STATE OF LOUISIANA
LEGISLATIVE AUDITOR

Louisiana Health Care Authority
Implementation of the Minimum Fee
in the State's Medical Centers

March 1993

Performance Audit

Daniel G. Kyle, Ph.D., CPA
Legislative Auditor

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March 17, 1993

Honorable Samuel B. Nunez, Jr.,
President of the Senate
Honorable John A. Alario, Jr.,
Speaker of the House of Representatives
and
Members of the Legislative Audit Advisory Council

Dear Legislators:

This is our report of the performance audit of the Implementation of the Minimum Fee in the State's Medical Centers, formerly known as charity hospitals. The audit was conducted under the provisions of Title 24 of the Louisiana Revised Statutes of 1950, as amended. All performance audits are conducted in accordance with generally accepted government auditing standards.

The report presents our findings, conclusions, and recommendations as well as responses from the Louisiana Health Care Authority, the agency responsible for implementing the minimum fee. We have also identified and reported two matters for legislative consideration.

Sincerely,

Daniel G. Kyle, CPA
Legislative Auditor

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[HCA-MF]

Office of Legislative Auditor

Executive Summary

Performance Audit

Implementation of the Minimum Fee in the State's Medical Centers

Act 893 of 1991 requires state medical centers (formerly charity hospitals) to collect a $3.50 fee from patients who are not medically needy or medically indigent. However, the fee is not being collected. Our study of the Louisiana Health Care Authority's proposed implementation of the minimum fee revealed the following:

- Ambiguities within Act 893 of 1991 may have contributed to the Authority's implementation plan being inconsistent with legislative requirements. The Authority interpreted the act by:
  - classifying the minimum fee as payment on account when the act says a charge in addition to charges for services received;
  - including exempt patient groups and excluding non-exempt patient groups in its revenue estimate; and
  - providing that medical centers collect the fee at the time of service when the act does not specify when the fee should be collected.
- Unless the Authority's policy which limits the amount to be charged to patients eligible to pay the fee is amended, the minimum fee will generate no additional revenue.
- Anticipated revenue from the minimum fee could negatively affect federal disproportionate share payments.
- Data used to estimate revenue from the minimum fee could not be verified.
- The Authority's estimated costs are based upon the presumption that the fee must be collected at the time of service.

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Audit Objectives

This audit of the implementation of the minimum fee in the state's medical centers, formerly referred to as charity hospitals, was conducted by the Performance Audit Division of the Office of Legislative Auditor. The audit objectives were:

- How did the Louisiana Health Care Authority develop the cost and revenue projections associated with implementing the minimum fee?
- Is collecting the minimum fee feasible?
- Will the minimum fee impact other facets of the state medical center system?

No Increased Revenue to Medical Centers

The Authority's interpretation of the minimum fee as "payment on account" rather than as a "service charge" will not generate new revenue to the state's medical centers. The estimates developed by the Authority are not estimates of revenue, but are estimates of "downpayments." If classified as a service charge, the minimum fee will generate new revenue to the medical centers because it will be collected in addition to charges for services rendered. (pages 9-10)

We recommended that the Authority classify the minimum fee as a service charge as required by Act 893 of 1991.

Summary of Agency Response

The Authority did not concur with our interpretation of Act 893 of 1991. The Authority responded that new revenues would be generated regardless because the rules extend a minimum fee (paid at the time of service) to those who owe nothing under the Liability Limitation Policy and to those who often do not fully pay bills owed.

Auditors' Comments

Paragraph A of Act 893 of 1991 (The Minimum Fee Act) exempts free care (medically indigent) patients from paying the minimum fee. Collecting $3.50 of an amount already due to the hospitals from patients who pay part of their care does not constitute new revenue.

Possible Reduction in Federal Funding

The minimum fee, classified as a service charge, could reduce the Medicaid disproportionate share payments. With nearly 88 percent of the system's budget coming from Medicaid, the Authority's medical centers have grown dependent on Medicaid funding. (pages 11-14)

We recommended that the Authority seek the assistance of the Department of Health and Hospitals to identify the possible short- and long-term effects of the minimum fee on disproportionate share payments and show these effects in its fiscal impact statement.

Summary of Agency Response

The Authority was in full agreement with this recommendation.

Act Contains Ambiguities Which May Have Contributed to Authority's Interpretations

The Minimum Fee Act contains ambiguities which may have contributed to the Authority's interpretation of the act. The act requires the fee to be charged for any treatment or service rendered. However, the act does not state when the fee should be collected and is unclear on who should be charged or exempted from the fee. (pages 14-15)

The Authority interprets "service units" as outpatient visits to clinics and emergency rooms. By excluding inpatient and other services, this interpretation limits revenue from the minimum fee and may exercise more discretion than the law intended. (page 15)

The act provides an exemption for those who are "totally without funds." Based on the presumption that the minimum fee should be collected at the time of service, the Authority interprets totally without funds to mean if a patient comes for services and says he or she does not have the $3.50 fee, the patient is considered totally without funds and the fee waived. The Authority estimates 75 percent of those eligible to pay the fee would use this exemption. However, the Authority could offer no empirical basis for this estimate. (pages 16-17)

Also, the Authority intends to charge the minimum fee to free care patients, when the act exempts this patient group. A new policy for determining free care eligibility has increased the

number of free care patients, thereby reducing the number of patients eligible to pay the fee. (pages 18-19)

We recommended that the Authority expand the definition of a "service unit" and examine all services provided by the medical centers to identify areas where the minimum fee could be assessed to comply with the intent of Act 893 of 1991.

Summary of Agency Response

The Authority responded that it understood the intent of Act 893 of 1991 was to address outpatient utilization. Authority officials said to expand the meaning of "service units" by the Authority would require changing the law or legislative clarification.

Matter for Legislative Consideration 2.1

The legislature may wish to consider amending LSA-R.S. 46:6(B) to clarify "service units" and "totally without funds" and state whether the fee is to be collected at the time of service.

Groups to Be Exempted, But Should Not Be

The Authority proposed other exemptions which are not allowed by the act. Those exemptions include the following:

1. Insured patients were exempted because insurance paid for some or all of their care;
2. Emergency room patients in an emergent condition were exempted because of the inhumanity of collecting the fee at this time;
3. Visits to clinics not staffed by a physician were exempted because these clinics are preventative in nature. We acknowledged that not imposing a fee in this situation might encourage preventative care, thus curtailing costly acute care in the future.
4. All obstetric and pediatric clinic visits were exempted because patients seen in these clinics are primarily Medicaid patients. (pages 19-21)

We recommended that the Authority submit a revised Fiscal and Economic Impact Statement reflecting the patient groups which can be charged the minimum fee.

Summary of Agency Response

The Authority responded that its draft rule merely proposes exemptions that the legislature is free to reject.

Matter for Legislative Consideration 2.2

The legislature may wish to consider amending LSA-R.S. 46:6 to specify all exemptions to the minimum fee including those which encourage preventative care.

Policy Must Be Amended to Receive Additional Revenue

Unless the policy which limits individual liability for receipt of state subsidized medical care is amended, the minimum fee will generate no additional revenue to the state medical centers. The Liability Limitation Policy was implemented January 1, 1992. This policy currently limits the amount to be charged to those uninsured and underinsured family units whose incomes exceed 200 percent of federal poverty income guidelines. Thus, with or without the minimum fee, affected family units pay the same predetermined amount annually. (pages 21-22)

We recommended, to effectively implement the minimum fee, the Authority should assess the impact of the minimum fee and this policy on each other prior to amending the Liability Limitation Policy in order to generate additional revenue.

Summary of Agency Response

The Authority responded, under its interpretation of the act, the Liability Limitation Policy has no bearing on who owes the minimum fee. The Authority intends to request the fee from both patients receiving free care and those who pay for part of their care.

Unverifiable Data

The data used by the Authority to estimate revenue from the minimum fee could not be verified as accurate and, in some instances, was incomplete. Because this data could not be reconciled by the Authority or by us, we cannot determine how much revenue the minimum fee will generate. (pages 23-24)

We recommended that the Authority, after expanding its definition of "service units," identify all services rendered to patients eligible to pay the minimum fee and base its revenue estimate on these services to comply with Act 893 of 1991.

Summary of Agency Response

The Authority responded that work is under way to improve its databases. However, Authority officials say it is not possible to obtain empirical evidence of the number of individuals who will avail themselves of the waiver provisions of the act.

Costs Dependent Upon Presumption of Collection at Time of Service

Although the Minimum Fee Act does not specify when the minimum fee should be collected, the Authority presumes the fee should be collected at the time of service. Based on this presumption, the Authority has estimated costs of $1,640,449 to collect the minimum fee. While this amount is supposed to include 89 collections positions and 9 accounting positions, we found this estimate to be mathematically incorrect. More importantly, with a programming change, the Authority could bill each patient who is eligible to pay the minimum fee through its billing system along with any other medical charges incurred, thus saving personnel costs. (pages 25-27)

We recommended that the Authority:

- implement the programming changes necessary to treat the minimum fee as a service charge as required by Act 893 of 1991, and
- revise the Fiscal and Economic Impact Statement to show the costs to be incurred by these programming changes.

Summary of Agency Response

The Authority responded that this recommendation is based upon an interpretation of Act 893 of 1991 with which it does not agree. Authority officials say if this audit's interpretation of the act is determined to reflect legislative intent, the Authority would agree with this recommendation.

Glossary

Categorically Needy	A group of Medicaid recipients which includes those who receive Aid to Families With Dependent Children (AFDC) or Supplemental Security Income (SSI). Federal law mandates Medicaid coverage of this group.
Disproportionate Share Payments	Additional payments by Medicaid to hospitals servicing a large percentage of the indigent patients.
Indigent	A person or family unit whose annual gross income is equal to or less than 200 percent of federal poverty income guidelines. (See medically indigent.)
Louisiana Health Care Authority	A political subdivision of the state charged with providing health and medical services to the indigent citizens of Louisiana through the state's medical center system.
Medicaid	A state and federal funded entitlement program that pays for medical services on behalf of certain groups of low-income individuals. For fiscal year 91-92, the funding percentages were federal government, 75 percent; state, 25 percent.
Medically Indigent	A resident of the State of Louisiana whose family unit size and gross income is equal to or less than 200 percent of the Federal Poverty Income Guidelines for that size family unit rounded up to the nearest thousand dollars. (See indigent.)
Medically Needy	A group of Medicaid recipients who meet the categorically needy criteria, except their income and resources exceed the amount allowed to the categorically needy. Their income and resources cover their daily expenses, but are insufficient to meet the costs of necessary medical care. States have the option of covering this group under Medicaid.

