISCAL YEAR 1984

	Major Indigent Health Care Programs		Poverty Population
	Public Exp. (in millions)	% of Total Expenditures	% of Total
HSA I	$74.1	14.0%	14.0%
HSA II	$65.8	12.5%	10.0%
HSA III	$117.5	22.2%	26.0%
HSA IV	$126.9	24.0%	19.0%
HSA V	$144.1	27.3%	31.0%

Indirect Public/Private Expenditures

Inclusion of bad debt and charity care provided by non-public hospitals in Virginia in 1984 and the amount of care provided by the two state teaching hospitals above the indigent care appropriation ($32.3 million) does not alter the imbalance noted under direct public expenditures.

The cost in this case would be considered a joint public/private cost since amounts that are uncompensated are cost-shifted to other payors. The cost shift ultimately is reflected in insurance premiums paid by employers.

The following chart shows the relationship of the combined direct public and indirect public/private cost versus poverty population for each HSA.

These combined figures still show that imbalances are most pronounced in the Southwest Virginia, Tidewater and Richmond area HSA's. The proportion of indigent health services in the Richmond area is 4.2% greater than the proportion of poverty population and the proportions of indigent health services in Southwest Virginia and Tidewater are 4.1% and 2.5% respectively below the proportion of poverty population.

FISCAL YEAR 1984

	Major Indigent Health Care Programs		Poverty Population
	Public & Private (in millions)	% of Total Expenditures	% of Total
HSA I	$93.8	12.8%	14.0%
HSA II	$93.4	12.8%	10.0%
HSA III	$160.9	22.0%	26.0%
HSA IV	$172.9	23.6%	19.0%
HSA V	$211.0	28.8%	31.0%

Data on Indigent Health Care Basically Show Three Things:

- That the indigent health care cost burden is increasing over time;
- That the indigent health care burden is uneven across types of providers i.e., public, proprietary and non-profit, with the greatest burden on the public providers of service and;
- That indigent health services provided across the health regions of Virginia are not proportionate to the poverty populations within those regions.

The mere fact that these trends exist says little about appropriate public policy for indigent health care. In order to formulate public policy, there must be a thorough understanding of who is included in Virginia's medically indigent population. Also, there must be a clear distinction between the cost of charity care and the cost of bad debt. Figures reported by hospitals on the basis of charges reflect such variables as desired profit margin or operating surplus and potentially overstate the financial burden of the hospital system.

The Medically Indigent Population in Virginia:

Medicaid Population - The low-income aged, blind and disabled and single parent families are the traditional Medicaid population. Recent changes in legislation at the federal level and in Virginia have added coverage for low-income children, certain low-income two-parent families with an unemployed head of household and low-income women who are pregnant for the first time.

While the Medicaid program is the cornerstone of the indigent health care program in Virginia, there are many factors which restrict its coverage. Categorical requirements and the extremely low income threshold cause many Virginians living below the poverty level to be excluded from coverage. Nationally, the proportion of poor and near poor covered by Medicaid has dropped significantly over the past decade, from 63 percent covered in 1975, to 46 percent today.

Furthermore, the program's reimbursement restrictions cause some health care expenses for the Medicaid population to appear in other public health programs or in the uncompensated care numbers reported by Virginia hospitals, i.e., fixed per diem payment based on median hospital cost and 21-day limit on hospital stays.

Underinsured and Uninsured Population – Persons without medical insurance are not automatically "medically indigent." Many are healthy and need no medical care or can afford to pay for what they need. But the uninsured and underinsured are at risk of becoming medically indigent if they are too poor to pay for basic services or if they experience catastrophic illness.

Several national and state studies have shown that 15% – 20% of the population has neither public nor private insurance coverage. Perhaps the most significant finding of these studies from a public policy standpoint is that a high proportion of the uninsured population is employed either all or part of the year. Various surveys show that from 44% to roughly half of the population without insurance are in fact employed. These are primarily people working part time, in small firms, in low wage–paying firms, or in non–union firms. It is estimated that 45% of the workers in firms of 25 or fewer employees lack insurance.

