

IV. The Fiscal Crisis in Indigent Healthcare

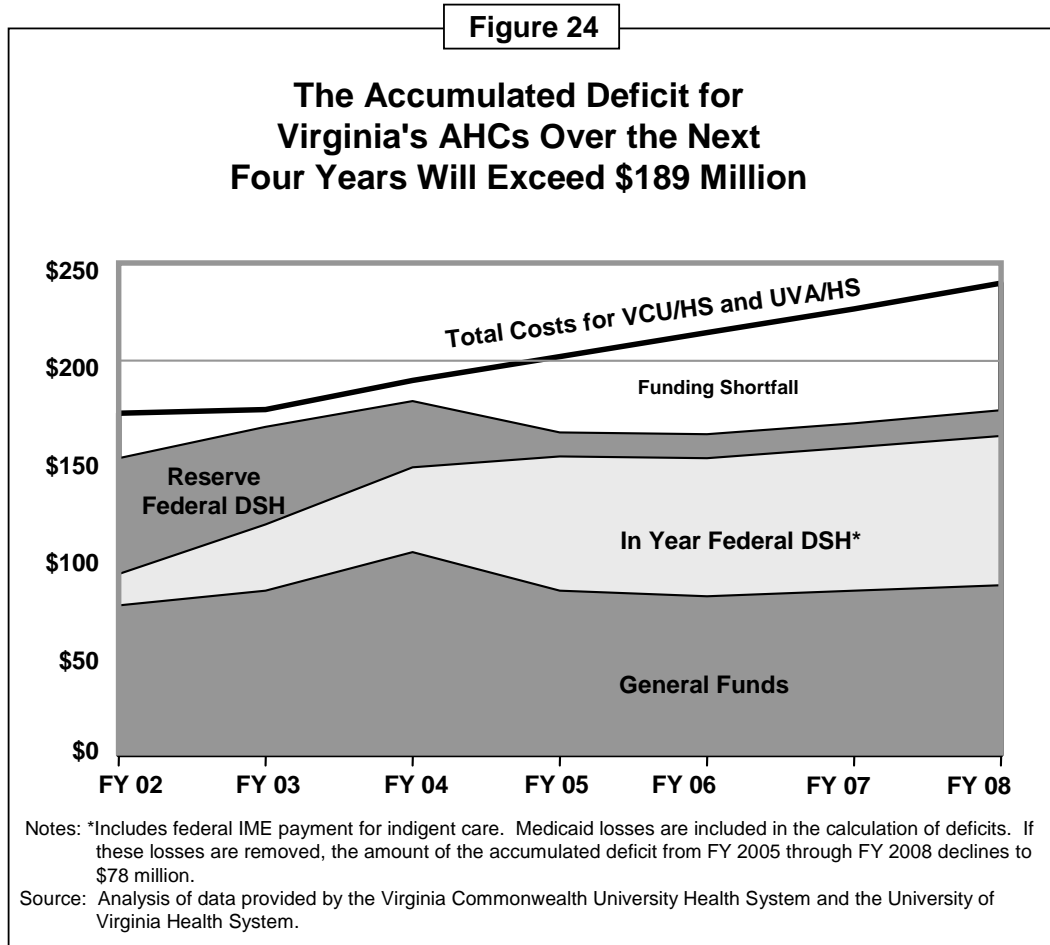
Over the past twelve years, Virginia has relied heavily on the Medicaid Disproportionate Share Hospital (DSH) program to pay for indigent healthcare at the State's two academic health centers (AHCs). Since Medicaid DSH payments are funded like all Medicaid payments, with 50 percent federal funds, paying for indigent healthcare through the DSH program has enabled the Commonwealth to provide the same amount of funding to the AHCs, but at half the cost to the State's general fund.

In early years of the program, which began in 1991, this funding strategy did not completely cover the cost of indigent healthcare at the AHCs but it saved the State approximately \$30 million annually. These savings were preserved because AHCs subsidized the non-covered portion of their indigent healthcare costs with profits earned from other revenue sources, such as private payers.

Since that time, the federal government has taken several steps to restrict the use of DSH. Concomitantly, the growth of managed care and increased competition from private hospitals has resulted in a loss of both patients and revenue at the AHCs. This has greatly limited their ability to subsidize mission-related activities, such as indigent healthcare, with other revenue sources.

Relying on unspent balances of the DSH program from previous years, Virginia has been able to maintain DSH funding for the AHCs while minimizing the strain on the general fund. However, when those unspent balances are fully

depleted in FY 2005, the current level of spending for the AHCs will not be sustainable, thereby exacerbating already existing shortfalls, and creating a substantial budget deficit over the next few years (Figure 24).



Operational changes in the AHCs will lessen the shortfall in future years but will not be sufficient to fully address this problem. Moreover, private hospitals, struggling with a loss of operating margins, declining Medicaid payment rates, and the growing problem of uncompensated care, are not likely to offer relief by increasing the amount of charity care they provide.

This chapter highlights Virginia's use of the Medicaid DSH program and presents its limitations as a key source of funding for indigent healthcare at

the AHCs. Moreover, changing trends in the financial condition of the hospital industry are briefly examined as an illustration of the difficulty that would likely be associated with any policy to expand the role of the private sector in the provision of unfunded charity care.

