Opinion: Proposals for Health Policy*

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Doing Away with Uncompensated Care of the Uninsured

As more people lose their health insurance, an increasing volume of uncompensated care is absorbing billions of dollars of limited resources of the nation's hospitals, health systems, and other provider organizations. As yet, no provider organization has developed a comprehensive management approach to address this growing problem. Currently, the money spent on uncompensated care is viewed as a drain on institutional bottom lines rather than as a fund dedicated to improving the health of uninsured patients and prospective patients. If an accountable executive were made responsible for managing this problem by paying for all of this care on a case-by-case basis as third parties do, uncompensated care could be eliminated. Payment for each case would come from the institutional resources no longer required for uncompensated care. There is reason to hypothesize that with effective management, a significant amount of the resources currently absorbed by uncompensated care could be shifted from excessive inpatient care to more productive, innovative community initiatives. This paper outlines a six-point management program designed to increase the income and decrease the expense currently associated with uncompensated care, while improving quality, patient satisfaction, and outcomes. The program can be carried out by an individual provider organization, or as a collaborative program involving two or more organizations. Recommended are demonstration projects to test the feasibility and net cost or cost savings of such an approach, preferably starting in one-hospital towns.

One sixth of the U.S. population is now without health insurance. The number of people without insurance protection has continued to increase every year since the beginning of the new century. As the situation grows worse, there is no consensus about what to do.

Pending the emergence of some national initiative for universal health coverage, communities are well advised to explore possibilities for dealing with the problem at the local level. In most communities today, uncompensated care is being provided not only to uninsured poor and disadvantaged people, but also to growing numbers of self-supporting, uninsured families who cannot

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pay hospital and physician bills that frequently add up to many thousands of dollars. Increasingly, filing for bankruptcy is the only answer for families, and for some institutions as well.

In many respects, the situation today resembles the environment that hospitals and physicians faced during the Great Depression of the 1930s, when hospitals dealt with a similar burden of providing uncompensated care to the general population, not just the poor. At that critical time, hospitals and other providers joined with community leaders to support the invention and spread of Blue Cross and Blue Shield prepayment plans. A voluntary approach seemed to be the only feasible way to go, since Franklin Roosevelt believed that the country was not yet ready for national health insurance, and involvement by the insurance industry was still years away. Self-supporting families struggling to make ends meet were unable to pay hospital bills, but were willing and able to prepay something each month for basic services. Of course at that time, physician and hospital bills were in the hundreds of dollars, not thousands. A capitation of a dollar a month for a family did not necessarily cover the entire cost of care, but at least brought a new income stream to the institutions. Hospitals and physicians were assured of some compensation. Most important, a financing mechanism was created for payment of the care, and eventually to hold the providers accountable, case by case.

An early Blue Cross pioneer once told me that he got the idea of monthly prepayment while working for a collection agency in New Jersey, helping families to post-pay their bills with a monthly amount that they could afford. Shifting from post-payment to prepayment led him to a new job and a new organization, as it led to a new world of hospital finance in which providers were compensated (if not fully reimbursed) for services to the insured. He admitted that it did not occur to him to combine prepayment and post-payment in a comprehensive monthly capitation for uninsured patients. I have often wondered whether the history of hospital finance would have evolved differently if he had thought of a second capitation program for uninsured *patients* in combination with his capitation program for the uninsured *population*. Maybe the time has come to expand the notion of capitation to cover uninsured patients.

Currently, hospitals, health systems and private practice physicians are collectively spending tens of billions of dollars annually providing uncompensated care, though they are not clearly accounting for these expenditures in any financial statements. As in the early 20th century, providers do not account for these expenditures separately from those spent on caring for paying patients. As a result, there is no clear responsibility over the management of these billions of dollars of expenditure. It is not possible to identify the sources of the money spent without a monumental effort, and no one is ultimately held accountable. These billions of dollars are lumped together as bad debt expense and charity care deductions, instead of being separately identified as money spent protecting the health of patients who do not pay. Why not use this money to compensate for the care of nonpaying patients, on a case-by-case basis?

If providers were compensated for this care on a case-by-case basis, as with all other classifications of care, the financing entity supplying the compensation would be in a position to hold the provider organization accountable for effective use of the money, and could be expected to develop programs to assure value received. After all, that is what health care financing entities do, both within and outside health services organizations.

