

June 24, 2011

Hamilton County Board of Commissioners
Hon. Mr. Greg Hartmann - President
Hon. Mr. Todd Portune
Hon. Mr. Chris Monzel
138 East Court Street Room 603
Cincinnati, Ohio 45202

RE: Indigent Care Tax Levy Review 2011
Hamilton County Tax Levy Review Committee (TLRC)

Dear Commissioners,

This is the report of a subcommittee of the Hamilton County Tax Levy Review Committee ("TLRC") formed to review the hospital funding portion of the Hamilton County Indigent Care Levy (the "Levy"), which is being considered for placement on the November 2011 election ballot. The subcommittee consists of the undersigned, Mr. Mike Wilson, Mr. Eppa Rixey and Mr. John Silverman.

The subcommittee would like to thank Mr. Tom Cooney, TLRC chair, and, the Board of County Commissioners ("BOCC") for providing us the opportunity to serve Hamilton County in accordance with the mission statement adopted by the BOCC for the TLRC. We also would like to express our appreciation for the support and insight provided by BOCC personnel, including particularly Lisa Webb.

This subcommittee has paid heed to Commissioner Monzel's advice "to go at it with a plain piece of paper and say, 'What do we need to do?'"

Being new to the TLRC and to the operation and mechanics of the Levy, we familiarized ourselves with the finances, indigent care services and facilities at University Hospital ("UH") and at Cincinnati Children's Medical Center ("Children's"). We would like to thank the dedicated professionals at UH and Children's for the time they spent with the subcommittee in facility tours and presentations and in answering requests for additional information. The interim and final reports from the subcommittee's consultant, HW & Co., provided useful information, instructive observations and recommendations and an analytical framework, as did the 2006 report of the Hamilton County Health Care Review Commission (the "2006 Report").

At the subcommittee's request, the Hamilton County Auditor and staff provided much-needed insight into how "outside millage" levies such as the Levy operate. The Hamilton County Prosecutor's Office similarly provided its expertise on Levy language and county power in the context of contracting for indigent care services.

We also familiarized ourselves with the legal requirements relating to indigent and charity care imposed on nonprofit Ohio hospitals such as UH and Children's. These requirements exist at the federal level – the non-inurement and nondistribution imperatives and community benefit requirements of federal tax authorities – and at the State of Ohio level – the requirement, most recently articulated by the Ohio Supreme Court in the *Dialysis Center* case in October 2010¹, that state property tax exemption depends on the charitable use of the property in question, that a hospital or other medical provider provide service “on a nonprofit basis to those in need, without regard to race, creed or the ability to pay.” In short, Ohio nonprofit hospitals are required to provide a substantial level of indigent care to maintain their federal and state tax exemptions, irrespective of public funding from sources such as the Levy.²

We also investigated the history of the Levy.³ The Levy was conceived in 1965 by then-City Councilmember Willis D. Gradison as a means of sharing the burden of financing operations and capital improvements at City-owned General Hospital (forerunner to UH) then shouldered exclusively by City residents and taxpayers. The *quid pro quo* for county taxpayer support would be to require General Hospital to treat (without charge) Hamilton County residents on a parity basis with City of Cincinnati residents.⁴

The Levy, for 1.5 mills, failed in the November 1965 election, when it was part of a levy package that included funding for Drake and Dunham Hospitals and child welfare. Recommended by “a high-level citizens committee,” it passed on a stand-alone basis at the May 3, 1966 primary election.

The equitable City/Hamilton County sharing of the funding obligation for General Hospital abruptly ceased soon after the Levy passed.⁵ In 1968, the City ended its funding of General Hospital operations (although it continued for a few years to fund some capital improvements). As a result of the City's withdrawal of operational funding support, by 1970, General Hospital was in perilous financial condition, with the (City-owned) University of Cincinnati, which now managed General Hospital, forced to request an emergency \$6 million infusion from Hamilton County and the City. Contemporary news accounts referred to General Hospital as a “troika” – owned by the City of Cincinnati, operated by the City-owned University of Cincinnati and financed in part by Hamilton County.⁶ With emergency financial support, General Hospital weathered the crisis and the Levy, reduced to 1.34 mills, was renewed in 1971.