THE EMERGING FUNDING GAP AT VIRGINIA'S AHCS

Based on current projections, Virginia's two AHCs face a funding shortfall in the FY 2004-06 biennium that will exceed \$34 million without projected losses in the Medicaid program and \$83 million if those losses are included. Historical losses in the indigent healthcare program and rapid use of previously unspent balances from the Medicaid DSH program are the primary cause of this budget problem. Contributing to this dilemma are more restrictive federal laws that have significantly reduced the amount of dollars that Virginia can claim through the Medicaid DSH program.

For example, in 1997, federal legislation was passed that capped the amount of federal DSH funds that would be available to states starting in federal fiscal year 1998. The result of this action limited Virginia's total available DSH to \$136 million annually in 1998, with the additional provision that this amount would decrease to \$114 million over five years. Though this later action was delayed, Virginia's current DSH cap is lower than it otherwise would have been but for the changes made to federal law.

As a part of a larger effort to improve the efficiency of its operations, both of the AHCs have initiated various strategies to reduce future costs and relieve some of the pressure on this funding source. Over the next four years

(FY2005 to FY 2008), these strategies are projected to reduce the funding needs for indigent healthcare. Nonetheless, even with these savings, the projected reimbursements would leave the AHCs \$189 million short of their projected needs by FY 2008. If Medicaid losses are excluded, the four-year accumulated deficit falls to \$78.3 million.

As these changes are taking place, the shifting financial climate for the hospital industry has reduced its ability to take on larger amounts of uncompensated care. Since 1997, hospital total margins have fallen by nearly 12 percent annually. Operating margins have declined by almost nine percent annually over this same time period. Further, due to the State's reimbursement policy for Medicaid payment rates to these providers, hospital reimbursements for Medicaid now cover only 71 percent of cost. These factors militate against any proposed policy to increase the amount of uncompensated care that private hospitals are asked to provide.

Changes to Federal Rules Affecting the Medicaid DSH Program Have Created a Budget Deficit Ranging From \$34 to \$83 million for Virginia's AHCs in the Next Biennium

Currently, Medicaid payments to the AHCs for indigent healthcare are paid under the Medicaid DSH program. The Medicaid DSH program makes special additional payments to hospitals that have unusually high indigent healthcare costs. All state Medicaid programs are required to have a DSH program and Virginia has had one since 1982. Since DSH payments are funded through the same federal matching provisions as the larger Medicaid program,

Virginia has been able to fund its indigent healthcare program at half the cost to the State general fund.

In 1991, the Commonwealth sharply increased DSH payments to the AHCs, through additional payments which are referred to as “enhanced” DSH. Enhanced DSH payments are made under State regulations approved by the federal government. When enhanced DSH was first implemented in 1991, it resulted in \$30 million annual savings in State general funds. With these enhanced payments, AHCs were able to cover 75 percent of the cost of treating its indigent patients. The revenue generated from other commercial insurers covered the remaining 25 percent.

Recent Federal Limits On DSH. While the federal government has allowed, and even required, states to provide DSH payments to some hospitals, it has taken three actions to limit states’ ability to significantly expand their use of the DSH program. First, from 1991 until 1993, federal regulations limited the statewide amount of total DSH funds (state and federal) to 12 percent of total Medicaid program expenditures. This limit had no real impact on Virginia’s program because DSH spending in the Commonwealth was substantially less than 12 percent of the State’s total Medicaid budget. During this period the only factor limiting the amount of enhanced DSH paid to the two AHCs was the level of State general funds appropriated for this purpose.

Second, in 1993, federal legislation was passed that limited the amount of DSH that could be paid to an individual hospital. Under this law, no hospital could receive DSH payments greater than the amount of its losses from

Medicaid and uninsured patients. Losses are defined as the difference between the actual cost of providing services and the payments received from Medicaid and uninsured patients. This federal limit still did not impact Virginia's DSH program, because the AHCs had very large losses from uninsured patients, and the enhanced DSH program was funding only about 75 percent of indigent healthcare costs.

More limiting was the third action taken by Congress in 1997, placing state-specific caps on the amount of federal DSH funds that would be available to states starting in federal fiscal year 1998. The result of this action limited Virginia's total available DSH to \$136 million (total funds) annually in 1998, with the additional provision that this amount would decrease to \$114 million over five years. From 1998 to 2000, Virginia's allocation decreased from \$136 million to \$128 million. From 2001 through 2002 the reductions were delayed and the amount of funds allocated to Virginia was increased to \$136.0 million. The DSH allocation for 2003 is \$140.0 million and will be increased by an annual inflation factor.

Depletion of Enhanced DSH Creates Shortfalls in AHCs. Over the period of 1991 to 2003, the amount of enhanced DSH funds used to support indigent healthcare at the AHCs has increased from approximately \$57 million to \$147 million. This amount of new DSH spending is not so much a measure of greater spending on indigent healthcare, but rather increased use of the enhanced DSH program to fund that care. The State has been able to spend more on DSH in some years than is suggested by that year's federal allocation,

because there were unexpended DSH amounts from past years (1995 through 2002), against which the State could still spend in a current year. While this obviously reduced the losses that AHCs were experiencing in the program, the cost of indigent healthcare was not fully reimbursed.

Because annual DSH spending exceeds the federal allocation and past year amounts are almost gone, staff at the Department of Medical Assistance Services report that the State's enhanced DSH balances are virtually depleted. This means that without a new source of funding, both of the AHCs are currently operating indigent healthcare programs at levels that are not sustainable beyond FY 2004.

