HCAP: Care to Play Again?

— Chris Whistler

Medicaid was created in 1965 to provide health care to low-income individuals. But gaps in the system have left many without insurance. As a result, hospital emergency rooms have found themselves strapped with enormous bills from providing last-resort care to these individuals. Ohio created the Hospital Care Assurance Program (HCAP) to financially help hospitals that are hit with a disproportionate share of low-income patients who are unable to pay for their own care. Over time, however, costs of HCAP and similar hospital disproportionate share programs in other states have exceeded federal funding capacity. In Ohio, for example, assessment dollars, matched with federal funds, provides the pool of funds which in seven years, has grown from $87 million to $565 million. The growth of these programs has stimulated discussions that have called for their reform, especially in light of recent attempts to balance the federal budget by 2002. The author describes the evolution of Ohio's HCAP and the issues and options to be considered in responding to further potential flexibility at the federal level.

Introduction

Although Title XIX of the Social Security Act of 1965 created the Medicaid program to provide health care to low-income individuals, the safety-net frequently misses the catch. Because of stringent eligibility requirements, which have been set as an attempt to control exorbitant costs, many are left without health insurance. With little or no preventive care, health problems in the "missed over" group exacerbate until medical attention becomes absolutely necessary. Enter the hospitals.

Often arriving via emergency rooms, these individuals seek medical care in the one setting that will take them: hospitals. Once billed as "charity care," but now mandated by law in Ohio (Am. Sub. H.B. 298 of the 119th General Assembly, effective July 1, 1992), hospitals treat these sick individuals as a last resort measure. Providing this treatment at one of the highest links in the health care cost chain has put many hospitals in a fiscal bind.

Making the problem worse for hospitals is the fact that many individuals who can afford insurance or can afford to pay for their own services refuse. Even individuals covered by insurance do not always pay their portions of the cost sharing plans. This bad debt must again be written-off by hospitals.

Adding to the burden, some of the hospitals with the highest proportions of charity care also treat the most Medicaid patients.[1] Because public health programs, like Medicaid, traditionally under-reimburse relative to private insurance plans and sometimes even to costs, revenues at these institutions suffer (assuming prices are not raised elsewhere to cushion the blow — a huge assumption).[2]

But the picture is not quite so bleak. As a way to compensate hospitals for their uncovered costs, states unveiled a financing technique to reimburse these costs in which all of the players are winners: that is, all are winners except

[1] The widely held notion that a hospital's Medicaid business is positively correlated with its level of uncompensated care may be less accurate in Ohio than in other states. Ohio hospital cost data suggests that the relationship is mixed.

[2] Estimates suggest that Ohio hospitals are reimbursed approximately 92 percent of their inpatient costs for Medicaid and Medicare patients ("Prospective Payment Assessment Commission: Medicare and the American Health Care System," *Commerce Clearing House Medicare and Medicaid Guide*, no. 701 (18 June 1992): 67.) However, the changing nature of business relationships in the health care industry, and the fact that the payment rates of commercial insurers are considered "proprietary," complicates such analyses. Some "insiders" would contend that Medicaid is actually the highest payer.

the single biggest contributor — the federal government. Enter the hospital disproportionate share (DSH) programs.

The Evolution

In addition to applying the "Boren Amendment" to inpatient hospital services, which allowed states to establish "reasonable and adequate" Medicaid reimbursement rates instead of requiring them to follow the Medicare rate structure, the Omnibus Budget Reconciliation Act (OBRA) of 1981 required states' Medicaid reimbursement systems to "take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs." However, states quickly created programs that went well beyond the intended funding capacity of Congress. This occurred because states were given the freedom to determine their own classification guidelines for DSH hospitals, as well as their own reimbursement methods.

While Ohio used its general reimbursement system to meet the requirement, other states were more creative.[3] Originally tapped by West Virginia and Tennessee, hospital DSH programs are a way to increase federal Medicaid funding without increasing state contributions. This funding mechanism begins with a tax (kindly referred to as an "assessment") on hospitals. Some hospitals even throw in a bit extra. It's called a "donation." (This increases the funding pool in ways discussed later.) Once this money is received by a state, it is then redistributed to the contributing hospitals based upon their relative charity care costs. But this redistribution doesn't leave anyone worse off (at least not until recent federal changes, discussed later).

The positive sum game (in terms of the hospitals) occurs through a funding match by the federal government at a rate equal to the Federal Medical Assistance Percentage (FMAP). Ohio's FMAP rate is approximately 60 percent. So for every $1 distributed to hospitals by the state (after the state receives 40 cents from hospitals in assessments), Ohio draws 60 cents federal match. When the federal contribution is combined with the assessments, the entire $1 distributed by the state is replaced. Thus, the hospitals' 40 cents becomes $1 without increasing costs to the state. With the increased funding pool, it is possible to give some hospitals more than they contributed without giving others less than their contribution.