¹ *Dialysis Center Inc. v. Levin*, 127 Ohio St. 3d 215 (Ohio 2010). The state sales tax exemption for charitable purposes is less restrictive than the property tax exemption, as it is available to all 501(c)(3) organizations.

² In most other Ohio counties, indigent care is provided by nonprofit hospitals without county financial support similar to the Levy.

³ At this point, the subcommittee would like to acknowledge the research assistance of Ms. Connie Song, a librarian at the undersigned's law firm.

⁴ “Extra Property Tax Levy Useful,” *Cincinnati Enquirer* (January 22, 1965); “County Ok's Hospital Tax Levy,” *Cincinnati Enquirer* (February 3, 1966).

⁵ “General Hospital Showed Profit Last Year But May Not for '72,” *Cincinnati Post* (September 6, 1972).

⁶ “General Hospital,” *Cincinnati Post* (February 4, 1971).

The City's financial position continued to deteriorate in the next few years. So, too, did the financial position of General Hospital – still City-owned and managed by the City-owned University of Cincinnati. In this period, General Hospital's patients were predominantly Medicaid and Medicare recipients: the scope and amount of Medicaid and Medicare reimbursements were continuing financial concerns. General Hospital then had relatively few paying patients. Contemporaries noted "the distinction between General [Hospital] – for the poor – and the other hospitals for those who can pay."⁷

Children's, which began accepting patients without regard to their ability to pay in 1971, also experienced financial pressure in the early 1970s, being forced to eat into its endowment to fund indigent pediatric care.⁸

As a result of these developments, a Levy renewal and increase – from 1.34 mills to 3.16 mills, of which Children's was to have the benefit of 0.66 mills – was proposed for the 1976 primary election. Levy passage would permit indigent pediatric services to be centralized at Children's.⁹ Strongly backed by civic leaders, the Levy passed despite the doubling in millage. The 1976 Levy effectively set the pattern for today's Levy, with UH and Children's being the sole hospital recipients of Levy proceeds for adult and pediatric indigent care, respectively.

The City's continuing financial woes – particularly the defeat in November 1976 of a proposed increase in the City earnings tax and resulting employee layoffs – led to the City's near complete withdrawal from involvement with General Hospital in 1978. The State of Ohio, which in 1976 assumed ownership and control of the University of Cincinnati (but not ownership of General Hospital), moved with alacrity to acquire General Hospital in late 1976.

After negotiations, the City agreed to lease the hospital complex to the State of Ohio, not to convey the fee. In July 1978, the General Hospital facilities were leased by the University of Cincinnati, subject to the terms of a master lease (subsequently amended in 1986 to extend the term and, *inter alia*, to remove a prohibition on assignment of the lease) and to the Operating Agreement embedded (then and now) in the City Municipal Code. In a 1996 opinion in the City suit to halt the "privatization" of UH, Judge Crush described the post-1978 situation as follows:

In summation, it is apparent that over a period of years the City of Cincinnati, by means of Charter amendments and ordinances, has effectively transferred all control and responsibility for running and maintenance of University Hospital to the Trustees of the University of Cincinnati, with no guidance as to how to run the Hospital or what the nature of the hospital should be. The only rights clearly left to the City are the right to return of the property in 2053, the right to require the Hospital to care for the poor, and

⁷ "Voters May Decide General Hospital's Fate," *Cincinnati Enquirer* (March 13, 1977).

⁸ "Children's Hospital Would Share in Tax Levy," *Cincinnati Enquirer* (May 20, 1976).

⁹ "Medical Director 'Gratified' – Hospital Levy Winning," *Cincinnati Enquirer* (June 9, 1976).

the right to require the Hospital to admit all persons regardless of race, color, credit or nationality.¹⁰

The Levy has since 1976 funded indigent care at UH and Children's, even as additional funding sources for indigent care, such as Ohio's HCAP program, became available in the 1980s. Of equal importance in terms of UH's finances were the emergence of UH as a hospital with a significant paying patient base, the creation, operation and ultimate dissolution of the Health Alliance and the creation of UC Health.

