REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

ACADEMIC HEALTH CENTERS' STUDY PURSUANT TO SJR 464

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 47

COMMONWEALTH OF VIRGINIA
RICHMOND
2000

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Preface

Senate Joint Resolution (SJR) 464, approved by the 1999 General Assembly, directed the Joint Commission on Health Care (JCHC) to study the financial and operational challenges facing academic health centers (AHCs) in Virginia. Specifically, SJR 464 directed the Joint Commission on Health Care to examine: (i) key financial and operational issues that impact the short-term and long-term viability of the academic health centers; (ii) the actions taken by the academic health centers to respond to these financial and operational issues; (iii) the financial and operational conditions of the Commonwealth's academic health centers relative to
that of academic health centers in other states; and (iv) key policy decisions and other actions that the academic health centers and the Commonwealth can take to ensure the long-term viability of the centers. A copy of SJR 464 is included as Appendix A to this report.

Based on our research and analysis during this review, we concluded the following:

- Academic health centers (AHCs) are affected by a number of marketplace changes that have occurred in recent years, including changes in reimbursement methodologies, increased managed care penetration, increasing numbers of uninsured persons, and the Balanced Budget Act (BBA) of 1997.

- The impact of the BBA has been substantial due to significant cuts in provider reimbursement under Medicare. For Virginia's AHCs, the BBA impact is substantial; for example, the University of Virginia (UVA) and the Medical College of Virginia (MCV) estimate the impact of the BBA provisions to be nearly $100 million at each institution over a 5-year period. One of the hospitals affiliated with Eastern Virginia Medical School (EVMS) estimates the impact to be $50-$100 million over the same 5-year period.

- Several AHCs across the country are facing financial crisis, including Allegheny Health System in Western Pa.; University of Pa. Health System; UCSF/Stanford; Massachusetts General Hospital; and Georgetown University.

- The most significant financial issue facing Virginia's three AHCs is the cost of unreimbursed indigent care. In FY 1998, this amounted to $32.6 million for VCU, $14.3 million for EVMS, and $12.8 million for UVA. All three AHCs

indicated that full funding of these costs is the most important action the Commonwealth could take to ensure their future financial viability.

- Funding of undergraduate medical education is another critical issue. The State Council of Higher Education for Virginia (SCHEV) adopted a policy that the Commonwealth should pay 50% of the direct cost of education for in-state students and 100% of the indirect costs for all students. MCV indicates that an additional $5.2 million is needed to fund the SCHEV guideline; EVMS indicated that $1.9 million is needed. UVA indicated that, under the current SCHEV guidelines, one could argue that the formula is funded; however, UVA suggested a different funding formula.

- Each of the AHCs also indicated that state funding of medical research is critical. EVMS suggested establishing a pool that all three AHCs could tap into to bring eminent researchers and programs to Virginia. UVA stated that without additional facilities they will have to turn down grants to conduct research.

- Medicaid managed care penetration presents a challenge for the AHCs, particularly MCV. Maintaining Medicaid patient days is critical to the AHCs because it drives the amount of disproportionate share hospital (DSH) funding and enhanced DSH payments which are important funding sources. The AHCs' greatest concern is being excluded from future Medallion II provider networks. Three potential actions to help ensure the AHCs retain their Medicaid patient base were identified: (i) directing the Department of Medical Assistance Services (DMAS) to include a provision in their Medallion II HMO contracts requiring the HMOs to include the AHCs in their provider networks; (ii) directing "default" enrollee assignments to the HMO with the highest percentage of AHC admissions; and (iii) providing "most favored nation" reimbursement to the AHCs. DMAS expressed serious concerns regarding the impact these potential actions could have on the Medicaid program.

- "Selective contracting" by managed care organizations (MCOs) also was identified as a concern by the AHCs, primarily MCV. Last year's SJR 108 study found that most MCOs "carve out" certain services and do not contract with the AHCs for these services. MCV's concern is that this practice not only reduces patient revenues, but also limits the clinical training that is provided to students. MCOs indicate that they contract with all hospitals in a similar fashion and often have an exclusive contract with a certain hospital or health system to provide specific services.

- MCV recommended that MCOs participating in the state employees' health benefits program be required to include the AHCs as "fully participating"

providers in all products offered. An alternative would be to require the MCOs to include the AHCs only in those products offered to state employees. The Department of Personnel and Training voiced two concerns with this proposal: (i) the potential impact on the cost of the program, and (ii) the potential that some MCOs will be less inclined to participate in the program. MCOs expressed concern that such a requirement would affect their ability to form cost-effective networks. Other providers also expressed concern that such an approach gives a competitive advantage to the AHCs, and limits their ability to be included in these same networks.

- In addition to the concerns regarding unreimbursed indigent care and undergraduate medical education, the AHCs were asked to identify other key financial and operational issues affecting their future viability. EVMS noted the following: (i) the impact of the BBA, (ii) lack of enhanced DSH payments for its affiliated hospitals; (iii) the cost of providing air ambulance service in Hampton Roads; and (iv) the need for enhanced AHC research.

- UVA identified the following specific issues: (i) adequacy of state funding for medical research; (ii) the need for UVA to retain and invest the interest on its daily cash balances; (iii) the ability to opt-out of VRS benefits for AHC employees; and (iv) the need to provide flexibility in salary administration for certain medical school employees rather than mandated across-the-board salary increases.

- VCU identified the following critical issues: (i) the potential of being left out of managed care networks serving state health programs; (ii) the need for additional autonomy from processing financial transactions through the state system, mandated salary increases and certain benefit programs; and (iii) the need to streamline the reimbursement and approval process for acquiring equipment through the Higher Education Equipment Trust Fund.

As part of the research for SJR 464, each AHC was asked to prepare a response to a series of questions from JCHC staff. The AHCs provided detailed information regarding their operations, financial viability, and other aspects of their institutions that was used extensively in preparing this report. It is also noted that, as part of the research for this review, Commission members, other interested legislators, and JCHC staff conducted site visits to all three academic health centers in the Commonwealth.

A number of policy options were offered for consideration by the Joint Commission on Health Care regarding the issues discussed in this report. These policy options are listed on pages 43-45.

Our review process on this topic included an initial staff briefing which comprises the body of this report. This was followed by a public comment

period during which time interested parties forwarded written comments to us regarding the report. The public comments (attached at Appendix B) provide additional insight into the various issues covered in this report.

On behalf of the Joint Commission on Health Care and its staff, I would like to thank Virginia Commonwealth University's Medical College of Virginia, the University of Virginia Health Sciences Center, Eastern Virginia Medical School, the Department of Personnel and Training, and the Department of Medical Assistance Services for their cooperation and assistance during this study.

Patrick W. Finnerty
Executive Director

December, 1999

TABLE OF CONTENTS

I.	AUTHORITY FOR THE STUDY/ORGANIZATION OF THE REPORT	1
II.	OVERVIEW OF CHALLENGES FACING ACADEMIC HEALTH CENTERS IN THE UNITED STATES	3
III.	CHALLENGES FOR ACADEMIC HEALTH CENTERS IN VIRGINIA	11
IV.	CHALLENGES FACING EVMS	25
V.	CHALLENGES FACING UVA	31
VI.	CHALLENGES FACING VCU	37
VII.	POLICY OPTIONS	43
VIII.	APPENDICES	

Appendix A: Senate Joint Resolution 464

Appendix B: Summary of Public Comments

I.
Authority for the Study/Organization of Report

Senate Joint Resolution (SJR) 464, approved by the 1999 General Assembly, directs the Joint Commission on Health Care (JCHC) to study the financial and operational challenges facing academic health centers (AHCs) in Virginia. Specifically, SJR 464 directs the Joint Commission on Health Care to examine: (i) key financial and operational issues that impact the short-term and long-term viability of the academic health centers; (ii) the actions taken by the academic health centers to respond to these financial and operational issues; (iii) the financial and operational conditions of the Commonwealth's academic health centers relative to that of academic health centers in other states; and (iv) key policy decisions and other actions that the academic health centers and the Commonwealth can take to ensure the long-term viability of the centers. A copy of SJR 464 is included as Appendix A to this report.

Academic Health Centers Provided Detailed Information to JCHC Staff to Respond to SJR 464; Site Visits Were Held At Each Institution

As part of the research for SJR 464, each AHC was asked to prepare a response to a series of questions from JCHC staff. The AHCs provided detailed information regarding their operations, financial viability, and other aspects of their institutions that was used extensively in preparing this report. It is also noted that, as part of the research for this review, Commission members, other interested legislators, and JCHC staff conducted site visits to all three academic health centers in the Commonwealth.

This report is organized into seven sections. This section overviews the authority for the study and discusses the outline for the report. The second section outlines challenges facing academic medical centers throughout the United States. The third section discusses challenges facing all three academic health centers in Virginia. The fourth section discusses the challenges facing Eastern Virginia Medical School/Medical College of Hampton Roads (EVMS). The fifth section discusses the University of Virginia's academic health center (UVA). The sixth section discusses challenges facing the Medical College of Virginia of Virginia Commonwealth University (VCU). The seventh section discusses policy options that the General Assembly may wish to consider with regard to academic health centers.

II.
Overview of Challenges Facing Academic Health Centers in the United States

AHCs Can Be Defined In Many Ways; For The Purposes Of This Report, AHCs Include The Medical College Of Virginia Hospitals, The University Of Virginia Health Sciences Center, And The Eastern Virginia Medical School

While there are different ways of defining an AHC, it would appear that under most any definition, EVMS, VCU, and UVA would be considered an AHC. Of these three institutions, EVMS is unique in that it does not own or operate a hospital. In addition to its teaching mission, EVMS provides physician services through its faculty practice plan to a number of hospitals in the Tidewater area. In addition to UVA, VCU and EVMS, there are a number of other hospitals across the Commonwealth that provide medical student training as part of their ongoing operation. Examples include residency programs at hospitals operated by INOVA Health System, Carilion Health System, Sentara Health System, and others. Moreover, some of these hospitals also provide substantial amounts of charity care.

While there is no one right or wrong definition, for the purposes of this report, AHCs include VCU, UVA and EVMS. However, those hospitals with a teaching function and high levels of charity care may well argue that some of the issues addressed in this report apply to them and that consideration should be given to including them in any actions taken as a result of this study.

Also, for purposes of this report, references to the AHCs include both the hospital as well as the associated physicians (faculty practice plans) who provide medical services to patients in the hospital as well as in associated outpatient clinics.

An academic health center is broadly defined as a higher education institution that includes, at a minimum, a medical school and at least one other health professions education program (such as nursing, pharmacy, or physical therapy). In Virginia, there are three institutions that meet this definition of an AHC: Eastern Virginia Medical School, the Medical College of Virginia campus of Virginia Commonwealth University, and the University of Virginia Health Sciences Center. Rightly or wrongly, academic health centers had long been considered the "cash cows" of universities. This clearly is no longer the case as academic health centers are facing an array of financial and operational challenges due to changes in the health care market place during the last two decades.

There are presently 125 U.S. medical schools. Together with their affiliated teaching hospitals, these institutions have long been at the forefront of clinical and research advances in the health sciences. For example, more than 50% of the National Institute of Health's extramural research grants go to medical schools (Pardes, 1997). During the era of cost-based reimbursement by third party payers, which prevailed from World War II until the early 1980's, academic health centers grew rapidly as third party payers would reimburse AHCs for patient care based on the cost structure that they had in place. This cost-based reimbursement structure encouraged the development of AHCs as large, complex organizations that invested heavily in bricks and mortar, technology, and staff.

The Health Care Marketplace's Move Away from Cost-Based Reimbursement Has Caused Difficulties for Academic Health Centers

In the early 1980's, the federal government prompted a significant change in health care reimbursement when the Medicare program began reimbursing hospital-based care using Diagnosis Related Groups (DRGs). The DRG reimbursement methodology was a prospective payment system, where hospitals were reimbursed a flat fee for treating a particular type of illness. The DRG-based approach to reimbursement was significant not only in that it directly effected Medicare payments, a significant payment source for most hospitals, but also because it was widely mirrored by private sector payers.

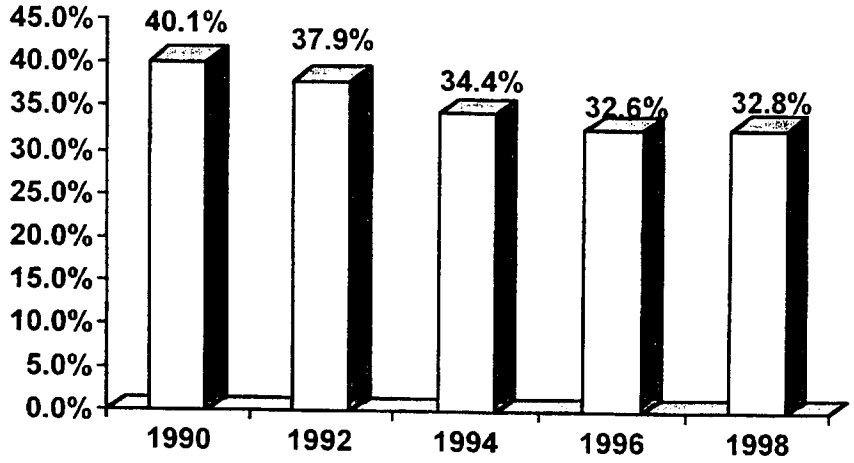
Increased Managed Care Penetration Presents Challenges for Academic Health Centers and Hospitals Generally

In addition to moving away from cost-based reimbursement in the early 1980's, the late 1980's and early 1990's saw the rise of managed care, particularly in urban health care markets. While managed care is typified by a variety of health care management strategies and contracting arrangements, one widely used technique by managed care organizations (MCOs) to control health care costs was to aggressively negotiate with providers on price, promising a large volume of patients in return for more favorable payment rates. MCOs also place an emphasis on keeping patients out of the hospital, whenever possible, and on reducing hospital inpatient stays.