While most were initially pleased with the funding results, it was not long before some in the federal government realized the programs were not altogether fiscally sound. While funds would go to the hospitals to help mend past and current perceived injustices, Medicaid costs were already growing out of control. Costs associated with the joint federal-state health care program for the poor were being driven sharply upward by health care inflation and expanding eligibility, so the new hospital DSH programs would be more than a little pinch in the federal budget.

The Health Care Financing Administration (HCFA) attempted to take action early to limit the use of provider tax/donation programs by states following court approval of West Virginia's program in 1985. In response to states' concerns, Congress generally fought to block these containment attempts.[4] Through OBRA 1987, however, Congress set minimum guidelines for payments to DSH hospitals, which have been amended many times since.

It was in response to OBRA 1987 that Ohio's hospital DSH program, called the Hospital Care Assurance Program

[3] In 1984, Ohio's reimbursement system for inpatient hospital services was changed from a cost-based system to a prospective payment system. The new system allowed rate adjustments for indigent care costs.

[4] Scott Mackey and Joy Johnson Wilson, "Federal Medicaid Provider Tax Restrictions," *NCSL Legisbrief*, no. 20 (May 1993).

Federal Medicaid Hospital Disproportionate Share Payments, 1989-2000
(in billions)

	1989	*1990*	*1991*	*1992*	*1993*	*1994*
U.S. Total	$0.4	$0.8	$3.1	$10.1	$9.6	$9.7
	*1995**	*1996**	*1997**	*1998**	*1999**	*2000**
U.S. Total	$8.5	$8.9	$9.4	$9.8	$10.3	$10.5

** Congressional Budget Office Projections, 1995.*
Source: Kaiser Commission on the Future of Medicaid.

(HCAP), came to be through Sub. H.B. 738 of the 117th General Assembly (effective July 20, 1988). Although HCAP has been revised since its inception and sunsets every two years, the provider tax/ donation funding mechanism in Ohio has remained intact.[5]

When proposals to balance the federal budget began to get serious in the 1990s, hospital DSH programs began to come under fire. The only problem was that they were highly political and the basic purpose they served addressed a well-documented need. Nevertheless, new federal regulations began to surface and most of the growth was slowed (and spending even temporarily declined). Among other provisions, federal legislation enacted in 1991 and 1993 included the following:

- state-specific ceilings on total DSH payments that are equal to 12 percent of each state's total Medicaid spending (P.L. 102-234, Medicaid Voluntary Contributions and Provider-Specific Tax Amendments of 1991);

- a guideline preventing the coverage of all bad debt (OBRA 1993); and

- limits in the amounts individual hospitals can receive in DSH payments (OBRA 1993).

Although federal cost increases seem to have lost their explosiveness, a few problems with the program cannot be overlooked. For one, despite lower growth, the base cost of the DSH program is very large. In times of budget cuts, protecting a program of its size takes a lot off the block. Second, because some states have been more aggressive than others in creating their DSH programs, payments are heavily concentrated in a small group of states. In federal FY 1993, eight states received almost two-thirds of all federal DSH payments.[6] Third, the amount of federal DSH funds a state receives is unrelated to the number of poor or uninsured individuals in the state.[7] Lastly, but to many a more important state-level issue: in a health care environment which puts increasing emphasis on preventive care, the cost effectiveness of providing first point of contact health care in a hospital setting has been called into question.

This brief look into Ohio's hospital DSH program, HCAP, attempts to provide a detailed overview of Ohio's program and to look into its future in light of recent federal reform proposals. In so doing, it will refer to the original discussions of reforming Ohio's Medicaid program through a proposal called "OhioCare." There have been discussions to expand Medicaid in preparation for the FY 1998-1999 budget; those proposed expansions are not addressed here.

Ohio's Program

Although HCAP has been refined on numerous occasions since its first run in 1988, two basic elements have remained constant over time. First, it is a redistribution program for inpatient and outpatient hospitals in which the pool of funds to redistribute is much larger than the original offering. Second, it is run by the Ohio Department of Human Services in consultation with the Ohio Hospital Association. These two points will be discussed in greater detail out of turn.

[5] Am. Sub. H.B. 298, Am. S.B. 324, and Sub. H.B. 870 of the 119th General Assembly expanded the initial program. Am. Sub. H.B. 117 of the 121st General Assembly most recently responded to federal changes through OBRA 1993.

