PERFORMANCE AUDIT REPORT

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

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

07PA26

Legislative Post Audit Committee
Legislative Division of Post Audit

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October 23, 2007

To: Members, Legislative Post Audit Committee

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This report contains the findings, conclusions, and recommendations from our completed performance audit, *KU Medical Center and KU Hospital: Reviewing Selected Operational Issues.* The report also contains appendices providing information about State and tuition expenditures on education, research and other, Attorney General Opinion No. 2007-13, and information on hospital board membership and representation.

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

We would be happy to discuss the findings presented in this report or any other items with any legislative committees, individual legislators, or other State officials. These findings are supported by a wealth of data, which may allow us to answer additional questions about the audit findings or to further clarify the issues raised in the report.

Barbara J. Hinton
Legislative Post Auditor

READER'S GUIDE

Get the Big Picture

Read these Sections and Features:

1. **Executive Summary** - an overview of the questions we asked and the answers we found.

2. **Conclusion** and **Recommendations -** are referenced in the Executive Summary and appear in a box after each question in the report.

3. **Agency Response** - also referenced in the Executive Summary and is the last Appendix.

Helpful Tools for Getting to the Detail

- In most cases, an "**At a Glance**" description of the agency or department appears within the first few pages of the main report.
- **Side Headings** point out key issues and findings.
- **Charts/Tables** may be found throughout the report, and help provide a picture of what we found.
- **Narrative text boxes** can highlight interesting information, or provide detailed examples of problems we found.
- **Appendices** may include additional supporting documentation, along with the audit **Scope Statement** and **Agency Response(s)**.

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EXECUTIVE SUMMARY

LEGISLATIVE DIVISION OF POST AUDIT

Overview of the KU Hospital and KU Medical Center

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

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

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

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

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

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

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

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

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

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

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

Spending per FTE on the Kansas City campus is higher than in Wichita. *Wichita went from spending $3,500 more per FTE than Kansas City in 2001, to $13,000 less per FTE in 2007. Wichita's spending per FTE from State operating grant moneys dropped by about 12% over this time frame, while Kansas City's spending per FTE remained about the same. Officials from both campuses cited several reasons for the disparities between the two campuses, including Kansas City having a different mix of students, and Kansas City having most of the administrative structure and support for the Medical Center as a whole.* ..... page 18

Differences in spending for research and education in Kansas City and Wichita have raised concerns in Wichita. *Wichita officials told us they were happy with the level of State support they'd received in the past for undergraduate medical education, but they want to expand the campus' clinical research program to help overcome accreditations citations Wichita has received related to research and scholarly activity.* ..... page 19

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

Question 1 Conclusion ..... page 21

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

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

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

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

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

For five states we reviewed and Kansas, we also noted that the chair of the hospital board typically is elected by board members, that officials affiliated with the medical school / university system were designated by statute or agreement to be board members in five of the six states (their representation on the board varied from 57% in Virginia to none in Nebraska), that officials affiliated with the teaching hospital were designated to be board members in only two states (Kansas and

Minnesota), and that other board members were appointed by a variety of individuals or entities. Medical Center and Hospital officials have differing opinions about trends in organizational structures among academic teaching hospitals and medical centers.

The Medical Center's and Hospital's <u>financial</u> relationship isn't defined in State law, and has been a source of contention between them. *Although the law says the mission of the Hospital is to "facilitate and support the education, research, and public service activities" of the Medical Center, neither the law nor the affiliation agreements between the Hospital and Medical Center specify what types of payments "count" as the Hospital's support of the Medical Center, or how much that overall support should be.* ..... page 28

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

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

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

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

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

Comparisons with other state medical centers have significant limitations, but the support the Medical Center has received from <u>all</u> its affiliated hospitals does appear to be relatively low. *Many factors contribute to differences between the amount one medical center receives as support verses another medical center. These can include the size and profitability of the teaching hospital, the amount of other funding sources such as State appropriations, and the amount of Medicare resident support.* ..... page 32

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

Question 2 Conclusion ..... page 35

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

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The value of the care provided to medically indigent patients may be recorded as either charity care or bad debt. *One of the Hospital's missions is to "continue the historic tradition of care...to medically indigent citizens of Kansas." For accounting purposes, the value of care provided to medically indigent can be recorded as either charity care or bad debt. Charity care refers to a determination by the Hospital (based on financial information provided by the patient) that the patient can't afford to pay for their care. Bad debt refers to patients who don't submit the financial information and can't afford their care. According to the American Hospital Association, charity care plus bad debt reflects the care hospitals provide to those who can't afford to pay their hospital bills—the medically indigent.*

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

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The Hospital's uncompensated care charges are much higher than estimates based on either discounted rates for paying-patients or the cost of care. *Because various discounts are applied to hospital charges, those charges typically don't reflect what's actually paid for care. These discounts are the portion of charges written off as a result of Medicaid and Medicare reimbursement rates, and discounts given insurance companies. For example, although a hospital may charge $17,000 for an appendectomy, the negotiated payment from one insurance company may be $7,000, and Medicare or Medicaid may set its reimbursement rate at $6,500. We found that, overall, the Hospital*

discounts charges for its paying patients by about 61%. Applying the 61% discount to the uncompensated care charges for fiscal year 2006 would reduce the value of that care from about $81 million (the amount charged) to about $31 million (the amount the Hospital likely would have received).

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

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

KU Medical Center and KU Hospital: Reviewing Selected Operational Issues

Before 1998, the University of Kansas Medical Center included both a hospital and a teaching/research facility. During the 1998 legislative session, the Legislature separated those functions and created a separate University of Kansas Hospital Authority to operate the University of Kansas Hospital.

The Medical Center now includes only the education/research function encompassing the Schools of Medicine (on campuses in both Kansas City and Wichita), Nursing, and Allied Health, as well as a graduate school. The Medical Center remained under the jurisdiction of the University of Kansas; the Executive Vice Chancellor of the Medical Center reports directly to the Chancellor of the University of Kansas.

The mission of the Hospital is to facilitate and support the education, research, and public service activities of the Medical Center and its health sciences schools. Its mission also includes providing patient care and specialized services not widely available elsewhere in the State, and continuing the historic tradition of providing care to medically indigent citizens of Kansas.

Recently, legislators have expressed concerns about operational issues related to both the Medical Center and the Hospital, and about the relationship between the two. Specifically, legislators have raised questions about where and how the Medical Center spends its money, the relationship between the two entities, and the value of indigent care provided by the Hospital.

This performance audit answers the following questions:

1. **How has spending for education and research functions from the Medical Center's operating grant changed in recent years, and how has that affected the amounts of money distributed to the Kansas City and Wichita campuses?**

2. **How does the relationship between the KU Hospital and the University of Kansas Medical Center compare to what is envisioned in State law, and to relationships that have been established between medical schools and teaching hospitals in other states?**

3. **Does the KU Hospital have a reasonable method for assigning a value to the care provided to patients who are indigent?**

For reporting purposes, we shortened the wording of Question 2.

To answer these questions, we collected information from the Medical Center about its expenditures, sources of funding, and its organizational and financial relationship with the Hospital. We interviewed Medical Center officials about their spending on research and education, the Medical Center's Cancer Center, and the Medical Center's relationship to the Hospital, and examined documentation related to the Medical Center's expenditures. We collected information from the Hospital about its revenues and expenditures, and reviewed documentation related to those expenditures. We also collected information and interviewed Hospital officials about the method the Hospital uses to assign a value to the indigent care it provides, reviewed generally accepted accounting principles related to this issue, and contacted medical schools in other states. In addition, we interviewed Hospital officials about the Hospital's relationship with the Medical Center.

A copy of the scope statement for this audit approved by the Legislative Post Audit Committee is included in ***Appendix A.***

In conducting this audit, we followed all applicable government auditing standards set forth by the U.S. Government Accountability Office, except that it wasn't practical for us to test the accuracy of information medical schools and teaching hospitals in other states report to the Association of American Medical Colleges regarding their organizational relationships and financial data. However, because we were using information from five sample states to show how the University of Kansas Medical Center and Hospital compare to other academic medical centers and hospitals, we called those states to confirm the comparability of the data they had reported related to their hospitals' support of their medical centers.

Also, because of time constraints we didn't test the expenditure information the KU Medical Center Research Institute provided us. These data are used to help show how much the Medical Center spent on research in fiscal year 2007. Because these data represent most of the Medical Center's 2007 spending in the research area, errors in these data could cause the Medical Center's total research spending to be overstated or understated. However, any errors in the data are unlikely to be significant enough to affect our overall findings and conclusions.

Our findings begin on page 9, following a brief overview.

Before 1998, the University of Kansas Medical Center provided education through its Schools of Medicine, Nursing, and Allied Health, and operated a hospital on the Kansas City campus. The KU Hospital provided general and specialized patient services, and served as a major teaching and research facility. Both entities were part of the University of Kansas.

The Legislature Created a Separate Hospital Authority In 1998 To Improve the Hospital's Financial Viability

By 1998, the KU Hospital was in financial trouble and had other serious problems, as described below:

- **financial problems.** The Hospital's revenue had been declining, and officials projected severe financial challenges in the near future.
- **a drop in the number of patients.** According to Hospital records, in just three years, the number of patients served by the Hospital had dropped 16%, from 109,000 in 1993 to 92,000 in 1996.
- **heart transplant program problems.** Reports in 1995 revealed that the Hospital's heart transplant program had refused donor hearts while continuing to accept transplant patients. As a result, the Hospital closed its transplant program in 1995.
- **lack of timely access to capital.** Before 1998 the Hospital needed legislative approval for bonded indebtedness. This made it difficult for the Hospital to obtain financing for strategic investments in programs or facilities as quickly as its private competitors.

In 1996, the Board of Regents hired consultants to review the Hospital's situation and report back to the Board with recommendations for addressing such problems. The consultants concluded that being regulated as a government agency had reduced the Hospital's ability to compete with non-regulated providers in four areas: capital financing and acquisition, human resources management, procurement practices, and information systems development.

The consultants recommended that the Hospital be reorganized—either as a public authority or a private corporation—to help it adapt to heightened competition in the local healthcare market and improve its ability to compete.

During legislative hearings on reorganizing the Hospital, both the Chair of the Board of Regents and KU Chancellor testified in favor of creating a public authority. The Board Chair noted that, by enhancing its competitive position, the Hospital would be able to deliver on its mission of supporting the Medical Center's education and research activities.

The Chancellor noted that having University and Medical Center officials serving as ex-officio members of the Hospital Authority

Board would maintain a "direct tie" between the Hospital and the University/Medical Center, and would ensure that the educational mission was always honored.

The 1998 Legislature created the Kansas Hospital Authority as an independent instrumentality of the State. The Authority is governed by a 19-member board of directors. Six members are ex-officio voting members and include four University/Medical Center officials—the Chancellor of the University of Kansas, the Executive Vice Chancellor of the Medical Center, the Executive Dean of the School of Medicine, and the Dean of the School of Nursing. The other two ex-officio members are the Hospital's President and Chief of Staff. The remaining 13 members are appointed by the Governor, subject to confirmation by the Senate.

The statute specified that the mission of the Hospital was to "… facilitate and support the education, research and public service activities of the University of Kansas Medical Center and its health sciences schools, to provide patient care and specialized services not widely available elsewhere in the State and to continue the historic tradition of care by the University of Kansas Hospital to medically indigent citizens of Kansas."

Although the Hospital retained the University of Kansas name, it's no longer part of the University or the Medical Center. The 1998 legislation clearly stated the Hospital wasn't a State agency, its employees weren't employees of the State, and it wasn't subject to State purchasing laws. The Hospital receives no State appropriations. As an independent instrumentality of the State, the Hospital:

- has more independent authority than State agencies
- has the power to provide its own funding outside of the State Treasury
- isn't required to submit budgets to the Governor or Legislature
- isn't required to follow State purchasing regulations, hiring and promotion regulations, or other requirements for State agencies

Further, the State and the University of Kansas are no longer responsible for the Hospital's debt.

Since it was spun off from the Medical Center, the Hospital's situation has improved significantly. In 2006, Hospital officials hired one of the original consultants to provide an updated assessment of the Hospital's situation. This consultant was formerly the president of Lash Group, the firm that produced the 1997 report entitled, *The Need for Governance/Ownership Change at KUH.*

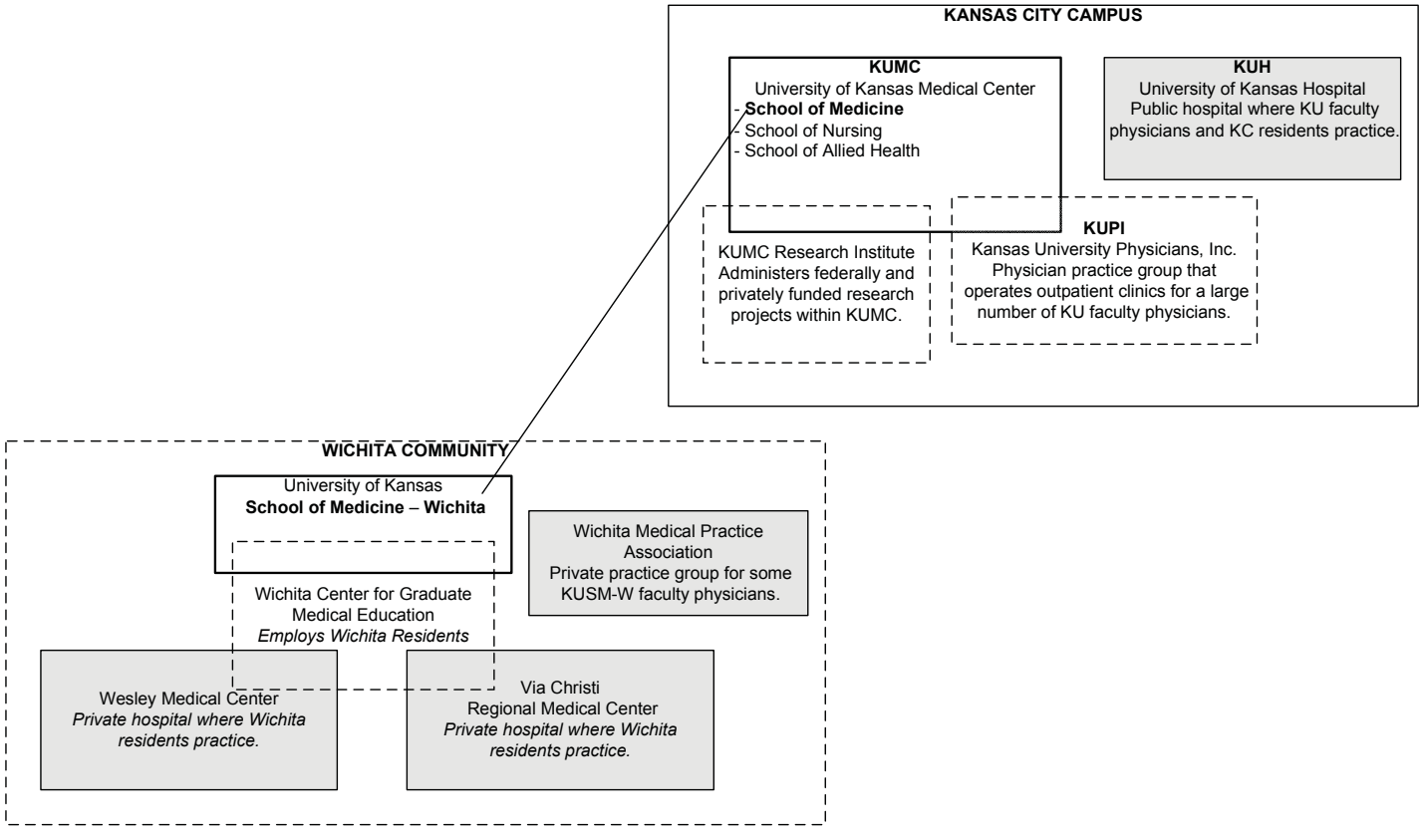
The updated report provided the following information:

- the Hospital's total revenues had grown from about $190 million in fiscal year 1998 to about $540 million in fiscal year 2006
- the number of inpatient days at the Hospital had increased from about 92,000 in fiscal year 1996 to more than 110,000 in fiscal year 2006, and the volume of inpatients had grown from about 14,000 in fiscal year 1996 to nearly 20,000 in fiscal year 2006
- the Hospital had reopened its heart surgery program
- the Hospital's capital expenditures had increased from $46 million during fiscal years 1993-1999 to $324 million during fiscal years 2000-2006

The Hospital and Medical Center Remain Intertwined

Although the Hospital and the Medical Center now are separate legal entities, they have overlapping interaction with students, residents, physicians, faculty, facilities, and the like. ***Figure OV-1*** summarizes those relationships at a high level. The listing on the next page shows the main groups involved in both entities.

Figure OV-1
KU Hospital and Medical Center (Kansas City and Wichita)



Source: LPA Analysis of KUMC and KU Hospital Relationship

The Hospital is the primary teaching hospital for the Medical Center in Kansas City. The Medical Center also has affiliation agreements with two other hospitals in Kansas City: Children's Mercy and Veteran's Administration Hospitals. Via Christi, and Wesley Medical Center serve as the primary teaching hospitals for the medical residents in Wichita.

Kansas University Physicians, Inc., (KUPI) is the Faculty Practice Plan for the physicians employed by the foundations that serve as both faculty for the Medical Center and medical staff for the Hospital. The Hospital has a "closed" staff, which means that only physicians who are faculty at the Medical Center are allowed to practice at the Hospital.

KU Medical Center—Kansas City campus houses the Schools of Medicine, Nursing, and Allied Health. The School of Medicine has students for four years of Medical School. The Kansas City campus operates its own residency program, and those residents are employees of the Medical Center. The Kansas City campus provides most of the administrative structure for the Medical Center as a whole, including executive management, accounting, human resources, and the like.

KU School of Medicine—Wichita campus (KUSM-W) was established by the Board of Regents in 1971 as a community-based component of the School of Medicine. The Wichita campus is affiliated with several local hospitals where students and medical residents are able to observe and treat patients. The Wichita campus is different from the Kansas City campus in a number of ways. For example, it serves only 3rd- and 4th-year medical students, and doesn't have Schools of Nursing or Allied Health. [***Figure OV-2*** shows the number of students and medical residents at the two campuses.] The Wichita campus also contracts with the Wichita Center for Graduate Medical Education (WCGME) to operate its residency program, and those residents are employees of WCGME.

Wichita Center for Graduate Medical Education (WCGME) is a non-profit corporation formed by collaborative efforts of the Medical Center in Wichita, Via Christi, and Wesley Medical Center. It employs and pays the medical residents in Wichita.

Medical Residents/Residency is a stage of postgraduate medical training in a primary care or medical specialty area. Medical residents have received their medical degrees, and spend their residency period caring for hospitalized or clinic patients, mostly under the supervision of more senior physicians.

Figure OV-2
Number of Students and Residents at Each Campus
Fall 2007

Number of students and residents:	
Kansas City Campus:	
School of Medicine	
Graduate	209
Medical Students	583
All Other[1]	86
School of Nursing	627
School of Allied Health	558
Residents	418
Other[2]	8
TOTAL, KC Campus	**2,489**
Wichita Campus:	
School of Medicine	
Graduate	40
Medical Students	105
All Other[3]	7
Residents	273
Other[4]	4
TOTAL, Wichita Campus	**429**
TOTAL, Both Campuses	**2,918**

[1] 60 Visiting Trainees, 24 MD/PhD Students, and 2 Clinical Psychology Pre-Doctoral Internship Students

[2] 8 Lawrence students taking at least half of their credit hours in Kansas City

[3] 7 Visiting Trainees

[4] 4 Nursing students taking at least half of their credit hours at Wichita

Source: Medical Center data

Although the Hospital And Medical Center Are Funded Separately, Certain Funds Flow Between the Two

The Medical Center is part of the University of Kansas, and as such receives some State appropriations. Other funding sources for the Medical Center can be summarized as follows:

- Hospital support revenue—funds provided by affiliated hospitals
- Federal support—primarily grants
- Tuition and fees

- Practice Plan revenue—revenues physicians and other providers generate from seeing patients
- Gifts/Endowment Fund revenue
- Payment from the Hospital for services it buys from the Medical Center (parking, utilities, etc.)

The Hospital receives no State appropriations. Its funding sources can be summarized as follows:

- Insurance payments for services rendered, including Medicaid and Medicare
- Patient payments for services rendered
- Gifts/Philanthropy
- Medicare and Medicaid funding for the residency programs
- Payments from the Medical Center for services it buys from the Hospital (uniforms, office space, etc.)

Some Medicare funding flows through the Hospital to the Medical Center. Every hospital that trains residents in an approved residency program is entitled to receive Medicare's direct graduate medical education payment, also known as DME. That payment is intended to cover the direct costs of training residents—such as residents' salaries, teaching physicians' salaries, and related overhead expenses.

The amount of DME paid is unique to each hospital, and was based on a formula calculated by the federal Centers for Medicare and Medicaid Services' predecessor in the 1980s. The amount periodically is updated by an inflation factor.

Teaching hospitals also receive an indirect medical education adjustment from Medicare, also known as IME. This payment is intended to recognize the high costs of inpatient care that teachings hospitals have, compared to non-teaching hospitals. The IME adjustment is an additional payment the hospital receives for each inpatient stay, and is based on the ratio of interns and residents to hospital beds.

At the Kansas City campus, the Medical Center and Hospital have a negotiated agreement specifying that the Hospital would pay the Medical Center only the direct funds (DME) it receives from Medicare. In Wichita, the two hospitals affiliated with the Medical Center's Wichita campus contribute some portion of both the direct and indirect graduate medical education funds they receive from Medicare to WCGME, which runs the residency program in Wichita.

The At-a-Glance boxes on the next page show the major funding and expense categories for both the Medical Center and the Hospital.

University of Kansas Medical Center
AT A GLANCE

Governed By: Board of Regents and University of Kansas.

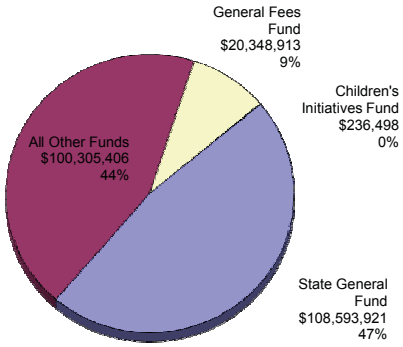
Staffing: The Medical Center has 2,482 full-time-equivalent positions.

Budget: The Medical Center's major funding comes from General Fund appropriations. The Medical Center also receives moneys from other sources, including federal grants and the Children's Initiatives Fund. For fiscal year 2006, the Medical Center took in and spent about $229.5 million as shown below. Most of these moneys were for salaries and wages and contractual services.

FY 2006 Expenditures

Type	Amount	% of Total
Salaries & Wages	$181,289,244	79%
Contractual Services	$26,281,391	11%
Other Assistance	$9,759,247	4%
Commodities	$6,755,227	3%
Capital Outlay & Improvements	$4,842,126	2%
Debt Service Interest	$557,503	0%
Aid to Local Units	$0	0%
Total Expenses:	**$229,484,738**	**100%**

Sources for Funding for Expenditures



Total Funding: **$229,484,738**

Source: Kansas Legislative Research Department, Budget Analysis, Vol. 1, FY 2008.

University of Kansas Hospital Authority
AT A GLANCE

Governed By: A 19-member board of directors made up of 6 ex-officio positions and 13 public members.

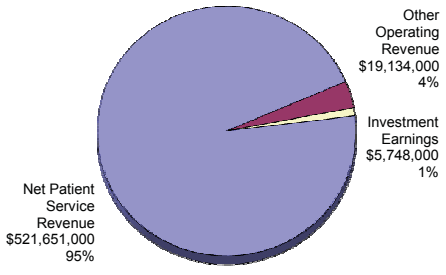
Staffing: The Hospital has 3,345 full-time-equivalent positions.

Budget: More than 95% of the Hospital's revenue is from providing patient services. For fiscal year 2006, the Hospital took in about $546.5 million in revenue and spent about $474.5 million. The Hospital's fiscal year 2006 revenue number includes $18.6 million of Medicaid and $5.5 million of Medicare payments for prior fiscal years. After excluding the prior year payments, the Hospital's fiscal year 2006 revenue exceeded expenses by $47.9 million. Most of the Hospital's $474.5 million in expenditures were for personnel and supplies.

FY 2006 Expenditures

Type	Amount	% of Total
Salaries & Wages, Benefits & Contracted Labor	$233,880,000	49%
Supplies	$114,191,000	24%
Other Operating Expenses	$54,470,000	11%
Purchased Services	$44,756,000	9%
Depreciation & Amortization	$21,254,000	4%
Interest Expense	$5,255,000	1%
Other non-Operating	$645,000	0%
Total Expenses:	**$474,451,000**	**100%**

FY 2006 Revenue



Total Revenue: **$546,533,000**

Source: University of Kansas Hospital Authority 2006 Financial Statements

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

ANSWER IN BRIEF: *Since 2001, research spending from all sources has increased from $49 million to $92 million, and has grown from 23% of total spending in 2001 to 32% in 2007. The Kansas City campus accounts for all but a fraction of that spending. The amount of the State operating grant spent for research accounts for only $3.6 million, and represents an unchanged 3% of State grant expenditures. However, more of the State grant now is being spent on other costs, and less on education. The Kansas City campus received almost all the $13.2 million increase in State grant moneys since 2001. Among other things, it uses State funds to pay for the Medical Center's Kansas City-based administrative operations, and to some residency program costs, an expense covered by different funding sources in Wichita. The big increase in research spending has come from other sources—primarily federal research grants generated by faculty on the Kansas City campus. The differences in the amounts spent on research between Kansas City and Wichita have raised concerns in Wichita, which has received accreditation citations for not having research opportunities. These and other findings are discussed in the sections that follow.*

The State Operating Grant Funded About 39% of The Medical Center's Spending in 2007

During this audit, we reviewed the sources of funding for the 2001 and 2007 expenditures at the Medical Center and its related entities—including the Medical Center's Research Institute and the Wichita Center for Graduate Medical Education. ***Figure 1-1*** shows the funding sources for the three entities combined (referred to simply as the Medical Center throughout the rest of this question).

