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# HMA

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HEALTH MANAGEMENT ASSOCIATES

*Review of Hamilton County, Ohio,  
Indigent Care Levy: Hospital Services*

PRESENTED TO  
HAMILTON COUNTY, OHIO

MAY 24, 2017

*Research and Consulting in the Fields of Health and Human Services Policy, Health Economics  
and Finance, Program Evaluation, Data Analysis, and Health System Restructuring*

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## Executive Summary

Health Management Associates (HMA) is pleased to present this report to the Tax Levy Review Commission (TLRC) on our review of the Hamilton County, Ohio, Health and Hospitalization Levy related to hospital indigent care services. HMA was engaged by the TLRC pursuant to the Hamilton County Tax Levy Policy that, among other things, requires that each proposed tax Levy undergo a performance review by a consultant prior to approval for the ballot.

The County's Health and Hospitalization Levy (the Levy) expires on December 31, 2017, and the Board of County Commissioners (BOCC) is considering whether to propose a Levy renewal to present to the voters this fall. The Levy has, for many years, included direct payments to two hospitals located in Hamilton County: University of Cincinnati Medical Center (UCMC) and Cincinnati Children's Hospital Medical Center (CCHMC). Both Hospitals have requested continued financial support from the Levy.

The scope of our review includes indigent medical care services at UCMC and CCHMC and several specific tasks and questions from the TLRC, including:

- The disposition of recommendations made as part of the last Levy review cycle.
- Whether the County and Hospitals have complied with the requirements of the current Levy.
- A financial assessment of the Hospitals, emphasizing Hospital charity care and other costs funded by the Levy.
- A review of the Hospital's financial assistance policies and their handling of uninsured and underinsured patients.
- An evaluation of factors to help inform the TLRC and BOCC decisions about the next Levy cycle:
  - Impact of the Affordable Care Act (ACA).
  - Hospital strategic plans.
  - Comparisons to other large Ohio counties.

To achieve the objectives of our study, we performed the following:

- Read past reports and correspondence related to the Levy.
- Researched and summarized information on several relevant topics such as the Ohio Medicaid program and its policies for reimbursing hospitals, the charitable activity requirements of tax-exempt hospitals, and community benefit reporting standards used in the health care industry.
- Interviewed officials from the County and each of the Hospitals.
- Reviewed and analyzed financial reports, policies and other documents from each Hospital.
- Attended presentations made by the Hospitals to the TLRC.
- Analyzed uncompensated care information for all Ohio hospitals and researched indigent care policies in five benchmark counties.
- Performed research and analysis related to the impact of coverage provisions in the ACA and proposed legislation to replace portions of the ACA.

Key findings and observations from our review are summarized as follows:

**Current Levy:** The current Levy was approved by the voters in November 2014 for a three-year period ending December 31, 2017. In total, over \$40 million of revenue per year is generated from the Levy. The BOCC allocated \$14.9 million to UCMC per year, and \$5.2 million in 2015 and \$4.7 million in 2016 and 2017 to CCHMC. The remainder of the Levy funds were allocated to support other County indigent care programs.

**Compliance with the Levy requirements:** Each Hospital is required to meet two financial tests. First, the cost of uncompensated care provided to Hamilton County residents must be at least equal to the Levy funds paid to the Hospital. This test was met by each of the Hospitals in each of the last three years. Second, the cost of community benefits (as defined in standards published by the Catholic Hospital Association) must exceed a minimum threshold stated in the contract. Both Hospitals easily exceeded the minimum threshold in each year.

There are several other contract provisions including many reporting requirements. For one of these requirements, UCMC did not supply the required information to the County on a timely basis. It was subsequently provided, and the County did not express concern with the timing.

**Financial Condition – UCMC:** The Hospital is a member of UC Health, an entity that also includes other health care facilities and a large physician group. UC Health has experienced a period of strong growth and improved operating results in recent years, although its operating margin is lower in the current fiscal year. The overall financial strength of the organization has improved in terms of both short-term liquidity and long-term sustainability. The Hospital carries an A2 bond rating, which is above average in the hospital industry. Levy funds represent a significant source of revenue but one that has declined: from 2011 to 2013 Levy payments were 1.9% of total operating revenues compared to 1.1% of operating revenues from 2014 to 2016.

**Financial Condition – CCHMC:** The Hospital has been very successful financially. Over the last three years its margins have averaged 9.0% of revenues, more than double the industry average, and its net assets (assets less liabilities) have increased by 30%. CCHMC's overall financial strength is equally impressive: The Hospital carries a relatively low amount of debt and has significant unrestricted cash and investments on its balance sheet and in supporting organizations. It has an AA2 bond rating, a high rating relative to most U.S. hospitals. Levy funds represent 0.2% of operating revenues.

**Financial Assistance Policies:** Both Hospitals have comprehensive policies and practices to address the needs of uninsured and underinsured patients, and both organizations provide extensive financial counseling and other resources to support their patients. Each Hospital complies with Internal Revenue Service (IRS) requirements for tax-exempt hospitals as called for in the ACA.

- UCMC offers full charity care to persons with household income of 150% of poverty and below and 70% discounts to patients with income levels between 150% and 200% of poverty. UCMC's income thresholds for financial assistance are at the lower end of the range that HMA typically encounters.

- CCHMC offers full charity care to persons residing in the primary service area with household income up to 200% of poverty and 48% discounts to patients with income levels between 200% and 400% of poverty. Patients outside of the primary service area may qualify for a 25% discount. These thresholds are at the higher end of the range that HMA typically encounters.
- Although UCMC has a larger discount percentage, it sets its standard charges at a much higher mark-up over cost than CCHMC. Consequently, CCHMC's discount is more generous.

**Coverage Assistance:** Both Hospitals have active programs to identify insurance coverage for uninsured patients and help patients obtain coverage where available.

As explained further below, Ohio implemented an expansion of Medicaid in 2014, which offers Medicaid coverage to hundreds of thousands of low-income uninsured adults in Ohio. Additionally, the ACA provides significant subsidies to citizens with household incomes below 400% of poverty to help them buy health insurance coverage, and it imposes financial penalties on individuals who do not acquire and on employers that do not offer insurance.

These coverage expansions and incentives under the ACA are especially important to UCMC, because its patient population is primarily adults. For many years, public coverage (via Medicaid and CHIP) has been available to children in households with income levels below 200% of poverty, but low-income adults had limited access to these programs. Consequently, the percentage of uninsured adults between the ages of 19 to 64 was previously more than double the percentage of uninsured children. CCHMC expected to receive relatively modest benefits from ACA coverage expansion, while UCMC anticipated significant benefits. In response to this opportunity, UCMC put in place a comprehensive program to identify candidates for Medicaid expansion and subsidized insurance and to help eligible persons get enrolled.

**Strategic Plans:** Based on HMA's review of the strategic plans, both Hospitals anticipate making additional investments in support of community health improvement. The strategic plans are to a large degree focused on improving the organization's financial health, as one would expect, but we noted a strong emphasis on community health improvement as well and nothing in the plans that run counter to the interests of the County.

In addition, we reviewed the Community Health Needs Assessment (CHNA) and corresponding action plan developed by each Hospital. A CHNA is required by IRS rules for tax-exempt hospitals. The current CHNAs and action plans appear to have appropriate target areas for health improvement and include goals for achieving a reasonable level of improvement as well as concrete plans to meet these goals.

**Comparisons:** To measure the relative burden of indigent care on UCMC and CCHMC, HMA obtained information on each Ohio hospital's Medicaid and uncompensated care costs. Using this information, we compared UCMC and CCHMC to all other Hamilton County hospitals.

CCHMC accounts for more than half of the Medicaid services provided by Hamilton County acute care hospitals and, because of its very large Medicaid patient population, its low-income patient burden is

significantly greater than the next largest Hamilton County hospital and more than double the Ohio average. CCHMC has the second smallest percentage of uncompensated care to total revenue in the County, although it ranks third in uncompensated care dollars.

UCMC has the second largest low-income patient care cost and the second largest low-income patient burden in the County, reflecting its large size and its large share of adult Medicaid services. UCMC provides the largest amount of uncompensated care, although the uncompensated care dollars are more widely distributed across the hospitals in the County than is the case with Medicaid.

Also, HMA compared the amount of indigent care burden in Hamilton County to other large counties in Ohio. Hamilton County hospitals have the highest percentage of indigent care of the six largest counties in the state.

Lastly, HMA obtained information from the five other largest counties in Ohio on their indigent care funding strategy. Cuyahoga County owns a safety net hospital and dedicates a general fund subsidy to support the hospital. The only other county in our sample providing direct support to its hospitals is Montgomery County, which dedicates \$5 million per year from its Human Services Levy to hospital indigent care.

**Impact of ACA:** The financial effect of the ACA on each Hospital was evaluated. There are many provisions of the ACA that impact hospitals, but we focused our review on two areas.

First, the impact of coverage expansion was evaluated. The ACA includes several provisions intended to increase health insurance coverage and decrease the uninsured population. The most significant coverage provision in terms of numbers newly insured has been the expansion of Medicaid to low-income adults (ages 19-64). The ACA also provided federal subsidies for private insurance and several insurance reforms that have positively impacted the uninsured rate. Between 2013 to 2015, Ohio experienced a 40% decrease in the number of uninsured residents. Over the same period Hamilton County's uninsured population was 47% lower. As of January 2017, Ohio's Medicaid expansion program has attracted 715,000 enrollees, and another 174,000 are receiving federal premium subsidies under the ACA health insurance exchange.

Second, the impacts of Medicare and Medicaid reimbursement reductions required by the ACA were considered. In its attempt to make the ACA budget-neutral from a federal budgetary standpoint, Congress included several planned revenue increases and expenditure decreases, including some large cuts in hospital Medicare payments and a potentially large reduction in Medicaid hospital funding. In addition, the State of Ohio implemented Medicaid reimbursement reductions to help address state budget shortfalls. The reductions were not part of the ACA but were indirectly associated with the decision to expand Medicaid.

To estimate the effect of the ACA coverage provisions, we used the change in uncompensated care cost (charity care and bad debt) from 2013 to 2016 as a proxy. Although many variables impact the amount of a hospital's uncompensated care, there is a strong correlation between uncompensated care and the

uninsured rate. Medicare and Medicaid impacts were estimated in coordination with Hospital management. The following table summarizes our estimates of the ACA effect on the two Hospitals.

Estimated Impact of ACA	UCMC	CCHMC
Decrease in uncompensated care costs	\$44,570,000	\$12,773,000
Medicare and Medicaid reimbursement cuts	(\$25,818,000)	(\$9,591,000)
<b>Net Gain, directly related to ACA</b>	<b>\$18,752,000</b>	<b>\$3,162,000</b>

Both Hospitals have seen substantial reductions in their uncompensated care burden. UCMC experienced a 52% decrease in its uncompensated care cost from 2013 to 2016, which is greater than the decrease in uninsured persons in the region. CCHMC experienced a 40% decrease, even though the number of uninsured children decreased at a much lower rate. Both Hospitals also incurred significant Medicare and Medicaid reimbursement losses directly related to the ACA, which partially offsets the gains from lower uncompensated care.

**Potential Health Care Reform Legislation:** The ACA is the target of intense partisan politics and an ongoing national debate about the role of the federal government in the nation's health care system. The new President and many members of Congress have vowed to repeal a significant portion of the law. In addition, federal financing for Medicaid could be converted to a per capita cap or block grant. Both options aim to control federal spending on Medicaid and provide states more flexibility in their management of Medicaid spending, but place the state and potentially providers at significantly greater financial risk.

On May 4, 2017, a bill referred to as the American Health Care Act (AHCA) was passed in the U.S. House of Representatives, which may dramatically alter the financing of care for low income people. The AHCA eliminates the individual and employer mandates under the ACA, cuts the subsidies for many individuals purchasing coverage through the insurance exchanges, reduces the federal funding for Medicaid expansion, implements a per capita cap on Medicaid spending, and may remove certain ACA insurance protections.

The AHCA has now moved onto the Senate where it will be passed, modified or rejected. Whether the AHCA or some modified version becomes law is uncertain. However, even if major health care legislation is not enacted this year, the key issues are likely to remain in the political spotlight.

The Congressional Budget Office analyzed a preliminary version of the AHCA and estimated that over a ten-year period, (1) the changes to ACA coverage provisions would result in 24 million more uninsured than would be the case under current law, and (2) federal Medicaid spending would be reduced by \$880 billion.

An independent study by the Urban Institute included a state-by-state analysis of the Medicaid impacts. The ten-year aggregate impact on Ohio was estimated to be a \$22 billion reduction in federal payments, representing 10% of estimated federal funding under current law. If Ohio decided to replace the lost federal funding with state funding, Ohio's Medicaid spending would have to increase by 22% over the ten-year period.

If the AHCA or similar legislation is enacted, it is likely that much of the ACA coverage gain experienced by UCMC, CCHMC and other hospitals in the region would be reversed. In addition, it is likely that most states, including Ohio, would opt to reduce the size of their Medicaid program using a combination of several possible levers, including:

- reducing (and possibly eliminating) coverage for the Medicaid expansion population
- reducing coverage for other optional eligibility categories
- reducing benefits where allowed under federal law
- cutting provider payments

Each of these options would negatively impact UCMC and CCHMC by increasing the number of uninsured Ohioans or increasing the Medicaid shortfall.

Although we do not know the fate of the “repeal and replace” efforts, clearly the concepts embraced by the current administration and congressional leadership could be very detrimental to hospitals financially.

**Recommendations for Next Levy Cycle:** Both Hospitals have requested that 2017 funding levels be continued under a new Levy. HMA was asked to evaluate this request in the context of two different funding levels. First, a continuation of the Indigent Care Levy at the same millage and, second, an increase in the Levy to account for the effects of inflation in recent years. Under the same-millage scenario, tax Levy revenue is estimated to be \$1.5 million per year lower than 2017 Levy revenue; under the inflation-adjusted scenario, tax Levy revenue is estimated to be \$3 million per year higher than 2017 Levy revenue.

In its evaluation of the Hospitals’ funding request, HMA considered several factors that are applicable under either future Levy scenario.

- Historically the primary purpose of the health and hospitalization Levy has been to support hospital care for the County’s uninsured and underinsured residents.
- UCMC and CCHMC are the leaders in the region in services to low-income individuals.
- The ACA coverage provisions have significantly reduced the Hospitals’ uncompensated care burden, especially at UCMC.
- Neither Hospital relies heavily on the Levy payments.
- Both Hospitals are at great risk financially if the federal government enacts ACA “repeal and replace” legislation and/or converts Medicaid financing to a per capita cap or block grant.
- County leadership may conclude that there are higher priorities for health care funding.

Some of the above factors lend support to the Hospitals’ requests to continue Levy funding at the same level as the current Levy; other factors suggest that the amount of hospital funding could be reduced.

On balance, the number of other high priority public health objectives may be the most compelling of these factors and, coupled with the scarcity of available funds, suggests that the County may be best served by considering a further reduction in the hospital percentage of Levy revenue.

- If the County moves forward with the inflation-adjusted Levy scenario, the direct hospital payment could remain at current levels and the additional Levy revenue could be used for other indigent care programs.
- If the County opts for the no-increase-in-millage scenario, an option is to reduce the hospital payments by the amount of the reduction in Levy revenue.
- The BOCC and TLRC may conclude that additional reductions to hospital direct payments are needed to adequately fund other high-priority programs. However, if additional reductions in hospital payments are deemed necessary, officials should consider a provision that allows the cut to be restored if federal legislation is passed that significantly reduces coverage or Medicaid funding.

In addition to evaluating future Levy funding scenarios, HMA has other observations and ideas for BOCC and TLRC consideration:

- Since their inception, the Levy payments have been in the form of a passive grant with certain contractual conditions. However, there could be synergies from greater coordination between the organizations, and greater collaboration with the County and other key stakeholders. The County should consider whether the hospital Levy payments, or a portion of the Levy payments, should be targeted to programs of mutual interest to the Hospitals and County leadership.
- Prior to 2011, hospitalization levies covered five-year periods. The Levy period was shortened to three years in 2011, in large part because of uncertainty about the ACA impact, and it was maintained at three years in 2014 because of continued uncertainty about ACA. The future of health care and the impact on the finances of the County's safety net are no more certain today than at the beginning of each of the last two Levy periods. However, there is an advantage to a longer Levy period because it provides a more certain long-term revenue picture for the County and the Hospitals at a time when there is significant concern about an uncertain future. Accordingly, the BOCC should consider a four-year or five-year Levy period.
- In our review of the contract provisions, we noted one instance of untimely submission of required data, and there are no formal procedures in place for the County to communicate expectations to the Hospitals to ensure all requirements are being met on a timely basis. The County should ensure that each reporting requirement has a specific due date or timeframe for completion; a checklist of contract provisions may help with ongoing monitoring of compliance.
- The Net Community Benefit test, whereby each Hospital is required to demonstrate that it is providing a quantifiable community benefit that meets or exceeds a stated threshold, is not a meaningful test in its current state because the threshold is set at a level that is too low. Rather than requiring a financial test that neither Hospital has difficulty meeting, the County may consider changing the test to ensure an ongoing commitment to the community. Alternatively, this test could be eliminated from the contract.

- The County could work with the state to investigate opportunities to leverage additional federal funding for Medicaid. Under federal policy, the state share of Medicaid expenditures may be financed by a technique called intergovernmental transfer whereby a local unit of government transfers funds to the state to serve as the state share of the Medicaid payment. It is possible to repurpose Hamilton County funding to leverage federal Medicaid match, thereby creating additional resources for the County. The state and County could work together to construct a permissible Medicaid plan to use County Levy revenues as the source of state match, and the resulting the Medicaid funding being returned to the County. There are several challenges and potential barriers to overcome, but the size of the potential financial gain may warrant further review of Medicaid financing options.

## Section 1 – Introduction and Scope of Engagement

Since the 1960s, a Tax Levy has been in place to support hospital indigent care in Hamilton County. The Levy was initially directed to one hospital, University of Cincinnati Medical Center (UCMC) (formerly known as Cincinnati General Hospital) in response to the dire financial condition of the City of Cincinnati, then owner of the Hospital, and the lack of insured patients accessing the hospital. In the mid-1970s, Cincinnati Children’s Hospital Medical Center (CCHMC) began to receive a portion of the Levy funding to permit centralizing pediatric indigent care at Children’s.

Many changes have occurred in the several decades of the Levy, such as using over half of the Levy revenue for other County health care-related programs. However, the Levy continues to provide directed financial support for indigent care to two of Hamilton County’s hospitals, UCMC and CCHMC.

Pursuant to the resolutions of the Board of County Commissioners (BOCC), the Tax Levy Review Commission (TLRC) was established to, among other things, secure an independent review of all tax Levy requests prior to a Levy proposal being placed on the ballot for voter consideration. The current Levy is set to expire on December 31, 2017, and the Levy is being considered for renewal. The TLRC has engaged HMA to perform a review of the hospital component of the Levy. A separate review of other indigent care programs funded by the Levy is being conducted as well.

