

Testimony
Ohio Hospital Association
Human Services Subcommittee
Representative Merle G. Kearns, Chair
March 18, 2003

My name is Bridget Gargan and I am vice president of State Policy and Advocacy for the Ohio Hospital Association. I am pleased to be here with my OHA associate Ryan Biles.

The OHA is a trade association representing over 180 primarily not for profit hospitals and health systems throughout the state. Our membership includes hospitals with as few as 30 beds and budgets of less than \$4 million per year, to institutions of over 1,000 beds and budgets in excess of \$500 million per year.

Today, I speak on behalf of the membership of OHA, the 230,000 individuals employed by our members and the various communities and patients they strive to serve, I thank you for the opportunity to outline important issues to hospitals in the context of Ohio's Medicaid program.

Medicaid is, in effect, the largest and most complex insurance company in the state of Ohio. No other insurance company anywhere has its risk profile, or its benefit complexity. And as such, the program has considerable repercussions for hospitals.

OHA would like to set the stage by outlining the economic environment hospitals are operating in and addressing several issues as they impact Ohio's hospital community and the Medicaid program:

- Medicaid managed care
- Medicaid fee-for-service reimbursement
- Uncompensated care
- Cost containment strategies by the state
- Eligibility and enrollment

In the last three years, 13 hospitals have closed in Ohio- more than in any other state. The number of people seen by Ohio's hospitals who are uninsured and incapable of paying for their care continues to rise.

The only thing that kept more hospitals from failing was an unprecedented run in the investment market. The fear is that as the market worsens and with the potential proliferation of specialty or boutique hospitals skimming profitable services we will see more hospitals in financial failure, and a reduction in services, particularly in unprofitable areas, like community outreach, burn care and trauma care.

And we are in the beginning stages of a caregiver shortage that could turn into a public health crisis as the baby boomers age.

Also, as science continues to try and improve everyone's quality of life by extending life and battling disease, hospitals face certain realities. New technologies and pharmaceutical developments provide exciting opportunities to improve health care, but they come at a high economic cost.

At the same time, times of war and poverty have cycled back and have created fiscal burdens on governments from the federal level to the states. With these hardships, it is tempting for political leaders to reduce the cost of programs like Medicaid. It is at the worst economic times when Medicaid enrollment for the working poor and reimbursement that keeps pace with inflation for providers are needed the most.

Though the primary importance of the Medicaid program is the health care it provides to the more than 1.5 million children, parents, elderly and disabled Ohioans who depend on it, a less publicized benefit is the role it plays in stimulating the state economy.

In January, Families USA, released a study, *Medicaid: Good Medicine For State Economies* which noted that Medicaid infuses more than \$8 billion into Ohio's economy, \$25.3 billion in new business activity and that more than 132,000 new jobs were created in Ohio as the result of Medicaid spending in FY2001.

I raise these issues because the economic environment in the hospital world is very relevant to the issue of Medicaid reimbursement. In effect, hospitals lose money on every Medicaid patient they see. Medicaid's pricing strategy has historically been to set provider reimbursement by assuming that the rest of the payers already cover a provider's operating costs.

That strategy may have made sense in the 1970s and 1980s, when many insurers paid hospital charges, but given today's economic realities the result is a Medicaid program that is helping undo the health care safety net it was meant to preserve. Over the last twenty years, virtually every payer with any market leverage has demanded and received significant discounts from hospital charges.

Hospitals also have Medicaid managed care to contend with. The use of full risk capitation as a strategy for controlling state expenditures has resulted in managed care plans in bankruptcies while hospitals have lost approximately \$50 million in unpaid bills. Consumers are left with nowhere to turn but hospital ERs for care.

Many are talking (again) about expanding Medicaid managed care for our most fragile citizens. But the fundamental flaw still exists; in a program funded on the margin, dollars appropriated by the General Assembly to pay for health care for the poor are instead diverted to health plans while consumers and providers suffer. In theory, capitation is supposed to encourage health plans to do aggressive utilization management and facilitate effective treatment in the most efficient setting. In this case, what we're seeing is aggressive payment management and precious little evidence of real care management. The simple fact is there isn't enough money to provide appropriate care for Medicaid consumers, pay providers a reasonable rate, and allow for the operating margin commercial managed care plans demand. Meanwhile, hospitals continue to serve as the safety net for the poor and uninsured.

When the average patient insured by Medicaid walked into an Ohio hospital in 2000, the hospital could expect to lose approximately 10 percent of the cost of providing care to that individual.