Impact on VCU/HS. To determine the impact of the funding shortfall at VCU/HS, the organizational changes being made at the health system in response to a consultant's report had to be accounted for. This report was developed by the Hunter Group, which is a nationally recognized healthcare consulting firm specializing in helping healthcare organizations improve strategic planning, operations restructuring, and financial performance.

The Hunter Group began its work at VCU/HS three years ago by conducting a comprehensive assessment of the entire operation. As a part of this assessment, the Hunter Group analyzed VCU/HS' management structure, all aspects of patient care, clinical resource management, administration, and the system's revenue structure. Based on this assessment, the Hunter Group produced a more than 1,000 page report with over 450 recommendations to overhaul the operation of the health system. The implementation of the plan is

slotted to cover a three-year period. The goal of the Management at VCU/HS is to target implementation of 100 percent of the recommendations. It should be noted that the Hunter Group has reported that approximately 75 percent of their recommendations are implemented in institutions that they have categorized as their “better” sites.

Some of the areas which management at VCU/HS have been and will continue to focus on for the purpose of generating savings based on the Hunter Group report include the following:

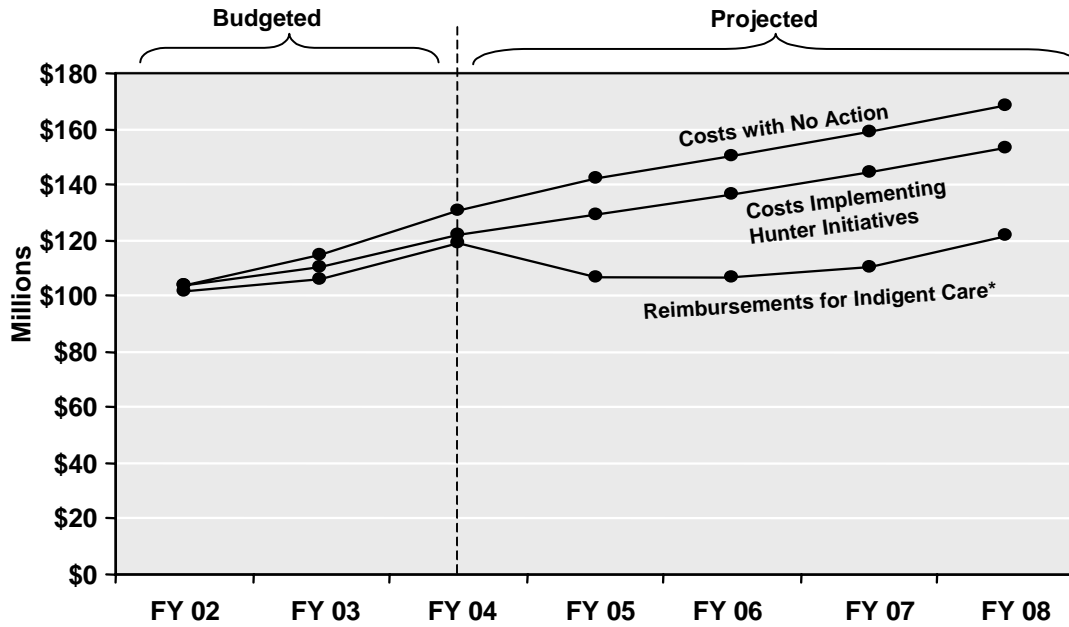
- Personnel productivity. VCU/HS plans to meet or exceed benchmarks for its hospital and practice plan
- Clinic Consolidation. VCH/HS plans to merge outpatient and hospital clinics for maximum efficiency and patient satisfaction
- Clinical Resource Management. VCU/HS plans to have physicians and hospital leadership collaborate to ensure appropriate and efficient use of resources for all disease and procedure groups.
- Overhead alignment. VCU/HS plans to bring overhead inline with Hunter supplied benchmarks
- Revenue enhancement. VCU/HS plans to renegotiate managed care contracts and enhance the total revenue cycle.

Figure 25 illustrates the impact of the declining reimbursements for indigent healthcare in future years for VCU/HS. In the top half of the figure, three trend lines are reported. The top line represents a projection of what the indigent healthcare costs would be out to FY 2008 if management at the VCU/HS chose not to implement any of the recommendations from the Hunter Group report.

