

III. The Cost of Patient Care in Virginia's Academic Health Centers

As State policymakers re-examine the role of AHCs, a significant portion of the ensuing debate will center on the costs associated with this healthcare model. Shifting market forces and greater competition from other hospitals have limited the ability of these facilities to cross subsidize the cost they incur in treating indigent patients, thereby necessitating a greater reliance on State general fund dollars. This has prompted important policy questions about how much the AHCs spend to treat patients, especially those persons who are indigent and uninsured.

Heightening interest in this issue is the dearth of straightforward cost data on Virginia's AHCs. Due in large part to the independence of these institutions and the complex nature of the healthcare business, the details of their operations are difficult to decipher. Accordingly, outside of the data put forward in abstruse audit reports, little is known about the overall cost of services in the AHCs, how these institutions compare to their peers on basic measures of efficiency, and the cost trends associated with indigent patient care.

This chapter examines the source of overall differences in patient costs between the State's AHCs and other providers in Virginia. In addition, results from a study comparing the performance of AHCs to peer institutions around the country are discussed. Finally, data on the cost of care for the indigent population are analyzed to assess how AHCs have managed the delivery of care to the poor over the past several years.

Consistent with the findings of several studies, this analysis found that the overall per-patient cost of care in the AHCs is higher than the levels observed for private hospitals. However, much of this difference can be attributed to the costs incurred by AHCs in developing the capacity to provide the specialized care and trauma services not typically funded in other hospitals.

Also, both UVA/HS and VCU/HS have worked with outside consultants to evaluate the efficiency of their operations. When compared to peer hospitals around the nation, both UVA/HS and VCU/HS performed as well as can be expected, given the broad missions of AHCs and the acuity levels of the patients treated.

These systems have also been able to contain growth in the indigent healthcare program over the past five years. This has been especially true for inpatient care. Key factors slowing the rate of growth in this program have been a decline in the total number of indigent patients who are admitted for inpatient care, the ability of staff at the two AHCs systems to reduce hospital stays for those who are admitted, and shifts in care protocols to the outpatient setting. Still, greater savings in both the inpatient and outpatient programs are possible if the AHCs find ways to better link the indigent healthcare program to the Medicaid and FAMIS programs.

THE IMPACT OF MISSION-RELATED ACTIVITIES ON PATIENT COSTS IN VIRGINIA'S AHCS

It has been widely documented that patients spend more for healthcare at AHCs than at private or community hospitals. What has not been as thoroughly examined or understood is whether and how the specific missions of

AHCs contribute to these higher costs. Without this type of information, policymakers have been unable to effectively debate whether the societal benefit of these missions equal or exceed the additional costs incurred in funding them.

This analysis found that the average per-patient cost of inpatient care for all payors in Virginia's AHCs is slightly more than \$10,400. This figure represents the cost per discharge prior to adjusting for case mix and outpatient caseload and is almost \$5,000 higher than the average cost observed in other hospitals in the Commonwealth. Using nationally derived weights, it is estimated that approximately 30 percent of the higher costs observed among Virginia's AHCs can be attributed to mission-related activities.

The need to fund stand-by capacity for emergency departments and specialized care were the most expensive of mission activities, accounting for 13 percent of per-patient costs. Activities funded with Indirect Medical Education dollars accounted for the second largest component of these costs at 12 percent. Once these variables are factored in, the cost per discharge for the AHC's is only slightly higher than that of other hospitals across the Commonwealth.

However, despite the higher per-patient costs relative to private providers, both of Virginia's AHCs compare favorably to hospitals around the country that have similar missions. Specifically, the costs at these institutions are at anticipated levels given a number of factors, such as the acuity level of their patients.

The Mission-Related Activities of Virginia's AHCs Add an Estimated 30 Percent to the Cost of Inpatient Care

In order to conduct the comparative analysis of inpatient costs for hospitals in Virginia, a number of important steps were required. First, using data from several sources, a measure of hospital cost based on the cost of care delivered to all patients had to be constructed. Much of the previous research on this issue has relied on hospital data from only the Medicare population as a proxy for all inpatient hospital costs. This problem was avoided for this study through the use of "all-payer" patient data. Drawn from hospital cost reports, these data provided cost information on all persons who received inpatient acute care in hospitals, excluding only those persons who received this care in long-term care units or through sub-providers.

Next, following a method used by a national healthcare consulting firm known as the Lewin Group, inpatient costs were calculated from the following cost centers from the hospital cost reports: (1) routine acute care costs not associated with long-term units, (2) inpatient ancillary costs based on the ratio of inpatient charges to total charges, (3) outpatient costs that were billed as a part of an inpatient stay using the ratio of inpatient charges to total charges, and (4) any other costs that were reimbursed as a part of inpatient care. The resulting data from each of the cost centers were summed and divided by the total number of patients reported to have received inpatient care, thus creating a measure of inpatient cost per-patient.

The final step in this analysis required that national weights, developed by the Lewin Group, be applied to the cost variable. This was necessary so that

the contribution to inpatient costs made by each variable could be estimated. The Lewin Group constructed these weights using a series of regression models, which measured the relationship between inpatient costs and a series of independent variables. These models included measures for the research, teaching, and specialized care missions of the AHCs, as well as measures of patient acuity and hospital wage costs.

The Impact of Mission-Related Activities on AHC Inpatient Costs.