When a Medicaid patient was treated in an outpatient setting in 2000, the hospital could expect to lose, on average, 25 percent of the cost of providing that care. Medicaid funding needs to continue to keep pace with inflation as reimbursement falls below cost. However, as we approach the coming biennium, it is a freeze on hospital reimbursement, not an inflationary update, that is being proposed.

Even in the face of the current shortfalls in reimbursement, a great majority of Ohio hospitals maintain a not-for-profit business model and a charitable mission. Furthermore, all of our hospitals provide care regardless of a patient's ability to pay. By regulation, Ohio hospitals are required to provide care free of charge to those individuals with incomes less than the federal poverty line. By choice, most Ohio hospitals have charity care programs that extend medical savings to benefit other uninsured patients.

The individuals we treat who have no insurance or Medicaid coverage, but fall below the poverty line, are generally the working poor. These people are often those who maintain employment, sometimes working multiple jobs, but whose employers do not offer health coverage. Medicaid does not cover them. Employers do not cover them. Hospitals, therefore, are left to provide this care without a guarantee of even a penny in return. In 2000, Ohio hospitals provided over \$550 million in care to the uninsured. Combined with Medicaid losses, Ohio hospitals reported uncompensated care of over \$710 million.

However, Ohio hospitals do have a program that partially reimburses uncompensated care with federal funding. Without requiring any state GRF funds, hospitals, in fact, provide the necessary assessments to draw down Ohio's federal allotment. The problem? That program, the Hospital Care Assurance Program, only brought \$330 million into the state to assuage that \$710 million shortfall in 2002. This year, the allotment will be reduced to under \$285 million of federal money--a nearly \$50 million cut that will further hamper some of Ohio hospitals' ability to survive.

If hospital Medicaid reimbursement cannot keep pace with inflation, the Ohio General Assembly is essentially forcing hospitals to increase the charges to private payers, effectively administering a large tax on employers and other purchasers of health care insurance.

Another issue affecting hospitals is a provision included in House Bill 95 that requires a hospital participating in the Medicaid program to treat patients enrolled in a Medicaid Health Maintenance Organization (HMO) that does not have a reimbursement contract with that hospital, yet accept only 95% of fee-for-service rates as payment in full.

Ohio hospitals cannot support a provision that mandates a financial relationship between private entities without a contract, especially considering the abysmal history of HMOs in Ohio's Medicaid program becoming insolvent. OHA also sees this provision as an act of price setting by the State and as an attempt to leverage HMOs over hospitals in negotiating managed care contracts. Ohio hospitals would be put at a major risk of bankruptcy, especially those without contractual relationships with HMOs, due to the passage of this provision.

The state faces a large deficit, but hospitals have been facing them for years. Increasing Medicaid funding and maintaining expanded eligibility will only help these crucial community assets survive and save Ohio's health care system from crumbling. OHA looks forward to working with the legislature and ODJFS in developing strategies to manage costs effectively, but Ohio hospitals cannot survive much longer if reimbursement rates do not rise with medical inflation.

Hospitals care about this issue because as stated earlier, we are 230,000 people taking care of people; because Medicaid is important to the financial viability of our members, hospitals; and because shortfalls threaten access to quality care in the most appropriate settings for all Ohioans.

The OHA Board of Trustees commissioned a Medicaid Task Force to coordinate the hospital community's approach to proposed cost-containment strategies and to address inadequacies in Medicaid reimbursement to hospitals overall. Established jointly with the Ohio Children's Hospital Association, membership of the task force represents 61 hospitals and health systems in Ohio. On December 13, 2002, the OHA Board of Trustees adopted the following statement, purpose and principles for the Medicaid Task Force.

Recognizing that the current environment of state revenues and expenditures has resulted in a budgetary crisis, solutions to balancing the state budget should look to the long term, not quick fixes. Any restructuring of financing and delivery of Medicaid acute care services should be made with due diligence, particularly with regard to the design, payment, and administration of the program.

Purpose

The purpose of the Medicaid Task Force is to preserve and improve access to quality care delivered to Medicaid patients, while maintaining the adequacy of payments to hospitals.

Principles

- 1. The program should be as simple as possible to administer.*
- 2. The program recognizes that different patient populations may require different delivery and funding solutions.*
- 3. Medicaid spending dollars follow the patient, regardless of venue. [Savings from reduced hospitalizations may be fully or partially offset by additional, medically necessary spending for the health care services that support non-institutional or ambulatory care. Preventing some hospitalizations will require investment in community-based alternative care, ranging from home health care to case management services.]*

The OHA position on statutorily mandated financial relationships between hospitals and HMOs stated by my colleague is based on recommendation of this Task Force.