Chapter One: Introduction

Study Initiation and Objectives

Although legislation was passed in 1991 requiring collection of a $3.50 minimum fee at all state medical centers (formerly known as charity hospitals), the Louisiana Health Care Authority has not begun collecting the fee. Act 893 of 1991 requires the Department of Health and Hospitals or its successor agency (Louisiana Health Care Authority) to promulgate rules implementing the fee in accordance with the Administrative Procedures Act. The Administrative Procedures Act requires agencies to publish a notice of intent 90 days prior to implementing rules operationalizing laws.

The notice of intent must include a fiscal impact statement approved by the Legislative Fiscal Office. Legislative Fiscal Office staff have not approved the Authority's fiscal impact statement due to the disclosure that projected implementation costs exceed anticipated revenues.

As a result, the Legislative Audit Advisory Council authorized the Legislative Auditor to assess the feasibility of collecting a minimum fee from clients at the state's medical centers. In particular, the council was interested in verifying statements made by medical center administrators that the cost to implement the minimum fee would exceed the revenue generated. As part of our audit effort, we addressed the following questions:

- How did the Louisiana Health Care Authority develop the cost and revenue projections associated with implementing the minimum fee?
- Is collecting the minimum fee feasible?
- Will the minimum fee impact other facets of the state medical center system?

Report Conclusions

The Louisiana Health Care Authority's proposed implementation of the $3.50 minimum fee is inconsistent with the requirements of Act 893 of 1991. The Authority has interpreted the act by providing that:

- **patients eligible for free care pay the $3.50 minimum fee when the statute exempts this group of patients;**
- **the minimum fee be classified as a "payment on account" when the act states a "charge" in addition to medical charges incurred; and**
- **the medical centers collect the fee at the time of service when the act does not specify when the fee should be collected.**

The Authority chose to include some patient groups in its revenue estimate while exempting some patient groups not allowed by the act. No additional revenue will be received from patients eligible to pay the fee unless a policy limiting their liability for medical care is amended. In addition, patient visit data could not be verified. The costs to collect the minimum fee are dependent upon the presumption that the fee must be collected at the time of service.

If the minimum fee is implemented as a service charge, anticipated revenues could negatively affect federal disproportionate share reimbursements to individual medical centers.

Background

Access to health care is a historic right in Louisiana. Louisiana is unique in that the state provides health care for all individuals who need it whether they can pay or not. Since 1813, the State of Louisiana has operated a charity hospital system to provide adequate health care to its medically indigent residents. Over the last 66 years, determining what constitutes medical indigency has generated considerable legislative interest.

Act 62 of the 1926 Regular Session enacted Louisiana Revised Statute (LSA-R.S.) 46:6, which statutorily limited admission for treatment at state charity hospitals to persons deemed "poor and destitute." Patients considered poor and destitute received health care free of charge. Anyone found guilty of fraudulently obtaining free care could be fined or jailed.

Later, Act 534 of the 1975 Regular Session amended the statute to allow treatment of persons who were poor and destitute or "medically indigent" (historically interpreted to mean any patient whose family unit size and gross income is equal to or less than state eligibility income standards) at the state's charity hospitals. Also, the provision for penalties was removed.

During the 1975 Regular Session, Senate Concurrent Resolution No. 47 directed a study of the feasibility of expanding the state Medicaid Program to include a medically needy program, as defined in Title XIX of the Social Security Act. According to the resolution, this program would be designed to serve those individuals who had sufficient income to meet their daily needs but not their medical expenses.

To participate in the medically needy program, an individual's income would have to lie between 100 percent and 133 1/3 percent of the eligibility levels for Aid to Families With Dependent Children (AFDC). As described in the concurrent resolution, the additional Title XIX monies received by implementing this program could improve health services to the marginally poor and stimulate the state's economy. The medically needy program made some medically indigent persons eligible for Medicaid while the state subsidized care for the remaining medically indigent persons.

In order to ensure federal matching funds for the state's public assistance programs, LSA-R.S. 46:443 required the Louisiana Health and Human Resources Administration (now the Department of Health and Hospitals and the Department of Social Services) to conform income and resources exemption policies with federal eligibility determination standards. In addition, this statute specifies that such income and resources exemption policies prevail in the event they conflicted with other specified state laws governing eligibility requirements for public assistance.

Act 669 of 1977 further amended the statute limiting admissions to state hospitals to allow treatment of any resident of the state. However, those who were determined not to be medically indigent or medically needy were to be admitted on a space available basis and reasonably charged for treatment or services received. This included those who were not eligible for Medicaid or free care, but were billed for services received. The state's medical centers cannot deny emergency treatment to anyone.

Ten years ago, an effort was made to collect payments from patients ineligible for state subsidized care. Specifically, in March 1983, the Department of Health and Human Resources, Office of Hospitals, then the state medical centers' oversight agency, instituted a policy to collect $10 for each emergency room visit and $5 for each clinic visit from patients who were **not** eligible for free care and had no third party payor, for example, insurance or Medicaid. The payment was applied to the patient's total bill for services.

Patients who did not pay were given self-addressed envelopes to remit the $5 or $10 owed or asked to sign a promissory note for the amount of services rendered. As a result of state budget reductions and state medical center staff reorganizations, this effort was discontinued.

In 1991, the statute limiting admissions to state medical centers was once again amended by Act 893 of 1991 (referred to in this report as the Minimum Fee Act) to require a minimum fee of $3.50 for services rendered in addition to the fees and charges for medical care. Pertinent parts of the amended statute read as follows:

> . . . Those persons who are determined not to be medically indigent or medically needy shall be charged a minimum fee of three dollars and fifty cents for any treatment or service rendered; and further shall be charged on a sliding-scale . . .
>
> *LSA-R.S. 46:6(A)*

The statute goes on to say:

> In addition to any schedule of fees or charges established by the Department of Health and Human Resources . . . there shall be charged a minimum fee of three dollars and fifty cents per service unit to every patient who is rendered services or treatment at that hospital, except that such fee may be waived for a patient who is totally without funds or if the imposition of such a fee would violate federal law or regulations relative to Medicaid or Medicare.
>
> *LSA-R.S. 46:6(B)*

The Department of Health and Hospitals operated the state's medical center system until January 1, 1992, when Act 390 of 1991 turned this function over to the Louisiana Health Care Authority. This act requires the Louisiana Health Care Authority to annually enter into a service agreement with the Department of Health and Hospitals.

The service agreement emphasizes the provision of medical care to the medically indigent and uninsured citizens of Louisiana and reaffirms that providing such care is one of the primary purposes of the Authority. The Department of Health and Hospitals maintains programmatic responsibility. In the first annual service agreement for fiscal year 1992, the Louisiana Health Care Authority is charged with the responsibility of implementing the minimum fee. However, the Authority has not begun collecting the minimum fee because its notice of intent has not been approved by the Legislative Fiscal Office.

Today, the Louisiana Health Care Authority medical centers not only provide inpatient care, but also provide outpatient care through the clinics and emergency rooms operated at the various medical centers.

Because the Authority's medical centers provide medical care to a primarily medically indigent population, Louisiana receives significant Medicaid reimbursements from the federal government to help pay for this indigent care. These significant reimbursements, or disproportionate share payments, are intended to provide additional funds to individual medical centers which service a large percentage of indigent patients.

For fiscal year 1992-93, the Authority's medical centers were budgeted to receive over $392 million, or almost 97 percent, of its $405 million budget from Medicaid and Medicare with the remaining 3 percent coming from fees and self-generated revenues. No state general fund money was budgeted to these medical centers for fiscal year 1992-93.

Scope and Methodology

This audit was conducted under the provisions of Title 24 of the Louisiana Revised Statutes of 1950, as amended. All performance audits are conducted in accordance with generally accepted government auditing standards as promulgated by the Comptroller General of the United States, with the limitations

noted below. Preliminary audit work began in August 1992, and fieldwork was completed in December 1992.

We obtained data from the Louisiana Health Care Authority on the number of clinic and emergency room visits to the state's nine medical centers identified for fiscal years 1984 through 1992. However, we only examined data from fiscal years 1991 and 1992 and this data could not be verified as accurate because the billing system is not useful as a management information system. Consequently, we could not estimate the amount of revenue to be generated by the minimum fee.

Because of time constraints and limited staff resources, we made limited tests to assess the reliability of the Authority's computer-generated data. We tested the reliability of reported summary data for outpatient visits to the clinics and emergency rooms, the services for which the Authority will charge the minimum fee. The tests consisted of comparing computer-generated information with patient visit data obtained by the Authority from the nine state medical centers.

Documentation was requested and obtained from the Authority regarding its assumptions and calculations used to develop the proposed rule for implementation. We analyzed this documentation and verified the calculations. Later, we obtained a memorandum from the Authority clarifying the analysis for assumptions and methodologies used in developing its proposed rule to implement the minimum fee.

Interviews were conducted of:

- Officials at the Louisiana Health Care Authority and the Department of Health and Hospitals regarding fee implementation, its impact on hospital operations, and federal reimbursement monies.
- Administrative staff at Medical Center of Louisiana at New Orleans and Earl K. Long Medical Center at Baton Rouge.
- Legislative Fiscal Office, federal Health Care Financing Administration, and Senate budget staff to determine (1) the feasibility of assessing fees on state medical center free care and Medicaid populations and (2) the impact of such fees on federal Medicaid reimbursement.

We observed eligibility screening at Earl K. Long Medical Center at Baton Rouge and Medical Center of Louisiana at New

Orleans. Current literature relating to cost-sharing strategies for public hospitals servicing low to moderate income populations was analyzed.

Regarding clarification of exemption requirements to the minimum fee found in Act 893 of 1991, we requested the assistance of the General Counsel to the Legislative Auditor. We reviewed relevant state and federal legislation on Medicaid/ Medicare and state eligibility determination policies and procedures regarding individual cost liability for receipt of health care services at a state medical center. We also examined the effect of revenue generated from the minimum fee on federal Medicaid disproportionate share payments to individual medical centers.

Report Organization

The remainder of this report is organized into two additional chapters.

- **Chapter Two** addresses how the Authority developed the estimate of revenue to be generated by the minimum fee.
- **Chapter Three** addresses how the Authority developed the estimate of costs associated with implementing the minimum fee.