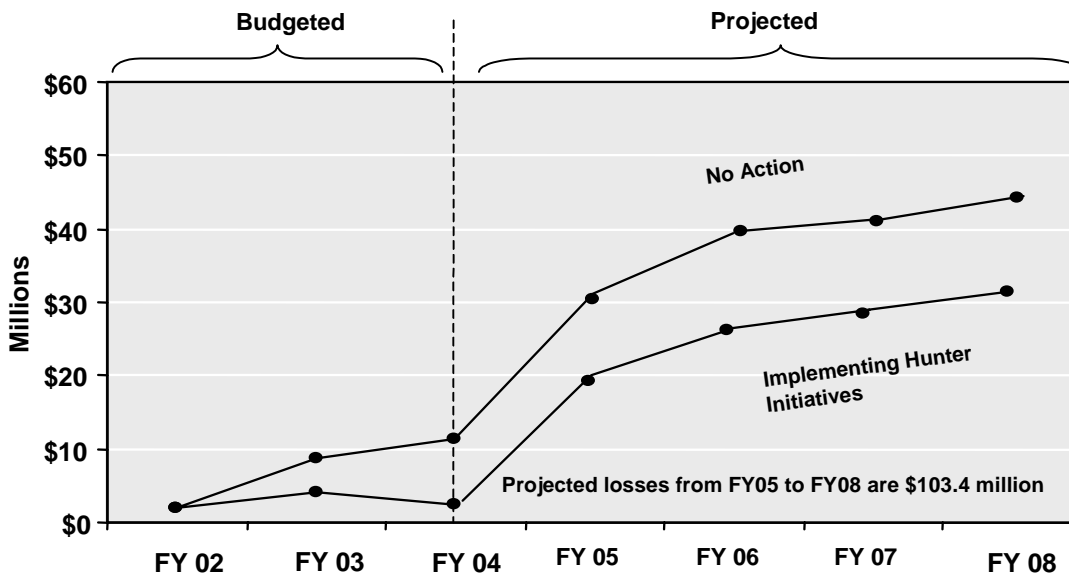
Figure 25

Effects of Implementing the Hunter Initiatives for the Virginia Commonwealth University Health System

Indigent Care Cost and Reimbursement Estimates



Difference Between Indigent Care Costs and Reimbursements



Notes: ** Reimbursements for indigent care include regular and enhanced Disproportionate Share Hospital (DSH) payments, indirect medical education (IME) payments related to indigent care, and the indigent care payments included in the 2002-2004 Appropriation Act. Medicaid losses are included. If Medicaid losses are excluded the figure drops to \$46 million.

Source: Analysis of data provided by the Virginia Commonwealth University Health System.

The middle line in the top half of Figure 25 projects VCU/HS future costs based on the Hunter Group recommendations that the organization has or is planning to implement. Based on this scenario, by FY 2008, VCU/HS is projected to be saving nearly \$15 million per year in its indigent healthcare program. This figure is taken out of the base through the reductions achieved between FY03 and FY05 and carries over each year through FY08.

The bottom line is a projection of reimbursements for indigent healthcare with the out years reflecting the loss of enhanced DSH appropriations. The projections include regular and enhanced DSH payments, indirect medical education payments, and the payments included in the 2002-2004 Appropriation Act. As indicated, reimbursements for indigent healthcare drop sharply after FY 2003 and remain considerable below the projected costs for the program out to FY 2008.

The bottom half of the figure reports the accumulated differences between projected costs for indigent healthcare under the different scenarios. If VCU/HS had taken no management actions, the difference between projected costs and what they are scheduled to receive in accumulated reimbursements from FY 05 to FY 08 total \$161 million. Thus, implementing some of the Hunter Group recommendations is projected to reduce the indigent healthcare funding needs of the system by nearly \$60 million, down to an accumulated shortfall of \$103 million. If the Medicaid losses are excluded, VCU/HS losses total \$46.3 million over this four-year period.

Table 2, highlights some of the changes that management at VCU/HS would need to consider for its indigent healthcare program to achieve reductions ranging from \$2 million to \$15 million per year. They include reductions in primary care services provided at the health system, a restructuring of the indigent healthcare program, and the rationing or elimination of certain types of healthcare.

Table 2		
VCU Health Systems Indigent Care Expense Reduction Options		
Amount of Funding Reduction	Strategies	Projected Savings
\$5 million	<ul style="list-style-type: none"> • Reduce Primary Care Capacity at VCU/HS • Expand the Virginia Coordinated Care program to provide primary care in community sites • Transition specialty services to less costly provider sites and partner with community hospitals and specialty providers to provide acute care services in lower cost settings 	\$2.5 million \$2.5 million
\$10 million	<ul style="list-style-type: none"> • Restructure Indigent Healthcare Program by prioritizing services to correspond to the funding availability • “Non-covered” services will be offered to patients at cost. • Implement cash collection policy in the ED for non-urgent services • Modify the medications provided to indigent patients to correspond with the list of covered services 	\$10 million
\$15 million	<ul style="list-style-type: none"> • Reduce or eliminate various acute care services provided under the Indigent Care program • Eliminate Outpatient Behavioral Health Services • Reduce number of medical diagnoses covered (for example, podiatry, allergy, dermatological services sub-specialty care, treatment for upper respiratory infections) • Eliminate various elective surgical procedures (for example tonsillectomy, repair of torn ligaments, cataract procedures) • Reduce or eliminate tertiary care/mission critical services • Reduce treatment for certain cancers for which there s limited chance for patient’s survival • Reduce number of transplants for each organ system • Reduce number of Neurosurgery procedures • Reduce number of joint replacement surgeries 	\$15 million

Impact on UVA/HS. Figure 26 reports the results of the same analysis conducted for UVA/HS. Over the past few years, UVA/HS has initiated a number of strategies to reduce cost or introduce greater efficiencies in the system. Most notably, UVA/HS formed a partnership with General Electric (GE) to transfer innovative management technologies from the widely recognized Six Sigma program to the UVA Medical Center. A total of six projects were established through the Six Sigma program. Some of the operational improvements as a result of the pilot projects were increased efficiency in appointment availability by physicians, a more expedited discharge process, and reductions in the length of time patients spent waiting in the emergency room.