[6] "Medicaid Special Financing Arrangements: Disproportionate Share Hospital Payments, Provider Taxes, and Intergovernmental Transfers." The Kaiser Commission on the Future of Medicaid. Washington, DC. April 1995, p.7.

[7] Ku, Leighton, and Teresa A. Coughlin. "Medicaid Disproportionate Share and Related Programs: A Fiscal Dilemma for the States and the Federal Government." The Kaiser Commission on the Future of Medicaid. Washington, DC. December 1994, p. ii.

Ohio Hospital Association — The Politics

When nearly 200 hospitals are asked to reallocate millions of dollars amongst themselves, one word quickly jumps to mind: politics. Even though everyone was a winner by design until recent federal restrictions (most still are), deciding which hospitals win the most can lead to battles of epic proportions. What would appear on the surface to be minor changes to formulas or definitions, in fact, can have serious consequences in terms of who gets what.

Herein lies the subtle beauty of the program. In a textbook example of government stepping aside for the private sector, the Ohio Department of Human Services has turned over the task of program design to the Ohio Hospital Association (OHA). That's not to say that the department has washed its hands of HCAP — it only cleansed itself from the part that doesn't always smell so sweet. The department sets the parameters for the size of the program, gives guidance on federal regulations, approves OHA's program plans, collects assessments, draws federal match money, and redistributes the pool to the hospitals. The political battle over the reallocation is left to the OHA. Once a plan is agreed upon by the OHA's members, the department takes over. Concerns of individual hospitals are voiced to the OHA.

The Framework

To briefly explain how the frequently revised HCAP works, we look to the most recent model.[8] The 1996 HCAP is the same as it has been in recent years, with a few minor exceptions stemming from new regulations in OBRA 1993. The program can be outlined in terms of the assessment, hospital groupings, funding pools, and conformity to federal guidelines.

In practical terms, HCAP begins with an assessment. All hospitals in Ohio are taxed 1.803 percent of total facility costs, less skilled nursing facility costs (referred to as "adjusted total facility costs"). Added to this $207.3 million are intergovernmental transfers from two public hospitals, University of Cincinnati Hospital and Metro Health Medical Center (Cleveland), totaling $17.3 million.[9] This $224.6 million pot of "state" money then draws a federal match of $340.8 million, bringing the total program pool to $565.4 million.[10]

In order to set the stage for the reallocation, the hospitals are divided into ten groups. Children's Hospitals are in Group 1, and governmental hospitals which provide interagency transfers (University of Cincinnati Hospital and Metro Health) are in Group 2. Based on their size (in terms of total facility costs) and their relative emphasis on Medicaid patients (Medicaid costs as a percentage of total costs), the remaining hospitals are placed in Groups 3 through 10.

The total program amount of $565.4 million is divided into seven pools of funds. Each pool of funds is then disbursed to hospitals meeting certain criteria in each of the ten hospital groups. For instance, the High Federal Disproportionate Share and Indigent Care Payment Pool (consisting of approximately $14 million) is distributed to hospitals (in each of the ten hospital groups) that meet the federal definition of high DSH hospitals. So money from each pool is disbursed across hospital groupings. The seven pools are summarized in the following table.

Two pieces of federal legislation have had significant impact upon the redistribution. Although they have sparked numerous programmatic changes, two of the changes have the greatest impact on this discussion. The

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[8] This description of the 1996 HCAP paraphrases information provided by the Ohio Department of Human Services.

[9] The transfers are made simply to increase federal matching funds.

[10] Like the primary Medicaid appropriation line item in Ohio's budget (400-525, Health Care/ Medicaid), Ohio is not required to "spend" an entire dollar on HCAP before receiving 60 cents. Only 40 cents is needed to get the federal 60 cents.

HCAP Funding Pools

Payment Pools	*Distribution Criteria*	*Amount (in millions)*
High Federal Disproportionate Share and Indigent Care	Distributed to hospitals in each of the ten groups meeting the federal definition of high DSH hospitals	$13.9
Medicaid Indigent Care	Distributed to hospitals based upon percentage of the hospital's Medicaid, Title V, and Medicaid shortfall to the total for the each hospital group	$187.2
General Assistance/ Disability Assistance and Uncompensated Care Under 100% of Poverty	Distributed to hospitals within each group based upon percentage of the hospital's costs associated with GA/DA and uncompensated care under 100% of the poverty level to the total for each hospital group	$327.0
Children's Hospitals Indigent Care	Distributed to children's hospitals based upon Medicaid costs	$12.6
Low Indigent Care Hospital	Distributed to each of the low indigent care hospitals who will receive in HCAP payments 90% or less of their assessment amount or up to their payment cap — whichever is less	$24.7
Hospital Care Assurance Group Residual	Equal to 60% of the total moneys distributed from pools 1-5 above the caps set in OBRA 1993. Redistributed within hospital groups based upon each hospital's percentage of the total remaining DSH limit	$20.3 — reallocated from pools 1-5
Statewide Residual	Equal to 40% of the total amount given to hospitals above their OBRA 1993 caps. Redistributed to hospitals across hospital groups based upon each hospital's percentage of the total remaining DSH limit	$13.5 — reallocated from pools 1-5
TOTAL		$565.4