The Legislature adopted an operating grant model to finance universities in 2001, moving away from the previous appropriations by line-item. The State operating grant consists of a base appropriation and an increased appropriation. The base amount goes directly to each university; in this case, to the Medical Center. There are no requirements in the law on how the base is to be spent.

The increase in appropriation goes to the Board of Regents, which has oversight over the money. The Board negotiates performance agreements with each institution. If the institution meets its performance goals for the year, it may receive the increased appropriation. If it fails to meet its goals, it does not receive the increased appropriation. The increased amount in one fiscal year becomes part of the base for the following fiscal year, regardless of whether the institution meets its goals.

Figure 1-1
Funding Sources and Expenditures (amounts in millions)
Fiscal Years 2001 and 2007

Type of Funding	2001(d)	2007	Change from 01-07 $	Change from 01-07 %	Total % of 2007 Total (All Source)
State Operating Grant	**$98.5**	**$111.7**	**$13.2**	**13.4%**	**39%**
Other Sources of Funding					
KUMC Research Institute (a)	$0.0	$71.6	$71.6	--	**25%**
Federal and Private (a)	$54.5	$11.5	-$43.0	-78.9%	**4%**
Department Earnings	$21.8	$27.6	$5.8	26.6%	**10%**
Graduate Medical Education (b)	$18.0	$23.4	$5.4	29.7%	**8%**
Tuition	$11.1	$22.1	$11.0	98.9%	**8%**
KU Endowment Association	$6.5	$8.2	$1.8	27.5%	**3%**
Cancer Center (c)	$0.0	$5.0	$5.0	--	**2%**
KU Hospital Services	$4.1	$4.1	$0.0	0.0%	**1%**
Fees	$1.4	$2.0	$0.6	45.9%	**1%**
KU Physicians, Inc.	$0.2	$0.8	$0.5	219.9%	**0%**
Total Other Sources of Funding	**$117.6**	**$176.2**	**$58.6**	**49.9%**	**61%**
Total All Sources	**$216.0**	**$287.9**	**$71.9**	**33.3%**	**100%**

(a) The KUMC Research Institute was created in 2004. The funding shown here for 2007 also includes federal and private dollars that are now accounted for through the Institute. The State dollars associated with the Institute are included in the State operating grant money.

(b) Includes expenditures from the Wichita Center for Graduate Medical Education.

(c) Special appropriation for fiscal year 2007.

(d) We didn't inflate the fiscal year 2001 expenditures for education and research to fiscal year 2007 dollars because spending in these areas depends more on how much federal and State funding is available than on the cost of goods and services as reflected by the consumer price index, which is used to inflate that cost.

Note: Figures may not add due to rounding.

Source: Expenditure information provided by the KU Medical Center, KUMC Research Institute, and the Wichita Center for Graduate Medical Education.

The Medical Center's Executive Vice Chancellor decides how to allocate the increase, and also has discretion on how to allocate State operating grant moneys and tuition. For fiscal year 2007, the State operating grant was $111.7 million (not including funding for the Cancer Center) out of a total $287.9 funding, or 39%.

Because the State operating grant funds less than half the Medical Center's spending, we expanded our review to look at other sources of funding as well. Although the audit question addressed only the State operating grant, we felt it was important to analyze and separately report on spending on research and education from all sources, from the State operating grant, and from other non-State sources, such as federal and private grants, fees, and endowment moneys.

We added spending from the Research Institute and the Wichita Center for Graduate Medical Education into our analyses to make our comparisons more accurate and meaningful. The reasons for those changes are explained on the next page:

- We added spending from the Research Institute for fiscal year 2007 to make it more comparable to 2001 spending. The Research Institute administers federal and private research projects and clinical trials. As ***Figure 1-1*** showed, before 2004 the Medical Center reported all spending on federal and private research under that category. Beginning in 2004, the Medical Center began transferring some of this funding to the Research Institute, and showing that spending under both the Research Institute and the federal and private research categories.

- We added spending from the Wichita Center for Graduate Medical Education (WCGME) for 2001 and 2007 to make comparisons between the Kansas City and Wichita campuses more accurate. Expenditures for medical residents at the Kansas City campus are accounted for in the Medical Center's expenditure data. However, expenditures for medical residents at the Wichita campus are accounted for in WCGME's expenditure data. The Wichita campus contracts with WCGME to operate its residency program, and those residents actually are employed by WCGME.

- We *didn't* include spending by the KU Physicians, Inc. (KUPI), because we weren't able to determine how much of those expenditures—much of which go for physician salaries—support education and how much support research. In fiscal year 2008, the KUPI budget was $120 million, which came mostly from fees for physician services and went mostly to patient care. About $60 million of that amount went directly for physician salaries. KUPI provides some limited funding for contractual services at the Medical Center (some employees perform work for KUPI activities).

In addition, we worked with Medical Center officials to categorize expenditures for the Medical Center as a whole and for each campus into three broad categories: education, research, and other. The other category includes student financial aid, purchasing, human resources, utilities, and the like.

Although we could attribute most spending to either the Kansas City or the Wichita campus, about $1.7 million in spending on "outreach" activities for both 2001 and 2007 couldn't be attributable to either campus. As a result, the spending shown in the following sections for each campus will be slightly less in total than the spending shown for the Medical Center as a whole.

Since 2001, There's Been a Significant Shift Toward Research Spending at the Medical Center, Mostly at the Kansas City Campus

Both the changes in spending for each category, and the percent of that spending that goes toward each category, are depicted in ***Figures 1-2 through 1-7*** on the next six pages. These figures show the increases and percentages:

- from **all sources**
- from the **State operating grant**
- from **other (non-State) sources**

Below each figure, we've highlighted some of the most germane points, or added explanations to help the reader better understand the information presented.

Figure 1-2
Increase in TOTAL Expenditures on Education, Research and Other (amounts in millions)

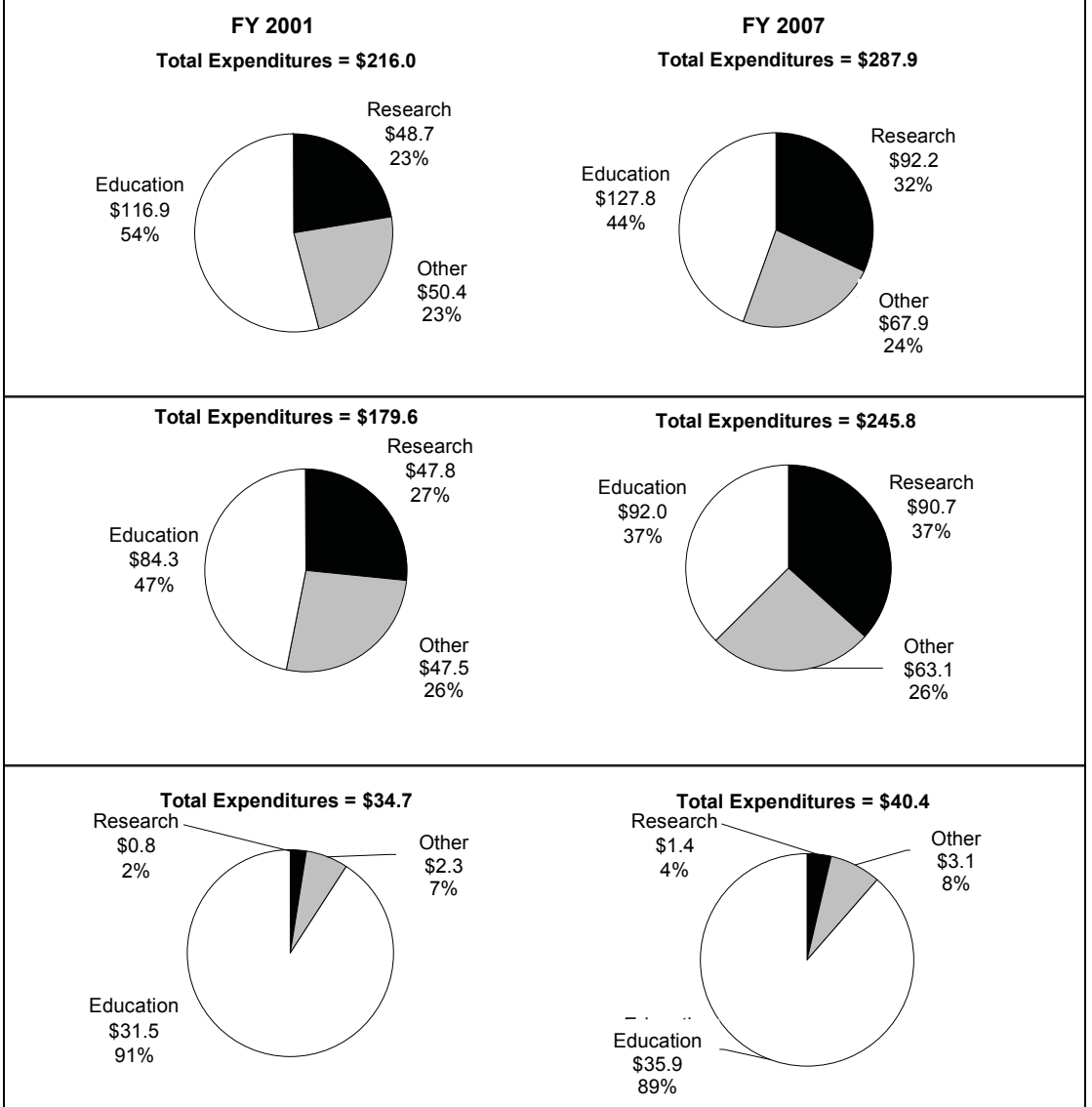
Source: Expenditure data from KU Medical Center, KUMC Research Institute, and Wichita Center for Graduate Medical Education.

Notes: Figures may not add due to rounding.
There is a separate "Outreach" category that isn't included in Kansas City or Wichita expenditures. Thus, Kansas City and Wichita do not add up to Overall expenditures.

Overall spending from all sources has increased by $72 million, or 33%, since 2001. As ***Figure 1-2*** shows:

- overall, research spending is up significantly at the Medical Center (90%)
- the Kansas City campus accounts for most of the overall spending, and for most of the spending increase ($66 million out of $72 million, or 92%). Kansas City's spending for research increased by 90%.
- the Wichita campus accounts for a small portion of the overall spending (14% in fiscal year 2007), and of the spending increase (8%).

Figure 1-3
Percent of TOTAL Expenditures on Education, Research and Other (amounts in millions)



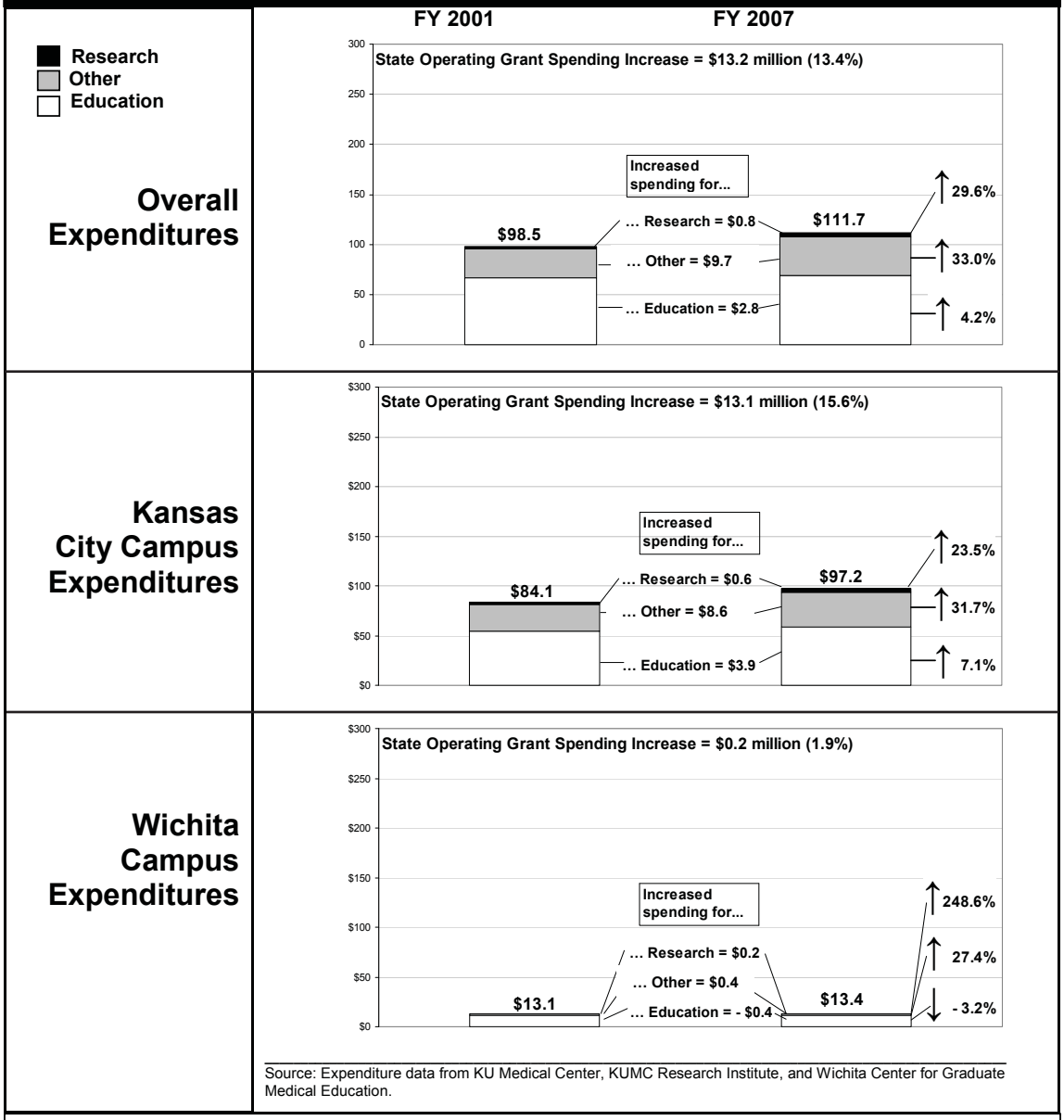
Source: Expenditure data from KU Medical Center, KUMC Research Institute, and Wichita Center for Graduate Medical Education.

Notes: Figures may not add due to rounding.
There is a separate "Outreach" category that isn't included in Kansas City or Wichita expenditures. Thus, Kansas City and Wichita do not add up to Overall expenditures.

There's been a significant shift in the percent of all sources of funds being spent on research since 2001. As ***Figure 1-3*** shows:

- overall spending on research from all sources grew from 23% of the total to 32%
- almost all spending on research happens at the Kansas City campus. From 2001 to 2007, research spending increased from $48 million to $91 million, or from 27% to 37% of its total expenditures. Kansas City's spending for research and education now are about the same.
- Wichita spends very little on research. Its spending on research was just $1.4 million in 2007, and had increased from 2% to 4%. The majority of Wichita's spending is on education, which in 2007 was 89% of its total.

Figure 1-4
Increase in STATE Expenditures on Education, Research and Other (amounts in millions)

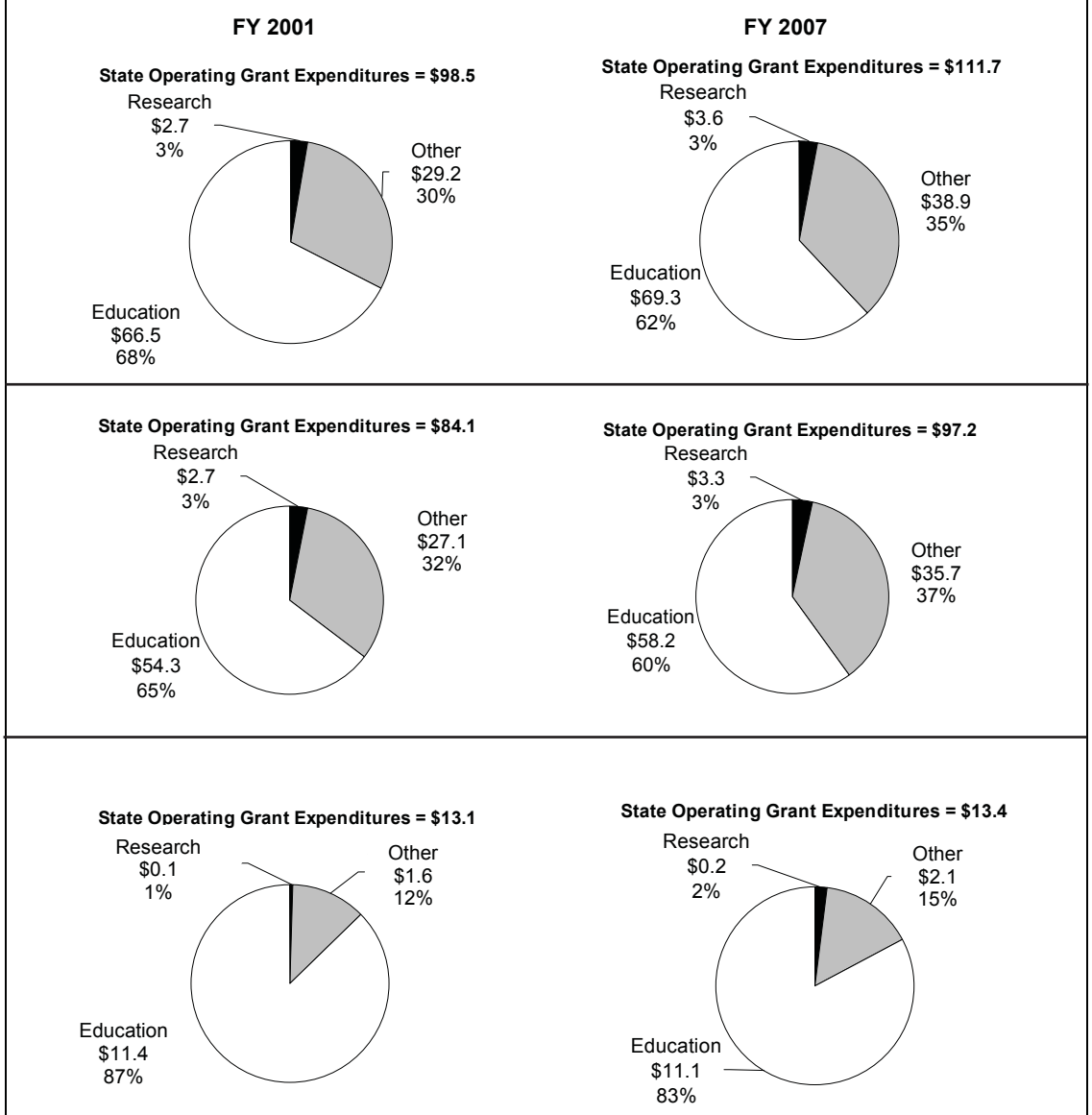


Notes: Figures may not add due to rounding.
There is a separate "Outreach" category that isn't included in Kansas City or Wichita expenditures. Thus, Kansas City and Wichita do not add up to Overall expenditures.

Overall spending from the State operating grant increased by $13 million, or 13%, since 2001. As ***Figure 1-4*** shows:

- overall, other spending accounted for almost $10 million of the increase, and was up 33%. Spending on research increased by only $800,000, or 30%.
- the Kansas City campus accounts for most of the overall State grant spending, and for almost all the spending increase ($13.1 million out of $13.2 million). Kansas City uses the State grant to pay for much of the administrative structure for both campuses, including financial aid administration, general administrative services, utilities, and executive management. It also uses the State grant to pay some residency program costs, including residents' salaries. In contrast, WCGME employs the medical residents for the Wichita campus, and pays their expenses using other funding sources.

Figure 1-5
Percent of STATE Expenditures on Education, Research and Other (amounts in millions)



Source: Expenditure data from KU Medical Center, KUMC Research Institute, and Wichita Center for Graduate Medical Education.

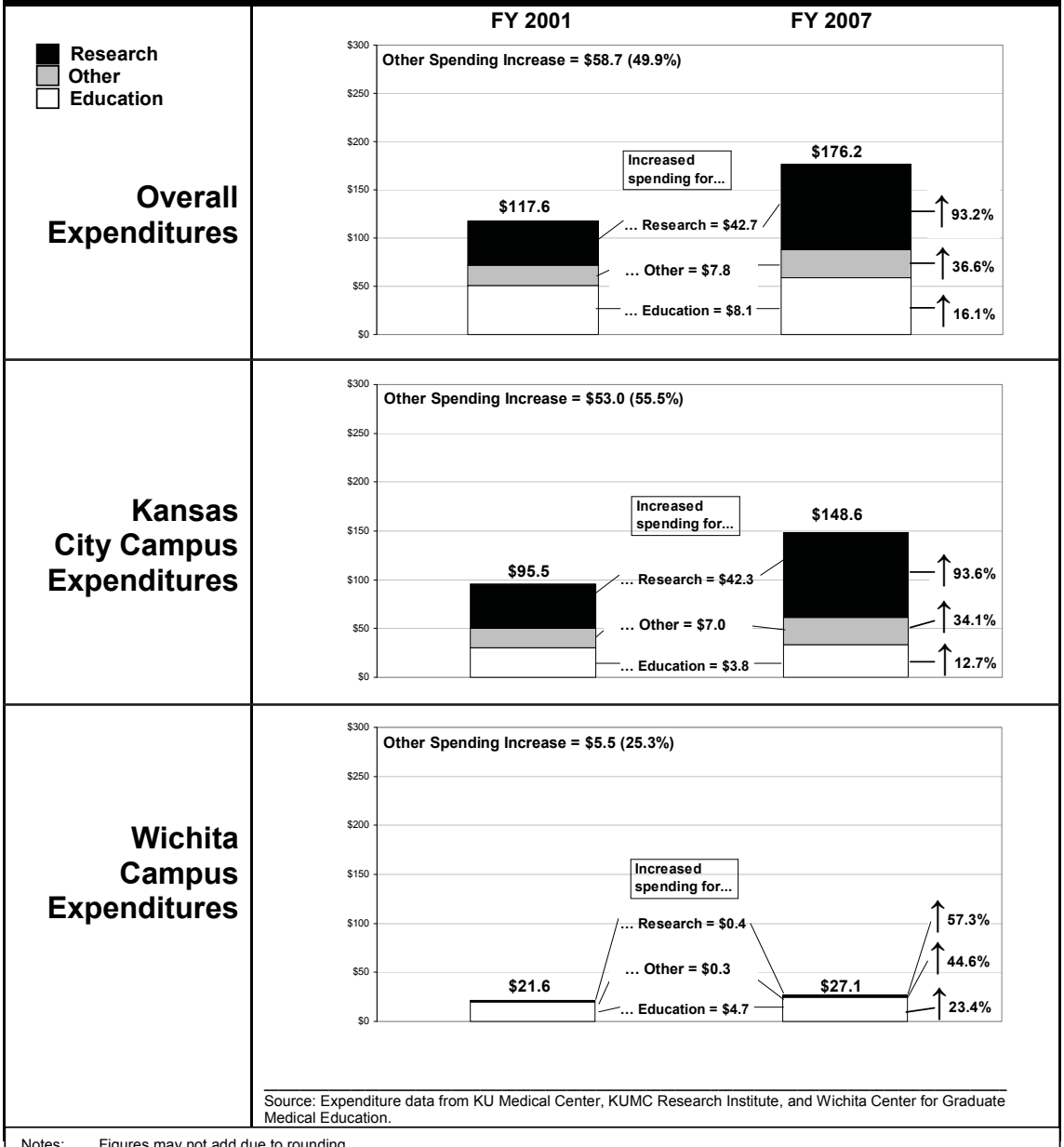
Notes: Figures may not add due to rounding.
There is a separate "Outreach" category that isn't included in Kansas City or Wichita expenditures. Thus, Kansas City and Wichita do not add up to Overall expenditures.

- although the dollar amounts are small, the Wichita campus significantly increased its research spending from the State operating grant (up 249%)
- a separate analysis looking at State operating grant and tuition payments combined showed all the same patterns (see ***Appendix B***)

The percent of State operating grant moneys being spent on research hasn't changed since 2001. As ***Figure 1-5*** shows:

- overall, most State operating grant funds are spent on education and other (97%). Education is still the largest category of spending, but has decreased as a percent of total State operating grant spending as other expenditures have increased.
- because the Kansas City campus gets most of the State operating grant, its spending patterns mirror the overall pattern
- at the Wichita campus, education spending is the largest category. Wichita spends very little on research.