Figure 1 shows hospital reimbursement as a percentage of total commercial medical spending. As can be seen from Figure 1, the percentage of total medical spending devoted to hospitals decreased significantly from 1990 to 1996 and has remained flat in the intervening years. As the JCHC found in its 1998 study of *Participation of Academic Health Centers in Managed Care Networks* (SJR 108), academic health centers are particularly challenged by the growth of managed care. The reimbursement levels offered by managed care organizations often does not meet the higher costs incurred by academic health centers.

Further, in some cases, academic health centers have expressed concern about being excluded from managed care networks.

Figure 1
Percentage of Commercial Medical Spending Paid to Hospitals: 1990-1998



Source: Health Care Advisory Board, Future Fortunes: Outlook for America's Hospitals and Health Systems.

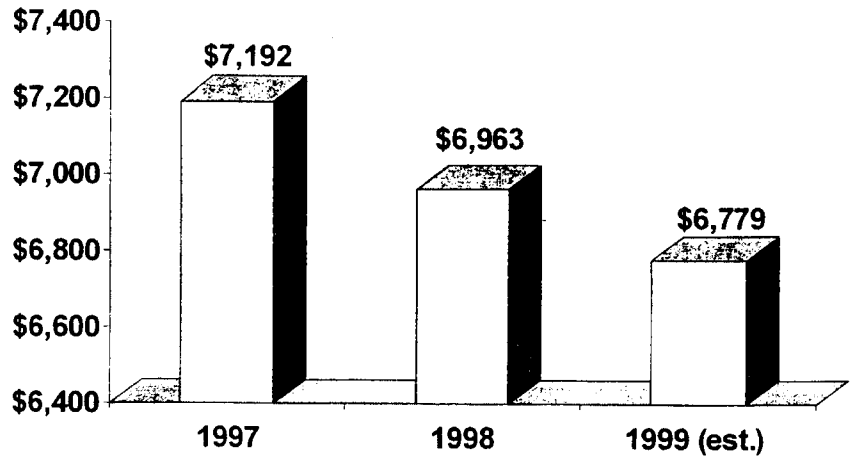
Balanced Budget Act of 1997 Causes Significant Revenue Losses for Academic Health Centers as well as all Hospitals

In addition to Medicare's shift way from cost-based reimbursement and the pricing pressures placed on hospitals (and other health care providers) by the growth of managed care, another challenge for hospitals, particularly academic health centers, was the Balanced Budget Act (BBA) of 1997. The BBA included a variety of changes to Medicare and Medicaid designed to slow the growth of these programs and, in certain expenditure categories, to actually cut expenditures.

One of the areas where the BBA actually cuts Medicare expenditures is in reimbursement for hospital services. There are several aspects of the BBA that negatively impact the hospital component of academic health centers. (The specific impact of the BBA on each Virginia AHC is discussed in Sections IV, V, and VI.) These include reductions in disproportionate share hospital payments through Medicaid and a variety of Medicare reductions affecting both inpatient and outpatient care. These Medicare reductions included reductions for inpatient reimbursement, skilled nursing payment reductions, and reductions in home health reimbursement.

According to the Health Care Advisory Board, a for-profit consulting group in Washington D.C, 70 percent of the savings realized from the BBA come from Medicare. Medicare inpatient prices actually decrease by 1.8 percent from 1997 to 2000. Figure 2 shows Medicare operating payments per case from 1997 to 1999.

Figure 2
Medicare Operating Payments per Inpatient Case: 1997-1999



Source: Health Care Advisory Board, Future Fortunes: Outlook for America's Hospitals and Health Systems.

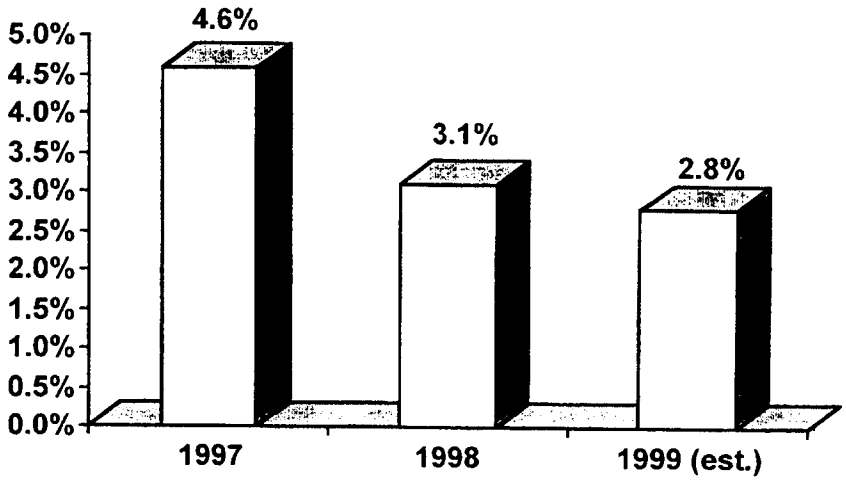
While the amount of the Medicare payment decrease may seem minor, compared with the increased costs facing health care providers due to tight labor markets and spiraling drug costs, these actual reductions translate into a significant decrease over time. As a result, the operating profit margin for U.S. hospitals decreased from 4.6 percent in 1997 to 3.1 percent in 1998, with a margin of 2.8 percent projected for 1999 (Figure 3). It should be noted that a 5 percent margin is considered the industry standard for sustainable capital reinvestment.

Bond Ratings of U.S. Not-for-Profit Hospitals Have Been Negatively Impacted by the BBA

The full effects of the BBA have not yet been felt, but BBA has already contributed to a nationwide downgrade of many non-profit hospitals' bond ratings. These downgrades include a number of academic health centers such as Baylor Health Care System, University Hospitals Health System in Cuyahoga County, Ohio, and the University of Pennsylvania Health System. In an October 1999 article entitled "Moody's predicts gloom for not-for-profits," *Modern Health*

Care reported that Moody's has downgraded $18.6 billion in debt during 1998-1999; this compares with only $2.8 billion in upgrades of debt. The $18.6 billion in downgrades represents nearly 1/3 of the total not-for-profit hospital debt rated by Moody's.

Figure 3
Operating Profit Margins, U.S. Hospitals: 1997-1999



Source: Health Care Advisory Board, Future Fortunes: Outlook for America's Hospitals and Health Systems.

A July 1999 special report from Moody's stated "the overall credit deterioration for U.S. not-for-profit hospitals that occurred in 1998 has accelerated at a greater pace through the first half of 1999, and the prognosis is for further declines in credit quality for the next quarter and beyond." The report added that "the total amount of debt downgraded in the first six months of 1999 has already exceeded the total cumulative debt downgraded for all of 1997 as well as that of any prior year since Moody's has been tracking rating changes in health care."

Congress is Negotiating Some Modifications to the BBA

As of November 12, 1999, Congress was considering making approximately $12 billion in modifications, over five years, to the reductions to health care providers through the BBA (this compares to over $70 billion in total reductions due to BBA over the five-year period). Some provisions for BBA relief, such as removing caps on outpatient physical and speech therapy, are of limited importance for academic health centers. The most significant consideration in the BBA for academic health centers would be some additional funds for graduate medical education.

It is not clear yet, however, how much impact this will have on teaching hospitals in Virginia, which receive relatively modest reimbursements for graduate medical education when compared with high cost states such as New York. A significant portion of the additional graduate medical education funding contained within the proposed BBA relief legislation would go to New York and a handful of other high cost states to retain their relatively high graduate medical education Medicare reimbursements for a longer period than originally contemplated under the BBA.

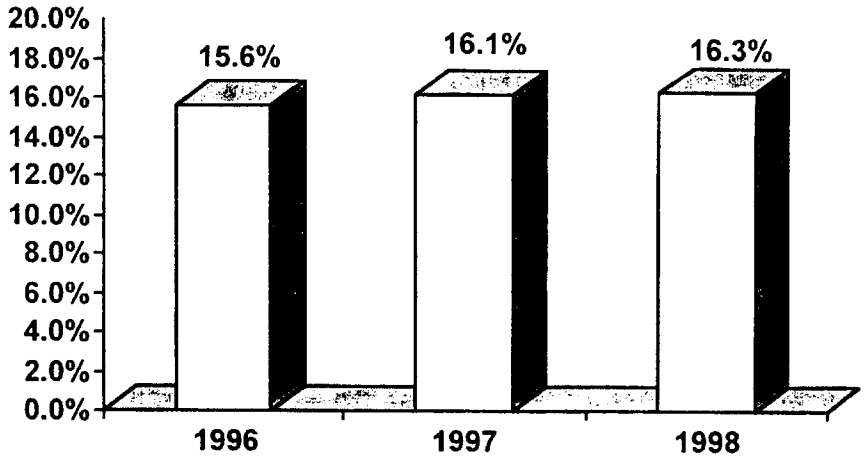
Financial Pressures Facing Academic Health Centers Nationwide

In addition to downgrades from bond rating agencies, nationwide, there have been a number of press accounts of the financial pressures facing academic health centers. For example, in Western Pennsylvania the Allegheny Health System has declared bankruptcy, while in Eastern Pennsylvania the University of Pennsylvania Health System experienced an operating loss of $90 million in 1998. In Northern California, the combined academic health center of the University of California at San Francisco and Stanford University (UCSF/Stanford) has faced significant staff cutbacks fueled by annual deficits in excess of $60 million dollars for the current year and projected deficits exceeding $100 million annually for future fiscal years. In Boston, Massachusetts General Hospital, in many ways the flagship hospital of American medicine, has had to significantly reduce staff due to a large operating deficit. In Washington, D.C., Georgetown University has attempted to sell its academic health center after the entire university's bond rating was downgraded due to the weak financial condition of its academic health center.

Continued Growth in the Number of Uninsured: Another factor that has contributed to financial difficulties among non-profit hospitals, including academic health centers, is the continued growth of the uninsured population in the United States. In 1992, there were approximately 38 million uninsured Americans. In 1998, according to the U.S. Census Bureau, 44.3 million Americans (16.3 percent of the population) lacked health insurance coverage for the entire year. This was an increase from 15.6 percent of the population in 1997 (Figure 4).

Federal law requires hospitals to treat urgent and emergent patients regardless of ability to pay. As the number of the uninsured increases, hospitals nationwide are facing increasing challenges in providing care to indigent and uninsured patients. Inasmuch as AHCs treat a large portion of the uninsured population, as the total number of uninsured persons increases, AHCs will continue to face increasing financial pressure from treating more and more patients without insurance coverage.

Figure 4
Percentage of Uninsured Americans: 1996-1998



Source: U.S. Census Bureau

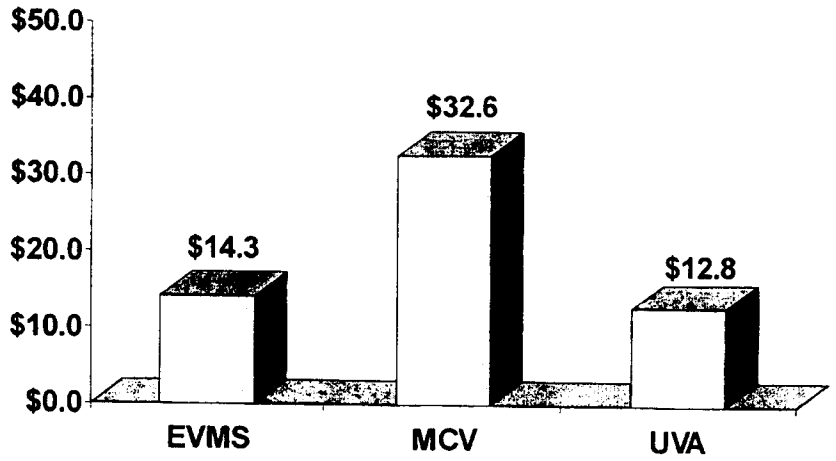
III.
Challenges for Academic Health Centers in Virginia

Section II describes the challenges facing hospitals in general and academic health centers in particular nationwide. This section discusses the specific challenges facing Virginia's three academic health centers.

The Unreimbursed Cost of Indigent Care Is The Most Critical Issue Facing Virginia's Three Academic Health Centers

The financial pressure created by treating indigent and uninsured patients impacts both the hospital and the physician practice components of the academic health centers. Each of the three AHCs stressed that the burden of unreimbursed indigent care is the single most critical issue that needs to be addressed by the Commonwealth. In previous years, prior to the growth of managed care and the other market pressures now facing the AHCs, this financial burden could be absorbed to some degree by other revenue-producing enterprises within the institutions. However, the market demands of managed care, the impact of the BBA of 1997, the growing number of uninsured persons, and the AHCs' other financial pressures make this an exceedingly difficult burden to carry into the future. Figure 5 shows the total unreimbursed indigent care reported by Virginia's three academic health centers for 1998.