The demographics of Hamilton County and the City dramatically changed since the Levy's inception in 1966. In 1970, the City's population (from the federal census) was 452,924, or nearly 49% of Hamilton County's population of 924,017. By 2010, the City's census population was 296,943, or 37% of Hamilton County's total population of 802,374.

The area's economy fluctuated over the 1976-2011 period. The economic gloom of the 1970s lifted in the 1980s and 1990s, when the area enjoyed a period of prosperity. On the other hand, the last decade has not been kind to Hamilton County. A commercial property appraisal recently reviewed by the undersigned in his "day job" included data from Economy.com and the US Bureau of Labor Statistics that showed a loss of 15% of total employment in Hamilton County over the 2000-2010 period. There was a loss of employment in each year of the decade. Further, Hamilton County Auditor information indicates a 7% decrease in aggregate real property values between 2008 and 2011. While the unemployment figures for Ohio and Hamilton County have improved somewhat in recent months, the Hamilton County taxpayer is, and has been, under significant economic pressure.

The subcommittee has drawn the following conclusions from its historical and other investigations:

- (1) County funding of General Hospital began as equitable burden sharing with the City but quickly became the sole local governmental support for indigent care. This development has influenced the subcommittee's assessment of the City's request for (partial) funding of the City's health clinics;

¹⁰ *Mallory v. Keating, Trustee*, Case No. A-96-06366 (slip opinion, pp. 21-22, December 27, 1996). The ultimate settlement of this litigation did not alter this fundamental arrangement. It should be emphasized that Hamilton County was neither a party to the litigation nor a party to the settlement agreement. In relevant part, Section 2 of the settlement agreement provides as follows: "The Health Alliance [predecessor-in-interest to UC Health] under agreement with the University of Cincinnati will continue to operate UH as a full service tertiary care facility accessible to persons within its service area and particularly those who are uninsured or underinsured and to provide quality care to all patients served in order to continue its mission of care to underserved populations and to provide high quality medical education provided that the Health Alliance receives adequate funding from the Hamilton County Indigent Care Levy and other sources of funding. . . ." In short, in this settlement the City did not agree to provide funding to UH for indigent care it purports to require and UH agreed to provide services to the underserved solely to the extent that parties other than the City provided "adequate funding." Odd indeed.

(2) Levy proceeds were initially directed to General Hospital for political reasons, not in recognition of the institution's capacities. Funding preceded, and was not linked to, the achievement of the excellence the subcommittee observed at today's UH;

(3) Similarly, Levy proceeds were directed to Children's to centralize indigent pediatric care and to relieve the pressure on Children's endowment. Funding again preceded institutional excellence;

(4) The Levy has evolved over time in response to changing demographic, economic and political conditions and developments in medical delivery systems and finance. The Levy should not be regarded as immune from adjustment or reconfiguration in response to today's changing conditions or to industry developments, including the planned advent in 2014 of the 2010 Patient Protection and Affordable Care Act, also known as "Obamacare."

In applying these conclusions to derive its recommendations, this subcommittee has been mindful of the TLRC's mission statement, which instructs us to strike the right balance between the public need for services and the ability of the taxpayer community to bear the burden of property taxes. Accordingly, we have approached our Levy review duties with a dual focus — the needs of medically indigent residents of Hamilton County and the economic environment in which the taxpayer community in Hamilton County finds itself in 2011. Provider interests necessarily deserve serious consideration but are not the subcommittee's primary focus.

As the subcommittee understands it, the medically indigent that are the primary intended recipients of Levy support are not Medicaid or Medicare recipients.¹¹ Hospitals receive reimbursement from federal and State of Ohio sources for their services to these patients, including HCAP support.¹² Nor is the Levy concerned with Hamilton County residents with insurance or other resources that are adequate to pay the full cost of care.

The Levy is primarily concerned with the uninsured or underinsured Hamilton County resident who is not Medicaid or Medicare eligible and who may be employed but nevertheless does not have the insurance or other resources to pay the full cost of needed medical care.¹³ The

¹¹ This understanding is consistent with our consultant's definition in its Final Report.

¹² Our consultant indicates that HCAP reimbursement of UH and Children's for uncompensated care is not reduced by their receipt of Levy proceeds.

