

ODJFS Response to Comments provided at the 2003 Hospital Care Assurance Program (HCAP) Forums

The following is the Ohio Department of Job and Family Services' (ODJFS) response to the comments presented at the Federal Fiscal Year (FFY) 2003 Hospital Care Assurance Program (HCAP) forums held in Toledo on December 10, Cleveland on December 12, Cincinnati on December 13, and Columbus on December 20, 2002. ODJFS held these forums prior to developing the HCAP 2003 policy so that the comments could be considered prior to proposing rules in March.

The following is a summary of comments received by forum attendees and ODJFS' response to those comments.

Comments regarding the principle use of the HCAP funds

Comment: HCAP distribution formula should be guided by the principle that HCAP funds should be targeted toward the medically indigent and the most vulnerable patients. HCAP funds should be maximized for use for the provision of uncompensated care. HCAP funds should follow the patient.

Comment: The original purpose of the HCAP program and the federal Disproportionate Share program is to recognize and reimburse hospitals, such as children's hospitals, which serve a disproportionate share of Medicaid and low-income uninsured patients with special needs.

Response: ODJFS agrees that the guiding principles of the state disproportionate share program are that the money should follow the indigent patients and that the dollars are to help compensate hospitals for uncompensated care costs incurred while providing care to the indigent.

Comments regarding ODJFS enforcement of HCAP policy

Comment: ODJFS was asked to continue to monitor hospital compliance with HCAP rules on informing patients about the HCAP program. In the experience of the organization who commented, many hospitals around the state do not implement the rules fully. They are out of compliance in terms of signage, language requirements, notice on hospital bills, and taking other steps to inform patients who might not be able to read their signs.

Comment: UHCAN Ohio engaged in an aggressive campaign of site visits and surveys of Columbus hospitals in 2000 and 2001. As a result of their findings and collaboration with the hospitals, the Columbus hospitals made significant improvements in their HCAP outreach. UHCAN hopes to replicate this work elsewhere and would be happy to provide technical assistance to local entities, including hospital associations, wanting to improve their HCAP outreach. After all, maximizing prompt enrollment in HCAP of eligible patients is in the hospitals' best interests.

Comment: One commentor was pleased about the new requirement for each hospital to have a third party sign off on its uncompensated care data. Increasing the reliability of the uncompensated care data is extremely important to the ability of HCAP funds to more closely follow the patients and, by extension, to the survival of HCAP.

Response: ODJFS will continue to monitor hospital compliance through our HCAP data reviews. In addition, ODJFS will continue to communicate and work with hospitals throughout the year to help them understand and comply with HCAP requirements. In addition, we look for opportunities to improve enforcement such as the implementation of the Independent Third Party Validation program. This new enforcement initiative was implemented in response to requests by hospitals and advocates for the indigent.

Comments regarding High-DSH hospitals

Comment: Indigent patients account for up to half of High DSH hospitals' patient volume. High DSH hospitals must establish a range of costly programs and services to accommodate the special needs of the indigent. Only a portion of the costs of these services are allocated to Medicaid on cost reports and many important costs are completely disregarded for purposes of the HCAP program (e.g., losses incurred for physician services). Children's hospitals (many of which qualify as high DSH) receive no Medicare DSH payments. Even as structured for the 2002 program year, HCAP fell short. In 2002, children's hospitals recovered only 90% of their costs—not counting at least \$4 million in losses from physician services and outpatient laboratories, two examples of service costs not typically counted in HCAP. By attempting, in recent years, to address hospital industry financial challenges unrelated to the indigent, HCAP dollars have been stretched increasingly thin and this has resulted in reducing the program's commitment to high-DSH hospitals.

Comment: In the face of an expected \$45 million cut in federal DSH funds for the 2003 HCAP program, ODJFS is urged to strengthen HCAP's commitment to the financial viability of high DSH hospitals. To that end, ODJFS should (at a minimum) maintain the current allocation for Pool 1 (High Federal Disproportionate Share and Indigent Care Payment Pool) and for Pool 2 (Medicaid Indigent Care Payment Pool) at the level of the HCAP 2002 program. We should use this opportunity to demonstrate clearly that HCAP cannot be a substitute for a well-funded Medicaid program or a well-funded program for the uninsured. Reduced federal funding demands a return to the program's priority goal—supporting high-DSH, safety net Medicaid providers.

