

HCAP TASK FORCE REPORT

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PROGRAM BACKGROUND

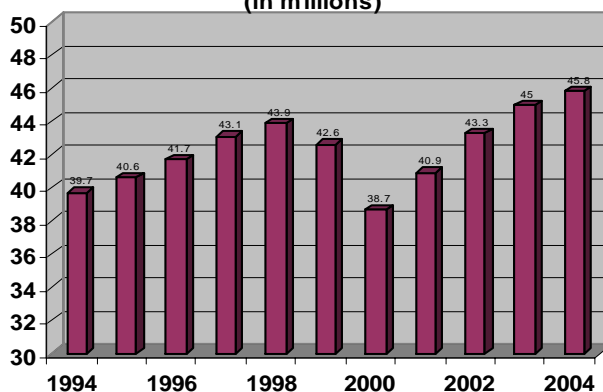
The American healthcare system leaves millions uninsured. Employers are paring health benefits in the face of ever-increasing insurance premiums. Legislatures in fiscal crises across the country have passed stricter eligibility standards for public insurance. And, as a result, the working poor often are left without insurance for quality healthcare.

In Ohio, over 1.3 million residents spend at least a portion of the year without any form of health insurance. Just like other Ohioans, they occasionally require hospital care. Unlike other Ohioans, they must pay for services that would otherwise be covered by commercial or public insurance. What they cannot pay becomes uncompensated care for Ohio's 194 private and public hospitals, and other acute-care facilities.

In the most recent year for which data is available, 2004, Ohio hospitals provided over \$718 million in care to uninsured patients for which no payment was received. Additionally, payments for care delivered to patients with Ohio Medicaid coverage fell short of covering what it cost hospitals to deliver their care. In 2004 alone, Ohio hospitals lost over \$204 million treating both Medicaid fee-for-service and managed care patients.

With a combined \$922 million

Uninsured Americans 1994-2004
(in millions)



Source: US Census Bureau, Current Population Surveys (CPS).

in annual losses stemming from the treatment of patients on Medicaid or without insurance at all, a staggering 4.86 percent of overall hospital costs are devoted to uncompensated care in Ohio.

While hospitals can control some factors like efficiency of delivering care, quality of care, and the prices they charge for certain services, the systemic breakdowns in the national healthcare delivery system are not issues easily dealt with at a hospital-specific level. However, in Ohio, the Hospital Care Assurance Program (HCAP) has existed since 1989 to help ease the challenge of hospitals' uncompensated care.

In 1989 Ohio hospitals were

first assessed a percentage of their total costs by the state, and then the assessments were matched with \$62 million in federal funding under the Medicaid Disproportionate Share (DSH) program. The federal funds were distributed to a group of hospitals that served extremely high volumes of low-income patients based on the costs of care for providing services to patients enrolled in the General Assistance Medical (GAM) program in Ohio, as well as on Medicaid costs. All hospitals received their assessments back from the program.

In 1992, though, the GAM program was eliminated. To ensure hospital care for the former GAM enrollees, every

hospital in the state was required to provide free care to all residents of Ohio living in poverty by legislation signed by then-Governor George Voinovich. In return, all hospitals with at least 1 percent Medicaid utilization would be eligible to receive a portion of the federal funding. In this program expansion, hospitals drew \$283.7 million in federal share through the HCAP distribution model in 1992. Again, no hospital paid more in HCAP assessments than it received from the distribution model.

However, in 1993, federal legislation set a funding limit for every hospital that participated in a Medicaid DSH program. The legislation prevented any hospital to receive Medicaid DSH funding in excess of the sum of the hospital's uncompensated care costs for the uninsured plus the shortfalls experienced from treating patients enrolled in Medicaid. Originally included in an omnibus budget reconciliation act, the limit has been known as the "OBRA Cap" and has caused a strange dilemma for hospitals in Ohio.

Because of the OBRA Cap, some hospitals must now pay an assessment that is greater than the amount of funding they are eligible to receive in return. Federal hold-harmless prohibitions enacted in recent years also eliminate the possibility of all hospitals receiving their full assessment amount back through the program.

In a negotiated settlement with the federal government, ten percent of hospitals in HCAP must lose at least ten percent of their assessment amount through the distribution. In HCAP 2006, this threshold was easily met, as 41 hospitals paid over \$16.2 million more in assessments than they received in distributions.