Hospitals and health systems could take the initiative to create internal financing entities to provide compensation for the care of nonpaying patients who are uninsured. Such an undertaking would be much easier for providers today than in the earlier critical period of the Great Depression because most current price structures are set high enough now to supply much (if not all) of the money that would be required to pay for the uncompensated care.

In any community, a provider organization could create a new department or subsidiary to oversee managing and paying for its uncompensated care, case by case, or simply assign this responsibility to an existing department, such as the community benefit or managed care department. In that way, any individual hospital could fund and develop an accountable and effective management approach to dealing with the uncompensated care problem, using existing resources for the most part. On a more collaborative community basis, involved providers and provider organizations could join to fund and empower a new not-for-profit organization that would pay

for and manage their uncompensated care. On an even more collaborative basis, the providers might partner with the local Blue Cross Blue Shield organization to take advantage of its historical roots and expertise in compensating care. Initially, institutions would be well advised to test the idea within their own organization before getting involved in more complicated collaborative approaches that might in the long run be most effective.

Whichever path were taken, all uncompensated care provided to uninsured patients could be paid for by the organizations giving the care, each of which could develop a comprehensive program to manage all aspects of the problem. On an individual hospital basis, the department or executive responsible for the program would use the money included in the budget for uncompensated care losses to pay for the care case by case. Since the money would be used to pay for the care provided to these patients, turning this money over to the new, accountable entity (inside or outside the sponsoring organization) would essentially be a wash, with no added cost to the provider. Some start-up money from community philanthropy, local businesses, local and national foundations and the government would be helpful to fund the infrastructure for the program, if required. There is reason to imagine that a systematic program to manage all aspects of the uncompensated care problem would provide enough additional income and enough reduction in expenses, even in the first year, to cover the financing entity's operating budget and much more, with no subsidy required.

Moving Toward Elimination of Uncompensated Care of the Uninsured

Currently, community benefit specialists at some hospitals and health systems throughout the country are beginning to explore the feasibility of one program model to manage all aspects of the uncompensated care problem and provide compensation for uninsured cases.

The following examination of this model offers insight about the opportunities as well as the obstacles for any initiative aimed at eliminating uncompensated care of the uninsured. This model consists of: A) the initial involvement of the uninsured patients; and B) gaining results from six basic initiatives.

A. The Initial Involvement

According to this model, a hospital would use a variety of methods to identify uninsured patients who anticipate problems in paying their bills, preferably prior to inpatient admission. No bill would be sent directly to these patients. These patients would be referred to the designated financing entity, either within the hospital or outside. All contacts with these patients would be coordinated through a counselor accountable to the new financing entity. This financing entity might subcontract some of its work to the collection department and other involved hospital departments, but the new entity would be accountable for results.

B. Six Basic Initiatives

The six initiatives consist of: 1) enrollment; 2) managed care; 3) humane collection effort; 4) advocacy; 5) philanthropy; and 6) promoting patient accountability.

Enrollment. No health insurer has ever enrolled hospital patients. The problem is that hospital patients are bad risks from an insurance perspective because they are most likely to be back soon. But that is precisely why providers should do everything to ensure that they are enrolled. Under this model, initial efforts should be made to enroll these patients in one or more of the many entitlement programs if they cannot afford insurance. Beyond that initiative, every uninsured patient should be enrolled in a new institutional initiative called the Comprehensive Care Assurance Program (CCAP) especially designed for uninsured patients. They should be entitled to all the program's benefits, irrespective of income, resources, and ability to pay.

Each CCAP participant would be charged a monthly amount, following counseling, negotiation, and agreement with the patient and the family. The amount would be based on the individual patient's financial requirements and resources, rather than on the hospital's retail charges. This monthly charge would cover the services being received, but also coverage for the 12-month period following discharge. The monthly charge would be reviewed and adjusted up or down every three months. Enrollment in CCAP might be developed in collaboration with the local Blue Cross Blue Shield plan and also with institutional business offices, and social service and commu-

nity benefit departments. Philanthropic organizations would be enlisted in helping the patient's family to pay the monthly charge, which might be as low as one dollar for charity patients but much higher for those with significant resources beyond their personal financial requirements. All CCAP enrollees would be encouraged and assisted to join at least one insurance or entitlement program within the 12-month coverage period.

