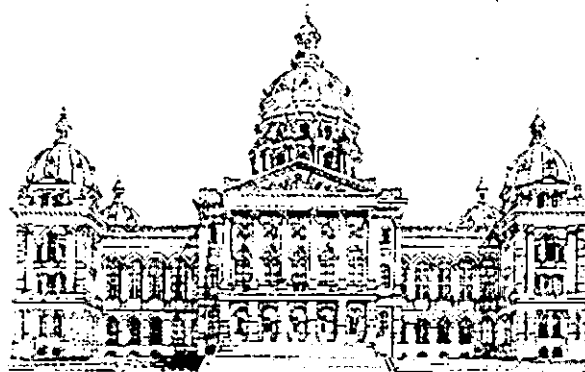


FINAL REPORT

**TREATMENT OF INDIGENT PERSONS
THROUGH UNIVERSITY OF IOWA
HOSPITALS AND CLINICS
STUDY COMMITTEE**



Presented to the
LEGISLATIVE COUNCIL
and the
IOWA GENERAL ASSEMBLY
January 1999

Prepared by the
LEGISLATIVE SERVICE BUREAU



Legislative
Service
Bureau

FINAL REPORT

Treatment of Indigent Persons Through University of Iowa
Hospitals and Clinics Study Committee

January 1999

MEMBERS

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Co-Chairperson
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Senator Robert Dvorsky

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AUTHORIZATION AND APPOINTMENT

The Treatment of Indigent Persons Through University of Iowa Hospitals and Clinics Study Committee was created by the Legislative Council, was authorized one meeting date during the 1998 interim, and was charged to "review the programs for treatment of indigent persons by the University of Iowa Hospitals and Clinics under Iowa Code Chapters 255 and 255A. The review shall include current programs and services and consideration of providing these services at alternative locations throughout the state."



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1. Overview.

The Study Committee held its authorized meeting on October 5, 1998. The Committee received presentations from persons representing various interests concerned with the system and made recommendations. The following presentations were made and are summarized in this report:

- ◆ Mr. R. Ed Howell, Director and CEO of the University of Iowa Hospitals and Clinics, provided an overview of the program.
- ◆ Dr. Ronald Eckoff, Iowa Department of Public Health, provided information relating to the Obstetrical and Newborn Indigent Patient Care Program.
- ◆ Mr. W. L. "Kip" Kautzky, Director, Department of corrections, provided information relating to inmate care and treatment through the University of Iowa Hospitals and Clinics.
- ◆ Ms. Lois Rude, Director, Linn County General Assistance, and Mr. Larry Sundall, Emmet County General Assistance, speaking on behalf of the Iowa State Association of Counties, provided testimony in support of the current program.
- ◆ Mr. James Zahnd, vice President/Public Affairs, Iowa Health System, provided testimony in support of the decentralization of the Indigent Care Program.

2. Presentations.

The following presentations were made to the Committee at its October 5, 1998, meeting:

A. University of Iowa Hospitals and Clinics – Overview of "State Papers" Program.

Mr. R. Edward Howell, Director and Chief Executive Officer, University of Iowa Hospitals and Clinics, discussed the Indigent Patient Care Program, often referred to as the "State Papers" Program.

Background and Operating Basics. Mr. Howell made the following points about the program:

- ◆ **Basics of the Program.** The program enables counties to refer indigent patients for care at the University of Iowa Hospitals and Clinics (UIHC). A major feature of the program is local control in that local community providers determine which patients will be referred to the UIHC. Annually, each county is assigned a quota for indigent patient referrals to the program, based on the last census. Counties are not restrained by cost when making referrals, only by number. After the initial referral of a patient, the patient can continue to receive care at the UIHC for the remainder of the calendar year using the same quota number assigned.

- ◆ **"Nonquota" patients.** Residents of state institutions, obstetrical patients and their newborns, and orthopedic patients are treated free of charge at the UIHC as part of the program.

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◆ **Transportation.** The program provides a free transportation service for indigent patients and works to also accommodate family members.

◆ **Compensation.** The UIHC consistently overearns the state appropriation funding for indigent patient care. In fiscal year 1997-1998, the appropriation for indigent patient care was \$31 million and the value of indigent patient services provided by UIHC was \$70.9 million (including waived professional fees totaling \$20.4 million). The excess costs of the program are primarily funded by other fees for services outside of the program.

◆ **Federal Funds Leveraging.** Federal law provides for leveraging of the state appropriation to obtain federal matching Medicaid dollars, payable only to state-owned hospitals. This is accomplished through Medicaid provisions allowing for supplemental disproportionate share and indirect medical education adjustments. In fiscal year 1997-1998, the UIHC payments back to the state, to equal the state appropriation for indigent patient care at the UIHC, were comprised of approximately \$20 million in federal dollars and \$10 million in state dollars.