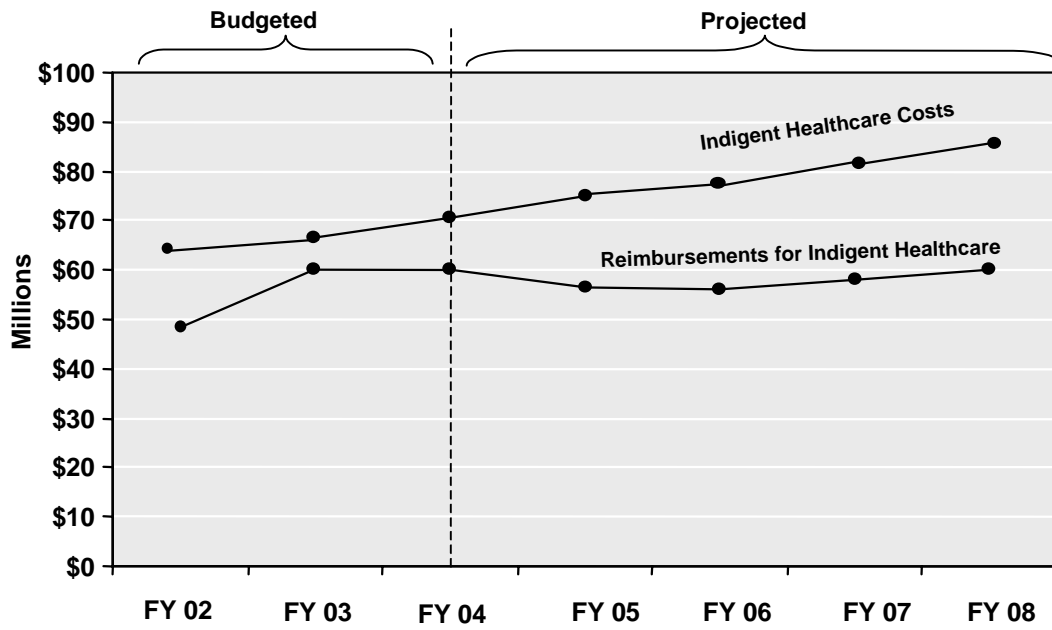
Through these and other actions, by FY 2008, UVA/HS' projected unmet funding need for indigent healthcare will be \$85.9 million. If Medicaid losses are disregarded, the unmet funding need drops to \$32 million. Because the cost savings strategies were put in place prior in FY 2002, projections of what the health systems cost would have been out to FY 2008 were these changes not made could not be reliably calculated.

In summary, even with projected savings from organizational efficiencies, together, the two health systems would face a shortfall over the next four years of nearly \$189 million. Should the Medicaid losses included in these projections be disregarded, the unmet funding need for Virginia's AHCs would be 41 percent of this amount, totaling \$78.3 million. While both of the State's AHCs can and have taken some actions that will reduce the fiscal pressure of the respective indigent healthcare programs moving forward, alone, these changes

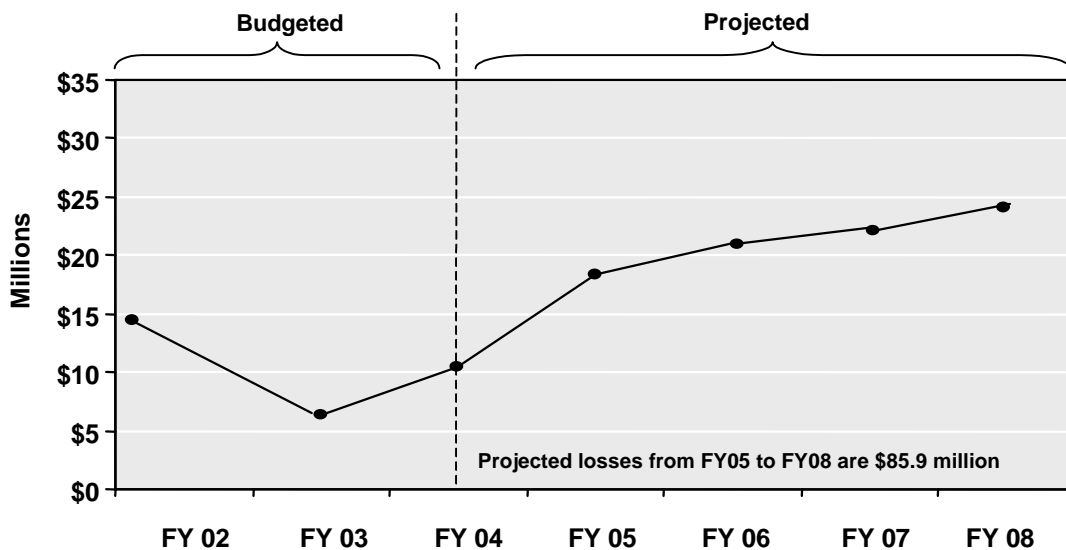
Figure 26

Effects of Implementing Cost Savings Initiatives for the University of Virginia Health System

Indigent Care Cost and Reimbursement Estimates



Difference Between Indigent Care Costs and Reimbursements



Notes: ** Reimbursements for indigent care include regular and enhanced Disproportionate Share Hospital (DSH) payments, indirect medical education (IME) payments related to indigent care, and the indigent care payments included in the 2002-2004 Appropriation Act. Medicaid losses are included. If Medicaid losses are excluded the figure drops to \$32.0 million.

Source: Analysis of data provided by the University of Virginia Health System.

will not be sufficient to close the emerging funding gap in Virginia's indigent healthcare program.

The Deteriorating Fiscal Climate for Private Hospitals Will Prevent this Industry from Significantly Increasing the Amount of Uncompensated Care it Currently Provides

As the funding available to pay for indigent healthcare diminishes, policymakers will likely look to the private sector to provide increased amounts of charity care to the uninsured. Similar to AHCs, private hospitals have historically funded their charity care efforts out of the profits from the health plans of the insured. Whether hospitals are willing to take on this increased burden in the future will probably be directly related to the financial strength of the industry.