By combining prepayment of future utilization with post-payment of current services in a single charge that considers an individual's personal resources beyond basic financial requirements, the institution's income from uninsured patients should be greatly increased, whether or not costs are completely reimbursed. Quite possibly, this increased income would be more than enough to fund the management of the CCAP activities.

Managed care. The methodology of "managed care" has never been systematically applied to uninsured patients because managed care organizations, though frequently overaggressive with the insured, have no incentive to be involved with the uninsured.

However, the potential improvement in quality from sensitively managing the care of the uninsured appears to be substantial. Those who have examined the charts of these patients—who frequently lack an involved, accountable personal physician—also see great potential for expenditure reduction as well. The charts of uninsured patients frequently indicate that when necessary services are ordered, duplication and delay are the common themes. Further, any suggestion of managing care beyond the hospital walls after discharge frequently is missing.

Humane collection effort. As currently managed at hospitals, most uncompensated care is classified as bad debt, with a lesser percentage identified as charity. But commonly, the decision as to whether a case is treated as charity or bad debt is ill-timed, excessively rigid, and based almost exclusively on the resources of the patient's family rather than its unique financial requirements. At many hospitals, decisions on "charity versus bad debt" are colored by confusion about governmental restrictions, and show little evidence of understanding the nature of either a bad debt or of charity.

Accounting rules identify a bad debt as a debt that should be collected, but one in which the cost of collection is estimated to exceed the amount owed. Many hospitals do not apply that test, but rather classify bad debts primarily on the aging of the account. Charity frequently is identified only on hospital admission, with no subsequent consideration of the growing magnitude of the bill and the unique financial requirements associated with ill health. Not infrequently, so-called "bad debts" are sold to commercial collection agencies, the most obvious evidence that these debts are not really so "bad." Staffs of commercial collection agencies have reported to me that at least half the cases turned over to them should have been classified as charity. As these agencies work hard to identify which of the "bad debts" should be pursued, they do not devote many resources to avoid inhumane collection efforts on the misclassified charity cases. To make matters worse, these bills are based on retail charges that usually include a significant mark-up to help the hospital cover the costs of uncompensated care.

Legal action to collect debts is generally limited to those patients with significant assets, such as a home or a car. Hospitals hardly ever take advantage of small claims court where the "Judge Judys" will nearly always demonstrate and support a hospital's disciplined, humane approach and respect for a family's resources. The excuse is that these claims are too small to take to court, apparently overlooking the value of exposing the public to humane resolution of hospital collection problems.

A more humane, and also more effective, collection effort could be linked with enrollment in a Comprehensive Care Assurance Program, which not only would deal with current hospital utilization but future use as well. Such a program would never take legal action to undermine a patient's assets and security. Rather, CCAP would attempt to assist the patient's family with financial counseling and support to help assure financial security for the present and into the future—the real key to payment of hospital bills. Counseling could involve assistance in increasing income and resources (including multiple entitlement and philanthropic programs), helping to reduce the cost of debt, and identifying and helping to manage financial requirements in relation to resources. The goal would be to reach agreement on a monthly amount, no matter how small, that could be built into the family's financial requirements.

Those non-charity patients choosing not to join

the CCAP would be referred back to the institution's business office. With a reduced collection staff, the business office would continue to take responsibility for collecting balance billing from the under-insured as well as those not participating in CCAP.

With more humane treatment of CCAP patients, and with the emphasis on monthly capitation tailored to the individual's resources and financial requirements, there is reason to expect both substantially increased income as well as reduced expense of collection.

Advocacy. Currently, little is known about the characteristics of uninsured patients receiving uncompensated care, in comparison with the characteristics of the entire uninsured population. Over a long period of time, almost everyone who is uninsured will come to the emergency department or be referred to the hospital by some individual provider or provider organization. But an analysis of the characteristics of the daily sample of uninsured patients would provide many clues about advocating for the uninsured that would simultaneously improve hospital performance and reduce the burden of serving uncompensated care patients.

What proportion of these families appears to be eligible for one or more entitlement programs, and why are these families not participating in them? What proportion has been declared ineligible erroneously or in conformance with policies and practices that are not legal or should be changed? How many work for employers that do not offer health insurance, but might be willing to help with the hospital bills of valued employees, if asked by the hospital (only after getting the permission of the patient's family)? How many can be referred to various philanthropic community organizations for financial aid and family counseling? How many have extended families and friends who are eager to help?

