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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 23, 2014

*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, 2014, and the Board of County Commissioners (BOCC) is considering whether to approve a new levy proposal for 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 Affordable Care Act and certain other key provisions impacting hospitals.

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

**Current Levy:** The current Levy was approved by the voters in November 2011 for a three-year period ending December 31, 2014. In total, over \$40 million of revenue per year is generated from the Levy. The BOCC initially allocated \$26.1 million per year to be paid to the two Hospitals (\$20.9 million to UCMC and \$5.2 million to CCHMC) and the remainder was allocated to support other County indigent care programs. For 2014, the UCMC allocation was reduced by \$6 million to \$14.9 million to provide additional funding for inmate medical care; in addition, the BOCC agreed that any balance remaining in the Levy fund as of December 31, 2014, will be payable to UCMC.

**Compliance with the Levy requirements:** The contract between the County and the Hospitals was not executed until April 2014. Seven interim agreements were signed to enable the County to make payments to the Hospitals while a comprehensive contract was being negotiated.

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 handily met by UCMC each year. CCHMC also met the test each year, although in the most recent year for which data is available (2013), the minimum requirement was exceeded by less than 9%. 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 a number of reporting requirements. Neither Hospital has complied with all of the reporting requirements. The County has not formally notified the Hospitals that they are out of compliance. To do so would trigger a 30-day period for the Hospitals to address the deficiencies; if compliance is still not achieved after 30 days, the Hospitals would be in default.

**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 margins have lagged behind industry averages. The overall financial strength of the organization has improved, in terms of both short-term liquidity and long-term sustainability. The Hospital carries an A3 bond rating, which is average in the hospital industry. Levy funds represent a significant source of revenue: from 2010 to 2013 Levy payments were between 1.7% and 3.0% of total operating revenues. Without the Levy payments, UC Health may have incurred operating losses in three of the last four years.

**Financial Condition – CCHMC:** The Hospital has been very successful financially. Over the last four years its margins have averaged 5.5% of revenues, and its net assets (assets less liabilities) have increased by 61%. CCHMC's overall financial strength is equally impressive: the Hospital carries a relatively low amount of debt and has significant unrestricted 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 0.3% of operating revenues.

**Financial Assistance Policies:** Both Hospitals have comprehensive policies and robust 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 new IRS requirements for tax-exempt hospitals as called for in the Affordable Care Act.

- UCMC offers full charity care to persons with household income of 150% of poverty and below and sliding scale discounts to patients with income levels between 150% and 200% of poverty. Most hospitals that HMA has experience with use higher income thresholds than UCMC.
- CCHMC offers full charity care to persons with household income up to 250% of poverty and sliding scale discounts to patients with income levels between 250% and 400% of poverty. These thresholds are at the higher end of the range that HMA typically encounters.
- At UCMC, all uninsured patients are eligible for at least a 40% discount from standard charges; CCHMC has a 25% minimum discount for all uninsured patients. 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 actually more patient-friendly.

**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 has recently implemented an expansion of Medicaid as permitted under the ACA, 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 and employers that do not acquire 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 has historically been more than double the percentage of uninsured children. CCHMC stands to receive relatively modest benefits from ACA coverage expansion, while UCMC could realize major benefits. In response to this opportunity, UCMC has put in place a comprehensive outreach 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 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 now required by IRS rules for tax-exempt hospitals. The current CHNAs appear to have appropriate target areas for health improvement and to 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 Disproportionate Share (DSH) losses from treating Medicaid and uninsured patients. Using this information we compared UCMC and CCHMC to all other Hamilton County hospitals and to other large hospitals in the state. As a percentage of its total revenues, UCMC has by far the highest DSH indigent care burden in the County and the highest among the 12 largest hospitals in the state. CCHMC ranks 4th out of 9 Hamilton County hospitals and 3rd of the 12 largest hospitals in the state.

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 and 36% greater than the state average.

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 Affordable Care Act:** HMA estimated the financial effect of the ACA on each Hospital. There are many provisions of the ACA that impact hospitals, but we focused our review on two areas with potentially large financial impact.

First, we estimated the impact of coverage expansion. Both Hospitals can expect a reduction in the number of uninsured patients and a corresponding reduction in uncompensated care. The improvement in revenue, however, will be somewhat offset to the extent that persons covered by employer-sponsored insurance migrate to Medicaid or to the new Marketplace Exchange because reimbursement rates will likely be lower than what the Hospitals currently receive under employer-sponsored insurance.

Second, we estimated the impact of Medicare and Medicaid reimbursement reductions that the ACA requires. In its attempt to make the ACA budget-neutral from a federal budgetary standpoint, Congress included a number of 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 is implementing additional Medicaid reimbursement reductions that are not part of the ACA but Hospital management believes these reductions are related to the decision to expand Medicaid.

The ACA coverage provisions are expected to take multiple years to reach full effect, and many of the reimbursement changes are phased-in over time. To simplify the analysis we selected 2017 as the point in time for estimating impacts. The following table summarizes our estimates of the effect on the two Hospitals.

**Table 1 - Estimated Effect of Affordable Care Act Provisions on Revenue of UCMC and CCHMC in 2017**

Annual Revenue Impact - Estimated 2017	UCMC	CCHMC
Increase from coverage expansion, Medicaid and Exchange	\$37,600,000	\$5,800,000
Decrease from migration away from employer insurance	(\$7,700,000)	(\$2,400,000)
Net Coverage Change	\$29,900,000	\$3,400,000
Medicare and Medicaid reimbursement reductions	(\$14,400,000)	(\$1,300,000)
<b>Net Impact of ACA</b>	<b>\$15,500,000</b>	<b>\$2,100,000</b>
Additional Medicaid Reductions, not part of ACA	(\$7,100,000)	Not significant

The estimated decrease in uncompensated care at UCMC is significant, but even with a benefit of this magnitude UCMC would continue to meet the financial tests called for in the Levy contract. On the other hand, CCHMC may not meet the minimum level of uncompensated care currently defined in the Levy contract.

**Considerations for Next Levy Cycle:** As a result of our analysis, HMA developed the following summary observations for TLRC consideration.

1. UCMC is likely to continue to rely on Levy funds to sustain reasonable operating results.
2. CCHMC may not meet the key financial test required in the current Levy contract, if ACA coverage expansion reduces the number of uninsured children.
3. The County should work with the hospitals to ensure all provisions of the contract are met.
4. The County should modify or eliminate the Net Community Benefits test.
5. The County should consider a three-year or four-year commitment to the Hospitals.
6. The County should consider whether using the Levy commitment to stimulate additional collaboration with the Hospitals will help achieve the County's goals for health improvement.
7. The County should investigate opportunities to leverage Medicaid funding in lieu of direct payments to hospitals.

## Introduction

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 38 year history of the Levy, including using a significant portion of the funding 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, 2014, 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 was conducted.

## 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 inpatient 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 phase-in and Medicaid expansion in Ohio on an annual basis for each service provided by Hamilton County.
- B. Include review of impacts of the Medicaid expansion in Ohio and the observed and likely reactions of providers and others to the ACA and also to Medicaid expansion.
- C. Build a data table with the potential 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. Review and finalize data table based on the review of the draft.

**Task 4:** Review prior recommendations from the TLRC and its hospital subcommittee, prior consultant reports (available on line at [www.hamilton-co.org](http://www.hamilton-co.org)), and the BOCC.

**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 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.

## Recent History and Overview of Current Levy

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

**Table 2 - Payments from Levy Proceeds based on Payment Date, 2007-2014**

	Annual for 2007-2011	Actual 2012	Actual 2013	Projected 2014
University of Cincinnati Medical Center:				
Base payments	\$25,480,000	\$21,490,000	\$20,900,000	\$16,990,000
Additional distribution of fund balance	\$0	\$0	\$0	TBD
Total UCMC	\$25,480,000	\$21,490,000	\$20,900,000	\$16,990,000
Cincinnati Children's Hospital Medical Center	\$5,880,000	\$5,200,000	\$5,200,000	\$5,720,000
Total direct payments to hospitals	\$31,360,000	\$26,690,000	\$26,100,000	\$22,710,000
Other indigent care programs	\$16,609,000	\$13,611,000	\$13,567,000	\$19,941,000
Administration, Auditor and Treasurer Fees	\$778,000	\$970,000	\$631,000	\$1,028,000
Grand total, before additional distribution	\$48,747,000	\$41,271,000	\$40,298,000	\$43,679,000

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

**Table 3 – Hospital Payments from Levy Proceeds based on Levy Year, 2007-2014**

	Annual for 2007-2011	Actual 2012	Actual 2013	Projected 2014
University of Cincinnati Medical Center:				
Base payments	\$26,000,000	\$20,900,000	\$20,900,000	\$14,900,000
Additional distribution of fund balance	\$0	\$0	\$0	TBD
Total UCMC	\$26,000,000	\$20,900,000	\$20,900,000	\$14,900,000
Cincinnati Children's Hospital Medical Center	\$6,000,000	\$5,200,000	\$5,200,000	\$5,200,000
Total direct payments to hospitals, before additional distribution	\$32,000,000	\$26,100,000	\$26,100,000	\$20,100,000

The above projection for 2014 excludes one component of UCMC payments. The BOCC approved a revision to the initial allocation for 2014 whereby the fixed allocation would be reduced by \$6,000,000 and the County would make an additional distribution to UCMC equal to the remaining uncommitted funds in the Levy fund at the end of the current Levy cycle. As of April 25, 2014, County officials estimate that such remaining fund balance will result in a \$4,720,000 additional distribution to UCMC. The actual fund balance at December 31 will vary from the April 25 estimate, perhaps materially, but if this estimate holds true, the additional distribution will offset most of the \$6,000,000 reduction.

<sup>1</sup> From Indigent Care Levy Recap from 2007-2011 and from 2012-2014 including 2014 projected, provided by Hamilton County Budget and Research Division.

When the Levy was last up for renewal in 2011, there were several recommendations made in the consultant's report and in a report to the Commissioners from a subcommittee of the TLRC formed to review the hospital portion of the Levy. These recommendations are summarized below along with comments about the disposition of each recommendation.

### **From the Consultant's Final Report dated June 6, 2011<sup>2</sup>**

#### **1. Consider reducing the upcoming Levy period from 5 years to 3 years.**

In June 2011, the coverage provisions of the ACA were three years away from becoming effective and enactment was uncertain because of pending lawsuits. It was expected that in 2014, more would be known about the implementation of ACA coverage expansion and the impact if enacted. The consultants noted that at the end of the three-year Levy cycle, consideration can be given to resuming the traditional five-year Levy period, as well as possibly consolidating the Indigent Care Levy with the Family Services Levy, which is also set to expire in 2014.

Disposition: This recommendation for 2012-2014 was followed.

#### **2. Consider continuing to provide funding from the Levy to UH and CCHMC.**

The consultants noted that both hospitals provided total cost of care to the indigent that exceeded the Net Community Benefit thresholds and provided cost of care to eligible residents of Hamilton County exceeding the Levy funding amounts. The recommendation to consider continuation of hospital funding was accompanied by a recommendation to establish targets and conditions for the hospitals:

1. The focus of the Levy dollars should be on preventative care rather than emergency care services.
2. An effort should be made by the Hospitals to reduce administrative costs.
3. Require UCMC to agree to continue to provide staff for OBGYN care at the City's Health Centers.
4. Achieve reduction of Hamilton County's infant mortality rates.

Disposition: Continued funding was provided to the two hospitals. The first and third recommendations were made a part of the contract with the hospitals (the third applies to UCMC only). The second and fourth recommendations were not included in the contract.

#### **3. Consider allocating some funding from the Levy to the City of Cincinnati Health Centers.**

The Cincinnati Health Department requested Levy funding to maintain the existing level of service at the City's Health Centers and to acquire additional staffing to improve access. In addition, enhanced ED diversion programs (see recommendation below) could shift some cost of care from the Hospitals to the Health Centers, but at a lower total cost. The consultants recommended shifting a portion of hospital Levy funding from the Hospitals to the Cincinnati Health Department.

Disposition: This recommendation was not adopted.

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<sup>2</sup> "Hamilton County Indigent Care Levy: Hospital Indigent Care Services Final Report" dated June 6, 2011.

**4. Emphasis on Emergency Department (ED) Diversion Programs:**

The consultants recommended that the County consider increased support for an enhanced ED Diversion Program to reduce the dependency on high-cost emergency care, as advocated by the Health Care Access Network (HCAN).

Disposition: Both hospitals presented evidence of emphasizing ED Diversion practices in their operations, and the hospital contract contains a provision requiring ongoing resources to enhance access to primary care.

**5. Reporting Requirements:**

The final recommendation was to require the Hospitals to provide data in the areas noted for targeted improvement in recommendation 2 above. This would provide the County with data that could be analyzed and measured to determine how effective the Hospitals were in implementing the aforementioned initiatives.