These hospitals are often facilities affiliated with other hospitals or systems, which benefit from the HCAP distribution in the aggregate, but their cooperation with the requirements of HCAP is crucial to the

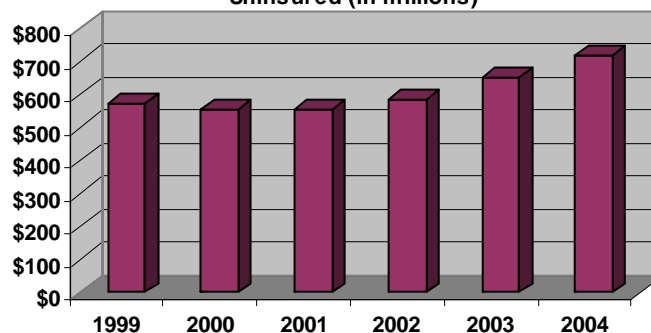
maintenance of the consensus supporting HCAP in the hospital community.

Since 1992, the HCAP free care requirement has held strong, providing hundreds of thou-

inflation. Thus, in the near future, HCAP policy decisions must be made without a guarantee of funding increases.

Representing the 194 hospitals in the state, the Ohio Hospital Association (OHA) has always

Ohio Hospital Uncompensated Care Costs to the Uninsured (in millions)



Ohio Hospitals spend hundreds of millions of dollars annually to provide care to uninsured patients. Data Source: Medicaid Cost Reports.

Since 1992, the HCAP free care requirement has held strong, providing hundreds of thousands of uninsured patients with necessary hospital care at no charge

sands of uninsured patients with necessary hospital care at no charge. The assessment and distribution program has evolved into a multi-tiered assessment, seven-pot distribution model, bringing \$326.4 million in federal funding annually to hospitals in need of the additional support.

However, HCAP funding still barely covers 35 percent of uncompensated care and Medicaid losses, and has been slashed and frozen in recent years. In 2003, a \$50.3 million reduction in the federal share of the program* was brought about by the federal Balanced Budget Act (BBA), signed by President Clinton in 1997. This represented a 15.2 percent cut in federal share and forced an \$84.9 million decrease in the total size of the 2003 HCAP program.

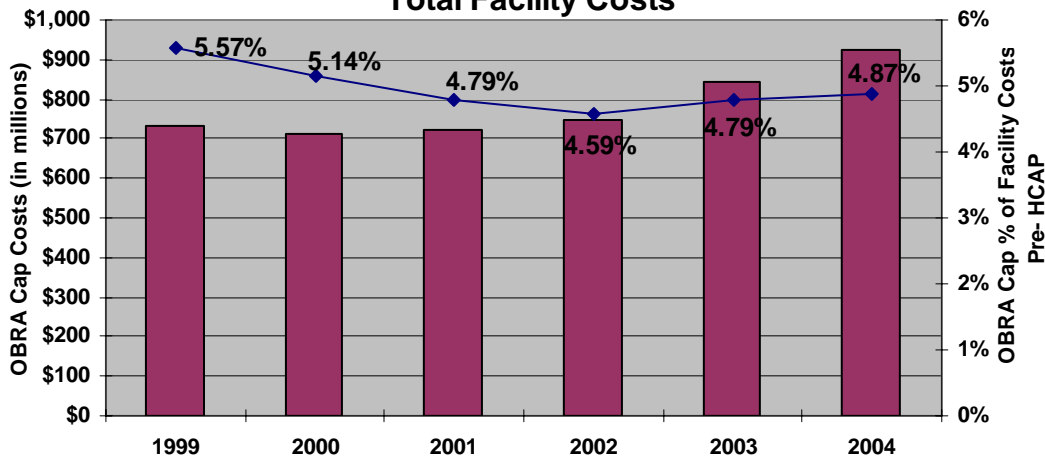
Though the pre-BBA funding levels have since been restored, the annual federal share of HCAP was frozen at just over \$325 million until 2009 or 2010, depending on the rate of

taken a keen interest in HCAP policy formation. The Ohio Department of Job and Family Services (ODJFS) administers the program for the state by crafting the program's rules, collecting the assessments, and making payments, but it relies heavily each year on the input of the hospital community on HCAP policy.