This population is not organized for advocacy, has very few advocates, and has a disproportionate share of families who do not know how "to work the system" in the United States, which frequently is quite different from their places of origin. The CCAP would have many opportunities to develop systematic advocacy approaches, both for individuals and for specific groupings.

Many institutions have demonstrated the value of this kind of initiative in advocating with the Medicaid program, with great benefit for the patients and the institution. With many other opportunities to mobilize support for uninsured patients, significant increases in institutional income could be anticipated.

Philanthropy. For many years during the 19th and 20th centuries, philanthropy was the principal source of financing uncompensated care. As institutional philanthropy shifted to bricks and mortar and capital requirements, only the children's hospitals continue to organize philanthropic initiatives to support uncompensated care. Many other hospitals can expect significant income from appealing to philanthropic individuals who want to help people in need at the same time they are helping institutions. Of special interest are initiatives to support the care of individual patients requiring intensive long-term therapy.

As one element of an institution's philanthropic program, a systematic ongoing initiative to raise money for the care of patients could be organized and managed to cover the cost of operation and to generate significant income.

Promoting patient accountability. With many uninsured patients receiving uncompensated care, there are a multitude of opportunities to promote more effective self-care, prevention, and lifestyle changes in conjunction with primary care givers and community organizations. With a long-term CCAP perspective, significant reduction in the volume of uncompensated care could be anticipated from such initiatives, but even some short-term impact is likely with selected diseases, such as asthma.

Next Step: Well-Designed Demonstrations

More effective management of uncompensated care would sharply focus the widespread concern about the uninsured at the point at which the uninsured become a temporary responsibility of the community's health service providers. Given the amount of money that providers are spending on uncompensated care, it would appear that the approach outlined in this paper has great potential for improved service and value at a time when the country does not appear to be ready for a program of universal coverage. Unfortunately, as yet there is no assurance that a program to do away with uncompensated care of the uninsured is actually feasible.

Some well-designed demonstration projects should provide insight into obstacles and effective ways of overcoming them. The country

needs demonstration projects to show whether there are real benefits, even if obstacles are overcome. Would uncompensated care of the uninsured actually disappear? Would the cost of managing the program exceed the value of the benefits? How would such programs affect the trends in insurance enrollment? How would such programs affect the volume of care of the uninsured of the sponsoring providers? There are many important questions that must be answered before such a new and radical idea achieves widespread adoption.

Individual hospitals, health systems and physician groups could sponsor such demonstrations on their own or with foundation or government support. Community-wide demonstrations would be even more instructive, but more difficult to design and organize and evaluate.

Some Frequently Asked Questions

In preparing this paper, I shared with many health care professionals the basic notion that money is available to compensate for uncompensated care, and found that most just could not "get it" at first. These included professionals who are associated with health service organizations and tend to be too close to the day-to-day problems to immediately grasp the potential of an entirely different approach that seems to contradict everything they know. Their questions were quite different from those of most policy experts, who are not connected with hospitals and are unfamiliar with the history and current state of hospital accountability and accounting practices.

The most common questions related to the *definition* of uncompensated care. The answer to that question illustrates the problem. Most hospitals define uncompensated care as that part of care provided to: 1) charity patients which is not billed on a case-by-case basis, as well as to 2) "bad debt" patients which *is* billed on a case-by-case basis, but not paid.

Such individuals are always classified as uncompensated care patients, even though there may be government, philanthropic, or other funds available to cover the expenses of meeting uncompensated care commitments, but not on a case-by-case basis. For example, nonpaying patients are classified as uncompensated care patients even in hospitals that receive significant "disproportionate share" payments from government in recognition of their commitment to provide uncompensated care. Some hospitals do classify Medicare, Medicaid and non-government contract losses as uncompensated care, but that is not an acceptable accounting practice since the care of these patients is paid for on a case-by-case basis, though usually at contract rates that the hospital enters into voluntarily and which are much lower than billed charges.

Of course, the expenses of serving uncompensated care patients are always met one way or another from a wide variety of sources. The focus of this paper is how to manage that money more effectively rather than to attempt the Herculean and much less productive task of tracing the sources of these funds.

Responding to all the questions posed would require so many detailed explanations and "asides" that the simplicity of the basic idea would be lost. Accordingly, I decided to respond to these questions in a series of answers to "frequently asked questions" or "FAQs," a practice that I learned from the Internet.

Isn't the plan simply slick accounting manipulations with no real change to be expected?