◆ **Comprehensive Care.** The UIHC provides comprehensive and quality care for all patients. The UIHC provides a one-class care delivery system. The majority of the indigent patients referred to the program have two or more diagnoses and require care not typically available in their local communities.

◆ **Enhancements to the Program.** Several programs to enhance the Indigent Patient Care Program have been developed in recent years. In 1997, the Care Management Program was instituted to provide care coordination and case management. The telemedicine program provides pre-visit and post-visit care for patients, although it has not yet been developed in many areas. Telemedicine is currently used mainly with correctional institutions and nursing homes.

◆ **Clinics.** The UIHC has expanded its clinics to several communities throughout the state, including Tipton, Belle Plaine, Lone Tree, Sigourney, and North Liberty. Clinics are also being developed in Tama, Toledo, and Wapello. The clinics provide primary care only. The UIHC is also involved in outreach activities in 37 other communities. Physicians and students are sent to primary care clinics. Indigent patients are treated at the main campus so that they can receive comprehensive care and so that costs of the transportation and other services are not doubled if the patient needs to be treated at the main campus after treatment at a clinic.

Decentralization of the Program. Mr. Howell's comments relating to the decentralization of the program include the following:

◆ **Effect on Local Hospitals.** Decentralization would have only a minor effect on the number of patients made available to the state's 116 other hospitals, even if the hospitals were able to provide the appropriate level of care.



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◆ **Endorsement of Current Program.** The Indigent Patient Care Program has been reviewed or endorsed by all of the entities with the greatest involvement in the program (Department of Corrections, Iowa Medical Society, Association of Iowa Hospitals and Health Systems, Iowa State Association of Counties Community Service Affiliate and Board of Supervisors Affiliate, and the Regents/UIHC).

◆ **Costs of Decentralization.** There is currently no model for decentralization which meets the same standards for care as the current program at the same costs. The current program allows the state to obtain federal matching Medicaid funds, channeled through the UIHC. The UIHC also waives professional fees, which may not be waived by local providers if decentralization occurs. The burden of any excess costs may shift property taxes if the program is decentralized. Currently, counties have control over referral of patients, without the cost concerns.

◆ **Health Education Programs.** Programs at the University of Iowa would be significantly affected by decentralization, because the UIHC relies on the consistent patient care base which the program provides.

◆ **Continuity of Care.** Decentralization would cause a disruption in continuity of care for indigent patients. Many indigent patients eventually need to be treated at the UIHC because of the level of care they require.

◆ **Administration Costs.** Costs associated with administering the program would increase with decentralization.

◆ **Liability for the Operation of the Program Would Change.** Currently, the UIHC has assumed liability for the program. Under decentralization, it is uncertain whether the county, the hospital, the physician, or the University of Iowa would be the liable party.

B. Iowa Department of Public Health – Overview of Obstetrical/Newborn Program.

Dr. Ronald Eckoff, Director of the Obstetrical/Newborn Program, Iowa Department of Public Health (IDHP), gave a brief overview of the program. Dr. Eckoff explained that the original state papers program provided obstetrical care in a centralized manner with all care being provided at the UIHC. However, in 1987, the program was changed so that obstetrical care was decentralized to allow deliveries to occur as close to the patients' homes as possible. Nine counties in eastern Iowa are exempted from the local delivery option, requiring care in the counties to be provided at the UIHC to allow for a patient base for the UIHC educational program. Medicaid eligibility for pregnant women has changed since the creation of the program so that more women are eligible to have their obstetrical care paid by Medicaid. The Statewide Obstetrical and Newborn Indigent Patient Care Program now covers the few women who do not meet Medicaid requirements.

C. Department of Corrections – Inmate Health Care.

Mr. Walter "Kip" Kautzky, Director, Department of Corrections, discussed the Inmate Health Care Program. He stressed the importance of the provision of uniform health care to inmates. The UIHC is the primary provider of inpatient care and outpatient consultations for inmates. Mr. Kautzky made the following comments about inmate health care and the possibility of decentralization.

Consistency in Treatment. Centralized treatment at the UIHC lowers the risk for inmate confusion and misunderstanding. Differing physician recommendations with decentralization may generate time-consuming inmate grievances. Centralization of specialty services also facilitates the Department's effort to monitor off-site services received.