Authority officials were given an opportunity to provide a written response to this report. The Authority's response has been inserted in the appropriate text of this report and is reproduced in Appendix A.

Chapter Two: Estimate of Revenue

Chapter Conclusions

The Louisiana Health Care Authority's revenue estimating methodology contained weaknesses. Primarily, the Authority has interpreted the minimum fee as "payment on account" as opposed to a "service charge," as required by the Minimum Fee Act. Thus, the minimum fee will generate no new revenue to the state hospital system. The Authority also presumed the act required the fee to be collected at the time of service. The act does not state when the fee is to be collected.

Some parts of the Minimum Fee Act are ambiguous or conflicting. This may have contributed to the Authority's interpretation of the act. The Authority chose to include exempted patient visits in its revenue estimate. In addition, the Authority proposed exempting some groups not statutorily allowed in the act. Also, the policy which governs free care eligibility and sets medical care liability was amended while the Authority was developing its revenue estimate. As a result, fewer patients are eligible to pay the minimum fee. Further, the minimum fee will generate no additional revenue unless this policy is amended.

No Increased Revenue to Medical Centers

The Authority has interpreted the minimum fee as "payment on account" rather than as a "service charge," as provided in Act 893 of 1991 (Minimum Fee Act). The Minimum Fee Act requires the $3.50 fee to be charged to those not eligible for free care or other public assistance **in addition to** charges incurred for medical services received. Thus, if implemented as interpreted by the Authority, the $3.50 minimum fee would generate no additional revenue.

Exhibit I on the following page shows the impact of the minimum fee on hospital revenue when treated as a service charge and then as payment on account.

Exhibit I

Comparison of Minimum Fee's Effects on Hospital Revenue When Classified as a Service Charge or as Payment on Account

If patient charges are $35.00:	As a Service Charge	As a Payment on Account
Minimum Fee - - - -	$3.50	$3.50
Balance Due From Patient - - - - - - - -	35.00	31.50
Total Charges	**$38.50**	**$35.00**

Source: Prepared by Legislative Auditor's staff

Exhibit I shows that the amount due from the patient would increase with the minimum fee classified as a service charge, rather than as a payment on account. As a payment on account, the patient pays an initial $3.50 and is later billed for the remaining $31.50. Therefore, the Authority's revenue estimates are not estimates of new revenue, but rather reflect estimates of partial payments. In effect, the hospital would be collecting "downpayments," not "additional charges."

Recommendation Number 1

The Louisiana Health Care Authority should classify the minimum fee as a service charge as required by Act 893 of 1991.

Louisiana Health Care Authority's Response

While acknowledging the ambiguity of Act 893, the Authority disagrees with the Legislative Auditor's interpretation with regard to (1) whom the legislature intended should pay the minimum fee, (2) when the legislature intended that the fee should be collected, and (3) what constitutes a "minimum fee" under the Act. The implementation approach incorporated into the draft LHCA Rules does not require classification of the minimum fee as a "service charge". The Rules will generate new revenues regardless, because they extend a minimum fee, paid at the time of service, to those who now owe nothing under the

liability limitation policy and to those who often do not fully pay bills owed.

Auditors' Comments

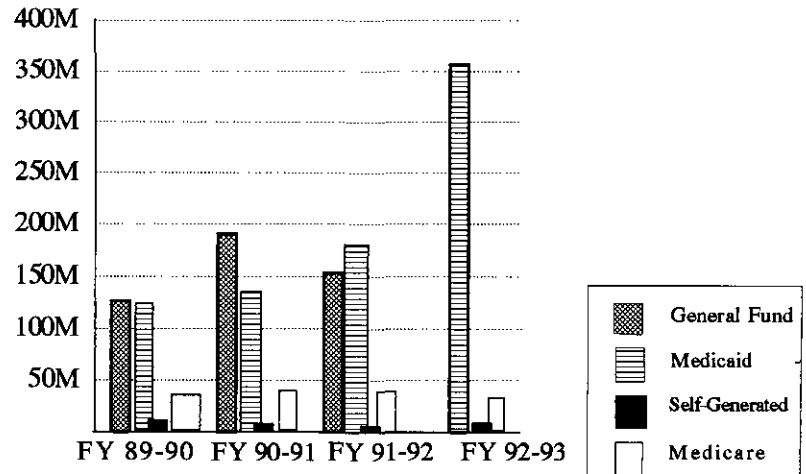
Paragraph A of Act 893 of 1991 (The Minimum Fee Act) exempts free care (medically indigent) patients from paying the minimum fee. Collecting $3.50 of an amount already due to the hospitals from patients who pay part of their care does not constitute new revenue.

Possible Reduction in Federal Funding

Additional money generated by the minimum fee could be partially offset by reduced federal payments. Authority officials determined that collecting this additional self-generated revenue could result in a reduction in federal funding. This reduction would occur in the "disproportionate share payments" to the state's medical centers. Disproportionate share payments are additional payments to hospitals that serve a large percentage of indigent patients.

Over the last four fiscal years, the Authority's medical center system has grown dependent on Medicaid funding. The amount of Medicaid funding has nearly tripled from $121,958,624 in fiscal year 1990 to $356,273,589 in fiscal year 1993. Exhibit II illustrates this growing dependency.

Exhibit II
Funding Sources for FY 89-90 Through FY 92-93



Source: Annual Executive Budgets

In fiscal year 1990, Medicaid was approximately 41 percent of the state's hospital system's budget, while slightly more than 42 percent of the budget was from the state general fund. The remaining 17 percent was from payments by patients, insurance companies, Medicare, and other third party payors. For fiscal year 1993, Medicaid alone is nearly 88 percent of the hospital system's budget, while none of the budget is financed through the state general fund. The remaining 12 percent is from payments by patients, insurance companies, Medicare, and other third party payors.

This significant increase in Medicaid funding is due to disproportionate share payments. Louisiana's statewide hospital system is designed to provide health care to the state's indigent citizens. As a result of state medical centers providing health care services to a large percentage of low-income patients, the state medical centers qualify for significant disproportionate share payments. Any amounts of disproportionate share payments received which exceed the amounts the medical centers are statutorily allowed to keep is transferred to the Department of Health and Hospitals to cover any shortfall in the Medical Vendor Payments Program.

The minimum fee, classified as a service charge, would enter into the calculation of the disproportionate share reimbursement as part of total hospital revenue. An example of this calculation is shown in Exhibit III on the next page. Since the total hospital revenue (which includes revenue from minimum fee) is in the denominator of the formula, any increase in self-generated revenue without a corresponding increase in Medicaid charges reduces the ratio. Thus, the disproportionate share rate is reduced, and when this rate is multiplied by the Medicaid inpatient revenue, the disproportionate share payment decreases.

Exhibit III shows the effects on hospital revenue if the minimum fee was to generate $35,000 to the hospital. Assuming the medical centers are able to collect 100 percent of the fees from patients, the example shows some gain in revenue. Overall hospital revenue only increases $22,931, because $12,069 of disproportionate share payments is lost. However, this example shows a need on the part of the Authority to fully identify in fiscal impact statements potential federal revenue to be lost resulting from the imposition of the minimum fee.

Exhibit III

Calculation of Disproportionate Share Payments
Example
Sample Hospital

	Without Minimum Fee		With $35,000 From Minimum Fee	
Free Care Charges - Inpatient	$415,566	= 3.78%	$415,566	= 3.78%
Total Inpatient Charges	$10,998,970		$10,998,970	
Medicaid Revenue (In & Outpatient)	$9,321,736	= 44.04%	$9,321,736	= 43.97%
Total Hospital Revenue	**$21,164,963**		**$21,199,963**	
Sum of Ratios		47.82%		47.75%
Less 25%		- 25%		- 25%
Difference		22.82%		22.75%
Standard Multiplier		X 3		X 3
Disproportionate Share Rate		**68.46%**		**68.25%**
		X		**X**
Medicaid Inpatient Revenue		$5,628,821		$5,628,821
Disproportionate Share Payment		**$3,853,739**		**$3,841,670**
Added to Total Hospital Revenue		$21,164,963		$21,199,963
Adjusted Hospital Revenue		**$25,018,702**		**$25,041,633**
Net Increased Revenue After $35,000 From Minimum Fee				**$22,931**

Source: Example obtained from Department of Health and Hospitals and modified by Legislative Auditor's staff to show possible effects of minimum fee on federal revenue.
Note: Method of calculating disproportionate share payments in effect as of December 31, 1992.

Recommendation Number 2

The Louisiana Health Care Authority should, with the assistance of the Department of Health and Hospitals, identify the effects of the minimum fee on disproportionate share payments in its fiscal impact statement.

Louisiana Health Care Authority's Response

The Authority is in full agreement with this recommendation.

Act Contains Ambiguities Which May Have Contributed to Authority's Interpretations

The Minimum Fee Act contains ambiguities which may have contributed to the Authority's interpretation of the act. The Authority's revenue estimate is based on the interpretations. The act does not state when the fee should be collected, nor is it easy to determine who should be charged or exempted from the fee. As a result, the Authority included exempted free care patients in its revenue estimates while excluding some patients who could be charged the fee. In addition to the Authority's interpretation of the minimum fee as payment on account, subsequent changes in free care eligibility requirements make the Authority's revenue estimate questionable.

Paragraph A of the act says, in part:

> . . . those persons who are determined not to be medically indigent or medically needy shall be charged a minimum fee of three dollars and fifty cents for any treatment or service rendered; and further charged on a sliding-scale . . .

Paragraph B of the act says, in part:

> In addition to any schedule of fees or charges . . . there shall be charged a minimum fee of three dollars and fifty cents per service unit to every patient who is rendered services or treatment at that hospital, except that such fee may be waived for a patient who is totally without funds or if the imposition of such a fee would violate federal law or regulations relative to Medicaid or Medicare.

The Authority based its interpretation of who pays the minimum fee on Paragraph B. Thus, the Authority plans to charge patient groups which are exempt from the fee while exempting some patient groups which can pay the minimum fee in its revenue estimate.

Service Units

The Minimum Fee Act says, "there shall be charged a minimum fee of three dollars and fifty cents **per service unit**." The Authority defined "service units" as outpatient visits to the clinics and emergency rooms at the medical centers, thereby excluding all inpatient and other services. Thus, by excluding inpatient and other medical services from paying the minimum fee, the Authority has limited the amount of revenue to be generated by the fee and may be exercising more discretion than the law intended.