Figure 5
Unreimbursed Indigent Care for Virginia's Academic Health Centers, 1998



Source: EVMS, VCU, and UVA responses to JCHC data requests.

It is important to emphasize that the unreimbursed costs of providing indigent care involve both the hospital and the physician practice components of academic health centers. Sections IV-VI will discuss each academic health center's particular situation in more detail.

State Funding of Undergraduate Medical Education Falls Short of SCHEV Guideline

Undergraduate medical education is defined as the four years of medical school that precede the award of the M.D. degree. Conversely, graduate medical education includes the internship and residency training (typically three to four years) that are required for a recipient of a M.D. degree to become licensed as a physician. The state has not historically been active in funding graduate medical education (GME), which is primarily funded through Medicare reimbursement. However, the state has long recognized a responsibility for funding undergraduate medical education.

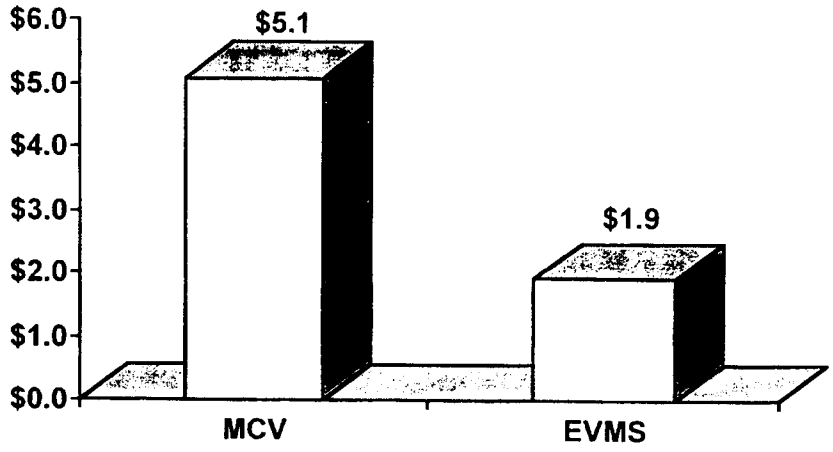
The State Council of Higher Education for Virginia (SCHEV) guideline for undergraduate medical education, adopted in January 1998, calls for the state general fund to pay 50 percent of the direct cost of undergraduate medical education for in-state medical students and 100 percent of the indirect cost of undergraduate medical education for all medical students. The remaining 50 percent of the direct cost of educating in-state medical students and the full direct cost of educating out-of-state medical students is to be funded from a combination of tuition and patient care revenues. SCHEV reaffirmed this policy earlier this year.

At present, state funding of undergraduate medical education falls short of the SCHEV guideline. Figure 6 shows the shortfall, according to the SCHEV guidelines, in state funding of undergraduate medical education costs at EVMS and MCV. UVA indicated in its response to JCHC that "if you accept this formula, then one might argue that the formula is fully funded." However, UVA also noted that "a more appropriate funding formula is one that says general funds and tuition will cover 100% of all direct and indirect costs for in and out-of-state students." Under this approach, UVA indicates there is a $7.4 million shortfall.

Academic Health Centers in Virginia Are Experiencing Some Difficulty in Retaining and Recruiting Key Faculty

As a result of the financial constraints they are facing, all three academic health centers reported some difficulty in recruiting and retaining key faculty members. In particular, responses emphasized difficulty in paying competitive salaries and, to a lesser extent, providing appropriate research facilities and support.

Figure 6
Shortfall in State Funding of Undergraduate Medical Education According to SCHEV Guidelines (Dollars in Millions)



Source: EVMS and VCU responses to JCHC data request.

For example, VCU reported "our physicians are paid less than the average salary (91 percent of the mean) of their peers at academic medical centers and much less than physicians in the private sector making it difficult to retain and recruit good faculty." UVA reported that "the School of Medicine has experienced an average turnover rate of 5.6 percent. The reasons cited most often for leaving include higher salaries, better research facilities [and support] . . . and the lack of opportunity for spouses. These are also the most commonly cited reasons for recruits to turn down offers at the School of Medicine." The response from EVMS indicated "faculty turnover increased from 6.5 percent in 1994 to 9.9 percent in 1998 but remains at an acceptable level."

State Funding of Medical Research Could be Improved

The state has not traditionally been active in funding medical research, other than some support for equipment purchases through the Higher Education Equipment Trust Fund. Medical research, in addition to its clinical value for patients, has significant economic development potential. Each of the responses from the three AHCs suggested ways in which state support of medical research could be improved. EVMS' response indicated "Providing a pool of funds that could be tapped by UVA, VCU, and EVMS to pursue exceptional opportunities to bring eminent researchers and programs to Virginia would be very helpful." It should be noted that this type of state effort would not be unprecedented. For

example, the state of Maryland provided substantial funding in recent years which played a role in an internationally-known infectious disease researcher choosing to locate at the University of Maryland, Baltimore rather than at VCU.

UVA's response emphasized the need for funding of research facilities. UVA's response stated "Additional research facilities are needed, as are more funds for infrastructure upgrades, operations, and maintenance to protect the state's investment in existing research facilities . . . If additional research facilities are not soon available, we will have to turn down grants to conduct research, as we simply do not have the lab space required for the work."

VCU's response on the issue of research support stated "the State can help us strengthen research by providing funds for maintaining and improving research facilities and libraries and by making funds available for service contracts to maintain research equipment purchased through the Higher Education Equipment Trust Fund." VCU also noted that "the State can also help us by requiring that indirect costs be budgeted for grants between state agencies. Only two of 32 grants awarded to [VCU] in FY 1998 by state agencies carried our DHHS cognizant agency rate."

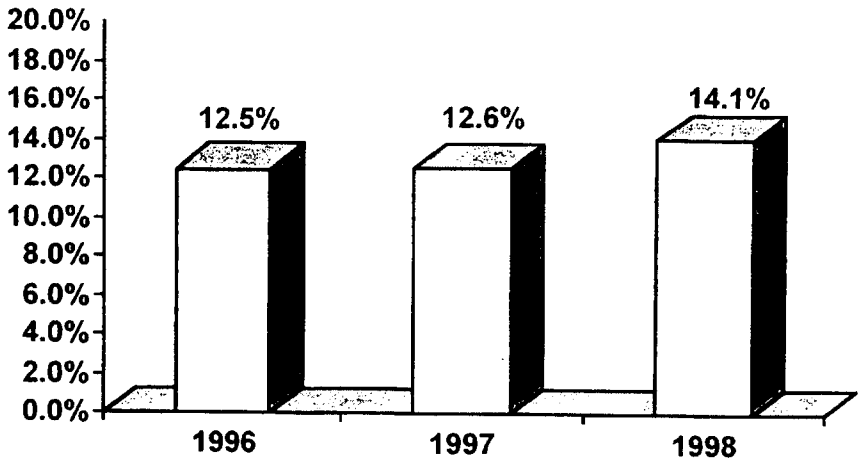
Growing Numbers of Uninsured Virginians Puts Pressure on Academic Health Centers

The previous chapter reported U.S. Census data showing an increasing number of uninsured persons in the United States. Virginia has been following the national trend in experiencing an increasing number of uninsured persons. According to data from the U.S. Census Bureau, the percentage of uninsured Virginians increased from 12.5 percent in 1996 to 14.1 percent in 1998 (Figure 7). The increasing number of uninsured Virginians puts additional problems on Virginia's traditional indigent care providers, which include all three academic health centers in the state.

As Discussed in the SJR 108 Issue Brief, Medicaid Managed Care Presents New Challenges for Academic Health Centers

The Virginia Medicaid program has implemented mandatory managed care for most participants in Hampton Roads and in Central Virginia (Medallion II). As was noted in the 1998 SJR 108 Issue Brief, retaining Medicaid patients is important to academic health centers because of financial reasons, particularly disproportionate share hospital (DSH) payments and teaching concerns. A reduced Medicaid patient load also can threaten the ability of teaching programs to expose students to an adequate number of cases. The issue brief completed earlier this year pursuant to HJR 656 discussed this issue in detail with regard to the impact of the declining number of Medicaid patients on obstetrics and family practice residency programs.

Figure 7
Percentage of Uninsured Virginians: 1996-1998



Source: U.S. Census Bureau

DSH Payments Are an Important Revenue Source for Academic Health Centers

The number of Medicaid patient days is a key factor in how the DSH payments are calculated. Accordingly, as the number of Medicaid patient days at the AHCs increases, so does the amount of DSH payments that the AHCs receive. DSH payments are particularly important for UVA and VCU, because both receive "enhanced" DSH payments.

In Virginia, hospitals become eligible for DSH payments when the percentage of their Medicaid inpatient bed days exceeds fifteen percent of their total inpatient bed days. For purposes of calculating DSH payments, hospitals in Virginia are divided into two types. The first type consists of the University of Virginia Medical Center (UVA) and the Medical College of Virginia (VCU) Hospitals. The second type consists of all other hospitals in the Commonwealth.

In addition to the regular DSH payments available to any hospital exceeding the 15 percent threshold, UVA and VCU both receive "enhanced" DSH payments. The purpose of these payments is to both compensate for the cost of serving low-income patients and to subsidize the teaching and research missions of the academic medical centers. DSH payments to the two academic medical centers are calculated using the following formula:

- The hospital's Medicaid utilization percentage in excess of fifteen percent, times 11, times the hospital's Medicaid operating reimbursement, times 1.4433 and (ii) the hospital's Medicaid utilization percentage in excess of thirty percent, times the hospital's Medicaid operating reimbursement, times 1.2074.

- The product of the hospital's low-income utilization in excess of 25 percent, times the hospital's Medicaid operating reimbursement.

For FY 1998, enhanced DSH payments to UVA totaled $35,102,339. The enhanced DSH payments to VCU for FY 1998 totaled $69,400,000.

To Draw Down DSH And Enhanced DSH Payments, AHCs Must Maintain A Certain Level Of Medicaid Utilization

The 1999 Appropriation Act appropriates $41,403,000 (general funds) and $44,141,364 (nongeneral funds) to DMAS for FY 2000 payments to UVA Medical Center, including DSH, enhanced DSH, and Medicaid payments. The 1999 Appropriation Act appropriates $74,985,600 (general funds) and $79,950,400 (nongeneral funds) to DMAS for payments to the Medical College of Virginia Hospitals Authority.

As previously noted, DSH and enhanced DSH payments are vitally important to the AHCs. To draw down these funds, they must achieve a certain level of Medicaid utilization. If Medicaid utilization drops below a given level, the AHCs cannot draw down their full Medicaid payment amounts included in the Appropriations Act. If Medicaid utilization is not maintained at the AHCs, the level of enhanced DSH payments decreases and the amount of unreimbursed indigent care increases.

Increasing The Number Of Medicaid Recipients Who Enroll In HMOs That Include The AHCs Would Help Ensure The AHCs Retain Their Medicaid Patient Base

Maintaining an adequate base of Medicaid patients was a key issue analyzed last year in the JCHC's SJR 108 study. The specific concern is that AHCs fear they will lose these patients to other hospitals as more and more Medicaid patients enroll in Medallion II HMOs.

DMAS currently pre-assigns all Medallion II enrollees to an HMO according to the following procedure:

1. clients previously enrolled in an Options HMO are pre-assigned to that HMO; previous Medallion clients are enrolled in the HMO selected by their Medallion primary care physician, if applicable;

2. clients not assigned under condition 1 are pre-assigned to the HMO of another family member, if applicable; and

3. clients not assigned under conditions 1 or 2 are pre-assigned to an HMO on an equal, random basis.

New clients have 60 days to change their pre-assigned HMO if they prefer to enroll in another plan. Once assigned, new clients have an additional 90 days to change without cause.

If the HMOs contracting with DMAS for the Medallion II program were required to include the AHCs as fully participating providers (assuming the AHC was in the HMO's service area), all of the Medallion II clients ultimately would enroll in an HMO which included the AHCs. If DMAS was directed to pre-assign those clients who currently are randomly assigned under condition #3 only to those HMOs which included the AHCs as fully participating providers, based on DMAS' data, a smaller number of the enrollees would be affected.

There are two variations of directing "default" assignments to HMOs which include AHCs in their provider networks. The first would be to let the appropriate AHC select the HMO. The HMOs do not favor this approach. The second variation would be for DMAS to assign these Medicaid recipients to the HMO which has the highest percentage of admissions at the AHC. The advantage of this approach for the AHCs is that it would increase the likelihood that if a Medicaid recipient was going to be admitted to a hospital, the admission would be at the AHC rather than another hospital in the network.

The AHCs Currently Are Included In Nearly All Medallion II HMO Networks; AHCs Are Concerned About Future HMO Provider Networks

Currently, the AHCs are included in nearly all of the Medicaid HMOs which are operating in their service area. This issue has less of an impact on UVA at this time because there are no Medicaid HMOs operating in their service area (with the exception of Louisa County). MCV currently participates in each of the five Medallion II HMOs (Virginia Chartered Health Plan, Optimum Choice, Southern Health Services, Sentara Family Care, and Trigon Healthkeepers) in Central Virginia. The only services carved out of these contracts are vision services under Southern and home health from Optimum Choice. EVMS provides physician services to a number of hospitals in Eastern Virginia, but does not own or operate a hospital as do MCV and UVA. EVMS officials indicated that while there was a serious concern regarding access to

certain Medicaid patients when Medallion II was first implemented, this issue has been resolved. However, EVMS officials indicated concern about possible reductions in Medicaid patients in the future.