Current Department Infirmary System. The Department has a limited number of nurses and contract physicians to provide care at 10 infirmary units. Decentralization would require restructuring of infirmary units. The Department is planning a 120-bed special needs facility at the Iowa Medical and Classification Center in Oakdale, which will include 20-30 beds to provide follow-up care to correctional patients seen at UIHC. Oakdale is five miles from the UIHC. Mr. Kautzky noted that a high-level Department of Corrections infirmary should be located as close as possible to a source of specialty consultation and treatment for a wide range of conditions to reduce the risks associated with transporting reasonably stable, seriously ill inmates long distances and to reduce security concerns.

Telemedicine. Telemedicine improves initial and ongoing care from a single source knowledgeable about offender health care, reduces the number of health care-related trips, and eliminates the security risks of transporting inmates.

Security. Development of more infirmaries would decrease some inmates' lengths of stay at UIHC and enhance security. Decentralization would complicate correctional officer supervision of inmate patients.

Transportation. Although the Department is concerned about the time spent by correctional officers in transporting inmates to the UIHC, the benefits of continuity of care, quality care, and centralized care outweigh the concerns. The Department attempts to use hospital transportation whenever possible. Also, inmate patients are often transported in conjunction with transportation of other inmates in the corrections system. Telemedicine will help to lower transportation costs.

Levels of Inmate Care. There are three levels of inmate care: primary infirmary program (including first aid and post-surgery care); UIHC outpatient care (infirmary doctors decide assistance is needed); and telemedicine (initial and follow-up consultations).



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D. Department of Human Services – Disproportionate Share Program.

Disproportionate Share. Mr. Don Herman, Administrator, Division of Medical Services, Department of Human Services, made a brief presentation regarding the Medicaid Disproportionate Share Program. Federal law requires state Medicaid programs to consider special payment needs in determining Medicaid payment rates for inpatient hospital care for hospitals that serve a "disproportionate share" of Medicaid-eligible and indigent patients. Under the Medicaid Disproportionate Share Hospital (DSH) Payment Adjustment Program, the necessary amount of state funds must be expended for DSH to draw down matching federal funds. In Iowa, approximately 15 to 20 hospitals meet the federal requirements to qualify to receive such payments. State funds appropriated for the Medicaid DSH program and federal moneys drawn down as a match for these funds are pooled and distributed to the 15-20 hospitals based upon a state formula found in the Medicaid rules. Currently, any amount remaining following this distribution is referred to as the supplemental disproportionate share.

Supplemental Disproportionate Share. Over the years, federal provisions have changed to limit the types of funding sources that a state can use to draw down federal funds for the DSH program. Other states had been using moneys generated by provider taxes and donations (both of which could later be reimbursed using the drawn-down federal funds), and these sources were virtually unlimited. Therefore, federal provisions were changed to limit or exclude the use of provider taxes or donations as a source of state matching funds, and the amount that any state could receive was capped. Additionally, states had to demonstrate that the state moneys expended and being used as a match were actually being used for patients for whom the DSH program was intended.

Fund Transfer. One option which remains as a source from which to generate state funds is the intergovernmental transfer. Under the federal rules for an intergovernmental transfer (42 C.F.R. 433.51), public funds which are used as the state's financial participation amount cannot be generated through a provider-specific tax or a donation, and the funds must be appropriated directly to or transferred from other public agencies to the state or local agency and under its administrative control.

In Iowa, the General Assembly appropriates funds to the Department of Human Services for the Medical Assistance Program and these funds are, in part, used to draw down a portion of the available federal funds for the DSH program. In order to draw down the remaining available federal funds for the DSH program, the Department of Human Services looks to the appropriation made in the education appropriations bill to the UIHC for indigent care under the State Papers Program. Because these funds meet the requirements for an intergovernmental transfer, including that the funds are expended for the indigent population, the Department uses these funds to draw down the

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remaining available federal funds. As an example, the current capped amount of federal funds available to Iowa under the program is \$8 million. With the state match for these funds, the total funds available are \$12 million for distribution under the state formula. Currently, approximately \$8 million is distributed to the 15-20 eligible Iowa hospitals. The remaining \$4 million is passed through the Department of Human Services to the UIHC (because the UIHC can demonstrate expending \$4 million for indigent patients) and the UIHC does an intergovernmental transfer back to the Department in the same amount, repaying the Department the portion of the \$4 million which is state dollars and depositing the federal portion of the \$4 million amount in the State General Fund.

E. Iowa State Association of Counties.

Mr. John Easter - Overview. Mr. Easter, Iowa State Association of Counties, stated that the current Indigent Patient Care Program is beneficial for three reasons: administrative efficiency (the county general assistance directors participate in the quota administrative process); costs (the program does not burden property taxes); and quality of care.

