

2008 Hospital Care Assurance Program

Public Forum

September 19, 2007

The Department of Job and Family Services hosted a public forum for the 2008 Hospital Care Assurance Program. The forum was held via video conference with participating sites in Cleveland, Columbus, Cincinnati and Toledo. The department accepted written and oral comments from those in attendance.

Written comments as provided to the department are presented in this document.

[John Callender](#), Ohio Hospital Association

[Ryan Biles](#), Ohio Hospital Association

[Nancy Fisher](#), MetroHealth System

[Molly Brudnick](#), Community Partners for Affordable, Accessible Health Care (CPAAHC)

**Ohio Department of Job and Family Services'
2008 HCAP Forum
Testimony Submitted by Ryan Biles, Manager of Health Policy
The Ohio Hospital Association – Columbus, Ohio
September 19, 2007**

Director Thomas and the staff of the Office of Health Plan Policy, thank you for the opportunity to testify this afternoon. My name is Ryan Biles, and I am Manager of Health Policy for the Ohio Hospital Association, which represents 170 hospitals and 40 health systems throughout the state of Ohio. Today, I would like to offer a few thoughts on the future of the Hospital Care Assurance Program (HCAP) from the perspective of the hospitals that serve this state.

From OHA's perspective, the purpose of HCAP is to make special payments to Ohio hospitals to underwrite a portion of the unpaid costs of providing health care services to Ohio's Medicaid population and individuals without health insurance coverage. For twenty years, Ohio hospitals have paid assessments to provide the state share of Ohio's disproportionate share (DSH) allocation, and the federal funding they have received in return has allowed them to continue to be able to offer free, medically necessary, hospital-level services to uninsured patients with incomes below poverty.

However, the federal funding those assessments have drawn have not kept pace with the growing challenges Ohio hospitals face, among them being the fact that over ten percent of Ohio's population have no health insurance¹ and uncompensated care costs for hospitals that have steadily increased since 2000. In fact, since 2000, Ohio hospitals have seen their uncompensated care costs increase, on average, by nearly \$2 million per hospital.² But since 2000, Ohio hospitals have seen their net reimbursement from HCAP decrease, on average, by \$82,800.

With federal funding frozen until 2010, and the program's funding a favored target of external special interest groups' health care reform proposals, the pressure surrounding this program has never been greater. OHA appreciates the department proposing a new model for 2008, but it has been our experience that even seemingly minor policy tweaks in HCAP can have extremely significant effects on individual hospitals. OHA's Task Force on HCAP, its Finance Committee, and its Board of Trustees all look forward to modeling the effects of the department's proposals and making recommendations back to ODJFS, based on the consensus of the hospital community.

Finally, OHA staff is looking forward to again working with the staff at the Office of Health Plan Policy to ensure that any HCAP policy reforms in 2008 create a more equitable program for all hospitals without threatening the crucial funding an increasing number of hospitals have come to rely upon.

Again, thank you very much for the opportunity to testify at today's hearing.

1—Source: U.S. Census Bureau

2—UCC are equal to the uncompensated care costs delivered to the uninsured plus Medicaid FFS and HMO losses

Hospital Care Assurance Program Funding – Is It Enough?

Eligible hospitals in Ohio participate in a federal program for facilities that serve a disproportionate share of Medicaid or other indigent patients. This program, the Hospital Care Assurance Program (HCAP), reimburses hospitals for a portion of the uncompensated care and Medicaid payment shortfalls they experience year in and year out. The program has been in existence since 1988.

In order to participate, hospitals must first pay an assessment that is used to draw down federal funding. No other state or General Revenue Funds (GRF) are used in this process. Once federal funds are drawn, they are distributed to all eligible hospitals through a complicated and fragmented distribution model. However, at least 10% of Ohio hospitals pay more in assessments than they receive from the distribution model every year. For the remaining hospitals, HCAP funds still fall far short of fully reimbursing Ohio hospitals for the uncompensated care and Medicaid losses they experience. A breakdown of both the costs of uncompensated care and the funding appropriated to reimburse hospitals for those costs in the 2007 HCAP model:

State Mandated Free Hospital Care

- Hospitals in Ohio are required to provide medically necessary care, free of charge, to those individuals with incomes at or below the Federal Poverty Line.
- As reflected by the most recent available data, Ohio hospitals provided \$405.1 million in free care to those with incomes at or below the Federal Poverty Line in SFY 2006.
- For these SFY 2006 losses, HCAP will use hospital assessments to draw \$326.4 million in federal funding.
- While Medicaid does not reimburse hospitals for any free care they are required to provide, HCAP will reimburse Ohio hospitals for 80.6% of their losses from this mandate.