### Scope of Engagement

HMA was engaged by the TLRC to perform the tasks enumerated below and to prepare a report on our findings and recommendations.

**Task 1:** Review Levy requirements, including intended usage and populations for hospital and inmate indigent medical care. Identify which services are mandated by law and which are discretionary. Services provided in the current Levy cycle include:

- A. Indigent medical care services at University of Cincinnati Medical Center.
- B. Indigent medical care services at Cincinnati Children’s Hospital Medical Center.

**Task 2:** Research the level of indigent care funding for comparable counties in Ohio. Examine how hospital medical indigent care in Hamilton County hospitals compares to other Ohio counties (major and neighboring) in terms of care provided to indigent residents (criteria could include number of indigent served, quality of care received, and need for services).

**Task 3:** Report on the impact of federal health care reform on Hamilton County’s hospital indigent care needs. This should include, but not be limited to:

- A. Detail on ACA and Medicaid expansion in Ohio on an annual basis for each service provided by Hamilton County.
- B. Review the impact of the Medicaid expansion in Ohio.
- C. Build a data table with the impacts of the ACA implementation and Medicaid expansion in Ohio for the Levy period.
- D. Review the draft table with each program’s management to assure completeness and accuracy.
- E. Finalize the data table based on the review of the draft.

**Task 4:** Review prior recommendations from the Health Care Review Commission, TLRC, prior consultant reports, commissioner directives, and current and prior Levy agency contracts.

**Task 5:** Review and analyze strategic plans.

**Task 6:** Determine systems in place for receipt of Levy dollars and usage for intended purposes. Specific questions include:

- How do the programs inform clients of the resources available to them through the Levy?
- How are the programs enrolling eligible individuals into health care programs?
- Number of applicants for Levy programs received?
- Number of applications approved or denied?
- Approval/application process?

**Task 7:** Determine if Levy requirements and recommendations are being or have been followed or implemented.

**Task 8:** Determine if the most recent Levy resulted in over- or under-funding of services. If over-funded, what happened with excess funding?

**Task 9:** Provide a comprehensive financial analysis, including total taxpayer support for hospital medical indigent care. Specific questions include:

- What is the total amount of charity care provided by the Hospitals?
- What are the Hospital's actual costs to provide services under the Levy?
- How do the Hospitals calculate their charity care costs?
- What percentage of the Hospital's total costs relates to charity care and services provided under the Levy?
- When charity care is provided, what rates are the patients charged relative to insured patients?
- What other subsidies are available to the Hospitals?

**Task 10:** Review all hospital medical indigent care Levy requests at different funding levels as determined by the TLRC during the review process.

**Task 11:** Provide recommendations for tax Levy potential cost savings, revenue enhancements, and organization or program improvements for hospital medical indigent care assuming successful passage of the proposed tax Levy.

**Task 12:** Based on the results of Tasks 1-11, make recommendations for future contractual conditions or requirements for the Hospitals and inmate indigent medical care upon passage of the Levy.

## Section 2 - Recent History and Overview of Current Levy

The current Levy was approved by the voters in November 2014 for the three-year period ending December 31, 2017. Under this Levy, the County allocated \$14.9 million per year for UCMC and an annual average of \$5 million per year for CCHMC.

The following is a history of the actual and projected expenditures from the Levy for the last three-year period. Also, the schedule shows the annual average expenditures for the preceding two Levy periods<sup>1</sup>.

**Table 1 - Payments from Levy Proceeds based on Payment Date, 2007-2017 (thousands of dollars)**

	Annual average 2007-2011	Annual average 2012-2014	Actual 2015	Actual 2016	Projected 2017
University of Cincinnati Medical Center	\$25,480	\$21,027	\$16,000	\$14,900	\$14,900
Children's Hospital Medical Center	\$5,880	\$5,200	\$5,200	\$4,700	\$4,700
<b>Total direct payments to Hospitals</b>	<b>\$31,360</b>	<b>\$24,993</b>	<b>\$21,200</b>	<b>\$19,600</b>	<b>\$19,600</b>
Other indigent care programs	\$16,609	\$15,706	\$19,201	\$20,788	\$21,206
Administration, Auditor and Treasurer Fees	\$778	\$876	\$636	\$780	\$896
<b>Grand total</b>	<b>\$48,747</b>	<b>\$41,576</b>	<b>\$41,037</b>	<b>\$41,168</b>	<b>\$41,702</b>

The above table reflects payments by the date the payment was made, not the fiscal year that the payments apply to. The following shows the Hospital payments based on Levy year:

**Table 2 – Hospital Payments from Levy Proceeds based on Levy Year, 2007-2017 (thousands of dollars)**

	Annual average 2007-2011
University of Cincinnati Medical Center:	
Base payments	\$26,000
Additional distribution of fund balance	\$0
Total UCMC	\$26,000
Children's Hospital Medical Center	\$6,000
<b>Total direct payments to Hospitals</b>	<b>\$32,000</b>

In 2014 the BOCC approved a revision to the initial allocation for UCMC whereby the fixed allocation would be reduced by \$6.0 million and the County would make an additional distribution to UCMC based on the remaining uncommitted funds in the Levy fund at the end of the current Levy cycle. In total, \$4.8 million of remainder funding was paid to UCMC — \$3.7 million in 2014 and \$1.1 million in 2015.

When the Levy was last up for renewal in 2014, there were several considerations made in the consultant's report and several recommendations were made in a report to the Commissioners from a subcommittee of the TLRC that was formed to review the hospital portion of the Levy. These

<sup>1</sup> From Indigent Care Levy Plan reports provided by Hamilton County Budget and Strategic Initiatives Department.

considerations and recommendations are summarized below along with comments about the disposition of each item.

### **Considerations from the Consultant's Final Report dated May 23, 2014<sup>2</sup>**

#### **1) UCMC is likely to continue to rely on Levy funds to sustain reasonable operating results.**

The Levy represents an important source of revenue for UCMC, and eliminating it could have adverse consequences. Historically, UCMC has provided significantly more uncompensated care than any other hospital in the region, and the Levy payments comprised a material portion of the organization's operating margin. However, in recent years the Hospital has made improvements in its financial performance, and the ACA is expected to produce a favorable net financial gain. Accordingly, the annual funding level could be reduced from the \$21 million annual level anticipated at the beginning of the Levy period to the current \$15 million level as per the 2014 Levy funding modification.

Disposition: This recommendation for 2015-2017 was followed.

#### **2) CCHMC may not meet the Annual Services test based on the current Levy.**

Under the Levy contract, the primary obligation of the Hospitals is to provide uncompensated care to Hamilton County's medically indigent population (referred to in the contract as "Services"). Each year, the annual cost of Services must exceed the amount paid to the Hospital from the Levy. In 2013, CCHMC had Services cost of \$5.7 million compared to \$5.2 million of Levy payments. There is a possibility that in future years, ACA coverage expansion may result in CCHMC's not meeting this critical requirement at the current Levy payment level.

There are three possible options to address this potential concern. First, if the Hospital is paid more than the Services cost it delivers, the Hospital could be required to refund the difference or apply the overage against future Levy payments. Second, the County could anticipate a reduction in Services and prospectively reduce payments to CCHMC. Third, the County could identify other services that CCHMC can provide.

Disposition: In the most recent contract, the definition of Services was modified to include the cost of uncompensated care provided by CCHMC employed physicians. This change increases the Services amount and, accordingly, increases the likelihood that the annual test will be met.

#### **3) The County should work with the Hospitals to ensure all provisions of the contract are met.**

There are six instances for UCMC and two instances for CCHMC where information called for in the contract was not supplied by the Hospitals to the County. The Hospitals indicated that the County did not request this information, and in one instance the Hospital is seeking additional guidance from the County to define the information to be supplied. The County should resolve each of these outstanding areas prior to the expiration of the current contract in December 2014. In future years, the parties should work to ensure that all provisions in the contract are relevant to the Levy.

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<sup>2</sup> Health Management Associates, "Review of Hamilton County, Ohio Indigent Care Levy: Hospital Services" dated May 23, 2014.

Disposition: This recommendation was adopted.

**4) Modify or eliminate the Net Community Benefits test.**

The Net Community Benefit test, whereby each Hospital is required to demonstrate that it is providing a quantifiable community benefit exceeding a stated threshold, is not a meaningful test in its current state because the threshold is set at a level that is too low. In 2013, UCMC and CCHMC reported community benefits that exceed the threshold by 12 times and 40 times, respectively. Rather than requiring a financial test that neither Hospital will have difficulty meeting, the County may consider changing the test to ensure an ongoing commitment to the community. For example, the contract could stipulate that net community benefit for the next three years be at least equal to 80% of the net community benefit from the most recent three years. This test would allow for some fluctuation in the numbers while establishing a more meaningful target.

Disposition: This recommendation was not adopted.

**5) Consider a three-year or four-year commitment to the Hospitals.**

The current Levy cycle was shortened from five years to three years, in large part because of uncertainty about the ACA. While the ACA has now been in place for four years, there is still considerable uncertainty about its effects. For example, the key coverage provisions for individuals and the mandate to obtain insurance became effective on January 1, 2014, and it will be at least two to three more years after that time before the changes and shifts in coverage stabilize. Also, certain key provisions for businesses were delayed until 2015.

The ACA is only one, albeit a very important, component of health care reform. Profound changes are occurring in all aspects of the health care delivery system, and as the County considers new strategies, it may benefit from having more flexibility than what the Hospital Indigent Care Levy has historically allowed.

Accordingly, the BOCC should consider a three- or four-year Levy period, or if longer, limiting the commitment to the Hospitals to three or four years.

Disposition: The new Levy period was established at three years.

**6) Consider using the Levy commitment to stimulate additional collaboration with the Hospitals to help achieve the County's goals for health improvement.**

Since their inception, the Levy payments have been in the form of a passive grant with certain contractual conditions. Based on review of the Community Health Needs Assessment (CHNA) completed by each organization, there is clearly an interest by both Hospitals in partnering with the County to achieve improvements in the health of its residents. There are several potential health needs that could be targeted, including improving access to and use of primary care, reducing infant mortality and obesity, and increasing healthy behaviors. Both Hospitals have active efforts underway to address the goals of their individual CHNAs, but there could be synergies from greater coordination between the organizations, and perhaps greater collaboration with other key stakeholders.

Disposition: This consideration was not adopted.

**7) Investigate opportunities to leverage Medicaid funding in lieu of direct payments to hospitals.**

Medicaid programs are jointly financed by the state and federal governments. In Ohio, every dollar of Medicaid spending consists of 37% state funding and 63% federal funding. The state share of Medicaid expenditures may be financed by a technique called intergovernmental transfer (IGT) whereby a local unit of government would transfer funding to the state to serve as the state share of the Medicaid payment. Redirection of Hamilton County funding could leverage critical federal funding thereby creating flexibility for the County.

Disposition: This recommendation was discussed with State of Ohio officials but not pursued.

**Recommendations from the TLRC Hospital Subcommittee Dated July 7, 2014<sup>3</sup>**

**Recommendation 1:** The Levy should be put on the November 2011 ballot.

Disposition: This recommendation was followed.

**Recommendation 2:** The Levy term should be three years (2015-2017) to allow the TLRC and BOCC to better assess the results of the transformation of healthcare financing.

Disposition: This recommendation was followed.

**Recommendation 3:** UCMC should be funded in the Levy at approximately \$13.5 million per year.

Disposition: The final Levy plan called for \$14.9 million of annual UCMC funding.

**Recommendation 4:** CCHMC should be funded in the Levy at approximately \$5 million per year.

Disposition: The final Levy plan called for CCHMC funding at an annual average of \$4.9 million.

**Recommendation 5:** In response to the consultant's report findings that CCHMC may be at risk for not meeting the annual services test, the test should be modified to include uncompensated care provided by CCHMC employed physicians.

Disposition: The recommendation is followed in the current contract.

**Recommendation 6:** In response to the consultant's report recommendation to consider using Levy resources to leverage additional Medicaid payments (referred to as "Medicaid Maximization"), the TLRC subcommittee met with State of Ohio and County officials to review the possibility. The review resulted in the conclusion that the idea may not be possible in the current regulatory environment and should not be pursued.

Disposition: No such Medicaid strategies have been pursued.

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<sup>3</sup> Report issued to the Hamilton County Board of Commissioners by the Tax Levy Review Commission, subcommittee formed to review the hospital funding portion of the Levy, dated July 7, 2014, "2014 Health and Hospitalization Levy Review - Hospitals".

**Recommendation 7:** To better evaluate the cost effectiveness of Levy spending and the impact of services to the indigent population, the County should work with the providers to develop enhanced reporting covering four broad areas – cost of indigent care, payer mix of County residents, overall County healthcare metrics, and health outcomes.

Disposition: The recommendation was not adopted.

HMA was informed by County staff that there have been no other reports of the TLRC or its subcommittees, prior consultants' reports, commissioner directives, or contracts other than as discussed in the preceding pages that are relevant to the Hospital portion of the Levy.

## Section 3 - Current Environment and Background

### Uncompensated Care in General

Hospitals in Ohio shoulder a large financial burden resulting from their responsibilities to provide free care and care that is reimbursed at below-cost rates. As of December 31, 2015, an estimated 746,000 residents had no insurance,<sup>4</sup> and as of December 31, 2016, there were 2,971,000 million enrolled in Medicaid.<sup>5</sup> Hospitals receive minimal payment for services provided to uninsured individuals, and the average hospital receives Medicaid reimbursement that is below cost. The most recent survey from the Ohio Hospital Association (OHA)<sup>6</sup> reports that in 2014, Ohio hospitals provided \$0.8 billion of charity care (at cost) and had \$1.3 billion of Medicaid losses.

Sources of funding to offset these losses vary from hospital to hospital but can be summarized into four categories:

- 1) **Disproportionate share (DSH) payments from Medicaid and Medicare.** Ohio Medicaid operates a DSH program called the Hospital Care Assurance Program (HCAP), which generates net payments of approximately \$374 million annually to Ohio hospitals. Additionally, Medicare has a DSH payment available to hospitals serving relatively high levels of low-income patients. The OHA estimates that Ohio hospitals received \$296 million annually in Medicare DSH.
- 2) **Charitable fundraising.** As most are tax-exempt charities and are often highly regarded in their communities, hospitals can generate significant amounts from gifts and donations. However, the more material gifts are often earmarked for capital investment and research and are not as frequently available to cover operating losses.
- 3) **Generating margins from private insurance.** Most hospitals incur losses in treating Medicaid patients and the uninsured; a growing number also lose money under Medicare. Typically, well over half of a hospital's patient care is provided at a loss. Hospitals are therefore required to

<sup>4</sup> From Source: U.S. Census Bureau, 2015 American Community Survey

<sup>5</sup> From [www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data](http://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data)

<sup>6</sup> Figures derived from "Community Benefit Report 2016" published by the Ohio Hospital Association, <https://ohiohospitals.org/Policy-Advocacy/Finance-Policy/Community-Benefit-Report.aspx>

offset these losses by generating gains from private insurance. This is sometimes referred to as the “cost shift.” A study from the American Hospital Association reveals that in 2014, hospital payments from private insurance averaged 144% of cost (while payments averaged 90% of cost for Medicaid).<sup>7</sup>

- 4) **Local government support.** As noted in the Comparative Review section of this report, Hamilton County is in the minority of local government units that provide direct financial support to hospitals. However, there are many county-owned and city-owned hospitals across the country, which may have losses absorbed by the larger governmental unit.

## Ohio Medicaid

Medicaid is a government insurance program for persons whose income and resources are insufficient to pay for health care. Medicaid is the largest payer in the U.S., covering more than 70 million people. It is a means-tested program that is jointly funded by the state and federal governments and managed by the states, with each state having broad leeway to determine eligibility and benefits. Medicaid recipients must be U.S. citizens or legal permanent residents and may include low-income adults, their children, and people with certain disabilities.

Most Medicaid expenditures are financed by the federal government. Federal financial participation is generally based on a fixed match rate that varies by state. In Ohio, the federal match rate is currently 62.3% for traditional Medicaid and 95% for the newly eligible population covered through Medicaid Expansion. The state is responsible for funding the remainder of the costs and may utilize transfers from local government units and provider assessments, fees, and taxes to finance a portion of the state’s share.

Ohio Medicaid reimburses hospitals for a full range of inpatient and outpatient covered services. Inpatient services are reimbursed using Diagnostic Related Groups (DRGs), a mechanism that establishes a prospective payment that varies based on the principal reason for the hospital admission. In addition to the DRG amount, teaching hospitals receive an add-on for medical education costs, and all hospitals receive a capital payment based on actual capital costs incurred. Outpatient services are reimbursed using a combination of fee schedules and cost ratios applied to hospital charges. Managed care plans may follow the same reimbursement formulas as the state, although managed care plans and hospitals are free to negotiate alternative payment terms.

Ohio Medicaid has adopted two supplemental pools to provide hospitals with additional reimbursement. One pool is referred to as the Upper Payment Limit (UPL) pool, which refers to federal regulations that limit the total Medicaid payments that a class of providers can receive. The second pool is the Hospital Care Assurance Program (HCAP), Ohio Medicaid’s DSH program as discussed below. Also, the state plan calls for an additional amount referred to as the Managed Care Incentive that is distributed to hospitals by the contracted managed care plans instead of the state.

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<sup>7</sup> American Hospital Association, “Trendwatch Chartbook 2016, Supplementary Data Tables, Trends in Hospital Financing”

To cover the state share of the UPL pool and Managed Care incentive and to provide the state with additional revenues to fund the Medicaid program, hospitals are required to pay a Franchise Fee. This fee is assessed on all hospitals based on expenses and will provide nearly \$600 million revenue to the state in FY 2017. Along with the federal match, the franchise fee generates additional funding for Ohio Medicaid, including funds for the UPL pool and Managed Care incentive.

### Medicaid Transformation Initiatives

For the last seven years, Ohio has focused on modernizing its Medicaid program, adopting several strategies intended to improve health outcomes, improve care coordination and reduce the rate of cost increase. In 2011, the Governor's Office of Health Transformation was established to lead many of the reforms. There are several initiatives being implemented or planned; some of the important initiatives involving UCMC and CCHMC and hospitals in general are summarized below:

- In December 2014, Ohio was awarded a federal State Innovation Model (SIM) test grant to implement several reform initiatives including:
  - A comprehensive primary care payment model that increases access to patient-centered medical homes (PCMH) statewide. PCMH is a team-based care delivery model led by a primary care provider who comprehensively manages a patient's health needs with an emphasis on health care value and quality. The program is a multi-payer initiative. In 2017 the plan is to launch the program with Medicaid across all fee-for-service and all managed care plans. Four commercial payers have been heavily involved in the design of the program and have committed to launching CPC programs by 2018. The aim is to expand across all payers in the next five years.
  - An episode-based payment model. An episode payment is a single price for all services needed by a patient for an entire episode of care. The goal is to reduce the incentive to overuse unnecessary services within each episode. All services, across all providers, for all payers for specific episodes, such as Total Joint Replacement, are tracked and an episode cost is calculated. Each type of episode designates a Principal Accountable Provider (PAP) that receives a report at the end of each year indicating the average cost per episode. Eventually, efficient PAPs will gain-share with the managed care plans. It has not been determined if inefficient PAPs will be penalized. Ohio is currently in Wave Three of the project. Wave one identified six types of episodes, Wave Two added another seven, and Waive Three has 35 more, including behavioral health episodes.
- Integrating care for persons with both Medicare and Medicaid. Historically, most medical benefits available to this population have been managed by Medicare, and most long-term care services have been managed by Medicaid. This program, called *MyCare*, is intended to coordinated care across the full continuum of services.
- Other focus areas include investing in the state's community behavioral health system, implementing a managed care long-term services and supports program, and increasing support for home- and community-based services.