Disposition: The contract with the hospitals requires no new reporting requirements.

**From the Report of the TLRC Subcommittee Dated June 24, 2011<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 (2012, 2013, and 2014)

Disposition: This recommendation was followed.

**Recommendation 3:** the Levy should not provide funding for Cincinnati Health Department

Disposition: This recommendation was followed.

**Recommendation 4:** that Levy funds in an amount of between \$5.75 million and \$6 million per annum be allocated to CCHMC in support of pediatric indigent care

Disposition: CCHMC funding was targeted to be \$5.2 million for each of the three years.

**Recommendation 5:** that Levy funds in an amount of between \$15.5 million and \$20.0 million per annum be allocated to UCMC in support of non-pediatric indigent care

Disposition: UCMC funding was targeted to be \$20.9 million for each of the three years, and later reduced for 2014.

**Recommendation 6:** that Levy providers be held responsible in their contracts with Hamilton County for achieving specific goals in implementing the Levy's new initiatives. (The Subcommittee report listed six

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<sup>3</sup> From report to the Hamilton County Board of Commissioners dated June 24, 2011, "Report of a subcommittee of the Hamilton County Tax Levy Review Committee formed to review the hospital funding portion of the Hamilton County Indigent Care Levy".

goals and one to four metrics for each goal. The goals were focused on improved quality of care and improved outcomes in care for diabetes, asthma, and cardiovascular disease, as well as advancing the primary care medical home model and establishing new community health registries.

Disposition: The contract with the hospitals includes none of the goals or metrics.

### **Activity from 2012 to 2014**

The Levy was approved by the voters in November 2011 for the three-year period ending December 31, 2014. Under this Levy, the County initially allocated \$20.9 million per year for UCMC and \$5.2 million for CCHMC.

In November 2013, the BOCC modified the intended use of the Levy proceeds for the third and final year of the current levy period. A transfer of approximately \$6.65 million of Probate Court and Sheriff's Department costs from the General Fund to the Indigent Care Levy Fund was approved. To partially offset this transfer, the fixed payment of Levy funds to UCMC was reduced by \$6.0 million to \$14.9 million for 2014.

In addition, the BOCC agreed to a provision whereby any uncommitted tax levy proceeds remaining in the Levy fund at the end of the current levy cycle shall be paid to UCMC. Any additional distribution to UCMC pursuant to this paragraph cannot cause the distribution to UCMC from the County in 2014 to be more than \$20.9 million.

The latest projection of 2014 revenues and expenditures shows an uncommitted balance of \$4.7 million in the Levy fund at the end of the year. Pursuant to the above provision, this amount would be paid to UCMC in addition to the \$14.9 million fixed payment, resulting in an estimated \$19.6 million total 2014 payment to UCMC.

These payments were conditioned on the hospitals, the University of Cincinnati, and the County executing an agreement regarding the use of the funds. As the parties worked toward securing an agreement, the BOCC authorized seven interim agreements between March 21, 2012, and November 30, 2013, to enable periodic payments to be made to the hospitals. A final agreement for 2012-2014 was executed in April 2014. HMA was informed that the final agreement supersedes the provisions of the interim agreements and extensions. For purposes of our review of contract provisions and hospital compliance therewith, HMA utilized only the terms of the final executed agreement.

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.

## Compliance with Current Levy Requirements

HMA reviewed the final agreement between the Hospitals and the County<sup>4</sup> and for each hospital requirement therein, made inquiries and performed review procedures to ascertain whether the Hospitals are in compliance. Based on the results of our inquiries and other procedures, both hospitals comply with the majority of the contract provisions including each of the primary financial tests called for in the contract.

There are a number of documents that the hospitals are required to provide periodically to the County. In six instances, UCMC did not supply the documents specified in the contract. In two instances CCHMC did not supply the documents specified in the contract. Two of the reporting requirements were not part of the interim agreements and were added to the final agreement. Given that the final agreement was executed less than 30 days prior to the date of this report, it is understandable that the reporting requirements have yet to be met.

Under the contract, the County is required to notify the hospitals of a failure to comply and provide 30 days to resolve the issues and achieve compliance. If noncompliance is not resolved within 30 days, the Hospital would be in default. We were informed by the Hospitals that the County has not communicated any compliance concerns.

The following table documents the results of our review in more detail.

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

Agreement Provision	UCMC	CCHMC
<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.	Based on review of information provided by the Hospital, UCMC meets this test.	Based on review of information provided by the Hospital, UCMC meets this test.
<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.	Based on discussions with the Hospital and review of its website, the Hospital complies with this provision.	Based on discussions with the Hospital and review of its website, the Hospital complies with this provision.
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.	Based on the information provided by the Hospital, we ascertained that physician services were excluded from the calculation of Services.	Based on the information provided by the Hospital, we ascertained that physician services were excluded from the calculation of Services.

<sup>4</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 April 2014.

Agreement Provision	UCMC	CCHMC
<b>3 Eligible Individuals</b> The 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.	The Hospital provided the County and HMA with a copy of its financial assistance policy revised on June 27, 2012. We were informed that the policy has not been revised since this date.	The Hospital provided the County and HMA with a copy of its financial assistance policy revised on April 1, 2014.
<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, as provided in Section 6(c) hereof.  To the extent Medicaid coverage is expanded in Ohio on or after May 1, 2013, each Hospital will develop plans and processes to assist in the enrollment of County residents that become newly eligible for Medicaid services.	We were informed the Hospital has maintained participating status with Medicare and Medicaid.  Not provided by the Hospital.  The Hospital has developed processes for enrolling County residents that are newly eligible for Medicaid.	We were informed the Hospital has maintained participating status with Medicare and Medicaid.  We reviewed documentation provided by the Hospital, noting compliance with this requirement.  The Hospital has developed processes for enrolling County residents that are newly eligible for Medicaid.
<b>4(b) Nondiscrimination</b> Each Hospital agrees that, as a condition to this Agreement, it shall not discriminate against any patient on the basis of race, color, sex, religion, natural origin, handicap, or any other factor specified in the law.	We were informed the Hospital has complied.	We were informed the Hospital has complied.
<b>4(c) Compliance with Agreement and Law</b> UC Health and each Hospital shall at all times be in compliance with the terms and conditions of this Agreement and each Hospital shall at all times be in compliance in all material respects with all laws, rules and regulations of any governmental authority applicable to the operation of a hospital facility.	We were informed the Hospital has complied.	We were informed the Hospital has complied.
<b>4(d) Accreditations</b> Each Hospital shall maintain all appropriate accreditations, certifications and licensures necessary to render the Services contemplated hereby.	We were informed the Hospital has maintained all necessary accreditations, certifications and licenses.	We were informed the Hospital has maintained all necessary accreditations, certifications and licenses.
<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	Based on our review, the Hospital meets this requirement for each fiscal year.	Based on our review, the Hospital meets this requirement for each fiscal year.

Agreement Provision	UCMC	CCHMC
<b>\$12,200,000 and CHMC shall provide a “Net Community Benefit” of \$4,000,000.</b>		
<b><u>4(f) Consultation Concerning Coordinated Medical Care</u> 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 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.</b>	We were informed of no specific requests by the County on coordination of care.	We were informed of no specific requests by the County on coordination of care.
<b><u>4(g) Emergency Room Diversion</u> 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.</b>	The Hospital presented evidence of emphasizing ED Diversion practices and continued focus on primary care.	The Hospital presented evidence of emphasizing ED Diversion practices and continued focus on primary care.
<b><u>4(h) Obstetric and Gynecology Services</u> UCMC and UC Health agree that UCMC will continue to provide the same level of care it currently provides for outpatient obstetric and gynecological services at the five (5) City of Cincinnati Health Department primary care health centers through at least December 31, 2014.</b>	We were informed that the Hospital continues to meet this requirement.	Not applicable.
<b><u>4(i) Criminal Records Check</u> The Hospitals shall meet with the Hamilton County Office of Reentry concerning the implementation of the Ohio Criminal Records Check law regarding the Hospital’s employment practices and procedures in relation to the passage of Ohio Senate Bills 160, 38 and 337.</b>	As of the date of this report, the requirement has not been met but the parties are working on scheduling the required meeting.	As of the date of this report, the requirement has not been met but the parties are working on scheduling the required meeting.
<b><u>6 Annual Performance Data</u> 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</b>	Information on visits and total cost of care is provided to the County. The report does not include the number of individuals treated.	We were informed that CCHMC does not provide this information to the County. CCHMC officials stated that the County has not provided written instructions related to this data.

Agreement Provision	UCMC	CCHMC
<b>furnished by the Hospital to Eligible Individuals during the fiscal year.</b>		
<b><u>7(a) Reporting Requirements</u> a copy of its final data for the prior fiscal year submitted to HCAP contemporaneously with its submission to HCAP</b>	Not provided by the Hospital.	We reviewed documentation provided by the Hospital, noting compliance with this requirement.
<b><u>7(b) Reporting Requirements</u> 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>	Not provided by the Hospital.	We reviewed documentation provided by the Hospital, noting compliance with this requirement.
<b><u>7(c) Reporting Requirements</u> 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 Community Benefit Standards</b>	We reviewed the documentation provided by the Hospital, noting compliance with this requirement.	We reviewed documentation provided by the Hospital, noting compliance with this requirement.
<b><u>7(d) Reporting Requirements</u> a report of the Hospital's efforts in enrolling patients in the Medicare and Medicaid programs</b>	Not provided by the Hospital.	We reviewed documentation provided by the Hospital, noting compliance with this requirement.
<b><u>7(e) Reporting Requirements</u> 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>	Not provided by the Hospital.	We reviewed documentation provided by the Hospital, noting compliance with this requirement.
<b><u>7(f) Reporting Requirements</u> 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>	The Hospital did not provide these forms to the County.	The Hospital did not provide these forms to the County.
<b><u>7 Additional Commitments from Sale of Drake Hospital</u> During the term of this Agreement, UC Health will report to Budget and Strategic Initiatives quarterly on the status of the Drake Agreement for Additional Commitments approved on March 13, 2012.</b>	Hospital officials informed us that one of the four commitments is in process but has yet to be completed; the other three commitments have been met. The quarterly reporting has not commenced.	Not applicable.

Agreement Provision	UCMC	CCHMC
<p><b><u>11 Insurance/Self-Insurance</u></b>  <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></p>	<p>We were informed the Hospital maintains the required insurance coverage.</p>	<p>We were informed the Hospital maintains the required insurance coverage.</p>
<p><b><u>14(b) Abortion Related Procedures</u></b>  <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.</b></p>	<p>We were informed that this requirement is met.</p>	<p>We were informed that this requirement is met.</p>

## Current Environment and Background

### Uncompensated Care in General

As in most states, 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 to millions of Ohioans. As of December 31, 2013, an estimated 1.5 million residents had no insurance, and nearly 2.4 million were enrolled in Medicaid. The most recent survey from the Ohio Hospital Association (OHA)<sup>5</sup> reports that in 2011, Ohio hospitals had \$1.2 billion of Medicaid losses. The average hospital receives Medicaid reimbursement that is well below cost. In addition, hospitals provided \$1.0 billion annually of charity care.

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 \$360 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 \$315 million annually in Medicare DSH. Both the Medicaid and Medicare DSH programs are subject to significant reductions under the ACA.
- 2) **Charitable fundraising.** As most are tax-exempt charities and are often highly regarded in their communities, hospitals are able to 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.

<sup>5</sup> Figures derived from "2013 Community Benefit Report" published by the Ohio Hospital Association, [www.ohanet.org/communitybenefit](http://www.ohanet.org/communitybenefit).

- 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, even after considering DSH payments and donations. Hospitals are therefore required to 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 2011, hospitals payments from private insurance averaged more than 130% of cost (while hospitals earned less than 5% margins across all payers).
- 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- and city-owned hospitals across the country, which may have losses absorbed by the larger governmental unit.

## Ohio Medicaid

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 typically follow the same reimbursement formulas as the state, although managed care plans and hospitals are free to negotiate alternative payment terms.

Ohio Medicaid has also adopted two supplemental pools to provide hospitals with additional reimbursement. One pool is referred to as the Upper Payment Limit (UPL) pool in reference to federal regulations that restrict how much an individual hospital can receive. The second pool is the HCAP, Ohio Medicaid's DSH program as discussed below. In addition, 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.

To fund 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 generates over \$500 million per year to the state. Along with the federal match, the franchise fee generates additional funding for Ohio Medicaid, including funds for the UPL pool and Managed Care incentive.

In the last two budget cycles, the state administration and legislature have adopted a number of changes included major reductions to Ohio Medicaid hospital reimbursement:<sup>6</sup>

- A new inpatient DRG model implemented on July 1, 2013, that increases total annual payments by an estimated \$84 million per year. According to modeling performed by the state and the

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<sup>6</sup> Analyses and projected impacts of recent Ohio Medicaid reimbursement changes were provided to HMA by the Ohio Hospital Association.