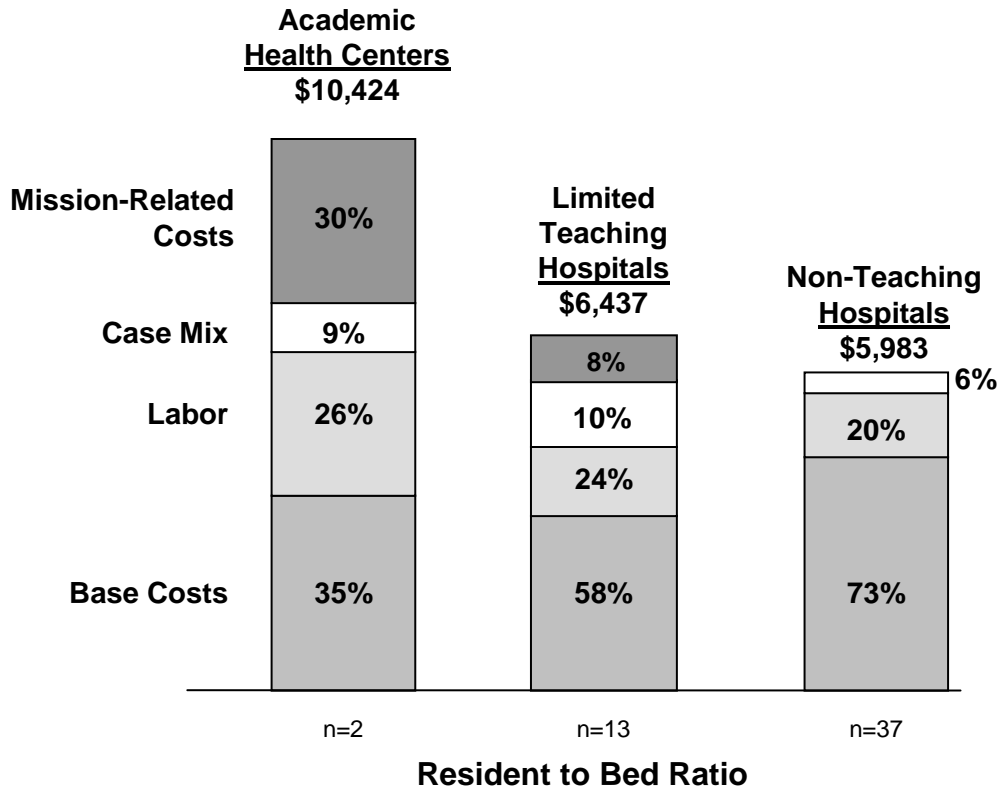
Figure 17 summarizes the results from the initial part of this analysis. As shown, using the cost report data, inpatient costs were calculated for three groups of hospitals: Virginia's two AHCs, hospitals with at least 100 beds and a limited teaching mission, and hospitals with a least 100 beds and no teaching mission.

Specifically, the average cost per discharge in the two AHCs was \$10,424 per patient. By comparison, the cost for patients who received their care from hospitals with a limited teaching mission was only \$6,437 – approximately 61 percent of the cost of care in the AHCs. In hospitals with no teaching mission the cost was \$5,983. While the results reveal that the cost of inpatient care in Virginia's AHCs is higher compared to the other two groups of hospitals, this is before adjustments are made to account for patient acuity and mission-related costs. Also, this figure has not been adjusted to account for the large outpatient volumes, including outpatient clinic activities of the AHCs.

Partly to that end, Figure 17 highlights differences in the components of these costs across the three groups of hospitals. The major factor

Figure 17

Inpatient Acute Care Costs Per Discharge for Virginia Hospitals With 100 or More Beds (Fiscal Years Ending in 2001)



Notes: Inpatient costs do not include costs related to subproviders or long-term care such as nursing facilities. Some percents do not add to 100 because of rounding. Cost data from one "limited teaching" hospital was not reliable and therefore excluded from the analysis.

Sources: Estimates calculated using national weights based on the methodology developed by the Lewin Group. (See *Health Care at the Cutting Edge: The Role of Academic Health Centers in the Provision of Specialty Care*, a report of the Commonwealth Fund Task Force on Academic Health Centers.) The inpatient costs per case are calculated from the Hospital Cost Report Information System (HCRIS) cost reports submitted to the federal Center for Medicare and Medicaid Services.

distinguishing AHCs from their counterparts is the mission-related activities of the AHCs. It is estimated that fully 30 percent of the costs in these facilities can be attributed to the unique role of the AHCs in the delivery of care. Only eight percent of the cost for hospitals with a limited teaching mission could be similarly

categorized. As anticipated, the hospitals without a teaching mission had no mission-related patient costs.

As shown in Figure 18, the particular mission-related activity that has the greatest impact on costs is the AHCs “stand-by capacity.” These are the

Figure 18

Breakdown of Inpatient Acute Care Costs for Virginia’s Teaching Hospitals Based on an Estimate of Mission-Related Costs (Fiscal Years Ending in 2001)

		VCU/HS (in millions)	UVA/HS (in millions)	Total (in millions)
Total Inpatient Costs:		<u>\$292.1</u>	<u>\$280.5</u>	<u>\$572.5</u>
*29% Mission Related Costs	4% Research	\$10.5	\$10.1	\$20.6
	12% Indirect Medical Education	\$33.6	\$32.3	\$65.8
	13% Stand-By Capacity**	\$36.5	\$35.1	\$71.6
	71% All Other Costs	\$211.5	\$203	\$414.5

Percent of Costs Associated with Each Cost Category

Inpatient Costs Associated with Acute Care by Teaching Hospital

* Notes: *These estimates are based on national weights developed using data from 1998. As a result the figure 29 percent does not precisely match the figure reported in Figure 17 which is based on 1999 cost data.
 **Stand-By Capacity includes intensive, emergency, and trauma capacity. Inpatient costs do not include costs related to sub providers or long-term care such as nursing facilities. Some percents do not add to 100 because of rounding.