first, P.L. 102-234 (Medicaid Voluntary Contributions and Provider-Specific Tax Amendments of 1991), became effective December 24, 1992.[11] Most notably (in terms of this paper), it removed states' "hold harmless" provisions which guaranteed that all hospitals would get back at least as much money from the reallocation as they gave under the program (through assessments and intergovernmental transfers) — the past guarantee was possible because of the federal matching funds. "Winners and losers" in Ohio are now decided through a process of ranking the hospitals in order of their relative costs for indigent care.[12] The ten percent of hospitals with the lowest indigent care burden, nineteen hospitals out of 185 in 1996, receive less from the reallocation than they paid in assessments. The total loss to these nineteen hospitals of $8.8 million satisfies the requirement that approximately ten percent of the hospitals lose at least ten percent of their assessment.

The second recent federal regulation impacting the reallocation, OBRA 1993, placed caps on the amounts hospitals can receive from the reallocation relative to their uncompensated care costs. Prior to OBRA 1993, thus prior to the 1996 HCAP, public hospitals were capped at receiving no more than 200 percent of their total uncompensated care costs. Private hospitals had no limit. Through OBRA 1993, all hospitals are now capped at 100 percent.

The final two funding pools have been added for the 1996 HCAP to ensure that this provision is met. Following the distribution of the first five funding pools, receipts by individual hospitals are compared to their own payment caps set by OBRA 1993. Any overages are subtracted from their allocations and placed in pools 6 and 7 to be distributed to hospitals below their caps. Following the distribution of this final $33.8 million, a final check is made to

[11] Mackey and Johnson Wilson, no. 20.

[12] Hospitals are ranked from one to 185 for each of four factors. The following three factors are calculated as a percentage of adjusted total facility costs: Medicaid costs (including those through health maintenance organizations), DA costs and uncompensated care costs for individuals with incomes at or below 100 percent of the federal poverty guideline, and the cost of uncompensated care for individuals above 100 percent of the poverty line. The fourth factor is the hospitals' number of Medicare SSI days as a percentage of total Medicare days. The four ranks are then summed for each hospital, and the hospitals are again placed in rank order from one to 185 — this time according to the sums of their ranks. (Rank totals can range from

(cont'd. on page 6)

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Calculating DSH Payment Caps

The formula used to calculate uncompensated care costs, which is used to determine the maximum amounts hospitals can receive from the reallocation, is the following:

DSH payment cap = Medicaid shortfall + DA costs + uncompensated care costs.

The Medicaid shortfall is the amount by which Medicaid reimbursement falls short of a hospital's actual treatment costs. (Because, loosely stated, Medicaid reimbursement is based on the average cost incurred by Ohio hospitals in treating a specific ailment, some hospitals can be reimbursed at rates below their costs.) Since the Disability Assistance (DA) program does not cover hospital services, costs associated with treating these individuals in a hospital setting are included in the formula. Lastly, uncompensated care costs include the costs of treating all other uninsured individuals — both those unable to pay and those who refuse to pay. Prior to OBRA 1993, hospitals were also allowed to include unpaid costs of caring for patients with insurance (i.e. if a patient refused to pay their copayment). While the latter costs cannot be used in calculating the payment caps, they are still permissible in determining relative payments between hospitals. (Note that prior to the program's termination, costs associated with treating the General Assistance population were also included.)

guarantee that the federal guidelines are not exceeded.

Program Growth in Ohio

The following table shows how quickly Ohio's HCAP has steadily grown from an $87 million program in 1989 to a $565 million program in 1996. When analyzing line item disbursements in terms of fiscal years, however (which has been omitted from the table to avoid confusion), it looks as if the department failed to operate a 1996 program (because no amounts were disbursed from the relevant appropriation line items in FY 1996). In fact the program was run, but difficulties in determining the distribution arose at the OHA, delaying the program from the estimated April, 1996, through June, 1996, time period until the beginning of FY 1997 (end of federal FY 1996). Since a number of the hospitals have already received their maximum allowable DSH payment in FY 1997, and because of administrative complexities for hospitals, a second program most likely will not be run in FY 1997. This does not mean, however, that the opportunity to receive federal DSH matching funds was missed for an entire year. Rather, funds have been received for each federal fiscal year — the program now simply occurs three months later than in the past.