There can be no definitive statements about the uninsured worker in Virginia because no survey has been conducted. However, a recent report commissioned by the Virginia Hospital Association on Uncompensated Care suggests that Virginia is likely to have a greater rate of uninsurance than the nation because of the mix of Virginia industries. In 1978, the construction, retail trade and service industries had the highest rates of uninsurance nationally. Virginia currently has a higher proportion of employment in these industry types than the nation had in 1983.

Another finding contained in a 1977 National Medical Care Expenditure Survey was that almost half of those who were always uninsured came from middle and high income families (families with incomes above $15,000 in 1977).

In order to devise a comprehensive public policy for dealing with medical indigency in Virginia, it is necessary to know what factors are contributing to the problem. For example, is employment–based insurance being denied to the working poor? Are increases in premium payments and coinsurance/deductibles for those with employment–based insurance causing workers to drop coverage for dependent children and spouses? Are Virginia's insurance laws on conversion and continuation rights for the newly unemployed too restrictive?

A study of the effect of insurance practices on demand for indigent health care must precede public policy formulation in this area.

Actions Taken in Other States to Deal with Indigent Health Care:

Policies Designed to Provide Health Care Coverage for Otherwise Uninsured

-- Expand Medicaid coverage to include the medically needy and add optional coverage for pregnant women and children (numerous states).

-- Expand buying power with existing dollars, i.e., capitated payment system for indigents in Minnesota (HMO model); selective contracting for specific number of hospital days with most efficient providers in Illinois.

-- Specify in law local responsibility for indigent residents' health care up to a dollar limit based on revenue capacity (Texas). State assistance is provided for indigent health care in excess of local responsibility.

-- Expansion of private sector insurance coverage (several states).

Mandate continuation of benefits to enable individuals who lose employment to continue coverage at group rate. Time limits range from 1–18 months.

Mandate conversion privileges to prohibit insurers from refusing to allow individuals losing group coverage to convert to individual coverage.

-- Establish catastrophic insurance programs (several states). None have been particularly successful.

-- Establish insurance risk pools (several states). These are not really geared to the indigent population since premiums are high.

-- Establish multiple employer trusts to enable small employers to purchase quality, affordable health insurance coverage on a pool basis or establish brokering service for health plans that are willing to provide coverage to small employer pools.

Policies Designed to Lessen Financial Burden Imposed on Providers of Uncompensated Care

-- Seek to lighten the burden on hospitals providing substantial amounts of free care through infusion of new funds

Differentiated Medicaid reimbursement for certain hospitals and/or direct subsidies to particular providers.

or

-- Sharing burden across hospitals

Revenue pools or "fair share" programs,i.e., Florida and South Carolina;

All-payor rate-setting with requirement that charity care be built into the charges that are paid by every patient or the third party responsible for his bill, including the federal government.

Applicability of Policies to Virginia:

-- Expanded Health Care Coverage

Medicaid

The first action that many states are taking is to maximize federal reimbursement under Medicaid by expanding benefits to optional categories of recipients. Virginia already has incorporated this strategy by offering coverage to the medically needy as well as categorically needy population. In addition, Virginia, as well as other states, recently have expanded coverage to include low-income children up to the age of five and low-income intact families with unemployed head of household. These expansions were required by the federal Deficit Reduction Act. Also, the optional category of first- time pregnant women who meet financial eligibility are now covered in Virginia.

One of the risks that a state assumes when it expands the Medicaid program to include optional categories is that it will have to assume a higher proportion of these costs in the future if the federal financial participation or match rate decreases. The federal match rate is recomputed every two years and is tied to a state's relative economic well-being.