Figure 1-6
Increase in OTHER Expenditures on Education, Research and Other (amounts in millions)



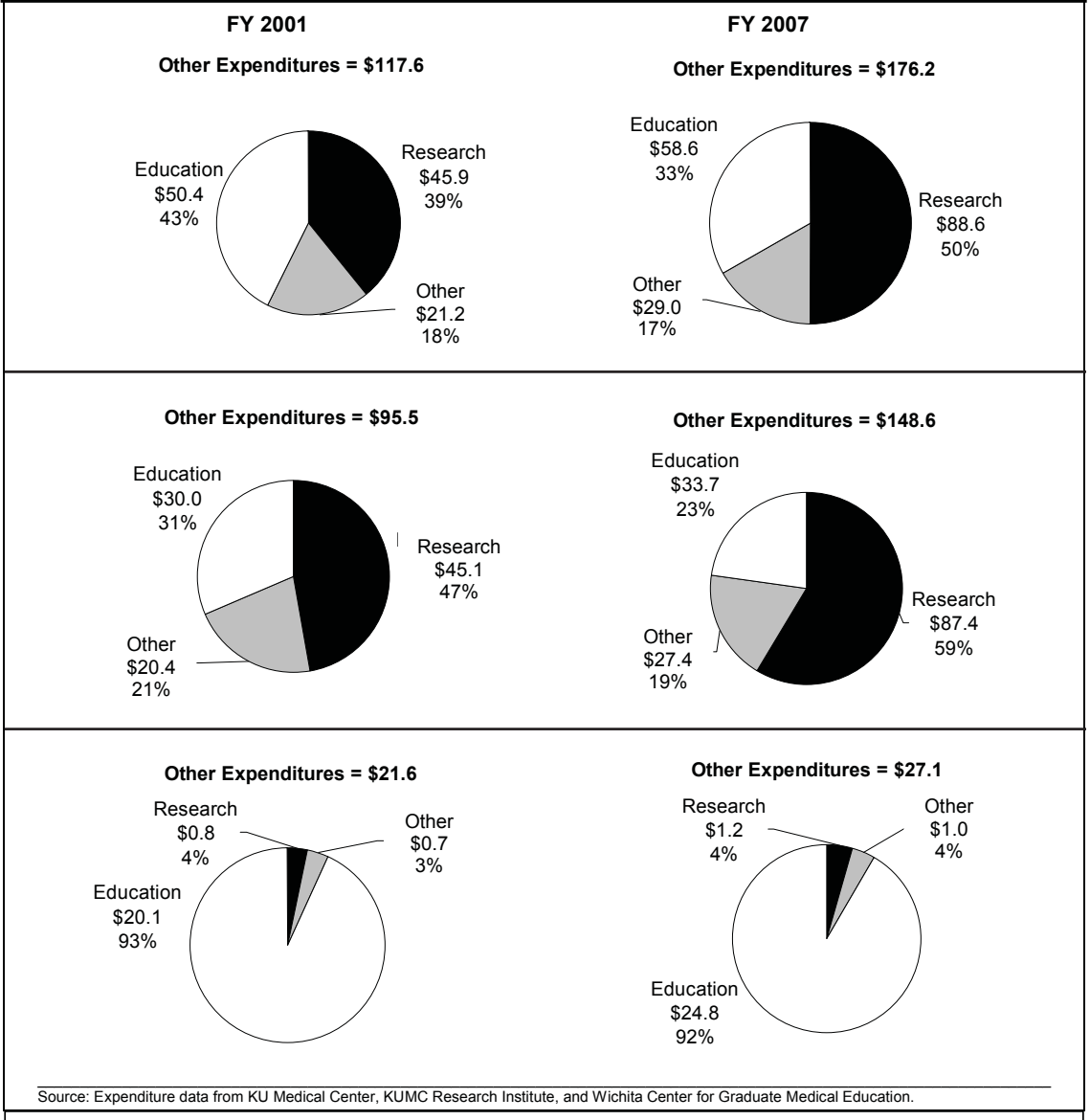
Source: Expenditure data from KU Medical Center, KUMC Research Institute, and Wichita Center for Graduate Medical Education.

Notes: Figures may not add due to rounding.
There is a separate "Outreach" category that isn't included in Kansas City or Wichita expenditures. Thus, Kansas City and Wichita do not add up to Overall expenditures.

Spending from other funding sources has increased by $59 million, or 50%, since 2001. As ***Figure 1-6*** shows:

- overall, research spending from other sources has increased significantly (up 93%)—primarily from federal research grants generated by faculty on the Kansas City campus
- the Kansas City campus accounts for most of the spending from other sources, and for most of the spending increase ($53 million out of $59 million, or 90%). Its spending on research has almost doubled since 2001.
- the Wichita campus has increased its research spending and its other spending from other sources since 2001. Almost all its increased spending went for education.

Figure 1-7
Percent of OTHER Expenditures on Education, Research and Other (amounts in millions)



Source: Expenditure data from KU Medical Center, KUMC Research Institute, and Wichita Center for Graduate Medical Education.

Notes: Figures may not add due to rounding.
There is a separate "Outreach" category that isn't included in Kansas City or Wichita expenditures. Thus, Kansas City and Wichita do not add up to Overall expenditures.

There has been a significant shift in total research spending from other sources since 2001. As ***Figure 1-7*** shows:

- overall, spending on research from other sources has grown from 39% of the total to 50%
- at the Kansas City campus, research has grown from $45 million to $87 million, and is now 59% of spending from other sources. Education now accounts for 23% of the total.
- at the Wichita campus, research spending from other sources accounts for just 4% of the total, and education spending accounts for 92%

The difference in amounts reimbursed for residents at hospitals in Kansas City and Wichita could be one explanation for why State funding is higher in Kansas City than in Wichita. Officials at the Medical Center told us that the Hospital receives the minimum amount of direct graduate medical education reimbursement per resident. They said this is due to issues with the Medicare base-year cost report, which was created when the Hospital was part of the University. At the time, there was an error in the report, and the school was under-reimbursed for its costs.

Thus, the Hospital receives a lower reimbursement rate than hospitals in Wichita do. State funding in Kansas City is higher than in Wichita, and this could be to supplement for the smaller amount of GME funding in Kansas City.

Spending per FTE on the Kansas City Campus Is Higher Than In Wichita

As part of this audit, we also looked at differences between the Kansas City and Wichita campuses in expenditures per full-time-equivalent (FTE) student/resident. That information is summarized in ***Figure 1-8.***

Figure 1-8
Enrollments and Expenditures per FTE Student/Resident
Fiscal Years 2001 and 2007

Campus	2001	2007	# or $ change	% change
Enrollment by Full-Time-Equivalent Student/Resident				
Kansas City	1,973.7	2,267.1	293.4	14.9%
Wichita	367.2	424.0	56.8	15.5%
Expenditures per FTE from All Sources				
Kansas City	$91,018	$108,406	$17,388	19.1%
Wichita	$94,533	$95,385	$852	0.9%
Expenditures per FTE from the State Operating Grant				
Kansas City	$42,607	$42,867	$260	0.6%
Wichita	$35,666	$31,512	-$4,154	-11.6%
Expenditures per FTE from Other Sources				
Kansas City	$48,411	$65,540	$17,129	35.4%
Wichita	$58,867	$63,873	$5,006	8.5%

Source: Expenditure data and enrollment totals from KU Medical Center.

As the figure shows, the Kansas City campus accounts for most of the Medical Center's FTE students/residents (84%). It also shows that enrollment levels on both campuses grew at about the same rate between fiscal years 2001 and 2007.

Expenditures per FTE showed many of the same patterns as ***Figures 1-2 through 1-7*** had shown. At the Kansas City campus, expenditures per FTE increased significantly—primarily because of the significant increase in research expenditures from other sources.

At the Wichita campus, expenditures per FTE increased at a much smaller rate overall, and went from being about $3,500 more per FTE than Kansas City in 2001, to $13,000 less per FTE in 2007. Wichita's expenditures per FTE from the State operating grant dropped by about 12%, and from other sources increased by nearly 9%.

We also noted that the Wichita campus now accounts for about 12% of the total spending from the State operating grant, and has about 16% of the Medical Center's enrollment. Conversely, Kansas City now accounts for about 87% of the State operating grant spending, and has about 84% of the enrollment.

Officials in both Kansas City and Wichita cited a number of reasons why expenditures per student weren't the same on the two campuses. Those reasons are summarized below:

- **the campuses have different types of students.** Kansas City supports students in all four years of the medical, nursing, and allied health programs, as well as residents and Ph.D. students. Wichita supports 3rd and 4th year medical students and residents.
- **spending for the type of student is different.** Kansas City officials pointed out that the first two years of medical school have courses that are expensive to maintain (e.g., anatomy lab).
- **the Kansas City campus supports most of the administrative structure and support of the Medical Center.** Although Wichita has some administrative costs and functions of its own, Kansas City pays for the bulk of the infrastructure support for items such as accounting, payroll, and IT services.
- **Most federal and private grants coming in to the Medical Center are for the types of basic science research that the Kansas City campus conducts.** Those grants have increased substantially since 2001.

Differences in Spending for Research and Education in Kansas City and Wichita Have Raised Concerns in Wichita

During the course of this audit, we heard several concerns about the differences in research spending at the Kansas City and Wichita campuses:

- most research occurs on the Kansas City campus, and very little on the Wichita campus
- although its programs are accredited, the Wichita campus has received accreditation citations in research and scholarly activity since at least 2005

- Wichita officials said they'd heard that some students and residents don't want to go to the Wichita campus because of the lack of research opportunities

As noted earlier, one reason why most research currently happens in Kansas City is that it primarily does basic sciences research, which involves fundamental research that is usually carried out in a laboratory setting. Significant amounts of federal and private grant funding for basic research have been available from the National Institutes of Health and other sources in recent years.

The Medical Center established the Wichita campus in 1971 to provide clinical education for 3rd and 4th year medical students and residents. Wichita conducts primarily clinical research on its campus. Clinical research is outcomes-based, where trials are conducted and work is done with patients to see which drugs, devices, or other remedies improve patients' health. Federal dollars generally aren't associated with this type of research.

Wichita officials want to further develop their campus' research program to alleviate concerns and remove accreditation citations. Wichita officials told us that they were happy with the level of State support they had received in the past for undergraduate medical education. However, they want more support for graduate medical education and they want to expand the campus' clinical research program to help overcome the citations Wichita has received and get more students and residents interested in going to Wichita. (The ***accompanying box*** describes one way the Wichita officials have tried to entice residents to join the Wichita residency program.)

Residents in Wichita Receive Higher Salaries and Benefits than Residents in Kansas City

One thing the Wichita Center for Graduate Medical Education has done to make the residency program more attractive is to offer higher salary and benefits to residents. For example, in fiscal year 2007:

- a first-year single resident would receive about $48,000 in Kansas City, and about $50,000 in Wichita.
- a first- year resident with a family would receive about $50,000 in Kansas City and about $58,000 in Wichita.

Wichita officials also said they thought students on both campuses should be given the same opportunities to conduct research, since it's the same School of Medicine and should be treated the same. In an effort to increase funding, Wichita officials told us they have approached Kansas City officials about receiving a larger portion of the research overhead that is part of most federal grants.

Kansas City officials indicated they support Wichita's desire to build up its clinical research program, because that's where Wichita's strengths lie. However, they indicated they don't support strengthening Wichita's basic research program because that would replicate the basic sciences research being done in Kansas City, and would result in the two campuses competing for similar grants.

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

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

ANSWER IN BRIEF:	*The Legislature created the University of Kansas Hospital Authority in 1998 to improve the financial viability of the KU Hospital. The current organizational relationship between the Hospital and Medical Center follows State law, and is similar to how teaching hospitals and medical schools are organized in many other states. However, the financial relationship between the Medical Center and Hospital isn't defined in State law, and has been a source of contention between the two. Although comparisons of financial support with other states have significant limitations, the amount of financial support the Medical Center has received in the past from all affiliated hospitals does appear to be relatively low. These and other findings are discussed in the sections that follow.*

The Legislature Created the Hospital Authority in 1998 To Improve the Hospital's Financial Viability

As mentioned in the Overview, by 1998 the Hospital faced a number of significant problems, including fewer inpatients, financial problems, no heart transplant program, and lack of access to capital for strategic investments. The 1998 Legislature spun the Hospital off from the Medical Center and made it an independent instrumentality of the State in hopes of making it more competitive and financially self-sufficient.

In addressing this question, we looked at the relationship between the Hospital and Medical Center from both an organizational standpoint and a financial standpoint.

The Organizational Relationship Between the Hospital and Medical Center Follows State Law and Is Similar to Many Other States

Although they are now separate legal entities, the Hospital and Medical Center continue to share the same main campus, most of the same physicians, and a number of basic services, such as police, security, laundry, and some utilities.

The law making the Hospital a separate entity was not very specific as to how the two organizations would relate to each other. We identified the following elements of organizational relationship in the law:

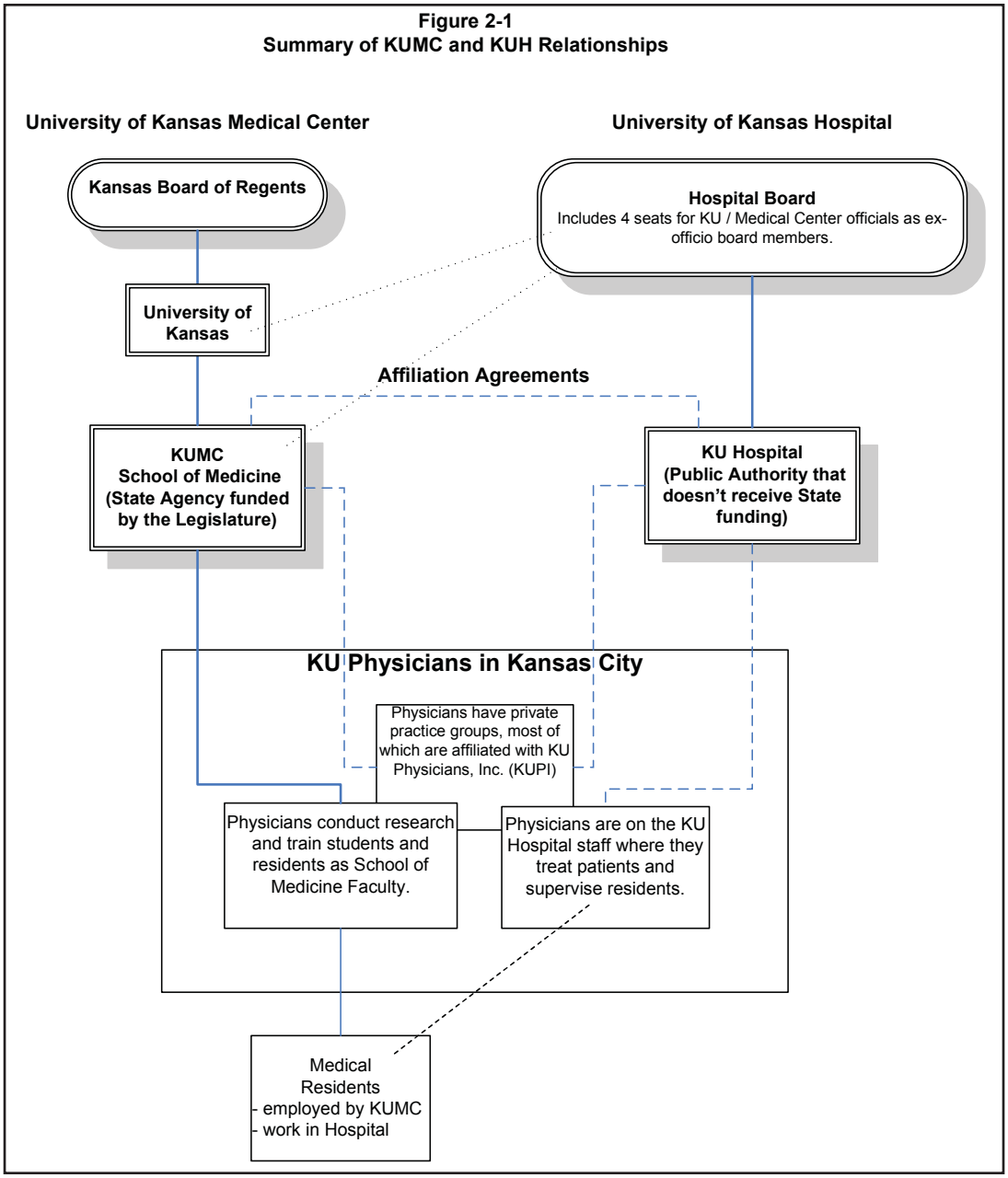
- The Hospital would operate as a separate legal entity independent of the Medical Center, with a separate oversight Board, a separate budget, and the like.
- The Hospital still would share many of the same resources with the Medical Center. The Hospital also was given specific authority to contract and make agreements for the exercise of its power, including acquiring space, equipment, services, and supplies.

- The law specified that four of the Hospital's governing Board members would be from the Medical Center or the University of Kansas.

The current organizational arrangement follows what was spelled out in State law. That relationship is summarized below:

The Hospital is operating independently of the Medical Center. ***Figure 2-1*** shows the current organizational relationship between the Hospital and Medical Center. As the figure shows, the Hospital is not part of the University or the Board of Regents any longer, and reports to its own board. Further, the Hospital used to be a part of the University, but now it's an independent instrumentality of the State and receives no State appropriations.

Figure 2-1
Summary of KUMC and KUH Relationships



The Hospital and Medical Center have entered into numerous agreements to clarify and codify how they would share facilities and staff. The agreements also define each party's responsibilities in certain areas. For example, one agreement specifies terms and conditions for the Hospital's lease of space from the University. This agreement also addresses the joint purchasing and sharing of utilities between the two entities. Another agreement addresses the sharing of physicians and residents between the School of Medicine and the Hospital. It also allows the School of Medicine to place residents at other hospitals, and for the Hospital to use residents that aren't from the University of Kansas. A description of the major agreements is shown in ***Figure 2-2.***

Figure 2-2
Description of Major Agreements Between the KU Hospital and the State Board of Regents or the University of Kansas

Hospital Agreement with:	Description of Major Agreements	Term
Board of Regents	*Master Ground Lease* – Establishes terms and conditions for the Hospital to lease the Hospital premises and buildings from the Board of Regents for 99 years at a total cost of $99.	99 years
University of Kansas	*Master Affiliation Agreement* – Primary terms and duties include mutual support of each entity's mission. The Hospital agreed to operate a state-of-the-art teaching and research hospital, maintain an economically viable and independently operated hospital, share certain functions such as public/ media relations and government relations, and collaborate on such things as provision of indigent care, allocation of space, recruitment of faculty, funding for graduate medical education, accreditation, curriculum, and the supervision of students and residents.	5 years
	License Agreement – Addresses the Hospital's use of the University's name, trade names, trademarks and service marks, such as "KU Medical Center," the Jayhawk logo, and the University's seal.	33 years
	Lease of Facilities – Specifies terms and conditions for the Hospital's lease of space from the University. This agreement also addresses the joint purchasing and sharing of utilities between the University and Hospital.	1 year
	Sublease of Facilities – Specifies terms and conditions for the University's lease of space from the Hospital. This agreement also addresses the joint purchasing and sharing of utilities between the University and Hospital.	1 year
School of Allied Health	*Academic Service Agreement* – Addresses the sharing of academic and clinical staff between the School of Allied Health and the Hospital.	1 year
	Student Clinical Affiliation Agreement – Sets terms and conditions and establishes the Hospital and Medical Center's responsibilities for training of School of Allied Health students at the Hospital.	1 year
School of Medicine	*Academic Service Agreement* – Addresses the sharing of physicians and residents between the School of Medicine and the Hospital. It also allows the School of Medicine to place residents at other hospitals, and for the Hospital to use residents that aren't from the University of Kansas. This agreement also specifies how much of the Hospital's Medicare graduate medical education funds must be paid to the School of Medicine.	1 year
	Student Clinical Affiliation Agreement – Sets terms and conditions and establishes the Hospital and Medical Center's responsibilities for training of School of Medicine students and residents at the Hospital.	1 year
School of Nursing	*Academic Service Agreement* – Addresses the sharing of academic and clinical staff between the School of Nursing and the Hospital.	1 year
	Student Clinical Affiliation Agreement – Sets terms and conditions and establishes the Hospital's and Medical Center's responsibilities for training of School of Nursing students at the Hospital.	1 year

Source: Affiliation Agreements

As required, the Hospital governing board includes representatives of the University of Kansas and the Medical Center. Four of the six ex-officio members on the Hospital Board are University/Medical Center officials—the Chancellor of the University of Kansas, the Executive Vice Chancellor of the Medical Center, the Executive Dean of the School of Medicine, and the Dean of the School of Nursing.

Recently, legislators and others have raised questions about Hospital Board nominations, the resignation of the Lt. Governor from the Board, and ex-officio membership on the Board. These issues are described more fully in the box to the right.

The Hospital and Medical Center's current organizational set-up is similar to many other states. We focused on the Medical Center's main campus in Kansas City for comparisons with other states' medical schools' main campuses. We found the following:

- ***Figure 2-3*** shows that, on their main campuses, 74% of the public medical schools have a single primary teaching hospital, where training is provided for students and residents from the medical school's main campus. The Medical Center's Kansas City campus also has one primary teaching hospital.

Figure 2-3
AAMC Public Medical School Members' Teaching Hospitals

Public medical schools with…	# of Public Medical Schools	%	# of Primary Teaching Hospitals
…no designated hospital as "primary affiliate"	14	19%	0
…one teaching hospital designated as primary affiliate (like KU Hospital)	55	74%	55
…two teaching hospitals designated as primary affiliates	5	7%	10
Total:	74	100%	65

Source: Association of American Medical Colleges (AAMC) data on public medical school members

- Of the 65 primary teaching hospitals on these public medical schools' main campuses, 35 (54%) are a separate legal entity from their affiliated school of medicine, like the KU Hospital. This information is shown in ***Figure 2-4***.

- Furthermore, 15 of the 35 primary teaching hospitals that are separate legal entities previously had common ownership with the school of medicine, like the KU Hospital did.

Figure 2-4
Legal Status of Public Medical School Teaching Hospitals

Public medical school's 65 primary teaching hospitals are…	#	%
…separate legal entities (like KU Hospital)	35	54%
…aren't separate legal entities	29	45%
…legal status isn't known	1	1%
Total:	65	100%

Source: AAMC data on public medical school members

Hospital Board Membership Issues Raised by Legislators and Others

On November 1, 2006, the Hospital Board submitted five slates of candidate names to the Governor to fill five open seats on the Hospital's Board of Directors. Although each slate included two names, the five slates together listed only five names for the five open seats. That effectively gave the Governor no choice as to whom to appoint [K.S.A. 76-3304(e) says "The Governor shall appoint one board member from each slate…"].

According to Hospital officials, the Governor subsequently asked the Board to withdraw those slates of candidate names, and asked that Lt. Governor Mark Parkinson, local bank president Robert Regnier, and University of Kansas Executive Vice Chancellor Richard Lariviere be nominated to the Board. The Board submitted new slates of nominees to the Governor on December 19, including Lt. Governor Parkinson and Mr. Regnier. It also submitted Mr. Lariviere's name to fill the ex-officio position as Executive Vice Chancellor [the words "of the Medical Center" were not shown on the list, even though that's the ex-officio position listed in the statute]. Although Mr. Lariviere isn't the Executive Vice Chancellor of the Medical Center, a Hospital official told us no one reviewed the statute at the time the Hospital CEO, the Hospital's legal counsel, the Governor, and the Lt. Governor met and decided Mr. Lariviere would serve on the board as an ex-officio member.

On December 20, 2006, the Governor sent the Hospital Board a letter saying she would proceed with the following appointments:

- Mr. Regnier (who would fill the seat occupied by Eric Jager, a local business executive whose term on the Board had expired in March 2005)
- Lt. Governor Parkinson (whose term had expired in March 2006, and who had submitted his resignation to the Board in June 2006)
- Dr. George Farha (Chairman of the Hospital Board who was continuing to serve on the Board after his term had expired in March 2006)
- Robert Honse (a former business executive who was continuing to serve on the Board after his term had expired in March 2006)
- David Kerr (a former State Senator, who was continuing to serve on the Board after his term had expired in March 2006)
- Mr. Lariviere, who would fill the ex-officio position of the Executive Vice Chancellor. [An ex-officio position was vacant because the statute makes both the Executive Vice Chancellor of the Medical Center and the Executive Dean of the School of Medicine ex-officio members of the Board. Currently Dr. Barbara Atkinson is serving in both capacities.]

As of October 2007, the Governor had made only one appointment because numerous issues had been raised about these nominations and appointments. In January 2007, however, Mr. Lariviere began attending Board meetings. Because he was supposed to be filling an ex-officio position on the Board, he was recorded in Board minutes as attending the meeting as a member of the Board of Directors.

In March 2007, three more Board members' terms expired. Like other members of the Board, they are continuing to serve until a successor is appointed and confirmed as provided for by law. State law doesn't impose a deadline for making appointments to the Hospital Board. Several questions have been raised about this series of events:

Was the way the Board initially submitted slates of nominees to the Governor permissible under State law? The Attorney General has issued an opinion stating that submitting these slates of nominees at the same time with only five different nominee names submitted for the five positions "effectively precludes the Governor from selecting between two candidates. Such a slate would not comply with the statute." The Attorney General suggested submitting a single slate and waiting for the Governor to make an appointment before submitting the next slate as a way to comply with the statute.

Can the Governor reject a slate of nominees or can the nominating committee withdraw a slate? The Attorney General Opinion stated this would be allowable only if a nominee died, was otherwise unable to serve, or didn't meet statutory eligibility requirements. That wasn't the case here.

Did Mr. Lariviere meet the requirements for serving as an ex-officio member of the Board? The Attorney General issued a letter to the Hospital's CEO and a subsequent formal opinion stating that, because neither of Mr. Lariviere's titles—Provost of the University of Kansas, or Executive Vice Chancellor of the University of Kansas—are listed as an ex-officio position in K.S.A. 76-3304(b), Mr. Lariviere wasn't entitled to serve as an ex-officio member of the Board. He indicated that "any purported appointment by the Governor has no legal validity." After this opinion was issued, Mr. Lariviere quit attending Hospital Board meetings.

