PERFORMANCE AUDIT REPORT

The KU Medical Center and KU Hospital: Reviewing Selected Operational Issues

Executive Summary

with Conclusions and Recommendations

A Report to the Legislative Post Audit Committee
By the Legislative Division of Post Audit
State of Kansas
October 2007

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Legislative Post Audit Committee
Legislative Division of Post Audit

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To: Members of the Kansas Legislature

This executive summary contains the findings and conclusions, together with a summary of our recommendations and the agency responses, from our completed performance audit, *KU Medical Center and KU Hospital: Reviewing Selected Operational Issues*.

This report includes a recommendation for the KU Hospital to continue to report the value of uncompensated care and bad debt as required by GAAP and to expand their usage of other more comparative methods of reporting the value of uncompensated care in other publications.

We would be happy to discuss the findings presented in this report with any legislative committees, individual legislators, or other State officials. These findings are supported by a wealth of data, not all of which could be included in this report because of space considerations. These data may allow us to answer additional questions about the audit findings or to further clarify the issues raised in the report.

If you would like a copy of the full audit report, please call our office and we will send you one right away.

Barbara J. Hinton
Legislative Post Auditor

EXECUTIVE SUMMARY
LEGISLATIVE DIVISION OF POST AUDIT

Overview of the KU Hospital and KU Medical Center

Before 1998, the KU Hospital and the KU Medical Center were both part of the University of Kansas. The Legislature created a separate Hospital Authority in 1998 to improve the Hospital's financial viability. The Hospital is still the teaching hospital for the Medical Center, but is no longer part of the University and is not a State agency. Since it was spun off from the Medical Center, the Hospital's situation has improved significantly—both revenues and inpatient numbers are up.

The Hospital and Medical Center remain intertwined. They have overlapping interaction with students, residents, physicians, faculty, facilities, and the like. Further, although the two entities are funded separately, certain funds flow between the two, such as Medicare payments for residency programs, and payments for services the two entities purchase from one another.

Question 1: How Has Spending for Education and Research Functions From the Medical Center's Operating Grant Changed in Recent Years, And How Has that Affected the Amounts of Money Distributed to the Kansas City and Wichita Campuses?

The State operating grant funded about 39% of the Medical Center's spending in 2007. *The Legislature adopted an operating grant model to finance universities in 2001, moving away from the previous line-item appropriations. The law has no requirements as to how the base amount—which goes directly to the university—is spent. In addition to the base amount, there's an increased appropriation each year as well. The increase goes to the Board of Regents, which distributes the moneys to institutions that have met performance goals. The goals are negotiated each year between the Board and the institutions.*

Because the State operating grant funds less than half the Medical Center's spending, we expanded our review to look at other sources of funding as well. In addition, we added spending from the Medical Center's Research Institute and the Wichita Center for Graduate Medical Education to make our comparisons between Kansas City and Wichita more accurate and meaningful.

Since 2001, there's been a significant shift toward research spending at the Medical Center, mostly at the Kansas City campus. *In our analyses, we classified all spending into three categories—research, education, and other—and looked at spending from all funding sources first, then separately from the State operating grant only and from all other (non-State) sources. We found the following:*

- *In 2007, the Medical Center spent $288 million from all funding sources, an increase of $72 million, or 33%, over 2001 spending levels. During those six years, research spending nearly doubled (to about $92 million a year), but spending for education and other costs were up as well. Given the big spike in research spending, it now accounts for about 32% of total spending, compared with 23% in 2001.*

- *In 2007, about $112 million of the Medical Center's total expenditures were funded with State operating grant moneys. Those State funds increased by $13 million, or 13%, since 2001. Research spending using State funds grew from just $2.7 million to $3.6 million, and stayed constant at 3% of total spending. Overall, 97% of the State operating grant was spent on education-related and other-related costs.*

- *In 2007, the remaining $176 million of the Medical Center's total expenditures was funded with other (non-State) sources of funds, including federal and private grants, fees, and endowment moneys. These other funding sources increased by $59 million, or 50%, since 2001. Research spending from these funding sources almost doubled (to about $89 million), and now accounts for 50% of total non-State spending, compared with 39% six years ago.*

Almost all the spending increases have occurred on the Kansas City campus, where spending from all sources rose from $180 to $246 million, or 37%. Spending on the Wichita campus rose from $35 million to about $40 million, an increase of almost 17%. Most of the research spending from other non-State sources can be attributable to federal research grants generated by faculty on the Kansas City campus. (The Wichita campus spent a total of only $1.4 million for research during 2007.)