The population covered under the Virginia Medicaid program is adequate. The fine-tuning that Virginia might consider relates to reimbursement policies, i.e., the 21-day hospital limit per spell of illness. It is estimated that this policy will cause cost-shifting of approximately $52.0 million during the current biennium ($24.5 million in general funds). About 6,000 of these uncompensated hospital days are related to neonatal care. Almost all of the neonatal days are considered medically necessary. The Department of Medical Assistance has submitted an addendum request for $11.5 million ($5.4 million in general funds) for the 1986-88 biennium to eliminate the 21-day hospital limit for neonatal days.

Buying Power

The state has made limited attempts to expand buying power with existing dollars through better management of the client. The most notable example of this effort is the nationally recognized nursing home pre-admission screening program whereby community placements are arranged as alternatives to nursing home care where appropriate. The Medicaid program also manages certain clients who are identified as abusive users by specifying a sole provider of service.

Virginia currently provides no incentives for the development of innovative service options that maximize available resources. This is an area that should be given more attention in the future.

Insurance Law

Virginia's insurance law contains fairly restrictive continuation and conversion features. When a person who is covered under a group plan loses his job, the insurer has the option of offering conversion to an individual policy or continuation under the group plan. If conversion is offered, the terminated employee must apply for the individual policy and begin paying a much higher cost premium within a month of leaving his job. If continuation is offered, the terminated employee must prepay the group rate for the 90 day coverage period before leaving his employment. Neither option is particularly attractive to an individual who has lost his job.

The Virginia Hospital Association report on Uncompensated Care suggests that the State could mandate continued group coverage at the group rate to help spread risks over a larger base and keep the premium low enough to encourage more individuals to continue coverage. An admitted problem with this suggestion is that employers would resist such a requirement and some might move toward self-insurance which would be exempted from State mandates through federal ERISA provisions.

During 1984, a legislative study committee considered the health insurance coverage available to individuals with chronic health problems. The feasibility of establishing an insurance risk pool was considered by the subcommittee and tentatively rejected on the basis of testimony from Blue Cross and Blue Shield that it acts as an insurer of last resort. All applicants are accepted by Blue Cross and Blue Shield regardless of their physical condition at the standard individual rate during open enrollment periods, subject only to the applicable waiting period. The individual premium was reported to be less than the risk pool premiums required in other states.

The Virginia Hospital Association report on Uncompensated Care suggests that this "service" offered by Blue Cross-Blue Shield is diluted by pre-existing condition rules, limitations of the length of open enrollment and the lack of any subsidy from the group side of the business, all matters that might be considered by the State.

The Hospital Association report also includes a recommendation to mandate auto insurance. The Association's sample of unpaid hospital bills in Virginia showed that almost 10% of uncompensated care involved trauma diagnoses and that these cases had disproportionately high unpaid balances. It was suggested that any strengthening of auto insurance requirements to assure insurance coverage with a medical component would provide an additional source of funds for hospitals treating accident victims.

The Virginia Hospital Association has adopted a series of independent steps intended to help solve several key uncompensated care issues. Among these steps is establishment of a Small Employer Insurance Initiative. The VHA intends to serve as a catalyst in overcoming market barriers to the development of reasonably priced voluntary insurance programs for the self-employed and for those working in small firms. The VHA will take the lead in assembling hospital, community, and philanthropic resources to support such an initiative during 1986.

-- Policies to Lessen Financial Burden Imposed on Providers

Differentiated Reimbursement/Direct Subsidies

Virginia provides additional reimbursement under Medicaid for hospitals which serve a disproportionate share of Medicaid recipients. In addition, Virginia provides direct subsidies for indigent care to the two state teaching hospitals, to the Eastern Virginia Medical Authority, and to other Virginia hospitals through the State-Local Hospitalization program. The State appropriation for these programs in the current biennium is $158.3 million. In addition, Virginia has provided direct subsidies to the two Children's Hospitals in Virginia.

Revenue Pools and "Fair Share" Programs

Revenue pools and "fair share" programs which have been implemented in other states have some appeal from the standpoint of neutralizing the competitive advantage of hospitals which are able to avoid dealing with the indigent population primarily because of location. However, these programs are in the infant stage and have not met the test of time. Virginia should investigate the experience of the Florida model and other state experiments as they end their first years of operation.

