Hospital Reimbursement for Welfare Patients

—Three Steps to Sound Financing—

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DO HOSPITAL officials and welfare officials—in towns, cities, counties, and States—cooperate fully in explaining to the public and to elected officials why costs in general hospitals are rising and why these hospitals need more revenue?

Rising hospital costs are forcing an increase in hospital rates for welfare patients, and the opportunity for cooperative interpretation by hospitals and welfare officials is too often overlooked when hospitals revise their rates or plan their programs to explain the changes to the public. Past experience indicates that the inflationary spiral continues for hospitals long after it has leveled off for business and industry. Thus, hospital officials are faced with the necessity of explaining both rising costs and the need for additional tax revenue at a time when there is a general outcry for tax reductions.

The cost to the community of hospital care for those people who cannot meet their hospital bills in full can be interpreted in a number of well-established ways. Most of these, however, will not bring results unless the method of reimbursement by welfare agencies for welfare patients is readily understandable and is fair both to the hospital and to the taxpayer. A program of reimbursement will be more readily accepted if it can be written into State statutes or local ordinances for all to see and as a guide to welfare officials.

Various types of hospital reimbursement programs are now included in the State statutes and local ordinances. But one pattern consistently meets the conditions of fairness and clarity. This pattern stems from an agreement between governmental and hospital officials that clearly sets forth which of the needy persons should be cared for from tax funds, which from grants funds for specific illnesses such as poliomyelitis, which from private donations such as community chest funds, and which from hospital endowment or free bed funds. Fortunately, these determinations do not have to be worked out independently in each section of the country, for the growth over the years of practical laws and local customs gives a partial answer.

Determining Responsibility—Step 1

A sound hospital reimbursement program for welfare patients should first determine which of the needy patients should be cared for from tax funds and which from voluntary hospital funds.

Most State governments provide hospital care for patients ill with tuberculosis or mental illness, while local communities provide care for those afflicted with communicable diseases in the infectious stage.

The Federal Social Security Act of 1935 (Public Law 271, 74th Cong., 1st sess.) has established four categories of financial help to the needy for which Federal grants are available

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to States: the aged, the blind, the dependent child, and the permanently and totally disabled.

In addition to these four groups, other needy persons or families, sometimes called indigents or paupers, are cared for by their communities when they are unable to provide for themselves the necessities of life—food, shelter, clothing, and medical care. Since the provision of all or one of these is a need that people face in varying ways and in various degrees, it has been difficult for both hospital and welfare officials to draw a clear-cut line for this fifth group between the responsibility of the tax-supported agency and the responsibility of the voluntary agency. This difficulty comes most clearly into focus for those persons who are only unable to provide medical care.

Generally accepted is the proposition that the most needy in this group of indigents or paupers are the responsibility of the tax-supported agency and that the less needy are the responsibility of the voluntary agency. Criteria which will serve as a guide in reaching a decision on greater or lesser need are now in use in many States and localities. The six criteria most commonly adopted in Connecticut are:

The nature and length of the illness.

The earning ability of the patient.

The number of persons dependent on the patient.

The financial resources of the patient.

The financial resources of relatives who might properly be expected to assist the patient.

The value to the community of prompt acceptance of the immediate expense of the patient's care.

Family Budget Yardstick

In addition to these six criteria, a yardstick in the form of a sliding scale can be developed from The City Worker's Family Budget which has been published from time to time by the Bureau of Labor Statistics of the United States Department of Labor. Such a sliding scale has come into general use and has been given recognition by the Connecticut and Illinois State Departments of Welfare in the family budgets they publish for use by welfare officials in determining the amount of assistance to be made available from tax funds to a needy person. However, it must be recognized that at best these criteria and the suggested yardstick can only be guideposts for the welfare official and the hospital credit manager when they consider the problem of needy individuals who each have their own peculiar situations to resolve. However, the criteria and the suggested yardstick do form an objective base for the conscientious welfare official or hospital credit manager.

Opportunity for Cooperation

In the application of these criteria and the suggested yardstick, the welfare official and the hospital credit manager have a great opportunity to work in close cooperation. When they have an understanding of each other's problems, both will discover that welfare statutes must be interpreted strictly and that they allow little opportunity for freedom of action or decision. They will also discover that the voluntary hospital has a far greater flexibility in its approach to welfare patients and is in a position to give prompt and immediate care in emergencies. Where the inflexibility of welfare statutes assures the needy person of suitable care when he meets the requirements set forth in the statutes, the greater flexibility of the hospital corporate setup permits the hospital to fulfill the charitable role so respected throughout the United States.

Cooperative welfare officials and hospital credit managers who recognize this relationship will do a better job for their communities and will be more prompt in meeting the needs of individuals who require medical or hospital care. They will find mutual advantage in using the resources to be found within their communities, such as the central social service index or the credit bureau, which accumulate financial information about local residents. And they will succeed best when they never forget that what they do must first of all be in the interest of the individual patient.

Relating Charges to Cost—Step 2

Hospital reimbursement should be based on an accepted hospital reimbursement formula which is automatically adjusted periodically.

Should the hospital reimbursement formula be based on cost or charges? Since the argument for hospital charges most generally presented is that the voluntary general hospital is

not expected to make money, it would be well to use a cost reimbursement formula and avoid the misunderstandings that develop when hospital charges are the basis of reimbursement. These misunderstandings arise from the failure of many general hospitals to relate charges to cost and from the sometimes overgenerous markup which is made for laboratory and X-ray examinations.