No. The plan calls for some changes in accounting classifications designed to discreetly identify and measure resources required to care for uncompensated individuals, not readily available with existing accounting practices. Such changes in accounting classifications are important as enablers to action.

The cornerstone of the program is a more intense management focus on accountability and measurement of how these resources are utilized to better care for this population. There are additional revenue sources identified to support the program, though the net cost also would be reduced through more effective and efficient care.

If this is such a great idea, why hasn't some institution tried it? Why aren't foundations funding demonstrations?

As currently organized, innovation within health service organizations is difficult and almost impossible when an innovative initiative cuts across the traditional management structure. That is the case with respect to effectively managing uncompensated care, which is currently thought of as the exclusive province of the business office.

The new approach would require collaboration with all clinical departments, the community benefit department, the social service department, the public relations department, and much more. Someone must be empowered to take charge and to effectively coordinate the activities of all these groups as they relate to the uncompensated care problem. In particular, activities that involve coordinating institution staff who have an external focus and those who have an internal focus are extremely difficult to manage—difficult, but not impossible.

Many of the recent federally funded Community Access Projects (now the Healthy Community Access Projects) are beginning to move in this direction, along with some projects funded by the W.K. Kellogg and the Robert Wood Johnson Foundations. In addition, many hospitals are currently involved to some extent in one or more of the six initiatives mentioned here, but without a comprehensive coordinated management program. With greater understanding that the key issue is managerial accountability, rapid progress could be expected. No one seems to realize at this time that no hospital in the country has anyone empowered and held accountable for dealing with the institution's uncompensated care problem in all its dimensions.

Wouldn't this kind of initiative slow down or interfere with the campaign for universal health insurance?

The current campaign is for universal coverage, not necessarily universal health insurance. Universal coverage eventually will be achieved by some combination of health insurance and health entitlements, with the necessity of community commitment to cover the relatively small number of patients who, for one reason or another, do not qualify for or join any of the insurance or entitlement programs. Even today, a large proportion of people with coverage are in entitlement programs with few, if any, insurance characteristics: the Indian Health Service, the Veterans Affairs program, the military, Medicaid, and others.

The development of programs to do away with uncompensated care is an important step on the way to universal care. Furthermore, recognition of the current role of community programs in dealing with otherwise uncovered individuals would reduce by billions of dollars the estimated new money required for universal coverage.

Why is this approach expected to bring in more income than traditional collection department strategies?

In my opinion, in the health field, collection efforts that focus on and empathize with the financial and health needs of a family over the long term, and which also promote individual responsibility with tailored, adjustable capitation payments, will always result in higher collections than an approach focusing on the institution's financial requirements. In addition, this approach involves obtaining income from sources that traditional collection initiatives hardly ever tap. Demonstration projects should focus on this issue.

What is the estimated per-member-per-month (PMPM) cost of operating the program? How much net income will each of the six initiatives contribute to covering the cost of managing the program?

Much will depend on the size and characteristics of the population covered, and the degree of collaboration, but the PMPM cost will certainly be less than the PMPM operating expenses of most health maintenance organizations (HMOs). Without the experience of demonstration projects to rely on, no initiative should be funded without a credible estimate of its costs and benefits.

My own personal assessment is that the reduced cost of caring for these patients due to managed care, including more systematic attention to self-help and prevention—especially for patients with chronic conditions—would save enough money to cover the cost of managing the program. Further, the added income from the enrollment, advocacy, humane collection, and philanthropy initiatives would more than cover the cost of managing these initiatives. Combined, managing these six initiatives effectively should not only be self-financing, but also contribute real cash to an institution's bottom line.

What are the incentives for physicians to participate?

Although there is little reliable information on physician involvement in uncompensated care, many of those who know something about private practice believe that there is an enormous unappreciated contribution by private practicing physicians. Based on anecdotal information only, my impression is that in many practices, un-

compensated care accounts for 2% to 3% or more of the total volume of service. Frequently, this involves the physician's commitment to maintaining and caring for long-standing patient relationships with families who find themselves temporarily in financial straits.

With financial involvement in a CCAP, physicians could be participating in a reliable organization that would assume responsibility for care of their patients who cannot pay. In addition, physicians could be paid for much if not all of their care of the uninsured, so that there would be little risk. They would have to expose themselves to formal audit of their uncompensated care, and function within the framework of a more systematic approach to managing uncompensated care, which might be difficult for some. For physicians, there is everything to gain and hardly anything to lose except a traditional mindset.