Future HMO Networks: The chief concern expressed by the AHCs with respect to retaining Medicaid patients is that they may be left out of future HMO networks. As Medallion II areas expand resulting in HMOs providing services to more Medicaid clients, and as the competition among the HMOs for covered lives increases, the AHCs fear that they will be excluded from these networks. To the degree they are excluded, the amount of enhanced DSH payments likely will be reduced creating further financial problems.

MCOs And Other Medicaid Providers Have Some Concerns Regarding Actions To Require Inclusion Of AHCs In Medicaid Networks

The HMOs have less concern regarding actions to increase the AHCs' Medicaid utilization than they do regarding any action to include the AHCs in the networks of HMOs participating in the state employee health benefits program (discussed later). While the AHCs currently participate in most Medicaid HMOs, there is still some concern on behalf of the managed care organizations that restrictions on network development may hamper their efforts to develop cost-effective networks in the future. Also, other Medicaid providers, some of whom have treated the Medicaid population for many years, likely would be concerned that such a provision would reduce the number of Medicaid patients they treat.

Another Potential Action Identified By VCU Would Be For The Medicaid HMOs To Reimburse The AHCs At A Rate No Lower Than The Highest Negotiated Payment Level For Any Similar Physician Or Hospital

VCU has suggested that another means of supporting the AHCs would be to include a provision in the Medicaid HMO contracts that would require the AHCs to be reimbursed at a rate no lower than the highest negotiated payment level for any similar physician or hospital. This provision ultimately may have an impact on the cost of the Medicaid program. Currently, the capitation rates paid to the HMOs are based on historical claims data irrespective of the reimbursement that HMOs pay to providers. However, if paying the AHCs a level no less than the highest rate paid to other providers increases the HMOs' costs, they likely will come to DMAS for an increase in their capitation rates. Other providers not entitled to this level of reimbursement likely would be opposed to taking such an action. Also, the HMOs would argue this reduces their ability to develop cost-effective networks. Another consideration regarding this issue is DMAS' current efforts to adopt a DRG-type of reimbursement system for inpatient care (discussed earlier).

Selective Contracting By MCOs Has Been Raised As A Concern By Some AHCs

As noted in last year's SJR 108 report, some MCOs contract with hospitals only for selected services and "carve out" other services. When a service is "carved out," the MCO's enrollees receive either reduced or no benefits when the particular service is received at the hospital. As a result, the "selective contract" results in the hospital providing these services to fewer patients.

Information Provided Last Year By Two Of The Three AHCs Indicates That Selective Contracting Is Occurring; In Some Instances The Contracting MCO Provides Coverage Only For Selected Services And Does Not Contract With Any Provider For A Comprehensive Package Of Services

Last year, MCV and UVA were able to provide specific, although somewhat different, data regarding their contracts with MCOs. Data was not immediately available from EVMS; however, EVMS officials stated that selective contracting (i.e., services being "carved out") had not yet become a serious problem for the institution. The AHCs indicated the information presented last year was still reflective of the current situation.

MCV Managed Care Contracts: Information provided by MCV indicates that it has contracts with 11 different MCOs, including nearly all of the major HMOs and preferred provider organization (PPO) plans in the area. The 11 MCOs with which MCV has a contractual relationship offer a total of 35 separate plans or products, some of which have different contract provisions. The MCV data shows that all 35 managed care plans/products have carved out at least one type of service. However, 27 plans/products carve out only one or two services, mostly home health services and mental health/substance abuse services. While the majority of carve outs apply to only one or two services, 6 plans/products carve out 3 or more services, and one plan carves out seven types of services.

UVA Managed Care Contracts: The managed care contracting information provided by UVA was in somewhat of a different format than MCV's data. The UVA data was more specific with respect to whether the contract included the medical center and/or the health services foundation (i.e., faculty practice plan) and whether the contract was for "general services" or "carve-out." However, there was no specific information on which services were "carved out."

UVA included information on a total of 74 managed care contracts. Of the 74 total managed care contracts, 41 include both physician and medical center services; 33 contracts are for either physician services only or medical center services only. With respect to whether certain types of services are carved out

(e.g., mental health /substance abuse, home health , etc.), 44 of the 74 contracts have no services carved out; 30 contracts carve out certain service(s). Twenty-eight of the 74 plans contract for both physician and medical center services with no carve outs.

MCOs Indicate That, In Many Circumstances, The Services That Are "Carved Out" Of AHC Contracts Also Are Carved Out Of Other Contracting Hospitals' Contracts

Representatives of several MCOs indicated that in many instances the services that are carved out of AHC contracts also are carved out of other hospitals' contracts as well. As previously noted, these services often are carved out because the MCO has a subcontract with another MCO to provide benefits for these services.

Another reason for some of the carve outs is because the MCO has negotiated an exclusive arrangement with either one hospital or a limited number of affiliated hospitals (e.g., Columbia or Bon Secours) to provide the service(s). In these instances, while the AHCs are affected by the carve outs, other private hospitals are affected similarly. By having an exclusive contract with one or a few hospitals, MCOs indicate they are able to direct a greater number of patients to the hospital(s) in return for a lower cost for the service(s). MCOs maintain that such arrangements enable them to hold down costs and provide their customers with lower premiums.

Requiring MCOs Which Contract With The State Employees Health Benefits Program To Include AHCs As Fully Participating Providers In All Of Their Managed Care Products Is One Action That Would Alleviate The Impact Of Selective Contracting; However, MCOs Oppose This Action

Through its state employee health benefits program, the Commonwealth provides health benefits to over 100,000 persons. One action that has been suggested to alleviate the impact of selective contracting on the AHCs is for the Commonwealth to require those MCOs which contract with the state's health benefits program to include the AHCs as a fully participating provider (i.e., no carve outs) in the networks that serve <u>all of their products</u>. This would include not only those products offered to the state program, but all other products offered to employer groups, etc.

In this scenario, MCOs submitting proposals to participate in the state program would include a certification in its bid/proposal stipulating that, if selected, it would include AHCs (which are located in its service area) in its provider network(s) as a fully participating provider for state employees and all other products.

Concerns Have Been Expressed By The MCOs, Other Community Providers, And The Department Of Personnel And Training About Requiring MCOs To Include The AHCs As Fully Participating Providers In All Products Offered By The MCO

Requiring that certain providers participate in a given managed care network raises serious concerns by MCOs that their ability to establish cost-effective networks will be jeopardized. MCOs express concern that if any provider, whether it is an AHC or any other type of professional or facility provider, is guaranteed entry into their networks, their ability to negotiate lower costs for their subscribers is hampered. MCOs questioned how they would be able to negotiate rates at all with an AHC when they are required to include the AHC in their networks. Another complicating factor identified by the MCOs is that UVA sponsors its own health plan, QualChoice. MCOs expressed concern that they would be required to include a hospital in their network that is associated with one of their competitors. A similar situation exists with VCU's Chartered Health Plan.

Some providers, both hospital and physician groups, also have expressed concern that such a requirement would place them at a competitive disadvantage. Requiring MCOs to include the AHCs in their networks for all products would limit the number of available "provider slots" in these networks and would lessen their chances of being included.

DPT Concerns: The Department of Personnel and Training (DPT), which administers the state employee program, expressed concern on two fronts. First, such a requirement may lead to increased program costs should the MCOs be required to include the AHCs in their networks in place of another provider which may be able to provide certain services at a lower cost. Any increased cost would be borne by the Commonwealth and state employees. The second concern is that some MCOs may be less willing to participate in the state program if they are required to include the AHCs in all of their product networks.

One possible alternative to this proposed action would be to require the MCOs participating in the state program to include the AHCs as network providers in only those products offered to state employees. While the concerns of MCOs and other providers regarding the impact of this approach would be reduced, the concerns would still exist. The AHCs would benefit less from this approach, but would still be included in those products offered to state employees.

Generalist Physician Initiative Has Caused Medical Schools to Refocus Their Efforts

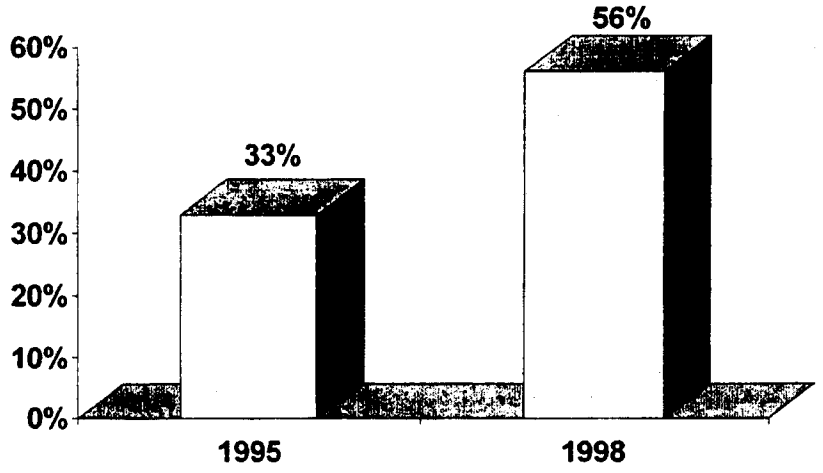
In addition to the financial challenges and managed care pressures described in earlier parts of this section, the medical school components of Virginia's three academic health centers have faced the challenge of refocusing their educational efforts to produce more generalist physicians and fewer specialist physicians.

A generalist physician is broadly defined as a physician such as an internist, family practitioner, or pediatrician who treats the whole range of illnesses that confront individual patients and serves as primary care providers. The demand for primary care providers has grown in particular as health plans increasingly use primary care physicians as gatekeepers to specialty care.

Through the Appropriation Act, the General Assembly has established a goal of having the state's three medical schools have 50 percent of their graduates enter generalist residencies. This contrasts with past trends where the majority of Virginia's medical school graduates, like the majority of medical school graduates nationwide, entered specialty residencies such as surgery, psychiatry, or radiology.

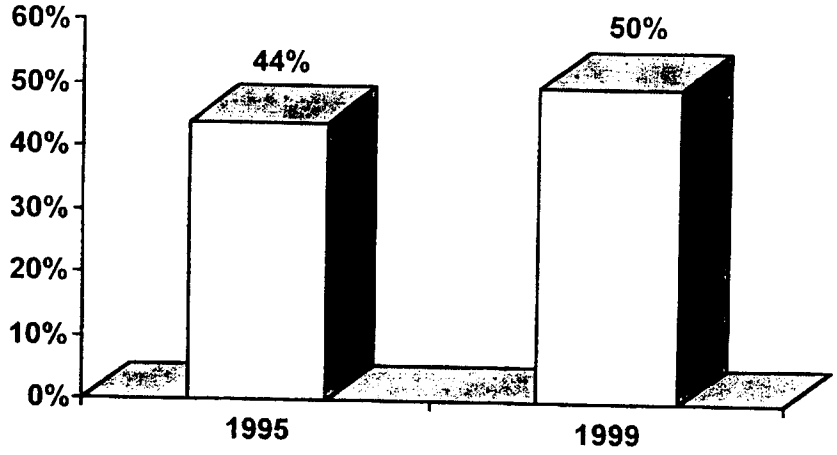
The Generalist Physician Initiative has been funded by a combination of grant funds from the Robert Wood Johnson Foundation, state general funds, and contributions from the three medical schools. All three medical schools have made significant progress in increasing the percentage of graduates entering generalist residencies. Figures 8 through 10 shows the progress reported by each medical school in meeting the 50 percent goal.

Figure 8
Percentage of EVMS Graduates Entering a General Practice Residency



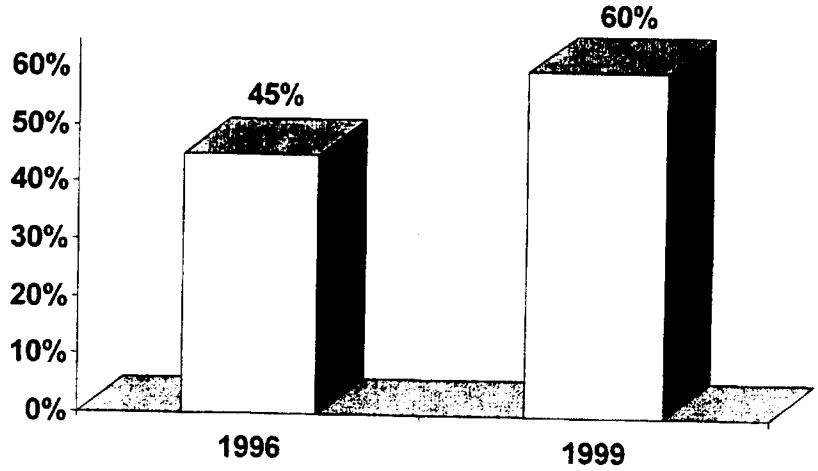
Source: EVMS response to JCHC data request.