In addition, the Authority exempted second and subsequent visits to outpatient clinics and emergency rooms in the same calendar day. While the Authority views the minimum fee as implementing legislative intent by being a "deterrent to overutilization of clinic services," the Authority chose to exempt second and subsequent visits to clinics and emergency rooms in the same calendar day. The basis for exempting these visits was that "such a practice would impose an unintended hardship in some cases." These statements are contradictory.

Further, the number of second and subsequent visits in the same day could not be identified by the Authority. When estimating revenue from the minimum fee, they estimated one percent of all visits to the outpatient clinics are by patients who may have more than one visit scheduled on the same day. The Authority could give no support for this estimate, but made it to allow for such occurrences.

Recommendation Number 3

The Louisiana Health Care Authority should expand its definition of a "service unit" and examine all services provided by the medical centers to identify areas where the minimum fee could be assessed to comply with the intent of Act 893 of 1991.

Louisiana Health Care Authority's Response

Since the Authority understood that the intent of Act 893 was to address outpatient utilization, the outpatient visit was used as the service unit. However, in the context of an acute care hospital, the concept of a "service unit" could be applied to an exceedingly broad range of activities, including major services such as surgeries, ancillary services such as lab tests, and a wide variety of nursing care and other services. A single patient would receive many such services in a single episode of treatment. Expansion of the meaning of "service units" by the Authority would require a change in law or a clarification of intent by the Legislature.

Totally Without Funds

The Minimum Fee Act does not specify when the fee must be collected. The Authority presumes the minimum fee is to be collected at the time of service and has based its revenue assumptions on this presumption.

Paragraph B of the Minimum Fee Act provides an exemption to those who are "totally without funds." The Authority has interpreted this term to mean if a patient comes for medical services and says he or she does not have the $3.50 fee, this individual is "totally without funds."

Because the Authority presumes the Minimum Fee Act requires collection at the time of service, it estimates that 75 percent of those eligible to pay the minimum fee will claim the totally without funds exemption. The Authority could offer no empirical basis for this estimate.

Again, if the Authority classifies the minimum fee as a service charge and uses the billing system to collect it, there will be no need to waive the fee. However, the minimum fee will only be collected when the patient pays the bill, thus making revenue unpredictable. The medical centers have had problems with collecting accounts.

Matter for Legislative Consideration 2.1

The legislature may wish to consider amending LSA-R.S. 46:6(B) to clarify "service units" and "totally without funds" and state whether the fee is to be collected at the time of service.

Exemptions for Medicaid/Medicare

The Authority appropriately exempted all patients in the Medicaid/Medicare group from the minimum fee. The Minimum Fee Act allows waiver of the minimum fee "if imposition of such a fee would violate federal law or regulations relative to Medicaid or Medicare." Federal Medicaid regulations prohibit imposing a charge, such as a co-payment, on Medicaid recipients unless the state's Medicaid plan provides for such a charge. The state's Medicaid agency (Department of Health and Hospitals) would have to amend the state's Medicaid plan to allow such charges and then obtain approval from the federal Health Care Financing Administration.

Even with federal approval, the $3.50 minimum fee could not be charged to Medicaid recipients because federal regulations only allow a maximum co-payment of $3.00 for outpatient services. A $3.00 co-payment can only be imposed if Medicaid pays more than $50.00 for the medical service received. The state's Medicaid agency could ask the Health Care Financing Administration for a waiver to assess a co-payment over $3.00. However, even after obtaining the waiver, this higher charge could only be assessed on instances where non-emergency services are furnished in a hospital emergency room. (These charges are tied to specific services.) Further, the state must establish to the Health Care Financing Administration's satisfaction that alternative sources of non-emergency, outpatient services are available and accessible to Medicaid recipients.

When co-payments are charged, the medical center's claim for Medicaid reimbursement is reduced by the co-payment amount. If the co-payment is not collected, the medical center sustains the loss.

Federal regulations also do not allow charges under any condition to be imposed on Medicaid recipients in the following categories:

1. Children
2. Pregnant women (all services relating to the pregnancy or medical condition which would complicate the pregnancy, including postpartum care)
3. Institutionalized individuals (inpatients in hospitals, long-term care facilities, or other medical institutions, which as a condition of receiving services in the institution, must spend all but a minimal amount of their income required for personal needs, for medical care costs)
4. Emergency services
5. Family planning
6. HMO enrollees

If the state's medical centers seek to collect the $3.50 minimum fee from Medicaid recipients, they would not be able to participate as a Medicaid provider and could lose their provider agreement. The provider agreement states that those who provide medical services to Medicaid recipients agree to accept Medicaid payment plus co-payments required by the state plan as payment in full. Any hospital which participated as a Medicaid provider and continued to impose excess charges might also be liable for criminal penalties.

See Appendix B for reproduction of information received from the Health Care Financing Administration relative to collecting co-payments from Medicaid recipients.

Free Care Patients

Although Paragraph A of the Minimum Fee Act exempts medically indigent, which includes free care patients, from the $3.50 fee, the Authority's estimate of revenue from the minimum fee includes them. As stated earlier, Paragraph A of the act exempts those who are "medically indigent or medically needy." Prior to January 1, 1992, medically indigent included all patients whose income was below federal poverty income guidelines, thus making these patients eligible for free medical care.

Because the Authority based its interpretation of the minimum fee on Paragraph B of the Minimum Fee Act, which requires the fee be charged to every patient, it included the free

care patient group as eligible to be charged the minimum fee in its revenue estimate.

Number of Free Care Patients Increasing

The Authority submitted its proposed rule to implement the minimum fee in March 1992, based on data as of June 30, 1991. However, effective January 1, 1992, the Department of Health and Hospitals implemented the Liability Limitation Policy. This policy changed the definition of indigent to include those family units whose gross income is equal to or less than 200 percent of the federal poverty income guidelines for that size family unit. Because of this new policy, some patients who were formerly responsible for payment of their own care are now eligible for care free of charge. Also, this policy limited the amount to be charged to those family units whose income exceeded 200 percent of the federal poverty income guidelines.

Authority officials say the Liability Limitation Policy maximizes disproportionate share payments and reduces collections efforts to patients unable to pay. When this policy was developed by the Department of Health and Hospitals, the department estimated that the number of patients eligible for free care would increase drastically. Department officials estimated that the number of billable patients would be reduced from approximately 132,500 to an estimated 38,850, nearly a 71 percent decrease. Conversely, 93,650 more individuals now qualify to be treated free of charge, thus increasing the number of free care patients.

Exemptions Not Contained in the Act

The Authority developed other exemptions to the minimum fee which are not contained in the Minimum Fee Act, but are predicated on its interpretation of the act. Those exemptions are:

1. insured patients;
2. emergency room patients in a life-threatening condition;
3. visits to clinics not staffed by physicians; and
4. visits to obstetric and pediatrics clinics.

Insured Patient Visits

Insured patients are not statutorily exempt from paying the minimum fee. The Authority exempted this patient group because their care, or the bulk of it, was paid for by insurance. As stated previously, the Authority has interpreted the minimum fee as payment on account, rather than as a service charge. Thus, the insured patients could be charged the minimum fee provided their incomes exceed 200 percent of the federal poverty income guidelines.

Emergency Room Patients in an Emergent Condition

Emergency room patients in life-threatening conditions were exempted by the Authority from the minimum fee. The Authority based this exemption on the assumption that assessing the fee at this time was inhumane. Once again, the Authority has presumed the fee must be collected at the time of service. Classified as a service charge, the minimum fee could be billed along with other charges for treatment rendered as long as the patient has gross income exceeding 200 percent of federal poverty income guidelines.

Visits to Clinics Not Staffed by a Physician

The Authority exempted visits to clinics not staffed by physicians. According to the Authority, these clinics are preventative in nature and usually staffed by a nurse or other professional staff. Patients being seen in these clinics are there for such things as blood pressure checks and dietary suggestions to maintain good health. The Authority did not estimate the number of these visits.

While the Minimum Fee Act does not provide an exemption for services of this nature, we acknowledge that not imposing a fee in this situation might encourage preventative care and thus help curtail more costly acute care in the future.

All Obstetric and Pediatric Clinic Visits

The Authority exempted all visits to the obstetric and pediatric clinics. According to the Authority, patients seen in these clinics are primarily Medicaid patients or become eligible for Medicaid. Federal Medicaid regulations forbid assessing any fees on pregnant women or children.

The Authority could not say how many patients treated in the obstetrics clinics were Medicaid eligible. Without this information, we could not assess the appropriateness of this assumption. However, those individuals treated in these clinics whose incomes exceed 200 percent of federal poverty guidelines could be billed the $3.50 minimum fee along with other medical charges incurred.

Recommendation Number 4

The Louisiana Health Care Authority should submit a revised Fiscal and Economic Impact Statement reflecting the patient groups which can be charged the minimum fee.

Louisiana Health Care Authority's Response

The Authority is comfortable with its interpretation of Act 893 and with the prudence of the exemptions that it has submitted in rulemaking. The Authority's draft Rule merely proposes exemptions that the Legislature, through oversight, is free to reject.

Matter for Legislative Consideration 2.2

The legislature may wish to consider amending LSA-R.S. 46:6 to specify all exemptions to the minimum fee including those which encourage preventative care.

Policy Must Be Amended to Receive Additional Revenue

The minimum fee will generate no additional revenue to the state medical centers unless the limit on the amount to be charged those patients eligible to pay the fee is amended. The Minimum Fee Act says:

> In addition to any schedule of fees or charges established . . . there shall be charged a minimum fee of three dollars and fifty cents per service unit . . .

Self pay patients, or those individuals who pay for their own care and whose incomes exceed 200 percent of federal poverty income guidelines, are not exempt from being charged the minimum fee. However, the Liability Limitation Policy, described previously, sets a maximum annual medical care liability for each family unit. The scale used in applying this policy can be found in Appendix C.

To effectively implement the Minimum Fee Act, the Authority would have to amend the Liability Limitation Policy to address handling the minimum fee in relation to liability limits. The Administrative Procedures Act gives specific guidelines for agencies to follow when amending any rule.