To be successful, wouldn't the initiative have to include all providers?

With universal involvement of providers, the program should have maximum potential impact, though getting organized and staying organized would be difficult in the current entrepreneurial and skeptical environment. There is no reason that an individual hospital or physician group could not go ahead on its own, with real possibility of success. Initial demonstrations probably should be located in one-hospital towns. The early history of Blue Cross indicates that evidence of success of initiatives with limited sponsorship leads to widespread community collaboration.

Do you really believe that all uncompensated care can be done away with?

No. The proposed program does not deal with problems associated with balance billing of under-insured patients, nor with patients who do not wish to become involved in the CCAP initiative. In addition, it does not involve patients being served by providers who do not participate. But it should be possible to significantly reduce, if not eliminate, the rest of uncompensated care. Furthermore, early experience of the Blue plans indicates that if successful, involvement of providers would spread, as would other initiatives to involve more of the uninsured and underinsured too.

Where does the money come from that hospitals now use for uncompensated care?

Hospitals fund uncompensated care from a wide variety of sources. Many "disproportionate share" and teaching hospitals and isolated rural institutions receive significant money from special governmental programs for which they qualify. Some receive money from the tobacco settlements in various states. Some receive money from pooled funds administered by the states. Payment contracts with most insurance organizations include an allowance for bad debts, and some include a modest allowance for charity as well. Some observers believe that these combined sources provide more than enough money to cover the cost of all uncompensated care.

Another source of funding for uncompensated care in most hospitals is the mark-up from a hospital's costs to its retail charges. At nearly all hospitals today, that mark-up can range from 50% to 100%, or even more. These mark-ups also account for a large part of the money in the bills that uncompensated care patients cannot or do not pay.

Finally, some of the money that goes into uncompensated care comes from borrowing and from dipping into capital. Even bankrupt hospitals provide uncompensated care, frequently at a rate higher than other hospitals in the community. The fact is that all uncompensated care is paid for one way or another, though not case by case. The proposed program to eliminate uncompensated care of the uninsured by case-by-case payment can be effective, irrespective of the sources of available money that no longer would be required for uncompensated care.

Wouldn't hospitals that were not involved refer all uninsured patients to those that were involved? Wouldn't they transfer all uncompensated care patients to the participating CCAP hospitals?

Although some hospitals in metropolitan areas attempt to minimize their uncompensated care with this strategy, their experience indicates that this type of "buck passing" is not as easy to manage legally as some might think. In addition, the actual impact is questionable and could be more to the advantage of the CCAP hospitals than to those attempting to avoid civic responsibility.

However, concern that uninsured patients

would self-select the hospital which combines post-payment and prepayment would be among the most important factors leading hospital executives to be hesitant about participating. That is an important reason why the earliest demonstration projects should start within individual hospitals in one-hospital towns or in communities where all of the hospitals collaborate.

Wouldn't a hospital lose a lot of money providing a full 12 months of coverage after discharge, along with post-payment for the current service within the same monthly capitation?

Not likely. Of course, the probability that these patients would return in the year following discharge would call for a very high capitation on a break-even commercial basis. But most would not be back during that time period and those that did almost certainly would receive uncompensated care anyway, so there would be no loss to the sponsoring provider on such patients. With prepayment combined with post-payment, the patients' families would be more likely to perceive added value, so that increased monthly payments could be expected over and above what is currently collected on a purely post-payment basis by collection departments and collection agencies.

Very little is known about the magnitude of post-payment accounts, the time interval involved, or the frequency of early readmission. Examination of these practices should precede any careful demonstration project.

Wouldn't this approach to managing uncompensated care require a new and cumbersome level of bureaucracy in an already complicated financing system?

Not necessarily. The entire program could be carried out by an individual hospital without establishing any new subsidiary or department. What is required is empowerment of one individual within an organization to be held accountable and to have the authority to assure coordinated involvement of every department with a role to play.

In nearly all my contacts with a wide variety of hospitals on this issue, I have found one or more individuals in various departments carrying out some aspects of the six initiatives outlined previously. What is always lacking is effective coordination and accountability for results. These can be achieved in a vital organization with little if any added bureaucracy or cost. As with infection control, so too would go control of uncompensated care: the basic work would occur where the patient received care and by those in contact with the patient and family, rather than by the individual or organizational unit accountable for results. Even with a coordinated program involving multiple hospitals, most of the work would be done at the hospital where the patient was receiving care.