OHA has made reaching consensus on the distribution of HCAP funding a chief priority since the inception of the program. The OHA's Board of Trustees has crafted and continually revised (most recently in 2005) a statement of purpose and goals that guide the association's policy recommendations. The OHA Board also has charged a Task Force of HCAP policy experts, the majority of which are current hospital CEOs, with evaluating the current distribution model and making recommendations for the future. This report is the culmination of the work of the OHA HCAP Task Force.

* - The federal savings achieved by reducing funding to the Medicaid DSH program was re-allocated to the Children's Health Insurance Program (CHIP). Total federal funding for Medicaid was not reduced.

Ohio Hospital OBRA Cap Costs vs. Total Facility Costs



Though uncompensated care delivered to uninsured patients and Medicaid losses have been increasing since 2000, the relative burden on Ohio hospitals has begun to increase over the past three years. Data Source: Medicaid Cost Reports.

QUICK SNAPSHOT — HCAP 2006

HCAP 2006 is comprised of \$219.2 million in hospital assessments and \$326.4 million in federal funding, giving the program a total size of \$545.6 million.

With \$328.7 million in uncompensated care from serving the uninsured below the poverty line, \$390 million in uncompensated care from serving the uninsured above the poverty line, and \$204

million in Medicaid losses, HCAP federal funding covers only 35.4% of the OBRA losses experienced by Ohio hospitals.

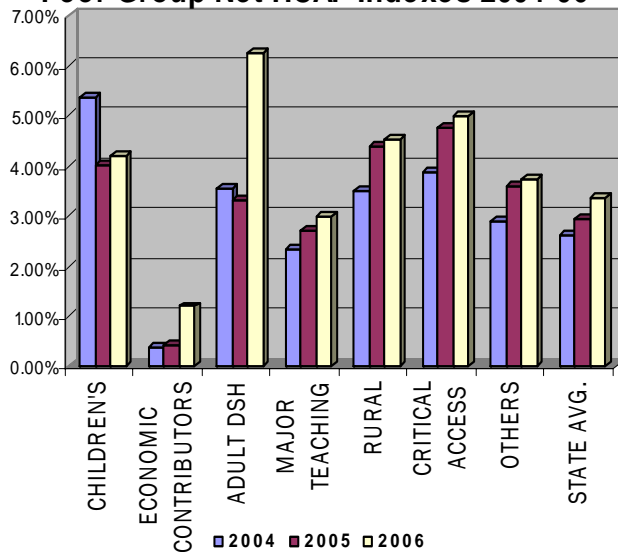
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HOSPITAL PEER GROUPS/NET HCAP INDEX

Major teaching hospitals, children's hospitals, hospitals that serve primarily low income patients, rural hospitals, and long term rehab hospitals all participate in HCAP. OHA uses a measure, called the Net HCAP index, to compare the relative burdens of individual and peer groups of hospitals as well as their treatment in HCAP in order to determine the most equitable distribution formula possible.

The Net HCAP Index is calculated by dividing the post-HCAP unreimbursed OBRA Cap costs by the total facility costs of a hospital or peer group.

Peer Group Net HCAP Indexes 2004-06



ENVIRONMENTAL FACTORS

The growing uninsured population, the freezes in payments in Medicaid, the expansion of Medicaid managed care, the shifting political tide, and the interests of individual hospitals all factor into maintaining the consensus for the HCAP model. Any analysis of the model's future must take into account these underlying changes.

THE UNINSURED

In 2005, 46.1 million Americans under the age of 65 lacked health insurance. While the number of uninsured Americans has been growing, who the uninsured are and the social and economic factors that place a person at risk of being uninsured, have not changed substantially over time. The uninsured are largely low-income adult workers for whom coverage is either unavailable or unaffordable.

Health insurance makes a difference in whether and when people get necessary medical care, where they get their care, and ultimately, how healthy people are. Uninsured adults are far more likely than the insured to postpone or forgo health care altogether and less able to afford prescription drugs or follow through with recommended treatments. The consequences of reduced access to care can be severe, particularly when preventable conditions go undetected.

As the number of uninsured increased by 11% between 2001 and 2004, total federal spending on the health care safety net increased by only 1%, leading to a decline in federal spending per uninsured person from an average of \$546 in 2001 to \$498 in 2004.

— Kaiser Family Foundation (*The Uninsured: A Primer, October 2006*)

Since 1996, uncompensated care delivered in Ohio hospitals to uninsured patients has grown at an average annual rate of 4.8 percent. Since 2002, that rate has increased to 7.6 percent. The loss of manufacturing jobs, particularly, has affected the number of uninsured individuals in Ohio. Workers forced from downsizing industries and into jobs with fewer benefits has been a common story in the state this decade.