Also, the information that Virginia hospitals currently report to the Health Services Cost Review Commission on charity care is inadequate both to measure the extent of the financial problem and to be used as an allocation tool should additional funds be available.

Reporting requirements must be properly defined and implemented in advance of any future consideration of financial assistance for hospitals with disproportionate charity caseloads.

All-Payor Rate Setting Programs

An all-payor rate setting structure is not felt to be an appropriate vehicle for Virginia at this time. The experience of these systems in other states has been called into question by the federal government and the chance of securing a required federal waiver for Medicaid and Medicare to participate is very limited.

RECOMMENDATIONS FOR FURTHER ACTION

ISSUE: In response to heightened awareness of the indigent health care issue, a number of states have established special deliberative groups to address the problem. A recent survey conducted by the National Conference of State Legislatures indicated that the provision of care to the medically indigent will clearly be one of the major health care issues state legislatures will consider in 1985–86. In addition to recent initiatives which have been implemented in several states, the actions of state legislatures this year could produce additional options that should be considered. It is felt that a focal point in Virginia is necessary for broad consideration of all aspects of the indigent health care issue.

RECOMMENDATION: A Governor's Task Force should be established to provide this focal point. The task force should represent a public/private effort to identify problems specific to Virginia and recommend appropriate actions to deal with those problems. This recommendation is contained in the October 1985 report of the Virginia Hospital Association on Uncompensated Health Care.

The task force membership should include the Secretary of Human Resources, the Secretary of Education, one legislative member from each of the House and Senate authorizing and appropriating committees, and a representative from each of the following: the insurance community, the Virginia Hospital Association, the Virginia Medical Association, the State Department of Health, the Department of Medical Assistance Services, the Health Services Cost Review Council. Finally, three business representatives should be appointed to include executives of both a large and small private employer in the state and a representative of the state Chamber of Commerce.

The Governor's Task Force should be the body designated to receive all reports recommended by the Indigent Health Care Study Committee in this document.

ISSUE: Charity care is reported by Virginia hospitals on the basis of charges rather than costs and is not based on consistent definitions of charity care versus bad debt. For this reason, the information collected by the Virginia Health Services Cost Review Council is useful only for year–to–year comparisons of combined charity care and bad debt. Since true bad debt does not represent the same type of public policy concern as charity care, the information cannot be used in a meaningful way to formulate policy on indigent health care. Furthermore, the information is only superficially useful as an indicator of relative fiscal stress across hospitals that is related to the indigent care caseload.

Section 9-158 of the Code requires that the Health Services Cost Review Council establish by regulation a uniform system of financial reporting by which health care institutions shall report their revenues, expenses, other income, other outlays, assets and liabilities, units of service and related statistics.

RECOMMENDATION: The Code of Virginia should be modified to specify that the Council shall develop, in consultation with the Auditor of Public Accounts, standard accounting definitions to be used by hospitals in reporting uncompensated balances as contractual allowances, bad debt or charity care.

It is also recommended that the Council adjust charges to estimated cost when it reports the charity care data by applying each hospital's ratio of operating cost to operating revenues.

ISSUE: The State has endorsed a goal of moving to 100% funding of the cost of indigent health care provided at the two state teaching hospitals. The current biennium appropriation was increased 42% in an attempt to reach 90% of the full funding cost.

In prior biennia, the teaching hospitals have presented the State's funding obligation in terms of charges rather than costs. Since charges are set high enough to recoup total uncompensated care which includes contractual allowances and bad debts as well as charity care, this method has the potential of overstating the appropriation shortfall for indigent care.

Language in the current Appropriation Act directs the Auditor of Public Accounts to design a report which captures the actual costs associated with indigent care.

RECOMMENDATION: The teaching hospitals should be required to adopt the Auditor's proposed cost report format in data submissions to the legislative money committees beginning with the fiscal year 1985 indigent care data. Appropriation Act language should distinguish between the appropriation for the cost of indigent health care and other funds that the General Assembly might provide to support the cost of medical education.