Wouldn't efforts to fund uncompensated care from philanthropy simply divert philanthropic funds from necessary capital projects?

Not likely. Any philanthropic campaign for care of individual patients should be organized and accounted for separately from other institutional philanthropic initiatives, and promoted to different potential donors, such as fully insured discharged patients. In general, contributions would be much smaller than contributions for capital projects. One hospital that I am acquainted with sent a personalized solicitation letter to every patient discharged, listing all of the services covered by third parties except for the television set. The response was not 100%, but contributions totaled considerably more than enough money to cover the solicitation costs. Philanthropic campaigns for care of individual patients may not raise a great deal of money, but the return on the money invested is usually surprisingly high, and every little bit counts. Furthermore, such a campaign calls attention to the charitable work of the institution.

What changes in financial statements would be required?

There would be a new category of both income and expense for the CCAP to discretely account for the performance of the program, along with corresponding reductions in bad debt and charity care levels. If CCAP became the responsibility of one of the existing departments, such as the community benefit department or the care management department, then the income and expenses associated with CCAP would be included along with the department's other income and expenses.

In addition, the combined prepayment and post-payment monthly charge to patients would require the inclusion of additional accounting treatment for appropriate accounting of the prepayment segment.

How would payment rates be determined?

The payment rates would be determined by negotiation, as is done by nongovernment "third parties" that compensate (if not reimburse) for care. Most logical might be a rate based on an estimate of the marginal cost of the service being paid for. As an alternative, payment might be based on some percentage of what Medicaid, Medicare or Blue Cross would pay for the same service.

Why doesn't the model for compensating for the care of uninsured patients apply to patients served by organizations other than hospitals and health systems, which do not charge for services to the uninsured or do not always receive payment for billed charges?

The services in these organizations also should be compensated on a case-by-case basis. They account for a large proportion of service to the uninsured, especially to those patients with limited resources. These include, for example, many federally qualified health centers; "free" clinics operated by physicians, nurses and medical students; local health department clinics, and much more. There is no reason that these organizations could not change their accounting practices, and their management and accountability structures to assure that the available money for serving the uninsured was paid and accounted for on a case-by-case basis. This should involve some added expense for the payment arrangements, but has great potential for reducing other expenditures and increasing the income associated with the uncompensated care provided.

This paper has focused on hospitals and health systems because they are currently much more sensitive to the uncompensated care problem, and more likely to move forward at this time with useful demonstration projects. Other providers can benefit from their experience. However, there is no reason why some of these other organizations could not be leaders, especially if hospitals were slow to innovate.

If physicians were not directly involved in the CCAP, wouldn't a hospital have to pay for primary care and specialty ambulatory services for CCAP patients not currently a responsibility of most hospitals?

Yes, if the services were provided by physicians not on the hospital payroll or by members of the medical staff not committed to the hospital's charitable mission as in the past. This obligation could cause a significant increase in expenses, with some offset in lower inpatient utilization. The probable reduction in inpatient costs from managing the care of patients of these physicians might more than offset this necessary added expense. Here again, a well-organized demonstration project would cast light on this problem.

Since it is well-known that even small monthly payments have disincentive effects, why is any increased income to be expected from the proposed monthly payment for care already provided, as well as needed care in the year after discharge?

Remember that the majority of uncompensated care patients in most hospitals are not charity patients, and are subject to large monthly bills after discharge, including not only hospital initiatives but also sometimes insensitive initiatives of commercial collection agencies. The question is not whether the more comprehensive, more humane approach proposed here has negative incentives. Rather, the question is whether a humane approach has greater positive incentives that might make a difference, as contrasted with current practices that are now the target of well-publicized nationwide legal challenges.

Isn't a strategy for getting the uninsured covered before they need hospital care better than an approach focusing on uninsured patients?

Yes, indeed! But it is not possible to get all of the uninsured covered before they actually become users of service, either in the near or long term. Until everyone has health coverage, it seems reasonable to give some attention to those who become patients before they become covered. Furthermore, there is reason to hypothesize that with more effective management of the billions of dollars currently being spent on nonpaying uninsured patients, the problem of covering the uninsured might be much less costly than now assumed. Also, initiatives to cover the uninsured likely would emerge more quickly than they currently do.

Note

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