### Medicaid Budget Reductions and Hospital Financial Performance

In the last three biannual budget cycles, the state administration and legislature have adopted several changes that reduce Ohio Medicaid hospital reimbursement. Additional Medicaid hospital payment reductions are included in the Executive budget proposal for the 2018-2019 budget cycle, which are even more significant than the cuts enacted in previous years. The 2018-2019 budget is being deliberated in the state legislature and will not be completed until June 2017. It is not known whether the executive recommendations for hospital reductions will be in the enacted budget, but UCMC and CCHMC management anticipate that at least some of the hospital reductions will be included.

Following is a summary of estimated annual and cumulative changes in hospital payments from the preceding six years and as proposed by the Administration for 2018-2019:<sup>8</sup>

**Table 3 – Estimated annual reductions in hospital Medicaid payments, 2012-2019**

in Millions	Annual Impact	Cumulative
<b>SFY 2012</b>	\$141	\$141
<b>SFY 2013</b>	\$141	\$282
<b>SFY 2014</b>	\$99	\$381
<b>SFY 2015</b>	\$107	\$488
<b>SFY 2016</b>	\$97	\$585
<b>SFY 2017</b>	\$107	\$692
<b>SFY 2018 (proposed)</b>	\$163	\$855
<b>SFY 2019 (proposed)</b>	\$263	\$1,117

The foregoing table attempts to isolate the reductions associated with changes in hospital reimbursement policy and does not consider the effects on hospital payments of changes in Medicaid enrollment or enrollee utilization of services. If the Administration's 2018-2019 budget proposals are adopted, by the end of FY 2019 hospital payments will be approximately \$1.1 billion lower than they would have been absent these changes in reimbursement policy.

In 2015, the Ohio Hospital Association estimated that on average, Ohio hospitals were reimbursed by Medicaid 81% of cost before consideration of supplemental payments and 92% of cost with supplemental payments and net of provider assessments and fees. The latter is slightly better than the national average of 90% of cost. However, if the 2018-2019 budget proposals are adopted, Ohio Medicaid payments to hospitals will be below the national average in relation to hospital cost.

### HCAP program

All states are required to make DSH payments to hospitals, although there is a great deal of flexibility in the federal requirements and, consequently, a great deal of variation from one state to another. Ohio's program is referred to as Hospital Care Assurance Program or HCAP.

<sup>8</sup> Provided to HMA by the Ohio Hospital Association.

Ohio has coupled its DSH program with a state law that requires all hospitals to provide free care for medically necessary services to persons who are at or below the federal poverty level (FPL) and who are ineligible for Medicaid. Hospitals must have a process to screen patients for eligibility, and when the patient is eligible, the care is provided at no charge.

It is important to note, that hospitals are *not directly reimbursed* for HCAP uncompensated care. Instead, Ohio Medicaid has financial models in place to generate and distribute several pools of funds. The amount of HCAP uncompensated care is a key determinant of how much a given hospital receives from these funds, but it is not the only factor.

The reimbursement model starts with a calculation of the hospital assessment (essentially a tax). The assessment is based on each hospital's costs as reported in their Medicare cost report. There are two assessment rates. In FY 2017 a rate of 1.5% on the first \$216 million of a hospital's cost and a rate of 1.0% applied to hospital costs greater than \$216 million.

Once the assessment is calculated and totaled across all hospitals, the state determines the total amount of HCAP payments. The hospital assessment is used by the state for the state/local share, and the federal match is added to derive total HCAP payments. For example, in 2016 the amounts were as follows:

Total hospital assessment	\$231,000,000
Federal match	<u>\$382,000,000</u>
HCAP funds	\$613,000,000

Under federal law, each hospital's DSH (HCAP) payment is limited. Referred to as the DSH Limit or OBRA Cap, the limitation is the hospital's Medicaid shortfall (cost less payments) plus the cost of uncompensated care provided to uninsured patients.

The HCAP funds are divided into seven different pools and each pool is distributed to hospitals that are eligible for the given pool. The two largest pools in FY 2016 are described as follows:

*High Medicaid pool:* 12% of HCAP funds are placed in a pool for hospitals with a very high percentage of patients that have Medicaid eligibility, and the money is distributed to these hospitals based on their share of Medicaid costs. In 2016, only 14 Ohio hospitals, including UCMC and CCHMC, were eligible to receive a share of this pool.

*DSH Limit pool:* 72% of HCAP funds are placed in a pool for all hospitals with DSH Limits greater than zero, and the money is distributed to these hospitals based on their share of statewide remaining DSH limit. Most Ohio hospitals have DSH limits greater than zero and receive payments from this pool.

The other pools are used primarily to make additional payments for children's hospitals (including CCHMC), critical access hospitals, rural hospitals, and uncompensated care for persons below 100% of poverty.

As implied by the term disproportionate share, hospitals with the highest proportion of Medicaid and uninsured care receive the largest HCAP payments and the largest HCAP net gains (payments less assessment). In contrast, hospitals with low Medicaid and uninsured patient volume may have HCAP losses, where the payment is less than the assessment. In 2016, 56 hospitals or one in four had HCAP losses.

## Requirements of Tax-Exempt Hospitals

Over half of U.S. hospitals are tax-exempt. Under Section 501(c)(3) of the Internal Revenue Code, hospitals may qualify for tax-exempt status if they meet certain federal requirements. The value of hospitals' tax-exempt status in terms of federal, state, and local taxes that would otherwise be due, coupled with the ability to raise funds through charitable contributions, is estimated to exceed \$20 billion annually.

For decades, the requirements of tax-exemption at the federal level were set forth in a vague community benefit standard. The general guidelines for hospitals to meet the charitable-purpose requirement for tax-exempt status were: (1) the hospital must be organized to serve the sick; (2) it must serve those who can pay little or nothing toward their care; (3) use of the facilities may not be restricted to any group of doctors; and (4) no net earnings may inure to the benefit of any individual.

In recent years, nonprofit hospitals have come under increasing public, congressional, and IRS scrutiny. Several congressional inquiries and more than 45 class-action lawsuits have challenged hospital tax-exemption. These inquiries and lawsuits have highlighted the vagaries of the community benefit standard, bringing into focus the need for comprehensive definitions and measurements of hospital charitable purposes.

In response, the Affordable Care Act (ACA) included provisions that require the IRS to develop a new section of the Internal Revenue Code, Section 501(r), which imposes additional requirements and standards for tax-exempt hospitals. A summary of Section 501(r) provisions is as follows.

- A. **Needs Assessment:** At least once every three years, a hospital must conduct a community health needs assessment and make the assessment available to the public. Each assessment must consider input from a broad range of interests, including the communities served by the hospital and individuals with public health expertise. An assessment may be based on current information collected by public health agencies or non-profit organizations and may be conducted together with one or more organizations, including related organizations.
- B. **Financial Assistance:** There are new financial assistance rules that include a financial assistance element and an access element. The financial assistance element requires each hospital to implement and publicize a written financial assistance policy. The policy must specify eligibility criteria, whether free or discounted care is available, and how the hospital calculates the amounts billed to patients. The financial assistance policy, or separate billing and collections policies, must also describe how to apply for assistance and the actions the hospital takes in the

event of non-payment. The access element requires each hospital with an emergency room to provide emergency medical care to all individuals, regardless of their ability to pay.

- C. **Patient Charges:** Tax-exempt hospitals are required to limit their charges for emergency or other medically necessary care provided to those who qualify under their financial assistance policy to no more than the amounts charged to insured patients. The amounts billed to individuals who qualify for financial assistance may be based on either the best or an average of the three best negotiated commercial rates or Medicare rates.
- D. **Collections Practices:** A tax-exempt hospital can no longer take “extraordinary” collection actions before making a reasonable effort to determine whether a patient is eligible under its financial assistance policy. Applicable legislative history indicates that extraordinary collection actions include lawsuits, liens on residences, arrests, and other similar collection processes.

Additionally, a redesigned Form 990 Schedule H was launched several years ago that requires submission of information regarding charity care, community benefits, community activities, bad debts, collection practices, community-building activities, and a health needs assessment. This form enables the federal government to collect a wide array of data about tax-exempt hospitals, which will inform the debate about the future of tax-exemption for hospitals.

### Catholic Hospital Association Community Benefit Standards

Measuring and reporting community benefits is an important activity for hospitals and the topic of one of the Hospital Levy requirements. The Catholic Hospital Association (CHA) publishes a set of recommendations for measuring community benefit that has become an industry standard and is referenced in the agreement between the hospitals and the County.<sup>9</sup> The CHA guidelines state that the following should be included in the measurement of community benefit:

- **Financial Assistance:** Free or discounted health services provided to persons who cannot afford to pay and who meet the eligibility criteria of the organization’s financial assistance policy. Financial assistance is reported in terms of costs, not charges. Financial assistance does not include bad debt.
- **Government-sponsored means-tested health care:** Community benefit includes unpaid costs of public programs for low-income persons – the shortfall created when a facility receives payments that are less than the cost of caring for public program beneficiaries. *Count:* Medicaid, CHIP and other programs for low-income or medically indigent person. *Do not count:* Medicare, Veterans Administration, and other government programs that are not means tested.
- **Community Health Improvement Services:** This category includes activities that are carried out to improve community health and do not generate patient care bills. Examples are health

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<sup>9</sup> Information is derived from reports published by the Catholic Hospital Association of the United States. See [www.chausa.org/communitybenefit/](http://www.chausa.org/communitybenefit/).

education, free screenings for underinsured and uninsured, support groups and self-help programs.

- **Health Professions Education:** This category includes educational programs for physicians, interns and residents, medical students, nurses and nursing students, pastoral care trainees, and other health professionals when that education is necessary for a degree, certificate, or training that is required by state law, accrediting body, or health profession society. Count the full cost of these programs, offset by subsidies, reimbursement and tuition.
- **Subsidized Health Services:** Subsidized health services are clinical programs that meet a community need and are provided despite a financial loss so significant that negative margins remain after removing the effects of financial assistance, bad debt, and Medicaid shortfalls. If the service were no longer offered by the hospital, it would either be unavailable in the area or fall to the responsibility of government or another not-for-profit organization to provide.
- **Research:** Research that may be reported as community benefit includes clinical and community health research, as well as studies on health care delivery that are generalizable, shared with the public, and funded by the government or a tax-exempt entity (including the organization itself). Do not count research where findings are used only internally or are proprietary. Count the total cost of the qualifying research programs, including direct and indirect costs.
- **Cash and In-Kind Contributions:** This category includes funds and in-kind services donated to community organizations or to the community at large. In-kind services include hours contributed by staff to the community while on health care organization work time, meeting space provide to community groups, and donations of food, equipment, and supplies.
- **Community-Building Activities:** These activities improve the community's health and safety by addressing the root causes of health problems, such as poverty, homelessness, and environmental hazards. They strengthen the community's capacity to promote the health and well-being of its residents by offering the expertise and resources of the organization.

## Affordable Care Act

The Patient Protection and Affordable Care Act, commonly called the Affordable Care Act (ACA), is a federal statute signed into law on March 23, 2010. It represents the most significant regulatory overhaul of the U.S. healthcare system since the passage of Medicare and Medicaid in 1965.

**Insurance Reform and Coverage:** Most importantly and most relevant to this report, the ACA creates new federal programs and requirements for health insurance. Significant insurance coverage reforms, many of which took effect on or before January 1, 2014, include the following:

- Medicaid eligibility is expanded to cover individuals and families with incomes up to 138% of the federal poverty level, including adults without disabilities and without dependent children. A 2012 Supreme Court decision made expansion optional, and Ohio opted to adopt the Medicaid

expansion. The level of federal financial participation is significantly higher for the newly-eligible enrollees: 100% through 2016, reduced to 90% by 2020.

- Health insurance Exchanges are established in each state as a new avenue by which individuals and small businesses can compare policies and buy insurance. Individuals and families whose incomes are below 400% of the federal poverty level receive federal subsidies if they purchase insurance via an Exchange. The size of the federal subsidy is calculated on a sliding scale based on household income.
- An individual mandate requires all individuals not covered by an employer sponsored health plan, Medicaid, Medicare, or other public insurance programs to secure an approved private-insurance policy or pay a penalty, with some exceptions.
- Guaranteed issue prohibits insurers from denying coverage to individuals with pre-existing conditions, and a partial community rating requirement limits rate variation based on age to a 3:1 ratio and prohibits variation based on gender or pre-existing conditions.
- Minimum standards for health insurance policies are established. Each plan must provide coverage for defined “essential benefits,” and cost-sharing limits are established.
- Businesses which employ 50 or more people but do not offer health insurance to their full-time employees will pay a tax penalty if the government has subsidized a full-time employee's healthcare through tax deductions or other means. This is commonly known as the employer mandate.

The ACA addresses many aspects of the health care delivery system other than insurance and coverage.

**Key Delivery System Reforms:** The law adopts several key delivery system reforms to better align provider incentives to improve care coordination and quality and reduce costs. These reforms include a value-based purchasing system for hospitals; voluntary pilot projects to test bundled Medicare payments; voluntary pilot programs where providers can form Accountable Care Organizations and share in Medicare cost savings; and financial penalties for hospitals with “excessive” readmissions and hospital-acquired complications. In addition, the law creates a Center for Medicare and Medicaid Innovation to test innovative payment and service delivery models.

**Wellness and Prevention:** The law invests resources in prevention and wellness. It requires public and private insurers to cover recommended preventive services, immunizations, and other screenings with no co-payment or deductible. It also initiates policies to encourage wellness in schools, workplaces, and communities and takes steps to modernize the public health care system.

**Regulatory Oversight and Program Integrity:** The law includes a significant number of provisions to reduce waste, fraud, and abuse in the Medicare and Medicaid programs. These include extending the Recovery Audit Contractor (RAC) program to Medicare Parts C and D and Medicaid and implementing

additional policies to enhance program integrity in Medicaid. Several new reporting requirements are imposed on tax-exempt hospitals as discussed above.

**Medicare and Medicaid Payment Changes:** The law takes several steps to reduce the rate of increase in Medicare and Medicaid spending. Hospitals are projected to contribute \$155 billion in savings over 10 years through reduced payment updates, decreases in Medicare and Medicaid disproportionate share hospital payments, and financial penalties.

**Revenue Provisions:** In addition to Medicare and Medicaid provider payment reductions, the new law is financed by taxing high-premium health insurance plans, raising the Medicare tax for high-income individuals, and imposing annual fees on the pharmaceutical, medical device, clinical laboratory, and health insurance industries.

The ACA has succeeded in reducing the number of uninsured Americans, introduced many well-received insurance reforms, and spurred investment in several delivery system improvements. However, the ACA has been criticized for its shortcomings, perhaps the most significant of which is failure to make health care more affordable for many people. The ACA marketplace Exchanges and Medicaid expansion make health coverage a good deal for those near the poverty line, but many of those who do not qualify for the largest subsidies struggle to pay health plan premiums and high deductibles. In the last two years, premium increases have been much larger than expected in many states, many health plans have curtailed or eliminated their participation in marketplace exchanges, and there is a great deal of uncertainty in many regional insurance markets.

The ACA faces an uncertain future. Beyond the economic realities, the ACA is the target of intense partisan politics and an ongoing national debate about the role of government in health care. The new President and many members of Congress have vowed to repeal a significant portion of the law. In early May 2017, a bill called the American Health Care Act (AHCA) was passed by the House that would cut the subsidies for many individuals purchasing coverage through the Insurance Exchanges and would over time reduce the federal funding for Medicaid. The Senate has begun working on its version of ACA reform. It is not known whether the Senate will pass, modify or reject the AHCA. The implications of “repeal and replace” are discussed later in this report.

## Section 4 - Compliance with Current Levy Requirements

HMA reviewed the final agreement between the Hospitals and the County,<sup>10</sup> and for each hospital requirement therein, made inquiries and performed review procedures to ascertain whether the Hospitals comply. Based on the results of our inquiries and other procedures, both Hospitals comply with the contract provisions including each of the primary financial tests called for in the contract, except for the requirement under Section 7c with respect to UCMC.

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<sup>10</sup> “Agreement Regarding Use of Portions of the Hamilton County Health and Hospitalization Tax Levy Proceeds to Support Indigent Care to Hamilton County Residents” dated June 2015.

The following table documents the results of our review.