Additionally, Medicaid eligibility standards have been tightened, so that a working couple with two children can earn only \$18,000 in 2006 (90 percent of the federal poverty threshold) before they would earn too much money to qualify for Medicaid benefits. Converging factors like these, along with general economic hard times and state budgetary fiscal crises, force up the number of uninsured and the resulting costs of uncompensated care delivered by hospitals.

With the rising costs of uncompensated care, HCAP has become strained to attempt to reimburse hospitals for uncompensated care delivered to patients above and below the poverty line, as well as for shortfalls in Medicaid. To illustrate the largest shortcoming of the current system, take a hospital that, in 2006, serves an uninsured patient in a family of 4 with a \$19,000 annual income. That hospital would receive 92 cents from HCAP for every dollar of cost incurred once the cost data reached the distribution model, only because the care delivered was to a patient with income below the current federal poverty level.

Now take that same hospital serving an uninsured patient in a family of 4 with a \$21,000 annual income. Though the patients would receive the same quality healthcare, the hospital would receive 0 cents from HCAP for every dollar of cost incurred to the non-HCAP eligible patient.

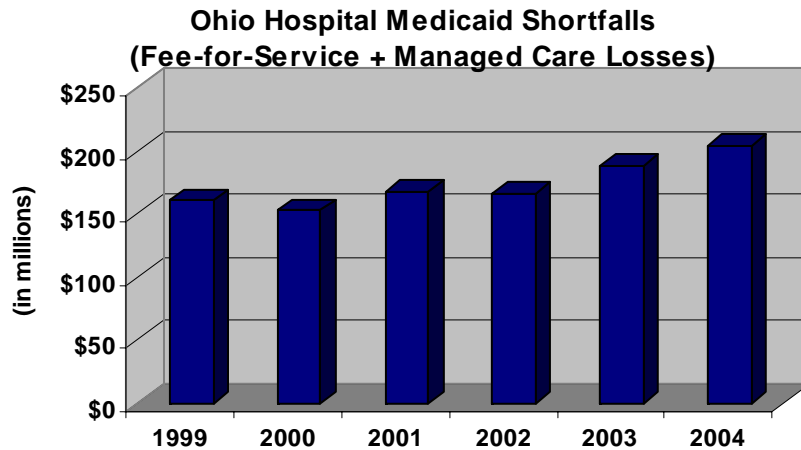
The potential for further increases in the number of uninsured and uncompensated care must be understood before proposing changes to the current HCAP methodology. Though admittedly not perfect, HCAP's system of attempting to reimburse hospitals for 100 percent of the cost of providing care to HCAP-eligible patients serves a bedrock principle of the program. Until additional funds can be secured or the problem of the uninsured lessened, hospitals that serve a disproportionate share of HCAP-eligible patients will continue to depend on this uncompensated care reimbursement methodology.

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—Kaiser Family Foundation, 2006

Furthermore, the reporting requirements for uncompensated care cost accounting have changed for Ohio hospitals beginning in 2007. Hospitals will now be required to deduct any payments received from uninsured patients who do not qualify for HCAP from the costs of providing their care, as opposed to the original requirement of netting from charges. This change will certainly affect OBRA caps and, as a result, could significantly alter the distribution of HCAP funding.

Data collected using the new requirements will not be available in total until spring of 2007, after rules for the 2007 program will be proposed by ODJFS. Any attempt to alter the uncompensated care distribution methodology at this time could end up having unforeseen consequences.



Data Source: Medicaid Cost Reports.

MEDICAID REFORM

Medicaid in Ohio has just begun a tremendous transformation. After one unsuccessful attempt in the mid-nineties, called OhioCare, Ohio's government has again decided to shift the management of the healthcare of Medicaid recipients to private insuring corporations in the hopes of saving money. These private insurers negotiate directly with providers, including hospitals, on the prices they will agree to pay for services delivered to their patients.

The Ohio General Assembly, in its 2005-06 biennial budget, instructed ODJFS to shift all Covered Families and

Children and a significant portion of Aged, Blind, and Disabled Medicaid recipients into managed care plans run by private insurers throughout the state. While this process has already started, its effects on HCAP will take longer to determine. Data used in HCAP is generally two years old due to reporting lags, and Medicaid managed care will not be fully implemented until mid-2007 at the earliest. Therefore, any analysis of the Medicaid portion of HCAP reimbursement must be grounded in an understanding of a managed care environment.