Is the Lt. Governor still a member of the Board, even though he has resigned from that position? The Lt. Governor's term on the Board expired in March 2006, and he submitted a letter of resignation to the Board in June 2006. The Governor has argued that, because he submitted his letter of resignation to the Board and not to her (the appointing authority), the Lt. Governor remains a Hospital Board member until a successor is appointed and confirmed.

The Attorney General found that current statutes don't specify who must accept a board member's resignation. He indicated that, under the common law rule, a resignation is effective only if it is accepted by the appointing authority. However, "acceptance" of a resignation doesn't require formal action, and can be based on the appointing authority's actions, such as appointing a successor, or "…in any manner treating the resignation as operative." In the opinion, the Attorney General indicated he wasn't able to determine whether the Governor has in effect accepted the Lt. Governor's resignation. This may be somewhat of a moot point—the Lt. Governor currently isn't acting as a Board member, and has attended only one meeting as a guest since submitting his letter of resignation.

- We also looked more closely at five states where the primary teaching hospital is a separate legal entity with its own governing board. We found that each of these hospitals and the affiliated public schools of medicine have negotiated agreements, and have university or school of medicine representation on the hospital's board of directors. The Medical Center and Hospital have those same arrangements.

Our review of the teaching hospitals' board representation in these five states and Kansas is summarized in ***Appendix D***. It showed the following:

- the chair of the hospital board typically is elected by board members
- officials affiliated with the medical school / university system were designated by statute or agreement to be board members in five of the six states. Their numbers varied from 12 of 21 voting members (57%) in Virginia to none in Nebraska. School / university-affiliated board members constituted a majority in two of those states.
- officials affiliated with the teaching hospital were designated by statute or written agreement to be board members in only two states—Kansas and Minnesota.
- other board members were appointed by a variety of individuals or entities, including governors, legislators, regents, and foundations.

Medical Center and Hospital officials have differing opinions about trends in organizational structures among academic teaching hospitals and medical centers. Hospital officials told us they thought the trend was towards a corporate model with more independent directors. Medical Center officials told us they thought the trend was toward greater alignment of academic and clinical entities, with a shift in control back toward the academic entity.

The Medical Center's and Hospital's Financial Relationship Isn't Defined in State Law, and Has Been a Source of Contention Between Them

Since it became a separate legal entity, the Hospital has entered into a number of financial agreements with the Medical Center, the various schools within the Medical Center, the KU Endowment Association, physician practice groups, individual physicians, and others specifying what services the parties agree to provide to each other, and what things the Hospital will pay for. This information is summarized in ***Figure 2-5.***

Neither the law nor the affiliation agreements between the Hospital and Medical Center specify what types of payments "count" as the Hospital's support of the Medical Center, or how much that overall support should be. The statutes state that the mission of the Hospital is to "…facilitate and support the education, research and public service activities of the University of Kansas Medical Center and its health sciences schools, to provide patient care and specialized services not widely available

Figure 2-5
Types of Service and Payment Agreements the Hospital
Had with the Medical Center or Other Faculty Physicians or Practice Groups,
And the Amounts Paid in Fiscal Years 2006 and 2007

Types of payments the Hospital makes…	FY 2006	FY 2007
A. Direct Contributions to the Medical Center. For example, the Hospital agreed to provide support for the Internal Medicine Fund and the School of Medicine to further education and research, and it agreed to provide assistance in the development of adequate education, training, and research opportunities in the Departments of Neurosurgery and Urology.	$2 million	$3 million
B. Payments for Resident Support. For example, the Hospital agreed to pay the Medical Center an amount equal to what the Hospital received from Medicare as reimbursement for direct graduate medical education (DME).	$6 million	$7 million
C. Payments Made Directly to the Medical Center for Professional Services. These are payments the Hospital makes directly to the Medical Center for services faculty provide the Hospital, such as medical ethics consultation services.	$0	$21 thousand
D. Indirect Payments for Professional Services. These are payments the Hospital makes to individual faculty physicians or faculty physician practice groups for services they provide the Hospital. For example, the Hospital agreed to provide assistance to the Kansas University Anesthesiology Foundation to adequately fund the recruitment, employment, and retention of anesthesiology specialists in order to support patient-care services and education/research activities of the School of Medicine.	$12 million	$17 million
E. Fee-for-service type payments between the Hospital and the Medical Center. For example, the Hospital agreed to pay the Medical Center for providing such administrative services as parking, police, security, and utilities, and the Medical Center agreed to pay the Hospital for such administrative services as cleaning, laundry, and switchboard services. Because the Hospital pays more for such fees than the Medical Center does, the dollars listed to the right show the net amount the Hospital pays that is over-and-above what it receives from the Medical Center.	$9 million	$7 million

Source: Medical Center and Hospital staff

elsewhere in the State and to continue the historic tradition of care by the University of Kansas Hospital to medically indigent citizens of Kansas."

The statutes don't define what constitutes support. According to Hospital and Medical Center officials and consultants we spoke with, support can mean many things. In addition to direct transfers of funds from a teaching hospital to a school of medicine, support can include such things as providing a large number and wide variety of patients, modern facilities, or up-to-date medical equipment and technology.

The Hospital and Medical Center have disagreed about which Hospital payments constitute "support" of the Medical Center. *Hospital* officials told us they have viewed all the types of payments

listed in ***Figure 2-5*** as benefitting the Medical Center. In addition, they pointed out that the Hospital provides a significant amount of in-kind support to the Medical Center, including the following:

- patient registration and medical records computer systems
- re-purchase of the Hospital's cancer center, which had been sold to Salick Health Care in 1992
- re-establishment of cardiovascular and cardiothoracic surgery at the Hospital
- construction of a hospital power plant, which allowed the Kansas Life Sciences and Clinical Innovation building to operate without additional University investment
- faculty recruitment packages in support of University recruitment efforts

Hospital officials also told us they maintain "unprofitable" service lines—such as obstetrics and psychiatry—because medical students and residents need experience in these areas.

Medical Center officials told us they viewed only the direct payments the Hospital made to the Medical Center as support (Items A-C on ***Figure 2-5***). Medical Center officials also told us they thought the Hospital should be providing more support, particularly in two areas:

- **indirect graduate medical education payments (referred to as IME).** Through the Medicare program, the federal government gives hospitals funding for medical residency programs. Those funds fall into two categories: direct and indirect. As noted in the Overview, Medicare direct graduate medical education funds (DME) are intended to provide hospitals with funding for direct costs incurred when training residents, including salaries for residents and the faculty that supervise them, clerical support, and other direct costs for institutional overhead, such as maintenance and electricity. The Hospital received approximately $6 million in Medicare DME in fiscal year 2006, the latest year for which information was available. Indirect graduate medical education funds (IME) are intended to provide funding for the extra costs hospitals incur when training residents for lab tests, supplies, and the like. The Hospital received $11.7 million in Medicare IME funding for fiscal year 2006.

  In an agreement originally negotiated in 1998, the Medical Center and Hospital agreed that the Hospital would pay the Medical Center the direct funds (DME) it receives from Medicare. Medical Center officials told us they thought the Hospital also should pay them the indirect funds (IME) the Hospital receives for training residents. Although IME is meant for the increased costs experienced by teaching hospitals, Medical Center officials pointed out that the two hospitals affiliated with the Medical Center's Wichita campus contribute a portion of both the direct and indirect graduate medical education funds they receive to the residency program in Wichita.

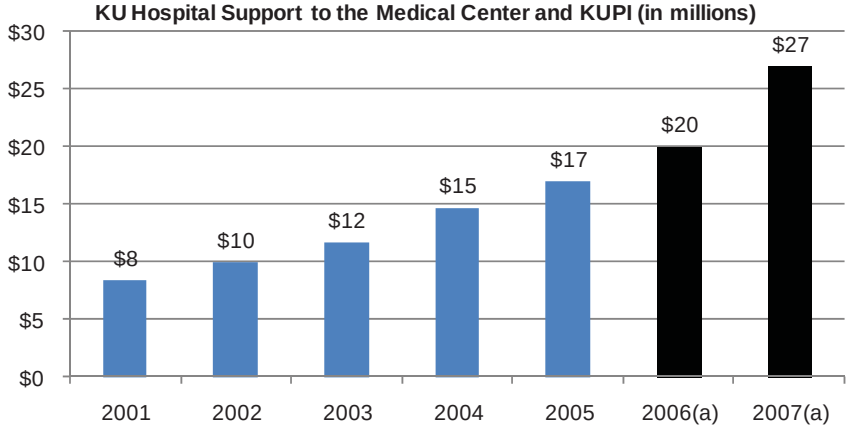
That program is operated by the Wichita Center for Graduate Medical Education (WCGME) under contract with the Medical Center and Wichita hospitals.

- **unrestricted contributions.** When the Hospital was split off from the Medical Center in 1998, it faced severe financial difficulties. However, its financial situation has improved significantly since then. In fiscal years 2004, 2005, and 2006, the Hospital's adjusted revenues exceeded expenses by $29 million, $50 million, and $48 million, respectively. (We adjusted the Hospital's revenues to account for Medicare and Medicaid payments the Hospital received in one year for services provided in prior years.) Medical Center officials told us that now that the Hospital's revenues are exceeding its expenses, they thought they should receive a reasonable share of that amount as part of the Hospital's mission to support the Medical Center.

With the help of a consultant, the Medical Center and Hospital have reached a tentative agreement on what types of things will constitute the Hospital's support of the Medical Center, and a base level for that support. In November 2006, the Hospital and Medical Center hired consultants to help them reach an agreement on the Hospital's support of the Medical Center. A final agreement hadn't been reached as of October 12, 2007, but Hospital and Medical Center officials had agreed on the following:

- **guiding principles that addressed what <u>types</u> of payments each would consider to be support.** These principles were "to be used to develop definitive agreements." In essence, the two entities have agreed to count Items A-D from ***Figure 2-5*** as support. Those payments are the Hospital's direct contributions, its payments for resident support, and its direct and indirect payments for professional services. The two entities have agreed <u>not</u> to count the Hospital's net fee-for-service type payments for administrative and support services, or the in-kind services it provides.

Figure 2-6
KU Hospital Support to the Medical Center and KUPI (in millions)



(a) LPA Analysis of KU Hospital and KUMC Data
Source: Chartis Hospital Support Presentation & LPA Analysis

These four types of payments totaled $20 million in fiscal year 2006, and $27 million in fiscal year 2007. As ***Figure 2-6*** shows, those amounts reflect an upward trend in the reported amount of Hospital support of the Medical Center since fiscal year 2001.

- **a future baseline level of support.** The two entities have agreed to work toward a baseline level of support that ultimately would be 10% of the Hospital's net patient revenue. They also agreed that Items A-D listed in ***Figure 2-5*** would count toward this baseline level of support.

  For fiscal year 2008, the amount of support the Hospital would provide is estimated to be about $42.5 million. That figure would be significantly higher than the Hospital's total payments for Items A-D in previous years.

Comparisons with Other State Medical Centers Have Significant Limitations, but the Support the Medical Center Has Received Does Appear To Be Relatively Low

Officials from the Association of American Medical Colleges (AAMC), the University HealthSystem Consortium (UHC), and other consultants told us it is difficult to compare the amount of support teaching hospitals provide medical schools. Factors that can contribute to the differences between the amount of hospital support the Medical Center receives, and how much these other states' medical schools receive, include:

- the size and profitability of the primary teaching hospital—a larger and more profitable hospital has more funds available to support its affiliated medical school. In addition, whether a primary teaching hospital receives a state appropriation impacts its ability to support its affiliated medical school.

- the more funding a medical school receives from other sources, such as the State appropriations or federal grants, the less support it needs from affiliated hospitals to operate its programs.

- the amount of Medicare graduate medical education funding a hospital receives impacts its ability to help pay resident stipends and other resident program costs. Because Medicare graduate medical education rates vary by hospital, the amount of funds hospitals have available to pass on to medical schools also varies.

The reader should be aware of these limitations in reviewing the information provided below.

To compare Kansas with other states' schools, we gathered data from the Association of American Medical Colleges (AAMC), which surveys public medical schools each year regarding the revenues they receive. These self-reported revenues include the amount of direct and indirect support these schools receive from **all their affiliated hospitals**, not just their primary teaching hospitals.

We gathered these data for a sample of five public medical schools that appeared to be most like Kansas—they had a single primary teaching hospital that had been split off from the school. Four of the five comparison states we selected are Midwest or neighboring

state schools. The fifth, Virginia Commonwealth, was selected because it served as a model for how the Hospital and Medical Center currently are structured. According to hospital data, fiscal year 2005 net patient revenues for the six primary teaching hospitals we compared ranged from $482 million for the KU Hospital to $1.8 billion for the University of Minnesota's Fairview Health System.

In our comparisons, we had to adjust what the Medical Center reported to the AAMC to make it more comparable with what other states had reported. We contacted officials at all five sample medical schools to verify that they had submitted information to AAMC for the same types of support payments (similar to the definitions the Hospital and Medical Center now have agreed to count as "support"), and that they had included the direct and indirect support from all their affiliated hospitals. They all reported that they had.

However, we determined that the information the Medical Center submitted for 2005 had excluded two types of indirect support payments that our five sample states had provided:

- **the Medical Center had excluded the indirect payments the Hospital had made to individual Medical Center faculty physicians or practice groups**

- **the Medical Center had excluded the indirect support the hospitals in Wichita had provided for the Medical Center's residency program in Wichita.** In Wichita, the hospitals provide funding directly to the Wichita Center for Graduate Medical Education, which actually employs the medical residents under contact with the medical center and pays their salaries and some administrative costs of the residency program. In Kansas City, by contrast, medical residents are employed directly by the Medical Center, so the Hospital pays the Medical Center directly for its support of the residency program there.

The Medical Center reported $13.6 million in financial support for fiscal year 2005 to the Association of American Medical Colleges (AAMC). To allow us to make comparisons based on the same definition, we added indirect payments the Medical Center didn't report to its reported amount. This increased the Medical Center's support that year to $35.5 million.

The amount of support the Medical Center received from all its affiliated hospitals in fiscal year 2005 was low compared to other state schools. The information we gathered from the five comparison state medical centers and our adjusted Kansas

information is summarized in ***Figure 2-7.*** That figure shows how hospital support, state funding, and federal funding compare for the five medical schools we contacted.

Figure 2-7
Hospital, State and Federal Support of State Medical Schools (FY 2005, in millions)

	Financial Support From All Hospitals		State Support		Federal Grants & Contracts		Hospital Support + Federal Support + State Approp.	
	$	Rank	$	Rank	$	Rank	$	Rank
Virginia Commonwealth University	$108.8	1	$31.9	5	$78.2	4	$218.9	4
University of Wisconsin	$74.3	2	$37.8	4	$153.4	2	$265.5	3
University of Colorado at Denver and Health Sciences Center	$66.2	3	$13.0	6	$293.1	1	$372.3	1
University of Minnesota	$50.3	4	$76.3	3	$146.5	3	$273.1	2
University of Nebraska	$40.6	5	$76.5	2	$47.3	6	$164.4	6
University of Kansas	$35.5	6	$83.3	1	$55.0	5	$173.8	5

Source: AAMC Data and officials from each university.

As ***Figure 2-7*** shows, the Medical Center received less in affiliated hospital support, less in federal grants and contracts, and more in State support than the other medical centers we contacted. Kansas ranked fifth out of six when all three sources are combined, and was very similar to Nebraska. As described more fully in Question 1, the Medical Center may receive more State support than other states because the Hospital's Medicare GME payment rate is low. As a result, State moneys are being used to supplement paying resident costs.

To try to account for large differences in the size of comparison hospitals and medical schools, we calculated amounts of support on a per resident/fellow basis. Those comparisons are shown in ***Figure 2-8.***

Figure 2-8
Financial Support of State Medical Schools per Resident / Fellow
Fiscal Year 2005

	Financial Support From All Affiliated Hospitals (in millions)		# Residents/ Fellows		Hospital Financial Support—per Resident/Fellow		Hospital Support + Federal Support + State Approp. per Resident/Fellow	
	$	Rank	#	Rank	$	Rank	$	Rank
Virginia Commonwealth University	$108.8	1	826	3	$132,000	1	$265,000	5
University of Wisconsin	$74.3	2	610	5	$122,000	2	$435,000	1
University of Colorado at Denver and Health Sciences Center	$66.2	3	886	1	$75,000	4	$420,000	2
University of Minnesota	$50.3	4	880	2	$57,000	5	$310,000	4
University of Nebraska	$40.6	5	439	6	$92,000	3	$374,000	3
University of Kansas	$35.5	6	689	4	$52,000	6	$252,000	6

Source: AAMC Data and officials from each university.

As ***Figure 2-8*** shows, the Medical Center ranked last in terms of the financial support it received from all its affiliated hospitals, both in total dollars and on a per-resident/fellow basis. The Medical Center also ranked last in total affiliated hospital, federal, and State support on a

per-resident/fellow basis. However, the reader should be aware these comparisons don't account for other differences between the Hospital and Medical Center, and hospitals and medical centers in other states.

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

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

ANSWER IN BRIEF: *The value of the care provided to medically indigent patients may be recorded as either charity care or bad debt, and is referred to as uncompensated care. When reporting the value of charity care or bad debt in its financial statements, the KU Hospital follows generally accepted accounting principles. Those principles require public teaching hospitals to report the value of that care based on their established charges for the services provided. However, reporting the value of uncompensated care (charity care plus bad debt) on that basis results in much higher dollar figures than if the care is valued based either on discounted rates for paying patients or the cost of the care. These and other findings are discussed in the sections that follow.*

The Value of the Care Provided to Medically Indigent Patients May Be Recorded as Either Charity Care or Bad Debt

State law requires the Hospital to provide care to medically indigent Kansans. K.S.A. 76-3302(a)(4) states that, "The mission of the University of Kansas hospital is to…continue the historic tradition of care by the University of Kansas hospital to medically indigent citizens of Kansas."

In our discussions with Hospital officials, we found that the value of the care provided to the medically indigent may be recorded in the Hospital's accounting records as either charity care or as bad debt. Here's why:

- the Hospital determines which patients can't afford to pay for the care they receive—and are therefore eligible for charity care—based on the financial criteria it adopts. For patients who cooperate with the financial assistance process and provide financial information showing they meet those criteria, the care they receive is recorded as charity care.

- Some patients who won't cooperate or submit this financial information also may be unable to afford their medical bills, but their care typically ends up being recorded as bad debt.

Although bad debt also can include people who could afford to pay their medical bills but didn't, Hospital officials told us most of their bad debt and charity care involves patients who don't have insurance. Further, according to the American Hospital Association, the total of charity care plus bad debt reflects care hospitals provide to those who can't afford to pay their hospital bills—the medically indigent.

For these reasons, in answering this question we used the combination of charity care and bad debt as the measure of indigent

care. Hospitals refer to charity care and bad debt as "uncompensated care." Uncompensated care does not include unfunded costs that result from inadequate Medicaid or Medicare payments, or from charges hospitals agree to write off as part of any agreements with health insurers. However, some hospitals do include unfunded Medicare/Medicaid costs in their hospital specific "community benefit" reports.

When Reporting the Value Of Uncompensated Care In Its Financial Statements, the Hospital Follows Generally Accepted Accounting Principles

Generally accepted accounting principles (GAAP) require hospitals to determine the value of the components of uncompensated care—charity care and bad debt—based on the hospital's established charges for the services provided.

The University of Kansas Hospital reported providing $80.9 million in uncompensated care in fiscal year 2006, based on its established charges. The Hospital reported charity care and bad debt that totaled $80.9 million in its audited financial statements, and $80.9 million of uncompensated care in its annual report.

Other hospitals follow the same methods for reporting charity care and bad debt in financial statements and annual reports. According to hospital officials and hospital's published financial statements, teaching hospitals in other states also follow GAAP and report charity care and bad debt in their financial statements based on established charges.

We also reviewed how other states' teaching hospitals report uncompensated care in their annual reports or community benefit reports. We found other hospitals do report uncompensated care based on charges in these reports, and sometimes they also report the cost of that care. The Medical College of Virginia Hospitals and University of Wisconsin Hospitals and Clinics report both charges and costs in their annual reports. Only 3 of the hospitals we contacted – The Nebraska Medical Center, Medical College of Virginia Hospitals, and the University of Wisconsin Hospitals and Clinics – publish community benefit reports. All 3 of these hospitals report uncompensated care charges in their community benefit reports though the Medical College of Virginia also reports uncompensated care costs.

The Hospital's Uncompensated Care Charges Are Much Higher Than Estimates Based on Either Discounted Rates for Paying- Patients or the Cost of Care

Although the value of charity care and bad debt reported in hospitals' financial statements is required to be based on established charges for that care, that figure may not be the most meaningful. Because various discounts are applied to hospital charges, those charges typically don't reflect what's actually paid for care.

Most health care is paid for by insurance companies, Medicaid, or Medicare. Those entities either negotiate or simply set how much they

will pay for services, regardless of hospitals' established charges. For example, a hospital may charge $17,000 for an appendectomy, but the negotiated payment from one insurance company may be only $7,000, and Medicare or Medicaid may set its hospital reimbursement rate at only $6,500.

In other words, the competitive market forces that establish the value of care are reflected in the amount insurance companies and government programs agree to pay for a hospital's services, not in how much the hospital charges.

Overall, the KU Hospital discounts charges for its paying patients by about 61%. To answer the audit question, we needed to determine the value of care provided to indigent patients based on the revenues the Hospital likely would have received if those same services had been provided to paying patients. Because this isn't the way GAAP or other entities look at the value of care being provided, we developed our own methodology.

Figure 3-1
LPA Analysis of the University of Kansas Hospital's Average Paying-Patient Charges, Discounts, and Revenue
Fiscal Years 2005 and 2006
(in millions)

	FY 2005		FY 2006	
	$	%	$	%
Total Charges – What the Hospital charged for care that Medicaid, Medicare, Insurance, the patient, or someone else will pay for.	$1,192	100%	$1,343	100%
Total "Discounts" – The portion of charges the Hospital wrote off as a result of Medicaid and Medicare's reimbursement rates and discounts given to insurance companies.	($743)	(62%)	($822)	(61%)
Average Net Hospital Revenue – Funds the Hospital expects to receive for paying patients.	$449	38%	$521	39%

Source: LPA Analysis of KU Hospital Financial Data

We calculated the average discount on charges the Hospital applies to services that aren't written off as charity care or bad debt. ***Figure 3-1*** shows those discounts for fiscal years 2005 and 2006.

Applying the 61% discount to the Hospital's uncompensated care charges for fiscal year 2006 would reduce the value of that care from about $81 million (the amount charged) to about $31 million (the amount the Hospital likely would have received).

In fiscal year 2005, the Hospital's uncompensated care costs were about one-third of its established charges for that care. A number of organizations—including the American Hospital Association, the Missouri Hospital Association, the Government Accountability Office, and the Healthcare Financial Management Association—report or recommend reporting the value of uncompensated care based on the costs of providing that care, rather than what the hospital charges for those services.

As mentioned, established charges aren't market-driven. The Healthcare Financial Management Association notes, "…there is great variance among providers' charges, and consequently very little comparability." The charge variance among hospitals can be due to a number of factors, including cost of living variances, case-mix variances, inpatient and outpatient usage, and hospital philosophy.

Officials from the Missouri Hospital Association surveyed Missouri- and Kansas City-area hospitals about their estimated uncompensated care costs in fiscal year 2005. Because of concerns some Kansas City-area hospital officials expressed about the comparability of previous surveys, Association officials specified a standard methodology for estimating uncompensated care costs for 2005.

Using this cost-based methodology, the University of Kansas Hospital reported uncompensated care costs of $24.6 million in fiscal year 2005. That's about one-third of the $73.3 million in uncompensated care charges the hospital reported that year in its audited financial statements.

The box below shows the results of the Missouri Hospital Association's survey for Kansas City area hospitals. Data for fiscal year 2006 is not yet available.

Comparison of Kansas City Area Hospitals' Uncompensated Care Costs

The Missouri Hospital Association developed a methodology for calculating uncompensated care costs that allows comparison of those costs between Kansas City area hospitals. Based on data self-reported by the hospitals, the KU Hospital provided more dollars worth of uncompensated care – based on the total cost of that care – than all but one other area hospital. KU Hospital has the 3rd highest Uncompensated Care Cost as a percentage of total expenses when compared to Kansas City area hospitals that provide $9 million or more in uncompensated care.

Kansas City Area Hospitals' FY 2005 Uncompensated Care Costs (in millions)

Hospital	Uncompensated Care Cost	Uncompensated Care as a % of Total Expenses
Truman Medical Center Hospital Hill	$41.7	16.9%
University of Kansas Hospital	**$24.6**	5.4%
Truman Medical Center Lakewood	$13.9	16.9%
Saint Luke's Hospital of Kansas City	$12.1	3.2%
Children's Mercy Hospitals and Clinics	$9.3	2.4%
Shawnee Mission Medical Center	$9.1	3.3%

In summary, the value of uncompensated care provided by the Hospital varies greatly, depending on the basis used for

the calculation. ***Figure 3-2*** shows the value of the Hospital's uncompensated care based on the three different valuation methods:

- The Hospital's charges for uncompensated care, as reported in its financial statements in accordance with GAAP reporting requirements
- Our analysis of how much the Hospital could have expected to receive for these services if it had provided them to paying patients
- The estimated cost of care reported by KU Hospital in the Missouri Hospital Association survey.