Comment: Medicaid FFS and HMO payments are being cut, this will have a larger impact on hospitals that serve a higher proportion of Medicaid patients. The effect of these cuts won't show up in the cost reports (the basis of HCAP data) for another 2 years. This will be in addition to the pending federal cuts in HCAP. The main purpose of HCAP and disproportionate share programs is to recognize and reimburse High DSH hospitals. Don't let the cuts to the HCAP program affect the high DSH hospitals.

Comment: In looking at HCAP 2002, children's hospitals and those hospitals that meet the federal definition of a high disproportionate share hospital (DSH) had the highest rate of recovery of their losses (when losses are defined by the federal hospital-specific payment cap—losses in treating Medicaid patients and the uninsured). Suburban non-teaching hospitals, as a group, had the lowest recovery of their losses.

Response: As in past programs, ODJFS will use the guiding principles of the state disproportionate share program in developing HCAP policy—the money will follow the patients. And ODJFS will work to minimize hospitals’ losses in uncompensated care costs and variations in HCAP payments.

Comments regarding the Disproportionate Share Limit Pool

Comment: The Disproportionate Share Limit Pool (Pool 4) distributes excessive HCAP funds to hospitals providing minimal uncompensated care. Explore decreasing, if not eliminating, that pool consistent with federal and state law. This is particularly important given the upcoming cuts in the total amount of HCAP dollars available to Ohio.

Comment: Replace the Disproportionate Share Limit with a more equitable pool that distributes dollars based on the unrecovered OBRA cap prior to the fourth pool or any other measure of uncompensated care. Pool four allocates over 17% of the total pool (or over \$90 million) to hospitals based on facility assessment, not uncompensated care. It attempts to return up to 50% of a hospital’s assessment, regardless of the amount of uncompensated care provided. The hospitals that received the largest percentage from the fourth pool were the big hospitals with low shares of indigent care. It is the one pool in the HCAP formula where HCAP funds do not follow the patient.

Comment: Without the annual contribution of over \$200 million paid by Ohio hospitals, over \$300 million in federal funds would not be available to the state. Unlike the rest of the Medicaid program, state dollars are not used to draw down federal funds in the HCAP program. Therefore hospital support is crucial to the program. While some organizations have recommended other uses of these funds, they have not proposed viable methods for attaining these funds. We believe those organizations should concentrate their efforts on seeking the expansion of other health care programs and not risk the existence and stability of the HCAP program.

Comment: Since 1993, between 19 and 25 hospitals per year have lost a combined \$90 million as a result of the program by receiving a distribution that was less than their paid assessment. These hospitals include children’s hospitals, rehabilitation hospitals, small and rural hospitals, and suburban community hospitals. The HCAP program impacts a contributing hospital’s ability to remain financially viable in the ever changing and demanding healthcare market place. The original purpose of the HCAP assessment was to generate sufficient funds to draw down Ohio’s maximum federal allocation, not to impose a tax on hospitals to cover the cost of indigent care. The HCAP assessment was not designed to as a mechanism to redistribute hospital funds from one hospital to another.

Comment: Those voicing their concerns about returning assessment dollars are not attentive to the whole of a hospital’s worth to its community. In addition to uncompensated care, hospitals provide such community services as medical education, advanced medical research, and support for community based health initiatives. Removing assessment return dollars in HCAP would impact the ability of many hospitals to continue serving their communities in areas other than the delivery of uncompensated care.

Comment: When hospitals initially agreed to be assessed it was with the understanding that they would at least be made whole for their assessment. Beginning in 1993, hospitals could no longer be held harmless under federal regulations. There is a fine balance in meeting the federal hold harmless restrictions and ensuring that economic contributor hospitals do not contribute more than they can financially bear. The

amount of a hospital's assessment has nothing to do with its level of indigent care or its Medicaid business; it is solely a product of the size of the hospital. ODJFS should maintain the current level of assessment return to all hospitals.