In that environment, payment rates will vary from hospital to hospital as opposed to having a statewide framework for reim-

bursement in the traditional fee-for-service model. Additionally, hospitals will report the costs of care and payments received for their Medicaid managed care business.

Monitoring the progress of the state's second attempt at managed care implementation will have many more implications than just HCAP. The first attempt resulted in tens of millions of dollars being owed to Ohio hospitals by defunct and bankrupt private insurers, resulting in litigation not yet resolved. Hospitals in this state are not eager to watch history repeat.

How the administration of Governor-elect Strickland proposes to specifically access that additional funding will be of great interest to Ohio hospitals.

POLITICAL CHANGES

Of course, those in office can also influence HCAP. With Governor-elect Ted Strickland coming to Columbus, hospitals eagerly await the new administration's specific policy proposals regarding Medicaid and HCAP.

According to the website www.tedstrickland.com/vision,

Governor-elect Strickland plans to "Stabilize health costs for government and businesses alike and advance the health of our citizens by increasing the number of Ohioans who have access to affordable, high-quality healthcare, preventing illnesses and injury and focusing on community-based services for children, families, older adults and

persons with disabilities." Accomplishing that stated goal of reducing the numbers of uninsured Ohioans will require additional funding. How the administration of Governor-elect Strickland proposes to specifically access that additional funding will be of great interest to Ohio hospitals.

In other states, Medicaid DSH funding has already been diverted from hospitals to expand coverage, or to other providers and private insurers. Proposals to increase the HCAP assessment on hospitals or to divert the funding from where it is needed most will certainly cause a great uproar in the hospital community in Ohio unless the systemic problems in the healthcare delivery system can be fixed as a result.

Beyond the potential for revolutionary Medicaid funding mechanisms, the political landscape in Ohio could bring reforms in other areas like education and tax policy over the next few years, but HCAP is always a potential political lightning rod, given the dollars and interests involved. Hospital consensus around HCAP policy is crucial in an uncertain political climate.

HOSPITAL PERSPECTIVES ON EQUITY

Agreement about HCAP policy is not always shared by all hospitals in the state. Occasionally, the OHA Board makes HCAP recommendations that some hospitals disagree with and those hospitals use public forums to air their differences.

A primary goal of the OHA is to have the most equitable HCAP distribution model possible, but views on fairness can vary. Each hospital in the association has a unique perspective on HCAP, but each year, it is always the ultimate goal to have all hospitals view the distribution as equitable. In years without this solid consensus, the program suffers from negative publicity and

attention, as opposed to a public focus on the often disregarded benefits of the program.

OHA will continue to try and foster an environment where discourse on HCAP is freely shared between member institutions without appearing divided publicly.

OHA will also aggressively defend the Board-approved principles for HCAP, as well as utilize them for guiding all future recommendations for the program's design.

UPPER PAYMENT LIMIT (UPL) PROGRAM CHANGES

The UPL program is another state/federal funding program that uses hospital dollars to draw federal funding to help address Medicaid shortfalls. Currently in Ohio, UPL funds are available only to publicly owned and operated hospitals, and their participation is voluntary.

Public hospitals first make intergovernmental transfers to ODJFS and then receive, via UPL, an amount equal to what Medicare would have paid (the upper payment limit) minus what Medicaid actually did pay for eligible services. Thus, the UPL program attempts to give Medicare-level payments, often much higher than Medicaid, to hospitals for providing services to Medicaid patients.

Further, all UPL funding that is returned to participating hospitals must be counted as a Medicaid payment and factored into HCAP. So, as a hospital increases its UPL draw, it would tend to decrease its amount of HCAP funding, since the hospital's OBRA cap would decrease with additional Medicaid payments.

The reason the UPL program bears further monitoring is because of the move to imple-

ment Medicaid managed care in Ohio. Since UPL payments are available only for fee-for-service Medicaid services, public hospitals in Ohio that have grown dependent on UPL payments could soon see that funding stream dry up. Federal UPL policy changes also threaten the size of Ohio's program.