The policy currently limits the amount owed for medical treatment in the state's medical facilities by those whose income exceeds 200 percent of federal poverty income guidelines. For example, an uninsured family of four with an annual income of $26,000 would be liable annually for the first $200 of the cost of medical services rendered to members of that family unit. All other medical costs incurred by this family unit during the year would be free of charge. Therefore, the family of four would pay only $200 whether they incurred minimum fee charges or not. Thus, the medical centers will not receive any additional revenue unless the Authority amends the Liability Limitation Policy.

Recommendation Number 5

Prior to amending the Liability Limitation Policy, the Louisiana Health Care Authority should assess the impact of the minimum fee and this policy on each other in order to ensure receiving additional revenue from the fee.

Louisiana Health Care Authority's Response

Under the Authority's interpretation of the Act and its proposed Rules, the liability limitation policy has no bearing on who owes the minimum fee. Both those who fall into the free care and those who fall into the partial pay categories will be requested to pay the minimum fee at the time of service.

Unverifiable Data

The data used by the Authority to estimate revenue from the minimum fee could not be verified as accurate and, in some instances, was incomplete. We received several reports from the Authority which listed the number of patient visits to the clinics and emergency rooms. We compared the totals on these reports to determine if data used to develop the Authority's revenue estimates was valid. The total number of patient visits on the reports did not match.

The first report was generated by the Authority's billing system. This report grouped the number of clinic and emergency room visits into categories of who is responsible for payment of the patient's account, for example, Medicaid or the patient.

The other reports contained similar information. They included the number of patient visits to the clinics and emergency rooms. This data was compiled by the Authority from data received directly from the individual medical centers. Hospital staff manually compiled this data from daily logs.

When asked why the numbers did not match, the planning director at the Authority told us the **billing system was not reliable as a management information system**. He also said the manual numbers generated by the individual medical centers were frequently updated and constantly changed, but were more reliable than those generated by the billing system.

An official in charge of the billing system was aware there were problems with coding within the system. In our discussions, he said he had identified one problem where the system was counting ambulatory surgery as a "visit" when it should not, but he was sure other problems existed with the data. This official was in the process of reconciling this data during our audit.

Although Authority officials acknowledged that data from the billing system was not reliable, the Authority determined the percentage of visits by patient category from the billing system-generated reports. These percentages were then applied to the manual numbers received from the medical centers in order to estimate the number of patient visits in each category.

Also, we examined the data received from the individual medical centers and compiled by the Authority to reports for fiscal year 1991. We compared three reports prepared from the same source, the individual medical centers. One report was incomplete, because it contained only ten months of data from the Medical Center of Louisiana at New Orleans. Some individual

medical center totals matched to all three reports, while others did not.

Because this data could not be reconciled by the Authority or by us, we cannot determine how much revenue the minimum fee will generate. The Authority's billing system is not designed to capture data in such a manner as would make estimating the number of visits eligible to pay the minimum fee easy.

Recommendation Number 6

After expanding its definition of "service units," the Louisiana Health Care Authority should identify all services rendered to patients eligible to pay the minimum fee and base its revenue estimate on these services to comply with Act 893 of 1991.

Louisiana Health Care Authority's Response

Work is underway to improve Authority data bases. The particular utilization data system upon which the cost estimates for the minimum fee legislation rest does not have significant problems and is a sound base for planning estimates. The serious issues in estimating the costs and revenues for the minimum fee legislation involve factors for which it is not possible to obtain empirical evidence, in particular the number of individuals who will avail themselves of the provisions of the Act that involve waiver of the minimum fee for those "totally without funds".

Chapter Three: Estimate of Costs

Chapter Conclusions

The Authority's estimate of costs to implement the minimum fee are based on the presumption that the fee must be collected at the time of service. Because of this presumption, over 95 percent of the costs calculated by the Authority for implementing the minimum fee is due to hiring new staff. Also, the proposed rule developed by the Authority contains mathematical errors. If the minimum fee is programmed to be billed to patients eligible to pay it, the Authority would save personnel costs.

All Costs Based on Presumption of Collection at Time of Service

Based on the presumption that the Minimum Fee Act requires collection at the time of service, the Authority estimated costs to be $1,640,449 to collect the minimum fee during the first year. However, the act does not specify when the minimum fee should be collected.

Based on its presumption of collection at the time of service, the Authority has estimated that it will require a total of 98 new positions to collect and account for the minimum fee. In developing its proposed rule, the Authority used an average of ten minutes per contact (attempt) to collect the fee from those required to pay or privately advise those who could not pay in the clinics and emergency rooms. The Minimum Fee Act says:

> . . . such fee may be waived for a patient who is totally without funds . . . Each such patient shall be privately apprised of such special treatment . . .
>
> *LSA-R.S. 46:6(B)*

According to the Authority's proposed rule, the 681,844 estimated contacts with patients eligible to pay the minimum fee will require 113,641 staff hours with each staff person devoting 1,550 hours per year. Thus, the Authority calculated 73 staff will be required to collect the minimum fee.

The Authority goes on to say due to logistical problems involving the location of clinics and for accounting functions, an additional 16 collections positions and 9 accounting positions will be necessary, bringing the total new staff needed to 98.

Cost Estimates Contained Mathematical Errors

The Authority's calculation of total personnel costs contained mathematical errors. The Authority estimated the total personnel cost to be $1,560,449 for 89 Clerk 3 positions and 9 Accounting Specialist 2 positions. However, we could not verify its calculations. Our calculations in Exhibit IV below show that the total cost for these 98 positions would be $1,853,789.

Exhibit IV

Legislative Auditor's
Computation of Personnel Costs Identified by Louisiana Health Care Authority

Position	Annual Cost, Including Fringe Benefits (Mid-Range)	Number of Positions	Total Cost Calculated by Authority	Total Cost Calculated by OLA
Clerk 3	$18,391	89	Not given	$1,636,799
Accounting Specialist 2	$24,110	9	Not given	$216,990
Totals		98	$1,560,449	$1,853,789

Source: Louisiana Health Care Authority and OLA staff's calculations
Note: The Authority's proposed rule only gave an overall total; therefore, no sub-totals appear in this exhibit.

In addition to the $1,560,449 estimated for personnel, the Authority also estimated another $80,000 would be needed for equipment and operating expenses for total costs of $1,640,449.

Costs Could Not Be Verified

We were unable to verify the costs to collect the minimum fee at the time of service as estimated by the Authority. The

Authority developed this information from discussions with medical center administrators. No documentation of these discussions was available for our review.

Using the Billing System Would Avoid Additional Personnel Costs

If the $3.50 fee is treated as a service charge as the Minimum Fee Act requires, the Authority, with a programming change, could add the fee to each patient's bill who is eligible to pay the fee. Using this option, the Authority would incur no additional personnel costs, only the costs of the programming change.

Recommendation Number 7

The Louisiana Health Care Authority should implement the programming changes necessary, treating the minimum fee as a service charge as required by LSA-R.S. 46:6. Also, the Authority should revise the Fiscal and Economic Impact Statement to estimate the costs to be incurred by these programming changes.

Louisiana Health Care Authority's Response

This recommendation is based upon an interpretation of Act 893 with which the Authority does not agree. Should the Audit interpretation be determined to reflect legislative intent, the Authority would agree with this recommendation.

Appendixes

Appendix A

Louisiana Health Care Authority's Response

LHCA LOUISIANA HEALTH CARE AUTHORITY

March 4, 1993

Dr. Dan Kyle, CPA
Legislative Auditor
1600 N. Third
Baton Rouge, LA 70802

Dear Dr. Kyle:

Enclosed are LHCA comments on the Audit Report on the Minimum Fee Legislation. We appreciate the opportunity to respond to the study.

Please let me know if you need additional information from the Authority.

Sincerely,

Charles F. Castille
Chief Operating Officer

cc William B. Mohon
Don Elbourne
Shirley Smith
Jack Edwards

P.O. Box 3947 • Baton Rouge, LA 70821 • (504) 342-4110 • FAX # (504) 342-4873

LHCA Response to the Minimum Fee Audit Study

The Office of the Legislative Auditor has conducted a legal analysis of Act 893 of 1991 and assessed proposed LHCA Rules prior to oversight review by the Legislature. The Audit analysis leads to two principal points in response:

- **Key language of Act 893 is so unclear and prone to conflicting interpretation that implementation probably should not proceed further until the Act's meaning is clarified by the Attorney General and/or the legislature.**

- **The draft LHCA Rules to implement the Act are based upon an understanding of legislative intent that was developed by listening to the debates and discussing the legislation and its implementation with key legislators. We remain confident that the interpretation of the Act reflected in the draft LHCA Rules is correct and consistent with the intent of the legislature. We acknowledge that the construction of Act 893 can lead to other interpretations and that the law is exceedingly ambiguous.**

While the Authority has proceeded with plans to implement Act 893, it agrees that whether implementation is "feasible" is a valid matter for the scrutiny of the Legislative Auditor. Unfortunately, because there are conflicting interpretations of the Act, a clear-cut answer to this question was not developed in the Report.

Principal Provisions of Act 893

The relevant provisions of Act 893 are contained in two sections of the law:

A. "Those persons who are determined ***not*** to be medically indigent or medically needy shall be charged a ***minimum fee*** of three dollars and fifty cents for any treatment or service; and further shall be charged on a sliding scale according to the financial status of the patient and the size of the family for which the person is responsible (emphasis added)."

B. "In addition to any schedule of fees or charges . . . , there shall be charged a ***minimum fee*** of three dollars and fifty cents ***per service unit to every patient*** . . . , except that such fee may be ***waived for a patient who is totally without funds*** or if the imposition of such fee would ***violate federal law or regulations*** relative to Medicaid or Medicare . . . .[If a waiver is given]

such patient shall be ***privately apprised*** of such special treatment . . . (emphasis added)."

The meaning of these two sections has been a major source of confusion about the Act. Since **Section B** is inclusive and imposes the minimum fee on "every patient" (with the exceptions specified), what is the meaning of **Section A**, which appears to impose the fee on the non-indigent? Is it merely redundant, or does it have some other meaning? From the unclear and confusing construction of the statute, the Office of the Legislative Auditor has interpreted **Section A** as **exempting** the indigent, since the section applies the charge only to the non-indigent. While we feel that the central meaning of the Act is reflected in **Section B**, it is not difficult to see why a case can be made for Audit position.