HCAP Payments by Program Year
(in millions)

	1989	*1990*	*1991*	*1992*	*1993*	*1994*	*1995*	*1996*
Hospital Taxes/IGTs*	$35.0	$38.3	$41.1	$187.6	$188.0	$200.1	$210.9	$224.6
Federal Match**	$52.1	$57.7	$63.2	$288.9	$284.9	$310.8	$325.6	$340.8
TOTAL	$87.0	$96.1	$104.4	$476.5	$472.9	$510.9	$536.5	$565.4

Source: Ohio Department of Human Services
** Hospital assessments and intergovernmental transfers disbursed primarily from line item 400-649 (Fund 651)*
*** Federal match disbursed primarily from line item 400-650 (Fund 3FO)*

Policy Options

Recent attempts by Congress to balance the federal budget by the year 2002 led to discussions involving the restructuring of some of the costliest programs. Since Medicaid spending currently represents about six percent of the federal government's annual total outlays, the program received a good deal of attention.[13] At the forefront of the discussions was the idea of giving each state a block grant

[12] *(cont'd.)* the lowest possible total of four to the highest possible total of 740.) The 19 hospitals (ten percent of the hospitals) with rankings from 167 to 185 (least indigent care exposure) are designated as the "losers."

[13] Office of Management and Budget. *Budget of the United States Government, FY 1997: Analytical Perspectives.*

of funds based upon their current federal Medicaid expenditures. Similar to the Personal Responsibility Act of 1996 (enacted on October 1, 1996), which reformed the welfare system, block grants would give states the freedom to design their own Medicaid programs, subject to much looser federal guidelines than are imposed today.

Naturally, these discussions stimulated thought on possible reform measures within the states. If states' received block grants for their federal share of Medicaid spending, and if enough freedom was given, programs could be tailored to meet specific desires within each state — such as expanding Medicaid eligibility to low-income, uninsured individuals. Furthermore, if the federal share of hospital DSH programs was included in the block grant, it might be fiscally possible.[14]

Because Ohio received a waiver of certain federal Medicaid requirements on January 17, 1995, it would not be necessary for Ohio to receive a block grant before it could use DSH funds to expand Medicaid eligibility.[15] In fact, that waiver, which gave federal approval to the state to reform its Medicaid program through the proposed "OhioCare" plan, approved an initiative which would allow Ohio to continue to tax hospitals and receive federal reimbursement; but, instead of redistributing the funds to the hospitals, the funds could be used to cover uninsured individuals with incomes up to 100 percent of the poverty line through managed care providers. As the coverage of newly eligible individuals would be phased-in (through the use of HCAP funds), direct payments to hospitals for uncompensated care would decline significantly.[16]

No implementing legislation for OhioCare has been introduced in the General Assembly, so no expansion of eligibility has occurred. Now, with national interest in freeing states from the bonds of many of the federal Medicaid guidelines, the possibility exists for states to have reform freedoms extending well beyond those of the OhioCare waiver. For Ohio, a block grant could mean the freedom to use HCAP funds in various ways other than expanding coverage to 100 percent of the poverty line.

So the question is this: given the freedom to alter or abolish HCAP, what avenue would be most beneficial? It seems that the possibilities are almost endless. The funds could be used, among other things, to raise reimbursement rates to providers, expand covered services, or expand eligibility; or, the existing HCAP could be altered to allow for different "winners and losers" among hospitals. Complicating this question is that another issue must be addressed before arriving at an answer: the most beneficial to whom?

Deciding Who Should Win

The prevalence of managed care programs seems to suggest that it is more cost effective to treat patients with preventive care rather than through procedures addressing the ailment after-the-fact. Thus, it would seem that providing the uninsured access to primary care would be more efficient than leaving their care to the charity of hospitals. Not only would it be less costly, it could benefit the uninsured by improving their health. But the notion of abolishing the reallocation provision of HCAP in favor of expanding coverage has serious ramifications, especially on the entities funding that initiative.

As previously stated, DSH programs were created as an attempt to reimburse hospitals for their losses due to the costs of providing charity care and due

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[14] Because of the imbalance of federal DSH payments between states, this issue was heavily debated during federal budget negotiations in the Spring of 1996. If federal DSH spending were to be reduced, the burden would have to fall most heavily on the eight states receiving nearly two-thirds of all federal DSH payments. Alternatively, if states were to receive their current federal DSH share in the form of block grants, those states with the largest DSH programs would be rewarded.