OHA, annual inpatient DRG payments to UCMC and CCHMC are estimated to increase by \$2 million and \$5 million, respectively.

- Several reductions in 2012-2013 used to help balance the state budget. The OHA estimated that the annual impact is a reduction of \$316 million per year. UCMC and CCHMC estimated impacts were \$8 million and \$14 million, respectively.
- Additional reductions being implemented in 2014-2015. These reductions are also for state budget purposes. The rationale provided by the state is that these cuts are acceptable because of the gains hospitals will experience from Medicaid coverage expansion in Ohio. The OHA estimates that, when fully phased in, these cuts will total \$250 million per year, including \$9 million for UCMC and \$3 million for CCHMC.

Prior to this latest set of changes, Ohio hospitals were on average reimbursed by Medicaid an estimated 82% of costs before consideration of supplemental payments and 95% of cost with supplemental payments. The latter is better than the national average of 89% of cost. However, after the above changes are accounted for, Medicaid payments will be only 75% of cost before supplemental payments and 87% of cost after including supplemental payments.

### 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.

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, a rate of approximately 0.84% on the first \$216 million of a hospital's cost and a rate of 0.66% applied to hospital costs in excess of \$216 million.

Once the assessment is calculated and totaled across all hospitals, the state is able to determine the total amount of HCAP payments. Medicaid is funded by a combination of state/local funds and a federal match. The federal match rate changes each year and varies by state; Ohio's federal match rate is approximately 63% in 2013. 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 2013 the amounts were as follows:

Total hospital assessment	\$211,000,000
Federal match	<u>\$367,000,000</u>
HCAP funds available	\$578,000,000

Under Ohio Medicaid policy, the HCAP funds are divided into seven different pools and each pool is distributed to hospitals that are eligible for the given pool. The three largest pools are described as follows:

*High Medicaid pool:* 7.85% of HCAP is 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 2013, only 13 Ohio hospitals, including UCMC and CCHMC, were eligible for this pool.

*Medicaid shortfall pool:* 20.40% of HCAP is placed in a pool for hospitals with Medicaid shortfalls (Medicaid costs exceed non-HCAP Medicaid payments), and the money is distributed to these hospitals based on their share of the Medicaid shortfall. Most Ohio hospitals have Medicaid shortfalls and receive payments from this pool.

*Disability assistance and uncompensated care:* 61.12% HCAP is placed in a pool and distributed to all eligible hospitals based on their share of uncompensated care for patients receiving disability assistance and patients at or below 100% of FPL. Most hospitals are eligible to receive payments from this pool.

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

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.

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/uninsured patient volume may have HCAP losses, where the payment is less than the assessment. In 2013, 44 hospitals or one in five 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 estimated value of hospitals' tax-exempt status in terms of federal, state, and local tax revenues foregone coupled with the ability to raise funds through charitable contributions is estimated to be well in excess of \$20 billion per year.

For decades, the requirements of tax-exemption at the federal level have been vague. 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 a particular group of doctors; and (4) no net earnings may inure to the benefit of any individual. Although certain states have taken a more aggressive stance over the years in setting requirements for tax-exemption, the federal government had done little in terms of setting criteria or taking direct enforcement action.

In recent years, however, nonprofit hospitals have come under increasing public, congressional, and IRS scrutiny. Much of this scrutiny has centered on hospital billing and collection practices (e.g., imposition of the highest possible charges on uninsured and underinsured patients accompanied by aggressive collection actions). 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 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 now conduct a community health needs assessment and make the assessment available to the public. Each assessment must take into account 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 adopt, implement, and publicize widely 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 that are 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 must now give “most favored nation” billing treatment to certain uninsured patients. That is, they are now 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 information regarding charity care, community benefits, community activities, bad debts, collection practices, community-building activities, and a health needs assessment. As a result of this form, the federal government is now collecting in a standardized way a wide array of data about tax-exempt hospitals. This information will inform the debate about the future of tax-exemption for hospitals.

### Catholic Hospital Association Community Benefit Standards

CHA Community Benefit Standards refer to guidance issued by the Catholic Hospital Association (CHA)<sup>7</sup>. A decade ago, when community benefit reporting was becoming the norm, there was considerable debate about what should be counted in the definition of Community Benefit. The CHA devised a set of recommendations that was considered to be balanced and reasonable; over time, it has become a default industry standard. The CHA guidelines state that the following should be counted:

- **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, VA, and other government programs that are not means tested.
- **Community Benefit Services:** As a general rule, count:
  - Programs that respond to an identified community need and are designed to accomplish one or more community benefit objectives.
  - Programs and activities directed to or including at-risk persons, such as underinsured and uninsured persons.
  - Programs offered to the broad community designed to improve community health.
- **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

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<sup>7</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/).

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 are provided despite a financial loss so significant that negative margins remain after removing the effects of financial assistance, bad debt, and Medicaid shortfalls. Nevertheless, the service is provided because it meets an identified community need and, if no longer offered, 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 report as community benefit 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 for a community benefit purpose. In-kind services include hours contributed by staff to the community while on health care organization work time, the cost of meeting space provide to community groups, and the donations of food, equipment, and supplies.
- **Community-Building Activities:** Community-building activities improve the community's health and safety by addressing the root causes of health problems, such as poverty, homelessness, and environmental hazards. These activities strengthen the community's capacity to promote the health and well-being of its residents by offering the expertise and resources of the health care organization. Costs for these activities include cash and in-kind donations and expenses for the development of a variety of community-building programs and partnerships.

## 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.

The ACA was enacted with the goals of increasing the quality and affordability of health insurance, lowering the uninsured rate by expanding public and private insurance coverage, and reducing the costs of healthcare for individuals and the government. It introduced a number of mechanisms—including mandates, subsidies, and insurance exchanges—meant to increase coverage and affordability. The law also requires insurance companies to cover all applicants within new minimum standards and offer the same premium rates regardless of pre-existing conditions.

Many sections of the ACA address 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 qualifying providers – including hospitals – can form Accountable Care Organizations and share in Medicare cost savings; and financial penalties for hospitals with “excessive” readmissions. In addition, the law creates a Center for Medicare and Medicaid Innovation to test innovative payment and service delivery models.

**Workforce and Graduate Medical Education:** The law provides grants and loans to enhance workforce education and training, to support and strengthen the existing workforce, and to help ease health care workforce shortages. It creates the National Health Care Workforce Commission to analyze the supply, distribution, diversity, and skill needs of the health care workforce of the future.

**Wellness and Prevention:** The law invests resources in prevention and wellness, including allocating \$12.9 billion over 10 years to the Prevention and Public Health Fund. It requires public and private insurers to cover recommended preventive services, immunizations, and other screenings with zero enrollee cost sharing (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.

**Quality, Disparities, and Comparative Effectiveness:** The law takes steps toward paying for quality rather than volume of services by implementing “pay-for-reporting” systems across all providers and moving many providers toward value-based purchasing systems in the future. It also applies financial penalties to hospitals with “high” rates of hospital-acquired conditions. The law establishes a national quality improvement strategy, creates a public-private institute to analyze the comparative effectiveness of treatments, and creates a patient safety research center to promote the adoption of best practices. In addition, it contains a number of provisions to improve the delivery of health care services, particularly to low-income, underserved, uninsured minority, and rural populations.

**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 a number of 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. The law also provides enhanced payments to rural hospitals, extends a number of expiring Medicare provisions, expands the 340B drug discount program, and provides additional payments to primary care physicians.

**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.

**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 January 1, 2014, include:

- 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 to 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.
- 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, unless the applicable individual has a financial hardship or is a member of a recognized religious sect exempted by the Internal Revenue Service.
- Health insurance Exchanges are established in each state (some operated by the state and some by the federal government at the state’s option) as a new avenue by which individuals and small businesses can compare policies and buy insurance (with a government subsidy if eligible). In the first year of operation, open enrollment on the Exchanges ran from October 1, 2013, to March 31, 2014. For plans starting in 2015, the proposed enrollment period is November 15, 2014 to February 15, 2015.
- The law includes subsidies to help people with low incomes comply with the mandate. Individuals and families whose incomes are between 133% and 400% of the federal poverty level will receive federal subsidies on a sliding scale if they purchase insurance via an Exchange. The size of the federal subsidy (via a tax credit) is calculated on a sliding scale based on household income.
- Small businesses will be eligible for subsidies for a limited period.
- Medicaid eligibility is expanded to include individuals and families with incomes up to 138% of the federal poverty level, including adults without disabilities and without dependent children.
- 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. In July 2013, this provision was delayed for one year.

## 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 527 beds and in 2013 had 30,212 inpatient admissions, 86,932 emergency department visits, and well over 300,000 outpatient visits. 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 a member of UC Health, a nonprofit corporation that owns or controls one other acute care hospital, a post-acute care facility, a 600+ physician organization, and other supporting entities. UCMC is the main teaching hospital for University of Cincinnati College of Medicine. Over 400 residents and fellows receive training at UCMC. In fact, UCMC was the first teaching hospital in the U.S.

### Financial Position and Recent Financial Performance

UCMC has experienced challenges in generating sufficient margins from operations but has a reasonably solid and improving financial position. UCMC recently received an A3 bond rating from Moody's Investor Services. This rating represents an upgrade from its previous rating of Baa. The rating agency cited UCMC's recent increase in market share and improving financial condition as reasons for the upgrade, along with approval of UCMC's direction and strategy.

The table below presents selected information from UC Health's audited financial statements for the four 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 Selected Financial Information, for the Years Ended June 30 (thousands of dollars)<sup>8</sup>**

	2010	2011	2012	2013
cash and investments	\$233,246	\$382,055	\$439,954	\$433,719
current assets	\$380,477	\$522,727	\$615,896	\$634,170
total assets	\$857,054	\$1,023,056	\$1,197,961	\$1,221,343
current liabilities	\$182,567	\$182,087	\$173,174	\$147,555
long-term financing	\$165,226	\$300,009	\$326,891	\$332,193
net assets	\$341,956	\$420,645	\$505,947	\$591,531
total revenue	\$859,845	\$921,446	\$1,155,333	\$1,206,240
total expenses	\$858,841	\$898,519	\$1,122,488	\$1,214,240
operating margin	\$1,004	\$22,927	\$32,845	(\$8,000)
days cash on hand	105	164	150	137
current ratio	2.1	2.9	3.6	4.3
debt to capital	0.33	0.42	0.39	0.36
operating margin	0.1%	2.5%	2.8%	-0.7%
average age of plant	10.1	11.1	11.1	11.4

<sup>8</sup> All amounts are derived from Audited Consolidated Financial Statements of UC Health for each of the fiscal years ended June 30, 2010 to 2013.

In 2012, UC Health acquired the University of Cincinnati Physicians organization (UCP) and began reporting the assets, liabilities, and operations of UCP in its financial reports in 2012. Consequently, comparisons between 2010-2011 and 2012-2013 in the table are affected by the inclusion of UCP in the latter period only.

**Financial Position:** From 2010 to 2013, net assets increased by \$250 million. Slightly more than half of this increase is a result of the acquisition of UCP; positive operating margins in three of the four years along with income earned on investments account for most of the remaining increase in net assets. UC Health has strong and growing liquidity, as reflected by a 32-day increase in Days of Cash on Hand (the number of days of average spending the entity's cash reserves will cover) and a doubling of its current ratio (current assets compared to current liabilities). Long-term borrowing has doubled, but the debt-to-capital ratio has remained relatively stable. 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 10% since 2010, reflecting 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. These strategies have produced very good volume growth in the last two years. Admissions at UCMC increased 7% between 2011 and 2013; admissions at West Chester increased over 50% in the same period. Through six months of 2014 admission growth slowed at both facilities but grew 7% when factoring in observation cases. Likewise, outpatient surgery growth has been very strong. UC Health is expanding service lines to differentiate itself, including a new bone marrow transplant service that started in March 2013 at UCMC. The system is also investing in ambulatory locations.

Operating margins were on an upward trend and reasonably strong in 2011 and 2012. 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. Financial statements for 2014 were not provided to HMA, but we were informed that operating performance has returned to 2011-2012 levels in the current fiscal year.

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, 2010 to 2013 (thousands of dollars)**

	2010	2011	2012	2013
Levy Payments	\$25,480	\$21,490	\$21,490	\$20,900
Total Revenues	\$859,845	\$921,446	\$1,155,333	\$1,206,240
Percentage - Levy Payments to Revenues	3.0%	2.3%	1.9%	1.7%

Over the four-year period, the sum of Levy payments exceeded the sum of operating margins by \$40 million. This should not be construed to suggest that UC Health would have lost \$40 million from operations without Levy revenue, because management interventions are possible to offset or lessen

the impact of a change in any revenue source. However, the analysis does underscore UCMC's historical reliance on the Levy funds.