County General Assistance Directors. Ms. Lois Rude, General Assistance Director, Linn County, opined that the current Indigent Patient Care Program provides the best care because of the continuity and quality of care. It does not limit counties' quota slots by a dollar amount. Ms. Rude is concerned that decentralization would involve dollar limits, increase administrative costs, and increase liability. Mr. Larry Sandall, General Assistance Director, Emmet County, expressed concern that decentralization would diversify care and decrease patients' access to specialty clinics. In rural areas, often there is access to specialty clinics only weekly or biweekly. He stated that the UIHC van service for the current program works extremely well and the quality of care at the UIHC is extremely high. He would like to see the current quota system improved by taking into consideration the poverty level of the individual county when allocating the quotas.

F. The Association of Iowa Hospitals and Health Systems.

Study of the Indigent Patient Care Program. Mr. Steve Brenton, President, Association of Iowa Hospitals and Health Systems (IHHS), explained that an IHHS task force conducted a study of the Indigent Patient Care Program in 1997. The task force reviewed the program and considered possible changes to the program. The task force identified criteria in three areas which would be used to evaluate the program: access to and quality of health care, medical education, and use of resources.



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Possible Changes in the Program. The IHHS has historically been supportive of the Indigent Patient Care Program, but would be supportive of change consistent with the following principles:

- ◆ Maintenance or improvement of the delivery of medical services to indigent patients.
- ◆ Sustenance or improvement of the education and training of health professionals.
- ◆ Assurance of timely access to a continuum of necessary, high-quality health care services.
- ◆ Assurance that the number of indigent care patients receiving care remains constant or increases and that a continuum of all necessary medical services is provided.
- ◆ Financing of proposed changes must occur in a manner consistent with available state and local resources and not impose undue administrative burden on affected health care providers.
- ◆ Retention of financial resources presently dedicated to providing indigent patient care.
- ◆ Allowance of a reasonable transition period prior to implementation for significant changes in the delivery of services or organization of education and training of health professionals.

G. Iowa Health System.

Mr. James Zahnd, Vice President of Public Affairs, Iowa Health System, supported decentralization of the Indigent Patient Care Program. His comments are summarized as follows:

Antiquated Program. The current Indigent Patient Care Program is antiquated and causes inappropriate and unnecessary hardship on patients and often requires the inappropriate and sometimes medically unsafe transfer of patients from distant sites in the state to Iowa City. Mr. Zahnd encouraged the Committee members to review programs operating in other states, such as Kansas.

Specialist Care. It is no longer necessary to travel to the UIHC for all specialist care. Today, highly competent, board-certified specialist care can usually be accessed anywhere within the state, without having to travel more than 100 miles.

Medical Class System. Insured persons currently may be treated in their own communities surrounded by family and friends, while uninsured persons are forced to leave their communities, family, and friends and to miss more work than would otherwise be necessary to obtain appropriate medical care.

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1998 Legislative Proposal. During the 1998 Legislative Session, a plan to partially decentralize the program was proposed. The plan would have allowed the UIHC to keep its appropriation, local providers to care for indigent patients and be compensated for such care, and patients to receive medical care where and from whom they wish to receive it.

Focus on Interests of Patients. Mr. Zahnd opined that the arguments proposed for decentralization do not focus on the best interests of the patients. These arguments should not take precedence over the care, comfort, safety, and access of the patients the program is intended to serve.

Retention of Federal Funding. Supplemental federal funding could likely be retained if decentralization was accomplished by making the UIHC the agency receiving and administering state funding, but requiring the UIHC to spend the funds with local providers whenever medical treatment in the local community is not contrary to safe medical practices.

Health Professional Education. If it is clinically and educationally necessary for medical students to have access to the indigent patient population, the students could be decentralized and sent to local communities.

Funding Is Not Funding for UIHC. The state and federal funding in question is not intended to supplement funding for the UIHC, but to provide medical care for the indigent.

3. Recommendations.

Legislative Committee. The Study Committee agreed to recommend to the Legislative Council that the recommendations and issues discussed by the Committee be submitted for review to a special committee comprised of representatives of the Human Services, Health and Human Rights, and Education Appropriations Subcommittees and the Human Resources Committees of the Senate and House of Representatives for consideration during the legislative session. The special committee should initially meet no later than January 25, 1999. Following review and consideration of all of the issues listed below, the special committee should make recommendations concerning the Indigent Health Care System to the full appropriations committees no later than February 19, 1999.

Comments and Recommendations. Co-chairperson Redwine summarized the members' comments and recommendations for consideration by the special committee as follows:

- ◆ Examine the funding mechanism for the Indigent Patient Care Program and consider options for accessing other funding streams.
- ◆ Examine other states' programs for treating indigent patients.
- ◆ Consider the importance of preventive health care.