Sources: The estimates are based on a decomposition analysis from the unpublished article “Mission-related Costs of Teaching Hospitals: Estimates of Graduate Medical Education, Clinical Research, and Stand-by Capacity” by Lane Koenig et. al. of the Lewin Group in November of 2002. The inpatient costs for the teaching hospitals were derived from the Hospital Cost Report Information System (HCRIS) cost reports submitted to the federal Center for Medicare and Medicaid Services based on the methodology in the Lewin Group article.

costs incurred by the facilities for staffing highly specialized functions such as burn care, neonatal intensive care, pediatric intensive care, and Level 1 trauma centers. The staffing of these and related functions are responsible for 13 percent of the additional costs of the AHCs.

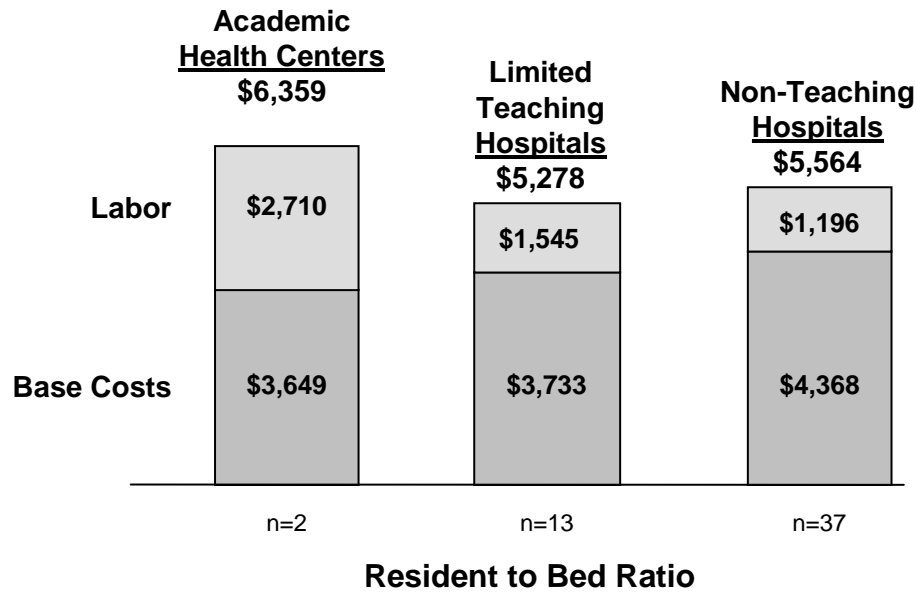
The education function, which measures the cost associated with teaching residents through clinical practice, adds 12 percent to the cost of care in the AHCs. The research mission accounted for in the national models based on whether the hospitals had a clinical research center and the amount of NIH funding received, displayed cost impacts of approximately four percent for the AHCs.

To more closely approximate the differences in treatment costs for AHCs compared to other hospitals in Virginia, the costs associated with case-mix and the mission-related activity of the academic health centers were subtracted from the overall costs of patient care. When this is done, Figure 19 indicates that the previously observed cost differences between Virginia's AHC and the two groups of private hospitals are substantially reduced.

Differences In Base And Labor Costs. The results presented in Figure 19 also show that the base costs for the AHC's -- defined as totals costs minus the costs of mission-related activities, case mix, and labor -- are relatively comparable to the hospitals with a "limited teaching" mission and are approximately 20 percent lower than that hospitals with no such mission. In regards to the labor component, the AHC's were found to have higher costs in

Figure 19

Inpatient Acute Care Labor and Base Costs Per Discharge for Virginia Hospitals With 100 or More Beds (Fiscal Years Ending in 2001)



Notes: Inpatient costs do not include costs related to subproviders or long-term care such as nursing facilities. Some percents do not add to 100 because of rounding.

Sources: Estimates calculated using national weights from *Health Care at the Cutting Edge: The Role of Academic Health Centers in the Provision of Specialty Care*, a report of the Commonwealth Fund Task Force on Academic Health Center. The inpatient costs per case are from the Hospital Cost Report Information System (HCRIS) cost reports submitted to the federal Center for Medicare and Medicaid Services based on the methodology developed by Koenig et al., at the Lewin Group.

this area than the other groups of institutions in the study. This is partially attributable to resident salaries and benefits. Within the AHC's there is a disproportionately higher number of residents when compared to the hospitals with a "limited teaching" mission. In addition, residents in "limited teaching" mission hospitals tend to specialize in primary care disciplines whereas, in the two AHCs, there are proportionately larger numbers of residents in the specialty disciplines.

A second factor that may influence the differential in the labor cost relates to the wage index for the localities where these hospitals reside. It should be noted that the area wage indexes in both Charlottesville (1.0566) and Richmond (0.9678) are higher than all other localities of the Commonwealth except Northern Virginia (1.0962). The range for the majority of the urban areas and cities across Virginia is between .82 and .91. Hence, if this variable were to be factored into the analysis, the difference between the per discharge salary costs would be reduced.

Finally, there are several specialized employees that are not generally found in other institutions that may contribute to the higher labor costs. These groups include coordinators for programs such as transplant and trauma services, as well as staff associated with “stand-by” programs that must be available 24 hours per day in order to maintain Level 1 Trauma status.

On a technical note, it cannot be stated with absolute certainty that the mission-related activities discussed here are responsible for 100 percent of the assigned costs based on the national weights. To the extent that the national regression models estimated by the Lewin Group omitted important variables, the coefficients representing the mission-related activities could capture the influence of these missing variables, leading to an overstatement of the reported impacts.

That said, however, the reported mission-related cost impacts are separate and apart from those variables that were explicitly incorporated in the models, such as the variables measuring hospital case mix and labor costs. This means that the mission-related costs (of whatever size) incurred by Virginia’s

AHCs, are not offset by the costs associated with the care of sicker patients or the payment of higher wages. In other words, these are additional costs, above and beyond those generated by the acuity of AHC patients and the associated labor costs – an important finding.