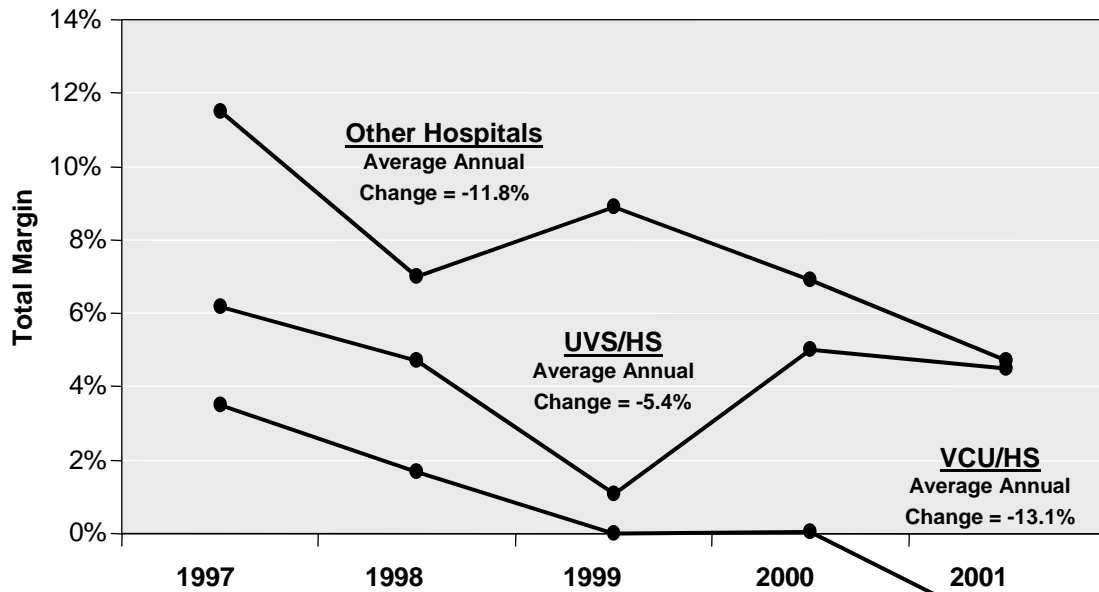
Trend In Hospital Margins. Two measures of the financial position and strength of the industry are hospital total margins and operating margins. Total margin is the most often used measure of hospital financial performance because it measures the degree to which all hospital revenue exceeds all expenses. At the end of an operating year, hospital chief financial officers prefer total margins of at least four percent to support capital reinvestment.

Operating margin more narrowly measures financial performance as it represents the degree to which operating revenue -- that is revenue generated only by hospital operations -- covers hospital operating expenses. Income from non-patient care activities such as the sale of assets, investment income, cafeteria sales, etc, is not included in the calculation of the operating margin.

Figure 27 separately reports the trend in total margins for the two AHCs and all other private hospitals. As shown, there has been a precipitous

Figure 27

Trends in Total Margins for Virginia Hospitals FY 1997 to FY 2001



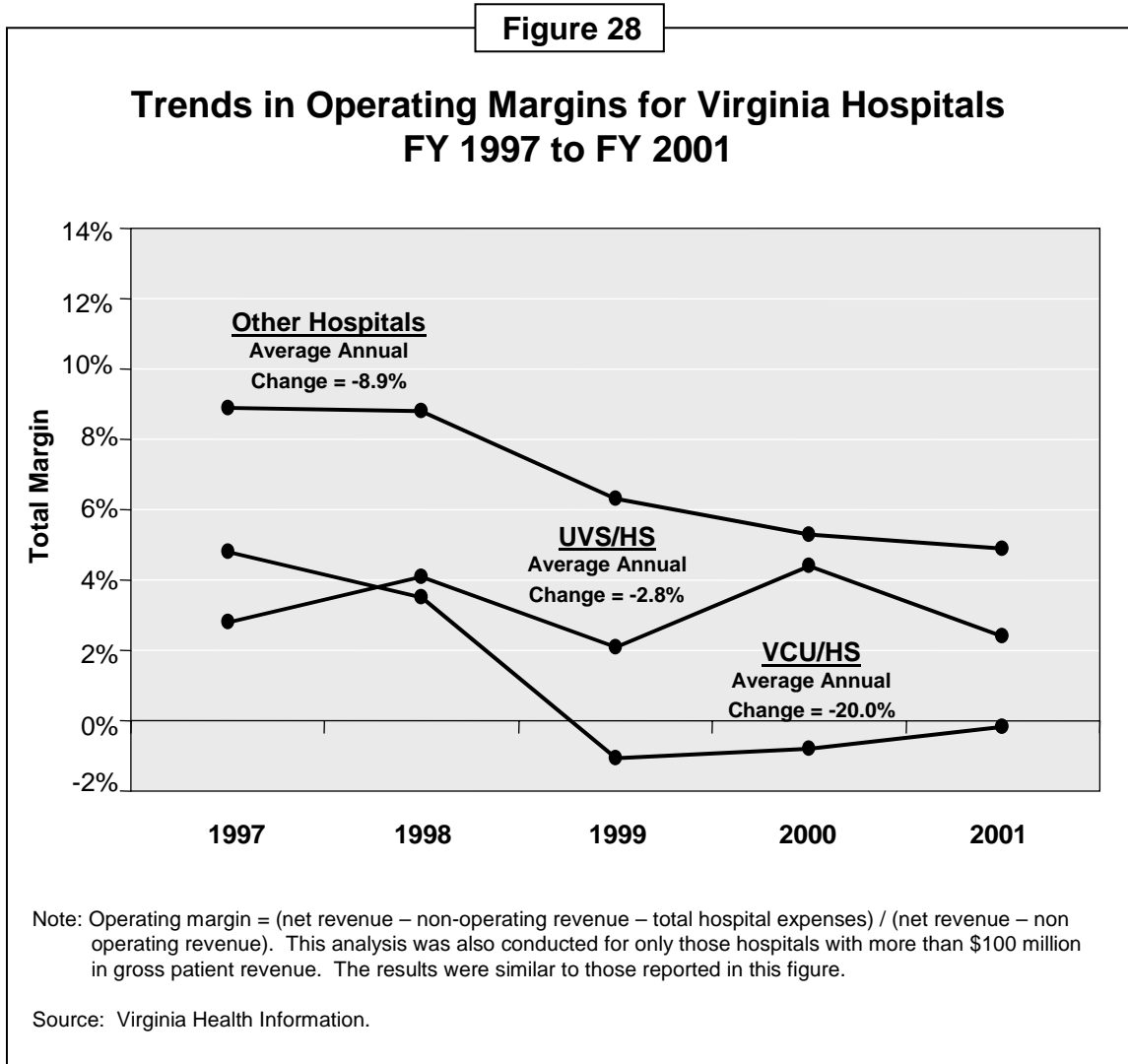
Note: Total margin = (net revenue – total hospital expenses) / net revenue. This analysis was also conducted for only those hospitals with more than \$100 million in gross patient revenue. The results were similar to those reported in this figure.