Response: The Disproportionate Share Limit pool provides a distribution of HCAP funds for uncompensated care reported by hospitals that have not received their maximum allowable amount of HCAP funds through other distribution pools. Like all the other pools in the HCAP formula, the disproportionate share limit pool never provides funding to a hospital in excess of their disproportionate share limit—the amount of uncompensated costs the hospital incurred while caring for indigent patients. This pool is consistent with Federal requirements for distributing disproportionate share funds and takes into consideration the state-wide impact of the HCAP program and access to hospital services.

Comments regarding the public input process for HCAP

Comment: ODJFS was repeatedly applauded for giving individuals and groups across the state the opportunity to give input into the HCAP formula, through regional forums, before drafting this year's formula. Also, several acknowledged the cooperation and understanding ODJFS has demonstrated in the past when developing HCAP policy.

Comment: ODJFS was asked to give the public at least two weeks more notice for the forums to provide enough opportunity for interested parties to communicate and coordinate with others interested in attending and participating at a hearing in their area.

Comment: ODJFS was asked to convene an advisory group to examine and explore the best use of DSH funds to maximize the reimbursement of uncompensated care and to recommend the best HCAP distribution formula for 2003. The group would be composed of health care providers, advocates (including the Ohio Hospital Association, consumer, community, and other health advocates), and government officials.

Response: Beginning with the 2001 HCAP program, ODJFS expanded its effort to gather public input on HCAP by holding the HCAP public forums. Based on positive responses received by ODJFS, this effort is being continued. Beginning this year, the forums are being held earlier in the year to allow for the earlier deadline imposed by CMS for finalizing the policy and to provide interested parties the opportunity to have input early in the policy making process. ODJFS will provide more timely notice of the date of future HCAP forums to interested parties. ODJFS posts notification of these forums on our web site at <http://www.state.oh.us/odjfs/ohp> (follow the links "Programs", "HCAP") and at local ODJFS offices.

In addition to the public input ODJFS collects through the forums, ODJFS also takes input throughout the year by meeting with interested parties, through telephone conversations and other correspondence, and through the formal rule making process (e.g., clearance and public hearings). These communications are designed and implemented to allow all interested parties the opportunity to have their comments heard and included in the program.

Comments regarding preventing the federal cut to the HCAP and other DSH programs

Comment: What is the state doing to prevent the federal cuts to the DSH programs and HCAP? How can others assist in that effort?

Response: ODJFS recognizes this is a huge potential problem for hospitals and impoverished Ohioans who use hospital services due to the lack of other health care resources. Governor Taft has made this issue a major Federal priority for the state of Ohio. He has and will continue to advocate directly with the Ohio Congressional Delegation urging them to prevent federal cuts to DSH. The Governor also intends to advocate on behalf of Ohio's interests through the National Governor Association. Those who would like to assist this effort can do so by contacting their congressional delegation who represent them in Washington, D.C. To make your communication most effective, include the specific local impact of DSH funding cuts (e.g., what would a reduction in funding mean to your hospital, community, etc.)

Comments regarding the use of recent HCAP policy in the 2003 HCAP program

Comment: Currently, Ohio's federal allocation is set to decrease from \$330 million in FFY 2002 to less than \$284 million in FFY 2003. Even in the face of these cuts, ODJFS is urged to adhere to the principles guiding the most recent programs as closely as possible.

Comment: The policy adopted regarding the redistribution of funds within the community that would have been distributed to a "closed" hospital should be extended to all HCAP years where ODJFS receives a valid and reliable cost report from a closed hospital.

Response: Due to the favorable response to recent HCAP models, ODJFS intends to propose an HCAP formula for 2003 that is similar to the 2002 HCAP formula. ODJFS will take into consideration the drop in federal funding and, as with past models, consider shifts in reported data on uncompensated care and on Medicaid consumers to make sure the dollars follow the indigent patients. In addition to recognizing the support for the policy used in the 2002 model, limiting changes in the 2003 HCAP policy to those resulting from changes in reported data and in federal funding also enables ODJFS to stabilize the program and its impact on hospital providers. Regarding closed hospitals, ODJFS will maintain prior year's policy which recognizes valid cost reports filed by closed hospitals in the year of closure and the year immediately following closure.