## Financial Assistance Policies

The following is taken from the UCMC website at <http://uhealth.com/financial/financial-assistance/>

UC Health is committed to extending financial assistance to qualified individuals. We assist underinsured and uninsured patients in navigating federal and state health insurance programs and help enroll those patients in the programs for which they are eligible.

We provide financial counselors who assist patients to determine eligibility and to complete the application process. We have also taken additional steps to build a convenient and patient-friendly process that maximizes enrollment in certain government-sponsored health insurance programs, to include Medicaid. For example, The University of Cincinnati Medical Center has partnered with the Hamilton County Department of Job and Family Services to support a team of caseworkers who are stationed at that hospital and who are responsible for determining Medicaid eligibility and assisting those eligible in the application process.

### Criteria for Financial Assistance:

- Before any financial assistance is granted, you must have already exhausted all other sources of payment including insurance, public assistance, litigation or third-party liability.
- Family income in relation to income guidelines
- Assets (e.g. home, bank account, stocks)
- Any additional financial hardship
- You must be receiving non-elective, medically necessary care

To determine if you may be eligible for available financial assistance programs, you must provide a completed Financial Assistance Application, along with a copy of one of the documents identified from Proof of Income and Proof of Residency. Upon receipt, we will process your application and notify you of our determination.

### *Notification:*

You will receive written notice of approval or denial of your request for financial assistance within approximately 14 days from the time we receive your completed application and supporting documentation. Incomplete applications will not be processed. If you are denied, it means that you did not meet the criteria by which to qualify for financial assistance and you are responsible for payment of the care you received. If you wish to appeal, you may call Customer Service and ask to speak to a supervisor.

UC Health treats all patients with dignity and respect from registration to the billing office. We will not discriminate in the determination of financial assistance eligibility on the basis of race, color, ethnic origin, sexual orientation, marital status, creed, age, sex or disability.

*Discount to Self-Pay Patients Who Do Not Qualify for Financial Assistance:*

UC Health facilities provide discounted pricing to uninsured patients who do not qualify for charity assistance. The discount is equal to 40% of the estimated gross charges for anticipated hospital services. It is automatically applied at the time of billing to all accounts designated as “self-pay” when charity assistance criteria are not met.

Patients without medical insurance or in some cases, those whose plan coverage does not pay for an anticipated hospital service, qualify for the uninsured discount. Whenever possible, financial counseling and discounted pricing will be discussed with patients prior to admission or before discharge from the hospital.

The following excerpts are from the UC Health current Charity Care and Financial Assistance Policy.

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.

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

a) 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.

b) Financial Counselors who may visit patients and their families on the floors as early in the medical visit as is 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.

2. Staffed at the Patient Financial Services office located at 3200 Burnet:

a) Access Unit - who provide pre-registration, insurance verification and pre-service collection of deductibles, copays, and uninsured services.

b) 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.

c) 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 V. below).

#### 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. UC Health has also taken additional steps to build a convenient and patient friendly process that maximizes enrollment in certain government-sponsored health insurance programs, to include Medicaid. For example, University Hospital has partnered with the Hamilton County Department of Job and Family Services to support a team of caseworkers who are stationed at that hospital and who are responsible for determining Medicaid eligibility and assisting those eligible in 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 is a United States citizen, 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:

Income less than or equal to 150% of FPG 100%

Income greater than 150% of FPG but less than or equal to 175% of FPG 75%

Income greater than 175% of FPG but less than or equal to 200% of FPG 50%

#### COMMUNICATION OF THE CHARITY CARE AND FINANCIAL ASSISTANCE POLICY TO PATIENTS AND THE COMMUNITY

UC Health is committed to publicizing this policy and the financial assistance programs available within the communities it serves by taking the following steps:

- A copy of this policy is posted on the UC Health internet website that patients can reference.
- Financial Counselors make a copy of this policy available to all uninsured patients and will provide a copy to any other person who requests it.
- Signs are posted throughout the Emergency Room and other areas within each hospital facility providing details of financial assistance available.
- Pamphlets are available in facility admitting and registration areas outlining those financial programs available to the uninsured.
- All Patient Financial Services correspondence, including patient statements and reminder letters, refer to available financial assistance programs.

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 the 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, a number of 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 40% from standard charges for all uninsured patients is notable, the Hospital's costs average approximately 30% of standard charges. Consequently, requiring an uninsured patient to pay 60% of charges is requiring them to pay double the cost of care on average.

### **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. A screening to identify all uninsured patients over a nine-month period was performed and further screening was done to identify those with four or more visits. These patients, totaling 4200, were selected for initial outreach. UCMC engaged an outside vendor to assist in the outreach program, which included contacting each patient by phone or mail with information about available coverage. In addition, UCMC established a Medicaid Expansion office in the lobby of their main administrative building across the street from the hospital.

These are the results of this initial outreach effort as of mid-April: approximately 1100 have been successfully enrolled in Medicaid, 350 applications are pending, 2300 are still being pursued, and the remainder were either rejected or failed to cooperate. While 1,100 new enrollees is a positive step, this represents a 25% conversion rate – lower than expected given that nearly all of the 4,200 persons initially targeted were expected to be eligible.

The Hospital has now moved onto Phase II, continuing the outreach effort with additional patients as well as continuing to follow 2300 from the initial list. Also, importantly, the Hospital remains vigilant in its ongoing financial counseling and Medicaid enrollment efforts. As existing and new patients make appointments or present for treatment, they are provided with information about Medicaid and offers of assistance, as has been the practice for years. These efforts may ultimately prove to be more effective than the targeted outreach campaign: a person with a current need for health care services is more likely to cooperate than a healthy person who has accessed the hospital in the past.

It remains to be seen how the coverage expansion ultimately affects hospital financial assistance programs. All legal residents of the U.S. have a mandate to enroll in either public insurance coverage at minimal cost (Medicaid) or private insurance at substantially subsidized cost (through the Health Insurance Exchange). Consequently, the only uninsured patients accessing the Hospital will be

undocumented immigrants, foreign residents, and those persons who will not or cannot follow the ACA mandate. It is likely that the majority of uninsured patients treated at UCMC will be in this last category.

Under the Hospital's policies, patients are expected to enroll in insurance programs for which they are eligible, and only if they are ineligible will uninsured persons qualify for financial assistance. If a patient will not or cannot enroll in a program for which he/she is now eligible, the Hospital would have the choice of granting financial assistance on an exception basis or billing the patient and following normal collection procedures. Seeking payment through normal collection procedures will frequently ultimately end by having the Hospital write off the balance as a bad debt; often the bill will be so high that the patient simply will be unable to pay.

As discussed later in this report, the coverage expansion under the ACA will not eliminate uninsured patients; in fact, it is likely that UCMC will continue to have Uncompensated Care Costs far in excess of the current Levy payment level. However, the above scenario raises an interesting question for Hamilton County: Should the Levy be used to support a UCMC financial burden when much of the burden is the result of resident choice not to accept the ACA coverage benefits instead of medical indigence?

### **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 UCMC followed by our comments based on our review of the calculation.

**Table 7 - Annual Services Test Results for UCMC, Fiscal Years 2011-2013**

	Cases	Charges	Cost Ratio	Cost
<b>Fiscal Year 2011</b>				
Hamilton County subset of HCAP Uncompensated Care	83,777	\$149,289,774	31.18%	\$46,550,312
Inmates from Hamilton County Sheriff's Office	1,130	\$4,969,296	31.18%	\$1,549,485
<b>Total Services</b>	<b>84,907</b>	<b>\$154,259,070</b>		<b>\$48,099,798</b>
Levy Payments				\$25,480,000
<b>Services in Excess of Payments</b>				<b>\$22,619,798</b>
<b>Fiscal Year 2012</b>				
Hamilton County subset of HCAP Uncompensated Care	88,586	\$165,505,775	30.41%	\$50,337,235
Inmates from Hamilton County Sheriff's Office	969	\$5,030,371	30.41%	\$1,529,946
<b>Total Services</b>	<b>89,555</b>	<b>\$170,536,145</b>		<b>\$51,867,181</b>
Levy Payments				\$21,490,000
<b>Services in Excess of Payments</b>				<b>\$30,377,181</b>
<b>Fiscal Year 2013</b>				
Hamilton County subset of HCAP Uncompensated Care	81,024	\$172,362,636	30.65%	\$52,833,960
Inmates from Hamilton County Sheriff's Office	836	\$5,121,916	30.65%	\$1,570,010
<b>Total Services</b>	<b>81,860</b>	<b>\$177,484,552</b>		<b>\$54,403,970</b>
Levy Payments				\$20,900,000
<b>Services in Excess of Payments</b>				<b>\$33,503,970</b>

The Hamilton County subset of HCAP Uncompensated Care represents the portion of the HCAP accounts that were Hamilton County residents. Cases represent encounters (inpatient admissions or outpatient visits). Charges are the amounts written off by the Hospital. The cases and 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. As a reasonableness check, we noted the following:

- Charges for the four previous years, 2007-2010, ranged from \$154 million to \$204 million. The 2011-2013 amounts range from \$154 million to \$177 million. The decrease from the previous four years to the most recent three years may reflect improvements in the economy.
- Per the report submitted to the state, HCAP Uncompensated Care charges (net of payments) totaled \$325 million in 2013. The Hamilton County subset is 54% of the HCAP total. We would expect that Hamilton county residents would comprise a larger percentage of the total, but this may reflect the fact that UCMC receives referrals from across the region.

Services to Hamilton County inmates are an appropriate increase to 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 considered to be funded by the Levy.

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 ratio in the submitted 2013 HCAP report was 29.3% of charges. Consequently, 30.65% could be slightly high, but a small variance in cost to charge would not 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 and that CHMC 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. 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 2011-2013**

FISCAL YEAR ENDED 6/30/11	Total Expense	Less Revenue	Net Benefit
Traditional Charity Care	\$43,176,497	\$4,563,568	\$38,612,929
Unpaid Cost of Medicaid	\$111,883,799	\$97,044,465	\$14,839,334
Community Health Improvement Services	\$14,486,203	\$0	\$14,486,203
Health Professions Education	\$50,818,409	\$18,761,262	\$32,057,147
Subsidized Health Services	\$143,284,300	\$121,930,679	\$21,353,621
Other Community Benefits	\$2,511,161	\$0	\$2,511,161
<b>Total</b>	<b>\$366,160,369</b>	<b>\$242,299,974</b>	<b>\$123,860,395</b>

FISCAL YEAR ENDED 6/30/12	Total Expense	Less Revenue	Net Benefit
Traditional Charity Care	\$39,891,800	\$4,517,789	\$35,374,011
Unpaid Cost of Medicaid	\$96,426,213	\$81,922,163	\$14,504,050
Community Health Improvement Services	\$14,571,203	\$0	\$14,571,203
Health Professions Education	\$49,376,012	\$20,051,853	\$29,324,159
Subsidized Health Services	\$113,673,829	\$91,398,309	\$22,275,520
Other Community Benefits	\$2,253,573	\$0	\$2,253,573
<b>Total</b>	<b>\$316,192,630</b>	<b>\$197,890,114</b>	<b>\$118,302,516</b>

FISCAL YEAR ENDED 6/30/11	Total Expense	Less Revenue	Net Benefit
Traditional Charity Care	\$43,176,497	\$4,563,568	\$38,612,929
Unpaid Cost of Medicaid	\$111,883,799	\$97,044,465	\$14,839,334
Community Health Improvement Services	\$14,486,203	\$0	\$14,486,203
Health Professions Education	\$50,818,409	\$18,761,262	\$32,057,147
Subsidized Health Services	\$143,284,300	\$121,930,679	\$21,353,621
Other Community Benefits	\$2,511,161	\$0	\$2,511,161
<b>Total</b>	<b>\$366,160,369</b>	<b>\$242,299,974</b>	<b>\$123,860,395</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 2011-2013**

	FY 2011	FY 2012	FY 2013
Net Community Benefit	\$123,860,395	\$118,302,516	\$143,486,805
Minimum Required	\$12,200,000	\$12,200,000	\$12,200,000
<b>Net in Excess of Minimum</b>	<b>\$111,660,395</b>	<b>\$106,102,516</b>	<b>\$131,286,805</b>

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

- The required Net Community of Benefit of \$12.2 million per year was met comfortably in each year and by nearly 12 times the required minimum in 2013.
- 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

UC Health completed a strategic plan in June 2012 that establishes priorities for the five-year period 2013-2017.<sup>9</sup> The plan is based on a comprehensive assessment of the external environment, UC Health's competitors, an internal assessment, and customer perceptions. Based on these assessments, strategies were developed that are grouped into five categories – quality and excellence, growth, resource stewardship, image, and partnerships. Lastly, the plan identifies from two to seven success factors (or objectives) in each of the five categories.

Our review and analysis focused on elements of the plan that may be germane to the interests of Hamilton County. The following summarizes our observations.