Source: Virginia Health Information.

drop in the total margin for private hospitals in the five-year period from 1997 to 2001. From a level of just over 11 percent, the average margin fell by 60 percent five years later to 4.7 percent. This represents an average annual decline of almost 12 percent a year. It is important to note that these trends include services and reimbursements from all payers.

As a point of comparison, UVA/HS finished FY 2001 with an total operating margin comparable to the average for private hospitals. VCU/HS, on the other hand, reported a negative total margin, having experienced a decline by an average of more than 13 percent annually since 1997.

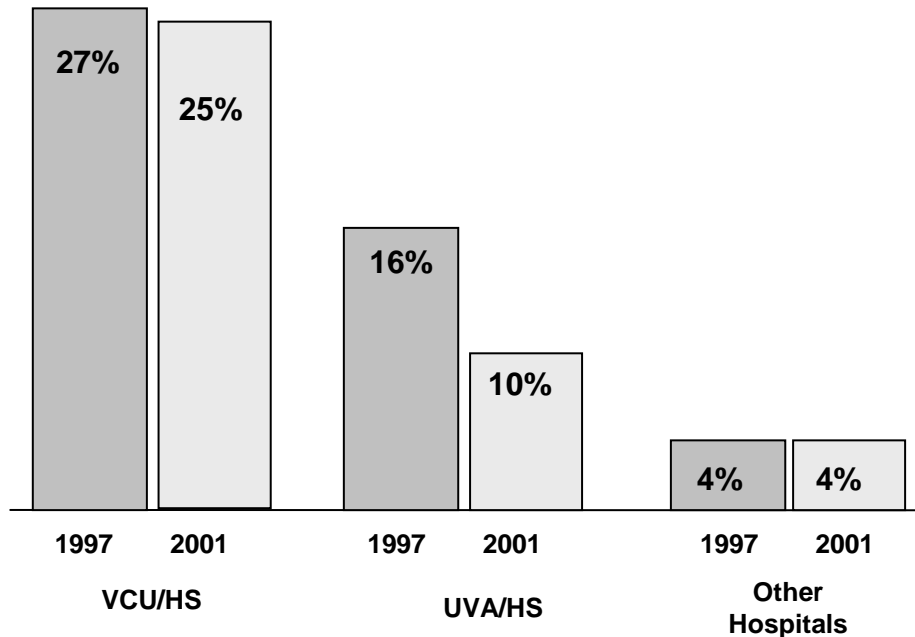
The direction of the trend for hospital operating margins was similar, although the decline was not as steep (Figure 28). This margin fell by 44 percent from a 1997 level of 8.9 percent to 4.9 percent in 2002. This represented an average annual decline of nearly nine percent. Comparatively, both of the AHC's reported operating margins that were considerably less than their counterparts.



With such steep margin losses, it is not likely that private hospitals are in a position to assume large portions of the indigent healthcare burden. As Figure 29 indicates, the industry may have reached the limit of indigent

Figure 29

Trends in Indigent Care Costs as a Proportion of Total Operating Expenses



Notes: Medicaid losses are not reflected in the figures reported here.

Source: Virginia Health Information.

charity care that it can comfortably provide in this financial environment. While there has been no erosion in the amount of indigent healthcare that hospitals have provided over the last five years, the figure remains at four percent of hospital operating expenses and has not changed since 1997.

