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## Statement for the record by the Ohio Hospital Association

### *Ohio Commission to Reform Medicaid Columbus – June 2004*

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The Ohio Hospital Association (OHA) represents over 180 primarily not for profit hospitals and health systems throughout the state. Our membership includes 30 bed hospitals operated with less than \$6 million per year and 1,000 bed institutions with annual budgets in excess of \$500 million.

On behalf of the membership of OHA, the 230,000 individuals employed by our members, and the various communities and patients they serve, OHA wishes to submit the following statement on issues concerning Ohio's Medicaid program. This statement will comment on the intrinsic value of the Medicaid program to Ohio, what policies Ohio hospitals are examining in order to help Ohio's Medicaid program survive and flourish, the millions of dollars Ohio hospitals lose each year in treating those patients insured by Medicaid, and the further unreimbursed care Ohio hospitals deliver to the indigent and uninsured.

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, its benefit complexity, or extreme changes in its covered population. As such, the program has considerable repercussions for hospitals.

Given that the next biennial budget is already shaping up to again be a challenging process, it is important to get a handle on what is happening with the program and what is happening in the health care marketplace.

Ohio's Medicaid program is only one of the many challenges facing Ohio hospitals in today's uncertain economic times. The last few years have been extremely difficult for Ohio's hospitals. In the last four years, 15 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 and we are in the midst of a caregiver shortage that could turn into a public health crisis as the baby boomers age.

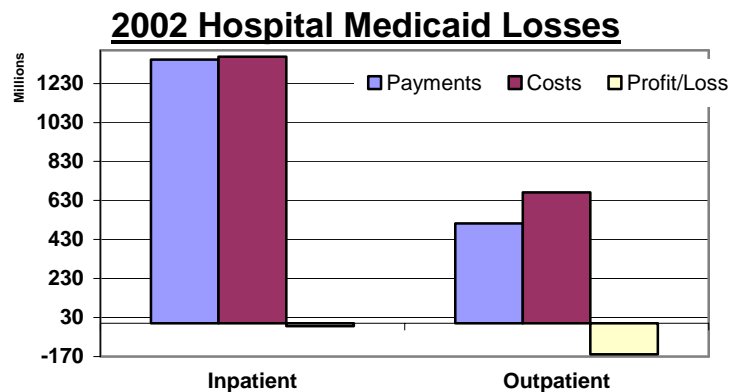
As science continues to try and improve everyone's quality of life by extending life and battling disease, hospitals and public policy makers face certain realities. New technologies and pharmaceutical developments provide exciting

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 levels of governments from the federal to the state. With these hardships, it is tempting for political leaders to reduce the cost and scope of safety net programs like Medicaid. However, it is at the worst economic times when increased Medicaid eligibility for the working poor and increased reimbursement for providers, at least keeping pace with inflation, are needed the most.

### Medicaid as a Thrifty Consumer

Medicaid payments fail to cover the cost of both inpatient and outpatient hospital care. On average, hospitals lose money on every Medicaid patient they see. Over the last twenty years, virtually every payer with any market leverage has demanded and received significant discounts from hospital charges. Given today's economic realities, the net result of these combined factors is a Medicaid program that is helping to undo the health care safety net it was meant to preserve.

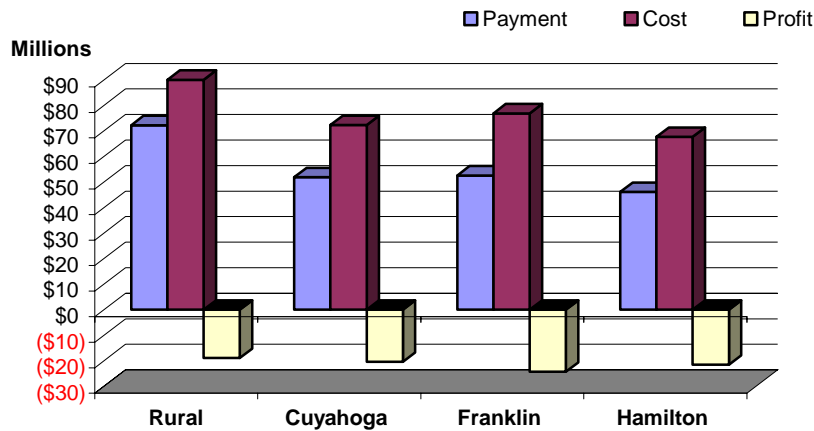
In 2002, Ohio hospitals provided acute care to Medicaid recipients that cost roughly \$1.7 billion. However, Medicaid paid hospitals just over \$1.5 billion for that care. Therefore, when the average patient insured by Medicaid walked into the average Ohio hospital in 2002, the hospital could expect to lose approximately 9 percent of the cost of providing care to that individual. That is not a margin most businesses can absorb and stay open. What is crucial to observe is the breakdown between inpatient and outpatient Medicaid losses Ohio hospitals endure.<sup>1</sup>



As the above chart notes, hospitals try to be as progressive as possible in terms of improving the quality of care to their patients. Many in the health care field agree that the future of acute health care delivery in this country will include an enhanced focus on the outpatient delivery setting. Hospitals in Ohio share this view and have been proactive in developing the capacity for delivering expedited outpatient care to all Ohioans. However, when a Medicaid patient was treated in an outpatient setting in 2002, the hospital could expect to

recover only 77% percent of the cost of providing that care. An industry cannot survive or continue to provide a service at a minus 23% profit factor. Medicaid funding, therefore, needs to be increased, not only for inpatient services, but also in this crucial, and possibly more cost-effective, area of reimbursement.