Figure 3-2
Value of Uncompensated Care Estimates
(in millions)

Value of Uncompensated Care Based on:	FY 2005	FY 2006
Established Charges	$73.3	$80.9
Paying-Patient Discounts	$27.6	$31.4
Estimated Costs	$24.6	n/a

Source: KU Financial Statements, LPA Analysis of KU Hospital Data and MHA Survey Data

As the table shows, the charge figure is roughly three times higher than expected revenues or costs. Although reporting the value of uncompensated care based on charges in financial statements is appropriate and required by GAAP, other organizations recommend using a cost-based valuation.

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

***RECOMMENDATION*:**

1. To ensure that the value of uncompensated care provided by the University of Kansas Hospital is reported in a meaningful way, the Hospital should:

   a. continue to report the value of uncompensated care and bad debt based on charges in its financial statements, as required by GAAP, and
   b. expand their usage of other more comparative methods of reporting the value of uncompensated care in its other publications, such as using a cost basis in its annual report.

APPENDIX A
Scope Statement

This appendix contains the scope statement approved by the Legislative Post Audit Committee for this audit on April 24, 2007. The audit was requested by Senators Hensley and Steineger, and Representatives Neufeld and Morrison.

KU Medical Center and KU Hospital: Reviewing Selected Operational Issues

Before 1998, the University of Kansas Medical Center included both a hospital and a teaching/research facility. During the 1998 Session, the Legislature separated those functions and created the University of Kansas Hospital Authority to operate the University of Kansas Hospital. The University of Kansas Medical Center now includes only the education/research function (encompassing the schools of Medicine (Kansas City and Wichita), Nursing, and Allied Health, as well as a graduate school) and remains under the jurisdiction of the University of Kansas. The Executive Vice Chancellor of the Medical Center reports directly to the Chancellor of the University of Kansas.

The mission of the University of Kansas Hospital is to facilitate and support the education, research, and public service activities of the University of Kansas Medical Center and its health sciences schools. Also included in the mission is providing patient care and specialized services not widely available elsewhere in the State, and continuing the historic tradition of providing care to medically indigent citizens of Kansas.

In 2001, the Legislature changed the way it funds State universities. Instead of multiple line-item appropriations, which had been used in the past, it went to a system of operating grants. The change was made to allow the institutions greater flexibility in managing their budgets.

Recently, legislators have expressed concerns about operational issues related to both the Medical Center and the Hospital, and about the relationship between the two. Specifically, they have raised questions about whether the Medical Center has been spending more of its operating grant on research, and if so, whether that is affecting the teaching/medical education functions on the school's campuses in Kansas City and Wichita. In addition, they have questioned whether the relationship between the Hospital and the Medical Center is fulfilling the statutory charge established when the Hospital Authority was created, and what level of support the Hospital is providing the Medical Center. Finally, legislators have expressed concern about how the KU Hospital determines the dollar value it assigns to care provided to indigent patients.

A performance audit of this topic would address the following questions.

1. **How has spending for education and research functions from the Medical Center's operating grant changed in recent years, and how has that affected the amounts of money distributed to the Kansas City and Wichita campuses?** To answer this question, we would review available data showing spending on teaching and research functions at the Medical Center (from both before and after the operating grant system was put in place) to determine whether there has been a significant shift in spending in recent years. If so, we

would interview officials at the Medical Center to determine why this shift has occurred. We also would analyze the amounts being allocated to the Kansas City and Wichita campuses to determine whether there has been any significant change in recent years. If so, we would talk to officials and review records to determine what accounts for those changes. We would conduct additional work in this area as needed.

2. **How does the relationship between the KU Hospital and the University of Kansas Medical Center compare to what is envisioned in State law, and to relationships that have been established between medical schools and teaching hospitals in other states?** To answer this question, we would review the statutes regarding the ways the KU Hospital is supposed to support the Medical Center. Through discussions with officials at the Hospital and the Medical Center and by reviewing records, we would determine the types and levels of support the Hospital has been providing to the Medical Center over the past five years. We would contact teaching hospitals in other states to determine the structures they have set up between their teaching hospitals and medical schools, and the relative levels of support they provide. We would compare the structure and levels of support in Kansas to the structure and relative levels of support in other states to determine whether Kansas' arrangement is typical. We also would determine what checks and balances have been put into place to ensure that the KU Hospital operates with the interests of the Medical Center in mind. We would conduct other work in this area as needed.

3. **Does the KU Hospital have a reasonable method for assigning a value to the care provided to patients who are indigent?** To answer this question, we would interview Hospital officials to find out how they determine the amount they report as indigent care. During our interviews with teaching hospitals in other states in Question 2, we would find out how those hospitals determine a value for indigent care, and compare that to the process followed by the KU Hospital. In addition, we would look at how the rates used in determining the value of indigent care compare with the rates for patients who have some type of employer- or insurance-based discount. This might involve comparing the rates for a sample of common procedures or services, or looking at a sample of negotiated agreements. We would conduct other work in this area as needed.

Estimated Time to Complete: 14 – 16 weeks

APPENDIX B

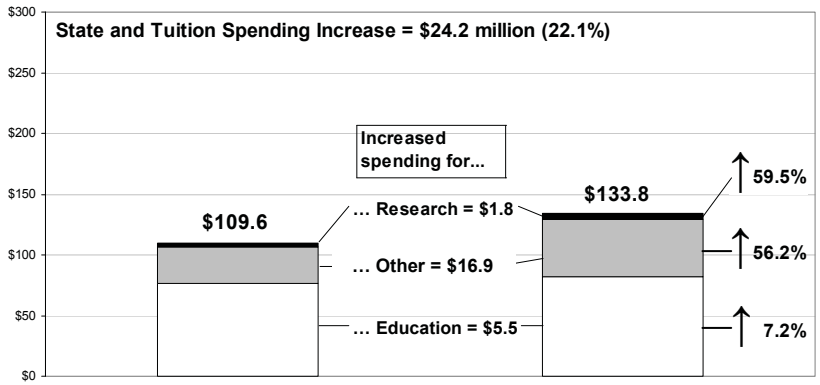
State and Tuition Expenditures on Education, Research and Administration

In addition to analyzing trends from State appropriations only, we also looked at spending from both State moneys and tuition dollars. These are two categories of funding that the Executive Vice Chancellor has discretion on where/how to spend. This analysis produced very similar results as our analysis of State expenditures only.

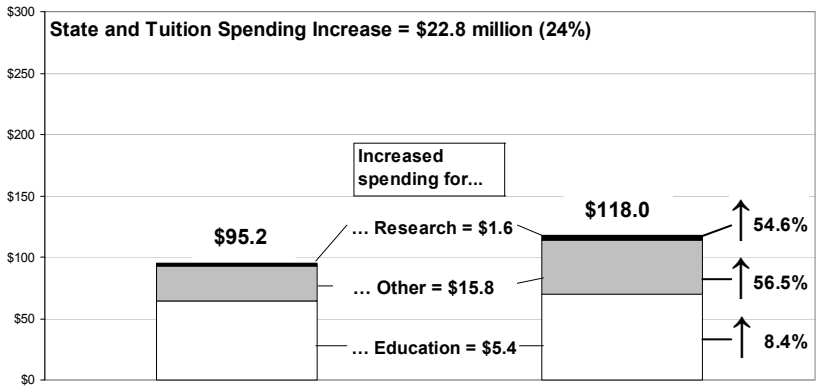
Appendix B
Increase in STATE and TUITION Expenditures on Education, Research and Other (amounts in millions)

Research
Other
Education

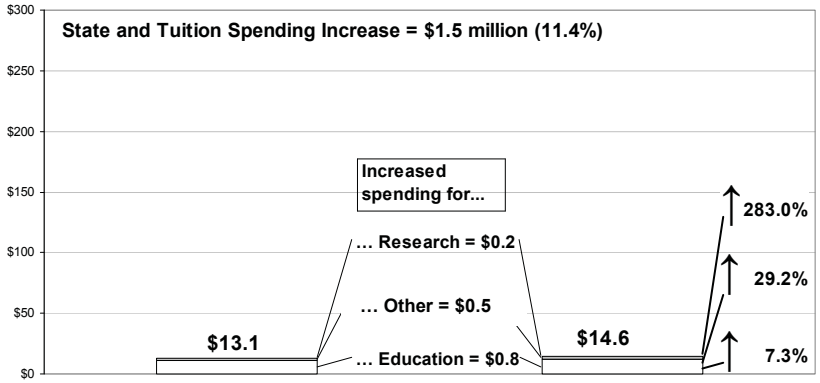
Overall Expenditures



Kansas City Campus Expenditures



Wichita Campus Expenditures



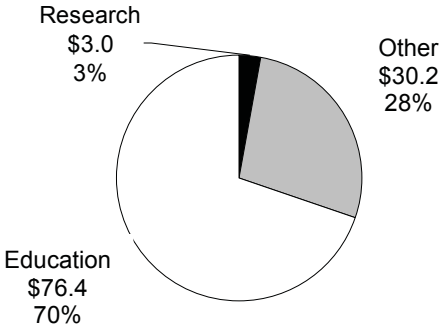
Source: Expenditure data from KU Medical Center, KUMC Research Institute, and Wichita Center for Graduate Medical Education.

Notes: Figures may not add due to rounding.
There is a separate "Outreach" category that isn't included in Kansas City or Wichita expenditures. Thus, Kansas City and Wichita do not add up to Overall expenditures.

Increase in STATE and TUITION Expenditures on Education, Research and Other (amounts in millions)

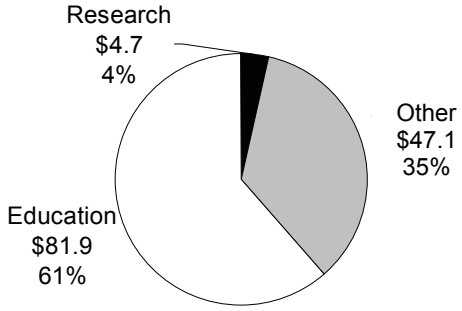
FY 2001

State and Tuition Expenditures = $109.6

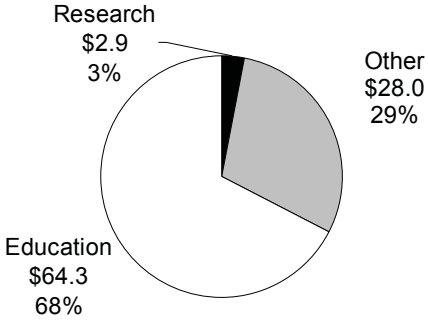


FY 2007

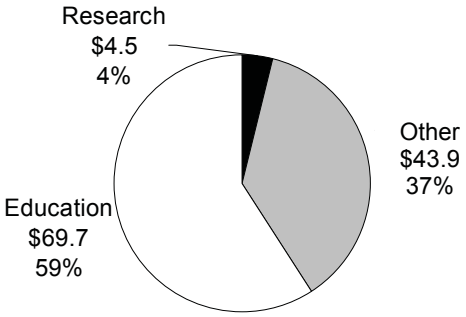
State and Tuition Expenditures = $133.8



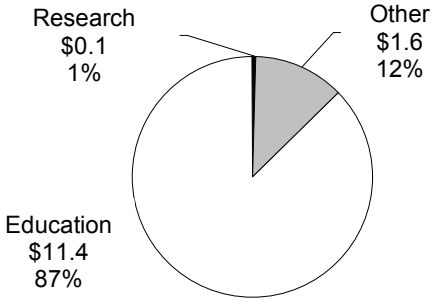
State and Tuition Expenditures = $95.2



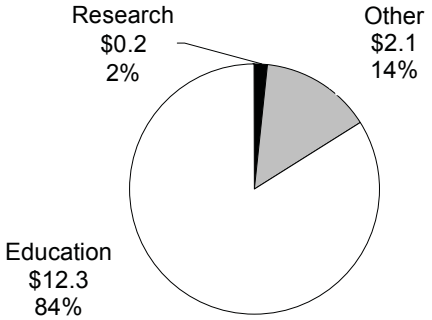
State and Tuition Expenditures = $118.0



State and Tuition Expenditures = $13.1



State and Tuition Expenditures = $14.6



Source: Expenditure data from KU Medical Center, KUMC Research Institute, and Wichita Center for Graduate Medical Education.

Notes: Figures may not add due to rounding.
There is a separate "Outreach" category that isn't included in Kansas City or Wichita expenditures. Thus, Kansas City and Wichita do not add up to Overall expenditures.

APPENDIX C

Attorney General's Opinion on Hospital Board Membership

This Appendix contains Attorney General Opinion No. 2007-13 issued on June 20, 2007 in response to questions Senators Schmidt and Hensley raised about the nomination and appointment process for members of the KU Hospital Authority Board. A May 16, 2007 letter the Attorney General sent to then Hospital CEO Irene Cumming and referenced in Opinion No. 2007-13, is also included in this Appendix.

June 20, 2007

ATTORNEY GENERAL OPINION NO. 2007- 13

The Honorable Derek Schmidt
Senate Majority Leader
Chairman, Confirmations Oversight Committee
State Senator, 15th District
P.O. Box 747
Independence, Kansas 67301

The Honorable Anthony Hensley
Senate Minority Leader
Vice-Chairman, Confirmations Oversight Committee
State Senator, 19th District
2226 S.E. Virginia Avenue
Topeka, Kansas 66605

Re: State Institutions and Agencies; Historical Property--University of Kansas Hospital Authority; Creation; Board of Directors; Membership; Nomination and Appointment Process; Board Resignations

Synopsis: Submitting multiple slates of nominees to the Governor to fill multiple vacancies on the Board of Directors (Board) of the University of Kansas Hospital Authority does not violate K.S.A. 2006 Supp. 76-3304. As the Governor can only select from a slate provided by the Board's nominating committee, common sense dictates that should a candidate die, be otherwise unable to serve, or not meet the statutory requirements, the Board's nominating committee should provide the Governor another slate of individuals. The Legislature has not imposed deadlines on the Governor for selecting an appointee or forwarding the appointment to the Senate for confirmation.

Gubernatorial appointees can exercise the powers, duties, and functions of a Board member only if the appointee is either: (1) confirmed by the Senate pursuant to K.S.A. 75-4315b; or (2) authorized by the confirmation oversight committee pursuant to K.S.A. 46-2601. However, a person nominated by the Board's nominating committee but not yet appointed by the Governor or confirmed by the Senate has the same standing as a member of the public to participate in open

meetings, to the extent allowed by the Board. As with any non-Board member, such person may attend and participate in discussions during a Board executive session if such person, in the Board's opinion, will aid its discussion. However, a gubernatorial appointee cannot vote until authorized by the confirmation oversight committee or confirmed by the Senate. Whether or not Board action is affected by virtue of a person voting on a matter in which the person had no authority to do so will depend upon the facts.

Finally, as Board members are public officers, a Board member's resignation will not create a vacancy on the Board unless and until it is accepted by the Governor. Such acceptance does not need to be formal. Rather, any conduct treating the resignation as operative is sufficient. Whether or not the Governor has accepted a Board member's resignation is a question of fact. Cited herein: K.S.A. 20-134; 20-2910; 20-2911; 20-3005; 20-3008; 46-2601; 75-4315b; 75-4317; K.S.A. 2006 Supp. 75-2701; 76-3302; 76-3304; 76-3306; 77-109; Kan. Const. Art. 1, § 3; Art. 2, § 18; Art. 3, § 5; Art. 15, § 1.

* * *

Dear Senators Schmidt and Hensley:

You inquire regarding the nomination and appointment process for members of the Board of Directors (Board) of the University of Kansas Hospital Authority (Authority). The Authority is an independent instrumentality of the State charged with operating the University of Kansas hospital.[1]

The statute governing this process is K.S.A. 2006 Supp. 76-3304 which provides, in part:

"(b) The authority shall be governed by a nineteen-member board of directors. Thirteen of the members shall be appointed by the governor, subject to confirmation by the senate as provided in K.S.A. 75-4315b, and amendments thereto. Members appointed by the governor shall be representatives of the general public who are recognized for outstanding knowledge and leadership in the fields of finance, business, health-care management, health care providers, legal affairs, education or government. Of the 13 members representing the general public, there shall be at least one member from each congressional district. Six members shall be ex officio voting members consisting of the chancellor of the university of Kansas, the executive vice chancellor of the university of Kansas medical center, the executive dean of the university of Kansas school of medicine, the chief of staff of the university of Kansas hospital medical staff, the president of the authority and the dean of the university of Kansas school of nursing.

[1]K.S.A. 2006 Supp. 76-3302; 76-3304(a).

. . . .

"(d) After the board of directors is appointed . . . members other than ex officio shall be appointed for a term of four years each. Whenever a vacancy occurs in the membership of the board prior to the expiration of a term of office, the governor shall appoint, in the manner provided by subsection (e), a qualified successor to fill the unexpired term. Each member shall hold office for the term of appointment and until the successor has been appointed and confirmed.

"(e) When a vacancy occurs or is announced regarding a member or members representing the general public, a nominating committee of the board after receiving input from the board and conferring with the board shall assemble a slate of not less than two nor more than three persons for each vacancy and shall forward each slate to the governor. The governor shall appoint one board member from each slate and shall forward each appointment to the senate for confirmation as provided in K.S.A. 75-4315b, and amendments thereto. Except as provided by K.S.A. 2005 Supp. 46-2601, and amendments thereto, no person appointed to the board shall exercise any power, duty or function as a member of the board until confirmed by the senate.

. . . .

"(k) The board may adopt, repeal and amend such rules, procedures and bylaws, not contrary to law or inconsistent with this act, as it deems expedient for its own governance and for the governance and management of the authority."

Your questions are, as follows:

1. Is the practice of submitting to the governor staggered slates of nominees that leave the governor no discretion in the persons nominated to fill multiple vacancies on the board permissible under K.S.A. 2006 Supp. 76-3304?

Answer: Section (e) of K.S.A. 2006 Supp. 76-3304 addresses the nomination process which provides that the Board's nominating committee "shall assemble a slate of not less than two nor more than three persons for each vacancy and shall forward each slate to the governor."

When interpreting this provision, an appellate court will first look to the intent as expressed in the language.[2] If the language is plain and unambiguous, the court is obligated to implement the expressed intent.[3]

[2] *Bluestem Telephone Co. v. Kansas Corp. Commn.,* 33 Kan.App.2d 817 (2005).

[3] *Id.*

Clearly, the nomination process does not prescribe a procedure for submitting slates to the Governor. Therefore, in the absence of legislation dictating a process, submitting two or more slates for multiple vacancies does not violate Section (e).

We also note that when Section (e) was amended in 2002 to increase the size of the Board, the appointment process was revised to more closely resemble the judicial appointment process which contemplates submitting multiple lists for multiple vacancies.[4]
We have been advised that the Board's nominating committee has been submitting two or three two-person slates for multiple vacancies at the same time rather than submitting one slate and waiting till the Governor makes her selection before submitting another slate. While the law does not require the latter procedure, the current process may inadvertently result in a slate containing a person who was previously appointed. For example:

Slate #1: Smith Jones
Slate #2: Jones White
Slate #3: White Davis

If the Governor appoints Smith from the Slate #1 to fill Vacancy #1 and White from the Slate #2 to fill Vacancy #2, the only person eligible for appointment for Vacancy # 3 is Davis which, effectively, precludes the Governor from selecting between two candidates. Such a slate would not comply with the statute.

In order to abide by the spirit of the law which presumes a meaningful choice among nominees, we suggest that the Board's nominating committee revise its practice of submitting multiple slates for multiple vacancies and consider submitting a slate of nominees only after the Governor has made her selection from a previously submitted slate.

2.

(a) Once a slate is presented to the Governor, may the Governor - either formally or informally - reject the slate or request that an alternate slate be presented to her?

(b) Once a slate is presented to the Governor, may the nominating committee withdraw the slate for the purpose of altering its composition or presenting an alternate slate?

Answer: Unlike other statutes authorizing the rejection or withdrawal of slates of nominees,[5] K.S.A. 2006 Supp. 76-3304 is silent. Section (e) provides that a nominating committee "shall assemble a slate" of individuals and "shall forward" the slate to the Governor. The Governor "shall appoint one board member from each slate" and then "shall forward each appointment to the senate for confirmation."

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[4]*Minutes,* Senate Public Health & Welfare, March 12, 2002, Attachment 3. K.S.A. 20-134; K.S.A. 20-2910.

[5]K.S.A. 20-134; 20-2910; 20-3008; K.S.A. 2006 Supp. 75-2701(f)(1).

Given the imperative that the Governor "shall" appoint a person from a slate of candidates, the Governor must select from the slate of candidates submitted to her. However, a literal interpretation of this provision is untenable in those, hopefully, rare situations where a nominee dies, is otherwise unable to serve, or does not meet the statutory eligibility requirements of Section (b).[6]

In filling a vacancy for an unexpired term, the Governor must appoint, in the manner outlined in subsection (e), "a *qualified* successor."[7] As the Kansas Constitution requires the Governor to faithfully execute the laws,[8] the Governor must adhere to the statutory criteria for Board membership imposed by the Legislature.[9] In our opinion, Section (e) requires the Governor to fill an unexpired term with a person meeting the statutory qualifications whose name appears on a slate submitted by the Board's nominating committee. In this same vein, the Governor is responsible for ensuring that a candidate for a full four-year term meets those same statutory qualifications.

While, presumably, the nominating committee vets all candidates and submits a slate of nominees meeting such requirements, this does not absolve the Governor of her responsibility to ensure that the person she appoints meets the statutory qualifications.[10]

Therefore, in order to avoid a construction that could lead to unreasonable and absurd results,[11] it is our opinion that, as the Governor can only select from a slate provided by the Board's nominating committee, common sense dictates that should a candidate die, be otherwise unable to serve, or not meet the statutory requirements, the Board's nominating committee should simply provide to the Governor another slate of nominees.

3. The statute provides that "no person appointed to the board shall exercise any power, duty or function as a member of the board until confirmed by the Senate."

a. Does [this prohibition apply] to persons who have been nominated by the nominating committee . . . but have not yet been appointed by the governor?

---

[6]"Members appointed by the governor shall be representatives of the general public who are recognized for outstanding knowledge and leadership in the fields of finance, business, health-care management, health care providers, legal affairs, education or government. [O]f the thirteen members . . . there shall be at least one member from each congressional district." K.S.A. 2006 Supp. 76-3304(b).

[7]K.S.A. 2006 Supp. 76-3304(d). Emphasis added.

[8]Kan. Const., Art. 1, § 3; *Barrett v. Duff,*114 Kan. 220 (1923).

[9]The legislature may constitutionally restrict, by way of statute, the gubernatorial choice of an appointee by imposing explicit qualifications. *Leek v. Theis,* 217 Kan. 784, 807 (1975).

[10]The Senate, in executing its confirmation authority, also has a duty to ensure that the appointee meets the statutory eligibility requirements. *Barrett v. Duff,* 114 Kan. 220 (1923); Attorney General Opinion No. 96-25.

[11]The legislature is presumed to intend that a statute be given a reasonable construction so as to avoid unreasonable or absurd results. *Tompkins v. Bise,* 259 Kan. 39 (1996).

Answer: Yes. K.S.A. 2006 Supp. 76-3304(e) is clear that gubernatorial appointees can exercise the powers, duties, and functions of a Board member only if the appointee is either: (1) confirmed by the Senate pursuant to K.S.A. 75-4315b; or (2) authorized by the confirmation oversight committee pursuant to K.S.A. 46-2601.

b. May a person not yet confirmed by the Senate participate in discussion in open sessions of the board?

Answer: Yes, to the extent allowed by the Board pursuant to the Kansas Open Meetings Act.[12] An appointee not yet confirmed would have the same right as any other member of the public to attend an open meeting of the Board.[13] As with any member of the public, participation in Board discussions is discretionary with the Board.[14]

c. May a person not yet confirmed . . . attend an executive session of the board?

Answer: Yes, but only if the person will aid the Board in its discussion.[15] Only Board members have the right to attend an executive session.[16] However, individuals who aid the Board in its discussions may be discretionarily admitted by the Board.[17]

d. May a person not yet confirmed . . . participate in an executive session of the board?

Answer: See Answer to Question 3(c).

e. May a person not yet confirmed . . . cast a vote on any question before the board?

Answer: No. The right to vote belongs only to gubernatorial appointees who have either: (1) been confirmed by the Senate pursuant to K.S.A. 75-4315b; or (2) authorized by the confirmation oversight committee pursuant to K.S.A. 46-2601.

4. Can the Provost of the University of Kansas who also holds the office of Executive Vice Chancellor of the university serve as an *ex officio* member of the Board?

Answer: No. See attached letter to Irene M. Cumming, dated May 16, 2007.

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[12]K.S.A. 75-4317 *et seq.*

[13]Attorney General Opinion No. 80-43.

[14]http://www.ksag.org/content/page/id/145

[15]Attorney General Opinions No. 82-176, 86-143, 87-170, 91-31, 92-51, 92-56. *See* http://www.ksag.org/content/page/id/147; http://www.ksag.org/files/shared/KOMA/pdf

[16]Attorney General Opinion No. 86-143.

[17]Note 15. *See* K.S.A. 2006 Supp. 76-3306(b).

5. Does the Governor or the Senate have any permissible involvement in determining who shall fill the six *ex officio* positions on the Board?

Answer: No. See attached letter to Irene M. Cumming, dated May 16, 2007.

6.

(a) Is there any limitation on the amount of time that may elapse between the governor receiving a slate of nominees and the governor choosing an appointee therefrom?

Answer: No. Unlike other statutes that impose appointment deadlines on the Governor,[18] K.S.A. 2006 Supp. 76-3304 imposes no such deadline.

(b) Is there any limitation on the amount of time that may elapse between the governor choosing an appointee and submitting the same to the Senate for confirmation?