[15] To be clear, it should be noted that the waiver was needed to expand eligibility; Ohio does not need a waiver to use a majority of HCAP funds for another program activity. Under provisions in OBRA 1993, the state is only required to make payments to federally-defined DSH hospitals. In other words, the current HCAP is much larger than necessary to meet federal requirements.

[16] While the initial OhioCare proposal stated that direct payments to hospitals for uncompensated care would be phased out by the third year of the OhioCare program, more recent estimates have assumed a DSH program of at least $50.0 million following total phase-in. Nonetheless, either scenario would significantly reduce these payments.

Most of the reform options contain some element of eligibility expansion ...

to the reimbursement practices of Medicaid. Although the programs originally allowed many hospitals to receive a windfall of funds much greater than needed to compensate for uncompensated care, recent federal regulations have restricted the possibilities for abuse. Now that hospitals are capped at receiving no more than their uncompensated care costs, it seems like the program finally may be moving in line with its original intent.

The OhioCare plan was based on the idea that if eligibility were expanded, there would no longer be a need (or the need would be greatly reduced) to reimburse hospitals for uncompensated care. If the intent is to have the Medicaid program provide reimbursement to hospitals for all costs that would otherwise not be reimbursed, this assumption may be flawed for various reasons. Not only does it overlook the uninsured with incomes above the expanded eligibility levels and bad debt, it also disregards the notion of under-reimbursement by Medicaid. The OhioCare funding notion is more troubling to hospitals on a different front, which was recognized by the Ohio Hospital Association during the original OhioCare talks.

Not only would OhioCare leave the remaining uncompensated care unreimbursed by the state (which, depending on your view, may simply be a cost of doing business, especially when the individuals hospitals are mandated to cover — with incomes below 100 percent of the poverty line — would be covered by Medicaid), the hospitals would be forced to foot the bill for the expanded eligibility through the 1.803 percent assessment on adjusted total facility costs.[17] In terms of profit, if both the assessments and the matching funds are shifted to HMOs rather than being reallocated, hospitals would clearly lose.

Continuing to tax hospitals literally would be equivalent, in most instances, to taxing them for the first time. (The "tax" was originally introduced to increase their funding.) The design of HCAP guarantees that most hospitals have their entire assessment (and then some) returned to them.

That is not to say that there is something intrinsically wrong with taxing the hospitals. As the tax status of some hospitals shifts from non-profit to profit, the question becomes even more interesting. Lawmakers would need to determine if such a tax is equitable and if it is the place of government to levy the tax. Furthermore, the viability of such a plan would need to involve a review of each hospital's balance sheet.

The framers of OhioCare touted that the money lost by hospitals would be replaced by payments to them through managed care contracts. In the aggregate, with some exceptions discussed above, this is true. While total revenue would fall because many new Medicaid eligibles would receive their health care in a variety of settings (not only hospitals), thus spreading out payments to various provider-types, hospital costs will also decrease. The catch is that the revenue (and costs) would be transferred to hospitals which contract with Medicaid-serving HMOs. (Assuming revenues are above costs, the profits would be transferred as well.) Those hospitals without Medicaid HMO contracts would surely lose again.

Expanding Eligibility — How Many Could Be Covered?

Most of the reform options contain some element of eligibility expansion, so this paper will explore that concept. To determine the costs of expanding eligibility to a certain level of poverty,

[17] Although the current assessment rate is 1.803 percent, a new rate is set each program year in order to maximize federal funds. Statute (most recently Am. Sub. H.B. 117 of the 121st General Assembly) places a maximum limit of 2.0 percent on the assessment rate. Thus, it remains to be seen what the rate might be if eligibility were to be expanded or if HCAP were to be changed in some other manner.

it is necessary to estimate the cost of covering a single individual and to estimate the number of uninsured persons (those not privately or publicly insured) below the relevant poverty levels. This section briefly describes the methodology used to obtain these estimates (while noting some of the potential statistical problems with the calculations), describes the cost estimates, and attempts to describe a few of the discrepancies between these estimates and those used in the OhioCare proposal.