Figure 9
Percentage of VCU Graduates Entering a General Practice Residency



Source: VCU response to JCHC data request.

Figure 10
Percentage of UVA Graduates Entering a General Practice Residency



Source: UVA response to JCHC data request.

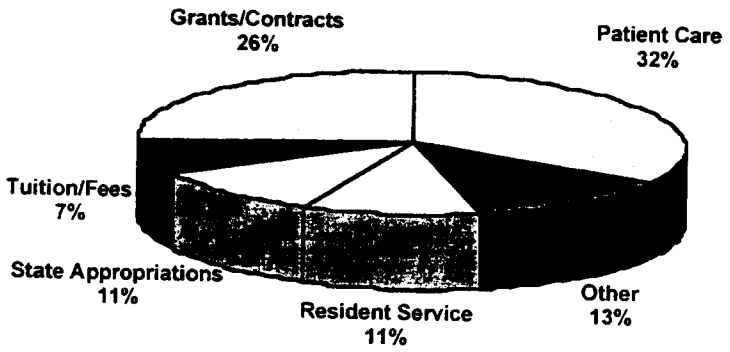
IV.
Challenges Facing EVMS

Overview of EVMS

EVMS is unique among Virginia's academic health centers in that it does not operate a teaching hospital. EVMS accepted its first entering class of medical students in 1973. Since that time, EVMS has developed a series of relationships with private sector hospitals in Hampton Roads. Eighty percent of EVMS's total clerkship and residency programs take place in six hospitals: Sentara Norfolk General Hospital (SNGH), Children's Hospital of the King's Daughters (CHKD), Bon Secours Depaul Medical Center, Bon Secours Maryview Medical Center, the Portsmouth Naval Medical Center, and the Veterans Affairs Medical Center in Hampton.

EVMS employs 285 full-time faculty members and 746 full-time staff members. It's community and part-time faculty total 1,033. EVMS's FY 1998 operating budget was $112.9 million. Figure 11 shows EVMS's revenues for 1998 and Figure 12 shows its expenditures.

Figure 11
EVMS, FY 1998 Revenues



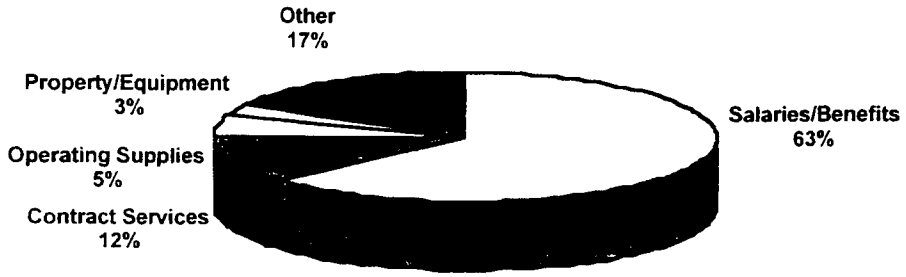
Source: EVMS response to JCHC data request.

As can be seen from Figure 11, state appropriations represent only about 10 percent of the total revenue for EVMS. This does not include patient care

revenues that may be reimbursed through Medicaid or the state employee health benefit plan. It should be noted, however, that since the Medicaid population in Hampton Roads is required to enroll in Medallion II, payments for Medicaid beneficiaries would be made by the Medicaid managed care health plans, not DMAS itself.

As can be seen from Figure 12, nearly two-thirds (63 percent) of the total expenditures at EVMS are attributable to salaries and benefits. This reflects the labor intensive nature of a medical school, where faculty are responsible for teaching, research, and patient care.

Figure 12
EVMS, FY 1998 Expenditures

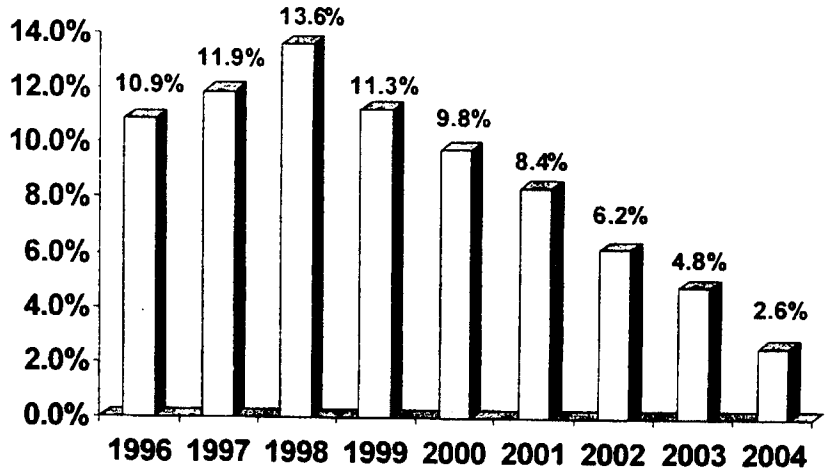


Source: EVMS at a Glance.

Declining Operating Margins for Affiliated Hospitals Is Cause for Concern at EVMS

Like virtually all hospitals in the United States, the teaching hospitals affiliated with EVMS are facing significant financial challenges as a result of the BBA, which was overviewed in Section II. For example, the Sentara Health System expects to lose between $50 million and $100 million in Medicare reimbursement during the next five years. BBA reductions are expected to reduce the operating margins at Sentara Norfolk General Hospital from 11 percent in 1997 to three percent in 2004. As noted previously, five percent is the minimum operating margin for maintaining quality and viability. Figure 13 shows current projections for operating margins for SNGH from 1996 to 2004. Figure 14 shows projected operating margins for CHKD from 1997 to 2002.

Figure 13
Operating Margins at SNGH (1996-1999 Actual; 2000-2004 Projected)



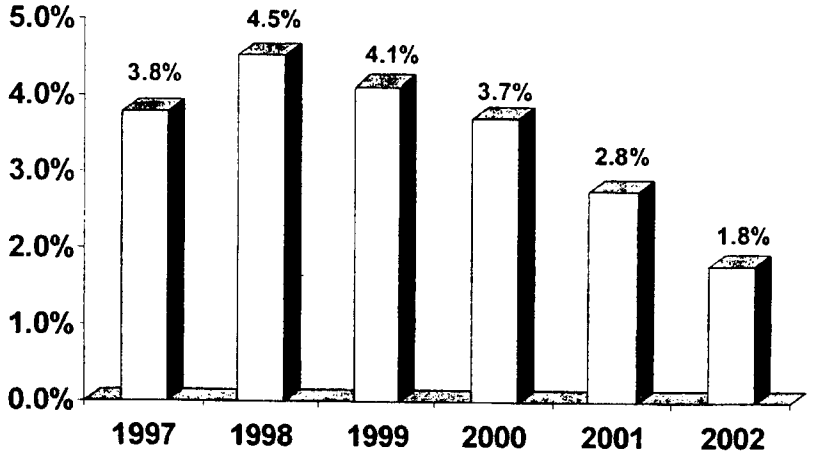
Source: EVMS response to JCHC data request.

In Addition To Funding Indigent Care and Medical Education, The Priority Concerns for EVMS Include DSH Hospital Methodology and Funding of the Air Ambulance Service in Hampton Roads

As with UVA and VCU, funding indigent care and undergraduate medical education are the priority concerns of EVMS. For indigent care financing, EVMS proposed that the state pay one-half of these costs ($7.15 million for EVMS). In addition, $1.9 million in additional state funds are needed to fund undergraduate medical education at EVMS. As part of the data request to each academic health center, JCHC staff asked for the AHC to list its priority items for the General Assembly to address in addition to undergraduate medical education funding and funding of indigent care, which were understood to be concerns of all three AHCs.

DSH Methodology: One concern identified by EVMS was the state's DSH methodology and the relatively favorable treatment this methodology gives to state teaching hospitals when compared with the teaching hospitals affiliated with EVMS. At present, only UVA and VCU qualify for the enhanced DSH reimbursement. As noted earlier, EVMS does not operate a teaching hospital. Rather, EVMS is affiliated with several Hampton Roads hospitals to provide clinical experience for its medical students and residents.

Figure 14
Operating Margins at CHKD (1997-1999 Actual; 2000-2002 Projected)



Source: EVMS response to JCHC data request.

Cost of Air Ambulance Service: Another key concern identified by EVMS was funding of air ambulance (Medevac) service in Hampton Roads. Sentara Norfolk General Hospital (SNGH), the largest of EMVS's affiliated teaching hospitals, currently funds an air ambulance service on behalf of all of Hampton Roads (SNGH is the only trauma center in the area). A recent study by the Joint Legislative Audit and Review Commission (JLARC) found that all four commercial air Medevac providers (including Sentara) reported that they operated at a loss during the most recent fiscal year. It is estimated that SNGH's air ambulance service lost approximately $525,00 during the most recent fiscal year. One option would be for the state to assume this service for Hampton Roads. Another option, which was recommended by JLARC, would be for the state to increase its Medicaid reimbursement for air ambulance services.

Enhancing Research Mission: EVMS also recommended a pool of funds that could be used by UVA, VCU, and EVMS to pursue exceptional opportunities to bring eminent researchers and programs to Virginia AHCs.

EVMS Has Taken Steps to Cut Costs and Reorient Its Curriculum

During the study, EVMS highlighted its efforts to cut costs and raise additional revenue in reaction to the changing health care environment. These steps include:

- EVMS reduced the cost of medical education in 1994 and has kept annual cost increases to 2.75 percent since then;

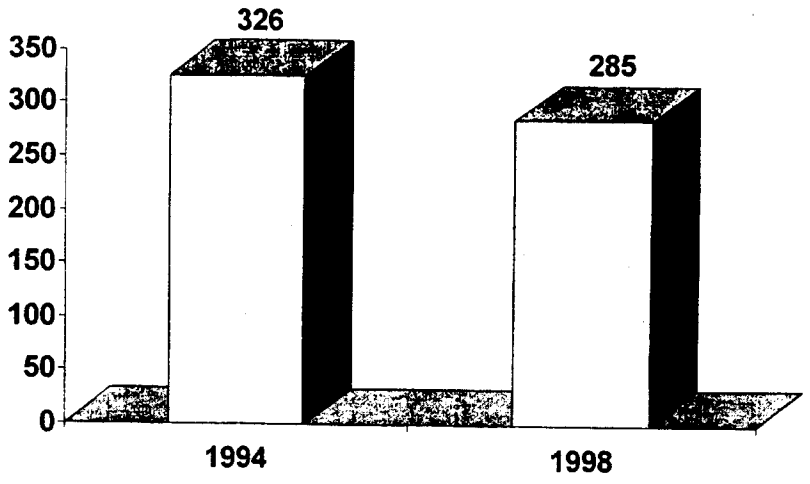
- EVMS has reduced the number of its residents by about 20 percent since 1994;

- EVMS has reduced its number of full-time faculty from 326 in 1994 to 285 in 1998 (Figure 15); and

- EVMS has nearly completed a major capital campaign to raise $62 million for its programs.

EVMS has also been active in reorienting its curriculum towards a more generalist orientation. As noted in the previous section, the percentage of EVMS graduates entering generalist residencies has increased from 33 percent in 1995 to 56 percent in 1998. EVMS students now gain hands-on, clinical experience in a generalist setting during their first year of medical school, a departure from past practices where the first two years of medical school were exclusively devoted to study of the basic sciences. Approximately 50 percent of EVMS' full-time clinical faculty serve in primary care departments.

Figure 15
Number of Full-Time EVMS Faculty: 1994 vs. 1998



Source: EVMS response to JCHC data request.

V.
Challenges Facing UVA

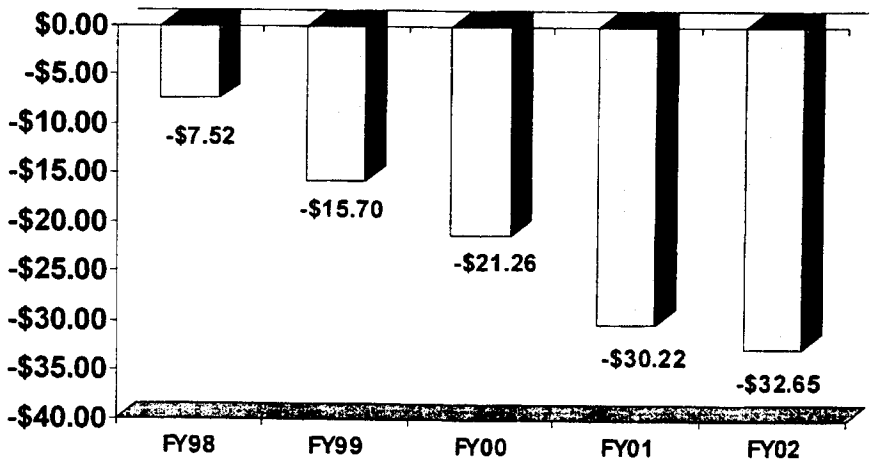
Overview of UVA's Academic Health Center

The University of Virginia's academic health center includes the University of Virginia medical center, schools of medicine and nursing, and an affiliated physician practice. The University of Virginia has recently organized its hospital, physician practice, and affiliated health plan (Qual Choice) into the University of Virginia Health System. UVA's patient base varies somewhat from MCV and EVMS in that UVA serves more rural jurisdictions; though like the other two academic health centers, UVA is heavily dependent on Medicaid patients both for the direct revenue provided, and, as is the case with MCV, because of the link to enhanced DSH payments.