The Medicaid Task Force encourages the 125th General Assembly to preserve healthy families eligibility unless there is a private sector alternative put in place. Earlier testimony enumerated the various eligibility categories of Medicaid, and that approximately 50,000 adults stand to lose their health insurance in this program.

To put this in perspective, in a family of four with a family income of up to \$36,800, the children of that household will qualify for health insurance coverage. The current budget proposal will preserve this coverage.

However, in order for adults in a family of four to qualify for Medicaid under current optional eligibility standards, the household income could not exceed \$18,400 per year. These are the adults currently at risk for losing coverage under the proposed budget. This group is truly the working poor, who can least afford to lose a commodity as precious as health insurance.

OHA is also concerned about the impact of proposed cut backs in optional Medicaid services for adults: vision, dental, podiatry, vision, chiropractics, and payments to psychologists. None of the adult groups covered by Medicaid, the working poor, or the aged, blind, and disabled, can afford to loose "optional" services of dental and vision coverage. Good visual and dental health is not only vital to personal well-being, but it is a major contributing factor to employability or even wanting a job. Under the current proposal, all adults would lose this benefit. The expected result of eliminating coverage for these services will be delayed treatment for dental problems which will then fester into more expensive medical problems, and problems navigating the workforce and society in general due to diminished visual acuity. Again, there's no prohibition against paying for more costly emergency care should minor dental and visual problems deteriorate to a point rrequiring medical intervention. These people will suffer more.

Co-pays are not a realistic option to offset costs, either. Emergency Services, and Family Planning Services are prohibited from assessing co-pays to Medicaid recipients by federal law. Children enrolled in Medicaid programs may not be assessed co-pays for any service. Therefore, we are left with the truly financially and medically needy upon whom these payments can be levied. Is it not realistic to expect these individuals to come up with copayments for services. Co-pays result in increased uncompensated care because these population groups least able to afford co-pay amounts (the Center for Medicare and Medicaid has established \$3 as the maximum copayment). Also, the practice if instituted has the potential to create perverse incentives to avoid cost effective preventive care. Once again, minor conditions that exacerbate into medical problems will still be covered, at a higher price to hospitals, and more suffering by patients. Look at who's covered:

<u>Mandatory Categories:</u>	<u>Emergency Svcs</u>	<u>Family Planning Svcs</u>	<u>Everything Else (Rx, Doc, Hosp, etc.)</u>
Families who met income and resources met requirements of the Aid for Families with Dependent Children state plan in 1996 (aka low income families)	Exempt	Exempt	Kids Exempt
Pregnant women and post partum women for 60 to 90 days	Exempt	Exempt	Exempt
Infants and children to age six with family incomes at or below 133 percent of the federal poverty level	Exempt	Exempt	Exempt
Children age six to 18 with family income below 100 percent of the federal poverty level	Exempt	Exempt	Exempt
Children receiving certain types of adoption assistance or foster care	Exempt	Exempt	Exempt
Families transitioning off of medicaid due to a change in income from employment or child support.	Exempt	Exempt	Kids Exempt
Individuals receiving SSI from federal government	Exempt	Exempt	Copay
ABD persons who meet Ohio's more restrictive financial eligibility criteria	Exempt	Exempt	Copay
ABD individuals who's income exceeds Ohio's financial eligibility criteria but who incur medcial expenses that reduce their excess income to Ohio's financial need standard for a given month (Spend Down)	Exempt	Exempt	Copay
Low income individuals who also receive Medicare	Exempt	Exempt	Kids Exempt

Optional Categories:	Emergency Svcs	Family Planning Svcs	Everything Else (Rx, Doc, Hosp, etc.)
Pregnant women, infants and children up to age six with family incomes between 134 and 150 percent of federal poverty level (pregnant women and Healthy Start expansions)	Exempt	Exempt	Exempt
Children between age six and 18 with family incomes between 101 and 150 percent of the federal poverty level (CHIP 1)	Exempt	Exempt	Exempt
Uninsured children ages 0 to 18 with family incomes between 151 and 200 percent of the federal poverty level (CHIP 2)	Exempt	Exempt	Exempt
Uninsured parents with incomes below 100 percent of the federal poverty level, but above the July 16, 1996 eligibility level (parent expansion)	Exempt	Exempt	Copay
Women with family incomes 200 percent of the federal poverty level who were screened through the Ohio Department of Health's Breast and Cervical Cancer program and found to need treatment for breast or cervical cancer	Exempt	Exempt	Co-pay
Children aged 19, 20, and 21 meet income and resource requirements of the AFDC state plan in effect on July 16, 1996.]	Exempt	Exempt	Co-pay
Persons who are disabled and enrolled in one of Ohio's 4 home and community based waiver programs	Exempt	Exempt	Co-pay