What is especially troubling to the industry is the widening gap between the cost of providing care to the uninsured -- both indigents and non-indigents -- and the amount of the reimbursement the industry receives from the government to defray these costs. For example, in 2000, the hospital industry provided care to the uninsured at a cost of more than \$473 million. Two years later this figure had increased by more than seven percent to \$509 million. Over

this same time period, the amount of reimbursement that the industry received from Medicaid and the Indigent Healthcare Trust Fund -- which accounts for about 28 percent of the industry's uncompensated care costs -- actually declined by almost one percent.

A contributing factor to this problem is the State's reimbursement policy for the Medicaid inpatient care program. Since a policy agreed upon by DMAS and an industry Task Force in 1996, hospital payments for Medicaid recipients are adjusted each time the new rates are calculated through a formula known simply as the "adjustment factor." This adjustment factor essentially reduces payments to hospitals based on the ratio of operating costs reimbursements to total operating costs from a previous year. The effect of this, as illustrated in Figure 30, has been that the industry has witnessed their Medicaid payment rates to private hospitals get discounted by an average of 38, 28, and 21 percent since 1997.

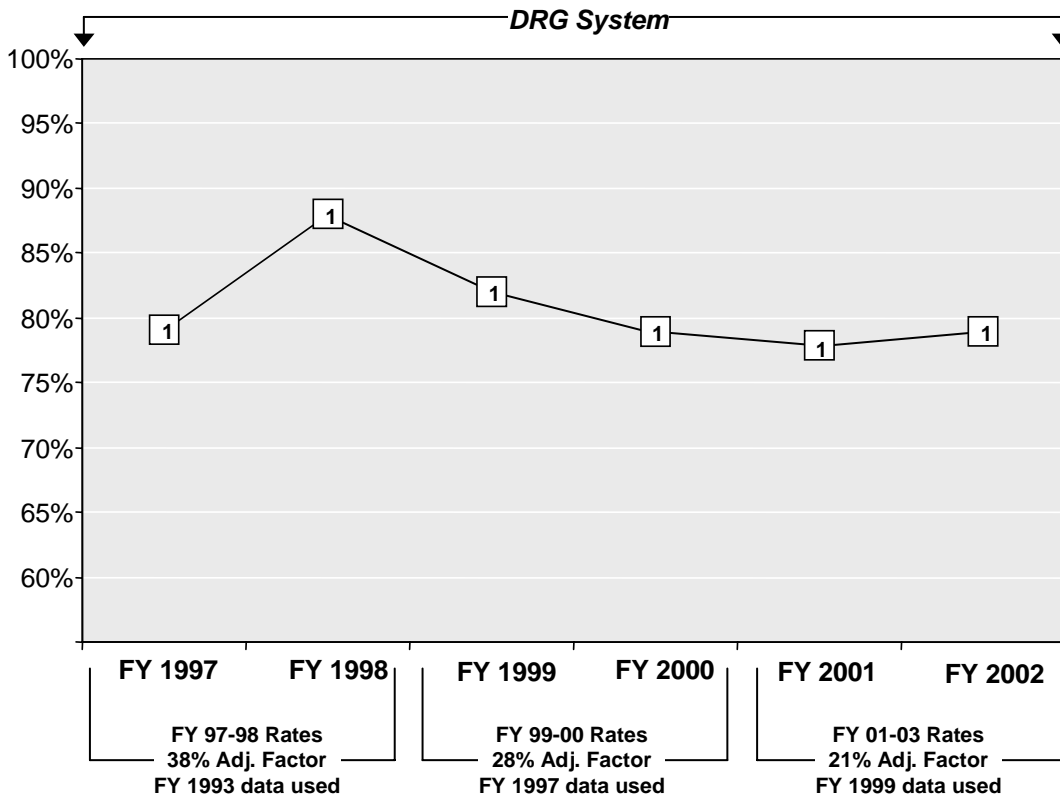
In conclusion, any effort to engage the hospital industry in a solution to funding problems for indigent healthcare at the AHCs must recognize two important facts. First, on average, excess margins, traditionally used by the industry to pay for uncompensated care in previous years no longer exist. Second, the industry is seriously concerned about the widening gap between the cost of the care they provide to the indigent population and the amount of the reimbursement they receive from government programs funded for this purpose.

In light of the worsening fiscal climate for the industry, the high cost healthcare needs of many indigent patients and the suppressed payment rates

Figure 30

Coverage Rates (Medicaid Payments Divided by Hospital Costs) for Fiscal Years 1997 to 2002 for Private Hospitals

$$\boxed{1} \frac{\text{Operating Payment} + \text{DSH}}{\text{Allowable Cost}} \longrightarrow \text{Coverage Rate Reported by DMAS}$$



Notes: DSH refers to disproportionate share hospital payments. Only Type II Hospitals are included in the coverage rates (the Medical College of Virginia and University of Virginia Medical Center are excluded). Fiscal year 1996 is not included in this analysis because the data for that year are incomplete. Included in the coverage rates are payments and costs for acute care, neo-natal intensive care unit (NICU), rehabilitation and psychiatric.

Source: Analysis of data provided by the Department of Medical Assistance Services and the Joint Legislative Audit and Review Commission report entitled *Review of the Medicaid Inpatient Hospital Reimbursement System, 2000*.

the industry receives for Medicaid patients, hospitals are not likely to take on a larger share of the indigent healthcare burden. This means that policy makers will either have to develop a plan to replace the loss of DSH revenue, or narrow the scope of the indigent healthcare program in terms of some combination of

eligibility and services. As the shortfalls are projected to occur beginning in FY 2005, the Governor and the General Assembly will need to address this issue in the next budget development process which begins in the fall of 2003.