¹³ "Indigent Don't Just Live In City," *Cincinnati Business Courier* (October 14, 1996). A study by the forerunner to Mercy Health Partners found in 1995-96 that 70% of the uninsured ER patients at what is now Mercy Hospital-Mt. Airy and Mercy Hospital-Western Hills, were employed.

particular needs of these medically indigent patients, who, if employed, may have little or no ability to attend to the medical needs of family members during business hours, must be understood and addressed in the Levy.

We have already noted the recent economic difficulties of taxpayers in Hamilton County occasioned by job loss and reductions in residential wealth. For most Hamilton County taxpayers, the subcommittee's other primary focus, there is simply no "extra money" with which to pay higher property taxes to support Levy agency requests. If taxes can be analogized to a religious tithe, that the size of the tithe varies with the size of the entire harvest.

There is also the fact of jurisdictional competition for businesses. Hamilton County businesses have the ability to react to higher property taxes by relocating to a lower tax jurisdiction, whether in adjacent Ohio counties, to a location along the I-74 corridor in Indiana or in Kentucky. This subcommittee believes the Levy must be sized and implemented in a way that helps Hamilton County to maintain a competitive position with respect to retention, creation and expansion of industrial and commercial enterprises.

Finally, with the assistance of Hamilton County Health Commissioner Tim Ingram, our consultant HW & Co., and others, we have familiarized ourselves with emerging trends in healthcare, exemplified locally by the Greater Cincinnati Regional Health Transformation Initiative (the "Initiative"). The Initiative is comprised of providers, local employer-purchasers of employee health care, health care consumers, industry experts and others. The Initiative's stated middle-term goals are to:

- Improve access to quality primary care.
- Give people the information they need to help them be better partners with their doctors.
- Publicly report consumer-friendly information on the performance of regional providers.
- Put technology to work so providers have the information they need when they need it.
- Help doctors and hospitals define and demonstrate "meaningful use" of electronic health records.
- Explore ways to pay for health care, so that value is recognized and rewarded.
- Reduce racial and ethnic disparities in health care.

Consistent with the Initiative's goals, our consultant has, in its final report (the "Final Report"), recommended that "the focus of [L]evy dollars . . . be on preventative care vs.

emergency care services,”¹⁴ and that reporting requirements for Levy-funded providers be altered to enhance Hamilton County’s ability to measure provider performance.¹⁵

The subcommittee believes that the Levy proceeds should be utilized in alignment with these middle-term goals and consultant recommendations, all in the manner and to the extent set forth in this report.

Against this backdrop, the subcommittee has the following specific recommendations:

**RECOMMENDATION 1: THE LEVY SHOULD BE PUT ON
THE NOVEMBER 2011 BALLOT**

The subcommittee unanimously recommends to the BOCC that the Levy, with the features we outline below (or similar features), be placed before the voters at the November 2011 election.

The subcommittee recognizes that the needs of the medically indigent in Hamilton County are substantial. Testimony from UH, Children’s and the Cincinnati Health Department (“CHD”) was received as to recent increases in demand for indigent care.

But to note the existence of this need (even an increasing need) does not compel the conclusion that the Levy be placed on the November 2011 ballot. Hamilton County’s Levy is atypical in Ohio. As noted by our consultant in its Final Report: “Hamilton County is the only county in Ohio with a levy directly serving its indigent residents and the hospitals caring for those residents.”¹⁶

There clearly are other ways of meeting with the needs of the medically indigent, ways that do not involve a dedicated Levy. Indeed, one of the promises of the 2010 Patient Protection and Affordable Care Act is to shrink, if not eliminate, the population of the medically indigent by providing insurance to nearly all Americans.

Nevertheless, given all the facts and circumstances as they exist in June 2011, this subcommittee concludes that the Levy, modified as set forth below in this report, represents the best way to address the needs of the Hamilton County medical indigent during the three (3) year suggested term of the Levy. We therefore unanimously recommend that the Levy appear on the November 2011 ballot.

We hasten to add that this subcommittee did not view the Levy as constituting an entitlement, either for the medically indigent or the providers of indigent care, and the above

¹⁴ *Final Report*, p. 4.