BBA's Impact on UVA is Estimated at More than $100 Million Over Five Years

UVA's response to the JCHC data request identified a number of challenges that UVA is facing in the operation of its academic health center. Notwithstanding current congressional negotiations regarding modifications to the Balanced Budget Act (BBA) of 1997, UVA is facing significant financial losses from its Medicare revenue stream as a result of BBA. UVA estimates that BBA Medicare cuts will cost up to $21.5 million in Medicare funding each year for the next five years. Figure 16 shows the projected impact of BBA on UVA.

Figure 16
Projected Impact of BBA on UVA (In Millions)



Note: Does not include changes to BBA being negotiated in Congress as of 11/12/99.
Source: UVA response to JCHC data request;

Other Financial Challenges Facing UVA

Additionally, UVA is facing significant challenges in maintaining its patient volume, including both Medicaid patients and patients with private insurance. An issue brief presented earlier this year pursuant to HJR 656 highlighted challenges facing all three academic health centers, particularly UVA and MCV, in maintaining their patient volume for labor and delivery services. Similar problems confront UVA in other areas such as pediatrics. The challenges in losing patient volume to lower cost competitors has both financial and educational implications.

Additionally, UVA's physician practice is facing the challenge of flat or decreasing reimbursement for increased work volume. This limits UVA's ability to use physician practice revenues to subsidize medical education and to recruit and retain key faculty.

Managed care is also growing in UVA's service area, albeit at a slower pace than is the case in Richmond or Hampton Roads. Managed care now represents 25 percent of total charges and reimbursements for inpatient services at UVA and 22 percent of total charges and reimbursements for outpatient services. At present, only Louisa County within UVA's service area is impacted by Medallion II, so Medicaid managed care is not yet a significant factor for UVA.

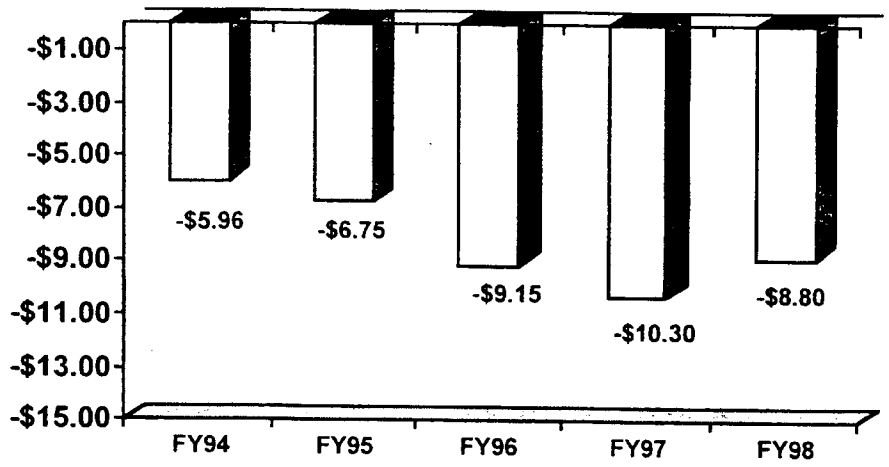
Although Unreimbursed Indigent Care at UVA Medical Center Showed A Decrease in FY 1998; Overall Losses Are Substantial

The indigent care burden for UVA's hospital and physician practice is substantial. Figure 17 shows the indigent care losses for UVA's physician practice (the Health Services Foundation or HSF). Figure 18 shows indigent care losses for the medical center. As seen in Figure 18, the Medical Center's unreimbursed indigent care losses decreased from $13 million in FY 1997 to $3.99 million in FY 1998. Nonetheless, the total loss for FY 1998 (physicians and the hospital) was approximately $12.8 million. The 1999 General Assembly appropriated $1.74 million to help address indigent care losses at UVA. Of this amount, $400,000 was provided to the School of Medicine and $1,344,364 was provided to the medical center.

Potential For Funding Unreimbursed Indigent Care on "Risk-Sharing" Basis: During the JCHC site visit, UVA suggested one possible way of funding future unreimbursed indigent care is through a "risk-sharing" agreement between the AHCs and the Commonwealth. Under such an arrangement, the Commonwealth and the individual AHCs would "share" the cost of unreimbursed indigent care through an established formula or methodology. In this way, the AHCs would have an incentive to contain these costs in order to reduce the

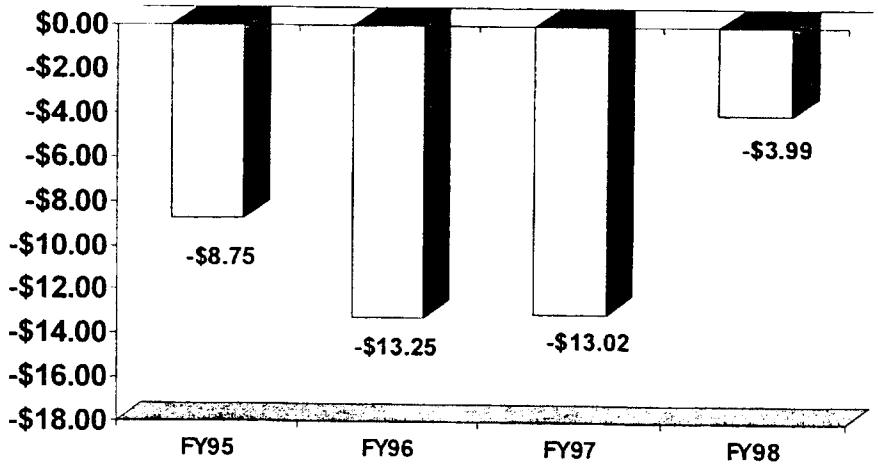
amount that they would be expected to carry. While not presented in the same terms, EVMS' proposal for the state to pay for one-half of the unreimbursed indigent care costs could be considered as a type of "risk-sharing" arrangement.

Figure 17
UVA HSF Indigent Care Losses (in millions)



Source: UVA response to JCHC data request.

Figure 18
UVA Medical Center Indigent Care Losses (in millions)

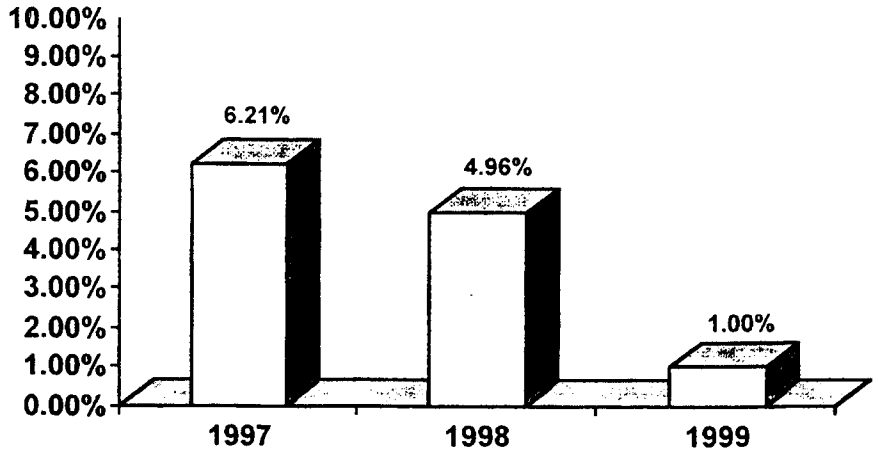


Source: UVA response to JCHC data request.

UVA's Operating Margins Have Been Shrinking

The operating margins for UVA's academic health center have been deteriorating significantly below the benchmark five percent level (Figure 19). The University's Board of Visitors has mandated that the academic health center maintain an operating margin of 4 percent. It is not clear whether this dictate will translate into operating reality, given the uncertainties related to the BBA, growing numbers of uninsured Virginians, and Medicaid inpatient reimbursement for state teaching hospitals.

Figure 19
Operating Margins at UVA Medical Center



Note: 1999 Margin is an estimated figure
Source: UVA response to JCHC data request

UVA Actions to Remain Competitive

UVA has undertaken a number of actions to remain competitive in an evolving health care market. These include:

- cutting costs through attrition, travel restrictions, cross-training, drug formularies, and other measures;
- opening outreach clinics throughout the service area;
- modernizing equipment;
- developing and marketing an HMO product (Qual Choice);

- adopting best practices;
- expanding marketing;
- purchasing primary care practices;
- increasing emphasis on ambulatory care; and
- examining private/public partnerships, corporate grants, and other development opportunities.

UVA's Business Plan For Its University Medical Associates Includes A Major Initiative Aimed At Managing More Effectively The Care Of Indigent Patients And Controlling The Associated Costs

During the JCHC site visit, UVA officials indicated that they are developing a business plan for the University Medical Associates primary care clinic to better manage indigent care patients and the costs associated with treating this population. The goals of the project are to: (i) integrate faculty/resident practice; (ii) decrease overall costs of care; (iii) improve access to care, thus decreasing or eliminating unnecessary emergency room and clinic visits; and (iv) improve patient and provider satisfaction. The plan is expected to be implemented by 2002 as a means of providing more cost-effective care for indigent patients.

UVA Recommended Policy Options

UVA's response to the JCHC data request suggested a number of options for the General Assembly to consider with regard to improving the viability of academic health centers. These include full funding of indigent care costs and increased funding of undergraduate medical education. With regard to funding undergraduate medical education, UVA indicates that it ranks 60th of 74 public U.S. medical schools. In addition, UVA suggested exploring federal waivers to improve funding of graduate medical education through Medicaid.

Administrative Issues: UVA also suggested several administrative changes to help UVA increase the competitiveness of its academic health center. These include:

- Allowing UVA to retain the interest on its daily cash balances;
- No longer requiring UVA to offer VRS as a retirement option to Health System employees (the VRS contribution rate is 10.85 percent versus an industry norm of five percent); this does not include the

required match under VRS for deferred compensation plan contributions;

- No longer requiring UVA to offer the severance package under the Workforce Transition Act;

- Giving UVA flexibility in salary administration rather than mandating across-the-board faculty salary increases.

Research Needs: UVA also recommended a number of actions to improve the ability of Virginia's academic health centers to fulfill their research missions. These include: additional research facilities, providing seed funds for joint ventures with industry, and encouraging joint ventures with other schools through financial incentives.

VI.
Challenges Facing VCU

Overview of VCU's Academic Health Center

VCU's academic health center is the largest of Virginia's academic health centers. VCU's academic health center consists of five health sciences schools: medicine, dentistry, allied health, pharmacy, and nursing. VCU's primary teaching hospital is the Medical College of Virginia Hospitals (MCVH), which is the largest hospital in Central Virginia. MCVH is a regional referral center, notable for its Level 1 Trauma Center, Neonatal Intensive Care Unit, Burn Unit, Organ Transplant programs, Massey Cancer Center, Cardiac services, and Spinal Cord Injury/Rehabilitation program. VCU's School of Medicine, the Medical College of Virginia (MCV), enrolls approximately 680 medical students and 693 graduate medical residents. There are also 394 students enrolled in graduate degree programs at MCV.

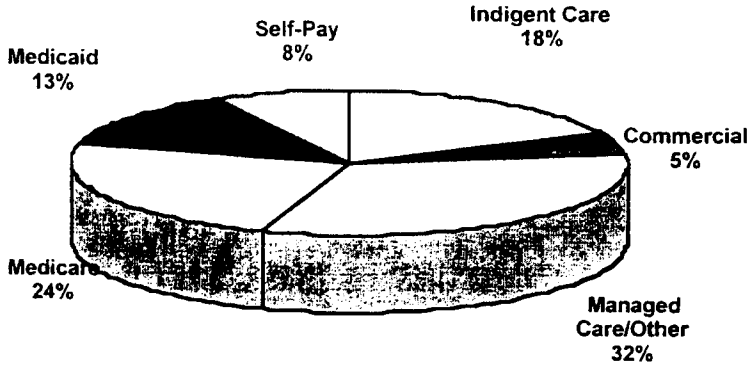
MCV is a major research institution. It ranked 54th of the nation's 125 medical schools in federal research grant expenditures. MCV was awarded $60 million in grants last year.

VCU's Academic Health Center is Heavily Dependent on Medicaid and Medicare

The payer mix for both MCVH and the MCV faculty group practice (MCV Associated Physicians or MCVAP) is heavily weighted towards Medicaid and Medicare. Both MCVH and MCVAP treat large numbers of indigent and uninsured patients. Figure 20 shows the payer mix for MCVH. Figure 21 shows the payer mix for MCVAP.