Also, not reflected in these numbers is the growing challenge administrations face at both UVA/HS and VCU/HS in finding the appropriate mix of research, teaching, and clinical effort among the physicians. With the growing competition in healthcare, physicians are being asked to increase their clinical productivity, thereby reducing the time available for other mission-related activities. Officials acknowledge that this is a growing source of tension that must be properly managed as the health systems move forward.

Virginia's AHC's Compare Favorably to Peer Hospitals Around the Nation

Because of the mission-related activities of the AHCs, comparing them with private hospitals that do not share similar goals can lead to misleading conclusions about the per-patient costs and operational efficiency of these institutions. An organization available for conducting these assessments is the University HealthSystem Consortium (UHC). This organization is an alliance of 87 university-owned academic health centers. With its clinical and research focus, UHC helps member AHCs pool resources, create economies of scale, improve clinical and operating efficiencies, and influence the direction and delivery of health care. In 2001, UHC conducted two following interdependent assessments of Virginia's AHCs:

- **Financial and Operational Benchmark Assessment.** UHC utilized its proprietary corporate information resource of comparative financial and operational data for academic health centers to evaluate the overall cost of UVA/HS and VCU/HS as compared to peer centers.
- **Clinical Data Base Analysis.** The UVA/HS and VCU/HS' clinical practice patterns and overall efficiency by clinical cohort were compared to a similar group of academic health centers using the UHC Clinical DataBase.

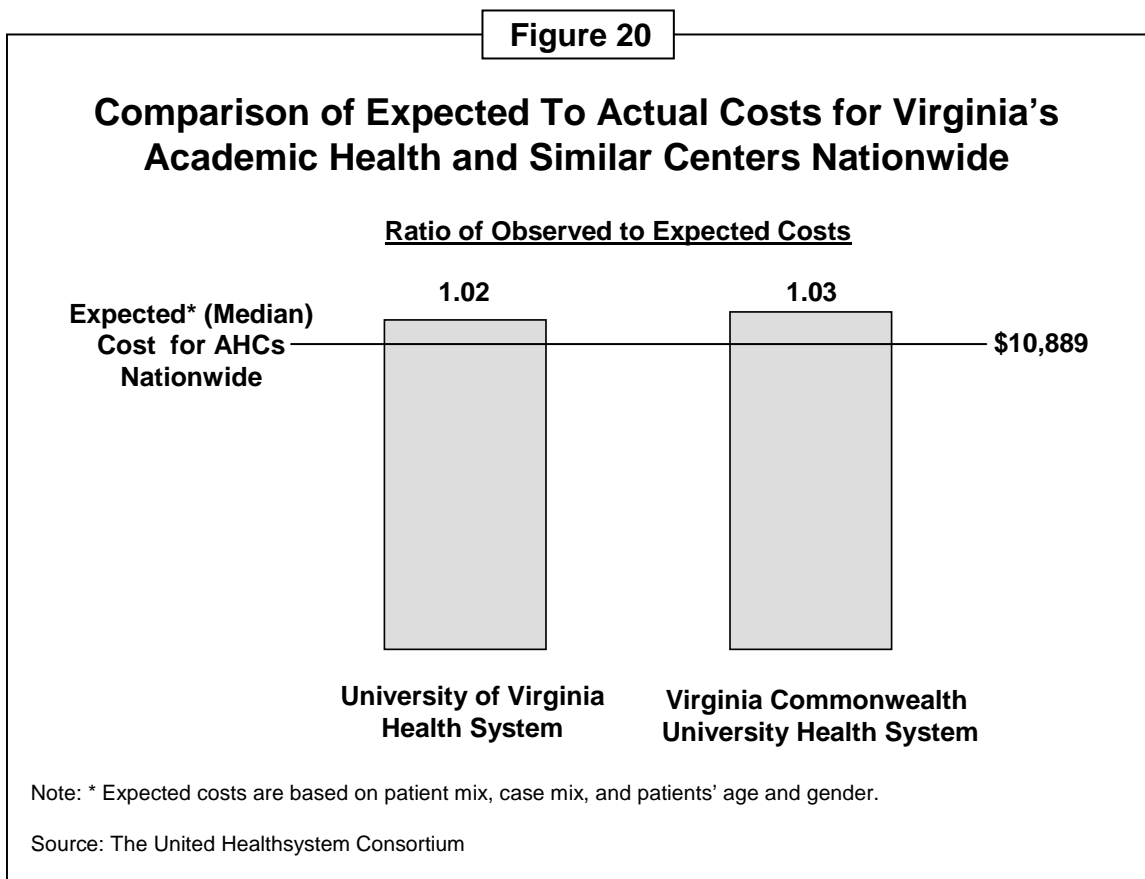
Twenty-five hospitals met the criteria of being comparable to UVA/HS and VCU/HS, including such hospitals as Vanderbilt University Medical Center, University of North Carolina Hospitals, Thomas Jefferson University Hospital, and Brigham and Women's Hospital.

Findings on Costs Per-Case and Operational Efficiency. A key finding of this study was that the measures of cost per-case, adjusted to account for the severity of patient illness -- which means costs divided by some measure of patient severity -- for both UVA/HS (\$7,306) and VCUHS (\$7,602), were less than the 50th percentile of the comparison group of hospitals (\$7,644).

Also, UVA/HS and VCU/HS' clinical practice patterns and the overall efficiency of each clinical cohort were compared to a similar group of academic health centers in the UHC Clinical Database. Statistics collected in the UHC Clinical DataBase were also adjusted for severity of case-mix using regression models that incorporate patient age, sex, payer, admission type, co-morbidities, severity of illness, and procedures known to affect outcomes.

These models generate an "expected" value of cost and length of stay (LOS) for each patient. The purpose of the "expected" value is to allow a meaningful "apples-to-apples" comparison that incorporates as much clinical

information on severity of illness as possible. Because of the composition of the quality comparison group (academic health centers), the expected value provides a useful risk-adjusted benchmark for examining clinical cohorts. As shown in Figure 20, the ratio of observed cost per discharge to expected cost per discharge for the UVA/HS was 1.02 and for the VCU/HS was 1.03. This means that the actual costs for these systems were essentially equal to the expected cost when compared to other participating UHC hospitals.