¹⁵ *Final Report*, p. 5.

¹⁶ *Final Report*, p. 1.

recommendation should not be understood as establishing through the Levy any such entitlement.

RECOMMENDATION 2: THE LEVY TERM SHOULD BE
THREE (3) YEARS (2012, 2013, 2014)

The future of the healthcare delivery systems in the U.S. is highly uncertain. The constitutional viability of the 2010 Patient Protection and Affordable Care Act is being tested in multiple jurisdictions and the effects of its full enactment, scheduled to occur in 2014, are unclear. While intended to increase the number of Americans with health insurance, thereby reducing the population of the medically indigent, a recent McKinsey study suggested that “Obamacare” may lead to the opposite (unintended) effect, that substantial numbers of employers may simply drop employee healthcare plans and instead pay the stipulated fines.¹⁷ Our consultant does not see any meaningfully drop in the needs of the medically indigent in Hamilton County before 2014 and has recommended that this subcommittee consider reducing the Levy term to three (3) years.¹⁸

The traditional five (5) year Levy cycle does not appear to this subcommittee to be optimal given the current uncertain state of healthcare delivery and finance. Therefore, for the reasons suggested by our consultant in its Final Report, we have considered, and unanimously recommend to the BOCC, that the Levy term be three (3) years, *i.e.*, 2012, 2013 and 2014.

A shorter term will also enable Hamilton County to assess the performance of the selected hospital providers of indigent care, UH and Children’s, in meeting the more rigorous performance standards we recommend below. We recognize that, in our recommendations, we are advocating somewhat of a departure from the *status quo* in terms of the emphasis placed on access to quality primary care and on the achievement of measurable healthcare outcomes. A shorter Levy period permits these new standards, as well as the selected providers, to be tested and, perhaps, adjusted without the burden of a longer-term commitment.¹⁹

RECOMMENDATION 3: THE LEVY SHOULD NOT
PROVIDE FUNDING FOR CHD

The subcommittee had the opportunity to meet with CHD personnel, including City Health Commissioner Dr. Noble Maseru, and to tour the Elm Street Health Center. We were impressed by the volume and quality of work that CHD and its dedicated professionals do in

¹⁷ “No, You Can’t Keep Your Health Insurance,” *Wall Street Journal* (June 8, 2011) (up to 50% of employers say they will definitely or probably pursue alternatives to their current health insurance plan after “Obamacare” is fully implemented in 2014).

¹⁸ *Final Report*, p. 2

¹⁹ *Final Report*, p. 5 (“... one of the [sub]committee’s considerations in reducing the Levy . . . to 3 years was for [UH and Children’s] to provide data in [specified] areas that can be analyzed and measured to determine how effective [UH and Children’s] were in implementing the various initiatives”).

delivering primary care to City residents. We were also impressed by CHD's resourcefulness in replacing City general fund support – which dropped from \$22.5 million in 2006 to \$13.7 million in 2011 – with funding from other sources. We are also cognizant of the City Council recommendation that Levy funds be provided for CHD's clinics and our consultant's recommendation that we consider such funding.²⁰

That said, we cannot recommend that Levy funding be allocated in support of CHD's clinics. Santayana was almost certainly correct: "Those who cannot remember the past are condemned to repeat it." Our historical investigation into the origins and development of the Levy – where the initial equitable sharing between the City and Hamilton County of the burden of funding General Hospital was followed by an abrupt City withdrawal from funding – unearthed a precedent that appears all too susceptible to repetition. The City's gradual withdrawal in the 1960s from funding General Hospital is mirrored in the gradually reduced funding for CHD in the 2006-2011 period. It is our unanimous recommendation that Hamilton County decline the invitation to participate in a foreseeable sequence of events that could end with the Levy being the primary (if not sole) source of local governmental financial support for CHD's clinics. The likely substitution of Levy dollars for City dollars in CHD funding does nothing to enhance indigent medical care.²¹

Even without the historical precedent, Levy funding of clinics under the political control of a sister jurisdiction would be problematic. Funding without the full ability to control how that funding is used should be avoided to the extent possible.