ISSUE: Sound policy on indigent health care cannot be developed until there is a clear understanding about the population at risk of medical indigency. A major component of this information relates to the uninsured and underinsured population. Factors like the degree of unionization in the state, the number of small employers and the concentration of industry type can have a major impact on the pattern within a particular state. Therefore, it is important to avoid generalizations from national data.

RECOMMENDATION: The Bureau of Insurance of the State Corporation Commission should conduct a comprehensive analysis of the degree of health insurance coverage of the general population. The study should include the employment status and income level of the uninsured population in Virginia and should highlight the variables that contribute to the absence of insurance coverage. Data also should be collected about the health status, health care needs and health care use of the population at risk of medical indigency.

ISSUE: Innovative financing programs to deal with indigent health care have been legislated in various states in the recent past, i.e., Florida, South Carolina, Nevada, Texas. In addition, voluntary efforts are underway in some states, i.e., the "Fair Share" program in Kentucky. The results of these efforts with their corresponding advantages and disadvantaged will be emerging over the next year to two years. These program should be thoroughly evaluated for their applicability to Virginia.

RECOMMENDATION: The Secretary of Human Resources should designate staff within the secretariat to conduct an on-going review and analysis of other states' actions in response to the indigent health care issue. This analysis should deal with legal and fiscal considerations as well as general policy concerns.

ISSUE: The State/Local Hospitalization Program is currently administered by the Department of Social Services while the Medicaid Program is administered by the Department of Medical Assistance. Given the size of the Medicaid Program ($600 million per year) as compared with the SLH Program ($9 million per year), the role of the SLH Program in the delivery of health services to the indigent is shaped by the service gaps found in the Medicaid Program.

There is currently a lack of uniformity between the Medicaid Program and the SLH Program in several areas: eligiblity criteria, screening processes, cost containment measures, (i.e. 21 day limit on hospitalizations, limiting hospitalization prior to surgery to one day, restricting weekend admissions) and hospital reimbursement rates. In order to improve the combined impact of these two programs, their policies and procedures must be more complementary and coordinated.

In addition, while the Department of Social Services manually administers the billing processes of the SLH Program, these tasks could be incorporated into the computerized Medicaid System.

RECOMMENDATION: Administration of the SLH Program should be transferred from the Department of Social Services to the Department of Medical Assistance on July 1, 1987. It is further recommended that the Department of Social Services retain the responsibility for eligibility determination at the local level as is done for the Medicaid Program.

ISSUE: Approximately $700,000 is expended under the SLH program each year on inpatient services for the treatment of mental illness. As the eligiblity determination for the SLH Program is done by the Department of Social Services at the local level, persons who require assistance for the treatment of mental illness are not connected to the Community Service Board System through the SLH Program.

For most individuals with mental illness, inpatient services are required to address episodic crisis, but do not offer a cure for the problem. Continued support and other community services are required to address the needs of this population. Therefore, it is important that coverage for inpatient psychiatric services be made available within the mental health delivery system.

RECOMMENDATION: An amount of $525,000 in general funds should be transferred from the SLH Program to the Department of Mental Health and Mental Retardation for the provision of inpatient mental health services. In addition, it is recommended that $105,000 in additional general funds per year be appropriated to DMHMR in order to offset a shortfall which would occur as a result of the difference in local match requirements between SLH (25%) and the Community Service Board System (10%). These actions will ensure the level of funds for these services will remain at a minimum of $700,000 per year ($630,000 State/$70,000 Local).

This transfer is being recommended to connect persons receiving inpatient services with a community support network. Therefore, the Community Services Boards will administer these funds according to SLH eligibility and reimbursement guidelines in order to minimize the impact of this transfer on recipients and health care providers.

Fund allocations by locality will be based upon the average expenditures under this diagnostic category for fiscal years 1985 and 1986.