**Table 4 - Review of Hospital Compliance with the Requirements of the Contract with the County**

Agreement Provision
<p><b>2(a) Services</b> On an annual basis, each Hospital shall render hospital inpatient and outpatient health and hospitalization services (“Services”) to medically indigent Hamilton County residents who are “Eligible Individuals” (as defined in Section 3 of this Agreement) that have a Total Cost (as the term “Total Cost” is defined herein) of at least the amount of the annual payments distributed to the Hospital under this Agreement for that year.</p>
<p><b>2(b) Physician Services and Costs</b>                      Each Hospital has a relationship with the University of Cincinnati’s College of Medicine and is a teaching hospital.                       No physician services which would normally be billed independently (as a professional fee) to a patient shall be included within Services or otherwise reimbursed by the County hereunder.</p>
<p><b>3 Eligible Individuals</b> Hospitals will provide the County with copies of any subsequent amendments to their charity care policies, and agree to secure the County’s approval prior to making any material changes to such policies to the extent such changes will impact this Agreement.</p>
<p><b>4(a) Participation in Medicaid Programs</b> Each Hospital shall continue to provide hospital Services to Medicare and Medicaid patients and shall continue to participate in the Medicare and Medicaid programs.                      Each Hospital will provide the County with an annual report of the Hospital’s Medicare and Medicaid enrollment activities.</p>
<p><b>4(b) Nondiscrimination</b> Each Hospital agrees that, as a condition to this Agreement, it shall not discriminate against any patient based on race, color, sex, religion, natural origin, handicap, or any other factor specified in law.</p>
<p><b>4(c) Compliance with Agreement and Law</b> UC Health and each Hospital shall comply with the terms and conditions of this Agreement and each Hospital shall comply in all material respects with all laws, rules and regulations of any governmental authority applicable to the operation of a hospital.</p>
<p><b>4(d) Accreditations</b> Each Hospital shall maintain all appropriate accreditations, certifications and licensures necessary to render the Services contemplated hereby.</p>
<p><b>4(e) Obligation to Provide Annual Net Community Benefit</b> During each fiscal year of the Hospitals that includes a year within the Term of this Agreement, UCMC shall provide a “Net Community Benefit” of \$12,200,000 and CCHMC shall provide a “Net Community Benefit” of \$4,000,000.</p>
<p><b>4(f) Consultation Concerning Coordinated Medical Care</b> In furtherance of the parties’ shared objective of cost-effective coordinated care for residents of County institutions, at the request of the County, the Hospitals will be consistent with their past practices, continue to consult with representatives of the County concerning the most appropriate way to coordinate medical care among the providers of primary or non-acute care and the Hospitals.</p>
<p><b>4(g) Emergency Room Diversion</b> In furtherance of the parties’ shared objectives of emphasizing primary care, UC Health and the Hospitals agree to devote the resources necessary to enhance access to such primary care through including but not limited to increased capacity to see patients, coordination with medical homes and outreach to Federal Qualified Health Centers.</p>
<p><b>4(h) Center for Respite Care</b> UCMC will provide the Center for Respite Care with not less than \$150,000 annually during the term of this agreement for the provision of homeless medical care.</p>
<p><b>6 Annual Performance Data</b> The Hospitals are to submit Performance Data annually, based on written instructions provided by the County, that shall include at least (a) the number of Eligible Individuals who received treatment at the Hospital during the fiscal year; (b) the total number of visits to the Hospital by Eligible Individuals during the fiscal year; and (c) the total Cost of care furnished by the Hospital to Eligible Individuals during the fiscal year.</p>
<p><b>7(a) Reporting Requirements</b> A copy of its final data for the prior fiscal year submitted to HCAP contemporaneously with its submission to HCAP</p>

Agreement Provision	
<b>7(b) Reporting Requirements</b>	A copy of its audited financial statements for the Hospital's previous fiscal year end, which in the case of UCMC will also consist of supplemental schedules (Revenue and Expense only) to the audited financial statements of UC Health
<b>7(c) Reporting Requirements</b>	A copy of each Hospital's Community Benefit report including, if it is not a part of such report, the aggregate Community Benefit, principal components thereof, and full calculations of each component as determined in accordance with the CHA standards.
<b>7(e) Reporting Requirements</b>	A report of the Hospital's efforts in enrolling patients in the Medicare and Medicaid programs
<b>7(f) Reporting Requirements</b>	An annual certification from each Hospital by January 2 following any fiscal year that Tax Levy funds are distributed, that such Hospital complied with Section 2 above
<b>7(g) Reporting Requirements</b>	A copy of each Hospital's IRS Form 990 (Return of Organization Exempt for Income Tax) Schedule H (Hospitals) for years filed during the term of this Agreement within 30 days of filing such returns
<b>11 Insurance/Self-Insurance</b>	Each Hospital shall procure and maintain for the duration of this Agreement several types of insurance (as listed in the agreement) at specified minimal limits and coverage through commercial insurance or a financially sound program of commercial insurance and self-retention.
<b>14(b) Abortion Related Procedures</b>	Tax Levy funds shall not be eligible for use, and shall not be used by Hospitals to pay for charges or costs associated with abortions or abortion-related procedures unless necessary to save the life of the mother.

- (1) UC Health wants to ensure that its community benefit data submitted to the County agrees with the amounts included in its IRS 990 return. The due date for the 990 return was extended to May 15, 2017 and, therefore, the community benefit data for FY 2016 was not ready to submit to the County on January 2, as stipulated in the contract. Preliminary data was provided in April, 2017.

## Section 5 - Analysis of Hospital Performance - UCMC

### Background and Overview

UCMC is the largest non-pediatric hospital in Hamilton County and the only non-pediatric academic medical center in the region. It operates 525 beds and in its fiscal year 2016 had 28,476 inpatient discharges, 83,279 emergency department visits, and over 600,000 outpatient registrations. UCMC operates the only Level 1 Adult Trauma Center and the only Adult Burn Center in the region. Several of its clinical programs have received national recognition.

UCMC is the main teaching hospital for University of Cincinnati College of Medicine. Approximately 480 residents and fellows receive training at UCMC. In fact, UCMC was the first teaching hospital in the U.S.

UCMC is a member of UC Health, a nonprofit corporation that owns or controls one other acute care hospital, a post-acute care facility, a 700+ physician organization, and other supporting entities. UC Health's purpose, mission, vision and values are as follows:<sup>11</sup>

#### Purpose

To advance healing and reduce suffering.

<sup>11</sup> From UC Health's website, <http://uchealth.com/about/>

**Mission**

We are committed to advancing medicine and improving the health of all people – regardless of race, ethnicity, geography or ability to pay – by fostering groundbreaking medical research and education, delivering outstanding primary and specialty care services and building a diverse workforce.

**Vision**

To use the power of academic medicine to advance the science of discovery and transform the delivery of care.

**Values**

- Patients and Families First
- Respect
- Integrity
- Inclusion
- Discovery
- Empathy

**Financial Position and Recent Financial Performance**

The table below presents selected information from UC Health’s audited financial statements for the five most recent fiscal years. The financial statements of UCMC are not separately audited, and management did not provide us with UCMC-only information.

**Table 5 - UC Health Financial Information for the Five Years Ended June 30 (dollars in thousands)<sup>12</sup>**

	2012	2013	2014	2015	2016
cash and investments	\$439,954	\$433,719	\$512,153	\$546,640	\$596,707
current assets	\$615,896	\$634,170	\$736,857	\$797,888	\$846,722
total assets	\$1,197,961	\$1,221,343	\$1,363,216	\$1,461,674	\$1,481,942
current liabilities	\$173,174	\$147,555	\$178,533	\$195,229	\$178,756
long-term financing	\$326,891	\$332,193	\$341,296	\$335,845	\$325,470
net assets	\$505,947	\$591,531	\$701,115	\$733,257	\$713,138
total revenue	\$1,155,333	\$1,206,240	\$1,323,295	\$1,459,022	\$1,548,976
total expenses	\$1,122,488	\$1,214,240	\$1,287,353	\$1,407,862	\$1,492,236
operating margin	\$32,845	(\$8,000)	\$35,942	\$51,160	\$56,740
days cash on hand	150	137	152	148	152
current ratio	3.6	4.3	4.1	4.1	4.7
debt to capital ratio	0.39	0.36	0.33	0.31	0.31
operating margin	2.8%	-0.7%	2.7%	3.5%	3.7%
average age of plant (years)	11.1	11.4	11.6	12.9	13.3

<sup>12</sup> All amounts are derived from Audited Consolidated Financial Statements of UC Health for each of the fiscal years ended June 30, 2012 to 2016.

**Financial Position:** From 2012 to 2016, net assets increased by \$207 million. Approximately two-thirds of this increase is from positive operating margins in the most recent three years; income earned on investments accounts for most of the remaining increase in net assets. UC Health has maintained a stable level of Days Cash on Hand (the number of days of average spending the entity's cash reserves will cover) while achieving a 30% improvement in its current ratio (current assets compared to current liabilities), reflecting increased liquidity. The debt-to-capital ratio has decreased significantly. Debt-to-capital ratio reflects the extent to which the entity relies on borrowing – a lower ratio is better. Average age of plant has increased by 20% since 2012, indicating that property and equipment have been depreciating at a faster rate than UC Health has spent on improvements and replacements.

**Operating results:** UC Health's market strategy has been focused on differentiating itself by using its brand name and tertiary and quaternary services to increase referrals and reduce outmigration for high-end services. UC Health is recruiting key specialists and primary care physicians and developing partnerships with area hospitals, enhancing its highly-specialized clinical programs and furthering population health initiatives. These strategies have produced substantial volume growth in the last five years in outpatient services throughout the primary service area and in inpatient cases at the West Chester facility, and higher inpatient case mix at UCMC. Patient revenues increased by an average of 8.3% per year from 2012 to 2016; operating expenses increases by 7.6% per year over the same period.

Operating margins have been on an upward trend and reasonably strong in each of the last several years except for 2013. UC Health experienced a large decline in operating performance in fiscal year 2013 because of costs incurred to implement a system-wide information technology (IT) platform and higher investment in physician recruiting and employment. In 2014-2016, operating margins as a percentage of revenue were 2.7%, 3.5% and 3.7%, respectively.

For the first eight months of fiscal year 2017, UCMC has experienced a sharply lower operating margin, in comparison to the previous fiscal year and the budget. Hospital management identified a decrease in Medicaid supplemental payments and a drop in inpatient admissions as the key factors.

The Levy payments have been an important source of revenue for UC Health, as shown below.

**Table 6 - UC Health Levy Payments and Total Revenues, 2012 to 2016 (thousands of dollars)**

	2012	2013	2014	2015	2016
Levy Payments based on Levy Year	\$21,490	\$20,900	\$19,700	\$14,900	\$14,900
Total Revenues	\$1,155,333	\$1,206,240	\$1,323,295	\$1,459,022	\$1,548,976
Percentage of Levy Payments to Revenues	1.9%	1.7%	1.5%	1.0%	1.0%

Over the last three-year period, UC Health revenue from Levy payments represented 37% of consolidated operation margins. This should not be construed to suggest that UC Health would have made 37% less from operations without Levy revenue, because management interventions are possible to offset or lessen the impact of a change in any revenue source. The analysis underscores UC Health's historical reliance on the Levy funds, although as the Levy payments have decreased over time and operating margins have improved, the extent of reliance on Levy revenues has decreased.

## Financial Assistance Policies

The following excerpts are from the UC Health Charity Care and Financial Assistance Policy in effect as of March 31, 2017.

*UC Health is committed to providing charity care to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay for medically necessary care based on their individual financial situation. Consistent with UC Health's mission, UC Health strives to ensure that the financial capacity of any person in need of health care services does not prevent the person from seeking or receiving care. UC Health will provide, without discrimination, care of emergency medical conditions to individuals regardless of their race, creed, ability to pay, or eligibility for financial assistance or government assistance.*

### **ELIGIBILITY AND APPLICATION PROCESS**

*Eligibility for charity care will be based on a patient's financial need. Financial need will be determined in accordance with procedures that involve an individual assessment of financial need, and may:*

- *Include an application process in which the patient or the patient's guarantor are required to cooperate and supply personal, financial and other information and documentation relevant to determining financial need;*
- *Include the use of external publicly available data sources that provide information on a patient's or a patient's guarantor's ability to pay;*
- *Include reasonable efforts by UC Health or each hospital within the UC Health system to explore appropriate alternative sources of payment and coverage from public and private payment programs, and to assist patients in applying for such programs;*
- *Consider the patient's available income and/or assets and all other financial resources available to the patient; and*
- *Include a review of the patient's outstanding accounts receivable for prior services rendered and the patient's payment history.*

*UC Health disallows actions that discourage individuals from seeking emergency medical care and complies with the Emergency Medical Treatment and Labor Act (EMTALA) as further detailed in UC Health's EMTALA policy. While it is preferred but not required that a request for charity care and a determination of financial need be made prior to rendering of non-emergent medically necessary services, the determination may be made at any point in the collection process. The need for financial assistance shall be re-evaluated at each occurrence of inpatient services and each subsequent time of outpatient services if the last financial evaluation was completed more than ninety (90) days from the last outpatient service, or at any time that additional information relevant to the eligibility of the patient for charity care becomes known. UC Health has adopted the guidelines set forth*

in Ohio Administrative Code 5160-2-07.17 in defining re-evaluation for financial assistance.

**IDENTIFICATION OF PATIENTS WHO MAY BE ELIGIBLE FOR FINANCIAL ASSISTANCE**

UC Health maintains an interdisciplinary team of associates that consists of patient site and Patient Financial Services resources that are trained to help patients and their families with billing, eligibility and payment plans.

Staffed in the Admitting department of each UC Health hospital facility are:

- Registration associates who focus on capturing accurate and up to date demographic information (e.g. home address, telephone contact numbers, place of employment) so that telephone assistance with the collections or financial assistance process (after patient discharge) is made easy. Each Registrar is knowledgeable of financial assistance programs and can refer interested patients to an in-house Financial Counselor. Registrars will request photo ID for proof of identity to protect against identity theft and ensure the application is accurate.
- Financial Counselors who may visit patients and their families on the floors as early in the medical visit as appropriate. By visiting patients while they are in-house, a Financial Counselor can help the patient identify which assistance programs he/she may be eligible for and help start the application process where appropriate. In some cases, the application process can be completed during the patient's stay.

Staffed at the Patient Financial Services office located at 3200 Burnet are:

- Access Unit - who provide pre-registration, insurance verification and pre-service collection of deductibles, copays, and uninsured services.
- Customer Service – who are available to receive patient telephone calls Monday through Thursday from 8:00 AM to 9:00 PM, Friday from 8:00 AM to 4:30 PM. Representatives can answer questions about a patient's bill, accept credit card payments, assist patient in completing a financial assistance application, and set up payment arrangements. Representatives are also available to assist patients in person during normal business hours.
- Program Administration – who, working closely with the Financial Counselor, start the application process and process applications for the state and local financial assistance programs (see Section VII. below).

For general questions, assistance with completing the financial assistance application or to request a free copy of the plain language summary and financial assistance policy, patients may call (513) 585-6200 or (800) 277-0781 during the hours noted above in section 2.b).

**ASSISTANCE IN DETERMINING ELIGIBILITY AND APPLYING FOR MEDICAID AND MEDICARE**

UC Health maintains interdisciplinary teams to assist underinsured and uninsured patients navigate federal and state health insurance programs and help enroll those patients in the

programs for which they are eligible. Included on this team are financial counselors who, in part, assist patients to determine their eligibility and complete the application process.

#### **DISCOUNT AVAILABLE FOR CERTAIN UNINSURED PATIENTS WHO ARE INELIGIBLE FOR MEDICAID**

To be eligible for this discount, UC Health must have determined that the patient satisfies all residency requirements per the state of Ohio Hospital Care Assurance Program (HCAP) guidelines, the patient cooperated in supplying all requested information, the patient is uninsured, and the patient does not have other assets that could be used to pay the hospital bill. In these circumstances, the amount of the discount from the charges will vary depending upon the Federal Poverty Guidelines ("FPG") published yearly by the United States Department of Health and Human Services, in the following manner:

<b>Income</b>	<b>Discount from Charges</b>
Less than or equal to 150% of FPG	100%
Greater than 151%, less than or equal to 200% of FPG	70%

The a plain-language version of the financial assistance policy in both English and Spanish has been provided to nine different community groups, is available to patients at all sites, and is posted on the UC Health website, to help increase awareness in the community and among eligible patients.

#### **BILLING AND COLLECTIONS POLICY**

In addition, UCMC has a separate policy covering patient billing and collection practices. Key provisions of the policy are summarized below:

Uninsured patients able to pay are expected to make payment as early as point of service and no later than 90 days after discharge. Insured patients are expected to make payment within 30 days of receipt of a bill. UC Health recognizes that some patients do not have ability to pay for their healthcare or can only afford to pay a portion of the charges. Consistent with its Charity Care and Financial Assistance Policy, UC Health maintains a team of associates who focus on helping patients secure financial assistance through the state Medicaid program, state and local financial assistance programs or flexible payment plans to resolve their bill in a timely manner. Throughout the patient's experience at UC Health, from registration through collection, options, which are outlined in this policy, are available to the patient.

Patients unable to pay the balance within 30 days are offered interest free monthly payment arrangements within the following guidelines:

<b>Balance</b>	<b>Months</b>
< \$ 500	1 to 6 months
\$ 501 - \$2,500	7 to 12 months
\$2,501 - \$5,000	13 to 18 months
> \$5,001	19 to 24 months

If at any time a patient states they don't have the means to pay, collection agencies will stop collection efforts and provide the patient with a UC Health financial assistance

*application to fill out and return. The patient's account(s) will then be put on hold for 30 days to allow for processing. The UC Health Program Administration department will make the final determination of charity program eligibility, based upon the information that patient submits.*

Based on review of UCMC policies and discussions with Hospital officials, HMA concludes that UCMC has appropriate policies and practices that are consistent with the requirements of the Levy, as well as the Section 501(r) requirements of the ACA.

Our experience suggests that UCMC's financial assistance policies cut off charity care at a lower income level than is typical. Many hospitals offer 100% discounts for income up to 200% or 250% of the federal poverty level (FPL), compared to 150% of FPL at UCMC. Also, while the discount of 70% from standard charges for all uninsured patients is notable, in 2016 the Hospital's costs averaged approximately 24% of standard charges. Therefore, the discounted amounts due from patients exceeds UCMC's cost for many services.

### **Coverage Expansion and Financial Assistance**

Since October 2013, after the State of Ohio approved plans to proceed with the coverage expansion of Medicaid as provided for in the ACA, the Hospital has undertaken additional proactive efforts to assist patients enrolling in Medicaid. In the first year following the decision to expand Medicaid, UCMC undertook an extensive outreach program to identify patients eligible for subsidized insurance and Medicaid coverage. Thousands of potentially eligible persons were contacted with information about the program and offers of enrollment assistance.

Over the last two years, UCMC has maintained a robust but more passive approach to helping the uninsured obtain coverage. As existing and new patients make appointments or present for treatment, financial assistance personnel meet with them about Medicaid and offers of assistance, as has been the practice for years.

The UCMC financial counseling program consist of a total of 30 employees. In addition to the internal staff, UCMC contracts with a third-party vendor to provide additional support for out-of-state Medicaid and overflow volumes. The scope of these efforts includes inpatients, transplants, emergency department, outpatient surgery, infusion services, diagnostics and hospital-based clinics. In addition, UCMC has bilingual staff to meet the needs of the Spanish-speaking community as well as access to interrupters for many more languages. UCMC also leverages software designed to automate Medicaid eligibility screening, which increases the capacity of the staff and improves accuracy.

UCMC provided the following statistics to demonstrate the results of these efforts:

- A 65% approval rate for Medicaid applicants.
- Over 7,000 patient accounts approved for Medicaid in 2014 and 2015, and over 8,000 in 2016. (Note, an individual may have several patient accounts in a year, and therefore the number of individuals enrolled in Medicaid is lower).

## Annual Services Test

The Contract between the County and Hospitals includes Section 2(a), Services:

On an annual basis, each Hospital shall render hospital inpatient and outpatient health and hospitalization services (“Services”) to medically indigent Hamilton County residents who are “Eligible Individuals” (as defined in Section 3 of this Agreement) that have a Total Cost (as the term “Total Cost” is defined herein) of at least the amount of the annual payments distributed to the Hospital under this Agreement for that year.

Based on the Hospitals calculation of Services and our review thereof, UCMC meets the test in each of the previous three years, although its level of uncompensated care has decreased since 2013. Following is the calculation provided by UCMC, followed by our comments based on our review of the calculation.