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- ◆ Retain but reexamine the county quota system for determining participation in the program.
- ◆ Consider providing an additional appropriation to provide health care to indigent patients in local areas.
 - ◆ Include counties in the decision-making aspects of the program.
 - ◆ Maintain the funding stream for the program through the UIHC.
 - ◆ Consider financial incentives or funding for expansion of telemedicine and distribution of University of Iowa medical students to hospitals and clinics throughout the state.
- ◆ The UIHC Medical Education Program and Indigent Patient Care Program are an integrated system in which each program is dependent on the other.

Note: As of January 25, 1999, the Co-chairpersons of the Study Committee had not convened a special committee to review the recommendations of this report. The Co-chairpersons determined that given that the General Assembly was currently in session and given the time limitations of the session, the Human Resources Standing Committees of the Senate and House of Representatives would be best suited to continue the study of indigent patient care.

4. Written Materials Filed With the Legislative Service Bureau.

- a. Briefing booklet for members of the Legislative Study Committee on the UIHC's Indigent Patient Care Program, prepared by the UIHC, dated October 5, 1998.
- b. Final Report of the Indigent Health Care Interim Study Committee, January 1997.
- c. Legislative Study Regarding Indigent Care, Inmates and Telemedicine prepared by the Iowa Department of Corrections and the University of Iowa Hospitals and Clinics, dated January 1, 1998.
- d. Compilation of UIHC aggregate net billings for indigent patient services, including aggregate net billings for each state institution and each county compiled by the Legislative Fiscal Bureau.
- e. Budget & Policy Issue Briefs from the Iowa Department of Public Health entitled "Decentralized Obstetric Services; Iowa State Papers Program" and "Statewide Obstetrical & Newborn Indigent Patient Care Program; Four Year Summary as of September 18, 1998."
- f. Memorandum dated September 21, 1998, from Mr. Frank Stork, State Board of Regents, regarding the Indigent Patient Care Program.
- g. Memorandum dated September 9, 1998, from Ms. Lois Ann Rude, Linn County General Assistance Director, regarding the Indigent Patient Care Program.

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- h. Letter to Senator John Redwine dated July 27, 1998, from Mr. James Zahnd, Vice President of Public Affairs, Iowa Health System (IHS), concerning the Indigent Patient Care Program, including the following enclosures:
- ◆ IHS 1998 Legislative Position on Medical Care for Iowa's Indigent.
 - ◆ IHS Talking Points on Medical Care for Iowa's Indigent.
 - ◆ House File 2326, considered by Seventy-seventh General Assembly, 1998 Session.
 - ◆ Senate File 2213, considered by Seventy-seventh General Assembly, 1998 Session.
 - ◆ Letter dated October 9, 1997, to Mr. R. Edward Howell, Director and CEO, UIHC, from Mr. Harold Miller, President of the Iowa Medical Society, concerning the Indigent Patient Care Program.
 - ◆ Presentation entitled "Medical Care for Iowa's Indigent," prepared by David Boarini, M.D., Thomas Carlstrom, M.D., and Kevin Cunningham, M.D.
 - ◆ UIHC 1998 Legislative Position on Iowa's Indigent Patient Care Program.
 - ◆ IHHS's "Principles to Use in Evaluation of Proposed Modifications of the Medical and Surgical Treatment of Indigent Persons Program."
 - ◆ Letter dated October 17, 1997, to Mr. Mike Abrams of the Iowa Medical Society from Dale P. Anderson, M.D., from the McFarland Clinic concerning Iowa's State Papers Program.
 - ◆ Letter dated October 3, 1997, to Mr. Samuel T. Wallace, President of Iowa Health System, from David Boarini, M.D., Chairman of the Board of the Iowa Clinic.
- i. Letter dated August 19, 1998, to Senator John Redwine from Patrick J. Duey, M.D., Medical Director of the Siouxland Community Health Center, concerning the Indigent Patient Care Program.
- j. Letter dated September 26, 1998, from Willard G. Kuehn, M.D., Clarinda Correctional Facility, concerning medical referrals of prisoners to the UIHC.
- k. Copies of overheads used by Mr. Walter Kautzky, Director of the Department of Corrections, during his presentation to the Committee on October 5, 1998.
- l. Testimony of Mr. Steve Brenton, President, Association of Iowa Hospitals and Health Systems, before the Committee on October 5, 1998.
- m. Testimony of Mr. James M. Zahnd, Vice President of Public Affairs for Iowa Health System, before the Committee on October 5, 1998.