- *Environmental assessment:* Health Care Reform is a major focus, and the plan recognizes the change that is occurring as the industry moves slowly but steadily from a volume-based model to a value-based model, where the goal is high quality and favorable outcomes at a reasonable cost. The plan also recognizes the need to improve the patient experience. Interestingly, the regulatory aspects of Health Care Reform (i.e., the ACA) are framed as challenges (negatives) – the effects of additional cost pressures on insurers and employers are expected to generate continued downward pressure on reimbursement, along with the direct reductions in Medicare/Medicaid reimbursement included in the ACA and other recent legislation. The plan does not address opportunities for improved coverage and access that the ACA offers.

The assessment emphasizes several other industry trends such as demand for and shortages of

<sup>9</sup> Information is derived from "UC Health Strategic Plan 2013-2017" dated June 27, 2012.

primary care physicians and mid-level providers, greater alignment of physicians with hospitals (often through employment), and higher patient expectations.

- *Internal assessment:* The plan identifies several strengths for the organization to leverage, including its many strong clinical specialties and its niche as the region's only adult academic medical center. Weaknesses were noted too, including a shortage of primary care physicians and its poor payer mix (high levels of indigent care). The plan also notes that UCMC image suffers from the perception that it is the provider of last resort. While these are noted as weaknesses, there is nothing in the plan that suggests an interest in improving payer mix by limiting services provided to the medically indigent.
- *Strategic priorities and objectives:*
  1. Increasing quality and excellence will be accomplished by achieving a significant increase in patient satisfaction scores, establishing new centers for excellence, and expanding on existing clinical strengths.
  2. For growth, recruiting additional primary care physicians and adding clinical capacity where UC Health is currently constrained are the major objectives.
  3. Resource stewardship is the term that encompasses creating value through lowering cost and embracing a set of activities referred to as population health. Many of the current "hot topics" in health reform are being worked on or considered, including Accountable Care Organizations, Patient Centered Medical Homes, and improved care coordination.
  4. Improving the image will be achieved by focusing on greater awareness of UC Health's strengths (and not shrinking from its position as the safety net for the region).

Overall, our impression is that UC Health's strategic plan is targeted to help the organization achieve its three-part mission of an academic medical center. A few of the strategic priorities will generate direct benefits to the local community, such as improving quality and enhancing primary care access (especially if underserved areas are targeted); other strategies that are intended to strengthen UC Health can generate downstream economic 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 now required to perform a Community Health Needs Assessment (CHNA) every three years. UC Health completed a CHNA in 2013 and published an implementation plan to address key findings in the CHNA later that year.<sup>10</sup> The CHNA involved an extensive quantitative review of the County's demographics and health status indicators and an extensive qualitative review that utilized interviews and focus groups.

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<sup>10</sup> Information is derived from "University of Cincinnati Medical Center Community Health Needs Assessment" and "Community Health Needs Assessment Implementation Plan", both dated May 2013.

For UCMC, five areas of community health improvement were identified: infant mortality, diabetes/adult obesity/hypertension, stroke, mental health, and cancer. UC Health decided to initially focus on the first three areas. For each area, an implementation plan was developed that identifies an overall initiative, an owner of the initiative, between three and six action steps, and a completion date.

## **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 598 registered beds, including 92 inpatient psychiatry beds and 33 residential psychiatry beds. In 2013, CCHMC had 30,804 inpatient admissions, 127,376 emergency department visits, and nearly 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 a number of supporting organizations, which perform fundraising and provide significant financial support to CCHMC.

### **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 four most recent fiscal years.<sup>11</sup>

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<sup>11</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, 2010 to 2013.

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

	2010	2011	2012	2013
cash and investments	\$272,264	\$325,093	\$428,570	\$509,106
current assets	\$596,850	\$651,696	\$769,524	\$865,211
total assets	\$2,210,440	\$2,468,440	\$2,632,831	\$3,014,072
current liabilities	\$205,160	\$208,075	\$247,454	\$266,886
long-term financing	\$489,536	\$500,903	\$488,588	\$521,269
net assets	\$1,222,514	\$1,533,855	\$1,476,335	\$1,966,105
total revenue	\$1,603,867	\$1,693,438	\$1,810,803	\$1,931,505
total expenses	\$1,539,438	\$1,640,035	\$1,682,055	\$1,778,685
operating margin	\$64,429	\$53,373	\$128,748	\$152,820
days cash on hand	69	78	100	111
current ratio	2.9	3.1	3.1	3.2
debt to capital	0.29	0.25	0.25	0.21
operating margin	4.0%	3.2%	7.1%	7.9%
average age of plant	6.9	6.6	6.8	7.7

**Financial Position:** From 2010 to 2013, net assets (unrestricted and restricted) increased by \$744 million, a 61% gain in three years, largely from positive operating margins and growth in restricted investments. CCHMC's cash reserves are relatively modest, as organizations with AA bond ratings typically have more than double 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 \$1.7 billion of investments held for CCHMC's future use in research and operations, including \$600 million that is unrestricted. CCHMC has strong and stable liquidity, as reflected by its current ratio (current assets compared to current liabilities). The debt-to-capital ratio has decreased sharply and 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 10% since 2010, 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 7.7 years is 25% better than the hospital median.

**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 89% for children age 0 to 14 and an unusually high 82% 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, especially over the last two years where its margins are nearly double the median for AA rated systems.

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

**Table 11 - CCHMC Levy Payments and Total Revenues, 2010 to 2013 (thousands of dollars)**

	2010	2011	2012	2013
Levy Payments	\$5,880	\$5,200	\$5,200	\$5,200
Total Revenues	\$1,603,867	\$1,693,438	\$1,810,803	\$1,931,505
Percentage - Levy Payments to Revenues	0.4%	0.3%	0.3%	0.3%

## Financial Assistance Policies

The following is taken from the CCHMC website at

<http://www.cincinnatichildrens.org/patients/resources/financial-assistance/>

If you are worried about paying your medical bills, we can help you through one of the financial assistance programs at Cincinnati Children's. We are committed to providing healthcare to children, regardless of family income.

What if I do not have health insurance? Financial counselors can help. All families who live in our primary service area and do not have health insurance are eligible for discounts and payment plans. Our primary service area includes Hamilton, Warren, Butler, Clermont, Boone, Kenton, Campbell and Dearborn counties. Discounts vary and are based on family income and size. To receive discounts and payment plans, or to apply for other financial aid programs, you will need to fill out an application in English or Spanish and meet certain requirements.

For more information, contact our financial counselors at 513-636-0201 or email [PFC@cchmc.org](mailto:PFC@cchmc.org).

Is there help if my health insurance does not cover my bills? Family financial advocates assist families that have health insurance but who need additional financial resources to cover medical bills for their chronically ill child. We identify and help families apply for programs including Medicaid, Social Security, waivers, developmental disabilities services, Bureau for Children with Medical Handicaps (BCMh), and other financial assistance and family support resources. Our family financial advocates can also help you resolve billing issues.

The following excerpts are from the CCHMC Patient Financial Assistance Policy.

CCHMC will provide Medically Necessary Hospital-level Services for any patient whose family resides in CCHMC's primary service area without regard to the family's ability to pay. This policy applies to inpatient, outpatient and emergency room services, and to professional services performed by CCHMC-employed providers.

CCHMC works with eligible patients and families to secure government assistance for Medically Necessary Hospital-level Services as a first line of service to patients and families. When requested, an

Uninsured/Underinsured Patient must complete an application for coverage under applicable governmental assistance programs. When an Uninsured/Underinsured Patient requires Medically Necessary Hospital-level Services, CCHMC offers the following financial assistance:

- Uninsured/Underinsured Patients/Families with Gross Income equal to or less than 200% of the
- Federal Poverty Guideline (FPG) shall receive all Medically Necessary Hospital-level Services free of charge to them.
- Uninsured/Underinsured Patients/Families with Gross Income that is between 201% and 250% of the FPG shall receive a 75% discount off Billed Charges.
- Uninsured/Underinsured Patients/Families with Gross Income that is between 251% and 300% of the FPG shall receive a 50% discount off Billed Charges.
- Uninsured/Underinsured Patients/Families with Gross Income that is between 301% and 400% of the FPG shall receive a 35% discount off Billed Charges.
- Uninsured/Underinsured Patients/Families with Gross Income that is greater than 400% of the FPG or who refuse to complete a Financial Assistance Application shall receive a courtesy discount of 25% off Billed Charges.

All patients/families who desire to participate in the CCHMC Financial Assistance Program must cooperate by completing a Financial Assistance Application and providing information to enable CCHMC to verify Gross Income. Refusal to complete the Financial Assistance Application or to provide such information shall mean that an Uninsured Patient/Family only will qualify for the courtesy discount of 25% regardless of income level.

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 post notice of its Patient Financial Assistance Policy at inpatient and outpatient admission areas and other locations as deemed appropriate.

CCHMC personnel will provide a patient/family with a Financial Assistance Application once the patient/family has been identified as uninsured.

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

We inquired of Hospital officials whether the Hospital is in compliance with the Section 501(r) requirements of the ACA. We were informed that CCHMC is substantially in compliance with those requirements and will comply with all the requirements once final rules are issued with guidance to providers. The policies we were provided do not address all aspects of 501(r) such as collection practices. Hospital officials informed us that these requirements, such as notifying patients of financial assistance before turning over to collection agency, are met.

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 reasonable in relation to industry norms. It should be noted, however, that its discount policy results in expected payments from higher-income uninsured patients that are well in excess of cost. CCHMC's average cost-to-charge ratio (actual costs of care compared to standard charges) is approximately 45%, compared to an average of 34% for all Ohio hospitals. This indicates that CCHMC sets its charges with a much smaller mark-up over cost than average. Consequently, a 25% discount at CCHMC is generally going to result in a smaller bill than the same discount at other hospitals. However, a bill that is discounted to 75% of charges is still greater than cost.

### **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 of having uninsured patients enroll in the Health Insurance Exchange and receive subsidized insurance coverage, and 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 nine full-time financial counselors.
- Counselors understand program eligibility rules and are skilled at managing the enrollment and validation processes for Medicaid and other programs.
- Employ eleven full-time family financial advocates.
- 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 2011-2013**

	Cases	Charges	Cost Ratio	Cost
<b>Fiscal Year 2011</b>				
Hamilton County subset of HCAP Uncompensated Care	N/A	\$11,961,129	60.45%	\$7,230,238
Levy Payments				\$6,000,000
<b>Services in Excess of Payments</b>				<b>\$1,230,238</b>
<b>Fiscal Year 2012</b>				
Hamilton County subset of HCAP Uncompensated Care	N/A	\$10,317,844	56.58%	\$5,838,021
Levy Payments				\$5,200,000
<b>Services in Excess of Payments</b>				<b>\$638,021</b>
<b>Fiscal Year 2013</b>				
Hamilton County subset of HCAP Uncompensated Care	N/A	\$10,435,975	54.35%	\$5,671,455
Levy Payments				\$5,200,000
<b>Services in Excess of Payments</b>				<b>\$471,455</b>

Hamilton County subset of HCAP Uncompensated Care represents the portion of the HCAP accounts that were Hamilton County residents. Cases represent encounters (inpatient admissions or outpatient visits). 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 supplied by the Hospital and were not audited. As a reasonableness check, we noted that the weighted average cost-to-charge ratio in the submitted 2013 HCAP report was 54.35% of charges, the same ratio as that supplied by the Hospital.

Based on this information, we conclude that CCHMC meets the required Services test in each year. In 2013, the required Services amount was only 9% greater than the Levy payments.

CCHMC officials point out that the Services calculation excludes physician services, per the contract. For every hospital admission and outpatient visit there is typically a physician component of the encounter, and physicians also incur losses on treating the medically indigent. As an organization that employs its physician staff, CCHMC is responsible for a significant amount of physician uncompensated care in addition to the hospital amounts shown above. Most hospitals do not bear the full extent of physician

uncompensated care because frequently the professional services are provided by private physician practices. Consequently, CCHMC bears a larger physician uncompensated care burden than the average hospital. The rationale for excluding physician services is that only hospital services should be compared to hospital levy payments. HMA supports the exclusion of physician services from the Services test but does agree the additional burden of physician indigent care should be acknowledged.