**Table 7 - Annual Services Test Results for UCMC, Fiscal Years 2014-2016**

	Charges	Cost Ratio	Cost
<b>Fiscal Year 2014</b>			
Hamilton County subset of HCAP Uncompensated Care	\$204,909,628	0.298	\$61,033,344
Inmates from Hamilton County Correctional Facilities	\$6,837,479	0.262	\$1,791,458
<b>Total Services</b>			<b>\$62,824,802</b>
Levy Payments			\$19,700,000
<b>Services in Excess of Payments</b>			<b>\$43,124,802</b>
<b>Fiscal Year 2015</b>			
Hamilton County subset of HCAP Uncompensated Care	\$85,739,706	0.266	\$22,819,740
Inmates from Hamilton County Correctional Facilities	\$6,928,048	0.250	\$1,734,901
<b>Total Services</b>			<b>\$24,554,641</b>
Levy Payments			\$14,900,000
<b>Services in Excess of Payments</b>			<b>\$9,654,641</b>
<b>Fiscal Year 2016</b>			
Hamilton County subset of HCAP Uncompensated Care	\$79,182,357	0.252	\$19,935,784
Inmates from Hamilton County Correctional Facilities	\$6,651,768	0.240	\$1,596,387
<b>Total Services</b>			<b>\$21,532,171</b>
Levy Payments			\$14,900,000
<b>Services in Excess of Payments</b>			<b>\$6,632,171</b>

The Hamilton County subset of HCAP Uncompensated Care represents the portion of the HCAP accounts that were accounts of Hamilton County residents. The charges were provided by UCMC and not audited. We were informed by UCMC officials that Levy accounts and HCAP accounts are identified by special adjustment codes in the Hospital’s financial system, and a careful review of each code was conducted to ensure that all charges included in the table above meet the definition for inclusion in the HCAP report.

We noted the Charges for the three previous years, 2011-2013, ranged from \$212 million to \$262 million. The 2014 charges were lower than any of the previous three years, while the 2015 and 2016

charges were approximately 60% lower than 2014 charges. These decreases reflect the positive impact that the coverage provisions of the ACA, particularly the Medicaid expansion, has had on UCMC uncompensated care.

Care provided to Hamilton County inmates is appropriately included in Services. Under its arrangement with the County, UCMC is required to provide care to inmates as needed without additional payment from the County, and therefore the inmate services are applicable to the Levy. The amounts in the table above are consistent with the previous three-year period.

The cost-to-charge ratio is used to adjust charges to the estimated cost of services rendered. The above ratios were supplied by the Hospital and not audited. We were informed that the Hospital performed a study of the Levy patient population to determine the mix of services and then applied ratios based on the population-specific mix. As a reasonableness check, we noted that the weighted average cost-to-charge ratios in the Medicare cost reports were 24.8% and 23.8% in 2015 and 2016, respectively. The ratios used by UCMC are higher, but the variance in cost ratios is not large enough to impact the conclusion that UCMC handily meets this Service test.

### Net Community Benefit Calculation

The County contract stipulates that UCMC shall provide a “Net Community Benefit” of \$12,200,000 per year. Community Benefit shall be determined pursuant to the CHA Community Benefit Standards in effect at the time of execution of the Agreement. In determining the “Net Community Benefit,” the Hospitals shall treat as off-setting revenues all amounts received pursuant to the Agreement and all amounts received from the HCAP program in the year of receipt. UCMC provided the Net Community Benefit calculation to us for each of the three most recent years.

**Table 8 - Net Community Benefit Calculation for UCMC, Fiscal Years 2014-2016**

FISCAL YEAR ENDED 6/30/16 (Preliminary)	Total Expense	Less Revenue	Net Benefit
Traditional Charity Care	\$24,596,374	\$14,900,000	\$9,696,374
Unpaid Cost of Medicaid	\$283,604,816	\$265,784,343	\$17,820,473
Community Health Improvement Services	\$6,247,337	\$7,575	\$6,239,762
Health Professions Education	\$64,130,489	\$15,052,807	\$49,077,682
Subsidized Health Services	\$136,466,235	\$88,635,282	\$47,830,953
Other Community Benefits	\$2,249,253	\$3,600	\$2,245,653
<b>Total</b>	<b>\$517,294,504</b>	<b>\$384,383,607</b>	<b>\$132,910,897</b>

FISCAL YEAR ENDED 6/30/15	Total Expense	Less Revenue	Net Benefit
Traditional Charity Care	\$23,135,988	\$19,700,000	\$3,435,988
Unpaid Cost of Medicaid	\$271,304,475	\$264,272,049	\$7,032,426
Community Health Improvement Services	\$6,810,327	\$12,025	\$6,798,302
Health Professions Education	\$72,852,334	\$16,027,841	\$56,824,493
Subsidized Health Services	\$177,431,280	\$142,746,782	\$34,684,498
Other Community Benefits	\$3,576,843	\$1,840	\$3,575,003
<b>Total</b>	<b>\$555,111,247</b>	<b>\$442,760,547</b>	<b>\$112,350,700</b>

FISCAL YEAR ENDED 6/30/14	Total Expense	Less Revenue	Net Benefit
Traditional Charity Care	\$76,295,675	\$38,375,688	\$37,919,987
Unpaid Cost of Medicaid	\$206,178,562	\$196,228,914	\$9,949,648
Community Health Improvement Services	\$7,253,629	\$10,125	\$7,243,504
Health Professions Education	\$80,419,530	\$18,817,786	\$61,601,744
Subsidized Health Services	\$154,103,516	\$129,255,810	\$24,847,706
Other Community Benefits	\$1,220,678	\$0	\$1,220,678
<b>Total</b>	<b>\$525,471,590</b>	<b>\$382,688,323</b>	<b>\$142,783,267</b>

Using the above Community Benefit costs, we compared the annual Net Community Benefit to the required minimum amount as follows:

**Table 9 - Net Community Benefit Compared to Minimum, UCMC for Fiscal Years 2014-2016**

	FY 2014	FY 2015	FY 2016
Net Community Benefit	\$142,783,267	\$112,350,700	\$132,910,897
Minimum Required	\$12,200,000	\$12,200,000	\$12,200,000
<b>Net Community Benefit over Minimum</b>	<b>\$130,583,267</b>	<b>\$100,150,700</b>	<b>\$120,710,897</b>

We reviewed these schedules and supporting documents provided by the Hospital, noting the following:

- The required Net Community Benefit of \$12.2 million per year was met comfortably each year.
- The information included in each category appears to conform to CHA definitions, although this conclusion is based solely on reading the descriptions in the supporting documents.
- All amounts appear to be stated at cost or converted to cost using reasonable ratios of costs to charges.
- Physician services were excluded as required in the contract.

## Review of Strategic Plan

HMA received a high-level summary of UC Health's most recent strategic plan and discussed the plan with UC Health leaders. The current plan was initiated in 2015 and took over a year to complete. UC Health underwent a comprehensive process that included an update of the organization's mission, vision and values. The process involved extensive stakeholder input, mostly from within the

organization, although community needs assessment findings were also an important input. Since the plan was approved by governance in mid-2016, UC Health leaders have been working on developing specific implementation tactics and targets to achieve the plan's objectives.

The plan is focused on four areas of interest, with several strategies for each area.

**1. Growth and Access:**

- Grow specialty services:
  - Expand key specialty services: UC Heart Lung & Vascular Institute, UC Cancer Institute, UC Gardner Neuroscience Institute
  - Create new strategic affiliations
  - Improving referral processes
  - Developing subspecialty bundles
- Serving vulnerable populations:
  - Eliminate barriers to cancer screenings
  - Develop new models to connect patients to mental health services
- Extend primary care availability
  - Establish off-campus primary care site and build capacity in existing locations
  - Evaluate use of new tools and technologies such as online scheduling, telehealth
  - Potentially develop a shared savings program with the University
- Diversify the work force

**2. Research and Education:**

- Attain National Cancer Institute designation
- Increase funding for clinical trials
- Expand improvement sciences program to enhance care delivery
- Build predictive analytics models
- Make broader use of all UC Health facilities for training
- Enhance the focus on multi-professional continuing education programs
- Increase accountability and support for clinicians as educators

**3. Performance and Culture: Improve performance using Lean performance improvement tools**

- Eliminating waste
- Improving processes in select clinical areas
- Reducing variations in care, including new critical pathways
- Sharing data, including provider performance data, to inform decisions

**4. Improving the Health of the Community:**

- Establish new strategic partnerships
- Creation of an "innovation corridor," funding and support of new healthcare innovation-focused businesses
- Increase workforce development with a focus on minority-owned business and suppliers
- Enhanced participation on community advisory committees

UC Health's strategic plan is targeted to help the organization achieve each component of the three-part mission of an academic medical center – patient care, education and research. Many of the strategic priorities will generate direct benefits to the local community if achieved, such as supporting innovation and enhancing primary care access (especially if underserved areas are targeted); other strategies that

are intended to strengthen UC Health can generate downstream economic and social benefits to the community. Nothing in the plan runs counter to the interests of the County.

### **Community Health Needs Assessment**

All non-profit hospitals are required to perform a Community Health Needs Assessment (CHNA) every three years. In 2015, UCMC joined with 19 other hospitals (including UC Health's other hospitals and CCHMC) to conduct a CHNA for a 19-county region that includes Hamilton County. The effort was led by The Health Collaborative, a nonprofit organization in Cincinnati created to achieve data-driven improvement in the health of the region. The group performed an extensive review of health-related measures, and conducted surveys, interviews and focus groups to assess the most important issues across the region and in each county within the region. The findings were published in January 2016.<sup>13</sup>

For Hamilton County, there were seven categories of health issues that had the strongest consensus: substance abuse, access to care, obesity, infant mortality, diabetes, mental health and systemic socioeconomic factors.

Following publication of the regional CHNA, a team from UCMC was assembled to prioritize community health needs and develop specific implementation strategies to address the highest priority needs. The results were published in April 2016.<sup>14</sup> Ten strategies were developed and are currently in various stages of implementation. The report includes a summary of the initiative, the expected impact, financial cost, staffing commitments and timing.

The range of strategies include some relatively simple steps (publishing information on a website) that were specifically requested by community leaders. The strategies also include several service expansions that are intended to provide greater access to care for underserved or high-risk populations that were identified as priorities in the CHNA. Examples include opening a new health center in the Avondale community, expanding Obstetrics/Gynecology services in targeted locations, and establishing a new Intensive Outpatient clinic for people with substance abuse disorders.

The implementation plan is responsive to the priorities identified in the CHNA and appear to require a significant time and financial commitments by the organization.

## **Section 6 - Analysis of Hospital Performance – CCHMC**

### **Background and Overview**

CCHMC is a full-service, nonprofit pediatric academic medical center established in 1883. The Hospital is one of the largest children's hospitals in the U.S. and has 592 licensed acute care beds at its main campus facility and 42 additional beds at its Liberty campus. In addition, CCHMC has 115 inpatient psychiatry beds and 30 residential psychiatry beds. In fiscal year 2016, CCHMC had 35,360 inpatient and short-stay admissions, 92,528 emergency department visits, and 33,903 surgeries. In addition, CCHMC

<sup>13</sup> "Community Health Needs Assessment" dated January 15, 2016, The Health Collaborative

<sup>14</sup> "Implementation Strategies 2017-2019" dated April 19, 2016, University of Cincinnati Medical Center

operates 12 outpatient care centers across the region and had over 1 million ambulatory outpatient visits.

CCHMC has several world class highly ranked clinical programs and offers virtually every major specialty. *US News & World Report*, publisher of what is often considered the most prestigious hospital rating, has CCHMC ranked third on its current list of best children's hospitals. CCHMC has a very large and important research enterprise and is the third-highest recipient of NIH grants for pediatric research. CCHMC's physicians comprise the Department of Pediatrics of the University of Cincinnati College of Medicine.

CCHMC's consolidated financial statements include multiple organizations under common management and control. The information we received does not segregate CCHMC from its affiliates and subsidiaries. Also, CCHMC owns supporting organizations, which perform fundraising and provide significant financial resources to CCHMC. The vision and mission of CCHMC are as follows:<sup>15</sup>

#### **Vision**

Cincinnati Children's Hospital Medical Center will be the leader in improving child health.

#### **Mission**

Cincinnati Children's will improve child health and transform delivery of care through fully integrated, globally recognized research, education and innovation. For patients from our community, the nation and the world, the care we provide will achieve the best

- medical and quality-of-life outcomes
- patient and family experience
- value

today and in the future.

### **Financial Position and Recent Financial Performance**

CCHMC has experienced strong growth in revenue, margins, and financial security. CCHMC maintains a bond rating of AA2 from Moody's Investor Services. The AA rating category reflects a high level of financial security, and only a small number of health care organizations have a higher bond rating.

The table below presents selected information from CCHMC's audited financial statements for the five most recent fiscal years.<sup>16</sup>

<sup>15</sup> From CCHMC's website, <https://www.cincinnatichildrens.org/about/mission>

<sup>16</sup> All amounts are derived from Audited Consolidated Financial Statements of Children's Hospital Medical Center and Affiliates for each of the fiscal years ended June 30, 2012 to 2016.

**Table 10 - CCHMC Financial Information for the Years Ended June 30 (dollars in thousands)**

	2012	2013	2014	2015	2016
cash and investments	\$428,570	\$509,106	\$545,969	\$795,612	\$873,493
current assets	\$769,524	\$865,211	\$1,019,213	\$1,326,367	\$1,395,573
total assets	\$2,632,831	\$3,014,072	\$3,415,523	\$3,900,112	\$4,017,213
current liabilities	\$247,454	\$266,886	\$332,276	\$382,664	\$278,096
long-term financing	\$488,588	\$521,269	\$467,542	\$712,008	\$706,887
net assets	\$1,476,335	\$1,966,105	\$2,409,076	\$2,519,350	\$2,552,659
total revenue	\$1,810,803	\$1,931,505	\$2,120,240	\$2,206,470	\$2,310,637
total expenses	\$1,682,055	\$1,778,685	\$1,947,840	\$1,996,846	\$2,097,151
operating margin	\$128,748	\$152,820	\$172,400	\$209,624	\$213,486
days cash on hand	100	111	108	154	162
current ratio	3.1	3.2	3.1	3.5	5.0
debt to capital ratio	0.25	0.21	0.16	0.22	0.22
operating margin	7.1%	7.9%	8.1%	9.5%	9.2%
average age of plant (years)	6.8	7.7	7.8	8.5	8.2

**Financial Position:** From 2012 to 2016, net assets (unrestricted and restricted) increased by \$1.076 billion, a 73% gain in four years, largely from positive operating margins and growth in restricted investments. CCHMC's cash reserves have grown significantly but are relatively modest, as organizations with AA bond ratings typically have more than CCHMC's days cash on hand (the number of days of average spending the entity's cash reserves will cover). However, CCHMC's supporting organizations have \$2.3 billion of investments held for CCHMC's future use in research and operations, including nearly \$900 million that is unrestricted. CCHMC has strong and improving liquidity, as reflected by its current ratio (current assets compared to current liabilities). The debt-to-capital ratio is well below the median for organizations with AA bond ratings. The debt-to-capital ratio reflects the extent to which the entity relies on borrowing – a lower ratio is better. Average age of plant has increased by 7% since 2012, reflecting the fact that property and equipment have been depreciating at a faster rate than CCHMC has spent on improvements and replacements, but the average age of 8.2 years is better than the median for AA-rated hospitals.

**Operating results:** CCHMC has a dominant market position as the only children's hospital in the region. Its market share in the primary service area is a very high 96% for children age 0 to 14 and an unusually high 89% for those aged 15 to 17 (where children's hospitals typically face more competition from adult hospitals). Although Ohio has several independent children's hospitals, CCHMC has a strong national and international draw because of its reputation and research. Its market position has enabled the organization to negotiate a diverse portfolio of favorable contracts with insurers, producing strong revenue growth and high margins.

CCHMC has been focused on initiatives to reduce its costs and make its services more affordable to the patients and families it serves. Major initiatives include supply chain savings in terms of obtaining reduced costs for purchased supplies and equipment, reducing the use of outside service vendors, and

changing clinical pathways for better outcomes. An additional initiative has been the creation of expanded urgent care services at both the main hospital as well as at the Liberty campus. CCHMC implemented enhanced triaging of patients coming to the emergency department and has diverted many patients not requiring ED services to lower-cost urgent care. After treatment, CCHMC refers patients and families to primary care practices to provide them with a medical home. In the first year under this program 23,000 emergency room visits were shifted to urgent care at an annual savings of \$7.4 million.

In response to the cost savings from these initiatives, CCHMC has reduced the prices it charges for many commonly used services. Whereas hospitals typically increase charges each year, sometimes well above inflation, CCHMC's charges per adjusted patient day in fiscal year 2017 are lower than its 2015 charges per adjusted patient day.

Tax Levy payments have been a modest source of revenue for CCHMC as shown below:

**Table 11 - CCHMC Levy Payments and Total Revenues, 2012 to 2016 (thousands of dollars)**

	2012	2013	2014	2015	2016
Levy Payments	\$5,200	\$5,200	\$5,200	\$5,200	\$4,700
Total Revenues	\$1,810,803	\$1,931,505	\$2,120,240	\$2,206,470	\$2,310,637
Percentage of Levy Payments to Revenues	0.3%	0.3%	0.2%	0.2%	0.2%

## Financial Assistance Policies

The following excerpts are from the CCHMC Patient Financial Assistance Policy effective July 1, 2016.