**2002 Geographic Hospital Outpatient  
Medicaid Losses in Ohio**



Further, specific service lines delivered in outpatient hospital settings are paid well below the costs of delivering those services. While the General Assembly saw the need to modestly increase outpatient surgery payments in the 2004-2005 biennial budget, other services need similar attention in the near future. Ohio hospitals, for example, lost over \$47 million in delivering outpatient laboratory services for the most recent year of available payment data. Outpatient radiology netted losses for hospitals in excess of \$41 million and other outpatient ancillary services create a net loss for hospitals of approximately \$25 million. By recommending an increase in outpatient Medicaid reimbursement, this commission would not only help Ohio’s hospitals continue to survive, it would make our state’s health care delivery system more efficient and perhaps divert some of the more costly inpatient care to the outpatient setting.

**Hospitals’ Burden of Uncompensated Care**

Even in the face of these 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 ability to pay. By law and regulation, Ohio hospitals are required to provide care free of charge to those individuals who earn an income less than the federal poverty line. By choice, most Ohio hospitals have charity care programs that extend medical savings to benefit uninsured individuals with incomes above the poverty line.

The individuals our hospitals treat, with incomes below the poverty line and who have no insurance or Medicaid coverage, 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 or do not offer affordable coverage. Hospitals, therefore, are left to provide this care without a guarantee of even a penny in return. Using preliminary SFY 2003 data, Ohio hospitals provided \$580 million in care to uninsured Ohioans, with incomes below and above the poverty line. With Medicaid losses, hospitals reported uncompensated care statewide of \$775 million.

However, hospitals do have a program that reimburses uncompensated care with federal funding. Without requiring any state funds, hospitals, in fact, provide the necessary assessments to draw down Ohio's federal allotment. The problem? That program, the Hospital Care Assurance Program, will only bring \$327 million into the state to fill a \$775 million shortfall in 2004. This level of federal funding is actually less than the funding in the 1996, 1997, or 1998 programs. Therefore, while Ohio hospitals have continually offered more and more free and other uncompensated care, the federal government has offered less and less money to fund the shortfalls.

Now, OHA shares these numbers with this commission in the hope that you will gain a better idea of the perspective of our hospital providers when it comes to government reimbursement. Medicaid covered 13.4 percent of our hospitals' patient days in 2002, at a 9 percent loss factor. On average, over 37 percent of our patient days are covered by Medicare, at a 3 percent average loss factor. With over half of an average Ohio hospital's book of business devoted to programs on which it loses a combined 4.5 percent, the hospital is left with but one recourse.

If hospitals continue to lose on federal and state insurance programs, both levels of government are forcing hospitals to increase the charges to private payers, effectively administering a large tax on employers and other purchasers of health care insurance. Cost-shifting sounds like dirty business, but when faced with these revenue streams, hospitals often have no choice but to shift the loss burden to paying customers in order to stay open.

As a result, OHA is supportive of efforts to expand, or at the very least maintain, the level of Medicaid enrollment in Ohio. Any man, woman, or child that can be extended health care insurance through Medicaid would be allowed greater access to primary care without having to resort to the hospital emergency room. The OHA believes that a more aggressive enrollment strategy would not only save the state of Ohio money in the long run, but it would lessen the burden of uncompensated care on Ohio hospitals and allow for individual's with few resources to have access to quality primary care—care that can improve the overall health of the residents of this state.

## **Medicaid as an Economic Force**

Though the primary benefit 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. Medicaid spending brings added federal dollars to Ohio, increases business activity, and creates new jobs within the state.

In January 2003, Families USA released a study, "Medicaid: Good Medicine For State Economies," focused on the economic benefit of Medicaid in Ohio and nationwide. The Families USA study found that every dollar spent on Ohio's Medicaid program in fiscal year 2001 translated into \$3.15 in new business activity. Medicaid infused more than \$8 billion into Ohio's economy, \$25.3 billion in new business activity, and the study also found that more than 132,000 new jobs were created in Ohio as the result of Medicaid spending in 2001.

## **Looking Towards Solutions**

The OHA is well aware that the Commission has a goal of controlling the growth of Medicaid costs while still providing the needed services to those who need them. We applaud the Commission for this.

However, the recent use of full risk capitation arrangements with Managed Care corporations has taken its toll on Ohio's hospitals. This strategy for controlling state expenditures has resulted in managed care plans in bankruptcy while hospitals have lost more than \$50 million in unpaid bills for services delivered to Medicaid HMO enrollees. The OHA cannot recommend to its members that they will be fulfilling their fiduciary duty of entering into contracts with these MCCs unless the state guarantees payment in full.

Ohio hospitals are more than willing to discuss coordinated disease management initiatives. We have been discussing such initiatives with groups around the state in order to make Medicaid more effective at managing or preventing diseases such as asthma, diabetes, and obesity while reducing the number of preventable hospitalizations. Ohio hospitals have similar goals. Ohio hospitals offer their willingness to participate in pilot programs or medical home models that are designed in ways that improve care delivery, enhance quality of life, save precious health care resources, and not be road maps to a slash and burn environment.

Ohio hospitals support many of the "Principles of Enhanced Care Management" offered by Medicaid's Director, Barbara Edwards, at the March meeting of the Commission. Providing and/or improving the concept of a medical home for

patients, the prevention and effective maintenance of chronic illness, consumer responsibility and education, disease management, and provider accountability are all notions that our members not only support, but actively pursue in their facilities today.

<sup>1</sup> Sources: *Preliminary state fiscal year 2003 Medicaid and Medicare Cost Reports*