### Net Community Benefit Calculation

The County contract stipulates that UCMC shall provide a “Net Community Benefit” of \$12,200,000 per year and 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 this 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 2011-2013**

FISCAL YEAR ENDED 6/30/11	Total Expense	Less Revenue	Net Benefit
Unpaid Cost of Medicaid and Charity Care	\$474,986,000	\$284,671,000	\$190,315,000
Subsidized Health Services	\$3,525,000	\$0	\$3,525,000
Community Health Improvement Services	\$3,128,000	\$0	\$3,128,000
<b>Total</b>	<b>\$481,639,000</b>	<b>\$284,671,000</b>	<b>\$196,968,000</b>

FISCAL YEAR ENDED 6/30/12	Total Expense	Less Revenue	Net Benefit
Unpaid Cost of Medicaid and Charity Care	\$496,190,000	\$307,132,000	\$189,058,000
Subsidized Health Services	\$44,496,000	\$41,708,000	\$2,788,000
<b>Total</b>	<b>\$540,686,000</b>	<b>\$348,840,000</b>	<b>\$191,846,000</b>

FISCAL YEAR ENDED 6/30/13	Total Expense	Less Revenue	Net Benefit
Unpaid Cost of Medicaid and Charity Care	\$518,477,000	\$322,847,000	\$195,630,000
Subsidized Health Services	\$1,036,000	\$639,000	\$397,000
<b>Total</b>	<b>\$519,513,000</b>	<b>\$323,486,000</b>	<b>\$196,027,000</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 2011-2013**

	FY 2011	FY 2012	FY 2013
Net cost of community benefits	\$196,968,000	\$191,846,000	\$196,027,000
HCAP/Levy net payments received	(\$18,065,000)	(\$18,126,000)	(\$19,317,000)
<b>Net Community Benefit</b>	<b>\$178,903,000</b>	<b>\$173,720,000</b>	<b>\$176,710,000</b>
Minimum Required	\$4,000,000	\$4,000,000	\$4,000,000
<b>Net in Excess of Minimum</b>	<b>\$174,903,000</b>	<b>\$169,720,000</b>	<b>\$172,710,000</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 by over 40 times the required minimum in each year
- The Hospital did not report costs of health profession education or community programs and outreach (except for a small amount in 2011). Had these amounts been reported, the Net Community Benefit total would be much larger.
- The Medicaid shortfall is much larger than that of the average hospital. On average, including supplemental payments, Ohio hospitals are reimbursed over 90% of costs. In contrast, CCHMC's Medicaid payment is approximately 66% of cost. We were informed that the main reason for this difference is a large number of Medicaid patients from Kentucky and Indiana and policies in these states that offer very low levels of reimbursement to hospitals from other states.
- 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 2015 Strategic Plan. The document does not describe the assessments and analyses underlying the plan and provides a brief outline of the organization's goals and objectives and initiatives being undertaken to achieve them. The following is our recap of the items most relevant to the County's interests.

### Goals:

- **Safety:** Be the safest hospital. Implement systems that reliably deliver safe care to our patients and protect the safety of our employees.
- **Outcomes:** Develop and embed tools for measuring and improving outcomes for 100 diseases and complex disorders and achieve at least 20% improvement for at least 50% of them and best-in-class outcomes for 20 high-impact diseases and complex disorders.
- **Care Integration:** Develop integrated, well-coordinated delivery systems across the continuum of care to improve quality and cost-effectiveness.
- **Community Health:** Lead, advocate and collaborate to measurably improve the health of local children and reduce disparities in targeted populations.
- **Productivity:** Optimize use of facilities and staff and improve patient flow to achieve 20% greater utilization of existing assets.
- **Cost:** Be a model for lowering health-care costs. Reduce inflation-adjusted and severity-adjusted cost per patient encounter by at least 5%.
- **Clinical Expansion:** Improve services for children with targeted diseases and complex disorders by strengthening existing programs and developing new ones.

**Initiatives:**

- Eliminate all preventable serious harm
- For 100 diseases and disorders:
  - Implement self-management programs
  - Embed standardized measures
  - Use improvement science outcomes research
- For 20 high priority diseases and disorders:
  - Integrate research, improvement science and information systems
  - Initiate multi-site improvement/research networks
  - Support team-based relationships for integrative care
  - Develop care management teams for complex patients
- Reduce infant mortality rate
- Reverse the trend of increasing childhood obesity
- Reduce hospital use by children with asthma
- Reduce system delays
- Increase RVU per clinical FTE
- Increase nurse presence for inpatients
- Increase billed hours per operating room
- Reduce ED length of stay
- Increase outpatient clinic utilization
- Reduce supply and drug costs
- Eliminate unnecessary diagnostic tests
- Reduce cost of shared services functions
- Develop at least two new interdisciplinary programs per year
- Expand at least one significant existing program per year
- Develop transitional care capability
- Develop long-term care capability

The plan does not directly speak to health care reform priorities, but several of the above initiatives are focused on important goals of health care reform. Also, while not mentioned specifically in the document we received, CCHMC has embarked on significant population health efforts, including agreements with health plans to take full risk for a large network of children.

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. UCHMC completed a CHNA in 2013 and published an implementation plan to address key findings in the CHNA at the same

time.<sup>12</sup> The CHNA is developed from the results of a 2011 survey called the Child Well Being Survey (CWBS). The 2011 CWBS included 2,100 telephone sessions with parents and other primary caregivers, roughly half from Hamilton County.

From analysis of the CWBS, six areas of pediatric health improvement were identified: infant mortality, obesity, asthma, injury, access to care, and mental health. For each area, an implementation plan was developed that identifies an overall initiative, a metric to measure progress, and between three and six action steps. Each of these areas is addressed in the 2015 Strategic Plan.

## Comparative Review of UCMC and CCHMC to Other Hospitals

The OHA publishes HCAP information<sup>13</sup> by hospital on its website. This offers the ability to make a number of useful and informative comparisons across all hospitals by county and statewide. We included two comparisons in this report:

- 1) *The DSH Limit.* This amount is indicative of the amount of care provided to low-income individuals (Medicaid and the Uninsured). In addition to reporting on the total DSH Limit, we calculated the DSH Limit as a percentage of total patient revenue. This percentage is indicative of the relative burden that a hospital bears for care to low-income patients.
- 2) *The HCAP net gain.* As noted above, the larger the HCAP net gain, the higher the amount of low-income care is provided. We calculated a ratio of HCAP payments to the HCAP assessment. This ratio further demonstrates the differences in low income patient burden from hospital to hospital.

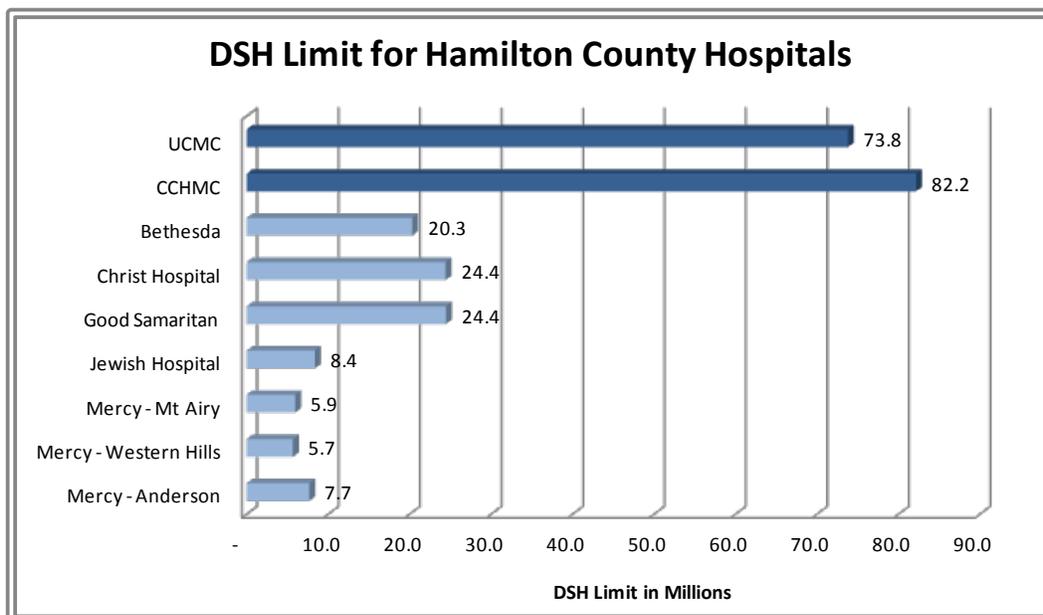
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<sup>12</sup> Information is derived from “Children’s Hospital Medical Center Community Health Needs Assessment Summary” and “Cincinnati Children’s Hospital Medical Center CHNA Implementation Strategy”, both dated June 30, 2013.

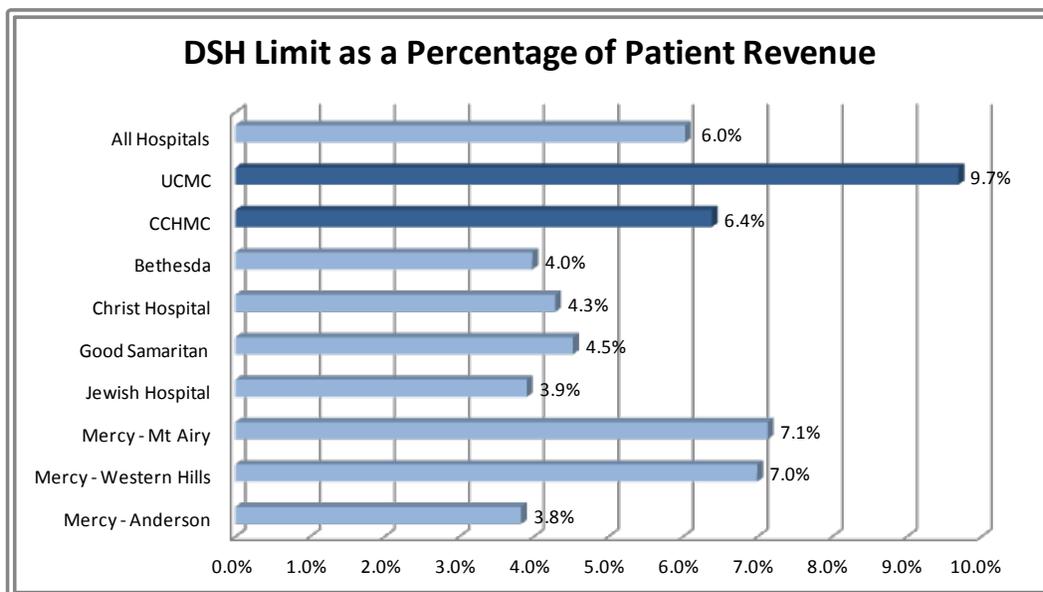
<sup>13</sup> The information in the graphs and tables on pages 43 to 46 is derived from a schedule published on the Ohio Hospital Association website, [www.ohanet.org](http://www.ohanet.org), titled “2013 Preliminary Ohio HCAP Model - Revised Aug 2013”. This schedule lists the DSH Limit, HCAP payments and HCAP Assessment for all Ohio hospitals as of August 2013.

### Comparisons within Hamilton County

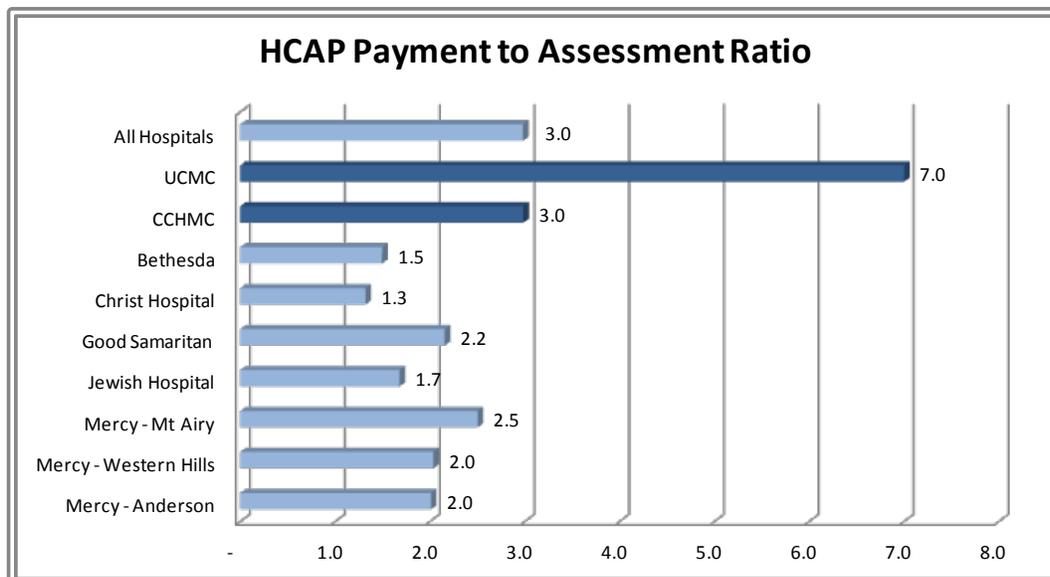
The following graphs are derived from the latest published HCAP data (as of August 2013).



UCMC and CCHMC represent 61% of the total DSH Limit for Hamilton County hospitals.



Compared to all other hospitals, UCMC has by far the largest percentage of patient revenue coming from Medicaid and Uninsured patients. CCHMC is slightly above average for Hamilton County and has the fourth largest percentage (of nine).