Answer: No. The Legislature has not imposed a deadline. However, as the Legislature has the power to provide for the appointment of all offices not otherwise provided for in the Kansas Constitution,[19] it may enact legislation imposing deadlines for selection of appointees and submission of appointees to the Senate for confirmation.[20]

7. In the event any person has exercised any power, duty, or function as a board member without lawful authority to do so, including casting a vote or votes on any matter before the board or participating in any board deliberations . . . what remedy or remedies would apply to ensure that such person's involvement has not improperly affected the board's activities?

Answer: Whether or not Board action is affected by virtue of a person voting on a matter in which the person had no authority to do so will depend upon the facts. If there were sufficient votes to pass a measure - notwithstanding the unqualified person's "vote" - Board action will be unaffected. If the number of votes was insufficient,[21] the question will be whether the unqualified person was acting as a "de facto" officer which, if so, may validate his or her actions.[22]

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[18]K.S.A. 20-2911 (30 days/district court judge vacancy); K.S.A. 20-3005 (60 days/Kansas Court of Appeals vacancy); Kan. Const., Art. 3, § 5 (60 days/Kansas Supreme Court vacancy).

[19]Kan. Const., Art. 2, § 18; Art. 15, § 1.

[20]*Leek v. Theis*, 217 Kan. 784, 808 (1975). *See* Attorney General Opinion No. 90-80.

[21]K.S.A. 2006 Supp. 76-3306(a).

[22]*Olathe Hospital Foundation, Inc. v. Extendicare Inc.,* 217 Kan. 546 (1975); Attorney General Opinion No. 83-133 ("An officer *de facto* is one whose acts, though not those of a lawful officer, the law, upon principles of policy and justice, will hold valid, so far as they involve the interests of the public and third persons, where the duties of the office were exercised under color of a known . . . appointment, void because the officer was not eligible . . . or, by reason of some defect or irregularity in its exercise, such ineligibility, want of power or defect being unknown to the public.")

8. What action would be required to constitute a formal resignation by a public board member, creating a vacancy on the board that would have to be filled as provided by statute, including new Senate confirmation, even if the vacancy were filled by appointment of the same person whose resignation created the vacancy?

Answer: The statutes governing the Board do not address resignations. However, the Authority's bylaws do provide for resignation,[23] as follows:

> "(a) Any Director other than an ex officio member of the Board may resign at any time by giving written notice to the Chairperson or the Secretary of the Authority. The resignation shall take effect on the date such notice is received or on any later date specified in the notice, and, unless otherwise specified therein, the *acceptance of such resignation shall not be necessary to make it effective."*[24]

The problem is that the bylaws conflict with the common law which provides that the resignation of a public officer is not effective until it is accepted by the appointing authority.[25] Until the resignation is accepted, it is simply an offer to resign.[26] If the common law controls rather than the bylaws, then a Board member's resignation is not effective until accepted by the Governor.[27]

Common law is the body of law derived from judicial decisions, rather than from statutes or constitutions.[28] The common law operates in Kansas where the Kansas Constitution is silent or the Legislature has failed to act.[29] Neither the Constitution or the statutes address either a generic process for the resignations of public officers or, specifically, the resignation of Board members.

While the Authority is an instrumentality of the State, it also operates as a corporate entity[30] and, as such, is authorized to establish bylaws.[31] Bylaws are self-imposed rules resulting from an agreement or contract between the corporation and its members to conduct the corporate business in a particular way.[32] Bylaws prescribe the rights and duties of the members with reference to the internal

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[23]By laws adopted pursuant to K.S.A. 2006 Supp. 76-3304(k).

[24]Amended and Restated Bylaws of the University of Kansas Hospital Authority, Art. IV, § 4.4(a). Emphasis added.

[25]*The State, ex rel. Hopkins v. Board of Education of the City of Council Grove,* 106 Kan. 863, 865 (1920); *Rogers v. Slonaker,* 32 Kan. 191, 193 (1884); *State ex rel. Toepke v. Clayton,* 27 Kan. 442, 445 (1882); Attorney General Opinion No. 90-1.

[26]*Rogers v. Slonaker,* 32 Kan. 191, 193 (1884).

[27]The Governor is the appointing authority. K.S.A. 2006 Supp. 76-3304(b)(e).

[28]*Noone v. Chalet of Wichita, LLC,* 32 Kan.App.2d 1230 (2004).

[29]K.S.A. 77-109; *Bland v. Scott,* 279 Kan. 962 (2005).

[30]K.S.A. 2006 Supp. 76-3304(a); 76-3308.

[31]K.S.A. 2006 Supp. 76-3304(k).

[32]*Schraft v. Leis,* 236 Kan. 28, 35 (1984).

government of the corporation, the management of its affairs, and the rights and duties existing among the members.[33]

The general rule is that bylaws affect only the corporation's members, directors, officers and those persons who deal with the corporation with notice of, or under circumstances that they are bound to take notice of its bylaws.[34] Therefore, while the Board is statutorily authorized to adopt bylaws that are "not contrary to law,"[35] such bylaws are limited to the Authority's "own governance and for the governance and management of the authority."[36] Therefore, insofar as resignations are concerned, the bylaws cannot control whether a resignation is sufficient to create a vacancy on the Board. As Board members are public officers,[37] it is our opinion that, in the absence of a statute, the common law prevails and, therefore, a Board member's resignation will not create a vacancy on the Board unless and until it is accepted by the Governor.

However, acceptance of the resignation does not need to be formal. Rather, any conduct on the part of the appointing authority "indicating a purpose to accept [the resignation] is

[33] *Id.* at 35.

[34] 18A Am.Jur.2d *Corporations* § 271.

[35] K.S.A. 2006 Supp. 76-3304(k).

[36] *Id.*

[37] *Durflinger v.Artiles,* 234 Kan. 484, 502-504 (1983)(*rev'd on other grounds Boulanger v. Pol,* 258 Kan. 289 (1995). *Sowers v. Wells,* 150 Kan. 630 (1939); Attorney General Opinions No. 2003-13, 2002-28, 2000-8.

sufficient, such as the appointment of a successor, or recognizing the existence of a vacancy, or in any manner treating the resignation as operative."[38] Whether or not the Governor has accepted a Board member's resignation is a question of fact.

Sincerely,

Paul J. Morrison
Attorney General

Mary Feighny
Deputy Attorney General

PJM:MF:jm

[38] *State, ex rel. Hopkins v. The Board of Education of the City of Council Grove,* 106 Kan. 863, 866 (1920); Attorney General Opinion No. 90-1.

May 16, 2007

Irene M. Cumming
Chief Executive Officer
The University of Kansas Hospital
3901 Rainbow Boulevard
Kansas City, Kansas 66160

Re: State Institutions and Agencies; Historical Property--University of Kansas Hospital Authority--University of Kansas Hospital Authority; Creation; Board of Directors; Membership; *Ex Officio* Members

Dear Ms. Cumming:

You inquire regarding whether the Provost of the University of Kansas who holds the office of Executive Vice-Chancellor of the University of Kansas is entitled to membership, as an *ex officio* voting member, on the Board of Directors of the University of Kansas Hospital Authority.

The answer is clearly no. K.S.A. 2006 Supp. 76-3304 establishes the University of Kansas Hospital Authority (Authority). The Authority is governed by a nineteen-member Board of Directors. Thirteen members representing the general public are appointed by the Governor and are subject to Senate confirmation. The remaining six members are "*ex officio* voting members" consisting of individuals who hold the following offices:

1. Chancellor of the University of Kansas;
2. Executive Vice Chancellor of the University of Kansas Medical Center;
3. Executive Dean of the University of Kansas School of Medicine;
4. Chief of Staff of the University of Kansas hospital medical staff;
5. President of the Authority; and
6. Dean of the University of Kansas School of Nursing.[1]

The term "*ex officio*" means "by virtue of the office."[2] Generally, *ex officio* members of a governing body are individuals who are members solely because they hold a particular

[1]K.S.A. 2006 Supp. 76-3304(b).

[2]Attorney General Opinions No. 82-93, 82-47, 79-94.

office as opposed to individuals who are members because they meet certain criteria.[3] As such, *ex officio* members are not appointed by the Governor and their terms of office "expire immediately upon termination of their holding such office."[4]

Because neither the office of Provost of the University of Kansas or Executive Vice-Chancellor of the University of Kansas is included in the list of *ex officio* positions in K.S.A. 2006 Supp. 76-3304(b), the individual holding either office is not entitled to membership on the Board of Directors of the Authority as an *ex officio* member. As the Governor's authority to appoint is limited to the thirteen members who are representatives of the general public, any purported appointment by the Governor of an *ex officio* member has no legal validity.

Sincerely,

Paul J. Morrison
Attorney General

PJM:MF:jm
cc: Sally Howard, General Counsel
Governor's Office

[3]Members appointed by the Governor are "representatives of the general public who are recognized for outstanding knowledge and leadership in the fields of finance, business, health-care management, health care providers, legal affairs, education or government." K.S.A. 2006 Supp. 76-3304(b).

[4]K.S.A. 2006 Supp. 76-3304(f).

APPENDIX D

Hospital Board Membership and Representation

This Appendix contains information on the composition of primary teaching hospital's governing board at public health science institutions in Colorado, Kansas, Minnesota, Nebraska, Virginia and Wisconsin. It shows board members designated in statute or in a written agreement, the number of board members, how the board chair is determined, how many board members are affiliated with the university, and how many members are affiliated with the hospital.

Hospital Board Membership and Representation				
State Name of the University's Medical Center Equivalent	**Primary Teaching Hospital Name**	**# of Voting Members on Hospital Board**	**Membership Specified Where?**	**Chair of Hospital Board**
Wisconsin School of Medicine and Public Health	University of Wisconsin Hospitals and Clinics Authority	13	Statute	Elected by board members
Virginia Virginia Commonwealth University Health Sciences	VCU Health System (parent of the Medical College of Virginia Hospitals)	21	Statute	Elected by board members
Kansas University of Kansas Medical Center	University of Kansas Hospital Authority	19	Statute	Elected by board members
Minnesota University of Minnesota Academic Health Center	Fairview Health Services -- Formed from the merger of the University of Minnesota's Hospital and the Fairview Health System	18	Agreement	Elected by board members
Colorado University of Colorado at Denver Health Sciences Center	University of Colorado Hospital Authority	9	Statute	Chancellor of the University of Colorado Health Sciences Center
Nebraska University of Nebraska Medical Center	The Nebraska Medical Center - Formed from the merger of the University of Nebraska Hospital and Clarkson Regional Health Center	12	Agreement	Elected by board members

Source: LPA analysis of Hospital Board membership information.

Hospital Board Membership and Representation (continued)			
State Name of the University's Medical Center Equivalent	**Designated Members of Hospital Board Affiliated With the School/University System**	**Designated Members of the Board With Ties to the Hospital**	**Other Members of the Board**
Wisconsin School of Medicine and Public Health	**7 university officials/faculty (54% of total):** ● Chancellor of the University of Wisconsin - Madison ● Dean of the University of Wisconsin -- Madison Medical School ● A chairperson of a department at the University of Wisconsin - Madison Medical School ● A faculty member of a University of Wisconsin health professions school other than the medical school ● 3 members of the board of regents	**None**	**6 other members:** ● 3 members nominated by the Governor ● each cochairperson of the Joint Committee on Finance ● the Secretary of Administration
Virginia Virginia Commonwealth University Health Sciences	**12 university officials/faculty (57% of total):** ● Vice President for Health Sciences ● President of the University ● 5 faculty physicians with hospital privileges appointed by various officials ● 5 non-legislative members of the VCU Board of Visitors (like the Kansas Board of Regents) appointed by the head of the Board	**None**	**9 other members :** ● 4 appointed by the Governor ● 3 appointed by Speaker of the House ● 2 appointed by Senate Committee on Rules
Kansas University of Kansas Medical Center	**4 ex-officio university officials (21% of total):** ● Chancellor of KU ● Executive Vice Chancellor of KUMC ● Executive Dean of the School of Medicine ● Dean of the School of Nursing	**2 ex-officio hospital officials (11% of total):** ● President of the Hospital ● Chief of the Hospital Medical Staff	**13 public board members** with at least one from each Congressional district (appointed by Governor)
Minnesota University of Minnesota Academic Health Center	**3 ex-officio university representatives (17% of total):** ● Sr VP for Academic Health Services ● Dean of the Medical School ● Senior Associate Dean for Clinical Affairs	**1 ex-officio hospital official (6% of total):** ● President/CEO of Fairview Health Services	**14 other members**
Colorado University of Colorado at Denver Health Sciences Center	**At least one.** The Chancellor of the University of Colorado Health Sciences Center, is ex-officio Chairman of the Board. However, no more than a total of 3 board members can be employees of the University of Colorado.	**None specified**, but no more than 3 can be employees of the hospital authority	**9 board members** with at least 1 from each Congressional district (appointed by the regents)
Nebraska University of Nebraska Medical Center	**None**	**None**	**12 board members** ● 6 appointed by the regents ● 6 appointed by the foundation that owned the private hospital that merged with the university's hospital

Source: LPA analysis

APPENDIX E
Agency Response

On October 15, 2007, we provided copies of the draft audit report to the University of Kansas Medical Center, the University of Kansas Hospital, and the Kansas Board of Regents. The Board chose not to respond to the draft report; the other two entities' responses are included in this appendix. Based on those responses, we made minor corrections and clarifications to the draft audit report that didn't affect any of our findings or conclusions.

In its response, the Medical Center indicated that our decision in Question 1 to count spending on student support and scholarship as "other" expenditures, rather than as "education" expenditures, didn't present an accurate picture because those expenditures were part of its educational mission. The amounts involved total about $6.7 million out of the $287.9 million the Medical Center spent in 2007, and mostly were spent from State operating grant funds.

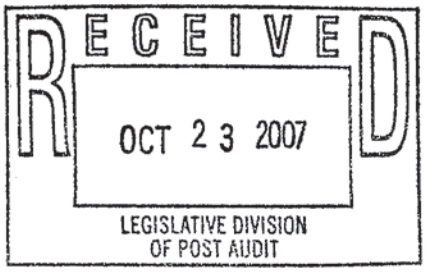
In analyzing the amount and percent of the Medical Center's expenditures that went for research, education, and other, we categorized as "education" only those direct education expenditures and instructional support types of expenditures related to providing assistance to academic programs. Because spending for student support and scholarships provide assistance to students, we categorized those expenditures as "other."

There's no right or wrong way to categorize these expenditures, so we think it can be useful for the reader to see them classified both ways—as we've presented them, and as the Medical Center's shows them in its response. To help the reader quickly see the differences between our analyses and the Medical Center's, we've prepared the following comparison table. As the table shows, the percentages are slightly different under the two ways of categorizing student support expenditures, but the overall patterns and trends generally are unchanged. Overall, our conclusions are the same.

Comparison of Percentages Spent on Research, Education and Other by Total & State Only Expenditures, Fiscal Years 2001 and 2007

		LPA Analysis		KUMC Analysis	
		2001	2007	2001	2007
	EXPENDITURES FROM ALL SOURCES				
MEDICAL CENTER OVERALL	Research	23%	32%	22%	32%
	Education	***54%***	***44%***	***57%***	***49%***
	Other	23%	24%	21%	19%
KANSAS CITY CAMPUS	Research	27%	37%	27%	37%
	Education	***47%***	***37%***	***49%***	***42%***
	Other	26%	26%	24%	21%
WICHITA CAMPUS	Research	2%	4%	2%	4%
	Education	***91%***	***89%***	***92%***	***90%***
	Other	7%	8%	6%	6%
	EXPENDITURES FROM THE STATE OPERATING GRANT ONLY				
MEDICAL CENTER OVERALL	Research	3%	3%	3%	3%
	Education	***68%***	***62%***	***69%***	***68%***
	Other	30%	35%	28%	29%
KANSAS CITY CAMPUS	Research	3%	3%	3%	3%
	Education	***65%***	***60%***	***67%***	***66%***
	Other	32%	37%	30%	31%
WICHITA CAMPUS	Research	1%	2%	0%	2%
	Education	***87%***	***83%***	***90%***	***88%***
	Other	12%	15%	10%	10%

KU THE UNIVERSITY OF KANSAS
Medical Center



October 22, 2007

Barbara J. Hinton
Legislative Post Auditor
Legislative Division of Post Audit
800 Southwest Jackson Street, Suite 1200
Topeka, KS 66612-2212

Dear Ms. Hinton:

Enclosed are the University of Kansas Medical Center's (KUMC) responses to the Legislative Post Audits draft reports on the performance audits; KU Medical Center and KU Hospital: Reviewing Selected Operational Issues and KU Medical Center and KU Hospital: Reviewing Selected Financial Issues.

The University of Kansas Medical Center enjoyed the opportunity to work with the staff of the Legislative Division of Post Audit during their study of the issues presented. Their professionalism and skill were evident throughout their interactions with our team. We want to commend Barbara J. Hinton and her team for accomplishing a great deal of work in a very short period of time. We strongly believe that as a result of their work, policy makers and the public will be better informed about the mission of their academic medical center. We appreciate the auditors' insights and their perspective. The information they have set forth in this report illuminates a number of complex questions and provides a valuable resource.

Because of the complexity of some of the issues involved we provide in our response additional context with which to evaluate the findings and data set forth in this audit.

We hope that legislators and others who look to this audit will take advantage of our open invitation to discuss any aspect of this audit with us. We look forward to a dialogue with legislators on how best to continue and build on the unprecedented momentum the University of Kansas Medical Center and Hospital have enjoyed over the last five years. Our success would not be possible without the support and leadership of many Kansans who believe in our mission of service, research, education and clinical care. We take seriously our role as a source of hope and healing for many Kansans.

If we can be of further assistance to the staff of the Legislative Division of Post Audit, the members of the Post Audit Committee or other members of the Kansas Legislature we hope you will not hesitate to call on us.

Very truly yours,

Barbara F. Atkinson, M.D.
Executive Vice Chancellor
Executive Dean, School of Medicine

BFA:dab

Enclosures

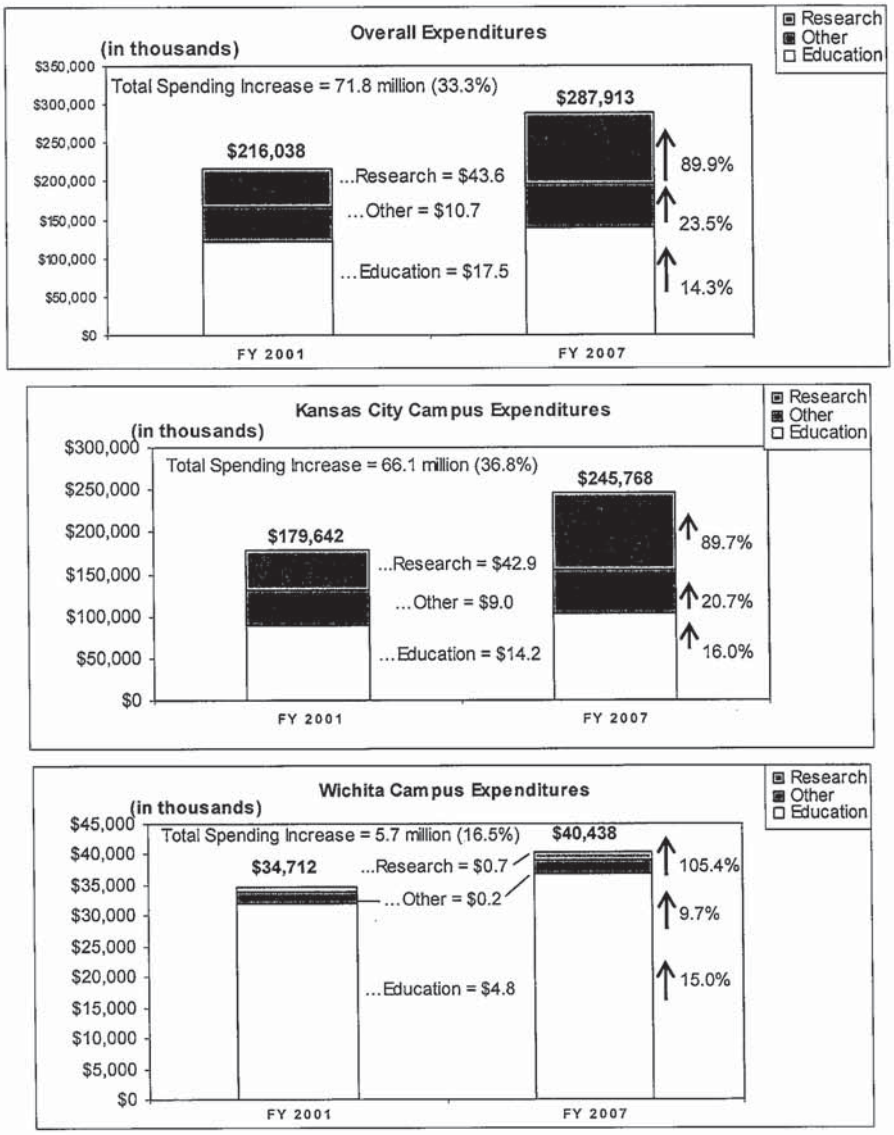
UNIVERSITY OF KANSAS MEDICAL CENTER (KUMC) RESPONSE TO LEGISLATIVE POST AUDIT REPORT; KU Medical Center and KU Hospital: Reviewing Selected Operational Issues.

Question 1: How has spending for education and research functions from the Medical Center's operating grant changed in recent years, and how has that affected the amounts of money distributed to the Kansas City and Wichita campuses?

Response: KUMC does not feel the comparison of expenditures or the characterization of a disagreement over research in Wichita is accurately expressed in the Legislative Post Audit report.

Expenditure Comparison: The Legislative Post Audit allocated student support and scholarship expenditures to the "other" category rather than "education." KUMC does not believe this presents an accurate picture as these expenditures are part of our education mission. We have reallocated these expenses and developed the same graphic representations. The Post Audit also included all expenditures by the Wichita Center for Graduate Medical Education (WCGME) in its expenditure comparisons. KUMC does not object to these funds being included. However, readers must understand that while KUMC has representatives on the WCGME Board, it does not control the Board or WCGME's expenditures.

Figure 1-2
Percent of TOTAL Expenditures on Education, Research and Administration (amounts in millions)



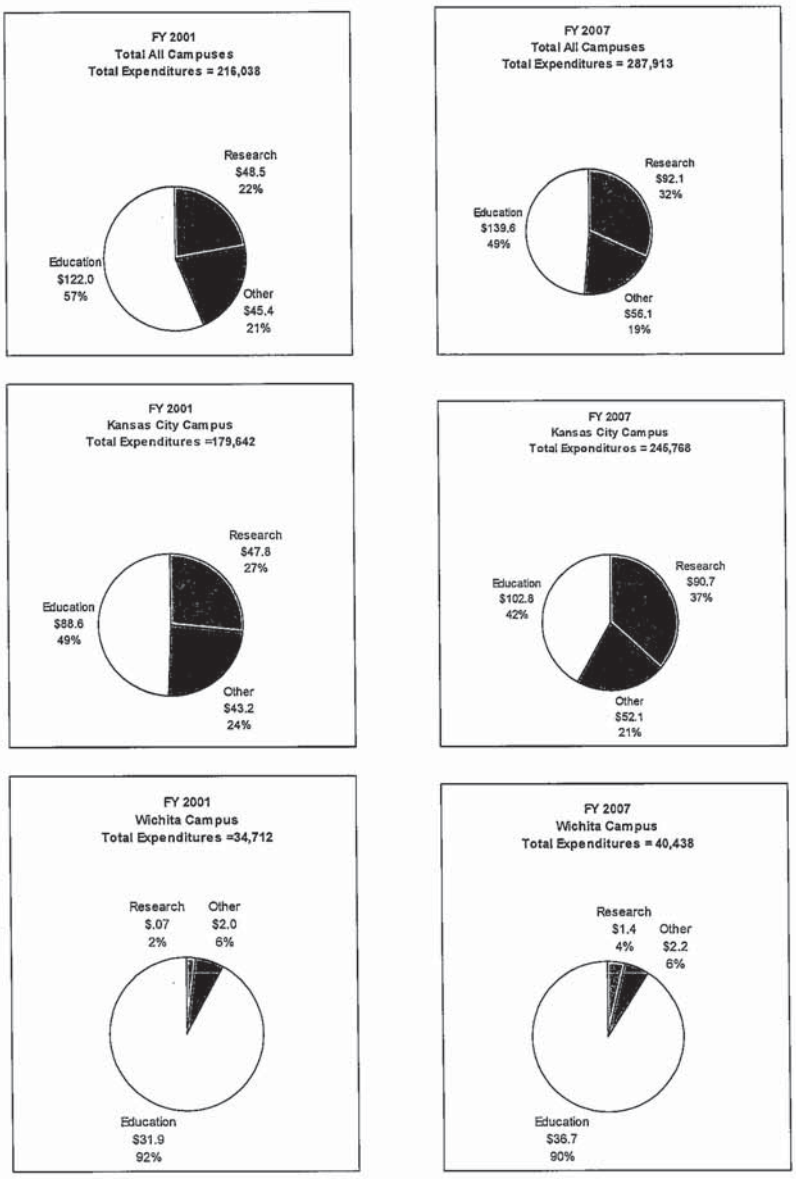
Overall spending from <u>all</u> sources has increased by $72 million, or 33%, since 2001. As **Figure 1-2** shows:

- overall, research spending is up significantly at the Medical Center (90%)
- the Kansas City campus accounts for most of the overall spending, and for most of the spending increase ($66 million out of $72 million, or 92%). Kansas City's spending for research increased by 90%.
- the Wichita campus accounts for 14% of the overall spending in fiscal year 2007 ($40.4 million of $287.9 million) and 8% of the spending increase ($5.7 million of $71.8 million).