RECOMMENDATION 4: THAT LEVY FUNDS IN AN AMOUNT OF BETWEEN \$5.75 MILLION AND \$6 MILLION PER ANNUM BE ALLOCATED TO CHILDREN'S IN SUPPORT OF PEDIATRIC INDIGENT CARE

We it leave to the BOCC to choose among the Levy funding levels that the TLRC has recommended: (1) Plan 1, which (after reflecting the decline in real estate values) produces approximately \$40.6 million in proceeds per Levy year; (2) Plan 2, which would reduce annual Levy proceeds to approximately \$38.0 million; and (3) Plan 3, which would reduce annual Levy

²⁰ *Final Report*, pp. 4-5.

²¹ To dispel any confusion as to why the subcommittee recommends against Levy funding for CHD, it is because we believe that each dollar of Levy funding would be matched by a dollar of withdrawn City funding. The City is facing, according to media reports, a \$33 million budget shortfall for 2012. Media reports indicate that at least four (4) City Council members have advocated cuts for the CHD health clinics. To believe that Levy funding would not be seized upon as justification for a reduction or withdrawal of City funding ignores the reality of the City's looming budget shortfall and the historical precedent involving General Hospital. To repeat, the substitution of Levy for City dollars does nothing to enhance indigent medical care. Our consultant's report, which understandably does not address the City's fiscal issues and did not have the benefit of the subcommittee's historical investigation, did not, in its recommendations, consider the likely substitution of Levy funds for City funds.

proceeds to approximately \$36.0 million.²² Under Plan 1, this subcommittee recommends that Children's receive \$6 million annually in support of its provision of pediatric indigent care to Hamilton County residents. Under either the Plan 2 or Plan 3 scenario, the recommended annual amount is \$5.75 million. These recommendations are unanimous.²³

This recommendation is the result of the emphasis Children's itself has placed on the delivery of primary care through clinics (including the Hopple Street Clinic Children's operates jointly with CHD) with hours of operation that are user friendly (the base clinic being open seven (7) days a week), on diversion of patients from the higher cost Children's emergency department to clinics or other primary care medical "homes" and on qualifying uninsured patients at Children's for Medicaid coverage or other non-Levy funding. The recommendation also takes into account the availability of Children's level one trauma center to Hamilton County's pediatric medical indigent.

We would expect Children's in the new Levy period to maintain its focus on preventive care and also to work to reduce administrative costs. Any contract with Children's for the new Levy period, (and we recommend that Hamilton County contract directly with Children's rather than indirectly through the UH contract), should, the subcommittee believes, have the performance and reporting requirements outlined below in Recommendation 6.

RECOMMENDATION 5: THAT LEVY FUNDS IN AN AMOUNT OF BETWEEN \$15.5 MILLION AND \$20.0 MILLION PER ANNUM BE ALLOCATED TO UH IN SUPPORT OF NON-PEDIATRIC INDIGENT CARE

The subcommittee unanimously recommends that between approximately \$15.5 million (Plan 3) and \$20.0 million (Plan 1) in annual Levy proceeds be allocated to UH in support of its provision of non-pediatric indigent care to Hamilton County residents.²⁴ We are aware that these recommended funding levels represent a material reduction in annual Levy support to UH but believe that the reductions are appropriate for a number of reasons.

First, UH has consistently highlighted, in its presentations to the subcommittee and other literature, its threefold mission, education, research and patient care. The subcommittee recognizes the value UH brings to the Greater Cincinnati community and the broader medical educational community through its pursuit of this mission. However, the Levy funds indigent

²² See the spreadsheet attached as Annex 1 for more detail.

²³ For a point of reference as to our Recommendations 4 and 5, the 2006 Report recommended a \$4 million annual allocation to Children's and a \$18 million annual allocation to UH.

²⁴ Under Plan 2, the funding amount would be \$17.5 million. We note that, at each of the three (3) proposed Levy funding levels, UH would have had, at the operating level, positive revenues in excess of expenses in each of 2008 (\$23.2MM/Plan 1; \$20.7MM/Plan 2; \$18.7 MM/Plan 3), 2009 (\$12.9MM/Plan 1; \$10.4MM/Plan 2; \$8.4MM/Plan 3) and 2010 (\$21MM/Plan 1; \$18.5 MM/Plan 2; \$16.5 MM/Plan 3).

care for Hamilton County residents, not medical education or research or UH's vision of being "a national leader in solving complex medical problems."