The ratio of HCAP payments to assessment is much higher for UCM than for other hospitals. CCHMC is at the average for Hamilton County and has the second largest ratio.

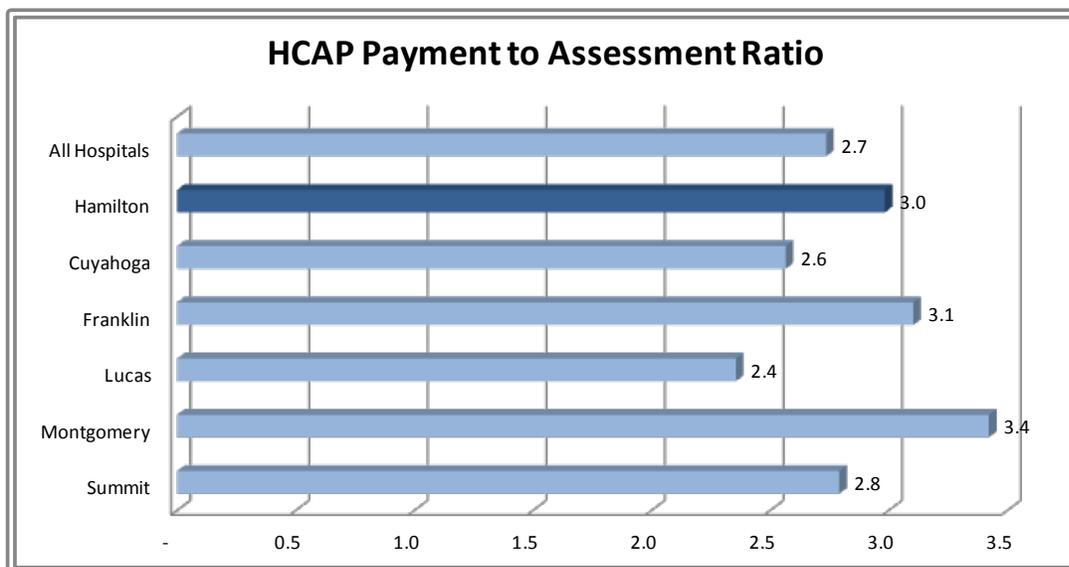
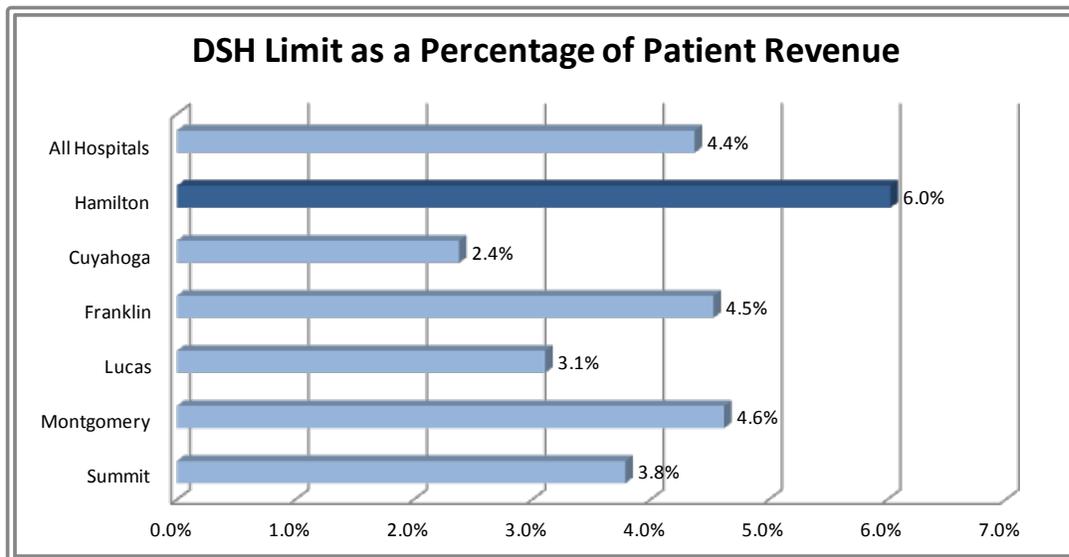
**Table 15 - DSH Limits and HCAP Payment to Assessment Ratio for 12 Largest Hospitals in Ohio**

Name	DSH Limit in millions	DSH Limit as a % of Patient Revenue	Ratio HCAP Payment to Assessment
Cleveland Clinic	\$41.5	1.1%	1.5
Ohio State University	\$61.1	3.9%	4.3
CCHMC	\$82.2	6.4%	3.0
University-Cleveland	\$32.6	2.5%	2.1
Riverside Methodist	\$52.8	5.2%	2.6
Nationwide Children's	\$27.6	2.9%	4.0
Miami Valley	\$43.8	5.7%	4.8
UCMC	\$73.8	9.7%	7.0
Mount Carmel	\$45.6	6.6%	3.0
Summa Health	\$15.1	2.3%	3.0
Toledo Hospital	\$14.4	2.2%	1.6
Metrohealth Medical	\$40.4	6.1%	9.2

In this peer group UCMC has the largest DSH limit in proportion to its revenue and the second highest ratio of HCAP payment to assessment. CCHMC is above the median for the DSH Limit metric but below the median for the HCAP metric.

### Comparisons to Other Counties

The following graphs are derived from the latest published HCAP data (as of August 2013).



Hamilton County hospitals in aggregate are well above the state average on the DSH Limit metric and slightly above average on the HCAP ratio.

## Direct Support Provided by Peer Counties to Hospitals

**Table 16 - Information on County Direct Support for Hospital Indigent Care**

Cuyahoga	Cleveland's safety net hospital, Metrohealth Medical Center, is part of county government. Metrohealth receives an operating subsidy each year to cover revenue shortfalls, principally because of uncompensated care. The 2013 subsidy was budgeted at \$36 million.  In 2013, the county was approved by the federal Medicaid agency for a special program referred to as a waiver, to provide coverage to low-income uninsured adults in advance of the statewide Medicaid expansion. This program allowed Metrohealth and the county to replace a large part of its uncompensated care financial burden with federal Medicaid funds at no additional cost to the state. The program is scheduled to end in 2014 with the implementation of ACA Medicaid expansion.
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.

### Impact of the ACA

The most important impact of the ACA is the opportunity to significantly reduce the number of uninsured residents. This is to be accomplished through two vehicles, Medicaid expansion and Health Insurance Exchanges.

### Medicaid Expansion

The ACA, as originally passed, required each state to expand Medicaid eligibility to adult citizens over 18 years old with household income of 138% of poverty or less. However, the Supreme Court ruled in June, 2012 that the Medicaid expansion could not be required by the federal government. Instead each state was given the option. In October 2013, Ohio elected to move forward with Medicaid expansion.

Prior to the ACA, Medicaid eligibility was typically limited to children from low-income families, 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 began on January 1, 2014. The full cost is initially funded 100% by the federal government. Beginning in 2017, the federal match decreases on a phased-in manner to 90% by 2020. This federal match rate far exceeds the match rate for pre-ACA coverage (which is 63% in Ohio).

## Health Insurance Exchanges and Tax Credit Subsidies

Persons with income levels between 138% and 400% of poverty will have access to subsidized private insurance purchased through a new 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 will face tax penalties if they elect to not enroll or purchase insurance. Also, employers with over 50 employees will face penalties if they do not offer insurance to their eligible employees (although implementation of this provision has been temporarily postponed).

These new policies will expand coverage to millions of Americans. However, according to the latest predictions of the Congressional Budget Office (CBO), there will be 29 million U.S. residents remaining uninsured after ACA implementation.<sup>14</sup> There are many reasons cited for this result:

- Many states not expanding Medicaid.
- Undocumented immigrants and others who do not meet the residency requirements of the law.
- Those who decide it is less expensive to pay the penalty than to buy insurance and are willing to risk that they will not incur a large health expense.
- Lack of awareness, understanding or cooperation.
- Those who object to government support and refuse on principle to buy coverage.

## Impact of Coverage Provisions, Ohio

It is too early to determine the extent to which Medicaid expansion and the Exchange subsidies will reduce the number of uninsured in Ohio and Hamilton County. As of April 30, 2014, nearly 309,000 Medicaid applicants were approved, including 185,000 who fell into the “newly-eligible” Medicaid category and 124,000 eligible for Medicaid under pre-ACA eligibility categories. There were also 120,000 applications still pending. The marketplace Exchange enrolled 155,000 individuals in Ohio. Detailed information about Hamilton County experience and information about the insurance status prior to either Medicaid or Exchange enrollment (individual or group insurance, or uninsured) is not yet available.

Most experts predict that it will take between two and four years for the full effect of coverage expansion to be realized. Consequently, six months of Medicaid and Exchange enrollment data is not conclusive. To gauge the potential long-term impact, three previous studies projecting Ohio results were reviewed for this report. A report by Milliman, Inc., for the Ohio Department of Insurance in 2011,<sup>15</sup> a

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<sup>14</sup> Information is derived from a report entitled “Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act”, April 2014 from the Congressional Budget Office.

<sup>15</sup> Estimates are derived from a report prepared by Milliman, Inc. dated August 21, 2011 for the Ohio Department of Insurance entitled “Assist with the first year of planning for design and implementation of a federally mandated American Health Benefit Exchange”.

report by Mercer Health and Benefits LLC for the Ohio Office of Medical Assistance,<sup>16</sup> and a report from the Urban Institute conducted in 2012.<sup>17</sup> The predicted changes in uninsured, Medicaid enrollment, and individual policies (where applicable) are summarized below:

***Milliman Report (change in insurance coverage 2010 to 2017)***

	2010	2017	Change	% Change
Uninsured	1,500,000	712,000	(788,000)	-53%
Individual insurance	350,000	735,000	385,000	110%
Employer group insurance	6,075,000	5,406,000	(669,000)	-11%
Medicaid	2,075,000	3,147,000	1,072,000	52%
Total	10,000,000	10,000,000	-	-

***Mercer Report (increase in Medicaid by 2017)***

Pre-ACA Insurance Status	Woodwork Effect	Newly Eligible	Total
Uninsured	173,000	307,000	480,000
Individual insurance	23,000	46,000	69,000
Employer group insurance	45,000	42,000	87,000
Other/Unknown	18,000	21,000	39,000
Total	259,000	416,000	675,000

***Urban Institute (estimated change in the uninsured by 2017)***

	2017 Estimate
Uninsured (58% decrease)	(925,000)
Medicaid-newly eligible	570,000
Medicaid-other	206,000
Exchange coverage	149,000

The Milliman study is the only one of the three that includes a comprehensive analysis of all of the likely effects of the ACA coverage expansion. While the most significant effect is a reduction in the number of uninsured, it is expected that some employers will drop employee coverage. Some more marginal, lower-wage companies struggle to afford health benefits for their employees and new minimum requirements on benefits may cause some of them to drop coverage, especially if they know that many of their employees will be eligible for Medicaid or subsidized marketplace Exchange plans. Also, it is expected that most persons who purchased individual policies prior to the ACA will obtain coverage from Exchange plans in the future. However, a migration to the extent projected by Milliman in 2011, especially from employer-based coverage to Medicaid, is much larger than what other studies have predicted and much larger than what we believe is likely.

<sup>16</sup> Information is obtained from a report prepared by Mercer Health and Benefits LLC for the Ohio Office of Medical Assistance dated February 13, 2013, entitled "Fiscal Impact of the Affordable Care Act on Medicaid Enrollment and Program Cost".

<sup>17</sup> Estimates are derived from a report issued by Hospital Policy Institute of Ohio in February 2013 entitled "Expanding Medicaid in Ohio".

For purposes of our ACA analysis, we will assume the following changes in the insured status of Ohio non-elderly residents:

**Table 17 - Estimated Changes in Insurance Status from Pre-ACA to 2017**

	Before ACA	2017 Estimate	Change	% Change
Medicaid	1,744,500	2,469,500	725,000	42%
Exchange	-	635,100	635,100	100%
Uninsured	1,460,800	657,400	(803,400)	-55%
Employer group insurance	5,590,600	5,311,100	(279,500)	-5%
Other Private	554,500	277,300	(277,200)	-50%
Other Govt	268,900	268,900	-	-
Total	9,619,300	9,619,300	-	-

The estimated decrease in uninsured Ohioans is a significant benefit for most hospitals, because they will be able to replace much of their charity care and uninsured bad debt with Medicaid and insurance reimbursement. However, the shift from private insurance to Medicaid will decrease reimbursement to hospitals. In addition, plans on the marketplace Exchange often carry larger out-of-pocket costs than employer-based insurance. High deductibles will result in increased bad debts, because many cannot or will not pay their patient balance.

### Impact of Other Provisions

As just noted, some provisions of the ACA will yield financial benefits to hospitals, but these gains will be somewhat offset by some of the additional taxes and federal spending reductions that Congress included in the ACA in an attempt 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 2016. 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

The ACA will have a much more material effect on UCMC than on CCHMC. For UCMC, 6.8% of its fiscal year 2013 expenses were for charity care, compared to 1.3% of 2013 expenses for CCHMC.