Note:

- Outreach expenditures amounted to $1.7 million in both FY 2001 and FY 2007. These expenditures are included in the following graphic representations for "overall" expenditure in each set so that the totals will tie back to the Medical Center's B-2 schedules on its financial reports. However, a graphic display of these expenditures has not been included.

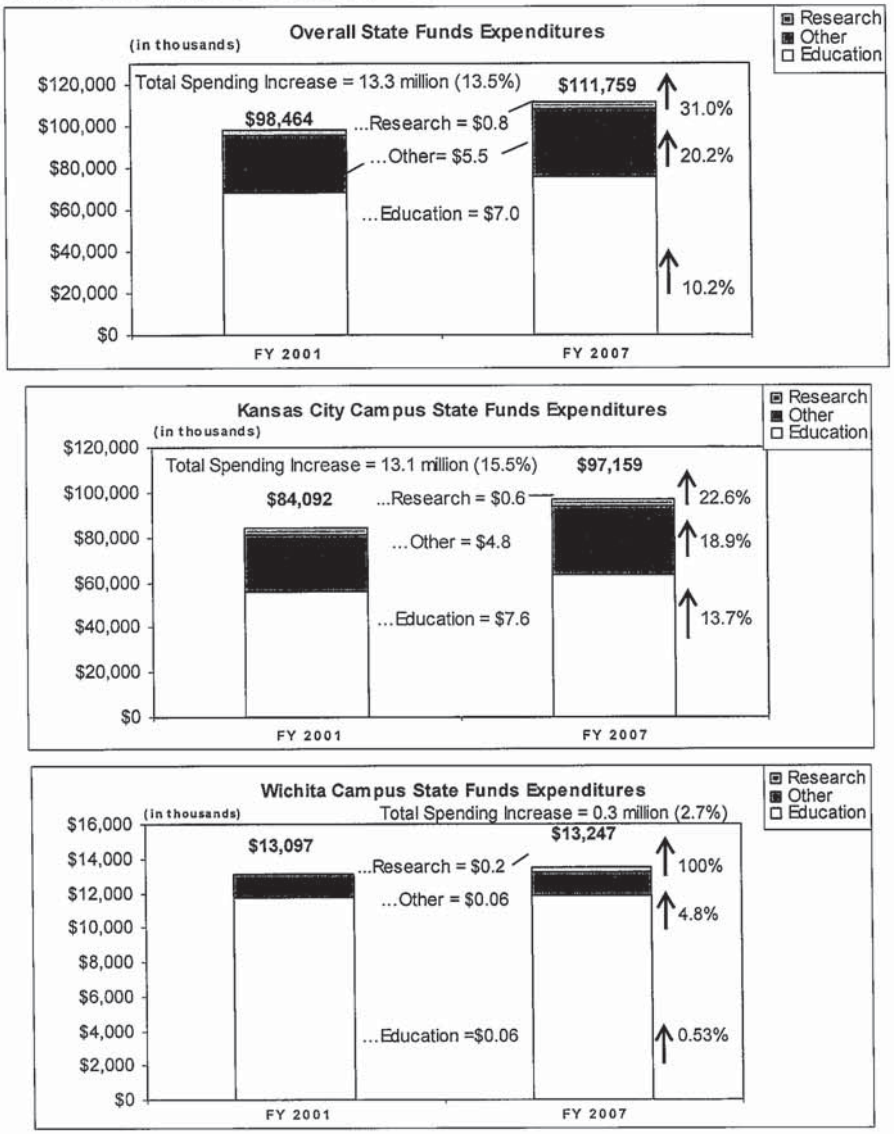
Figure 1-3
Percent of TOTAL Expenditures on Education, Research and Administration (amounts in millions)



There's been a significant shift in the percent of <u>all</u> sources of funds being spent on research since 2001. As **Figure1-3** shows:

- overall spending on research from all sources grew from 23% to 32% of total expenditures.
- almost all spending on research happens at the Kansas City campus. From 2001 to 200 research spending increased from $48 million to $91 million or from 27% to 37% of its <u>total</u> expenditures. Kansas City's spending for education is still the largest area of investment.
- Wichita spends little on research. Its spending on research was $1.4 million in 2007. The majority of Wichita's spending is on education, which in 2007 was $36.7 million o 88% of its total expenditures.

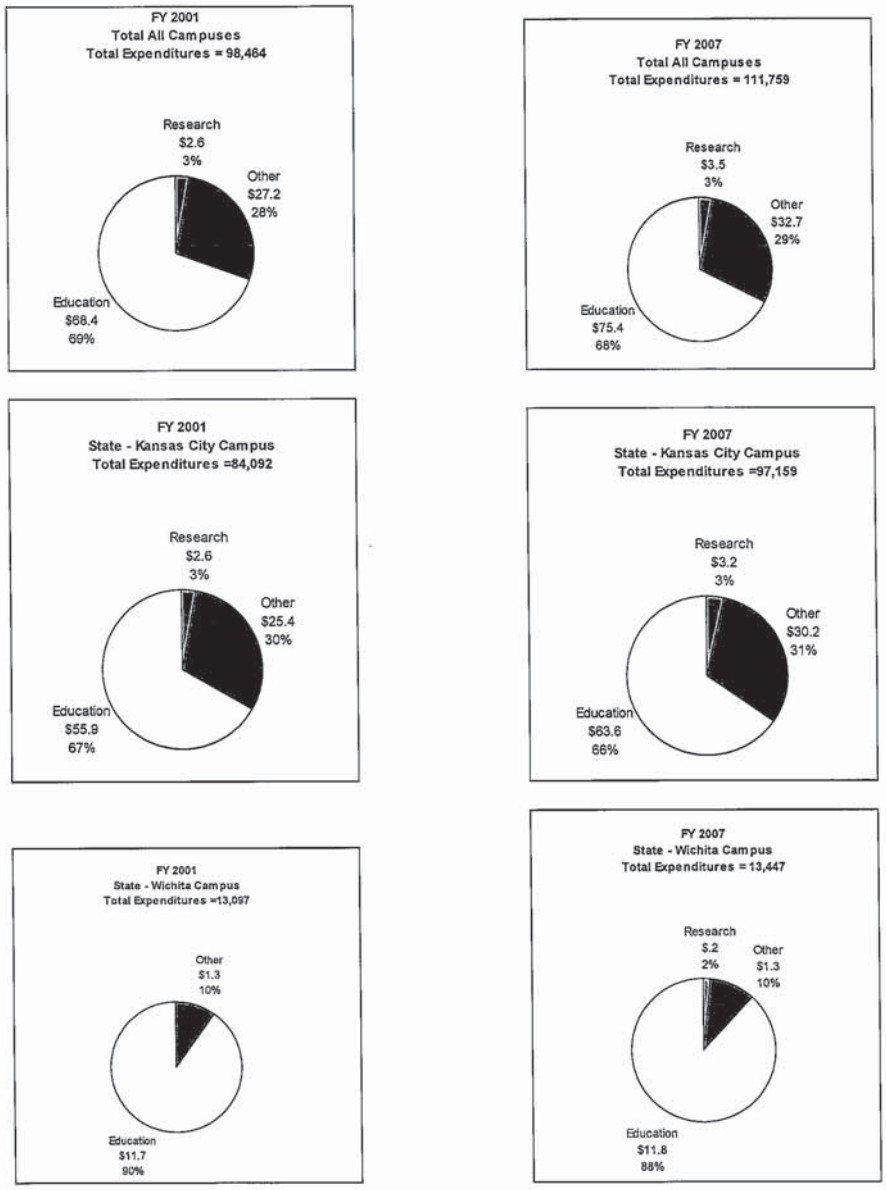
Figure 1-4
Percent of STATE Expenditures on Education, Research and Administration (amounts in millions)



Overall spending from the <u>State Operating Grant</u> increased by $13 million, or 13% since 2001. This is an increase of 2.2% per year. As **Figure 1-4** shows:

- overall State Operating Grant spending increased by $7 million for education, by $.8 million for research, and by $5.5 million for other categories.
- the Kansas City campus accounts for most of the overall State grant spending and for most of the increase ($13.1 million of $13.3 million). It should be noted that Kansas Ci has 85% of the students and uses the State grant to pay for much of the administrative structure for both campuses including financial administration, general administrative services, utilities, and executive management. It also uses the State grant to pay some graduate medical education cost, including resident's salaries. In Wichita, State grant funds are contributed to WCGME by contract to pay expenses including resident salarie

Figure 1-5
Percent of STATE Expenditures on Education, Research and Administration (amounts in millions)

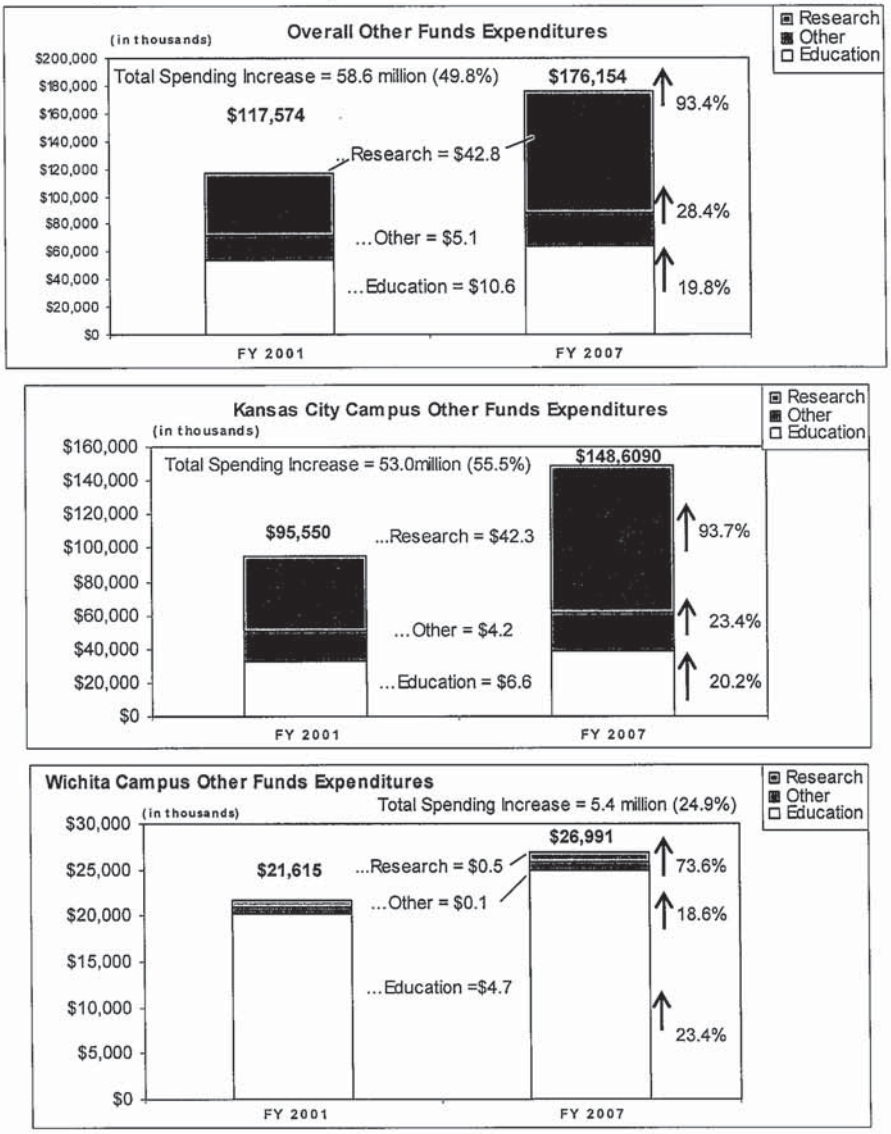


- a separate analysis of State operating grant and tuition expenditures is included at Appendix "A

The percent of State grant money being spent on research has not changed since 2001. As **Figure 5** shows:

- overall most State operating grant funds are spent on education and the allocation has remained almost constant (down 1%).
- because the Kansas City campus gets most of the State grant, overall spending patterns mirror t allocation.
- at the Wichita campus, education spending is the largest category consistent with education as primary mission of that campus.

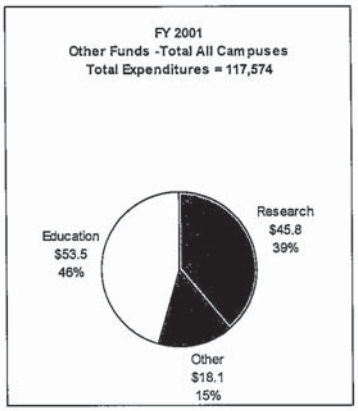
Figure 1-6
Percent of OTHER Expenditures on Education, Research and Administration (amounts in millions)

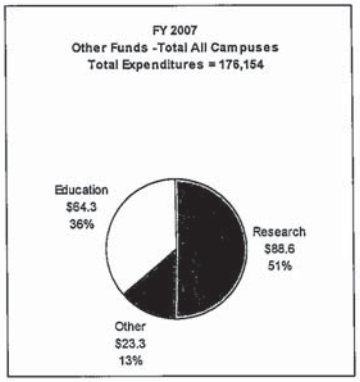


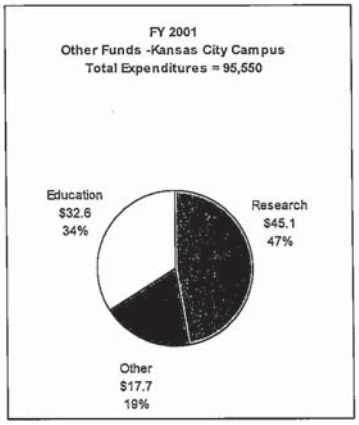
Spending from <u>other funding</u> sources has increased by $59 million, or 50% since 2001. **Figure 1-6** shows:

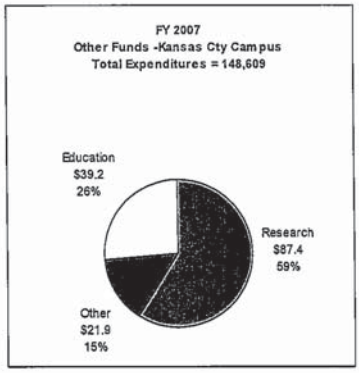
- overall research spending from other sources has increased most significantly (up 93
  primarily from federal research grants generated by faculty on the Kansas City campu
- the Kansas City campus accounts for most of the spending from other sources, and fo
  most of the spending increase $53 million of the $59 million (or 90%). Its spending
  research has almost doubled since 2001, reflecting success in the extremely competit
  world of research funding.
- most of the increase on the Wichita campus was in education reflecting the primary
  mission of that campus. The research investment at Wichita needs to grown as discu
  elsewhere in this response.

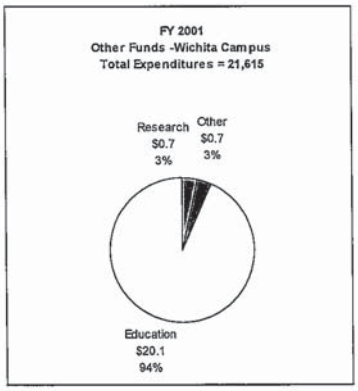
Figure 1-7
Percent of OTHER Expenditures on Education, Research and Administration (amounts in millions)

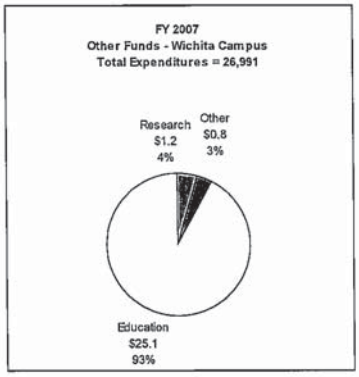












Before drawing any conclusion with respect to KUMC priorities based on these charts, it is important to understand that the "other" category is very broad and includes everything from $2 million dollars in parking expenditures to $750,000 in telemedicine and $629,000 in rural health services that are part of the broader KUMC mission. The bottom line is that education remains the major area of investment of both total and state expenditures. The data also reflects KUMC's success in growing its research enterprise funded by external sources bringing millions of dollars into Kansas each year.

Of particular concern to KUMC is the suggestion in the Post Audit report that the allocation of state funds for education in Wichita decreased between FY 2001 and 2007. While the State allocation remains roughly the same, a more appropriate assessment is contained in Appendix "A" that includes tuition.

It shows a $12 million increase in education compared to a $10 million increase in other spending. As reflected in both the Post Audit analysis, and KUMC's reallocation of expenses, there has been an increase in education expenditures of $17.5 million on both campuses (Figure 1-2) and that education remains the largest area of expenditure from both "state" (66%, Figure 1-5) and "all" (49%, Figure 1-3) resources. There are major differences between campuses. These are explainable by the very different nature of programs on the two campuses reflected in the Post Audit's findings.

The appropriateness of the overall funding and state support in Wichita is clearly stated in a letter from the Wichita Dean, attached as Appendix "B." Both campuses are also in agreement that increased funding for Graduate Medical Education in Wichita is required.

Graduate Medical Education (GME): GME is an extremely complex issue. Some background on its organization, accreditation, and research requirements are important to an appropriate conclusion.

Institutions and individual programs in graduate medical education are authorized ("accredited") to provide educational programs leading to eligibility for certification in the various medical and surgical specialties by the Accreditation Council for Graduate Medical Education (ACGME). The ACGME conducts periodic site visits and reviews of every accredited sponsoring institution and program. Program site visits and reviews are conducted by specialty specific Residency Review Committees (RRCs) within the ACGME. There are a total of 26 specialty specific review committees and one for the transitional general clinical programs. Institutional reviews are conducted by the ACGME's Institutional Review Committee (IRC).

Following each site visit, the ACGME issues a Notification Letter informing the executive officers of the sponsoring institution and the program of the review findings. These letters report the accreditation status of the institution or program, the proposed date of the next site visit, and an assessment of the degree to which the institution or program is in compliance with the published accreditation standards of the ACGME. Each letter contains either an acknowledgement of substantial compliance with the relevant ACGME requirements, or an itemized listing of the areas in which a program or institution is not in compliance. A review committee's finding that a program or an institution is not complying with, or where there are significant deficiency in compliance with, a particular accreditation standard or ACGME policy or procedure is referred to as a citation.

In organizing its Notification Letters, the ACGME always includes a section entitled "Areas Not in Substantial Compliance (Citations)" constructed as follows:

- If no citations were identified by the Review Committee, this section will include a statement of commendation to the program or institution for demonstrating substantial compliance with the requirements without citation.
- If the program received a 4 or 5 year review cycle, this section will include a commendation for demonstrating substantial compliance with the ACGME Requirements for Residency Education, as well as a list of areas of noncompliance, or citations.
- If the program received a 1 or 2 year review cycle, this section will include a list of the areas of noncompliance, or citations, as well as a statement warning that the program's or institution's accreditation will be in jeopardy at the time of the next review if these areas have not been adequately addresses, and/or other major areas warranting citation develop.

Receipt of a letter containing one or more citations must be clearly distinguished from any adverse action that the ACGME might propose or take. A citation is simply a finding of fact based on information available to a review committee at the time of the committee deliberation. However, a review committee may enforce an action against the accreditation of a program should there be an excessive number of citations or should the program or institution fail to correct one or more areas not in substantial compliance between RRC or Institutional site visits. Institutions and programs failing to adequately address citations may be placed on probation. If the causes for probation are not addressed, or if new deficiencies emerge on a subsequent visit, the institution or program may lose its accreditation. Residents completing their training in non-accredited programs are not eligible for certification or even to sit for the certifying examination of the member boards of the American Board of Medical Specialties (ABMS). Such residents are generally unable to obtain licensure. Even in those jurisdictions where a license can be obtained without board certification, healthcare organizations, and insurance plans often deny such physicians the credentials necessary to practice. Non-accredited institutions or programs are also ineligible for graduate medical education payments under the Medicare and Medicaid programs.

Among the many ACGME accreditation requirements is that institutions and programs provide opportunities to participate in scholarly activities. Review committees check to see that residents, fellows and faculty regularly participate in organized clinical discussions, rounds, journal clubs, and conferences. Review committees also expect that a program's faculty establish and maintain an environment of inquiry and scholarship with an active research component. Scholarship includes contributions of faculty to new knowledge, encouraging and supporting resident scholarship, and contributing to a culture of scholarly inquiry by active participation in organized clinical discussions, rounds, journal clubs and conferences. The ACGME has adopted an expanded definition of scholarship which recognizes not only the traditional scholarship of discovery (research as evidenced by grants and publications), but also the scholarship of integration (translational or cross-disciplinary initiatives that typically involve more risk and fewer recognized rewards), the scholarship of application (patient-oriented research that might include the systematic assessment of the effectiveness of different clinical techniques), and the scholarship of education (includes not only educational research but also creative teaching and teaching materials). As demonstration of sufficient scholarly activity, at least some members of a program's faculty must show one or more of the following:

- peer-reviewed funding

- publication of original research or review articles in peer-reviewed journals or chapters in textbooks
- publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings
- participation in national committees or educational organizations.

Programs must demonstrate that the faculty are not only qualified in terms of credentials and experience, but are also active participants in teaching and mentoring residents. Faculty are expected to encourage and support residents in scholarly activities. In order to pursue scholarly activities, residents not only need to work and learn in a culture that values and nurtures scholarship (i.e., faculty actively engaged in and rewarded for scholarly activities) but also need to learn specific skills, such as transforming an idea into a research question (experimental, descriptive or observational), choosing an appropriate study design, determining what instrumentation to use, preparing for data collection, management and analysis, ethical conduct of research, and the rules and regulations governing human subjects research.

While most review committees have yet to adopt formal criteria by which to judge the adequacy of a program's scholarly efforts, some general guidelines are emerging. For example, the Anesthesiology Residency Review Committee has taken the position that, in general, programs are cited for concerns about departmental scholarly activity when less that half of their faculty have authored any original, peer-review manuscripts or published any reviews, chapters or abstracts within the preceding five years. Further, this particular RRC has found that participation in lectures, journal clubs, and/or anesthesia committees alone is not evidence of satisfactory scholarly activity. Rather, while "these activities are expected and important and considered an essential part of a program's academic endeavors . . . they cannot substitute for publications in scholarly journals and other academic pursuits which are essential for the specialty to advance and for trainees to gain exposure to the way research is conducted." Other RRCs, including those for Internal Medicine and its subspecialties, have adopted different, sometimes less stringent guidelines.

Given the focus that the ACGME and its RRCs is placing on scholarly activity and the academic environment in which graduate medical education programs operate, a logical question is, "What types of research are required to support residency programs?" It is clearly not the intent of the ACGME to force all sponsoring institutions and programs to build bench or basic science research infrastructure. As noted above, the ACGME recognizes the scholarship of integration (translational or cross-disciplinary initiatives), the scholarship of application (clinical or other patient-oriented research, including the effectiveness of different clinical techniques), and the scholarship of education (educational research as well as innovations in teaching and the creation of new teaching materials). Thus, it is entirely possible that the scholarship requirements for residency and fellowship programs can be completely addressed through investment in clinical and translational research programs as well as by creation of interdisciplinary research programs between medical schools and schools of public health and/or local and regional community organizations. While the organization and conduct of clinical, translational and educational research programs require significant investments to assure adequate numbers of faculty with adequate release time, there is no need to commit the resources and incur the risks necessary to establish basic science research programs solely to support the stability and growth of graduate medical education.

All programs in Wichita are accredited at this time. Some have received citations related to research and scholarly activity. The following are examples:

- "Faculty Research and Scholarly Activity – The faculty have not been productive in scholarship and publication. Only one or two people have been involved in such activity."
- "Resident Scholarly Activity and Research – There is no formal journal club. There seems to be a lack of resident activity in research and publication."
- "Program support for resident and faculty scholarly activity, some of which results in pee-reviewed publications and presentations, must be emphasized."
- "There is inadequate scholarly activity by the faculty. Only these peer reviewed publications, including one case report, were published in the last five years."
- "Both the program director and the faculty should document improved scholarly activity. For example, the program director documented only one publication in five years and only a few abstracts."
- "Institutional responsibilities for residents, resident participation in educational and professional activities: The Institution provides inadequate resources and support for resident scholarly activity. Residents in Anesthesiology, Family Medicine, and Psychiatry expressed serious concern regarding insufficient research opportunities, substantiating some of the evidence already available regarding this.

These comments support the need for improved and expanded research in Wichita. They also clearly point out the type of research growth that would be beneficial, i.e., clinical, outcomes, translation, patient oriented and public health, not laboratory based basic research. The Executive Vice Chancellor has publicly supported enhanced funding for GME in Wichita to assure adequate faculty time to pursue research and scholarly activity.

Conclusion:
The administrations on both campuses of KUMC are committed to assuring the best possible use of the available resources and that all students and residents have the opportunity to participate in appropriate and meaningful scholarly activity and research.

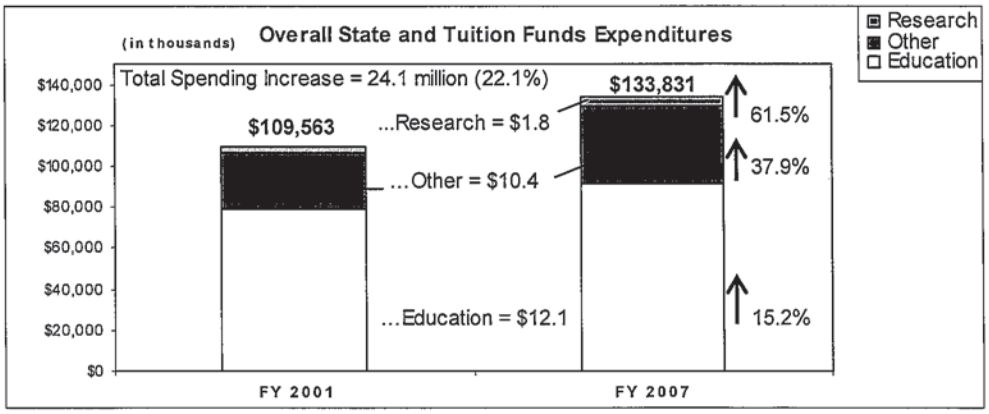
Question 2: How does the relationship between the KU Hospital and the KU Medical Center compare to what is envisioned in state law and to medical schools and teaching hospitals in other states?