In conclusion, while Virginia's AHCs have a substantially higher overall per-patient cost than private hospitals in the Commonwealth, the empirical evidence presented here indicates that those additional costs are largely attributable to the unique missions of the AHCs. Further, when these operations

are more appropriately compared to peer teaching hospitals around the country, their relative costs are at expected levels, after accounting for differences in patient risk and other factors that influence the cost of care.

COST TRENDS FOR INDIGENT HEALTHCARE IN VIRGINIA'S AHCS

Although Virginia's AHCs have a long-standing history of service to the poor and uninsured, both of these systems face new challenges and fiscal pressures that threaten their indigent healthcare programs. In the midst of this environment, legitimate questions are being asked about whether the AHCs are working to contain cost in the delivery of care to the indigent population. This study examined this issue by focusing on the cost trends for indigent healthcare for the State's two AHCs.

The general findings do support the view that AHC staff are making considerable progress in their efforts to contain the costs of indigent healthcare. From FY 1998 to FY 2002, the average annual rate of increase in the total indigent healthcare program was just more than two percent. This was less than the average annual rate of change observed for hospital inflation, which grew at a rate of 3.7 percent over this time period.

Both VCU/HS and UVA/HS have been able to slow the rate of growth in the inpatient component of the program by aggressively managing the length of time that patients spend in the hospital. Since FY 1998, the average length of stay for indigent patients has dropped by approximately five percent at both UVA/HS and VCU/HS.

UVA/HS has experienced a growth in costs in the outpatient programs of 9.3 percent that substantially exceed the rate of hospital inflation. At VCU/HS, growth in outpatient costs was a modest 1.8 percent. For UVA/HS the higher cost of outpatient care can likely be attributed to a growth in physician costs as well as innovations developed and introduced in both AHCs that have resulted in aggressive movements of care from inpatient to outpatient settings.

Additional savings are potentially available to help defray indigent healthcare costs for the AHCs. Patient data show that as many as 13,000 children who are served in the indigent healthcare program likely qualify for the federally supported FAMIS or Medicaid programs. The costs of treating these patients were \$7 million.

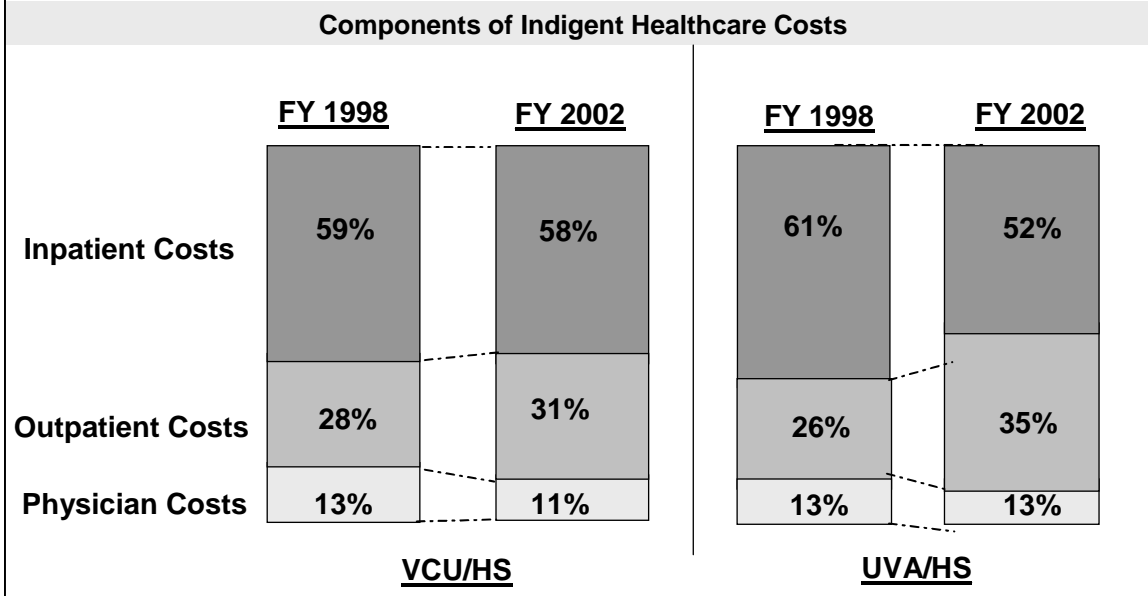
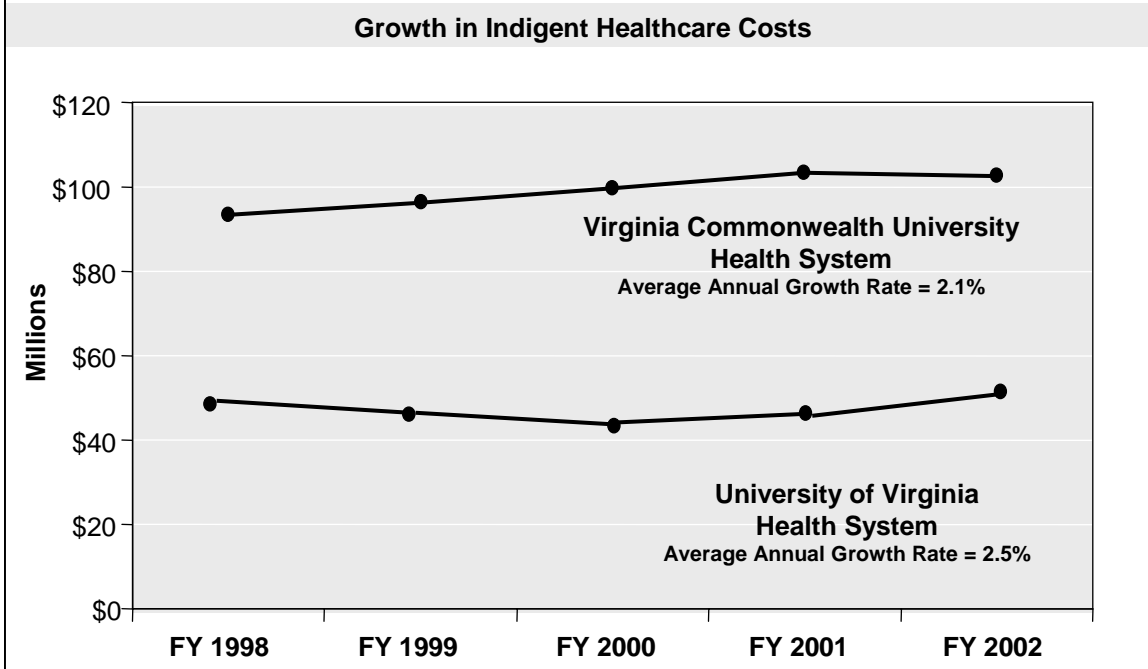
While Virginia's AHCs Have Worked to Control Indigent Healthcare Costs, Both Opportunities and Future Challenges Remain