*CCHMC will provide care for emergency medical conditions to any patient without discrimination and regardless of financial assistance eligibility or ability to pay. CCHMC further prohibits any actions that would discourage individuals from seeking emergency medical care, such as demand for payment before receiving treatment for emergency medical conditions or debt collection activities that interfere with the provision, without discrimination, of emergency care.*

- *CCHMC will provide financial assistance for medically necessary services to any patient who resides in Ohio or CCHMC's Primary Service Area (PSA) and will work with eligible patients and families to secure government health care program assistance.*
- *For those patients with a family income at or below 200% of the Federal Poverty Level (FPL), as demonstrated by completion of a Financial Assistance Application, services will be provided at no charge to the patient/family.*
- *For those with a family income above 200% of the FPL, services will be provided at a 48% discount on Charges Billed to the patient/family. A Financial Assistance Application is not required to receive this 48% discount.*
- *Patients residing in the United States, but outside of Ohio or CCHMC's Primary Service Area, will receive a 25% discount on Charges Billed for medically necessary services.*

- *If a patient has out-of-pocket expenses that total more than 25% of the patient's/family's Gross Income in any one year, CCHMC will work with them on a payment plan such that they will not be required to pay more than 25% of their Gross Income to CCHMC in that year.*
- *CCHMC will not take any extraordinary collection efforts on any amounts due by individuals (patients and individual guarantors) for medically necessary services.*
- *Under no circumstances will the amount owed by a patient/family residing in the PSA or State of Ohio exceed Amounts Generally Billed (AGB), which means the amounts generally billed for emergency or other medically necessary care to individuals who have insurance covering such care. For the period beginning July 1, 2016, the AGB Percentage is 52%.*
- *Patients/families who seek financial assistance under this Policy at the 100% discount level must complete a Financial Assistance Application (attached as Appendix A) and provide proof of income, residency, and family size through documentation listed on the Application. CCHMC will provide a patient/family with a free Application upon request or identification of uninsured status. A free copy of the Application, in English or other languages, may be requested by calling a financial counselor at 513-636-4427, e-mailing PFC@cCHMC.org, or writing to CCHMC Patient Financial Services, 3333 Burnet Avenue, MLC 5011, Cincinnati, Ohio 45229. Applications are also available online at <http://www.cincinnatichildrens.org/patients/resources/financial-assistance/>.*
- *Applications will be processed by the Financial Customer Service Department within 30 business days of receipt of all required documents.*
- *Family Financial Advocates are available to assist patients and families and are located at 3333 Burnet Avenue, Cincinnati, OH 45229, in the main hospital.*
- *Without charge, CCHMC will make this Policy, the accompanying Application, and a plain-language summary available in paper during the initial intake process for new patients and upon request for established patients, and by posting notice of the availability of financial assistance prominently at outpatient, emergency, and inpatient admissions areas and on CCHMC's website. Copies will be available in multiple languages, in a manner representative of the community that CCHMC serves. CCHMC will also include a conspicuous written notice on billing statements to notify and inform recipients of this Policy with contact information for the Financial Assistance Program and the website address of applicable materials.*
- *After making reasonable efforts to determine eligibility for financial assistance and applying any available financial assistance, and after the passage of sixty days from billing, CCHMC may take the following actions in the event of non-payment of amounts due after all available financial assistance has been applied:*
  - *CCHMC will send four monthly statements notifying the guarantor of any partial payments received, any remaining balance due, and any other circumstances for non-payment. If a payment plan has not been established, these accounts may be transferred to an outside collection agency. Neither CCHMC nor collection agents working on its behalf will take extraordinary collection efforts to obtain payment.*

Based on review of CCHMC policies and discussions with Hospital officials, CCHMC has appropriate policies and patient- and family-friendly practices that are consistent with the requirements of the Levy.

We inquired of Hospital officials whether the Hospital complies with the Section 501(r) requirements of the ACA and were informed that CCHMC is complying with all requirements.

Our experience suggests that CCHMC sets its cutoff point for financial assistance at the high end of the income range compared to what is typical. Its discount percentage for families with higher incomes is also generous in relation to industry norms. CCHMC's average cost-to-charge ratio (actual costs of care compared to standard charges) is approximately 43%, compared to an average of 25% for all Ohio hospitals. This indicates that CCHMC sets its charges with a much smaller mark-up over cost than average. Consequently, a 48% discount at CCHMC would generally result in a smaller bill than the same discount would generate at other hospitals.

### **Coverage Expansion and Financial Assistance**

The ACA coverage expansion has a small impact on CCHMC's Medicaid business because CCHMC does not serve adults, and adults are the primary beneficiaries of Medicaid expansion. Even without the ACA expansion, children have been eligible for Medicaid or CHIP coverage if family income is at or below 200% of FPL. The Medicaid expansion extends coverage to adults with income at or below 138% of FPL. There is benefit to the Hospital of having uninsured patients enroll in the Health Insurance Exchange because families with incomes up to 400% of FPL receive subsidized insurance coverage, which means that some otherwise uninsured children now have coverage. Hospital officials indicated that their financial counseling efforts take Exchange opportunities into account.

CCHMC has had long-standing policies and practices aimed at getting uninsured patients covered by Medicaid and other insurance. The following information was provided by the Hospital about the steps they have taken.

- Employ 17 full-time family financial advocates. Advocates understand program eligibility rules and are skilled at managing the enrollment and validation processes for Medicaid, other government programs, and alternative payor solutions.
- Assist the underinsured/insured chronic care families obtain additional resources.
- Help families apply for local, state and federal programs to limit out-of-pocket and bad debt.

### **Annual Services Test**

The Contract between the County and Hospitals includes Section 2(a), Services:

On an annual basis, each Hospital shall render hospital inpatient and outpatient health and hospitalization services ("Services") to medically indigent Hamilton County residents who are "Eligible Individuals" (as defined in Section 3 of this Agreement) that have a Total Cost (as the term "Total Cost" is defined herein) of at least the amount of the annual payments distributed to the Hospital under this Agreement for that year.

Following is the calculation provided by CCHMC and comments from our review of the calculation.

**Table 12 - Annual Services Test Results for CCHMC, Fiscal Years 2014-2016**

	Charges	Cost Ratio	Cost
<b>Fiscal Year 2014</b>			
Hamilton County subset of HCAP Uncompensated Care	15,731,827	0.502	7,898,634
Levy Payments			5,200,000
<b>Services in Excess of Payments</b>			<b>2,698,634</b>
<b>Fiscal Year 2015</b>			
Hamilton County subset of HCAP Uncompensated Care	14,116,316	0.469	6,620,831
Physician services to Hamilton County eligible persons	1,921,616	0.469	901,276
<b>Total Services</b>			<b>7,522,107</b>
Levy Payments			5,200,000
<b>Services in Excess of Payments</b>			<b>2,322,107</b>
<b>Fiscal Year 2016</b>			
Hamilton County subset of HCAP Uncompensated Care	13,660,504	0.471	6,430,403
Physician services to Hamilton County eligible persons	2,009,246	0.471	945,811
<b>Total Services</b>			<b>7,376,214</b>
Levy Payments			4,700,000
<b>Services in Excess of Payments</b>			<b>2,676,214</b>

In previous Levy periods, the Annual Services Test included hospital uncompensated care only. For the 2015-2017 period, the agreement with the County specifies that for CCHMC the uncompensated care of physician services provided to Hamilton County eligible individuals are included in addition to hospital services.

Hamilton County subset of HCAP Uncompensated Care represents the portion of the HCAP accounts that were accounts of Hamilton County residents. Charges are the amounts written off by the Hospital. The cases and charges were provided by UCMC and not audited. We were informed by CCHMC officials that Levy accounts and HCAP accounts are identified by special adjustment codes in the Hospital's financial system.

The cost-to-charge ratio is used to adjust charges to the estimated cost of services rendered. The above ratios were derived from the Hospital's annual Medicaid cost report Schedule F, which calculates the charges and cost for hospital uncompensated care. We compared the ratios in the above table to the submitted cost report, noting agreement for all years.

Based on this information, we conclude that CCHMC meets the required Services test in each year.

### Net Community Benefit Calculation

The County contract stipulates that CCHMC shall provide a "Net Community Benefit" of \$4,000,000 per year. Community Benefit shall be determined pursuant to the CHA Community Benefit Standards in effect at the time of execution of the Agreement. In determining the "Net Community Benefit," the Hospitals shall treat as off-setting revenues all amounts received pursuant to the Agreement and all

amounts received from the HCAP program in the year of receipt. CCHMC provided the Net Community Benefit calculation to us for each of the three most recent years.

**Table 13 - Net Community Benefit Calculation for CCHMC, Fiscal Years 2014-2016**

FISCAL YEAR ENDED 6/30/16	Total Expense	Less Revenue	Net Benefit
Traditional Charity Care	\$14,938,000	\$0	\$14,938,000
Unpaid Cost of Medicaid	\$723,222,000	\$481,448,000	\$241,774,000
Subsidized Health Services	\$6,369,000	\$4,069,000	\$2,300,000
HCAP and Tax Levy Payments	\$0	\$31,473,000	(\$31,473,000)
<b>Total</b>	<b>\$744,528,000</b>	<b>\$516,990,000</b>	<b>\$227,538,000</b>

FISCAL YEAR ENDED 6/30/15	Total Expense	Less Revenue	Net Benefit
Traditional Charity Care	\$13,295,000	\$0	\$13,295,000
Unpaid Cost of Medicaid	\$690,323,000	\$457,469,000	\$232,854,000
Subsidized Health Services	\$12,079,000	\$4,814,000	\$7,265,000
HCAP and Tax Levy Payments	\$0	\$29,955,000	(\$29,955,000)
<b>Total</b>	<b>\$715,697,000</b>	<b>\$492,238,000</b>	<b>\$223,459,000</b>

FISCAL YEAR ENDED 6/30/14	Total Expense	Less Revenue	Net Benefit
Traditional Charity Care	\$17,787,000	\$0	\$17,787,000
Unpaid Cost of Medicaid	\$567,249,000	\$418,759,000	\$148,490,000
Subsidized Health Services	\$11,227,000	\$4,473,000	\$6,754,000
HCAP and Tax Levy Payments	\$0	\$29,641,000	(\$29,641,000)
<b>Total</b>	<b>\$596,263,000</b>	<b>\$452,873,000</b>	<b>\$143,390,000</b>

Using the above Community Benefit costs, we compared the annual Net Community Benefit to the required minimum amount as follows:

**Table 14 - Net Community Benefit Compared to Minimum, CCHMC for Fiscal Years 2014-2016**

	FY 2014	FY 2015	FY 2016
Net Community Benefit	\$143,390,000	\$223,459,000	\$227,538,000
Minimum Required	\$4,000,000	\$4,000,000	\$4,000,000
<b>Net Community Benefit over Minimum</b>	<b>\$139,390,000</b>	<b>\$219,459,000</b>	<b>\$223,538,000</b>

We reviewed the schedules provided by the Hospital, noting the following:

- The required Net Community of Benefit of \$4 million per year was met 36 times over in fiscal year 2014 and 56 times in each of the latest two years.
- The Hospital did not include the costs of health professions education, research or community programs and outreach in its calculations. Accordingly, the above tables understate the Hospital's full community benefit using CHA guidelines. On its website, CCHMC reported 2015

costs of \$33 million for medical education, \$86 million for research and \$6 million for community outreach, a total of \$125 million additional community benefit cost.

- All amounts appear to be stated at cost or converted to cost using reasonable cost-to-charge ratios.
- Physician services were excluded as required in the contract.

## Review of Strategic Plan

We reviewed CCHMC's summary document associated with its 2020 Strategic Plan. The document provides a brief outline of the organization's goals and targeted outcomes. It does not describe the assessments and analyses underlying the plan, nor does it include the initiatives being undertaken to achieve the goals and desired outcomes. The following is a recap of the document.

### Goals:

- *Reduce serious harm to our patients by another two-thirds on our journey to zero*
- *Achieve a 40-percentage point improvement in CCHMC sites of care where patients and families report a consistently exceptional experience*
- *Bend the cost curve for care, keeping CCHMC's costs flat over the next five years*
- *Improve each year the number and percent of children with chronic disease with an exceptional outcome*
- *Decrease inpatient bed days for children in targeted neighborhoods by 20%*
- *Reduce infant mortality in Hamilton County by one-third, saving 32 lives per year*
- *Help Cincinnati Public Schools achieve 90% third-grade reading proficiency*
- *Double our premier scientific and clinical advances from 3 to 6*
- *Reach over 1 million lives through local and destination care and partnerships*
- *Realize and sustain employee engagement at 90%+*
- *Increase the percentage of positions filled by internal candidates by 15%*
- *Reduce OSHA recordable incidents by 50% on our journey to eliminate all harm*

### Target Outcomes:

*Deliver exceptional, safe, and affordable care for every child and every family, every day*

- *Standardize appropriate parts of our operating systems and care algorithms so we can individualize care for our patients and families*
- *Work as a team with our families and patients as critical partners to continuously deliver exceptional care*
- *Reduce the overall cost of care by standardizing, eliminating waste and increasing transparency*

*Help Cincinnati's kids to be the healthiest in the nation through strong community partnerships*

- *Build upon successes to align and scale change in child health and well-being*
- *Develop a highly effective primary care system that is connected and integrated with the community*

- *Reduce infant mortality and prematurity*
- *Improve kindergarten readiness and third-grade reading*
- *Address social influences of health in two neighborhoods*
- *Organize effectively internally and externally to achieve these collaborative breakthroughs*

*Transform child health with our collaborative culture of discovery, translation and learning*

- *Elevate CCCHMC research across the full discovery continuum, and grow our expertise in omics, biomedical informatics, systems biology and collaborative networks*
- *Attract, develop and retain the best talent*
- *Fuel advances through internal/external collaboration and partnerships*
- *Accelerate high-potential discoveries into practice*

*Improve the lives of children everywhere by creating deeper connections with families, care providers and organizations*

- *Ensure that we remain the community hospital and health system of choice for all local children*
- *Build a “best in class” end-to-end system and external partnerships for purposeful growth outside our local service area*
- *Increase the speed and scale with which we commercialize our specialized knowledge and technology*

*Realize our full potential by engaging, inspiring and enabling all employees to make a difference*

- *Cultivate a collaborative, caring and professional culture that lives our beliefs and values*
- *Invest in our people and grow the skills needed for today and tomorrow*
- *Streamline and simplify our work, empowering front-line flexibility, decision-making and continuous improvement*
- *Set the standard for learning among healthcare organizations*

*Data: Produce better insights, connections and productivity by unlocking the power of our data and technology*

*Infrastructure: Support our strategic advancement by improving the capacity and effectiveness of our key infrastructure*

*Financial: Ensure a sustainable economic model and resources to fund ongoing and long-term*

Overall, our impression is that CCHMC’s strategic plan is targeted to help the organization achieve its three-part mission of an academic medical center and to also achieve important benefits for the local community.

## Community Health Needs Assessment

All non-profit hospitals are now required to perform a CHNA every three years. CCHMC completed a CHNA in 2016 and published an implementation plan to address key findings in the CHNA at the same time.<sup>17</sup>

The CHNA is developed from extensive analyses of published external data and community input. Regarding data: the report identified 17 resources that were researched to obtain local data and national benchmarks covering a wide variety of health and socioeconomic issues. Regarding community input, the process included interviews of 1,579 randomly selected adults, written surveys completed by 450 caregivers, key informant interviews of 31 individuals representing 24 community organizations, and focus groups.

From the assessment, six child health priority areas were identified: mental health, obesity, safety and unintentional injury, asthma, early literacy/school readiness and infant mortality.

For each child health priority area, an implementation plan was developed that identifies between two and four action steps, the anticipated impact and a plan for evaluation. Each of these areas is addressed in the 2020 Strategic Plan. The implementation plan is responsive to the priorities identified in the CHNA and appear to require a significant time and financial commitments by the organization.

## Section 7 - Comparative Analysis

The purpose of this section is to assess the relative burden of indigent care on UCMC and CCHMC compared to other acute care hospitals and to assess the extent to which county governments provide financial support to their safety net hospitals.

### Comparison of UCMC and CCHMC to Other Hospitals

All hospitals participating in Medicare are required to submit an annual report to the federal government, referred to as the cost report, which includes information on the hospital's Medicaid and uncompensated care costs in the S-10 schedule. Children's hospitals and certain types of specialty hospitals are not required to complete the S-10 schedule, and many in the health care industry are critical of the S-10 data because of concerns about accuracy and consistency. Although it is not an ideal source, it is the best publicly available source of hospital uncompensated care.

The following charts show information about two measures that are intended to represent the size of the Hospital's low-income patient population in dollars and relative to the size of its total patient care operation.

- Low-Income patient care cost, which includes the cost of services to Medicaid patients plus charity care and bad debt costs.

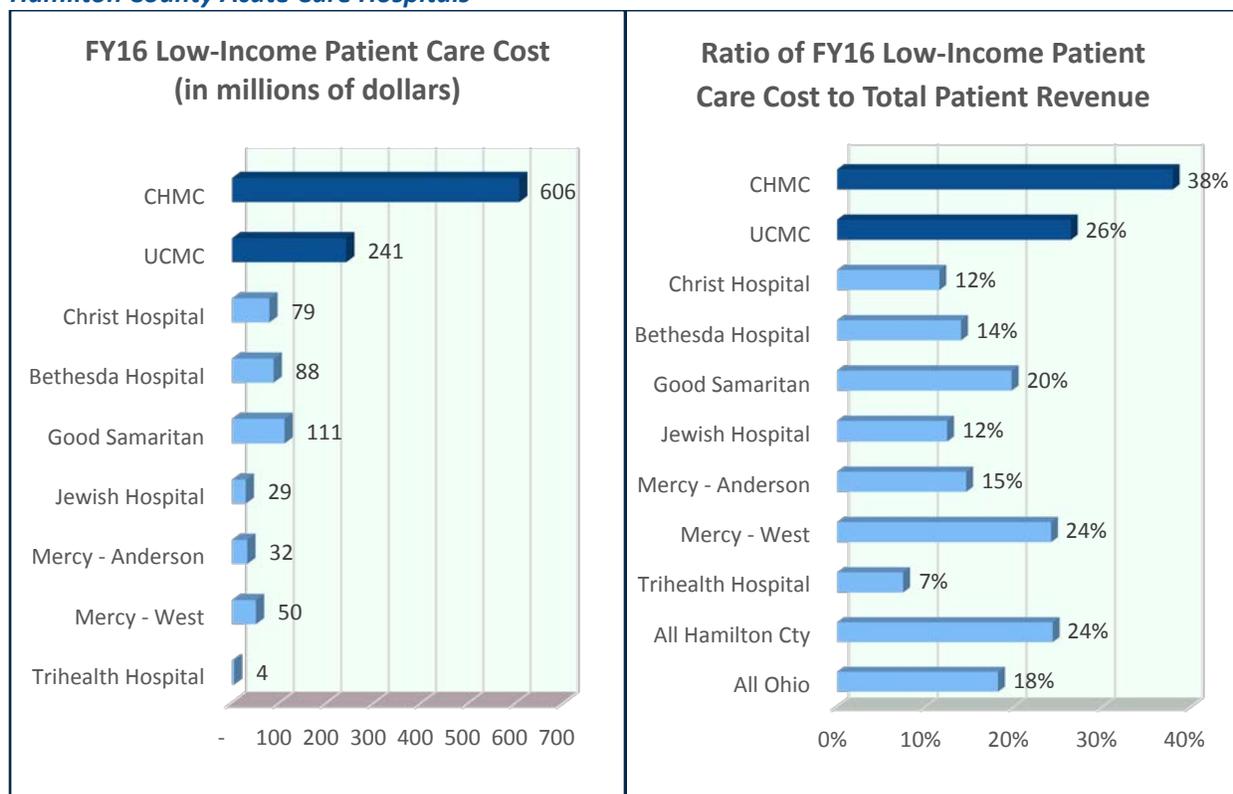
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<sup>17</sup> Information is derived from "Cincinnati Children's Hospital Medical Center Community Health Needs Assessment" and "Cincinnati Children's Hospital Medical Center CHNA Implementation Strategy", both dated June 30, 2016.

- Uncompensated care cost, which includes charity care and bad debt costs only (excludes Medicaid).