In addition, Kansas City accounted for most of the increase in State grant spending ($13.1 million out of $13.2 million). Differences in the amounts reimbursed for residents at hospitals in Kansas City and Wichita could be one explanation for why State funding is higher in Kansas City than in Wichita.

Spending per FTE on the Kansas City campus is higher than in Wichita. *Wichita went from spending $3,500 more per FTE than Kansas City in 2001, to $13,000 less per FTE in 2007. Wichita's spending per FTE from State operating grant moneys dropped by about 12% over this time frame, while Kansas City's spending per FTE remained about the same. Officials from both campuses cited several reasons for the disparities between the two campuses, including Kansas City having a different mix of students, and Kansas City having most of the administrative structure and support for the Medical Center as a whole.*

Differences in spending for research and education in Kansas City and Wichita have raised concerns in Wichita. *Wichita officials told us they were happy with the level of State support they'd received in the past for undergraduate medical education, but they want to expand the campus' clinical research program to help overcome accreditations citations Wichita has received related to research and scholarly activity.*

The Medical Center established the Wichita campus in 1971 to provide clinical education for 3rd and 4th year medical students and residents, and the clinical research Wichita now conducts on its campus generally doesn't attract many federal dollars. Kansas City officials told us they support building up Wichita's clinical research program, but they don't support strengthening Wichita's basic research program because that would replicate the research being done in Kansas City.

Question 1 Conclusion. *Research spending nearly doubled at the Medical Center between 2001 and 2007 (it now totals about $92 million), but spending for education-related and other costs were up as well. Almost all the increase in research spending was attributable to increases in federal research grants generated by faculty at the Kansas City campus, not to shifts in how State funds have been spent. The bulk of the $112 million State operating grant continues to be spent for education-related or other costs; research spending from those funds grew from just $2.7 million to $3.6 million. Wichita officials told us they've been happy with the amount of State funding they've received for undergraduate medical education in the past, but they want to increase their research spending, which now totals just $1.4 million. Options for the Wichita campus to obtain additional research dollars include generating its own federal research grants, seeking additional community philanthropic funding, working with Medical Center officials to identify existing funding that can be tarted for that purpose, and seeking additional funding from the Legislature, much as the Kansas City campus did for the Cancer Center.*

Question 2: How Does the Relationship Between the KU Hospital and KU Medical Center Compare to What Is Envisioned in State Law and to Medical Schools and Teaching Hospitals in Other States?

The Legislature created the Hospital Authority in 1998 to improve the Hospital's financial viability. *At that time, the Hospital was facing numerous problems. The Legislature spun it off from the Medical Center and made it an independent instrumentality of the State in hopes of making it more competitive and financially self-sufficient.*

The organizational relationship between the Hospital and Medical Center follows State law and is similar to many other states. *The law is not very specific, but we identified three main elements of their organizational relationship. The current arrangement between the Hospital and Medical center follows what was spelled out in law:*

- *The Hospital is operating independently of the Medical Center and has its own oversight board and budget*
- *The Hospital and Medical Center have entered into numerous agreements to clarify and codify how they would share facilities and staff.*
- *The Hospital governing board includes representatives of the University of Kansas and the Medical Center.*

Further, the Hospital and Medical Center's current organizational set-up is similar to many other states (we focused on medical centers' main campuses). Like 74% of public medical schools, the KU Medical Center has a single primary teaching hospital (the KU Hospital). The majority of primary teaching hospitals in other states are separate legal entities from the public school of medicine, as is the case in Kansas City. Further, almost half of those that are a separate legal entity previously had common ownership with the school of medicine, as is the case in Kansas City.