As noted in Chapter I of this report, there are two major components of Virginia's indigent healthcare program: inpatient care for persons whose health problems are more acute; and, ambulatory care for those whose illnesses or health problems can be treated in outpatient settings. Efforts to understand cost trends in this overall indigent care program must include a separate analysis of these program components within Virginia's two AHCs.

Overall Program Cost Trends. As shown in Figure 21, both VCU/HS and UVA/HS have done reasonably well in containing growth in the costs of their respective indigent healthcare programs. In FY 1998, the cost of the entire indigent healthcare program at VCU/HS was just over \$95 million. Five years

Figure 21

Trends in Indigent Healthcare Costs at Virginia's Academic Health Centers (FY 1998 to FY 2002)



Note: Medicaid profits/losses are reflected in these numbers.

Source: University of Virginia Health System and Virginia Commonwealth University Health System.

later, the costs had grown to over \$103 million, which represents an average annual increase of just 2.1 percent. The trend for UVA/HS was similar. The cost for the program in FY 1998 was approximately \$49.5 million. By FY 2002, this figure had increased by less than three percent annually to \$54.6 million.

Inflation factors published by Data Resources Incorporated (DRI) are “market basket” measures of inflation in hospital inputs. Cost increases that hover around inflation are indicative of normal or expected growth, not influenced by internal program pressures. From FY 1998 to FY 2002, hospital inflation was 3.7 percent -- higher than the growth in indigent healthcare costs at both AHCs.

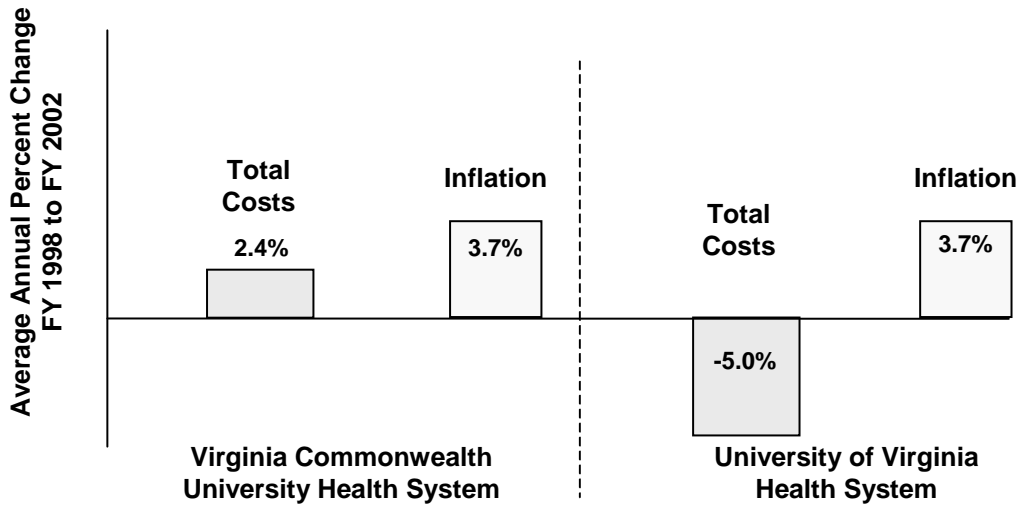
When the data are separated by components of indigent care -- inpatient and outpatient costs (bottom of Figure 21) -- the numbers indicate that inpatient care is responsible for most of the costs in the two programs, but as a proportion of total costs, the numbers are declining. For both systems, inpatient costs went from 63 to 52 percent of total indigent care costs. Notably, the outpatient costs as a percent of total indigent healthcare costs increased at both VCU/HS and UVA/HS. The increase was more pronounced at UVA/HS, growing from 26 percent of costs in FY 1998 to 35 percent of costs five years later.