The final category of Medicaid eligibility is Disability Assistance. This is a state-funded program that came about due to state law enacted in 1991. It is a state and county funded program that provides limited medical benefits to very low-income individuals who are ineligible for federal programs and are unemployable due to age, physical or mental disability. Most of these persons are medication dependent. The number of persons qualifying for this benefit is just over 16,000. The state is looking to reform this program, in part because it relies solely on state (and local) funding sources.

Lastly, I'd like to address the issue of "care management," as introduced in the biennial budget bill. There is no doubt that the cost of caring for Aged, Blind, and Disabled Medicaid recipients is growing at unsustainable rates. However, "care management," in the managed care/HMO variety, is not a viable option.

First, this is a heterogeneous population, comprised of four distinct groups: disabled children, physically disabled but cognitively intact non-elderly adults, the developmentally disabled, and people with severe and persistent mental illnesses. Overlapping these categories, but significant on both quantitative and policy dimensions, are people with AIDS, those with substance abuse problems, the blind, and people with traumatic brain injuries. The main thing these groups have in common is that the state has become responsible for providing their basic health care needs.

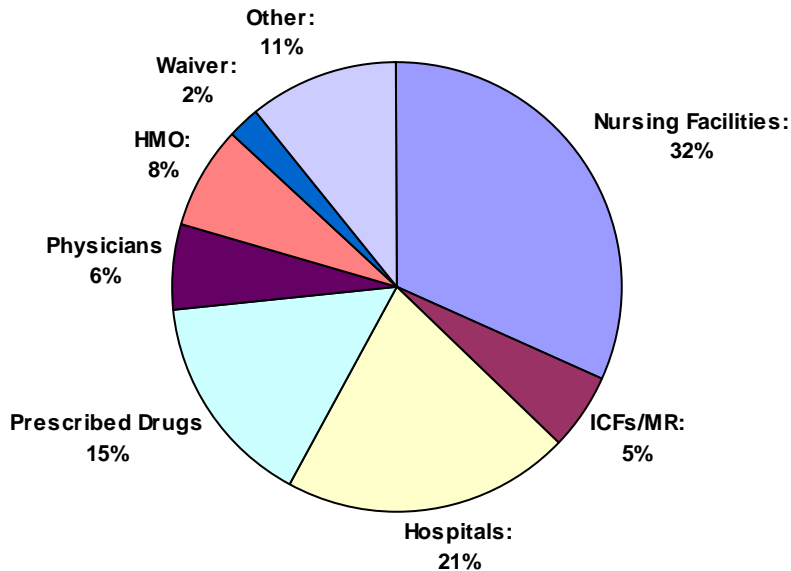
There are a few rare specialized managed care plans, generally affiliated with academic medical centers, which have successfully managed care for segments of this population. Effective assessment, care planning, and case management may greatly benefit Aged, Blind and Disabled Medicaid recipients, and at the same time reduce consumption of health care services through providing appropriate, high-quality preventive services. So why is managed care, in the HMO model such a bad idea? Because it is difficult to risk-adjust capitation payments for these beneficiaries. Medicaid managed care plans, the evidence

suggests, have only the most rudimentary capacity to care for persons with chronic, debilitating conditions. In August, 2002, the National Bureau of Economic Research concluded that private managed care plans are unlikely to deliver cost savings to state and federal governments without reducing health care quality for Medicaid recipients.

Therefore, the Ohio Hospital Association Medicaid Task Force strongly advocates that the state should take measures:

- (1) To create and strengthen effective restrictions and safeguards for HMOs that enroll Covered Families and Children populations under the Medicaid program, and,
- (2) To ensure that Aged, Blind, and Disabled populations continue in fee-for-service Medicaid with market basket updates, with the development of managed care non-risk bearing alternatives encouraged. Demonstration projects may run a continuum of:
 - a. Designing a payment system with incentives for physicians to take on aged, blind, and disabled Medicaid consumers (case management fees)
 - b. Demonstration projects capitating management of primary care
 - c. Demonstration projects similar to that run by the Bureau of Workers' Compensation Health Plan Partnership program.

Finally, I invite you to evaluate where Medicaid dollars go, and to enact a budget that fully funds Medicaid, as well as levels the field for all providers:



Thank you.