Two Reimbursable Cost Formulas

The "government reimbursable cost formula," which is based on the Handbook on Accounting, Statistics and Business Office Procedures for Hospitals (American Hospital Association, 1950), is generally accepted. It is supported by a detailed chart of accounts, by well-accepted definitions, and by established accounting procedures. It has certain weaknesses, notably its failure to prescribe procedures for segregating outpatient expense from inpatient expense, for separating the expense of a specific revenue-producing service department, for setting up a plant ledger, and for computing depreciation. In addition, the "form of certification by a public accountant" does not require certification that the general ledger accounting is in accordance with the system recommended by the American Hospital Association.

The government reimbursable cost formula established the principle of the average per diem cost as the most acceptable method of payment. Although the basic weakness of averaging is that no two patients or hospitals are the same, the formula is simple to administer and is readily understood. This principle has been accepted by welfare agencies in Connecticut. The Connecticut Hospital Association has developed a formula and forms which correct the deficiencies of the government reimbursable cost formula but maintain its principles. These forms are set forth in the Cost Accounting Manual of the Connecticut Hospital Association (November 1952).

Neither the government reimbursable cost formula nor the Connecticut reimbursable cost formula attempts to segregate the per diem cost of so-called ward service from the average per diem inpatient cost. While it can be argued that the ward cost should reflect more exactly the cost of service given to welfare patients, the fact that most hospitals are designed so that ward patients and other patients are served from the same nursing station reduces the accuracy of allocating the cost of nursing service between classes of patients. This reduction in accuracy may discredit the hospital's ward cost since nursing service which comprises one-third of hospital expense will be allocated if ward cost is segregated on opinion rather than on fact. Forms and procedures for developing a ward cost have, however, been published by the United Hospital Fund of New York and the Massachusetts Health Department.

Securing Program Acceptance—Step 3

To insure the program's acceptance and introduction, hospital trustees must take the leadership in educating the public, the welfare officers, and the elected officials both about the benefits to be gained from the program and also about the problems of the general hospital in providing the high quality of care which the public has come to expect of the medical, nursing, and related professions. Who is best equipped to assume leadership? Can the welfare officer, who is restricted by statute or ordinance, find time from the pressure of his duties to educate the public? Can the hospital administrator, who is employed to provide patient care and required to balance the budget, command the ear of the public and elected officials? Is not the hospital trustee, who carries without compensation the responsibility for patient care in the hospital and who represents the interest of the public, the logical person to take the lead in educating the public?

The Hospital Trustee, the Leader

It would seem that the hospital trustee is best fitted for this task. Hospital trustees include businessmen, professional men, and enterprising women who are generally established and respected as community leaders. The public is prepared to listen when they speak, and elected officials readily accept the validity of their arguments. They do not have the handicaps of being appointed officials or of being accused of earning their salaries as the welfare officer or hospital administrator might be.

What must the trustee do to secure acceptance of the program? He first must persuade trus-

tees of other hospitals to join with him in accepting the program and in promoting its acceptance. This can be done through the official hospital association or council or through a special committee which represents a majority of community hospitals and which has been set up with this single objective in mind.

Second, time will be saved if the hospital trustee contacts the highest government official in the community—the governor, the county supervisor, or the mayor—in order to explain the difficulty of general hospitals in obtaining more revenue and to secure the appointment of an official study committee whose report it is hoped can eventually be the basis for a legislative proposal.

Third, the hospital trustee must obtain facts. Again the simplest, and the most satisfactory, method of getting the facts is from a uniform accounting and reporting program, one which uses, for example, the standard forms based on the chart of accounts set forth in the Accounting Manual of the American Hospital Association. A set of forms can also be found in the appendix to the Cost Accounting Manual of the Connecticut Hospital Association.

An alternate method, but one which is likely to incur greater expense and usually does not have such a permanent effect, is to have a firm of public accountants prepare a statement of comparative information for each of the participating hospitals.

These facts will be invaluable to the hospital trustee. If they are certified, the facts will limit discussion on the merits of the situation and will quickly gain the acceptance that is the trustee's goal. With the facts, the program will gain a new respect in the eyes of the welfare officer and the elected official, for these men are accustomed to dealing with facts, and from them they can logically proceed to the solution of the problem.

It is at this point that the trustee should provide his greatest leadership. He should be ready with a clearly thought-out program, and he should be flexible enough to adjust procedures without sacrificing principle. He should be ready to demonstrate that the general hospitals are equal partners with the welfare agencies in this program. The hospital, in turn, has an obligation to adjust itself to standard government procedure without permitting government to usurp the hospital trustee's responsibility to provide the best in medical care that the community can afford.

Finally, when the program is ready to be enacted into law, the trustee should lose no time telling the hospital's story and describing the proposed program to the general public. Telling the story orally with the support of visual aids is the most effective method of achieving this end. In a day when the written and spoken word deluges everyone, the public's attention must be captured if the hospital spokesman is to gain acceptance for the program. What does gaining the attention of the public mean? It starts with the hospital's own family, the hospital's patients, their families, and those who contribute to the community chest, and it extends to those who represent the community in the legislature or on the city council. If such a start is made, then there is a place for news releases, editorials, and leaflets. Finally, legislative hearings at the State capitol or in the city hall should be fully attended by the trustee and his supporters in order to capture the attention and understanding of legislators occupied with hundreds of important matters in the public interest.

Results of a Sound Program

Such a program will require the staff work which the busy hospital trustee cannot afford to provide. It will require expert legal advice in the drafting of legislation and in dealing with government officials. It will need skilled public relations advice in dealing with the public, and it will demand effective communication between hospitals. Finally, it will need followup, for the details of putting such a program into operation are many and complicated.

What will be the result? A sound program of hospital reimbursement for the welfare patient will put the general hospital back on a secure footing and will provide welfare patients with hospital care at the time it is most needed. More important, it will insure the continuation of the good medical and nursing care that is the hallmark of general hospitals in the United States.