Figure 22 examines changes in the overall costs of each of the component programs by comparing the changes to a measure of hospital inflation. As shown at the top of Figure 22, the total costs for inpatient hospital care for the indigent population was not only less than the rate of hospital inflation, but they actually declined for UVA/HS -- down five percent. VCU/HS witnessed minor growth of 2.4 percent. This growth rate was only 54 percent of

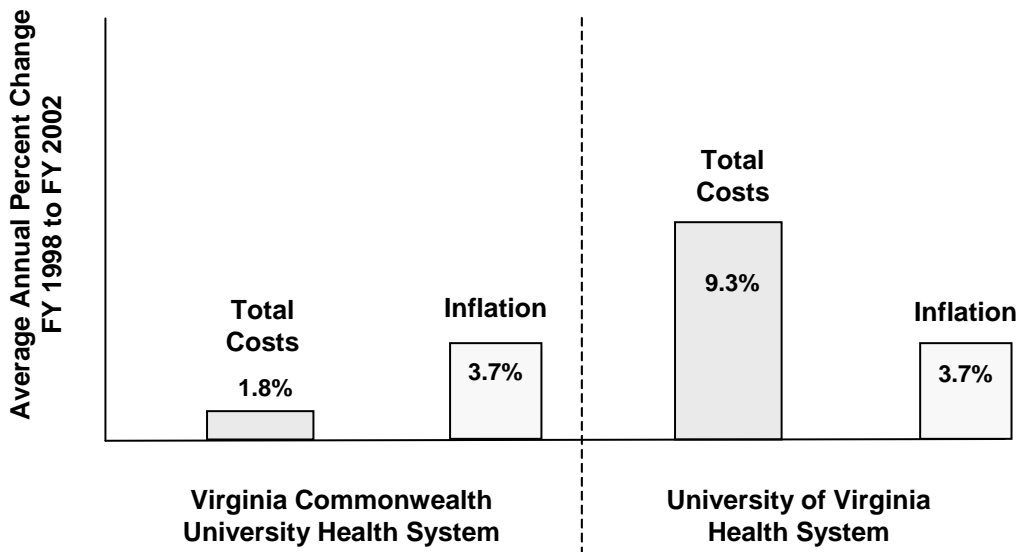
Figure 22

A Comparison of the Trends in Indigent Healthcare Costs To Hospital Inflation (FY 1998 to FY 2002)

Inpatient Indigent Care Trends



Outpatient Indigent Care Trends



Note: The inflation shown is the hospital inflation factor calculated by Data Resources Inc.

Source: University of Virginia Health System and Virginia Commonwealth University Health System.

the average annual increase observed for the rate of hospital inflation over this same time period.

The cost trends for outpatient care were more pronounced, especially for UVA/HS (bottom of Figure 22). Over the five-year period in question, these costs grew by an average of almost 9.3 percent per year at UVA/HS which was twice the rate of inflation. By comparison, the outpatient costs at UVA/HS grew by just under two percent.

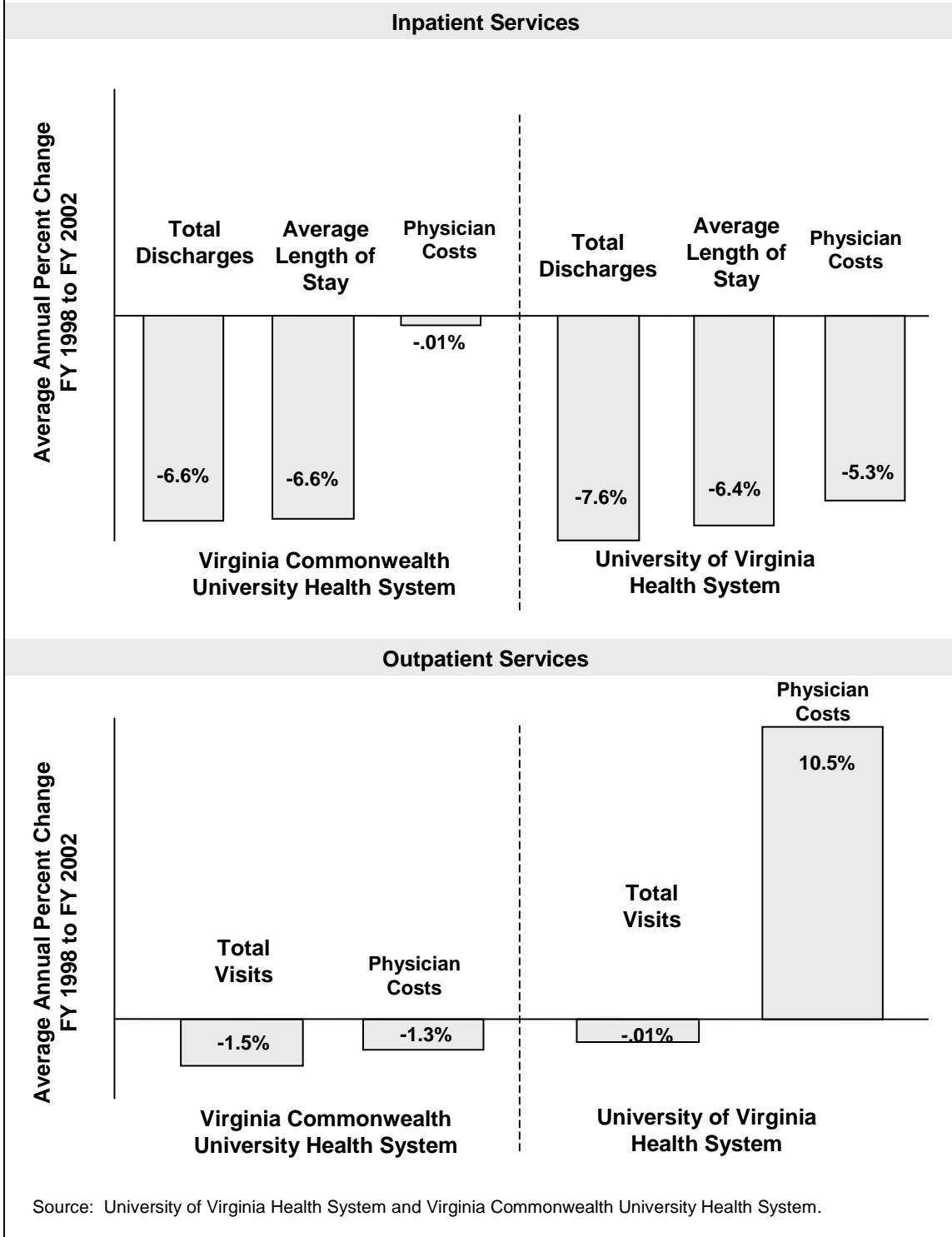
Factors Impacting Cost Trends. What factors are influencing these cost trends? What do they suggest about the management and operation of the State's indigent healthcare program? To address these questions, utilization and physician cost data were examined for both inpatient and outpatient program. The results are reported in Figure 23.