HMO Capitation Rates Paid by Medicaid
FY 1997 Statewide Average (12-month total)

Eligibility Category	*Yearly Rate*
Age 0*	$4,603.30
Age 1*	$1,018.80
Ages 2-13	$512.86
Male ADC Ages 14-44	$927.31
Female ADC Ages 14-44	$1,907.30
ADC Ages 45+	$2,532.44
Healthy Start Ages 14-64*	$5,056.57

**Rate not needed for this analysis if eligibility expansions do not exceed 133% of the federal proverty level*

Methodology

The rates used to estimate the costs of providing health care coverage to the uninsured are based upon the costs of covering current Aid to Dependent Children (ADC) and Healthy Start Medicaid eligibles through managed care plans. The following table shows the average FY 1997 capitation rates paid to Medicaid-serving HMOs by the Medicaid program.[18] Because Medicare provides health care to most senior citizens and Medicaid covers low-income, pregnant women and infants through the Healthy Start eligibility category, the low-income, uninsured population, by comparison, is relatively inexpensive. For this reason, the assumption is made that the costs of covering the uninsured individuals are most closely related to children ages 2 through 13, males ages 14 through 64, and females ages 14 through 64 who are not pregnant.[19] Thus, the rates for Healthy Start women (ages 14 through 44) and children less than age 2 are not used in this analysis.

The estimates of Ohio's uninsured population are based upon an analysis of the 1996 Current Population Survey (CPS) by the Ohio Department of Development's Office of Strategic Research.[20] Estimates of the number of uninsured individuals by age, gender, and income have been derived. This study's estimates of the costs of expanding Medicaid eligibility to individuals with higher incomes than the current eligibility caps have accounted for the age and gender distributions of the expanded groups through the use of the age/gender specific Medicaid HMO capitation rates for FY 1997.

It should be noted that the author's intent was simply to make rough estimates of the costs of expanding Medicaid eligibility to various income levels for the purpose of illustration — not to make precise calculations which can be used for budgetary purposes. Thus, FY 1997 HMO capitation rates (the most recent data available) have been incorporated with estimates of the uninsured for calendar year 1995 (the most recent estimates available through the CPS). The estimates give a rough idea of what it might cost to expand coverage for one year at FY 1997 rates. Attempts have not been made to adjust the estimated number of uninsured persons to FY 1997 levels because it is unclear how the number and distribution of the uninsured may have changed since 1995 (i.e. adjustments would serve only to complicate the matter further).

Although the CPS data is generally considered to be one of the best sources of data on the uninsured (and, thus, is widely used), there are two major issues related to the use of the CPS data which could significantly bias the

[18] These rates are considered to be the "average" rates for all counties because the department actually uses area specific rates to account for geographic differences in health care utilization and costs. For ease of illustration, note that the rates in the table are based on twelve months of coverage; however, Medicaid pays HMOs on a monthly basis.

[19] The validity of this assumption depends upon the relative health status of the uninsured population compared with current Medicaid eligibles.

[20] The insurance-related questions in the 1996 CPS refer to health care coverage during calendar year 1995. Information regarding coverage in 1996 will be available following the March, 1997, supplement of the 1997 CPS. The effects on the estimates of using 1995 data rather than data from 1996 are unclear. The state of the economy in any given year is likely to have an effect on the number of uninsured persons. Determining the extent to which changes in the economy affect the number of uninsured persons would involve various additional analyses, such as a study of whether people who become employed during strong economic times also become insured.

estimates of the uninsured. Both issues stem from the sampling technique of the CPS. First and foremost is that the CPS data is obtained through a survey which asks a series of questions that can be aptly summarized by the following single question: "at any time in 1995, were you covered by a health care plan?" The wording of the question may lead to a serious understatement of the uninsured because individuals with only partial-year coverage would respond "yes" to the question and, in turn, be considered insured (even if they were only covered by a health care plan for a week). Consequently, calculations of the number of persons who are uninsured at a given point in time could be biased downward.

A second, potentially greater "risk" regarding the accuracy of these estimates is the treatment of the former General Assistance (GA) population by the CPS sample. Because the CPS health care questions ask those being surveyed whether they were covered by a health care plan, public or private, in the prior year (the number of uninsured is calculated), it is necessary to add those individuals who received health care coverage through GA in 1995 to the number of uninsured persons. Unfortunately, in terms of this analysis, the GA program ended mid-year 1995. Thus, it is difficult to accurately determine the number of former GA recipients who received coverage in 1995 and, in turn, need to be added to the estimate of the uninsured. Furthermore, the potential sampling bias of such a small group is quite tremendous. Therefore, this estimate does not include an adjustment for former GA recipients who received health care coverage in 1995.