Medicaid Fee-For-Service and HMO Losses

- Also in SFY 2006, Ohio hospitals incurred a \$305.7 million shortfall as a result of treating Medicaid patients in both inpatient and outpatient settings.
- No federal funding will remain after reimbursing the mandated free care to address shortfalls in Medicaid this year.

Hospital Uncompensated Care to the Uninsured

- Further, in SFY 2006, hospitals treated uninsured patients with incomes above the Federal Poverty Line and incurred losses of \$454.5 million.
- Hospitals will receive \$0 in reimbursements for any of these costs from HCAP.
- With HCAP funding levels frozen by the federal government until 2009, Ohio hospitals will continue to provide this care without an expectation for even a penny in payments for 2 more years.
- Therefore, the \$326.4 million that HCAP will generate in 2007 for Ohio hospitals is extremely valuable to our hospitals for helping to address issues such as insufficient Medicaid payments and uncompensated care delivered to uninsured and underinsured patients alike, yet it falls far short of being a solution to the \$1,165.3 million gap between the costs of delivering care to these vulnerable populations and what our hospitals receive in payments for that care.

HCAP Funding – Is It Enough? (cont.)

SFY 2006 HCAP
(Payments To Be Made In 2007)

Federal Funds (DSH)	\$ 326,400,000
GRF Funds	\$ <u>0</u>
Total HCAP Funds	\$ 326,400,000

Cost Of Care To Uninsured
Individuals With Income
At Or Below The Federal
Poverty Line \$ 405,100,000

Cost Of Care To Medicaid
Patients Not Covered Via
Medicaid Payments –
Medicaid Losses \$ 305,700,000

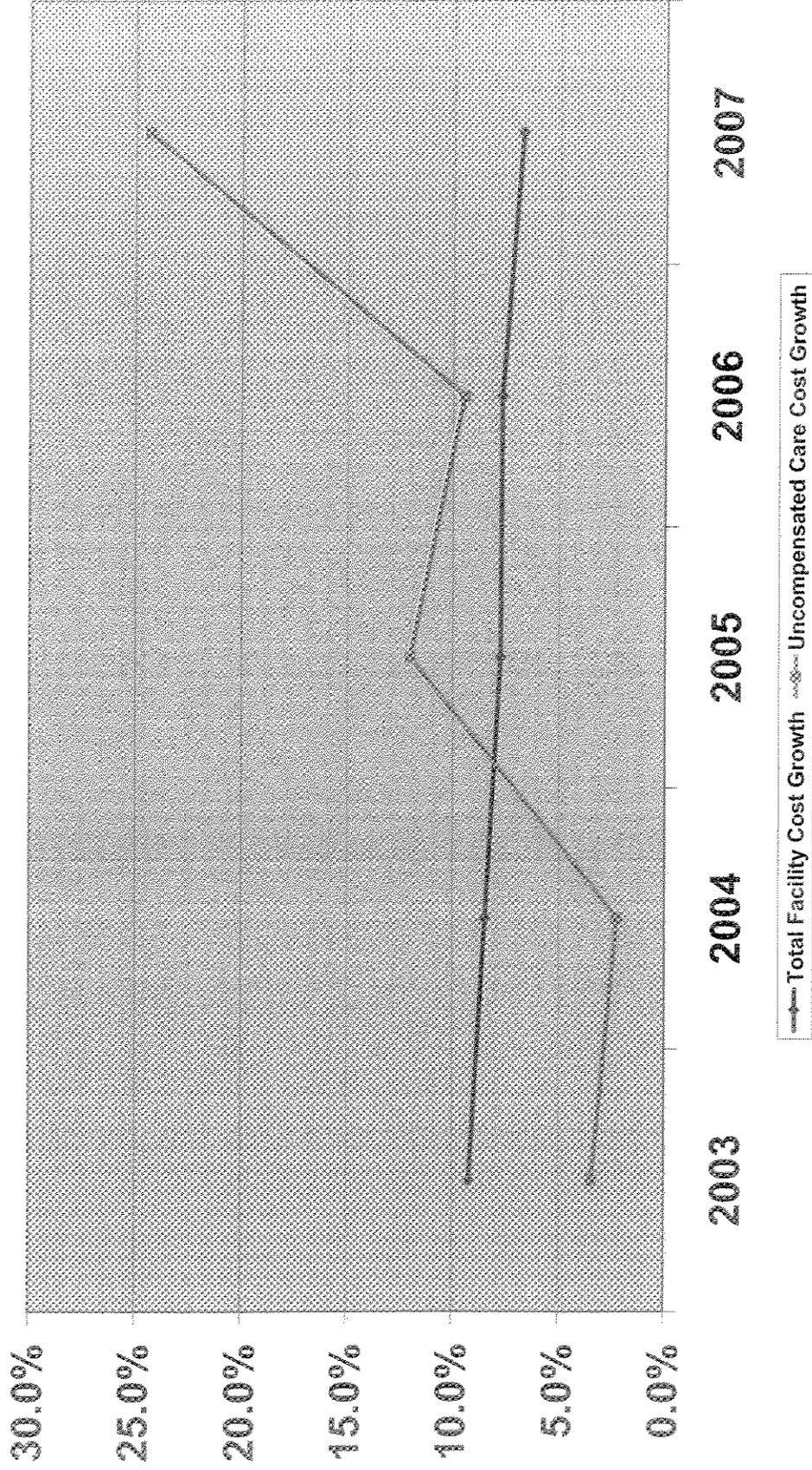
Cost Of Care To Uninsured
Individuals With Income
Above The Federal
Poverty Line \$ 454,500,000