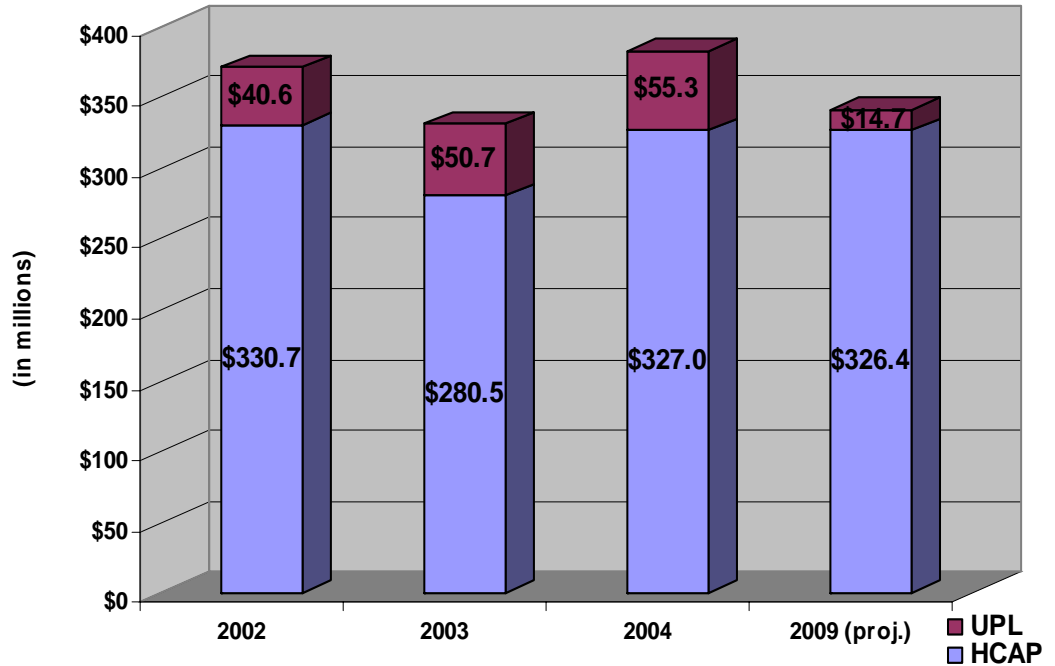
As a result, those hospitals will take less UPL, have larger OBRA caps, and take larger amounts of HCAP funds than they currently do—funds that non-public hospitals currently rely on.

In 2006, OHA commissioned an independent consulting firm to analyze the future impact of the UPL reductions, via managed care or federal changes, and other UPL-related factors on HCAP. In their report, it was determined that public hospitals stand to lose over \$20 million in combined UPL and HCAP funding from 2005 levels, and that non-public hospitals stand to lose over \$21 million in funding from HCAP. This type of significant shift of funding could threaten the consensus around HCAP policy in the very near future, especially if the federal share of HCAP does not increase.

An independent report determined that public hospitals stand to lose over \$20 million in combined UPL and HCAP funding from 2005 levels, and that non-public hospitals stand to lose over \$21 million in funding from HCAP.

CMS no longer wields a rubber stamp—the process to achieve changes in HCAP has become much more difficult.

HCAP & UPL Federal Share



With HCAP federal funding levels frozen until 2009 (projected), an independent report determined that Ohio hospitals stand to lose a combined \$41 million in federal funding due to reductions in the UPL program.

FEDERAL CLIMATE AT CMS

All changes to Ohio Medicaid policy, including HCAP, must be approved at the federal level by the Centers for Medicaid and Medicare Services (CMS). CMS administers the two large government insurance entitlement programs, but has taken on a more active role in Medicaid policy formation recently. In Ohio the last two years, CMS has been particularly active in overseeing the proposed changes to HCAP. Slight tweaks to the distribution, such as shifting funding to account for additional Critical Access Hospitals or using federally-allowable OBRA cap multipliers for public hospitals, have brought intense scrutiny from CMS.

The agency not only takes issue with proposed changes, but also routinely requests ODJFS provide information on seemingly unrelated

aspects of the program whenever a change is proposed. The relationship between ODJFS and CMS has become strained in this federal administration, and further efforts to tweak the program in the near future could put ODJFS and OHA in uncomfortable positions. CMS no longer wields a rubber stamp—the process to achieve changes in HCAP has become much more difficult.

Hence, any proposed change to HCAP being considered by OHA must be evaluated with not only the association's principles of the program in mind, but also with the likelihood of CMS to ultimately agree with the change.