Interpretation of Act 893

There are several significant areas in which the Act requires interpretation: *Who should pay? For what do they pay? When do they pay? What is the nature of the payment?*

Audit Implementation Scenario

Based upon its interpretation of the Act, the Office of Legislative Auditor recommends that it be implemented as follows:

- The medically indigent (currently, those below 200 percent of poverty) and the Medicaid eligible ***are exempt.***
- Those who have conventional insurance or who have incomes over 200 percent of poverty ***are subject to the minimum fee.***
- A ***"service charge" of $3.50 should be added to the bills*** of those who have insurance or who have incomes over 200 percent of poverty.

Thus, under this interpretation, $3.50 would be added to the bills of those already billed, and those who pay nothing would continue to pay nothing.

Under this interpretation, important questions are raised with several other provisions of the bill. What should be the operational meaning of *"totally without funds"*, since only the insured and those above 200 percent of poverty would be charged. There would appear to be no patient who could owe the fee but be "totally without funds". Similarly, it becomes difficult to interpret the requirement to *"privately advise"* a patient of the fee waiver if the $3.50 charge is added to their bills. The phrase "minimum fee", contained in the Act, is not consistent with the concept of a new charge that is added to a bill that is already owed. If a patient owes a bill of, say, $200, an increase to $203.50 would not seem to represent the imposition of a "minimum" fee.

LHCA Proposed Rule

The Authority has interpreted Act 893 as an attempt by the legislature to assure that all patients pay something for services rendered, even when they are otherwise exempt from payment under the sliding scale/liability limitation policy. This was proposed both as a matter of principle and with the expectation that there would be some deterrent effect that would reduce a perceived (but empirically nonexistent) overutilization of services in emergency rooms and clinics.

Consistent with this interpretation, the Authority has prepared proposed rules which:

- Apply the $3.50 minimum charge to ***all*** outpatient visits, with certain specified exceptions (see below) which must be subjected to legislative scrutiny under the Administrative Procedures Act oversight process.

- Provide for collection of the minimum fee at the time of service.

- Conceive of the minimum fee as a payment on account rather than as a new charge for some hypothetical service.

The Authority Rule provides that, when those who have arrived for service assert that, *at the time,* they are "totally without funds" to pay for those services, Medical Center personnel will "privately apprise" them that the minimum charge is waived. The patient will continue to owe whatever amount that his or her position on the sliding scale indicates, and will be billed accordingly.

Exceptions Under LHCA Proposed Rule

Act 893 specifically charged the Authority to engage in rulemaking to implement the legislation. No definitions of key terms were included in the statute, leaving the Authority to operationally define (subject to oversight) all of the following: "medically indigent", "medically needy", "service unit", "totally without funds", and "privately advise". In exercising this considerable latitude, the Authority also invoked rulemaking discretion to propose for legislative review the following exemptions to the minimum fee provisions:

- **Medicaid and Medicaid eligible patients**

  These categories cannot be charged under federal regulations. The Audit Report correctly analyzed the Medicaid requirements that necessitate this exemption, which were also anticipated explicitly in Act 893.

- **Persons making obstetric or pediatric visits**

  Under federal Medicaid-SOBRA rules, almost all mothers and children in our hospitals fall into an income range (up to 133 percent of poverty) in which they are potentially Medicaid eligible. Special efforts are made to complete the eligibility determination process for these individuals. If a person were to pay the fee and were later determined Medicaid eligible retroactive to the date of the clinic visit, we would be obligated under federal rules to refund the payment. To comply with this requirement would require a special tracking and monitoring system. Accordingly, the application of the minimum fee to this category of patients would result in significant new costs and virtually no revenue.

- **Persons judged by medical personnel to be in an emergent condition.**

  A relatively small percentage of patients in any emergency room are true emergencies. Studies have shown that from 6-10 percent of the LHCA Medical Center ER patients are so classified through a triage process. In such cases, it is both impractical and inhumane to attempt to extract a $3.50 payment on account at the time of service. These patients most often are trauma and heart attack victims. Overutilization of services is not an issue in such cases. Even though not exempt under Act 893, the draft LHCA Rule proposes to exempt these patients under the discretion implicit in its rulemaking authority, and subject to legislative oversight. Such patients would still be billed according to the sliding scale.

- **Persons with conventional insurance**

  Persons who pay insurance premiums already pay for health care far in excess of the $3.50 minimum. They are considered to be in compliance with the minimum payment already, since their insurance carriers will reimburse the Medical Centers for roughly their cost of care.

- **Persons making their second or subsequent visit during the same day**

  Since the intent of the legislation is to achieve a deterrent effect by making everyone pay something for care, this objective presumably is accomplished if the minimum payment is made. If a patient is referred on to a second clinic in the same day, then no additional deterrent effect is achieved by subsequent charges. Patients in such cases will be billed according to their position on the sliding scale.

- **Persons receiving services in a clinic not staffed by a physician**

  Such clinics are generally run by nurses for preventative or educational purposes. We generally try to encourage attendance as a means of helping the patient avoid costly complications. An example might be nutritional counseling or blood pressure monitoring. Subject to legislative review, the Authority proposes that these non-physician visits not be considered a "unit of service" under the Act.

Remaining Issues

There remain important but unanswered questions about the minimum fee legislation that will be of concern to the legislature during oversight and in the longer term.

- **Is implementation of the "minimum fee" feasible? Will collection of the minimum fee in a manner consistent with the intent of Act 893 generate more revenue than it costs?**

  The "minimum fee" could be implemented regardless of cost, of course. But the best information indicates that it will not be cost effective. Driven almost entirely by personnel requirements, costs are expected to exceed revenues by a considerable amount in each of the first three years.

  Costs. The cost estimates, detailed in the Fiscal and Economic Impact Statement accompanying the draft Rules, reflect the added time required for a very large number of patient encounters on a matter that is not presently necessary.

  First, it is estimated that there will be nearly **700,000 clinic visits** by persons who are **not exempt** under the provisions of the proposed rule (aside from being "totally without funds" at the time of service). This represents a very large volume of new or additional patient contacts during which the fee must be explained and paid, a receipt issued, and instructions given; **or** during which the person must be "privately advised" that the fee is being waived, if they have made a claim to be "totally without funds". The time required for such a process for 700,000 individuals will require a substantial number of new positions. In the current structure of clinics there simply are not any significant number of staff available to whom the collections/counseling function can become added duties. In fact, there already are insufficient personnel in these clinics for the existing patient volume.

Second, the Audit Report has raised the serious additional concern that minimum fee implementation will reduce the disproportionate share reimbursement rate, diminishing by around one-third the net revenues from the minimum fee. The Authority had not understood that this would be the case when the draft Rules were prepared. The Authority agrees with the Audit Report that this is a factor which it should explore more fully.

Revenues. Although since the minimum fee has not been previously charged and there is no hard empirical evidence available, it is estimated that revenues will be greatly diminished over the potential maximum by the provision allowing those "totally without funds" to claim waiver from payment.

- **Will imposition of a minimum fee charged at the time of service deter overutilization of services and thus reduce costs?**

It may deter utilization, but there is no reason to believe that it will deter ***overutilization.*** One of the most widespread and pernicious misunderstandings of the LHCA Medical Center operations is that there is a pattern of overutilization. This misperception is based on anecdotal evidence frequently repeated, and on a misunderstanding of the dynamics of patient flow.

First, no one closely familiar with Medical Center operations believes that well people come to our waiting rooms simply to "hang out" or to seek care when they are feeling fine. Frequently, the ***families and friends of patients who have no transportation*** will bring them to the hospital and wait for them while they are there. Sometimes children will be brought when there is no one to care for them at home. The fact that there are well people in the building does not indicate overutilization of services, but it does generate misleading anecdotes.

Second, empirical evidence on this point has recently been developed. A recent Legislative Audit of LHCA Emergency Rooms drew a random sample of ER patient records and calculated the percentages of diagnoses that were for emergent, urgent and routine care. The auditors who conducted this analysis were asked in the exit conference with Authority personnel whether there were any cases in the sample whose diagnosis indicated that they did not in fact require medical treatment. The answer was **"no"**. When asked if any patients in the sample, had they been deterred from obtaining that care, would have been denied treatment that their medical diagnosis indicated that in fact they needed, the answer was **"yes".**

Third, the lower income population that uses the LHCA Medical Centers frequently **underutilizes** health care services to the detriment of their long term health. For example, the lack of sufficient prenatal care by mothers in out hospitals has been the cause of premature and low birthweight babies and of more

serious problems with newborns. ***Underutilization of services*** undoubtedly is a major factor **that increases costs** that are associated with more serious medical conditions.

Conclusion

Staff of DHH and the Authority held several conversations with the principal authors of the Minimum Fee legislation and extensively monitored legislative deliberations both in 1991 when it originally passed, and in 1992 when an attempt to repeal certain provisions was extensively debated on both the House and Senate floors. The general approach reflected in the draft Rule to implement the Act was based in large part on the understanding of legislative intent that this close observation provided. However, we fully agree with the Legislative Audit Report that the actual language of the Act itself is exceptionally vague, apparently contradictory and often misleading. It is possible that new legislation is need to clarify the statutes before implementation should proceed further.

Appendix B

Letter From Health Care Financing Administration

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

6325 Security Boulevard
Baltimore, MD 21207

22 Feb

Sharon B. Johnson
Auditor-In-Charge
Office of Legislative Auditor
State of Louisiana
Baton Rouge, Louisiana 70804-9397

Dear Ms. Johnson:

I am responding to your questions concerning co-payments and the application of recent legislation enacted in Louisiana. Your questions and my responses are as follows:

QUESTION

Since the code of Federal regulations gives the Medicaid agency authority to levy co-payments, can the State legislature authorize another State agency to collect the minimum fee from Medicaid recipients?

RESPONSE

Yes. Federal law and regulations do not preclude the Louisiana Health Care Authority, which operates the State's charity hospitals, from collecting any deductible, coinsurance, or co-payment required by the State Medicaid plan to be paid by the individual. However, only the State Medicaid plan can authorize a copayment requirement for Medicaid recipients. Any copayment imposed on a Medicaid recipient under the State plan must be deducted from the State's claim for medical assistance.

QUESTION

Can this fee be charged to Medicaid recipients?

RESPONSE

It appears it can be charged for institutional services. For outpatient services, it cannot be charged. For institutional services, the regulations at 42 CFR 447.54 require the maximum copayment for each admission may not exceed 50 percent of the payment the State agency makes for the first day of care in the institution. This applies

only to inpatient services and not outpatient hospital services (even though provided by an institutional provider). A $3.50 copayment would probably be acceptable under these circumstances.