Total Uncompensated Care \$ 1,165,300,000

Federal Funds (DSH)/HCAP Funds - \$ 326,400,000

Net Uncompensated Care Not Reimbursed By Federal Medicaid DSH And/Or State Funding	\$ 838,900,000
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Ohio Hospital Uncompensated Care Growth vs. Total Facility Cost Growth 2003-07



**Testimony before the
Ohio Department of Job & Family Services
On
Ohio's Hospital Care Assurance Program (HCAP)**

by

**John E. Callender
Senior Vice President
Ohio Hospital Association**

**Wednesday, September 19, 2007
3:00 p.m.**

Director Thomas and representatives of the department, it is my pleasure to be here today with my colleague Ryan Biles to discuss the history of Ohio's Hospital Care Assurance Program (HCAP) and the Principles and Goals OHA has followed for the many years we have been involved with various Administrations in the administration of this program.

Today's HCAP program was born out of the retreat by state and local governments from meeting the financial costs associated with providing care to Ohio's poor. In the early 1990s, Ohio government at both the state and county level determined they could no longer continue to fund the Disability Assistance Medical Program and the General Assistance Medical Program, and discontinued funding of both programs.

This decision by the Governor, the Ohio General Assembly and the various counties meant that over \$150 million a year that was paid to Ohio hospitals to cover the cost of inpatient/outpatient pharmacy and emergency room services to this population would no longer be paid.

Instead of meeting its obligation to finance the cost of health care to Ohio's poor, the state shifted that responsibility to the federal government and Ohio's hospitals by applying to expand the HCAP program. The HCAP program then and now does not contain any general revenue funds or local tax dollars. It is funded solely by an assessment on hospitals and federal funding. This fact alone, regardless of the wishes of various groups throughout Ohio, bestows upon OHA and the Ohio hospital community a special relationship and accountability for this program.

Attached to my testimony is a copy of OHA's Principles and Goals for the operation of the program. We welcome this hearing today and the effort put forth by the department to introduce new ideas for the distribution of HCAP funds.

We pledge to evaluate this proposal and respond to this proposal in a timely fashion.

I would be pleased to respond to any questions you might have.

OHA BOARD-APPROVED HCAP PRINCIPLES

Preamble:

UNCOMPENSATED HEALTH CARE SERVICES ARE NOT FREE HEALTH CARE SERVICES. HEALTH CARE SERVICES ARE BOTH SOCIAL AND ECONOMIC GOODS WHERE THE COST OF PROVIDING SERVICES, IF NOT PAID FOR BY THE INDIVIDUAL RECEIVING THE SERVICES OR THEIR THIRD-PARTY PAYER, MUST BE MET BY SOME OTHER ENTITY. THE HOSPITAL COMMUNITY HAS ASSUMED THE RESPONSIBILITY FOR ENSURING ACCESS TO HEALTH CARE SERVICES FOR THE VAST MAJORITY OF AMERICA'S UNINSURED POPULATION. HOWEVER, THIS BURDEN CAN NO LONGER BE BORNE BY CHARITABLE CONTRIBUTIONS, LOCAL GOVERNMENT SUBSIDIES, PROFITS FROM THE CARE OF THOSE WITH INSURANCE, AND SPECIAL PAYMENTS TO HOSPITALS MADE AVAILABLE THROUGH THE MEDICARE AND MEDICAID PROGRAMS. THIS BURDEN IS A THREAT TO THE FINANCIAL VIABILITY OF OHIO'S HOSPITALS AND BUSINESS COMMUNITY.