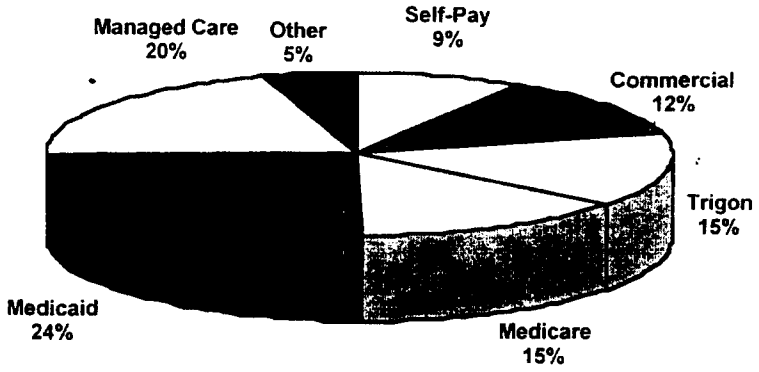
As Figure 20 indicates, over one-third (37 percent) of the revenue for MCVH is provided by Medicaid or Medicare. As Figure 21 reflects, 39 percent of MCVAP's payer mix is represented by Medicaid and Medicare. Another significant trend has been the percentage of revenue coming from managed care for both organizations. The increase has been particularly striking for MCVH (Figure 22). The trend towards more managed care is significantly accelerating partially as a result of the Richmond area now being part of Medallion II (mandatory Medicaid managed care).

Figure 20
MCVH, FY 1998 Payer Mix



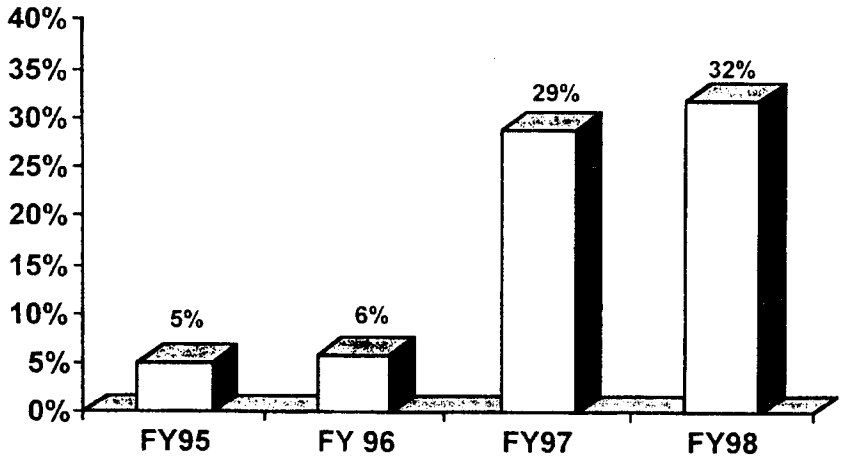
Source: VCU response to JCHC data request.

Figure 21
MCVAP, FY 1998 Income Payer Mix



Source: VCU response to JCHC data request.

Figure 22
Managed Care as a Percentage of Gross Revenue for MCVH



Source: VCU response to JCHC data request.

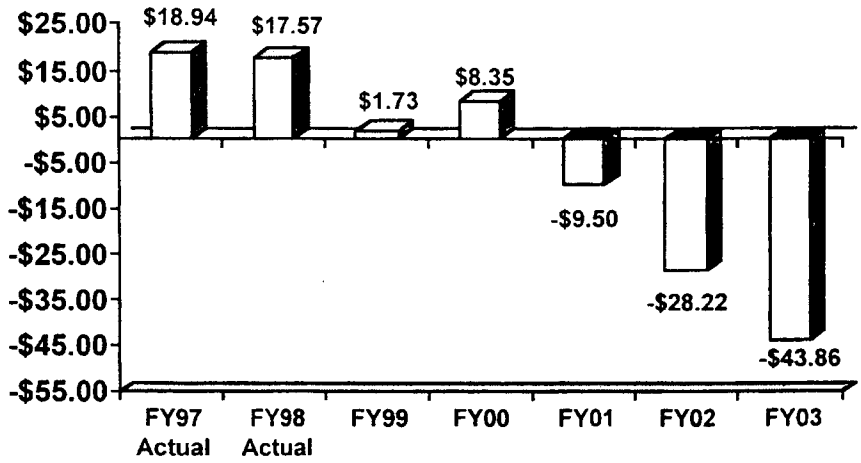
Projected Operating Losses are a Critical Concern for VCU's Academic Health Center; BBA Has Significant Impact

When considered as a common enterprise, MCVP and MCVAP are projecting a declining margin over the next several years that will place the academic health center well below the suggested five percent benchmark for an operating margin. In fact, significant losses are projected for FY01 onward if current trends continued. As with EVMS and UVA, VCU indicates that the BBA is having a significant impact on its operations. VCU estimates that the BBA will result in revenue cuts of $8.8 million over the next five years. Figure 23 shows the actual net income for MCVH and MCVAP viewed as a common enterprise in FY97 and FY 1998, as well as projections through FY03.

VCU's Greatest Financial Concern Is Unreimbursed Indigent Care

Despite state funding for indigent care through DSH and appropriations made by the 1999 General Assembly, officials at MCVP and MCVAP continue to express grave concern about losses related to indigent care. (The 1999 Appropriation Act provided an additional $7.6 million in FY 2000 ($3.7 million GF and $3.9 million NGF to DMAS for indigent care at MCVH. The Act also included language to allocate an additional $7.4 million for indigent care in 1999-2000.) Figure 24 shows the projected losses from indigent care at MCVH and MCVAP taken as a common enterprise.

Figure 23
Net Income for MCVH and MCVAP (in millions)



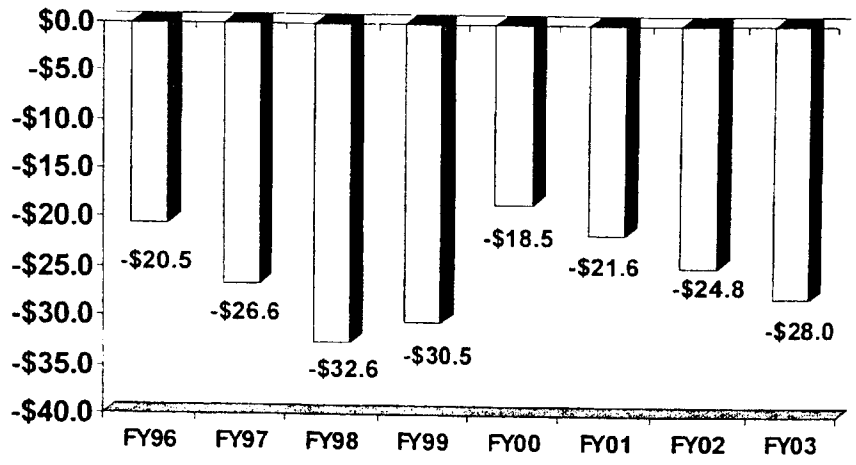
Note: FY 00-FY 03 are estimated figures
Source: VCU response to JCHC data request.

Creation of the MCV Hospitals Authority

The 1996 General Assembly approved legislation that created the Medical College of Virginia Hospitals Authority, removing MCVH from many of the regulatory structures that bind state agencies in areas such as personnel, procurement, and capital outlay. According to VCU's response to a JCHC data request "the authority structure allows the hospital to issue bonds, acquire property by right of eminent domain, create non-profit corporations, enter joint ventures, and make rules and regulations governing hospital operations that allow [MCVH] to compete more effectively in the ever changing, competitive, market driven health care environment."

One important caveat in the legislation creating the authority is that MCV employees who were employed prior to the effective date of the legislation were able to opt (as most did) to remain in the Virginia Retirement System and the State Employees Health Benefits programs. Newly hired MCV employees are in a different, less expensive retirement plan operated by the hospital as well as a health benefit plan offered by the hospital. Consequently, the benefit costs for "grandfathered" MCV employees are considerably higher than would be the case in most private sector hospitals.

Figure 24
Indigent Care Losses for MCVH and MCVAP (in millions)



Note: FY 00-FY 03 are estimated figures
Source: VCU response to JCHC data request.

VCU Actions to Cut Costs

Recognizing the financial challenges it faces, VCU's academic health center has taken a number of actions to try to cut costs and achieve administrative efficiencies. These actions include designing a less expensive retirement and health benefits package for newly hired MCVH employees, eliminating a large number of vacant positions, seeking to merge redundant administrative positions, and beginning targeted layoffs (after efforts to place employees whenever possible).

In addition to these cost-cutting measures, MCVH and MCVAP have taken steps to improve their competitive position. This includes MCVAP's building and subsequent ongoing expansion of its outpatient facility at Stony Point in order to improve its primary care and ambulatory care base. Other actions include a series of task forces held during the summer to explore creation of a VCU health system, which would begin to manage the physician practice and the hospital as more of a common clinical enterprise. Finally, MCV has purchased a Medicaid HMO to compete more effectively in a Medicaid managed care environment.

VCU Recommended Policy Options

VCU's response to the JCHC data request indicated that its top priority is full state funding of indigent care provided by academic health centers. VCU's

response noted that funds from the tobacco settlement are one potential source of funds for this priority. For FY 2000, the estimated cost of full funding of indigent care provided by VCU would be $18.5 million in addition to funds already appropriated by the General Assembly; for FY 2001, the amount increases to $21.6 million. By 2002 this cost would grow to an estimated $24.8 million.

VCU's second priority was additional funding for undergraduate medical education. For example, in FY99 VCU requested an additional $5.2 million in funding for undergraduate medical education. VCU's response notes that VCU's state support ranks 64th out of the 74 U.S. public medical schools.

VCU's third priority would be preferential treatment for managed care. As noted earlier in the issue brief, options include requiring all vendors bidding on state employee programs or the Medallion II program in Central Virginia assure that VCU academic health center is a full participant in any network offered to either group, with a provision that rates of fee schedules for VCU's academic health center would be adjusted for the risk or selection differences experienced by academic health centers. Another option suggested by VCU would be default assignment of Medicaid enrollees to the health plan or plans chosen by VCU (this would apply only to Medicaid recipients who did not indicate a preference with regard to health plans).

Other policy options suggested by VCU include granting agency autonomy for VCU. This would include exempting VCU from having to process financial transactions through the state system, from mandated salary increases, and from certain benefits programs (such as the new Virginia Sickness and Disability Program). VCU also suggested "streamlining the reimbursement and [approval/pre-approval process] for acquiring equipment through the Higher Education Equipment Trust Fund. VCU also recommended additional state financing of debt service for research space and expanding the availability of low cost group health insurance to certain part-time employees and faculty. Finally, VCU recommended a statewide strategy for building and maintaining the information technology infrastructure and increased funding for research facilities, libraries, and maintenance of equipment purchased through the Higher Education Equipment Trust Fund as well as requiring state agencies to include reimbursement of indirect costs in their contracts with VCU.

VII.
Policy Options

The following policy options, for the most part, are not mutually exclusive. They do not necessarily represent the full range of options that the General Assembly may wish to pursue.

I. **Take No Action.**

II. **Introduce budget amendments providing full funding for unreimbursed indigent care at each academic health center. Based on projections and FY 1998 actual numbers, the FY 2001 cost would be approximately: $21.6 million for VCU; $14.3 million for EVMS, and $12.8 million for UVA.**

Note: VCU's amount assumes funding in the 1999 Appropriation Act will continue. EVMS' response proposed funding at the 50 percent level for unreimbursed indigent care; this approach is another option for all three academic health centers.

III. **Introduce a joint resolution directing the Joint Commission on Health Care, in cooperation with the AHCs, the House Appropriations Committee, the Senate Finance Committee and the State Council for Higher Education in Virginia to develop a "risk-sharing" model for funding unreimbursed indigent care.**

IV. **Introduce budget amendments (one for each academic health center) providing funding for undergraduate medical education in accordance with SCHEV guidelines. The amendments would total $1.9 million (GF) for Eastern Virginia Medical School and $5.2 million (GF) for Virginia Commonwealth University's Medical College of Virginia School of Medicine.**

V. **Introduce a budget amendment (language) directing each academic health center to submit restructuring plans to the Joint Commission on Health Care, the Chairmen of the House Appropriations Committee and Senate Finance Committee, and the State Council for Higher Education in Virginia. These plans should address: (i) proposed spending of any additional funds allocated by the General Assembly for indigent care and/or undergraduate medical education, (ii) actions underway at each academic health center to achieve continued administrative efficiencies, (iii) performance measures for measuring improvements in medical education, indigent care, and**

operational efficiencies related to additional funding provided by the General Assembly.

VI. Introduce a budget amendment allowing UVA to retain the interest earned on its daily cash balances.

VII. Introduce legislation allowing the University of Virginia Health System to opt out of the Virginia Retirement System for all new employees.

VIII. Introduce legislation providing additional administrative autonomy to VCU's academic health center (particularly the School of Medicine) with regard to processing of financial transactions and other administrative issues.

IX. Introduce a budget amendment (language) exempting the medical school faculty and employees of state academic health centers from any across-the-board salary increases approved by the General Assembly.

X. Introduce legislation and a companion budget amendment creating a fund to provide seed money for innovative medical research at Virginia's academic health centers. This fund could be administered by the State Council on Higher Education for Virginia.

XI. Introduce a budget amendment (language) directing the Department of Medical Assistance Services to examine the advisability of revising its disproportionate share hospital (DSH) methodology to address the indigent care burden faced by teaching hospitals affiliated with Eastern Virginia Medical School.

XII. Introduce a budget amendment (language) directing the Joint Commission on Health Care, in cooperation with the Department of Medical Assistance Services, to examine the advisability of revising Medicaid reimbursement methodologies to improve state support for graduate medical education, to compensate for declining federal support through Medicare.

XIII. Introduce a memorializing resolution to Virginia's Congressional Delegation highlighting the problems caused by the Balanced Budget Act of 1997 for Virginia's academic health centers.