Copayments for outpatient services would be subject to the regulations at 42 CFR 447.53 which allow the State to impose a nominal deductible, coinsurance, co-payment, or similar charge upon categorically and medically needy individuals. Federal regulations at 42 CFR 447.54 specify the maximum co-payment chargeable to a recipient be based on the State's payment for the service. Any co-payments the State plan imposes cannot exceed the amounts specified in the regulations. (42 CFR 447.54(a)(3)) The maximum co-payment that can be charged under the regulations is $3.00, except that a waiver may be obtained from HCFA under certain circumstances to charge higher amounts for services received at a hospital emergency room as explained below. The $3.50 co-payment enacted by the Louisiana legislature "in addition to any established fees or charges" exceeds the nominal co-payment permitted by Federal regulations for outpatient services and cannot be charged to Medicaid recipients for these services.

QUESTION

What sanctions could the State suffer from your agency as a result of charging this fee to Medicaid recipients?

RESPONSE

If the State charges a co-payment that exceeds the maximum amount allowed, then the State would be out of compliance with its State plan. Under Section 1916 of the Social Security Act, HCFA could invoke compliance remedies under section 1904 of the Act to terminate federal funding of the State plan, or to limit federal funding to part of the State plan not affected by the State's failure to comply. Additionally, a State charity hospital that charges the recipient more than the amount permitted under the State plan is violating the requirements under 42 CFR 447.15, which the State must enforce. A State charity hospital which sought to collect excess recipient charges would not be able to participate as a Medicaid provider and could lose its provider agreement. Furthermore, a hospital which did participate, but continued to impose excess recipient charges as a condition of admission or continued stay, might be liable for criminal penalties under section 1128B(d) of the Act.

QUESTION

Can the minimum fee be limited to Charity hospitals and not other providers of indigent care? If it is limited to the Charity hospitals and not charged by other Medicaid providers, would the State suffer any sanctions from your agency?

RESPONSE

Yes, the fee can be limited to Charity hospitals as long as the State can demonstrate that the copayments do not affect the freedom of choice of Medicaid recipients, and all recipients have sufficient and equal access to Medicaid providers who do not charge the copayment. Access to providers who do not charge the copayment is necessary in order to comply with the requirements of Section 1902(a)(10)(B) of the Social Security Act. This provision requires that the services for all categorically needy recipients and all recipients within a covered medically needy group be equal in amount, scope, and duration.

QUESTION

Is there a way that those excluded from co-payment under the Federal regulations can be charged the minimum fee?

RESPONSE

No. Section 1916 of the Social Security Act and implementing regulations at 42 CFR 447.53 are very specific about those individuals who are exempt from co-payments.

QUESTION

Can the minimum fee be a flat fee or must it be on a sliding scale as listed in the Federal regulations?

RESPONSE

The Federal regulations at 42 CFR 447.55 allow the State plan to provide for a standard, or fixed co-payment amount for any service. For non-institutional services, the standard co-payment amount may be determined by applying the maximum co-payment amounts specified in 42 CFR 447.54(a) and (b) to the agency's average or typical payment for that service. However, the $3.00 maximum may not be exceeded.

QUESTION

What must the State do in order to obtain the necessary waiver to assess co-payment in excess of those in Federal guidelines?

RESPONSE

The requirement that cost sharing charges must be nominal may be waived only with respect to nonemergency services furnished in a hospital emergency room as specified in section 1916(a)(3) and (b)(3) of the Act and implementing Federal regulations at 42 CFR 431.55(g). Under this requirement, the Secretary may by waiver permit a State to impose a co-payment of up to double the "nominal" co-payment amounts as specified in 42 CFR 447.54(a)(3). The State, however, must establish to HCFA's satisfaction that alternative sources of nonemergency, outpatient services are available and accessible to recipients.

I hope that you find this information helpful.

R. Abato

Rozann Abato
Acting Director
Medicaid Bureau

Appendix C

Liability Limitation Schedule

Appendix C: Liability Limitation Schedule

RULE

Department of Health and Hospitals
Office of the Secretary

The Department of Health and Hospitals, Office of the Secretary, is adopting, effective January 1, 1992, the following rule to be contained in LAC 48:1.Chapter 21. This replaces the existing Chapter 21.

Title 48
PUBLIC HEALTH--GENERAL
Part 1. General Administration
Subpart 1. General

Chapter 21. Liability Limitation Schedule for DHH Provided Services

§2101. Statement of Purpose, Scope and Eligibility

A. The Department of Health and Hospitals' (DHH) Liability Limitation Schedule will standardize the method by which DHH will limit the annual amount which the client/patient is responsible to pay by using the Federal Poverty Income Guidelines as a basis for determining what portion, if any, of a patient's/client's charges will be billed.

B. Any bona-fide resident of the state of Louisiana shall be eligible for services or treatment by any facility owned and operated by the DHH. Those persons who are determined not to be indigent shall be billed in accordance with this policy for any treatment or services received. However, in no event shall emergency treatment be denied to anyone. Persons seeking treatment shall furnish all information requested by the facility or program office providing the service. Eligibility established in one office may be used for service/treatment in any facility or program throughout the DHH.

C. The DHH Liability Limitation Schedule will apply to all offices of DHH exclusive of the Office of Public Health, which provide services for which there is a charge to the patient/recipient/client except as expressly prohibited by federal or state statutes, rules or regulations.

D. This policy will apply, but not be limited to the following DHH programs and services.

1. Inpatient and outpatient services provided by state general hospitals.

2. Inpatient and outpatient services provided by the Office of Human Services.

3. Residential facilities and out-of-home care (See definition below).

E. Nothing in this policy is intended to be in conflict with federal or state law, rule or policy pertaining to the provision of services to the indigent.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:259.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, LR 15:92 (February 1989); repealed and repromulgated LR 17: (December 1991).

§2103. Definitions

The following definitions shall apply to the DHH Liability Limitation Schedule for patient billing:

A. *Indigent* - as used herein means any client, patient, or recipient whose family unit size and gross income is equal to or less than 200 percent of the Federal Poverty Income Guidelines for that size family unit rounded up to the nearest thousand dollars.

B. *Gross Income* - as used herein means income as determined under Federal Title XIX (Medicaid) guidelines. Gross income as determined shall be rounded down to the nearest thousand dollars when applied to the DHH Liability Limitation Schedule.

C. *Dependent* - as used herein means all persons dependent on the household income as accepted by the Internal Revenue Service (IRS) for federal income tax purposes. In case of a minor not claimed as a dependent or income tax purposes, the parents are still responsible for payment based on the Liability Limitation Schedule but may increase the dependent deductions by the client(s) in question. (See Appendix A for IRS definition).

D. *Family* - for purpose of establishing liability limitations under this policy, the basic family unit is defined as consisting of one or more adults and children, if any, related by blood, marriage, adoption, or residence in the same household.

E. *Responsible Persons* - as used herein means the client's parents or guardians if the client is under the age of 18, unless someone else claims the client as a dependent, in which case it is that person. If the client is over 18, the client is responsible for his/her contribution based on his/her gross family income and allowed deductions, unless claimed as a dependent, in which case the claimant becomes responsible for the fee toward the cost of care based on the claimant's family income.

F. *DHH Residential Facilities and Out-of-Home Placements* - state mental hospitals and schools for the mentally retarded or developmentally disabled, inpatient treatment facilities, and out-of-home placement programs operated or partially funded by the Office of Human Services.

G. *Third-Party Payor* - as used herein shall mean any party other than the service recipient and/or family unit and the state who is or may be legally liable for payment of incurred expenses.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:259.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, LR 15:92 (February 1989); repealed and repromulgated LR 17: (December 1991).

§2105. Regulations

A. Billing for services rendered shall be made to the client/recipient/patient or responsible party in accordance with this policy.

B. A person responsible for the payment of charges for services rendered who refuses or fails to supply the information necessary for an accurate determination of the liability limitation on services rendered shall be presumed to pay the full charge for services rendered and shall be billed accordingly. Any person who is potentially eligible for medical assistance benefits from any federal or state program who refuses to provide evidence of application for said benefits shall be presumed to be able to pay the full charge for services rendered and shall be billed accordingly, or in the case of voluntary, nonemergent services, may be refused DHH assistance, dependent upon individual program policies.

C. Eligibility will be good for one year. Periodic checks may be made with the responsible person to make charge adjustments as necessary. The responsible person shall be advised of his responsibility to report any change in the family unit income, employment, composition, etc.

D. If the responsible person refuses to assign insurance benefits to the treating facility to cover the charges for services/treatment received, the responsible person will be presumed to be able to pay full charges for services/treatment and shall be billed accordingly.

E. Wherever applicable, billing for services rendered shall be sent monthly to the client or responsible person in accordance with the Liability Limitation Schedule. When a recipient/client becomes delinquent in his account, the delinquency shall be handled in accordance with DHH Policy #4300-76, regarding collection procedures for patient bills.

F. All insurance companies or any other third party payor which the responsible person claims has issued a policy or contract covering the charges for treatment/ services, or who is otherwise legally responsible for payment, shall be liable and billed the full charge for services rendered. Billings shall be made directly to the insurer or other third-party payor by the treating facility after securing execution of the necessary forms (including an assignment of benefits to the treating facility) by the respon- sible person. The responsible person shall be liable for the amount of charges not covered and/or paid by insurance or other third-party payor up to the amount that the responsible person would have been obligated if no third-party had been involved. In the case where Medicare is the third-party payor, charges cannot exceed the amount of coinsurance or deductible allowed by Medicare.

G. The following procedure applies to those hospitals without designated counsel for liability intervention appointed by the attorney general under R.S., Title 46. For liability cases only, upon receipt of a letter from an attorney or an insurance company or other third-party payor requesting a patient's records, the attorney or company shall be sent, within 30 days from receipt, a bill for full charges applicable to that patient. At the same time as the mailing of that bill, a copy of that patient's file pertaining to charges for treatment/services and their collection, as well as a copy of the requesting letter, shall be forwarded to the Division of Fiscal Management. Patient's records are not to be released until a properly executed consent by the patient, parent or guardian (as applicable) is received and the fee for copies of records is paid in advance, except to any office of the DHH for the purpose of facilitating the meeting of its responsibilities.