ISSUE: Despite the fact that 75% of the funding for the SLH Program is provided by the State, the program continues to be a local option program. In addition to the local option feature which promotes unequal access to services across the State, the lack of coordination of program procedures with the Medicaid Program also is problematic.

Recommended eligibility guidelines are established by the State Board of Social Services but localities are not required to follow these guidelines. Therefore, while a resident may be eligible for SLH in one county, a resident of another county with similar income and resources may not be eligible for SLH.

In addition, the SLH Program as it is currently administered does not require a locality to establish an annual service plan outlining what services will be available under the SLH Program. As localities do not have to commit themselves to participation in the program, continuation of the program is often jeopardized by changing fiscal conditions at the local level.

Localities choosing to participate in the SLH Program are required to negotiate hospital reimbursement contracts with their local hospitals. The issue of whether or not it is advisable for the reimbursement rates for the SLH Program to be consistent with the Medicaid reimbursement rates should be addressed.

Several cost containment measures (i.e. restricting hospital admissions to 21 days, limiting hospitalization prior to surgery to one day and limiting weekend admissions) have not been applied to the SLH Program. Therefore in some instances, SLH funds provide coverage for Medicaid patients beyond the 21 day limit.

A bill was introduced during the 1984 Session to address several of the management problems mentioned above. This bill was carried over to the 1985 Session primarily because localities felt that the funding level should be reviewed at the same time that management changes are proposed. This bill was passed by during the 1985 Session pending recommendations of this study committee.

RECOMMENDATION: The Department of Medical Assistance should submit a report to the General Assembly by October 1986 which identifies a strategy for setting uniform eligiblity criteria under the SLH Program, offers recommendations concerning the SLH hospital reimbursement structure, and the value of applying Medicaid cost-containment features to the SLH Program. In addition to addressing these issues, the Department is encouraged to propose any other modifications to the SLH Program which would enhance the delivery of health services to the indigents in the Commonwealth.

In order to recognize the greater degree of State control that will accompany implementation of uniform eligibility criteria and the requirement that localities submit an annual SLH plan, it is recommended that the State match for SLH be increased from 75% to 80%. This increased match will be initiated in July 1987 when any approved management changes become effective, and will require approximately $500,000 in general funds in fiscal year 1987-88.

ISSUE: For several years, complaints have surfaced over the formulas applied to the two health programs which are funded through state and local support: the State/Local Hospitalization Program and the State/Local Cooperative Health Program.

The State-Local Hospitalization (SLH) formula is based strictly on population and is allocated on a semi-annual basis. At the end of each six months, those localities exceeding their initial allocation may request funding from the reserve fund. The reserve fund includes monies designated through the Appropriation Act as a setaside, in addition to monies which were allocated but not spent by localities. The major problems with this formula are as follows:

The formula is based upon population with no adjustment for the size of the poverty population or the access of residents within certain localities to the teaching hospitals.

The allocation formula distributes available funds to all localities regardless of whether they plan to participate in the program. Therefore, a pool of unexpended funds is automatically generated which reverts to the reserve fund to be tapped by a few localities.

Reserve funds are dispersed retrospectively on a reimbursement basis. Localities must first spend 100% local funds in the SLH Program before they request reimbursement from the reserve account. This limits access to the reserve fund to only those localities who can afford to risk spending local funds on the chance that state reimbursement will be forthcoming. Many of the poorer localities will not assume this risk.

There has been no effort to determine if initiation of a sliding scale for the local match requirement on this program would encourage localities to participate in the program.

The second formula under consideration, the State/Local Health Department Cooperative Formula, was established in 1954 and has undergone little change since that time. The local match requirement is based on a locality's fiscal condition which is measured by the estimated true value of real estate, and varies between 18 to 45 percent. A report completed by the Joint Legislative Audit and Review Commission in 1979 noted the following problems with the formula:

The use of the estimated true value of real estate as a measure of fiscal capacity contributes to financial disparities among health departments. When the formula was established, local real estate taxes were by far the single most important source of locally raised taxes. Today both cities and counties depend upon a more diversified tax base.