#### UCMC

The Hospital can expect to see a large reduction in its uninsured patient population. Whether the reduction is more or less than the 55% forecasted in the table above is in question. One factor that could cause the ultimate reduction to be larger: a person who has no urgent need to access health care may be less inclined to enroll in Medicaid or sign up for Exchange coverage than a person presenting to a

hospital with a serious illness or injury. As most of a hospital's services (based on cost, not quantity) are patients with serious illness or injury, there is a reasonable potential that UCMC will ultimately experience a larger reduction of its charity care than the estimates of the reduction in the uninsured.

Conversely, UCMC has a large Medicare population and receives a significant amount of HCAP payment. As a result, UCMC will experience a significant decrease in reimbursement from the "deficit reduction" provisions of the ACA.

HMA estimated the impact on UCMC of the ACA coverage expansions and the Medicare and Medicaid payment reductions included in the ACA. Most of the ACA impacts build-up or phase-in over several years. HMA selected 2017 as a point in time for all of the estimates. Key assumptions made by HMA include the following:

- A 55% reduction in charity care as a result of coverage expansion. HMA assumed that 75% of the uninsured reduction will be funded under Medicaid and 25% will be from individuals enrolled on the Exchange.
- A migration of individual and employer-based coverage to Medicaid and a migration of employer-based to Exchange coverage will occur within UCMC payer mix. Medicaid will not reimburse hospitals as well as private insurance, and Exchange coverage is expected to result in lower reimbursement than employer-based coverage. These factors offset part of the benefits of reduced charity care.
- Medicare payments will be 3.4% lower as a result of reduced rate updates from 2014 to 2017. In addition, the reduction of Medicare DSH payments and other provisions of the ACA result in additional payment changes. HMA is using estimates provided by UCMC management.
- Medicaid HCAP payments will be reduced when the change in federal DSH allotments begin in 2016. The reduction could be as large as 45% by 2021, although in 2017 the impact of the ACA cuts will be much smaller. For purposes of this analysis, HMA is using an 11% reduction in Ohio HCAP.
- In addition to the changes mandated by the ACA, the State of Ohio has implemented hospital reimbursement reductions in 2014-2015 and is considering a redistribution of HCAP; UCMC management believes these cuts are related to the decision to expand Medicaid.

Following is the estimated 2017 impact of ACA coverage and associated reimbursement changes.

**Table 18 - Estimated Impact of ACA Coverage and Associated Reimbursement Changes for UCMC, 2017**

<b>Impact on UCMC</b>	<b>2017 Estimate</b>
Impact of coverage expansion - Medicaid	\$24,000,000
Impact of coverage expansion - Exchange	\$13,600,000
Conversion of private insurance to Medicaid	(\$5,600,000)
Conversion of private insurance to Exchange	(\$2,100,000)
<b>Net Coverage Change</b>	<b>\$29,900,000</b>
Medicare reductions - productivity	(\$5,600,000)
Medicare reductions - DSH	(\$4,400,000)
Medicare reductions - other	(\$1,600,000)
<b>Net Medicare Reductions</b>	<b>(\$11,600,000)</b>
<b>Medicaid reductions - DSH</b>	<b>(\$2,800,000)</b>
<b>Net Impact of ACA - UCMC</b>	<b>\$15,500,000</b>
<b>Additional Medicaid Reductions, not part of ACA</b>	<b>(\$7,100,000)</b>

The above reflects a positive impact of nearly \$30 million per year from ACA coverage provisions. UCMC had over \$82 million of charity care costs in fiscal year 2013; the \$30 million annual estimate represents a 36% reduction.

The reimbursement losses that result from ACA's Medicare reductions and the Medicaid DSH reduction impact on HCAP will offset most of the reimbursement gains that result from the extension of coverage benefits. The remainder is an important expected benefit, but it is not nearly as large as one might think would occur from a 55% reduction of the uninsured. Additionally, the benefit will be further eroded as Medicaid reimbursement reductions enacted in the Ohio budget for 2014 and 2015 are implemented.

After considering the favorable ACA impact as estimated above, UCMC would continue to meet the current Annual Services test as stipulated in the contract. In FY 2013 UCMC had \$53 million of Services (defined as the cost of uncompensated care provided to eligible Hamilton County residents); the contract requires that Services exceed amounts received from the Levy. The estimates in the table above assume that 55% of the uninsured will be covered after the ACA impacts are fully realized. The result is an estimated 45% of UCMC's Annual Services, or \$25 million, would remain. This exceeds the Levy amount received in any of the years of the current Levy.

### **CCHMC**

The Hospital's patients are children, who have a higher rate of insurance coverage than adults. In Ohio, an estimated 8% of persons 18 and under are uninsured, compared to 18% for adults under age 65. Between Medicaid and CHIP coverage, every legal resident under the age of 18 with family income up to 200% of poverty is eligible for public coverage. Also, while many adults with higher incomes choose to forego health insurance for themselves, it is less common for families with dependent children to make this choice. Consequently, the ACA coverage expansion will not have nearly as large an effect on CCHMC as it will on UCMC. In fact, two other ACA coverage provisions are already in effect and already reflected

in CCHMC's current numbers: 1) a provision that allows dependents up to 26 years old to be covered under their parents' policies, and 2) prohibitions on coverage denials due to pre-existing conditions.

CCHMC will likely see a reduction in the number of uninsured patients. Some parents will take advantage of the new opportunities under the ACA. Some patients are over 18 years old and are eligible for Medicaid for the first time. Also, there is a phenomenon referred to as the "woodwork effect": persons who were already eligible for Medicaid are visiting marketplace Exchange websites and finding that they are Medicaid-eligible, and others may learn about eligibility because of all of the media attention and other "buzz" that is increasing general awareness in the population.

In its 2013 report to the state of Ohio, Mercer<sup>18</sup> estimated that 72,000 uninsured children in Ohio would gain Medicaid coverage from the so-called woodwork effect by 2017. This represents approximately 30% of Ohio's 230,000 uninsured children. In addition, Mercer estimates that 51,000 children currently covered by private insurance will migrate to Medicaid by 2017. CCHMC officials believe that the Mercer estimates are overly optimistic. In response to this concern, HMA selected a 75% factor to apply to the Mercer estimates. The Mercer study does not address Exchange coverage, but HMA estimates that for every three children added to Medicaid, another will enroll in an Exchange plan.

HMA applied the above estimates of coverage shifts to CCHMC and, using Hospital reimbursement information, estimates the effect in 2017 of ACA coverage expansion on CCHMC. The Ohio Medicaid budgetary reductions in 2014-2015 are not expected to have a material net effect on CCHMC and are therefore not included. The results are as follows:

**Table 19 - Estimated Impact of ACA Coverage and Reimbursement Changes for CCHMC, 2017**

Impact on CCHMC	2017 Estimate
Impact of coverage expansion - Medicaid	\$3,500,000
Impact of coverage expansion - Exchange	2,300,000
Conversion of private insurance to Medicaid	(2,400,000)
<b>Net Coverage Change</b>	<b>\$3,400,000</b>
Medicaid reductions - DSH	(1,300,000)
<b>Net Impact of ACA - CCHMC</b>	<b>\$2,100,000</b>

As shown above, the net impact of the ACA changes on CCHMC is estimated to be relatively modest: \$2.1 million is less than 0.2% of revenue.

However, if the ACA has more than a minimal effect on CCHMC's charity care, the Hospital may no longer meet the Annual Services test called for in the contract. CCHMC had Annual Services (the cost of uncompensated services provided to eligible Hamilton County residents) of \$5.7 million in FY 2013. This

<sup>18</sup> Information is obtained from a report prepared by Mercer Health and Benefits LLC for the Ohio Office of Medical Assistance dated February 13, 2013, entitled "Fiscal Impact of the Affordable Care Act on Medicaid Enrollment and Program Cost".

barely exceeds the \$5.2 million that the Hospital receives annually from the current Levy. If the ACA reduces CCHMC's uncompensated care costs by 8% or more, (all other things being equal) the Hospital would no longer comply with this important provision of the contract.

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

The Hospitals together requested that the TLRC endorse and the BOCC approve a renewal of the current Levy. The request letter does not specify an annual amount but implies that the 2014 funding level would be continued, with an adjustment for inflation.

HMA was not asked to evaluate other funding levels. However, the scope of the engagement includes an evaluation of whether the current funding levels should be reduced in light of anticipated ACA coverage expansion.

## Considerations for Next Levy Period

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

UCMC provides significantly more uncompensated care than any other hospital in the region. Its DSH limit as a percentage of patient revenue (an indicator of the significance of uncompensated care to the hospital's operations) is more than 60% greater than the average Hamilton County hospital and nearly 40% greater than the hospital with the next largest percentage.

The Hospital has improved its financial performance in recent years and this past winter received an upgrade on its bond rating, an indicator that the longer-term outlook is more positive than in the past. Also, the ACA is projected to produce a favorable net gain for UCMC. However, there are significant downward pressures on reimbursement from the federal and state government payers and from private insurers, which will continue to present very important financial challenges to the Hospital.

The Levy represents an important source of revenue for UCMC, and eliminating it could have adverse consequences at this time. Given the potential for a significant net benefit under the ACA, the funding for UCMC could be reduced from the \$21 million per year level initially anticipated in the current levy to the \$15 million per year level as per the 2014 levy funding modification.

### 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. Once the ACA coverage expansion is fully in place, the Hospital can expect a decrease in the number of medically indigent patients and therefore potentially a decrease in their Services cost. 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, the reduction in uninsured residents may result in CCHMC 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 would 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.

As an example of the third option, CCHMC currently receives additional compensation for providing health care services to the Juvenile Detention Center. In 2013, CCHMC was paid approximately \$1.4 million by the Juvenile Detention Center. Rather than make this additional payment, the County could request that CCHMC provide this function at no additional charge to the County and instead include the cost in the calculation of Services. There may be other programs and initiatives that could be used instead of or in addition to Juvenile Detention Center medical care to ensure that CCHMC provides a sufficient amount of Services in comparison to its Levy payments.

**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 has not been supplied by the Hospitals to the County. According to the Hospitals, the County has not made requests for this information, and in one instance the Hospital believes additional guidance is needed from the County to define the information needed.

The County should resolve each of these outstanding areas prior to the expiration of the current contract in December 2014. Resolution could be achieved by communicating new due dates to the Hospitals, making a formal request for the information (thus triggering the 30 day period for curing noncompliance), or agreeing to waive the requirement for one or more of the years covered by the contract. If the Hospital believes that additional guidance is needed, the Hospital should make a written request for such guidance.

In future years, the parties should work to ensure that all provisions in the contract are relevant to the Levy. The parties should work toward having an executed contract in place by the end of the first quarter of 2015 and then establish mechanisms to monitor the agreement. The County should ensure that each reporting requirement has a specific due date or timeframe for completion. Lastly, a checklist of contract provisions may help with ongoing monitoring of compliance.

**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 in excess of a state 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.

Alternatively, this test could be eliminated from the contract.

**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 just became effective on January 1, 2014 and most experts agree it will be at least two to three more years before the changes and shifts in coverage stabilize. Also, certain key provisions for businesses were delayed until 2015.

Perhaps more importantly, Hamilton County and all communities are facing a broader set of questions about the future of health care. 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. As a major purchaser and provider of health care services, Hamilton County is working to establish a plan for its role and to ensure that its citizens get the most value for their taxes. As the County considers new strategies, it may benefit from having more flexibility than what the Hospital Indigent Care Levy has historically allowed.

There is an advantage to a longer Levy period because it provides a more certain long-term revenue picture for the County. However, locking in a commitment to continue Levy payments to UCMC and CCHMC for a longer term is a risk because of the potential for dramatic changes in health care. 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.

**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 a greater extent 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, 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.

It may be difficult to develop a plan in time to include in the next Levy cycle. Instead, the County and the Hospitals could agree on an approach to develop and implement a plan for delivery system enhancement before the end of the next Levy cycle.

**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. Below are two examples:

- Instead of expending \$20 million of direct payments to local hospitals, the County could transfer (IGT) \$7.5 million to the state, which in turn utilizes the funding as the state share of a \$20 million supplemental Medicaid payments to local hospitals. Leveraging the federal funding allows for \$12.5 million to remain with the County to address other needs.
- The County could transfer the entire \$20 million to be used as the state share of nearly \$54 million in enhanced Medicaid payments to local hospitals. The increased payments would create flexibility for the hospitals to assist the County with its local health initiatives.

The concept of leveraging additional funding is not new, and there are a variety of hospital specific and statewide limits that the Medicaid agency must comply with as Medicaid spending is not unlimited. Further dialogue with the state and the providers is necessary to confirm the extent to which intergovernmental transfers could be utilized.