For five states we reviewed and Kansas, we also noted that the chair of the hospital board typically is elected by board members, that officials affiliated with the medical school / university system were designated by statute or agreement to be board members in five of the six states (their representation on the board varied from 57% in Virginia to none in Nebraska), that officials affiliated with the teaching hospital were designated to be board members in only two states (Kansas and Minnesota), and that other board members were appointed by a variety of individuals or entities. Medical Center and Hospital officials have differing opinions about trends in organizational structures among academic teaching hospitals and medical centers.

The Medical Center's and Hospital's financial relationship isn't defined in State law, and has been a source of contention between them. *Although the law says the mission of the Hospital is to "facilitate and support the education, research, and public service activities" of the Medical Center, neither the law nor the affiliation agreements between the Hospital and Medical Center specify what types of payments "count" as the Hospital's support of the Medical Center, or how much that overall support should be.*

The Hospital and Medical Center have disagreed about which Hospital payments constitute "support" of the Medical Center. Hospital officials told us they thought the following benefitted the Medical Center:

- *Direct contributions to the Medical Center*
- *Payments for resident support from Medicare*
- *Payments made directly to the Medical Center for professional services*
- *Indirect payments to faculty physicians (rather than to the Medical Center) for professional services*
- *Fee-for-service type payments for such things as parking, security, and the like*

They also pointed out that the Hospital provides a significant amount of other in-kind support to the Medical Center.

Medical Center officials told us they viewed only the direct payments the Hospital made to the Medical Center as support (only the first three bullets shown above). They said they thought the Hospital should be providing more support in two areas: indirect graduate medical education payments, and unrestricted contributions.

With the help of a consultant, the Medical Center and Hospital have reached a tentative agreement on what types of things will constitute the Hospital's support of the Medical Center (the first four bullets shown above), and a base level for that support. For fiscal year 2008, the base amount of support is estimated to be $42.5 million, which would be higher than support payments in prior years ($20 million in 2006, and $27 million in 2007).

Comparisons with other state medical centers have significant limitations, but the support the Medical Center has received from all its affiliated hospitals does appear to be relatively low. *Many factors contribute to differences between the amount one medical center receives as support verses another medical center. These can include the size and profitability of the teaching hospital, the amount of other funding sources such as State appropriations, and the amount of Medicare resident support.*

We chose five states for comparison, and made upwards adjustments to what the KU Medical Center previously had reported as support to make it more comparable to those states (the Medical Center had excluded support it receives from Wichita hospitals). After this adjustment, the amount of support the Medical Center received from all its affiliated hospitals in fiscal year 2005 appeared to be low compared to the other state schools. The range was $108.8 million in Virginia to $35.5 for Kansas. We also accounted for size differences between the schools by putting support dollars on a per-resident/student basis, but the results were the same.

Question 2 Conclusion. *It appears the Medical Center has tended to receive less financial support from all its affiliated hospitals than public medical schools in other states. The amount of financial support the KU Hospital provided in the past likely has been impacted by a number of things, such as the Hospital's size, profitability, Medicare rates, and the separate mechanisms for funding the residency programs on the Wichita and Kansas City campuses. Although the Hospital's enabling legislation requires the Hospital to "support" the Medical Center, we weren't able to determine how much financial support the Hospital should provide given the complexities of their relationship and how medical education and healthcare are funded. Nonetheless, the Medical Center and Hospital are working on an agreement that would significantly increase the Hospital's financial support of the Medical Center's mission.*

Question 3: Does the University of Kansas Hospital Have a Reasonable Method for Assigning a Value to the Care Provided to Indigent Patients?