Second, we were disappointed with UH's responses to our expressed concern with the access of the medically indigent in Hamilton County to UH's primary healthcare facilities. Invited several times to offer to increase the hours of operation at Hoxworth Clinic, UH declined, citing staffing and financial reasons. While UH acknowledged the value of the work HCAN performed in its ED diversion pilot program²⁵, UH declined at the June 13, 2011 hearing to consider funding that program other than with Levy proceeds or grant funding. This stands out in stark contrast to Mercy Health Partners, which received a similar ED diversion program grant but which now self-funds its own diversion program.²⁶

Third, the subcommittee is concerned there may be an inordinate level of tension between UH and CHD, especially as regards the provision of primary care to the non-pediatric medically indigent. We, of course, understand that CHD was seeking Levy funding, which UH rightly viewed as potentially leading to a reduction to its Levy funding. We also acknowledge the past litigation history between the City and UH and the imminent (in 2013) expiration of the 2003 settlement agreement between them. That said, and acknowledging that the animosity we observed emanates from both sides, it is unfortunate that UH and CHD do not have a relationship that would enable them – as Children's and CHD do – to jointly operate one or more primary care clinics or other initiatives (except as compelled by the 2003 settlement agreement). The medically indigent in Hamilton County would be better served by a more cooperative relationship.²⁷

The recommended level of Levy funding for UH takes into full account the excellence of UH's level one trauma center, Air Care medical helicopter program and the level 1 burn center.

In the new Levy cycle, we would expect that UH further emphasize primary care and devote the resources necessary to enhance access to that care, in the form of longer clinic hours of operation or in other forms (such as developing relationships with FQHCs). We would also expect UH to devote its own resources to ED diversion programs, whether furnished by HCAN or through development of in-house capacity. We also expect that UH would continue to support the OB-GYN clinic at CHD in the manner it currently does through the entire Levy period, as that support, required by the 2003 settlement agreement between the City and UH, would otherwise end in 2013. Administrative cost reductions should be pursued, in line with our

²⁵ HCAN determined that approximately 10% of UH's ED visits were avoidable.

²⁶ In communications subsequent to the preparation of the initial draft of this report, UH indicated that the June 13, 2011 statement to the TLRC at the public hearing did not represent UH policy and that UH will, in fact, self-fund an expanded ED diversion program. We applaud that decision.

²⁷ In communications subsequent to the preparation of the initial draft of this report, UH expressed the opinion that UH's relationship with CHD is more positive than we perceived, citing UH senior staff service on the Board of Health and assistance to CHD in obtaining "look-alike" FQHC status.

consultant's recommendation. Any contract with UH for the new Levy cycle should have the performance and reporting requirements described in Recommendation 6.

RECOMMENDATION 6: THAT LEVY PROVIDERS BE HELD RESPONSIBLE IN THEIR CONTRACTS WITH HAMILTON COUNTY FOR ACHIEVING SPECIFIC GOALS IN IMPLEMENTING THE LEVY'S NEW INITIATIVES

Greater Cincinnati is home to one of the most "wired" health care systems in the country. Due to the local healthcare systems' investment in electronic medical records (fortuitously, each major healthcare provider has acquired the EPIC platform) and Healthbridge, medical results can be readily exchanged among providers electronically.

These system attributes make feasible our recommendation that the BOCC establish the following as the primary mission for Levy-funded providers in this three (3) year period: that Levy funds be used to incentivize development of a coordinated healthcare system across all of Hamilton County available to the medically indigent, with an emphasis on preventative care. This recommended system would achieve meaningful and improved healthcare quality, safety and cost-efficiencies and also reduce healthcare disparities over the three (3) year Levy term.

In furtherance of this mission, Levy-funded healthcare providers would optimize the use of secure common technologies for interoperable health information flow across Hamilton County's healthcare systems. This will make possible optimal coordinated health care services for Hamilton County residents, including the medically indigent population, while reducing avoidable ED usage and hospital admissions and readmissions.²⁸

This subcommittee unanimously recommends setting the following goals and metrics for Levy-funded providers.