H. Whenever a service is requested, in addition to an eligibility card, one of the following shall be checked to verify identity:

1. Medicaid card;
2. a valid driver's license;
3. voter's registration card;
4. a recent utility bill;
5. birth certificate;
6. picture identification;

I. The secretary of DHH or his designee will be authorized to approve exceptions to the Liability Limitation Schedule Policy.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:259.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, LR 15:92 (February 1989); repealed and repromulgated LR 17: (December 1991).

§2107. Liability Limitation Schedule

A. Each office shall develop internal management procedures for billing. A copy of these procedures shall be housed in the Office of Management and Finance, Division of Policy and Program Development.

B. Family income shall be determined in accordance with Federal Title XIX (Medicaid) guidelines.

C. Any individual or family unit who is "indigent" as defined herewith shall be eligible for treatment/services in any state facility or through program offices at no cost to the family unit.

D. Any family unit whose gross income exceeds 200 percent of the Federal Poverty Income Guidelines for that family unit rounded up to the nearest thousand dollars shall be liable for treatment/ service in accordance with the DHH Liability Limitation Schedule.

E. The DHH Liability Limitation schedule is used as follows:

1. The Federal Poverty Guidelines are multiplied times 200 percent and rounded UP to the nearest thousand dollars.

2. The family unit income rounded DOWN to the nearest thousand dollars is compared to the scale.

3. For each $1,000 over the Federal Poverty Income Guidelines for the appropriate family unit, the responsible person is liable for $200 of the total cost of services provided.

F. The secretary of DHH shall have the authority to adjust the Liability Limitation Schedule to the same extent that changes in the Federal Poverty Income Guidelines are published annually in the *Federal Register*.

G. When documented medical bills, incurred within the 12 months prior to treatment/service equals to or exceeds 20 percent of the annual gross family unit income, treatment/services shall be provided at no cost to the family unit. The period of eligibility begins at the date at which liability reached the 20 percent figure through the end of calendar year. Such patients with third-party payors or potential third-party payors shall be provided no cost medical services or only that portion of their bill for which no third-party payor is or may be liable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:259.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, LR 15:92 (February 1989); repealed and repromulgated LR 17: (December 1991).

§2109. Regulations for Services and Facilities Other Than State General Hospitals

A. Long-term Inpatient Clients Receiving Social Security

1. Facilities treating patients who receive Social Security funds shall arrange to have those funds, less a personal needs allowance, paid directly to the treating facility.

2. Upon receipt of the Social Security payment, the treating facility shall apply those payments to the bill. The excess of those Social Security payments over the charges for treatment shall be deposited into an account maintained by the facility/program on behalf of the patient/client. Upon discharge of the patient/client or upon his demand, the balance of funds remaining in that account shall be paid to the patient/client or the responsible person as provided by law.

3. If payment of Social Security funds directly to the treating facility/program is not made, billing shall be in accordance with this policy.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:259.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, LR 15:92 (February 1989); repealed and repromulgated LR 17: (December 1991).

J. Christopher Pilley
Secretary

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DEPARTMENT OF HEALTH AND HOSPITALS

ANNUAL LIABILITY LIMITS FOR SERVICES PROVIDED

	FAMILY SIZE														
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
INCOME															
0 – 13,00	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
14,000	200	0	0	0	0	0	0	0	0	0	0	0	0	0	0
15,000	400	0	0	0	0	0	0	0	0	0	0	0	0	0	0
16,000	600	0	0	0	0	0	0	0	0	0	0	0	0	0	0
17,000	800	0	0	0	0	0	0	0	0	0	0	0	0	0	0
18,000	1,000	200	0	0	0	0	0	0	0	0	0	0	0	0	0
19,000	1,200	400	0	0	0	0	0	0	0	0	0	0	0	0	0
20,000	1,400	600	0	0	0	0	0	0	0	0	0	0	0	0	0
21,000	1,600	800	0	0	0	0	0	0	0	0	0	0	0	0	0
22,000	1,800	1,000	200	0	0	0	0	0	0	0	0	0	0	0	0
23,000	2,000	1,200	400	0	0	0	0	0	0	0	0	0	0	0	0
24,000	2,200	1,400	600	0	0	0	0	0	0	0	0	0	0	0	0
25,000	2,400	1,600	800	0	0	0	0	0	0	0	0	0	0	0	0
26,000	2,600	1,800	1,000	200	0	0	0	0	0	0	0	0	0	0	0
27,000	2,800	2,000	1,200	400	0	0	0	0	0	0	0	0	0	0	0
28,000	3,000	2,200	1,400	600	0	0	0	0	0	0	0	0	0	0	0
29,000	3,200	2,400	1,600	800	0	0	0	0	0	0	0	0	0	0	0
30,000	3,400	2,600	1,800	1,000	200	0	0	0	0	0	0	0	0	0	0
31,000	3,600	2,800	2,000	1,200	400	0	0	0	0	0	0	0	0	0	0
32,000	3,800	3,000	2,200	1,400	600	0	0	0	0	0	0	0	0	0	0
33,000	4,000	3,200	2,400	1,600	800	0	0	0	0	0	0	0	0	0	0
34,000	4,200	3,400	2,600	1,800	1,000	200	0	0	0	0	0	0	0	0	0
35,000	4,400	3,600	2,800	2,000	1,200	400	0	0	0	0	0	0	0	0	0
36,000	4,600	3,800	3,000	2,200	1,400	600	0	0	0	0	0	0	0	0	0
37,000	4,800	4,000	3,200	2,400	1,600	800	0	0	0	0	0	0	0	0	0
38,000	5,000	4,200	3,400	2,600	1,800	1,000	0	0	0	0	0	0	0	0	0
39,000	5,200	4,400	3,600	2,800	2,000	1,200	200	0	0	0	0	0	0	0	0
40,000	5,400	4,600	3,800	3,000	2,200	1,400	400	0	0	0	0	0	0	0	0
41,000	5,600	4,800	4,000	3,200	2,400	1,600	600	0	0	0	0	0	0	0	0
42,000	5,800	5,000	4,200	3,400	2,600	1,800	800	0	0	0	0	0	0	0	0
43,000	6,000	5,200	4,400	3,600	2,800	2,000	1,000	200	0	0	0	0	0	0	0
44,000	6,200	5,400	4,600	3,800	3,000	2,200	1,200	400	0	0	0	0	0	0	0
45,000	6,400	5,600	4,800	4,000	3,200	2,400	1,400	600	0	0	0	0	0	0	0
46,000	6,600	5,800	5,000	4,200	3,400	2,600	1,600	800	0	0	0	0	0	0	0
47,000	6,800	6,000	5,200	4,400	3,600	2,800	1,800	1,000	200	0	0	0	0	0	0
48,000	7,000	6,200	5,400	4,600	3,800	3,000	2,000	1,200	400	0	0	0	0	0	0
49,000	7,200	6,400	5,600	4,800	4,000	3,200	2,200	1,400	600	0	0	0	0	0	0
50,000	7,400	6,600	5,800	5,000	4,200	3,400	2,400	1,600	800	0	0	0	0	0	0
51,000	7,600	6,800	6,000	5,200	4,400	3,600	2,600	1,800	1,000	0	0	0	0	0	0
52,000	7,800	7,000	6,200	5,400	4,600	3,800	2,800	2,000	1,200	200	0	0	0	0	0
53,000	8,000	7,200	6,400	5,600	4,800	4,000	3,000	2,200	1,400	400	0	0	0	0	0
54,000	8,200	7,400	6,600	5,800	5,000	4,200	3,200	2,400	1,600	800	0	0	0	0	0
55,000	8,400	7,600	6,800	6,000	5,200	4,400	3,400	2,600	1,800	800	0	0	0	0	0
56,000	8,600	7,800	7,000	6,200	5,400	4,600	3,600	2,800	2,000	1,000	200	0	0	0	0
57,000	8,800	8,000	7,200	6,400	5,600	4,800	3,800	3,000	2,200	1,200	400	0	0	0	0
58,000	9,000	8,200	7,400	6,600	5,800	5,000	4,000	3,200	2,400	1,400	600	0	0	0	0
59,000	9,200	8,400	7,600	6,800	6,000	5,200	4,200	3,400	2,600	1,600	800	0	0	0	0
60,000	9,400	8,600	7,800	7,000	6,200	5,400	4,400	3,600	2,800	1,800	1,000	200	0	0	0
61,000	9,600	8,800	8,000	7,200	6,400	5,600	4,600	3,800	3,000	2,000	1,200	400	0	0	0
62,000	9,800	9,000	8,200	7,400	6,600	5,800	4,800	4,000	3,200	2,200	1,400	600	0	0	0
63,000	10,000	9,200	8,400	7,600	6,800	6,000	5,000	4,200	3,400	2,400	1,600	800	0	0	0
64,000	10,200	9,400	8,600	7,800	7,000	6,200	5,200	4,400	3,600	2,600	1,800	1,000	200	0	0
65,000	10,400	9,600	8,800	8,000	7,200	6,400	5,400	4,600	3,800	2,800	2,000	1,200	400	0	0
66,000	10,600	9,800	9,000	8,200	7,400	6,600	5,600	4,800	4,000	3,000	2,200	1,400	600	0	0
67,000	10,800	10,000	9,200	8,400	7,600	6,800	5,800	5,000	4,200	3,200	2,400	1,600	800	0	0
68,000	11,000	10,200	9,400	8,600	7,800	7,000	6,000	5,200	4,400	3,400	2,600	1,800	1,000	200	0
69,000	11,200	10,400	9,600	8,800	8,000	7,200	6,200	5,400	4,600	3,600	2,800	2,000	1,200	400	0
70,000	11,400	10,600	9,800	9,000	8,200	7,400	6,400	5,600	4,800	3,800	3,000	2,200	1,400	600	0
71,000	11,600	10,800	10,000	9,200	8,400	7,600	6,600	5,800	5,000	4,000	3,200	2,400	1,600	800	0
72,000	11,800	11,000	10,200	9,400	8,600	7,800	6,800	6,000	5,200	4,200	3,400	2,600	1,800	1,000	200
73,000	12,000	11,200	10,400	9,600	8,800	8,000	7,000	6,200	5,400	4,400	3,600	2,800	2,000	1,200	400
74,000	12,200	11,400	10,600	9,800	9,000	8,200	7,200	6,400	5,600	4,600	3,800	3,000	2,200	1,400	600
75,000	12,400	11,600	10,800	10,000	9,200	8,400	7,400	6,600	5,800	4,800	4,000	3,200	2,400	1,600	800