XIV. Introduce a budget amendment implementing JLARC recommendations related to air ambulance reimbursement through Medicaid (this will impact both EVMS and UVA).

XV. Introduce legislation to require that managed care organizations participating in the state employee health benefits program include the academic health centers (hospital and faculty practice plans) in their provider networks as fully participating providers (i.e., no services to be "carved out") for all products offered to state employees by the MCO.

XVI. Introduce a budget amendment directing the Department of Medical Assistance Services to include a provision in their contracts with health maintenance organizations (HMOs) that requires the HMO to include the academic health centers (hospital and faculty practice plans) in their provider networks as fully participating providers (i.e., no services to be "carved out").

XVII. Introduce a budget amendment (language) directing the Department of Medical Assistance Services to implement a procedure wherein Medallion II clients currently assigned to HMOs on a random basis be assigned to an HMO which includes the academic health centers in their networks as fully participating providers (i.e., no services to be "carved out").

XVIII. Introduce a budget amendment directing the Department of Medical Assistance Services to include a provision in their contracts with health maintenance organizations (HMOs) that requires the HMO to reimburse the academic health center(s) at a rate no lower than the highest negotiated payment level for any similar physician or hospital.

APPENDIX A

SENATE JOINT RESOLUTION NO. 464

Directing the Joint Commission on Health Care, in cooperation with the Commonwealth's academic health centers, the State Council of Higher Education for Virginia, and the Senate Finance and House Appropriations Committees to study current and future financial and operational issues affecting the Commonwealth's academic health centers.

Agreed to by the Senate, February 4, 1999
Agreed to by the House of Delegates, February 15, 1999

WHEREAS, the Commonwealth's three academic health centers, the Medical College of Virginia of Virginia Commonwealth University, the University of Virginia, and the Eastern Virginia Medical School conduct medical research, train a variety of health professionals, provide highly specialized patient care and treat a substantial portion of the state's indigent and uninsured patients; and

WHEREAS, the Commonwealth's academic health centers face a myriad of pressures on their traditional functions, including the rising costs of uncompensated care, leveling and targeting of research funding, new demands for health professional curricula, and the financing of graduate and undergraduate medical education; and

WHEREAS, academic health centers across the country are experiencing many of the same competitive and financial pressures; and

WHEREAS, a consequence of the academic health centers' traditional functions has been that their costs of providing patient care is generally higher than those of nonteaching hospitals; and

WHEREAS, the health insurance marketplace continues to move towards managed care health insurance plans; and

WHEREAS, managed care imposes significant competitive pressures on the academic health centers to compete with nonteaching hospitals for inclusion in managed care provider networks; and

WHEREAS, a 1998 study of the academic health centers by the Joint Commission on Health Care found that in some cases managed care organizations "selectively contract" with the academic health centers, which reduces third-party reimbursement for certain services and limits the patient base for teaching purposes; and

WHEREAS, retaining Medicaid patients is critical to the academic health centers in terms of generating disproportionate share hospital payments and providing a diverse patient base for medical education; and

WHEREAS, the academic health centers continue to provide a large share of indigent care in the Commonwealth; and

WHEREAS, in fiscal year 1997, even with enhanced disproportionate share hospital payments, the University of Virginia and the Medical College of Virginia of Virginia Commonwealth University reported $30.2 million and $42.6 million respectively in unreimbursed charity care; and

WHEREAS, the State Council of Higher Education for Virginia recommended in 1997 a methodology for funding undergraduate medical education and the unreimbursed indigent care provided by the medical school faculty; and

WHEREAS, the many financial and operational issues facing the academic health centers are complex, interrelated and present significant long-term health policy implications for the Commonwealth; and

WHEREAS, a comprehensive study of the financial and operational issues facing the academic health centers would provide critical information upon which to base future budgetary and health policy decisions affecting the academic health centers; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Commission on Health Care, in cooperation with the Commonwealth's academic health centers, the State Council of Higher Education for Virginia, and the Senate Finance and House Appropriations Committees, be directed to study current and future financial and operational issues affecting the Commonwealth's academic health centers. The study shall include, but not be limited to: (i) identifying key financial and operational issues that impact the short-term and long-term viability of the academic health centers; (ii) identifying the actions taken by the academic health centers to respond to these financial and operational issues; (iii) examining the financial and operational conditions of the Commonwealth's academic health centers relative to that of academic health centers in other states; and (iv) identifying key policy decisions and other actions that the academic health centers and the Commonwealth can take to ensure the long-term viability of the centers.

The services of a consultant, estimated to cost $50,000, will be required for the Joint Commission on Health Care to complete the study. Such expenses shall be funded by a separate appropriation from the General Assembly.

The Joint Commission on Health Care shall submit its findings and recommendations to the Governor, the Senate Finance and House Appropriations Committees, and the 2000 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

APPENDIX B

JOINT COMMISSION ON HEALTH CARE

SUMMARY OF PUBLIC COMMENTS: ACADEMIC HEALTH CENTERS' STUDY (SJR 464)

Organizations Submitting Comments

A total of ten organizations submitted comments in response to the SJR 464 report on academic health centers.

- Carilion Health System
- Department of Medical Assistance Services
- Eastern Virginia Medical School
- INOVA Health System
- Medical College of Virginia
- Medical Society of Virginia
- Trigon
- University of Virginia Health System
- Virginia Association of Health Plans
- Virginia Hospital and Healthcare Association

Policy Options Included in the SJR 464 Issue Brief

I. **Take No Action.**

II. **Introduce budget amendments providing full funding for unreimbursed indigent care at each academic health center. Based on projections and FY 1998 actual numbers, the FY 2001 cost would be approximately: $21.6 million for VCU; $14.3 million for EVMS, and $12.8 million for UVA.**

Note: VCU's amount assumes funding in the 1999 Appropriation Act will continue. EVMS' response proposed funding at the 50 percent level for

unreimbursed indigent care; this approach is another option for all three academic health centers.

III. **Introduce a joint resolution directing the Joint Commission on Health Care, in cooperation with the AHCs, the House Appropriations Committee, the Senate Finance Committee and the State Council for Higher Education in Virginia to develop a "risk-sharing" model for funding unreimbursed indigent care.**

IV. **Introduce budget amendments (one for each academic health center) providing funding for undergraduate medical education in accordance with SCHEV guidelines. The amendments would total $1.9 million (GF) for Eastern Virginia Medical School and $5.2 million (GF) for Virginia Commonwealth University's Medical College of Virginia School of Medicine.**

V. **Introduce a budget amendment (language) directing each academic health center to submit restructuring plans to the Joint Commission on Health Care, the Chairmen of the House Appropriations Committee and Senate Finance Committee, and the State Council for Higher Education in Virginia. These plans should address: (i) proposed spending of any additional funds allocated by the General Assembly for indigent care and/or undergraduate medical education, (ii) actions underway at each academic health center to achieve continued administrative efficiencies, (iii) performance measures for measuring improvements in medical education, indigent care, and operational efficiencies related to additional funding provided by the General Assembly.**

VI. **Introduce a budget amendment allowing UVA to retain the interest earned on its daily cash balances.**

VII. **Introduce legislation allowing the University of Virginia Health System to opt out of the Virginia Retirement System for all new employees.**

VIII. **Introduce legislation providing additional administrative autonomy to VCU's academic health center (particularly the School of Medicine) with regard to processing of financial transactions and other administrative issues.**

IX. **Introduce a budget amendment (language) exempting the medical school faculty and employees of state academic health centers from**

any across-the-board salary increases approved by the General Assembly.

X. Introduce legislation and a companion budget amendment creating a fund to provide seed money for innovative medical research at Virginia's academic health centers. This fund could be administered by the State Council on Higher Education for Virginia.

XI. Introduce a budget amendment (language) directing the Department of Medical Assistance Services to examine the advisability of revising its disproportionate share hospital (DSH) methodology to address the indigent care burden faced by teaching hospitals affiliated with Eastern Virginia Medical School.

XII. Introduce a budget amendment (language) directing the Joint Commission on Health Care, in cooperation with the Department of Medical Assistance Services, to examine the advisability of revising Medicaid reimbursement methodologies to improve state support for graduate medical education, to compensate for declining federal support through Medicare.

XIII. Introduce a memorializing resolution to Virginia's Congressional Delegation highlighting the problems caused by the Balanced Budget Act of 1997 for Virginia's academic health centers.

XIV. Introduce a budget amendment implementing JLARC recommendations related to air ambulance reimbursement through Medicaid (this will impact both EVMS and UVA).

XV. Introduce legislation to require that managed care organizations participating in the state employee health benefits program include the academic health centers (hospital and faculty practice plans) in their provider networks as fully participating providers (i.e., no services to be "carved out") for all products offered to state employees by the MCO.

XVI. Introduce a budget amendment directing the Department of Medical Assistance Services to include a provision in their contracts with health maintenance organizations (HMOs) that requires the HMO to include the academic health centers (hospital and faculty practice plans) in their provider networks as fully participating providers (i.e., no services to be "carved out").

XVII. **Introduce a budget amendment (language) directing the Department of Medical Assistance Services to implement a procedure wherein Medallion II clients currently assigned to HMOs on a random basis be assigned to an HMO which includes the academic health centers in their networks as fully participating providers (i.e., no services to be "carved out").**

XVIII. **Introduce a budget amendment directing the Department of Medical Assistance Services to include a provision in their contracts with health maintenance organizations (HMOs) that requires the HMO to reimburse the academic health center(s) at a rate no lower than the highest negotiated payment level for any similar physician or hospital.**

Summary of Individual Comments

Carilion Health System

Robert Manetta commented in support of a modified version of Option XI suggesting that the option be modified to apply to all Virginia teaching hospitals and not just to EVMS. He also expressed support for Options XII and XIV. Carilion concurred with the comments submitted by INOVA.

Department of Medical Assistance Services

Dennis G. Smith, Director, expressed concern regarding the policy options which relate to Medicaid contracts with managed care organizations. He commented in opposition to Options XVI, XVII, and XVIII. Mr. Smith also noted that some data in the report was inaccurate and needed to be re-evaluated.

Eastern Virginia Medical School

C. Donald Combs, Ph.D., Vice President for Planning and Program Development, did not comment on specific options but indicated it concurs with the findings of the report and fully supports efforts to address adequate indigent care.

INOVA Health System

Donald L. Harris, Vice President, expressed support for a modified version of Option XI which would apply to all teaching hospitals and not just EVMS. INOVA noted that it is also a teaching hospital, affiliated with four medical schools and is the largest provider of care to the uninsured in its area. INOVA expects to provide $37.7 million in unreimbursed care in 1999. Mr. Harris also expressed support for Options XII and XIV.

Medical College of Virginia

Hermes A. Kontos, M.D., Ph.D., Vice President for Health Sciences and Dean, School of Medicine, clearly expressed opposition to Option I. Dr. Kontos expressed support for Option II. He specifically stated that of all the policy options, the full funding of the cost of indigent care must take precedence.

Medical Society of Virginia

Lawrence K. Monahan, MD, President, expressed support for Options II and X.

Trigon Blue Cross Blue Shield

Leonard L. Hopkins, Jr., Vice President, Public Policy Officer, stated, "While Trigon appreciates the competitive and financial challenges that academic health centers are facing, we oppose policy options which inject government into the competitive marketplace and hamper the ability of managed care organizations to negotiate freely with providers (Policy Options XV, XVI, and XVIII). We also are opposed to Policy Option XVII, which would change the way in which Medallion II clients are assigned to contracting HMOs."

University of Virginia Health System

William E. Carter, Jr., Senior Associate Vice President for Operations, expressed support for Options II through VII, IX, X, XII through XVI, and XVIII.

Virginia Association of Health Plans

Lynn M. Warren, RN, MPH, Director of Policy, expressed opposition to Options XV, XVI, XVII, and XVIII and stated that while it appreciates the concerns expressed by the academic health centers, it is opposed to options which "impede health plans' ability to negotiate provider contracts in the open market."

Virginia Hospital and Healthcare Association

Christopher S. Bailey, Senior Vice President, expressed opposition to Option I. Mr. Bailey expressed support for Options II, VI through X, and XIV. Mr. Bailey expressed support for Option IV if it were modified to include a re-examination of the adequacy of the SCHEV guideline in view of the changing health care environment. Support was also expressed for Option XI if it were modified to include all Virginia teaching hospitals and not just EVMS. Again, he supported Option XII provided that the option is intended to address the needs of all teaching hospitals in the state. Lastly, VHHA would support Option XIII noting that any memorializing resolution or letter to the congressional delegation should explain that additional modifications to the BBA are needed during next years congressional deliberations.

JOINT COMMISSION ON HEALTH CARE

Executive Director

Patrick W. Finnerty

Senior Health Policy Analysts

Joseph J. Hilbert
William L. Murray, Ph.D.
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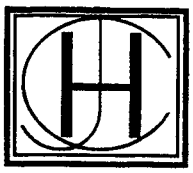

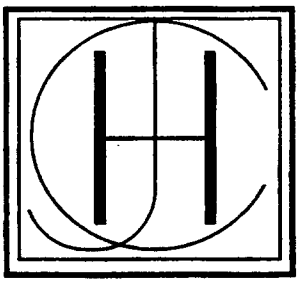

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