Goal 1: Improve Medical Care provided to indigent population of Hamilton County through expanded utilization of Patient-centered "medical home" model to reduce reliance on hospital Emergency Rooms and reduce the number of preventable admissions into hospitals.

Metric 1. 100% of indigent ED patients seen at UH and Children's will be assigned a Patient-centered "medical home" that meets the NCQA standards.

Metric 2. 100% of the indigent patients assigned to a "medical home" will have follow-up contact from the "medical home" to establish a relationship and coordination of preventative care.

²⁸ We noted with interest Mercy Health Partners' transition coaches initiative to reduce unnecessary hospital readmissions.

Goal 2: Improve healthcare system efficiencies for indigent diabetic population.

Metric 1. 100% of indigent Diabetic "medical home" patients will have D-5 measures collected and be managed for optimal diabetes care. BMI data will be collected on this population.

Metric 2. 100% of indigent Diabetic "medical home" patients shall receive ongoing care coordination including an initial follow-up call within 30 days of "medical home" enrollment. Follow-up contact is to assure optimal diabetes care.

Metric 3. Reduce ED visits and hospital admissions by diabetic patents enrolled in "medical homes" by at least 15% per year against the base line number.

Metric 4. Reduce self-reported smoking among diabetic patients at all "medical home" providers by 5% from baseline in 12 months and 10% in 24 months.

Goal 3: Improve healthcare system efficiencies for indigent asthma population.

Metric 1. 80% of "medical home" indigent asthma patients shall be rated as "well controlled" by the physicians and patients.

Metric 2. 80% of these patients will show a 15% reduction of asthma patients ED visits and hospital admissions due to uncontrolled asthma.

Goal 4: Increase seasonal influenza vaccination rates for indigent asthma population across all "medical home" providers.

Metric 1. Ninety percent (90%) of high-risk asthma population to receive seasonal influenza vaccine

Metric 2. Seventy-five percent (75%) of general asthma population will receive seasonal influenza vaccine.

Goal 5: Indigent patients with cardiovascular disease shall receive "optimal cardiovascular care".

Metric 1. 80% of patients with cardiovascular disease enrolled in "medical homes" will show a 10 point improvement in blood pressure and 10 point improvement in LDL cholesterol levels within the first 12 months of enrollment with the "medical home". BMI data will be collected for this population.

Goal 6. All Levy-funded providers shall submit data to secured community health registry.

Metric 1. To be determined later this year as a percentage of records sent to the community health registry.

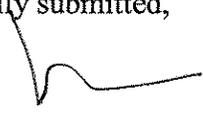
A softer metric is cooperation with other healthcare provider systems. We would expect that all Levy recipients consistently exhibit a willingness to cooperate with other healthcare providers in Hamilton County in serving the needs of the medically indigent. To repeat, all nonprofit hospitals in Hamilton County, not just Levy recipients, provide some level of indigent healthcare services. The promise of a shared platform (EPIC) for electronic medical records will be unrealized if participants are unwilling to cooperate in efforts to maximize the efficient delivery of healthcare, particularly preventative primary care, through the sharing of medical records and otherwise.

In order to monitor the specific metrics and goals established for Levy-funded providers, a committee would be appointed by the BOCC, with the membership to consist, potentially, of TLRC members, County or other Health Commissioners and industry professionals. This committee would consist of 7 to 9 individuals and meet no less frequently than quarterly to review the contracts that will be put in place for funding from the Levy. Continued payments from Levy funds would be contingent on the progress made by Levy-funded providers toward the established goals.

The above goals are consistent with the Initiative mentioned above and also with the recommendations of our consultant in the Final Report.²⁹ This subcommittee also recommends that the Levy contracts with Children's and UH reflect the "prudent buyer" standards and best practices noted in one of the attachments to the 2006 Report.

This subcommittee has striven to be tough-minded without being hard-hearted. We believe, and hope, we have succeeded in this task.

Respectfully submitted,

By: 

Edward E. Steiner

²⁹ Final Report, pp. 4-5.