TASK FORCE FINAL RECOMMENDATIONS

With the statement of purpose, principles, and current environmental factors in mind, the OHA HCAP Task Force presents its final recommendations for the Hospital Care Assurance Program in 2007 and beyond:

1. ACHIEVE AND MAINTAIN POLITICAL

CONSENSUS

Hospitals each have unique perspectives and communities to serve. Complexity in the distribution is the result of attempting to address the needs of hospitals as peer groupings of institutions serving similar communities.

Greater simplicity could be achieved quite easily, technically. However, the political consensus of hospitals in Ohio would be threatened with large swings and less predictability in the distribution.

With the environmental factors at play, a large but controversial public program could draw the attention of reform-minded policymakers. Only a program with broad-based support amongst the hospital community will weather the external factors poised to derail HCAP. The Task Force recommends the OHA Board weigh the political consensus before recommending any changes to the program in the future.

2. MAINTAIN CURRENT UNCOMPENSATED CARE REIMBURSEMENT METHODOLOGY, BARRING ADDITIONAL FEDERAL FUNDING

2006 was a record year in HCAP. It was the first year uncompensated care delivered to patients in poverty grew larger than the total allotment of funds to reimburse all uncompensated care, both under the poverty line and above.

OHA staff has modeled many variations for increasing the reimbursement for uncompensated care above the poverty line, but at this time, the Task Force, with the advice of the OHA Finance Committee, is not compelled to recommend reducing the allotment for reimbursing uncompensated care delivered to patients in poverty. The Task Force recommends that the OHA Board not change the uncompensated care reimbursement methodology in HCAP.

3. USE THE NET HCAP INDEX TO EVALUATE FAIRNESS, BUT NOT TO DISTRIBUTE FUNDS

The Net HCAP Index was developed by the OHA as one way to measure the fairness of HCAP. It is the percentage, for every hospital or peer group, of its total facility costs that are OBRA cap costs left unreimbursed after HCAP, and it gives a normalized glimpse of a hospital's relative burden of uncompensated care after the model distributes funds from year to year.

The Task Force recommends that the OHA Board continue to use the net HCAP index as one of several methods for evaluating the fairness of the model, but the Task Force, after much study and consultation with the OHA Finance Committee, does not recommend implementation of any mechanism to distribute funding based on individual net HCAP indexes at this time.

4. SHIFT INCENTIVES

It is concerning to this Task Force that the current HCAP system contains provisions that encourage financial inefficiency. It is also concerning that hospitals eligible for other federal funding sometimes choose to rely on HCAP funding instead. But it is most alarming that Medicaid payments have not kept pace with potential HCAP reimbursement.

All patients eligible for Medicaid must be encouraged by hospitals to apply for coverage instead of applying for HCAP. But with Medicaid payments frozen below cost, this perverse incentive remains part of HCAP. Thus, Medicaid payments must be kept in-line with the rising costs of healthcare.

Further, all hospitals eligible to receive additionally federal funding, such as UPL funding, must be incentivized to access those funds, as maximizing federal funding also alleviates some of the financial pressures on HCAP.

Finally, a uniform cost accounting system for Medicaid and uninsured patients must be simply defined and demanded by government in order to ensure the accuracy of data submitted by hospitals and used in crucial funding programs like HCAP. Fraud and abuse must not be tolerated in healthcare delivery.

The hospital community, in cooperation with the state, must continue to ensure that patients are correctly classified by income and that funds are appropriately distributed by the program.



Ohio Hospital Association

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The Ohio Hospital Association was established in 1915 and currently represents 170 short term acute-care hospitals and 30 hospitals for veterans, long-term acute-care and rehabilitation services throughout Ohio. OHA has more than 1,900 personal members of 11 affiliated societies, representing disciplines from hospital marketing to human resources. The association is governed by a 21-member Board of Trustees which includes representatives from each of OHA's four districts - Central, Northeast, Northwest, and Southwest. Current and potential member hospitals adhere to a dues structure established by the Board of Trustees.

OHA works to help its members do what they do best - meet the health care needs of their communities. Whether it's a problem affecting small and rural hospitals, teaching hospitals, specialty hospitals, urban or suburban hospitals, an individual member or specific professional group, OHA is ready to serve.

OHA MISSION

OHA is a membership-driven organization that provides proactive leadership to create an environment in which Ohio hospitals are successful in serving their communities.