Clearly, the decline in the number of indigent patients being treated through inpatient admissions and the aggressive management of the patient hospital stays are key factors in the containment of inpatient costs. At VCU/HS both inpatient discharges and the length of time patients remained hospitalized dropped by an average rate of 6.6 percent. In the case of UVA/HS, the decline in total patient discharges was even greater (7.6 percent) and they managed to reduce hospital stays by nearly at nearly the same rate as VCU/HS.

On the outpatient side, increased visits do not explain the growth in costs for either system. This means that both health systems are likely spending more on patients who are now being cared for in the outpatient clinics of the

Figure 23

**Trends in Utilization for Indigent Healthcare Services
(FY 1998 to FY 2002)**



Source: University of Virginia Health System and Virginia Commonwealth University Health System.

AHCs. Rising physician costs may be partly responsible for the growth in outpatient costs at UVA/HS. However, staff at both VCU/HS and UVA/HS indicated that many of the patients who are now seen in the clinics have greater acuity levels and, in the past, would likely have been admitted to the more expensive inpatient setting at the hospital.

AHCs have led the industry in the development of procedures that have allowed more complex services and procedures to be moved out of the inpatient environment, especially in the area of Ambulatory Surgery. Virginia's two AHC's have been instrumental in introducing clinical innovations through the development of programs such as Centers for Minimally Invasive Surgery. Procedures that have been perfected in the AHC's have resulted in reductions in costs and enhancements in the overall quality of the care provided in other health care settings.

With the movement of services out of the inpatient arenas, the acuity level of patients cared for in ambulatory settings has increased, requiring modifications in the types of staffing support needed and a growth in the utilization of more costly medications and supplies to support patient care. So while treating these patients in the community has raised the cost of outpatient care, staff at both systems believe that additional costs are more than offset by the savings accrued from not having admitted and treated these patients in the more expensive inpatient setting.

Attempts to better understand AHC trends in unit costs for both inpatient and outpatient services are clouded by problems associated with the

manner in which the AHCs presently account for indigent patients in their financial reporting. Accordingly, a more precise analysis of the change in the unit cost of indigent care at the AHCs must be held in abeyance until these methodological problems are addressed.

Recommendation (1). To enhance its monitoring of the indigent care program at Virginia's AHCs, DMAS should work with staff at these facilities to develop a standard and uniform reporting process. This process should require AHCs to make annual reports on the number of indigent patients treated by the health systems, the cost of the services on both a total and per-unit basis, and the acuity level of the patients that were treated. DMAS should work with the AHCs to ensure that the methodological problems that presently hamper the reporting of unit cost are resolved in a uniform manner and that these data are reported for both inpatient and outpatient services.

In summary, while both systems appear to have done a good job managing cost increases in their indigent healthcare programs over the past five years, management at these institutions will face challenges as they move forward. To the extent that competition from other hospitals force the AHCs to pressure physicians to perform more clinical work and generate revenue, the time available to spend teaching residents is minimized. Moreover, if both systems continue to curb costs in their inpatient program by shortening patient stays, the time available to residents to learn from patients under their care is reduced.

Finally, if either of these systems works to lower costs by moving more patients to ambulatory settings, the relevant schools of medicine will have to ensure that clinicians are available in these settings to train residents. This will be especially difficult if these clinicians are expected to take on heavy patient loads as well. So while these strategies are clearly effective vehicles for

controlling the growth of indigent healthcare costs, if they are too aggressively applied, the teaching mission of both of these systems could be seriously threatened.

Possible Cost Shift to Medicaid and FAMIS Offers Promise of Savings

When program data on patients served through the Indigent Care Program (ICP) were examined, the numbers reveal that a substantial percentage of children from low-income families are being treated through ICP. For VCU/HS, the data show that in FY 2002, nine percent of all deliveries were for children whose mothers were covered by ICP. At UVA/HS, approximately 19 percent of the deliveries fell within this category.

Incentives Needed To Encourage Medicaid/FAMIS Enrollment. It appears that once a woman has been deemed eligible for ICP by hospital staff, there is no incentive to apply for Medicaid if she becomes pregnant. The staff at both AHCs' encourage women to complete Medicaid applications, but they stop short of terminating the patients' eligibility for ICP should they refuse to apply for Medicaid. Thus patients assume no risk of losing coverage under ICP by failing to complete a Medicaid application. This is an area that presents opportunities for both UVA/HS and VCU/HS to develop policies that would make pregnant women ineligible for ICP support if they do not complete and submit a Medicaid application.

A similar scenario occurs for the pediatric population. Children can be covered under the ICP when their parents are deemed eligible. However, due to changes in employment status or financial circumstances of their parents,

children may actually become eligible for Medicaid or FAMIS. Again, there is no incentive for parents to submit applications for these programs given that their children are “covered” under ICP.

Hospital service data from FY 2002 revealed that at Virginia’s two AHCs, the cost of caring for patients who were under the age of 18 and eligible for the ICP exceeded \$7 million. In total, there were over 13,400 children who qualified for the ICP. An estimated \$4 million of the costs of caring for these children can be attributed to patients who fell within eligibility categories that qualify them for Medicaid – incomes below 133 percent of the Federal Poverty Level (FPL). Another \$1.7 million is attributed to patients whose incomes were above 133 percent of FPL but below 200 percent of this threshold, making them potentially eligible for FAMIS.