Fiscal disparities are perpetuated by "across the board" increases in State appropriations to all localities regardless of present service levels or need; and localities have considerable discretion to define their own level of support for local health services.

RECOMMENDATION: The Joint Legislative Audit and Review Commission should be asked to conduct a study of formulas used in the SLH Program and the State/Local Cooperative Health Department Program, and make recommendations on formula revisions. The study should include cost estimates for formula alternatives presented and should be completed prior to the 1987 legislative session.

ISSUE: The health care needs of the low-income population are currently being addressed through a variety of public and private programs. However, the lack of coordination among various health care providers at the local level limits the public sector's ability to serve this population.

Innovative approaches to the delivery of health care to the low income population have been tried in other states and are listed in the front section of this report. In addition to exploring new programs or the expansion of existing programs at the State level, it is possible to improve services to this population by supporting local initiatives which can deal directly with the specific health care needs of a community's low-income population.

Local efforts which identify the health care service gaps, and mobilize both public and private health care providers to address these issues have been successful in other areas of the country. In many instances a central intake service which provides pre-screening and referral services can reduce hospital utilization and improve the health services provided to this population.

RECOMMENDATION: The State should appropriate $1.0 million in general funds for four model projects in FY 1988 in order to encourage localities to employ innovative techniques when addressing the health care needs of their low-income population. Each grant should be awarded as a competitive bid at a sum not to exceed $250,000.

Recognizing the regional inequities which currently exist in State-financed health care services for the indigent population, it is recommended that two model projects be targeted to the Tidewater health services area, and two model projects be targeted to the Southwestern health services area. As mentioned previously in this report, the percentage of poverty which exists in the Tidewater and Southwestern areas is higher than the percentage of indigent health care funding these areas receive from the State.

The administering agency for these grants should be the Department of Medical Assistance Services. This Department should administer these grants on a schedule which will ensure bid awards by July 1987.

APPENDIX I

BAD DEBT & CHARITY CARE

	Bad Debt & Charity Care ($ millions)				As % of Total Revenues			
	1981	1982	1983	1984	1981	1982	1983	1984
HSA I								
Nonprofit	$8.30	$10.16	$12.75	$12.61	4.9	5.0	5.7	5.4
Proprietary	0.10	0.05	--	--	4.7	2.1	--	--
Public	19.34	22.55	28.45	33.70	19.6	18.6	18.9	19.6
					10.2	10.0	11.0	11.5
HSA II								
Nonprofit	12.18	14.25	23.62	24.21	4.2	4.1	6.0	5.8
Proprietary	2.18	1.20	2.35	3.19	4.0	2.2	3.2	4.4
					4.1	3.8	5.6	5.6
HSA III								
Nonprofit	21.09	24.89	28.87	31.62	6.0	6.1	6.4	6.5
Proprietary	4.34	6.65	12.54	10.56	4.6	6.1	8.9	6.3
					5.7	6.1	7.0	6.5
HSA IV								
Nonprofit	11.87	12.93	15.91	16.11	5.5	5.0	5.6	5.7
Proprietary	4.20	5.05	5.66	7.87	2.3	2.3	2.2	3.0
Public	26.09	34.39	52.49	57.67	22.0	25.2	28.4	27.5
					8.1	8.5	10.2	10.8
HSA V								
Nonprofit	35.77	38.51	50.86	58.97	6.6	6.2	7.2	8.1
Proprietary	2.48	2.61	3.59	6.15	4.4	4.3	4.4	6.3
Public	0.12	0.56	0.48	0.28	1.4	5.7	5.1	2.8
					6.4	6.1	6.9	7.8
TOTAL STATE	$148.06	$173.79	$237.58	$262.94	6.8	6.8	8.1	8.4

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TOTAL STATE	$148.06	$173.79	$237.58	$262.94	6.8	6.8	8.1	8.4

Respectfully Submitted,

L. Cleaves Manning, Chairman

Dorothy S. McDiarmid

Franklin M. Slayton

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