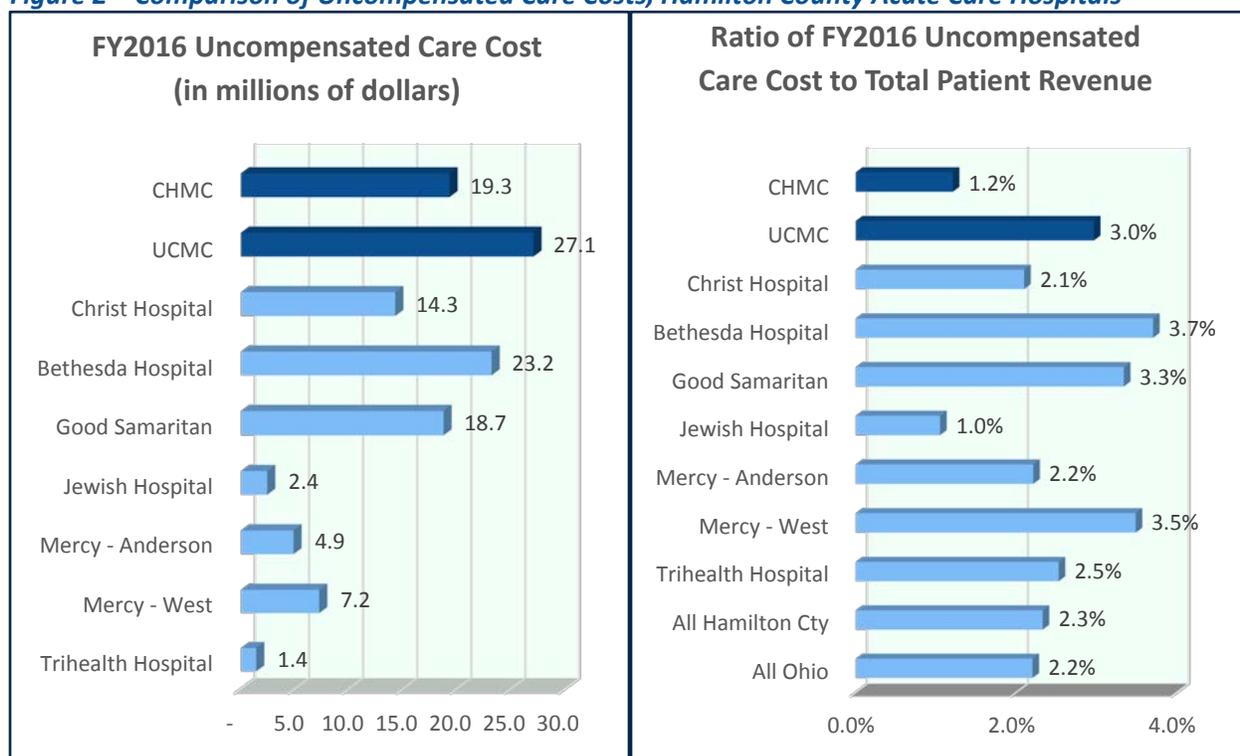
In these charts, UCMC and CCHMC are compared to other acute care hospitals in Hamilton County and the average across all hospitals in Ohio. Additionally, the Hamilton County average is compared to the average from each of the five other largest counties in Ohio.<sup>18</sup>

**Figure 1 – Comparison of Low-income Patient Care Costs (Medicaid plus Uncompensated Care), Hamilton County Acute Care Hospitals**



<sup>18</sup> All information in these charts is derived from Schedule S-10 of CMS Form 2552-10 (the Medicare cost report) from the hospital fiscal year ended between 7/1/15 and 6/30/16, except for CCHMC, for which the data is derived from its Community Benefit Report for fiscal year 2016.

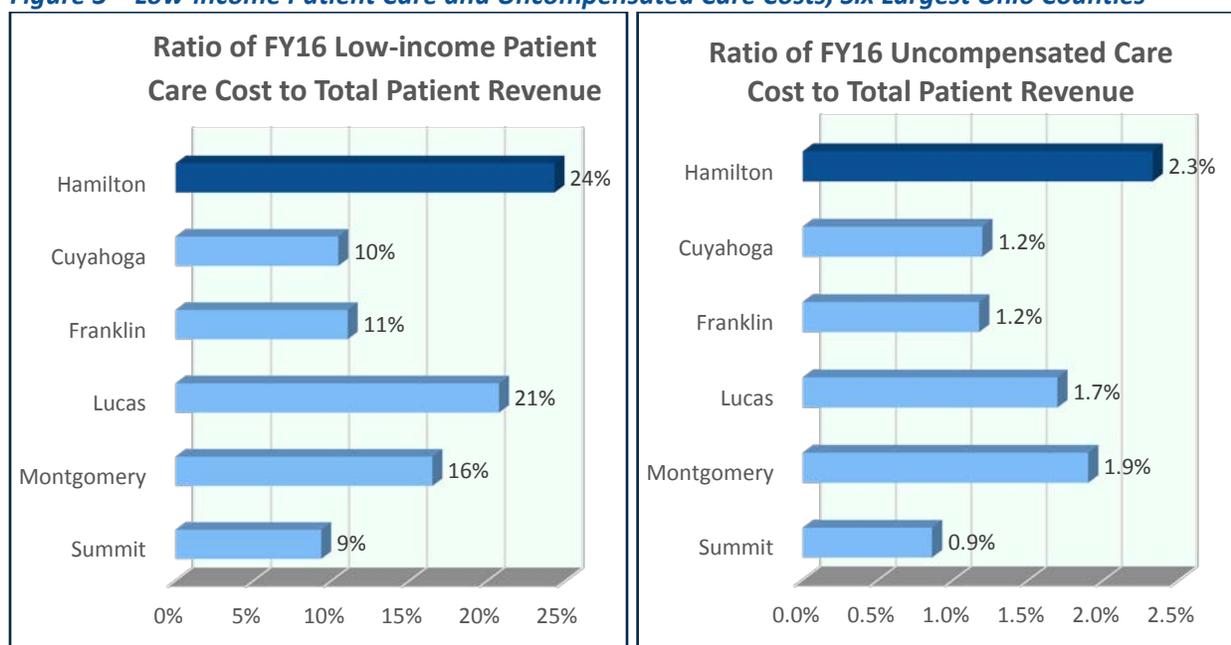
**Figure 2 – Comparison of Uncompensated Care Costs, Hamilton County Acute Care Hospitals**



CCHMC accounts for more than half of the Medicaid services provided by Hamilton County acute care hospitals and, because of its very large Medicaid patient population, its low-income patient burden is significantly greater than the next largest Hamilton County hospital and more than double the Ohio average. Because relatively fewer children lack insurance, CCHMC has the second smallest uncompensated care burden in the County, although it ranks third in uncompensated care dollars.

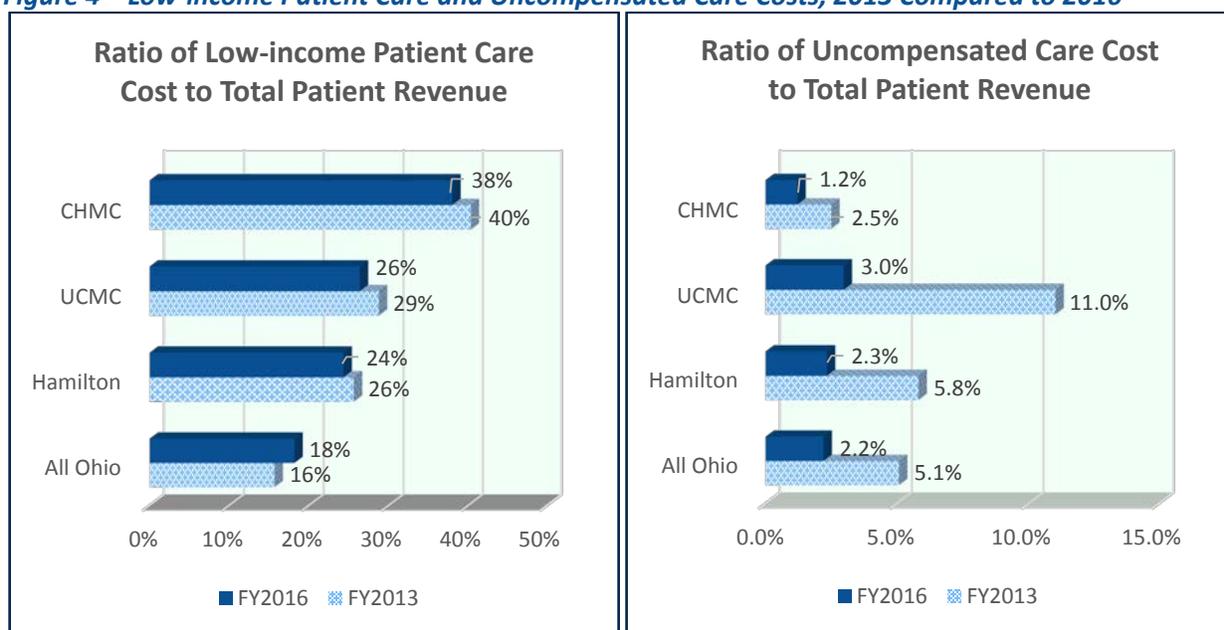
UCMC has the second largest low-income patient care cost and the second largest relative low-income patient burden in the County, reflecting its large size and its large share of adult Medicaid services (UCMC provides 40% of the adult Medicaid services in the County). UCMC provides the largest amount of uncompensated care, although the uncompensated care dollars are more widely distributed across the hospitals in the County than is the case with Medicaid.

**Figure 3 – Low-income Patient Care and Uncompensated Care Costs, Six Largest Ohio Counties**



Hamilton County hospitals have significantly higher rates of Medicaid and uncompensated care than the other five largest counties in the state. Hamilton County’s population is not significantly different from the rest of Ohio, in terms of Medicaid enrollment and uninsured. However, its two largest hospitals (UCMC and CCHMC) care for a significant number of low-income patients referred from other regions.

**Figure 4 – Low-income Patient Care and Uncompensated Care Costs, 2013 Compared to 2016**



Both UCMC and CCHMC experienced modest decreases in low-income patient care cost from FY 2013 to FY 2016, consistent with the County in aggregate. The dramatic decrease in uncompensated care at UCMC is associated with the improved access to health insurance under the ACA.

## Direct Support Provided by Peer Counties to Hospitals

**Table 15 - Information on County Direct Support for Hospital Indigent Care**

Cuyahoga	Cleveland's safety net hospital, Metro Health Medical Center, is part of county government. Metro Health receives an operating subsidy each year to cover revenue shortfalls, which are principally due to uncompensated care. The 2017 subsidy is budgeted at \$33.4 million.
Franklin	No indigent care funding is provided to hospitals.
Lucas	No indigent care funding is provided to hospitals.
Montgomery	The Human Services Levy includes a \$5 million annual allocation for indigent care that is available to all hospitals located in the county. Hospitals submit claims for eligible care to county residents and are reimbursed at Medicaid-equivalent rates. The funds are distributed in this manner until the \$5 million is exhausted.
Summit	No indigent care funding is provided to hospitals.

## Section 8 - Impact of the ACA

### Health Insurance Coverage

The most important impact of the ACA has been the reduction in the number of uninsured residents. This has been accomplished primarily through two vehicles, Medicaid expansion and Health Insurance Exchanges, but also through a series of insurance reforms that removed barriers to gaining coverage from private insurers.

### Medicaid Expansion

Prior to the ACA, Medicaid eligibility was typically limited to low-income families with children, persons with disabilities, low-income pregnant women, and the aged poor (who receive most of their medical care coverage from Medicare). The CHIP program provided additional coverage to children in families with income up to 200% of poverty, and many states (including Ohio) provided additional coverage to small groups of non-disabled, non-aged adults. However, most low-income adults were not eligible, which was the most important reason for high levels of uninsured residents.

The ACA Medicaid expansion offered coverage for adults without disabilities or dependent children and with family incomes up to 138% of the federal poverty level, beginning on January 1, 2014. The full cost was initially funded 100% by the federal government. Beginning in 2017, the federal match decreased to 95%, and it will continue to decrease on a phased-in manner to 90% by 2020. This federal match rate far exceeds the match rate for pre-ACA coverage (which is 62% in Ohio).

As of January 2017, there were 715,000 newly-eligible people enrolled in Ohio Medicaid. Although the previous insurance status of these persons is not tracked, it fair to assume that the large majority were uninsured.

## Health Insurance Exchanges and Tax Credit Subsidies

Persons with income levels between 138% and 400% of poverty without employer-sponsored coverage have access to subsidized private insurance purchased through an online insurance marketplace for individuals, referred to as the Health Insurance Exchange. States had the option to create their own Exchange or use a version established by the federal government (Ohio chose the latter). Even under a federally operated Exchange, the plans offered are state-specific. To create additional incentives for the uninsured to acquire health insurance, all persons face tax penalties if they elect to not enroll or purchase insurance. Also, employers with over 50 employees face penalties if they do not offer insurance to their eligible employees.

Currently, 12.2 million individuals acquire health insurance through a marketplace exchange, including 239,000 in Ohio. There are 9.4 million persons receiving premium subsidies pursuant to the ACA, including 174,000 in Ohio.

## Other Coverage-Related Impacts on Hospitals

**Mandatory insurance reforms:** The ACA includes several insurance protections that have resulted in more individuals being able to acquire or maintain insurance. Some of the more significant changes are:

- Insurers are prohibited from denying coverage to individuals with pre-existing conditions.
- Minimum standards for benefits are established, and many annual and lifetime caps on benefits are no longer allowed.
- Dependent children may be covered by their parents' policies until age 26.

**Enrolling more children in Medicaid:** An expected outcome of Medicaid expansion was an increase in enrollment from those previously eligible for Medicaid, especially children. Sometimes referred to as the "woodwork effect," the concept is that as adults enroll in Medicaid, they may also enroll previously eligible children.

**Migration from private insurance to Medicaid and subsidized exchanges:** The availability of publicly funded coverage via Medicaid and marketplace Exchanges was widely anticipated to result in some decreases in employer-sponsored insurance, as certain employers may opt to allow their employees to obtain health insurance through ACA-initiated vehicles. This phenomenon is referred to as crowd-out.

The effect of each of these coverage changes was estimated prior to their implementation. The mandatory insurance reforms and the woodwork effect are positive financial changes from a hospital perspective, because more low-income uninsured can obtain and maintain coverage. The crowd-out scenario, if it occurred, would have a negative financial impact on hospitals, because reimbursement from employer-sponsored insurance typically exceeds reimbursement from the new publicly funded options. HMA is not aware of studies that have attempted to quantify the actual impact in Ohio and is therefore unable to estimate the effects on UCMC and CCHMC.

## Changes in Number of Uninsured

In the seven years since its passage and three years since the major coverage provisions were implemented, the ACA has succeeded in reducing the number of uninsured in the U.S. At the end of

2015, an estimated 29.7 million U.S. residents (9.4%) were uninsured compared to 45.2 million (14.5%) at the end of 2013 and nearly 50 million when the ACA was enacted.<sup>19</sup> The percentage reductions in Ohio and in Hamilton County are similar, as shown below.

**Table 16 – Information about Uninsured in Ohio and Hamilton County, 2015 and 2013**

	Ohio	Ohio	Ohio	Hamilton	Hamilton	Hamilton
	2015	2013	Change	2015	2013	Change
Total Population	11,442,029	11,398,298	43,731	799,419	796,793	2,626
Uninsured	746,276	1,257,556	(511,280)	48,592	91,852	(43,260)
Percentage Uninsured	6.5%	11.0%	-4.5%	6.1%	11.5%	-5.4%
<b>Uninsured by Age</b>						
under 18	114,981	140,846	(25,865)	5,565	9,001	(3,436)
18 and over	631,295	1,116,710	(485,415)	43,027	82,851	(39,824)
<b>Uninsured by Income</b>						
under \$25,000	192,443	394,873	(202,430)	14,747	34,077	(19,330)
\$25,000 to \$75,000	378,364	645,127	(266,763)	25,048	45,099	(20,051)
over \$75,000	175,469	217,556	(42,087)	8,797	12,676	(3,879)

Source: U.S. Census Bureau, 2015 and 2013 American Community Survey

## Impact of Other Provisions

As just noted, the coverage provisions of the ACA yield financial benefits to hospitals, but these gains are partially offset by federal spending reductions that Congress included in the ACA to make the ACA budget-neutral.

- The Medicare program is undergoing annual reductions that started in 2011 and will continue until 2019. Many of the reductions target hospitals. The two most significant reductions are: 1) hospital rate updates are being reduced by approximately 1% per year, accumulating to an 11% reduction over nine years, and 2) beginning in 2013, Medicare DSH payments are being phased down by an estimated 60% to coincide with the expected drop in the level of the uninsured.
- Medicaid DSH allotments are being reduced by \$18 billion over a multi-year period, starting in 2018. At its highest annual level, the cut will be nearly 50% of Medicaid DSH. This is likely to cause significant reductions in Ohio's HCAP payments.

## Estimated Impact on UCMC and CCHMC

Many of the ACA effects cannot be reasonably measured. For most specific provisions, it is not possible to identify the actual effects, because they are inseparable from the myriad of other variables that have influenced patient mix, payer mix and financial performance of the Hospitals. However, there are three significant areas where reasonable estimates may be made.

<sup>19</sup> U.S. Census Bureau, American Community Survey 1-Year Estimates, SELECTED CHARACTERISTICS OF THE UNINSURED IN THE UNITED STATES

- 1) The extent to which uncompensated care has decreased since 2013. Both Hospitals experienced significant decreases in their uncompensated care costs from FY2013 to FY2016 (information for FY2017 is not yet available). ACA coverage provisions are not the only factor that influence uncompensated care, but it is believed that there is a high degree of correlation between ACA impact and uncompensated care. For UCMC, the information was obtained from the Ohio Medicaid cost report, which captures the cost of uncompensated care for each fiscal year. For CCHMC, data included in its Community Benefit Report is utilized.
- 2) The impact of the Medicare reimbursement reductions imposed on hospitals. To mitigate the impact on the federal budget of increased Medicaid funding and premium subsidies, the ACA included several reductions in Medicare reimbursement, many of which targeted hospitals. Some of the reductions began in 2011, and some are phased-in over a ten-year period. UCMC provided HMA with estimates of the FY 2017 effect of cumulative Medicare payment reductions that were included in the ACA. For CCHMC, Medicare represents less than 1% of its patient activity; therefore, the effect of the Medicare payment reductions is immaterial.
- 3) Changes in Medicaid DSH and the effect on Ohio HCAP payments.
  - Pursuant to federal law, every hospital has a limit on the amount of Medicaid DSH payments they may receive in each year. The limit is based in part on services to the uninsured. With fewer uninsured persons, many hospitals, including UCMC, are experiencing significant decreases in their DSH limits. UCMC's preliminary DSH limit decreased from \$74 million in 2013 to \$19 million in 2016, restricting the HCAP payments it can receive. Although Ohio HCAP is not part of the ACA per se, the impact on UCMC's HCAP payments is directly related to the ACA.
  - The ACA requires a cut in federal funding for Medicaid DSH beginning in 2018, ranging from \$2 billion to \$8 billion per year in savings nationally. For purposes of this analysis, HMA used the midpoint of this range, or \$5 billion annually. The law requires the CMS to allocate the cuts by state. The allocation has not yet been established and, therefore, HMA assumed that Ohio's share of the reduction will be equal to its share of current DSH funding. In FY 2016, Ohio received 3.7% of federal Medicaid DSH allotment and therefore, we assume Ohio will absorb 3.7% of the DSH cuts.