Purpose:

THE PURPOSE OF THE HOSPITAL CARE ASSURANCE PROGRAM (HCAP) IS TO MAKE SPECIAL PAYMENTS TO OHIO HOSPITALS TO UNDERWRITE A PORTION OF THE UNPAID COSTS OF PROVIDING HEALTH CARE SERVICES TO OHIO'S MEDICAID POPULATION AND INDIVIDUALS WITHOUT HEALTH INSURANCE COVERAGE.

The Four Main Principles of HCAP:

- **DISTRIBUTE ALL AVAILABLE FEDERAL DISPROPORTIONATE SHARE HOSPITAL DOLLARS THROUGH A FORMULA THAT IS EQUITABLE AND FAIR, STABLE, PREDICTABLE, TIMELY, SIMPLE, DE-POLITICIZED, AND IN ACCORDANCE WITH STATE AND FEDERAL LAW AND BOARD-APPROVED INDEXES.**
- **ADDRESS THE UNIQUE ECONOMIC NEEDS OF HOSPITALS THAT SERVE A DISPROPORTIONATE SHARE OF MEDICAID AND UNINSURED PATIENTS.**
- **MINIMIZE HOSPITAL LOSSES FROM THE IMPACT OF ANY ASSESSMENT.**
- **REIMBURSE UNCOMPENSATED CARE PROVIDED TO INDIVIDUALS WHO ARE UNINSURED OR COVERED BY THE MEDICAID PROGRAM.**

The HCAP Advocacy Agenda of the OHA:

HCAP IS NOT SUFFICIENTLY FUNDED TO FULLY REIMBURSE HOSPITALS FOR ALL OF THE COSTS OF PROVIDING UNCOMPENSATED CARE. UNTIL SUCH TIME THAT THE PROGRAM IS FULLY FUNDED, THE MAIN GOAL OF THE ASSOCIATION'S ADVOCACY EFFORTS RELATED TO HCAP WILL BE TO INCREASE THE FEDERAL FUNDING OF HCAP. ADDITIONALLY:

- **HCAP IS NOT A SUBSTITUTE FOR A WELL-FUNDED MEDICAID PROGRAM WITH ADEQUATE REIMBURSEMENT FOR INPATIENT AND OUTPATIENT HOSPITAL SERVICES. THE OHA WILL CONTINUE TO ADVOCATE FOR PAYMENT INCREASES IN MEDICAID.**
- **FUND THE STATE SHARE OF HCAP WITH A BROAD-BASED, STATEWIDE FUNDING SOURCE. THE OHA WILL ADVOCATE FOR A SUBSTITUTE FOR HOSPITAL ASSESSMENTS, PROVIDED THAT OHIO HOSPITALS WOULD RETAIN BOTH THE STATE AND FEDERAL FUNDS GENERATED BY HCAP.**
- **REPEAL THE FEDERAL LAWS THAT PROHIBIT HOLD HARMLESS PROVISIONS ON PROVIDER ASSESSMENTS.**

Good Afternoon

My name is Molly Brudnick and I am here today to represent Community Partners for Affordable Accessible Health Care (CPAAHC) from Cleveland, Ohio. We are a grassroots organization of individuals and organizations working to ensure that all residents of Greater Cleveland have ready access to affordable quality health care.

I am here today to speak to the HCAP program and some concerns that we have had and continue to have about the formula used to distribute dollars to our hospitals. When examining the HCAP Distribution formula, CPAAHC believes that the following principles should drive the development of that formula:

- 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 patients.

The last point where we have and continue to take issue with the Department is we believe that those hospitals that provide the greatest level of uncompensated care should receive HCAP dollars in direct proportion to the care provided. To us this only makes sense in that the purpose of these dollars is to cover the cost of uncompensated care. Therefore, those that do the most should receive the most. We do not believe that principle is reflected in the current formula and more specifically in the ongoing use of the Disproportionate Share Limit Pool which is a key component of the formula..

We have and continue to believe that the Disproportionate Share limit pool should be eliminated. This pool allocates a significant percentage of total HCAP dollars to ensure that all hospitals receive a return of at least 50% of their yearly HCAP assessment. It is rewarding hospitals (particularly large hospitals) that are providing minimal uncompensated care with HCAP funds. It is the one pool in the HCAP formula where clearly HCAP funds do not follow the patient.