The value of the care provided to medically indigent patients may be recorded as either charity care or bad debt. *One of the Hospital's missions is to "continue the historic tradition of care...to medically indigent citizens of Kansas." For accounting purposes, the value of care provided to medically indigent can be recorded as either charity care or bad debt. Charity care refers to a determination by the Hospital (based on financial*

information provided by the patient) that the patient can't afford to pay for their care. Bad debt refers to patients who don't submit the financial information and can't afford their care. According to the American Hospital Association, charity care plus bad debt reflects the care hospitals provide to those who can't afford to pay their hospital bills—the medically indigent.

When reporting the value of uncompensated care in its financial statements, the Hospital follows generally accepted accounting principles. *Those principles require hospitals to determine the value of care based on the hospitals' established charges for the services provided. The KU Hospital reported providing $80.9 million in uncompensated care in fiscal year 2006, based on its established charges. The Hospital reported this figure in its financial statements and annual report.*

The Hospital's uncompensated care charges are much higher than estimates based on either discounted rates for paying-patients or the cost of care. *Because various discounts are applied to hospital charges, those charges typically don't reflect what's actually paid for care. These discounts are the portion of charges written off as a result of Medicaid and Medicare reimbursement rates, and discounts given insurance companies. For example, although a hospital may charge $17,000 for an appendectomy, the negotiated payment from one insurance company may be $7,000, and Medicare or Medicaid may set its reimbursement rate at $6,500. We found that, overall, the Hospital discounts charges for its paying patients by about 61%. Applying the 61% discount to the uncompensated care charges for fiscal year 2006 would reduce the value of that care from about $81 million (the amount charged) to about $31 million (the amount the Hospital likely would have received).*

A number of organizations report the value of uncompensated care based on the costs of that care, rather than on the charges for that care. In fiscal year 2005, the Hospital's uncompensated care costs were about one-third of its established charges for that care. In summary, the value of uncompensated care provided by the Hospital varies greatly, depending on the basis used for the calculation.

Question 3 Conclusion. *As required by generally accepted accounting principles, the University of Kansas Hospital reports the value of the components of uncompensated care (charity care plus bad debt) based on charges in its financial statements. However, those figures may not be very meaningful, and make comparisons difficult because hospital charges are so variable. Cost-based figures, which the Hospital has reported, can be more meaningful and comparable to what other hospitals report. Furthermore, both the American Hospital Association and Healthcare Financial Management Association suggest reporting the value of uncompensated care based on the costs of providing that care.*

Question 3 Recommendation. *We recommended that the Hospital report the value of uncompensated care using more comparative methods in other publications, such as its annual report. The Hospital generally agreed with this recommendation.*

These Appendices can be found in the full report:

APPENDIX A: *Scope Statement*

APPENDIX B: *State and Tuition Expenditures on Education, Research and Other*

APPENDIX C: *Attorney General's Opinion on Hospital Board Membership*

APPENDIX D: *Hospital Board Membership and Representation*

APPENDIX E: *Agency Responses*

Both the Hospital and Medical Center agreed in part with the audit's findings and conclusions. Further, both provided additional explanatory material. The Medical Center indicated that our decision in Question 1 to count spending on student support and scholarship as "other" expenditures, rather than as "education" expenditures, didn't present an accurate picture because those expenditures were part of its educational mission. The amounts involved total about $6.7 million out of the $287.9 million the Medical Center spent in 2007, and mostly were spent from State operating grant funds. There's no right or wrong way to categorize these expenditures, so we think it can be useful for the reader to see them classified both ways—as we've presented them in the body of the report, and as the Medical Center's shows them in its response (Appendix D). Overall, our conclusions are the same.

This audit was conducted by Chris Clarke, Melissa Doeblin, and Ivan Williams. Leo Hafner was the audit manager. If you need any additional information about the audit's findings, please contact Chris at the Division's offices. Our address is: Legislative Division of Post Audit, 800 SW Jackson Street, Suite 1200, Topeka, Kansas 66612. You also may call us at (785) 296-3792, or contact us via the Internet at LPA@lpa.state.ks.us.