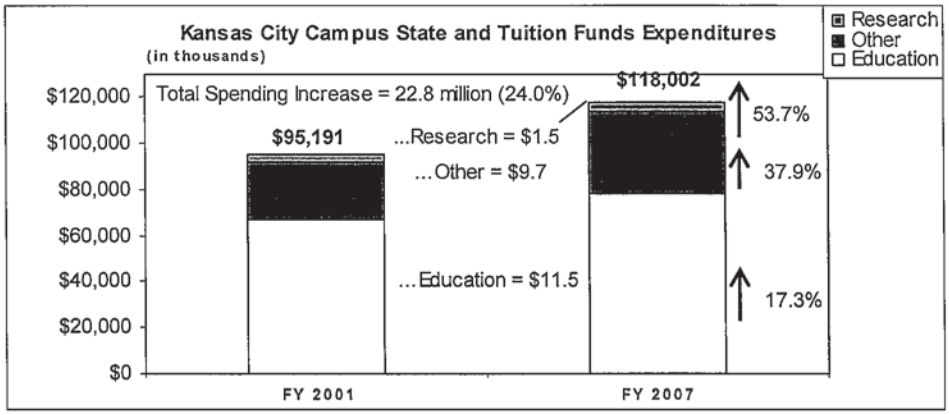
Response: KUMC concurs with the Legislative Post Audit "Answer in Brief" and "Conclusion." in that it confirms that relative to appropriate peers total hospital support for the research and education mission of the medical center is low. We value our partnership with the University of Kansas Hospital and recognize that their continued success will pave the way for additional support. The KU Hospital has a statutory obligation to support the mission of the health sciences schools and the hospital attempts to meet that obligation in a number of important ways. The success of the KU Hospital is important to the medical center and that is why the medical center provides support for the hospital in many essential ways. While it is never easy to provide a specific "apples to apples" comparison between one academic medical center and another we believe that strong evidence, reinforced by the findings of this audit, suggest that the hospital can and should do more to support the educational and research enterprise. That is precisely why we are working to forge a new affiliation agreement with the KU Hospital. We are engaged in productive discussions to reach a resolution of what level of support from the KU Hospital is appropriate and the medical center is committed to resolving

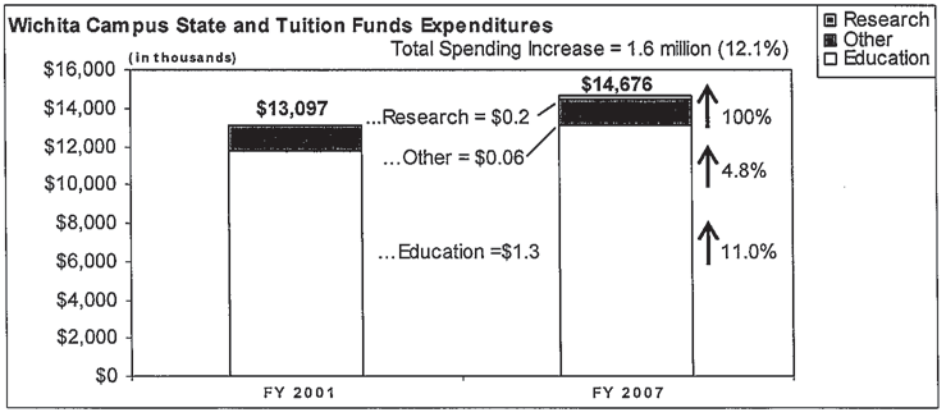
those issues in a mutually satisfactory and beneficial manner. So, while hospital support has been lagging and thereby compromising the rate of growth of education and research programs, we are confident that future support from the KU Hospital will grow and become an even more important resource in leveraging the investment of Kansas taxpayers in their academic medical center.

APPENDIX A

Increase in STATE and TUITION Expenditures on Education, Research and Administration (amounts in millions)





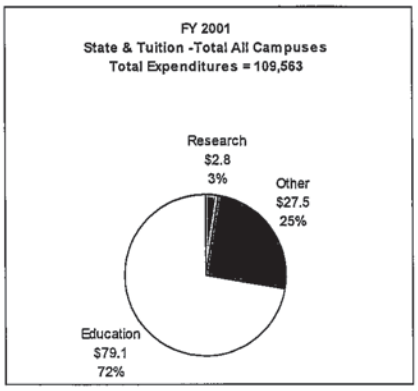


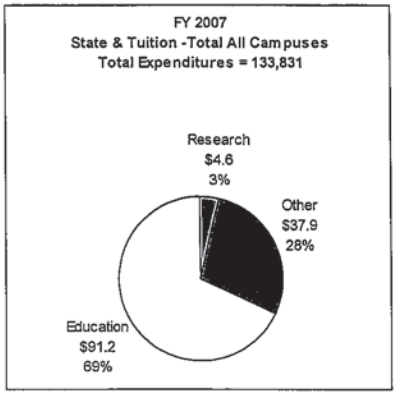
State and Tuition Expenditures increased $24 million or 22% between FY 2001 and 2007. This is an annual increase of 3.7% which is almost one full percent below the average annual increase in the Higher Education Price Index during this period making the maintenance of existing programs difficult and growth beyond inflation a major challenge.

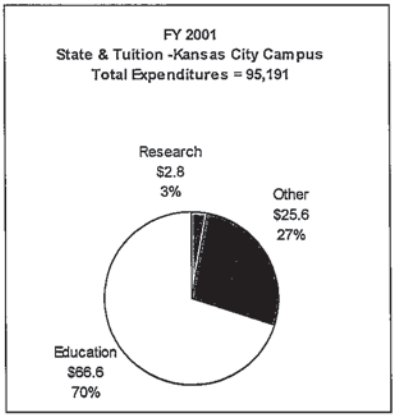
- The largest expenditure for KUMC, as a whole (69%) and both campuses (Kansas City 66% and Wichita 88%) remains education which increased by $12 million.
- While "other" increases in Kansas City have been greater it should be remembered that many expenses from electronic library subscriptions to utilities are paid from the Kansas City "other" budget.

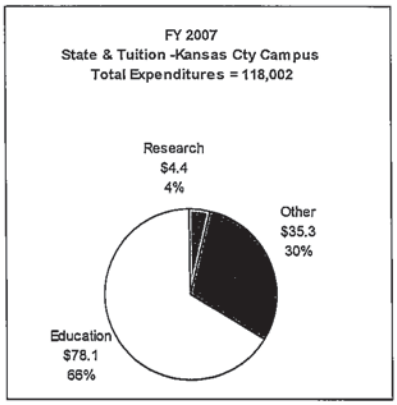
APPENDIX A

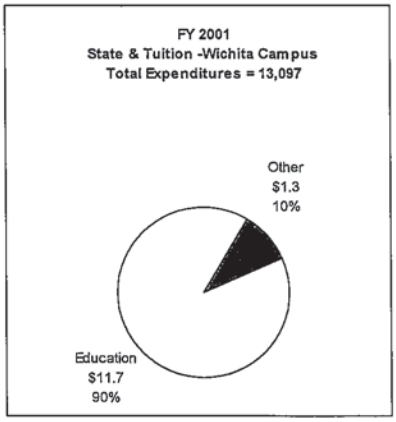
Increase in STATE and TUITION Expenditures on Education, Research and Administration (amounts in millions)

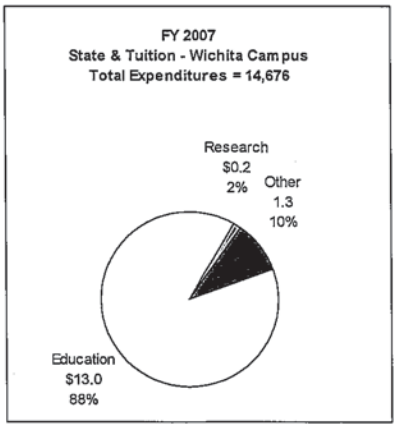












THE UNIVERSITY OF KANSAS
School of Medicine
Wichita

October 19, 2007

Barbara Atkinson, MD
Executive Vice Chancellor
Office of the Vice Chancellor
2032 Murphy Administration Building
Mail Stop 2015
3901 Rainbow Boulevard
Kansas City KS, 66160-7100

Dear Dr. Atkinson,

After reading the Kansas Legislative Division of Post Audit Report, believe it's important that I clarify a few points.

On page 12, the following sentence is incorrect: "Wichita officials told us that they were happy with the level of state support they had received in the past, but that they want to expand the campus basic research program to help overcome the citations Wichita has received and get more students and residents interested in going to Wichita." There are two very important issues to clarify here:
* Wichita officials ARE happy with the level of state support we receive for undergraduate medical education.
* We ARE NOT happy with the level of state support we receive for graduate or residency education. Increased state support is needed for graduate medical education, and our Wichita Center for Graduate Medical Education is asking the state for increased support to educate our residents.

Wichita officials stated that we have one accredited medical school in Kansas with two campuses. Students and residents on both campuses need to be exposed to good research and they need to have the opportunity to participate in research if desired. However, Wichita officials were misunderstood:
* We DO NOT feel that basic research is needed on the Wichita campus.
* We DO, however, want to enhance clinical and translational research on the Wichita Campus.

Office of the Dean
1010 N. Kansas | Wichita, KS 67214-3199 | (316) 293-2600 | Fax (316) 293-2628 | http://wichita.kumc.edu

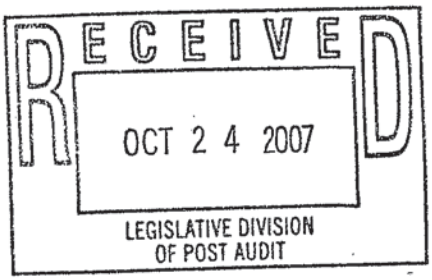
We apologize for any confusion our statements may have caused.

Sincerely,

S. Edwards Dismuke, MD, MSPH
Dean and Professor

THE UNIVERSITY
OF KANSAS HOSPITAL
KUMED

Bob Page
President & Chief Executive Officer
Hospital Executive Office



October 22, 2007

Ms. Barbara J. Hinton
Legislative Post Auditor
Legislative Division of Post Audit
800 SW Jackson Street, Suite 1200
Topeka, KS 66612-2212

Dear Ms. Hinton:

The following is the response of The University of Kansas Hospital to the draft audit report entitled KU *Medical Center and KU Hospital: Reviewing Selected Operational Issues*.

Although the financial support from The University of Kansas Hospital to the University of Kansas School of Medicine has been the subject of much discussion in the past months, the overall parameters for a future financial relationship have been agreed upon by the two institutions. While both the hospital and the university may want to clarify points in the Post-Audit report, the "contention" between both organizations regarding this topic is now in the past and the two organizations are committed to moving forward with a new relationship and a new era of cooperation.

Question 2. How does the relationship between the KU Hospital and the University of Kansas Medical Center compare to what is envisioned in State law, and to relationships that have been established between medical schools and teaching hospitals in other states?

We concur with LPA's conclusion that the current organizational relationship between the KU Hospital and KU Medical Center follows State law and is similar to how teaching hospitals and medical schools are organized in many other states. Furthermore, LPA notes in the report that "The Legislature created the University of Kansas Hospital Authority in 1998 to improve the financial viability of the KU Hospital" (page 23) and that "Since it was spun off from the Medical Center, the Hospital's situation has improved significantly" (page 4). While LPA addresses recent questions that have arisen relative to KU Hospital board membership, in our view these have been resolved by the Attorney General (Opinion 2007-13, attached in Appendix C).

As noted above, we believe KU Hospital and KU Medical Center have reached agreement on the overall parameters for unrestricted mission support. We also agree with LPA's finding concerning IME, that these funds are intended to offset the additional costs incurred by hospitals in training residents.

LPA focuses the remainder of its report on the financial relationship between the KU Hospital and the KU Medical Center. LPA summarizes its findings by saying that "Comparisons with other state medical centers have significant limitations but the support that the medical center has received does appear to be relatively low".

We believe some explanatory comments are warranted about the limitations in comparisons of financial support described by the LPA.

First, LPA noted that data comparisons to other schools are very difficult to make and the AAMC report which was used by the LPA report has significant limitations *when used for this purpose* due to the complexity of funds flow at each school as well as relative size of the schools and hospitals involved. In addition, these data are self-reported by schools of medicine and are not normalized or benchmarked. The AAMC report does not take into account the various structures, appropriations, programs, inter-organizational transfers or other local conditions at the reporting institutions. We note that as an example of this data deficiency that the LPA staff had to adjust the data the KU Medical Center submitted to the AAMC in 2005 to try to normalize their data against that provided by the five sample states.

Other differences LPA cites include wide variations in the compare group in size based on revenues and whether the hospitals receive direct appropriations. One of the compare group hospitals, The University of Colorado Hospital, received $35 million in governmental appropriations that is not reflected in the AAMC reports. KU Hospital receives no State appropriations.

Second, in most academic medical centers, the financial relationship isn't defined by state law but instead is negotiated between the hospital and school involved in order to be able to adjust quickly to the ever-changing environment. At the time of the formation of the Authority, the immediate goal was for the Hospital to stabilize its operations and financial challenges. However as time has passed and the situation improved, the financial support from the Hospital to the Medical Center has grown at a rate greater than that of the increase in its operating revenue. As noted by LPA in Figure 2-6, support in 2001 was $8 million and had increased to $27 million by the year 2007, a 238% increase. During that same period the Hospital's total operating revenue increased from $252 million to $589 million, or a 134% increase.

It should also be noted that while the financial performance has improved significantly (the Hospital was recently upgraded from an A- to an A rating by Standard and Poor's), there is still a long way to go. Most hospitals of equivalent size (based on net patient revenue) are higher rated per the 2006 Standard and Poor's median report primarily because their cash reserves are two to three times that of the Hospital Authority.

As has been noted, however, both the Hospital and University have reached agreement on the overall parameters for a future financial relationship. The "contention" between both organizations regarding this topic is now in the past and the two organizations are committed to moving forward with a new relationship and a new era of cooperation.

Other Mission Priorities-

We believe that LPA did not provide adequate focus on the other priorities that were listed in the Act creating the Hospital Authority that clearly looked beyond financial support to the Medical Center as missions of the Authority:

> 76-3302. Findings, purpose. (a) The legislature of the state of Kansas hereby finds and declares that:
>
> ... (4) the mission of the university of Kansas hospital is to facilitate and support the education, research and public service activities of the university of Kansas medical center and its health sciences schools, to provide patient care and specialized services not widely available elsewhere in the state and to continue the historic tradition of care by the university of Kansas hospital to medically indigent citizens of Kansas;
>
> (5) to provide for the education and training of health care professionals, to provide a clinical setting for biomedical research, and to ensure the availability of quality patient care including specialized medical services not otherwise widely available, it is necessary that the university of Kansas hospital be a facility of the finest possible quality;
>
> (6) such quality hospital, health care and related facilities require specialized management and operation to remain economically viable to earn revenues necessary for its operation and to engage in arrangements with public and private entities and other activities, taking into account changes that have occurred or may occur in the future in the provision of health care and related services; and
>
> (7) the needs of the citizens of the state of Kansas and of the university of Kansas medical center and its health sciences schools will be best served if the university of Kansas hospital is transferred to and operated by an independent public authority charged with the mission of operating a teaching hospital for the benefit of the university of Kansas medical center, providing high quality patient care and providing a site for medical and biomedical research.

Further, LPA refers to the 1997 Lash Group report. In that report, Lash Group identified twelve (12) vulnerabilities of KU Hospital which endangered the Hospital's viability and mission as the Legislature defined it above. Those vulnerabilities were as follows:

1. No defined linkage strategy
2. Lack of service differentiation
3. Declining admissions / minimal outpatient growth
4. Shifting payment mechanisms
5. Eroding subsidies for education
6. Inadequate funding for charity care
7. Limited cash reserves
8. Limited management flexibility and decision autonomy
9. Lack of timely access to capital
10. Limited attractiveness to potential business partners
11. Inefficient and costly operating practices and
12. Reduced innovation

In addition, as was described in the 1995 Legislative Post Audit report "Reviewing Certain Financial Management Practices at The University of Kansas Medical Center"

when the hospital was a part of the Medical Center, any monetary transfers at that time from the Hospital to the Medical Center were for the purposes of providing a fair share of overhead, not for general financial support. These types of payments are similar to those listed in line E. of Figure 2-5 of the current LPA report.

We believe that subsections 5 – 7 of the Act establishing the Authority, noted previously, required the Hospital Authority's focus on continuous improvement in the quality of patient care and patient outcomes, specialized medical services, improvement in patient satisfaction, growth in patient volumes, reinvestment of financial reserves, and significant enhancements in capital improvements. This has resulted in an overall environment which addresses the Lash-identified vulnerabilities and provides significant support and value to the education, research and public service activities of the University of Kansas Medical Center. The following are some examples of these achievements:

Quality and Patient Satisfaction-

- On October 11, 2008, it was announced that The University of Kansas Hospital ranked #5 in the nation for overall quality and patient safety among academic medical centers. Of the 83 academic medical centers providing data to the University HealthSystem Consortium, only Brigham and Women's Hospital in Boston, the Mayo Clinic, Methodist Hospital – Clarian Health in Indianapolis and Rush University Medical Center in Chicago ranked higher. This survey measured safety, effectiveness, equity, efficiency, and patient centeredness. Over the past two years, the University of Kansas Hospital has improved from 33rd to 5th in the rankings.

- *U.S. News & World Report* ranked KU Hospital 30th in the nation for heart care and heart surgery in its 2007 "Best Hospitals" issues. It was the highest ranking on any list for any Kansas City-area hospital. KU Hospital's mortality rate tied for fourth best among the 50 "Best Hospitals" on the heart and heart surgery list.

- In patient satisfaction, KU Hospital ranked in the 84th percentile among all hospitals in the Press Ganey survey and the 94th percentile among academic medical centers for the recently completed fiscal year. Of hospitals in Kansas City using the same survey, KU Hospital ranked first (six of the last seven quarters). At the time of the Hospital Authority transition, the Hospital's patient satisfaction ranking was at the 5th percentile.

- In December 2006, the hospital earned Magnet designation from the American Nurses Credentialing Center, becoming the first Kansas-based hospital to do so. Only 3.5 percent of the nation's health care organizations achieve Magnet designation.

- KU Hospital ranks first in the Kansas City area for benefit to the community in a survey of area hospitals by the Missouri Hospital Association. The survey takes into consideration such areas as charity care and support for education.

- KU Hospital was one of 10 large-company finalists in *The Kansas City Business Journal's* 2007 "Best Places to Work" program.

- The Society of Thoracic Surgeons recently provided the Hospital's cardiac surgery program a "3 star" rating, their highest category of quality. That puts us in the top 15 percent of heart surgery programs in the nation.

- Our hospital was the first hospital in a six state region to receive the Annual Performance Achievement Award from the American Heart Association (AHA) for stroke care. The hospital

had to demonstrate at least 85 percent compliance in seven key performance measures, such as speedy treatment, and sustain it for 12 consecutive months.

- *The Wall Street Journal* highlighted the success of The University of Kansas Hospital and interviewed staff for three articles: "Hospitals Take Consumers' Advice," "Vein Attempts? Making Needles Easier to Bear" and "The Informed Patient."

- ABC News' "Healthy Life Now" segment interviewed Beth Clark, RN, director, Cardiovascular Services, about our "door-to-balloon" times or how quickly we speed care to heart attack patients. In fourth quarter 2006, we averaged 68 minutes for "door-to-balloon" time, compared to the 90-minute national standard.

Programs and Capital Improvements-

- The re-acquisition of the cancer center in 2000, which was previously contracted to Salick Health Care in 1992 by the University, provides a key element in the University's quest for NCI Comprehensive Cancer Center designation. On August 6, 2007 we opened The University of Kansas Hospital Cancer Center and Medical Pavilion in Westwood, Kansas, the largest outpatient cancer center in the area. Cancer–related investments since 2000 total over $75 million.

- In October 2006, we opened the $77 million Center for Advanced Heart Care. It provides a state-of-the-art environment to care for heart patients, including the region's first and only stereotaxis electrophysiology center. LPA noted the heart program was in serious difficulty at the time of the Hospital Authority transition.

- Since 1998, the hospital has invested over $300 million in other capital improvements for expansion of capacity, technological advances, improved patient environment, information technology, and building and support infrastructure. We continue to re-invest to correct legacy issues of historic undercapitalization in building and deferred maintenance (e.g. a ten-year capital investment project of over $80 million to replace air handling units in the Bell Memorial Hospital building).

- A few additional examples of this capital investment since 1999 include KU MedWest, a 60,000 square foot outpatient and ambulatory surgical center in Shawnee; PET scanner and Cyclotron; IMRT technology in Radiation Oncology; new OB/GYN and Family Medicine clinic space on the main campus; upgraded digital imaging technology in mammography, sonography, 64-slice CTs and MRIs; added a sixth floor onto the Bell Memorial Hospital building, creating space for six additional patient care units; replacement of all emergency generators serving the hospital; complete renovations to patient care units / intensive care units; and renovations to the operating rooms and post-anesthesia care units.

- The hospital provides services not generally available in the community, both for the citizens of Kansas and region, as well as a clinical educational setting for the school of medicine. The hospital has the area's only nationally-accredited Level I Trauma program. The Burnett Burn Center continues to be the only one of its kind in the area. The University of Kansas Hospital Poison Control Center provides services to the entire state of Kansas, as it has for the last 25 years. In addition, the Hospital has provided inpatient and outpatient services for all core curriculum components of the School of Medicine, regardless of financial results.

- Other examples of support which are not directly financial include (1) the purchase in 1998 of a primary care physician network with several locations around the KC metro area and offering these locations as training sites; (2) the re-establishment of cardiovascular and cardiothoracic surgery at the Hospital, which enables students and residents to receive clinical education in these areas without having to go to another hospital; (3) the construction of a dedicated power plant for the hospital, which removed the hospital from the University's power plant, creating utility capacity to enable the University's Kansas Life Sciences and Clinical Innovation building to be

operational without additional investment by the University or State of Kansas; and (4) an ongoing advertising and marketing campaign featuring medical staff physicians as faculty members, improving the image of academic medicine and correspondingly the image of KU Medical Center.

Growth-

- Patient discharges have increased from 13,082 in fiscal year 1998 to 20,874 in fiscal year 2007, an increase of 60%.
- Outpatient encounters increased to 270,537 in FY07.
- The hospital's case mix index, an indication of the seriousness of illness of patients increased from 1.3631 in FY98 to 1.6378 in FY07.
- The increased volume and mix of patients provides a significantly richer environment for education and clinical research.

While the increase in patient satisfaction and quality scores cannot be measured in financial terms, it is clearly of significant value to the teaching mission. These and other significant improvements in mortality and quality patient care by the Hospital provide a clinical training environment which puts the patient first and thereby provides an ethical and modern teaching environment to students and residents.

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

The University of Kansas Hospital agrees that there can be improved reporting by hospitals on their uncompensated care burden in addition to the calculations of charges. While the addition of cost reporting for uncompensated care has merit, The University of Kansas Hospital believes it also requires some additional conditions to be meaningful.

For one, there is a lack of uniform definitions of cost reporting among hospitals. The value of the cited Missouri Hospital Association cost report was that all hospitals were subject to the same methodology. Without a similar mandated specific methodology for all hospitals, "apples to apples" comparisons will be just as difficult as they are now with comparison on charges.

The other issue is how to account for government appropriations or special tax levies to hospitals designed to compensate them for charity care. The University of Kansas Hospital receives no such appropriations from either state or local governments. The Missouri Hospital Association survey subtracted those funds from the uncompensated care amounts. If allowances are made for these tax subsidies in the chart on page 39 of the Post Audit report, it would look like this:

Kansas City Area Hospitals' FY 2005 Uncompensated Care Costs
(in millions)

Hospital Name	Uncompensated Care Total	Tax Subsidy	Net Uncompensated Care Total	Net Uncompensated Care as % of Total Expenses
University of Kansas Hospital	$24.60	$0.00	$24.60	5.40%
Truman Medical Center Hospital Hill	$41.70	$18.40	$23.30	9.40%
Saint Luke's Hospital of Kansas City	$12.10	$0.00	$12.10	3.20%
Shawnee Mission Medical Center	$9.10	$0.00	$9.10	3.30%
Children's Mercy	$9.30	$2.90	$6.40	1.60%
Truman Medical Center Lakewood	$13.90	$12.00	$1.90	2.30%

If a standard for reporting can be adopted, and accommodations made for public charity care subsidies, The University of Kansas Hospital would be very supportive of a cost-based uncompensated care reporting system. Regardless of the measurement methodology, KU Hospital has continued to meet its obligations to the State of Kansas in continuing the historic tradition of providing care to the medically indigent citizens of Kansas.

Thank you for the opportunity to review and provide comments on this report. The management team of The University of Kansas Hospital commends the audit staff for their professionalism and diligent work on this assignment.

Sincerely,

Bob Page
President and Chief Executive Officer