At this time, we would like to refer you to an article in Crain's Business from earlier this year (copies provided). The headline reads "Providers contending with rise in uninsured".. It makes the point that hospitals are seeing more people than ever without insurance which stretches both the hospitals' finances and their ability to respond. The report shows that MetroHealth System's uncompensated care has more than doubled in the last 3 years going from 121 million in 2004 to an estimated 230-240 million in 2007.

With the number of uninsured continuing to rise, the demand for HCAP funds increasing and poverty becoming a major issue across our state; the Disproportionate Share limit pool is not an allocation that can continue to be maintained. On the contrary,

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we believe that in its place there should be an additional allocation to Ohio's major safety net hospitals that are providing the heaviest amount of uncompensated care.

Another major concern that we have is the almost exclusive involvement of the Ohio Hospital Association in the development of the HCAP distribution formula. To the best of our knowledge, they have been the principle group determining the content of the distribution formula. We have constantly requested that others be part of that process but have seen little happen. True, the community has been able to provide comments in hearings such as these, but when it comes to the actual distribution formula, this has been provided by the Ohio Hospital Association. While we respect this group and their commitment to health care; we feel strongly that they should be part of a process, not the sole contributor.

In conclusion, we request that the ODJFS establish an advisory committee to develop the HCAP formula. The advisory committee should be composed of representatives of the Ohio Hospital Association, Health Policy Institute of America, members of our State Legislature and Health care consumer and advocacy groups such as UHCAN -Ohio and CPAAHC.

In addition to developing an HCAP formula that fully reflects the points made earlier, this committee would

1. Review the current HCAP formula process to determine where and how it could benefit from additional community input.
2. Establish and put into process a procedure that would ensure that no one group would have undue influence on the development of the HCAP formula.
3. Establish and put into place a procedure to ensure that HCAP continues to adhere to the overall purpose of the program.

We would hope that the current administration would realize that there currently are serious inequities within this program. We cannot continue to justify current actions because that is the way that it has always been done. It is time to ask if the overall purpose of the HCAP program is adequately reflected in our current formula governing how the dollars will be distributed. We have made today's request before. We would hope that this year our request is followed by real action.

Thank you for the opportunity to present our concerns. We look forward to your reply.

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STATE OF OHIO



September 19, 2007

Ohio Department of Job and Family Services
30 East Broad Street
Columbus, Ohio 43215

RE: 2008 Hospital Care Assurance Program – Public Forum September 19, 2007

Dear ODJFS:

The MetroHealth System (MHS) appreciates the opportunity to comment and share its views regarding the 2008 Hospital Care Assurance Program (HCAP). Being one of the state's largest Medicaid providers and also one of the largest providers of uncompensated care, MHS is heavily dependent on both the HCAP and supplemental Upper Payment Limit (UPL) funding dollars. Thank you for your support of these programs.

Historically a guiding principle of the HCAP program is to assess and distribute the available HCAP funds through a formula that is fair and equitable and that **the dollars should follow the patients.**

We are concerned about the underfunding of POT 3A in the distribution model. POT 3A is designed to reimburse uncompensated care rendered to persons living at or below the federal poverty level and, in the current HCAP model, is underfunded. The amount allocated under POT 3A remained at \$316M in the 2007 model reflecting a funding level that has declined to **78.1%** of the total uncompensated care costs reported under this category. Meanwhile, POTs 4A, 4B and 5 lock in funding for specific types of hospitals (rural, critical access and childrens' hospitals). Further, POT 6 essentially gives back unallocated funds to hospitals based on their total facility costs. None of these POTs allocate funds with the intent to follow the patients that are provided a disproportionate share of uncompensated care. POT 3A specifically meets that principle and is the more fair and equitable way to distribute DSH funds to all hospitals.

We request that POT 3A be fully funded before POTs 4A, 4B, 5 and 6 are allocated any funding.

We are also concerned about the use of a proxy to determine outpatient Medicaid HMO payments in lieu of the actual payment data provided in the shortfall portion of the OBRA Cap calculation. The actual payment data is the more accurate measure of Medicaid managed care shortfalls. We believe that the current proxy methodology violates the intent of CMS. Ohio now collects the data necessary to determine actual payments.

We request that the actual Medicaid HMO payments be used in calculating the Medicaid shortfall for the OBRA cap calculation.

Thank for the opportunity to provide this information during the public comment period.

Sincerely,

Nancy Fisher Crum
Vice President & Chief Financial Officer

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