Based on the assumptions outlined above, the estimated direct and indirect impacts of the ACA on UCMC and CCHMC are as follows:

**Table 17 – Annual Impact of Affordable Care Act**

	UCMC	CCHMC
Uncompensated care cost, FY 2013	\$92,875,000	\$32,065,000
Uncompensated care cost, FY 2016	\$48,305,000	\$19,292,000
Decrease in uncompensated care cost	\$44,570,000	\$12,773,000
Medicare reimbursement reductions	(\$7,437,000)	\$0
Impact on Medicaid DSH limit	(\$14,794,000)	\$0
Proforma Medicaid DSH reduction	(\$3,588,000)	(\$9,591,000)
Total reimbursement reductions	(\$25,818,000)	(\$9,591,000)
<b>Net impact, directly related to ACA</b>	<b>\$18,752,000</b>	<b>\$3,182,000</b>

The State of Ohio and Hamilton County have also made changes since 2013 in hospital Medicaid reimbursement and hospital Tax Levy payments, respectively, that have reduced revenues to UCMC and CCHMC. These changes were for budgetary purposes and were not directly related to the ACA, but Hospital management believes that the expected financial benefits from the Medicaid expansion was a key factor in the state and County decisions to change its budgetary priorities.

Based on the Hospital's self-reported information, UCMC and CCHMC experienced reductions in uncompensated care costs of 48% and 40%, respectively. UCMC's change in uncompensated care costs corresponds with the decrease in the number of uninsured persons in Ohio and Hamilton County. CCHMC's change significantly exceeds the corresponding decrease in uninsured children, and may reflect the positive effects of ACA insurance reforms such as eliminating annual benefit caps. The reimbursement losses that result from ACA's Medicare reductions and the Medicaid DSH reductions offset much of the coverage-related gains. As one might expect, the net gains for UCMC are far greater than for CCHMC, because the ACA targeted coverage for uninsured adults.

## Section 9 - Potential Health Care Reform Legislation

As discussed in Section 3, Congress and the Administration are working on legislation to repeal and replace significant features of the ACA. In addition, policymakers are vetting proposals that would fundamentally change the structure and financing of Medicaid. Federal financing for Medicaid could be converted to a per capita cap or block grant, both of which aim to control federal spending on Medicaid and provide states more flexibility in their management of Medicaid spending. Under current law, the federal government matches state Medicaid spending at a rate determined by a formula set in statute; federal spending increases in response to the rise in the cost of providing care to enrollees, with no limit on total federal contributions. Under at the per capita cap or block grant approaches currently being considered, federal Medicaid spending would rise at a specified growth rate, irrespective of the actual rise in Medicaid spending in a state.

On May 4, 2017, a bill referred to as the American Health Care Act (AHCA) was passed in the U.S. House of Representatives, which eliminates the individual and employer mandates under the ACA, cuts the subsidies for many individuals purchasing coverage through the insurance exchanges, reduces the federal funding for Medicaid expansion, and implements a per capita cap on Medicaid spending.

The bill has moved to the Senate. Many industry analysts predict that the AHCA is not likely to pass in the Senate in its current form. Provisions of the AHCA may be modified or the Senate may decide to write its own bill. It is also possible that the Senate will not be able reach a majority agreement on any comprehensive set of changes. Even if it does, the House and Senate may not be able to agree on a final bill.

Whether the AHCA or some modified version becomes law is uncertain. However, even if major health care legislation is not enacted this year, the key issues are likely to remain in the political spotlight. Therefore, it is instructive to understand the key AHCA provisions and consider their potential impact. The following sections summarize key provisions of the AHCA and discuss the potential impacts of these or similar provisions on Hamilton County

## **Key Provisions of the AHCA**

### **Subsidized Marketplace Insurance and Eliminating Mandates**

Under the ACA, persons with incomes between 100% and 400% of the poverty level are eligible to receive premium subsidies to reduce the cost of acquiring health insurance. The credit amounts are based on a percentage of the premium for a benchmark plan and decrease as income increases. Under the AHCA, the sliding scale credits will be replaced by flat tax credits after a two-year transition period. The proposed tax credits increase with age of the person and decrease for taxpayers with higher income levels.

On a national average basis, the AHCA tax credits will be lower than the ACA premium subsidies. However, experience would vary widely from region to region, because there is enormous variation in the cost of a benchmark plan. Based on analysis performed by the Kaiser Family Foundation, most exchange enrollees in Hamilton County would receive higher levels of federal support under the AHCA than they receive under the ACA.

Another key provision of the AHCA is the elimination of individual and employer penalties for not acquiring health insurance. Eliminating the mandate is likely to result in a portion of current marketplace enrollees deciding to forego health insurance, and some employers may decide to no longer to offer coverage.

In its initial analysis of the AHCA,<sup>20</sup> the Congressional Budget Office (CBO) estimated that between 8 million and 9 million people with private insurance would become uninsured. The elimination of the

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<sup>20</sup> The Congressional Budget Office (CBO) published a cost estimate and impact analysis of the initial version of the AHCA in March 2017. As of the date of this report, the CBO has yet to complete its analysis of the final AHCA bill passed by the House of Representatives.

mandates will also result in a reduction in Medicaid enrollment. The CBO estimates that 5 million Medicaid enrollees would drop coverage if the mandates are eliminated.

### Funding for Medicaid Expansion

The AHCA does not repeal Medicaid expansion. Instead, it eliminates the enhanced federal match for persons that enroll under a state's expansion program on or after January 1, 2020. Each month thousands of enrollees drop coverage or lose eligibility and thousands more gain coverage. The AHCA will continue to provide 90% federal financing for the enrollees in the program at 12/31/19, but the federal match rate for new enrollees will decrease to the state's traditional match rate (62% in Ohio). As the expansion population shifts from grandfathered enrollees to new enrollees, a significant portion of the cost will shift from the federal government to the state.

Ultimately, Ohio would be responsible for up to 38% of the Medicaid expansion program, compared to 5% in 2017 and 10% in 2020 under the ACA.

### Per Capita Cap on Medicaid Spending

The AHCA will limit the growth in federal Medicaid spending per enrollee to the annual rate of medical inflation. While the formulas are complex, a simplified explanation of the proposed per capita cap is as follows:

Fiscal Year 2016 is the base year. The FY 2016 per-enrollee amounts are inflated using the Medical Consumers Price Index (M-CPI). Beginning in FY 2020, the base period costs per enrollee plus inflation will be multiplied by the current number of enrollees to derive a spending target. If actual spending exceeds the target, the federal share of the excess is recouped by the federal government. Each of these calculations is state-specific.

The concern about the per capita cap is that most states have experienced Medicaid spending increases per enrollee that are greater than inflation in most years. Although Medicaid increases have generally been lower than private insurance and Medicare increases, Medicaid per-enrollee spending increases have historically exceeded M-CPI increases. For example:

**Table 18 – Medicaid per Enrollee Percentage Increases Compared to Medical CPI, 2000-2011**

Cumulative percentage increase in per-enrollee spending from 2000-2011	Medicaid- US	Medicaid- Ohio	Medical CPI
<b>Disabled</b>	63%	72%	53%
<b>Children</b>	83%	150%	53%
<b>Adults</b>	77%	100%	53%

As shown above, for a relatively recent 11-year period, the increase in Medicaid spending per enrollee far exceeded the rate of medical inflation nationally and even more so in Ohio. In the most recent five-year period, Ohio has managed to maintain Medicaid spending increases per enrollee well below inflation, through concerted efforts to control costs and through provider reimbursement reductions. However, over an extended period, this recent trend would be extremely difficult to maintain.

In its AHCA impact estimate, the CBO assumed that Medicaid costs per enrollee will grow by 4.3% per year and the M-CPI will increase by 3.7% per year. The 0.6% annual difference would result in significant reductions in federal Medicaid spending over time.

### **Impact of Key AHCA Provisions**

The CBO estimated that from 2017-2026 the AHCA will result in 24 million fewer people covered by insurance and an \$880 billion reduction of federal spending on Medicaid. As noted above, the CBO did not publish state-by-state estimates.

The Urban Institute completed an independent analysis of the impact on Medicaid spending of the initial AHCA legislation.<sup>21</sup> Urban Institute projected a lower aggregate impact of Medicaid changes on federal spending than the CBO, \$457 billion from 2019 to 2028.

Importantly, the Urban Institute projected the results for each state. The ten-year aggregate impact on Ohio was estimated to be a \$22 billion reduction in federal payments, representing 10% of estimated federal funding under current law. Ohio's state match was projected to be \$98 billion under current law. If Ohio decided to replace the lost federal funding with state funding, Ohio's Medicaid spending would have to increase by 22% over the ten-year period.

The more likely outcome is that Ohio would opt to reduce the size of its Medicaid program using a combination of several possible levers including:

- reducing (and possibly eliminating) coverage for the Medicaid expansion population
- reducing coverage for other optional eligibility categories
- reducing benefits where allowed under federal law
- cutting provider payments

Each of these options would negatively impact hospitals, including UCMC and CCHMC, by increasing the number of uninsured Ohioans or increasing the Medicaid shortfall.

In addition, the AHCA changes to Marketplace Exchange subsidies and eliminating mandates would result in increases in the number of uninsured. The impact on UCMC and CCHMC would be a reversal of a significant portion of the coverage gains described in Section 8 above.

Although we do not know if there will be a final "repeal and replace" law this year and whether the current AHCA provisions will be included, clearly the concepts embraced by the current administration and congressional leadership could be very detrimental to UCMC and CCHMC financially.

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<sup>21</sup> Urban Institute, "The Impact of Per Capita Caps on Federal and State Medicaid Spending", March 2017

## Section 10 - Considerations for Next Levy Period

### Review of Levy Request for the Next Cycle at Levels Identified by the TLRC

The Hospitals requested that the TLRC endorse and the BOCC approve a renewal of the current Levy. The request letter states that the 2017 funding level should be continued.

HMA was asked to evaluate this request in the context of two different funding levels: first, a continuation of the Indigent Care Levy at the same millage and, second, an increase in the Levy to account for the effects of inflation in recent years. County officials estimate the revenue generated from each of these scenarios as follows:

**Table 19 – Estimated Indigent Care Levy Revenue (in thousands)**

REVENUE ESTIMATES	2018
No change in millage	\$38,983
With inflation increase	\$43,477

For reference, the Levy revenue from 2015-2017 has averaged \$40,700,000 per year and is projected to be \$39,700,000 in 2017. The no-change-in-millage scenario represents a \$1.5 million per year decrease in Levy revenue compared to 2017, while the inflation-adjusted scenario represents a \$3 million increase per year in available revenue, compared to the 2017.

In its evaluation of the Hospitals' funding request, HMA considered several factors that are applicable under either future Levy scenario.

**Historically the primary purpose of the health and hospitalization Levy has been to support hospital care for the County's uninsured and underinsured residents.** Through 2011, well over half of the Levy revenue was directed to UCMC and CCHMC. In the 2012 renewal, the Levy was reduced and most of the Levy revenue decrease was allocated to the Hospitals. In the current Levy, the Hospitals' payments were further reduced and now represent about 48% of total Levy expenditures.

**UCMC and CCHMC are the leaders in the region in services to low-income individuals.** In 2016, UCMC and CCHMC accounted for 71% of the Medicaid services provided by Hamilton County hospitals and 39% of the uncompensated care provided by Hamilton County hospitals.

**The ACA coverage provisions have greatly benefited UCMC.** The Hospital has seen an estimated \$18 million annual net positive impact directly-related to the ACA and its share of uncompensated care among County hospitals has decreased significantly since the ACA coverage expansion began.

**Neither Hospital relies heavily on the Levy payments.** UCMC has improved its operating margin and financial position in recent years, and its Levy payments now represent less than 1% of revenues. CCHMC has had extraordinarily strong financial performance for several years and has very large financial resources at its disposal, and its Levy payments represent 0.2% of revenues.

**Both Hospitals are at great risk financially if the federal government enacts ACA “repeal and replace” legislation and/or converts Medicaid financing to a per capita cap or block grant.** Legislation that curtails subsidized coverage and either reduces or eliminates Medicaid expansion could reverse most of the ACA benefit UCMC has realized. A per capita cap or block grant that results in significant reductions in Ohio’s Medicaid program would harm both Hospitals, but especially CCHMC because of its very high Medicaid patient load.

**County leadership may conclude that there are higher priorities for health care funding.** The County is facing several public health concerns, including but not limited to the high incidence of opiate and other substance abuse, infant mortality, and access to dental care. While access to care by uninsured and underinsured residents continues to be an issue, the success of the ACA coverage expansion has made this somewhat less of an issue. The TLRC and BOCC will need to consider whether these needs outweigh the risk that reducing hospital Levy payments would adversely affect services provided by these hospitals to County residents.

Some of the above factors lend support to the Hospitals’ requests to continue Levy funding at the same level as the current Levy; other factors suggest that the amount of Hospital funding could be reduced.

On balance, the high priority of other public health objectives may be the most compelling of these factors, and coupled with the scarcity of available funds, suggests that the County may be best served by considering a further reduction in the Hospital percentage of Levy revenue.

- If the County moves forward with the inflation-adjusted Levy scenario, the direct hospital payment could remain at current levels and the additional Levy revenue could be used for other indigent care programs. This outcome would result in the Hospitals receiving the same amount of funding but a smaller percentage of the new Levy (approximately 46% instead of the current 48% of Levy expenditures).
- If the County opts for the no-increase-in-millage scenario, the County could reduce the Hospital payments by the amount of the reduction in Levy revenue, approximately \$1.5 million per year.
- The BOCC and TLRC may conclude that additional reductions to Hospital direct payments are needed to adequately fund other high-priority programs. Both Hospitals currently have the financial resources to absorb a reduction in County payments without adversely impacting their mission to serve the community. However, if additional reductions in Hospital payments are deemed necessary, officials should consider a provision that allows the cut to be restored if federal legislation is passed that significantly reduces coverage or Medicaid funding.

## Other Considerations

**Consider using the Levy commitment to stimulate additional collaboration with the Hospitals to help achieve the County’s goals for health improvement.**

Since their inception, the Levy payments have been in the form of a passive grant with certain contractual conditions. As established in the Community Health Needs Assessment (CHNA) completed by each organization, there is an interest by both Hospitals in partnering with the community to achieve improvements in the health of its residents. There are certainly several potential health needs that could

be targets of opportunity, including improving access to and use of primary care, improving access to dental care, addressing opiate addiction, reducing infant mortality and obesity, and increasing healthy behaviors. Both Hospitals have active efforts underway to address the goals of their individual CHNAs, but there could be synergies from greater coordination between the organizations and greater collaboration with the County and other key stakeholders.

The BOCC should consider whether the hospital Levy payments, or a portion of the Levy payments, should be targeted to programs of mutual interest to the Hospitals and County leadership.

**Consider a four-year or five-year Levy period.**

Previous hospitalization levies covered five-year periods. The Levy period was shortened to three years in 2011, in large part because of uncertainty about the ACA impact, and was maintained at three years in 2014 because of continued uncertainty about ACA and the future of health care finances.

The future of health care and the impact on the finances of the County's safety net are no more certain than at the beginning of each of the last two Levy periods. However, most signs point to more challenging times for hospitals, financially. The strong possibility of ACA reform and reduced federal participation in health care financing is likely to result in significant downward pressure on hospital margins. There is an advantage to a longer Levy period because it provides a more certain long-term revenue picture for the County and the Hospitals at a time when there is significant concern about an uncertain future. Accordingly, the BOCC should consider a four-year or five-year Levy period.

**Establish more formalized contract management controls.**

In our review of the contract provisions, we noted one instance of untimely submission of required data, and there are no formal procedures in place for the County to communicate expectations to the Hospitals to ensure all requirements are being met on a timely basis. The County should ensure that each reporting requirement has a specific due date or timeframe for completion; a checklist of contract provisions may help with ongoing monitoring of compliance.

**Modify or eliminate the Net Community Benefits test.**

The Net Community Benefit test, whereby each Hospital is required to demonstrate that it is providing a quantifiable community benefit more than a stated threshold, is not a meaningful test in its current state because the threshold is set at a level that is too low. In the most recently available year, UCMC and CCHMC reported community benefits that exceed the threshold by 11 times and 56 times, respectively.

Rather than requiring a financial test that neither Hospital has difficulty meeting, the County may consider changing the test to ensure an ongoing commitment to the community. For example, the contract could stipulate that net community benefit for the next three years be at least equal to 80% of the net community benefit from the most recent three years. This test would allow for some fluctuation in the numbers while establishing a more meaningful target.

Alternatively, this test could be eliminated from the contract.

**Should the County work with the state to investigate opportunities to leverage additional federal funding for Medicaid?**

Medicaid programs are jointly financed by the state and federal governments. The state share of Medicaid expenditures may be financed by a technique called intergovernmental transfer (IGT) whereby a local unit of government transfers funds to the state to serve as the state share of Medicaid payments.

It is possible to repurpose Hamilton County funding to leverage federal Medicaid match, thereby creating additional resources for the County. The state and County could work together to construct a permissible Medicaid plan to use County Levy revenues as the source of state match, with the resulting the Medicaid funding being returned to the County. For example, assume a blended federal match rate of approximately 70% (62% for traditional Medicaid, 90% for the expansion group). Each \$1,000 spent by the State may generate a \$2,300 federal match. If the County eliminated \$20 million per year of hospital Levy payments and replaced it with an IGT to the State, the State would have the means to generate \$66 million of additional Medicaid funds.

To make this idea work requires the following:

- It starts with establishing a plan to address one or more community priorities with additional Medicaid payments. There are permissible vehicles to supplement provider payments for hospitals as well as other classes of providers. If the County prioritizes improved access to primary care or certain types of specialty care or dental care, access may be improved by enhancing Medicaid reimbursement in these areas. There are also opportunities to utilize Medicaid funds for needs other than currently reimbursable services to current Medicaid enrollees; some states have obtained federal support for longer-term delivery system investment, expanding the menu of covered services, and expanding the number of eligible beneficiaries.
- There are limits and conditions under Medicaid that must be adhered to. For example, a new program or state plan amendment must meet Medicaid cost effectiveness tests that are part of the federal regulatory structure.
- The full support of the state is needed. Our understanding is that past County efforts to leverage additional Medicaid payments have been rejected by State officials.
- It needs to be understood that implementation would change the essential nature of the Levy (or the portion of the Levy used for this idea) from support of indigent care to enhancing Medicaid.

Implementing this idea may not be practical. There is resistance at the state level to developing programs that have regional-only benefit and resistance at the federal level to increasing Medicaid spending. Also, given the potential for a per capita cap on Medicaid in the future, the State will be extremely wary of any program that increases Medicaid spending in Ohio.

Despite these concerns and potential barriers, the size of the potential financial gain may warrant further review of Medicaid financing options.