Because of these and other potential "risks" to the estimates, it is important to note again that the following calculations have been performed for discussion purposes only.[21] The primary purpose of this analysis is to illustrate that Medicaid eligibility could be expanded to a significant number of individuals through the use of the HCAP funds. A final analysis of the costs of expanding eligibility would require the establishment of detailed programmatic guidelines as well as unlimited access to the Department of Human Services' databases.[22]

Costs of Expansion

The following table displays estimates of the costs of expanding eligibility to uninsured individuals with incomes at or below various poverty levels. If all $565.4 million of the 1996 HCAP funding was used to expand Medicaid eligibility through the use of contracts with HMOs, eligibility could be extended to uninsured individuals with incomes at or below 125 percent of the poverty line, or nearly 380,000 individuals! As the table shows, the estimated cost of covering individuals with incomes up to 125 percent of poverty is around $527.7 million, so eligibility, according to these numbers could be extended slightly higher.[23]

Costs of Expanding Medicaid Eligibility to the Uninsured

Expansion Level	*Uninsured Persons*	*Amount (in millions)*
≤ 100% of poverty	252,100	$342.3
≤ 125% of poverty	377,595	$527.7
≤ 200% of poverty	640,975	$920.6
All uninsured	1,330,492	$1,975.8

Although the OhioCare proposal uses state and federal HCAP funds to expand eligibility, a federal block grant likely would allow for eligibility expansion through means other than continuing the tax on hospitals. If only the federal share of HCAP ($340.8 million) were to be used to fund an eligibility expansion, the estimates indicate that Medicaid eligibility could be expanded to nearly all uninsured

[21] One additional "risk" worth noting is that the 1996 CPS estimates do not account for Medicaid eligibility expansions which have occurred since the survey. Most notably, the Healthy Start eligibility category added 13 year-old children in families with incomes below 100 percent of the poverty line who were not already on Medicaid (as it will continue to add one age group each year until children through age 18 are covered).

[22] For most estimates of this magnitude, the Department of Human Services generally contracts with actuaries outside the department. For instance, the department is currently engaged in a 16-month contract with Lewin-VHI of Fairfax, Virginia, (at a cost of up to $750,000) to provide insight into Medicaid restructuring possibilities, including estimating the costs of various eligibility expansions.

[23] It is quite likely that only $548.1 million of the entire 1996 HCAP funding pool would be available for eligibility expansions. Intergovernmental transfers of $17.3 million likely would be excluded from the $565.4 million program total since they are only made to draw additional federal match.

individuals at or below 100 percent of the poverty line.[24] (According to the estimates, it would cost about $342.3 million to provide health care coverage to over 250,000 individuals at or below the poverty line.)

A Note on OhioCare

Why do the estimates in this study contrast with the Administration's estimates of OhioCare, which claimed that HCAP funds (state and federal) could be used to expand eligibility up to only 100 percent of the poverty line, but for up to 500,000 individuals? In addition to the potential statistical problems of this study discussed above and the fact that the base years for the two analyses differ, there are a couple of potential problems with the estimates of OhioCare that should be noted.

For starters, when OhioCare estimates were completed, there were no managed care savings assumptions. The FY 1997 capitation rates build-in a six percent savings relative to providing services through a fee-for-service arrangement.[25] More significant in terms of costs is that the estimate of the number of individuals with incomes at or below 100 percent of poverty, which was used in OhioCare estimates to calculate the number of uninsured individuals, was at the high end of the CPS confidence interval rather than the point estimate. Using the upper limit generates an estimate of the uninsured that is nearly 200,000 higher than that derived using the point estimate (which has a higher statistical probability of being correct than the upper limit). Thus, the statement was made that OhioCare could cover up to 500,000 uninsured Ohioans (the upper limit) with incomes at or below the poverty line; however, the OhioCare cost estimates were reduced through the assumption that only 75 percent of those newly eligible for services would enroll — which kept OhioCare "cost neutral."[26] (This could have been done for many reasons, including to ensure the availability of funds.)

The Effect of Expanding Eligibility on Hospitals

According to the estimates of this study, if coverage were to be expanded to 125 percent of poverty, hospitals would only receive about $340.9 million back through managed care contracts (out of the total cost of $527.7 million).[27] But these revenues correspond with similar costs generated by serving the covered individuals. Because the 1.803 percent assessment on the hospitals would generate $207.3 million, the revenues would only exceed the assessment costs by about $133.6 million. Thus, any costs to hospitals associated with covering the expanded population, in the aggregate, of over $133.6 million would represent a loss to the hospitals. (This does not even include the costs of any remaining uncompensated care.)

Another consideration is that those hospitals without contracts with Medicaid-serving HMOs would not receive a portion of the $340.9 million. Of course they also would not have the costs associated with serving the new eligibles, but they would not have the opportunity to obtain profits from the new eligibles that would chip away at the impact of the 1.803 percent assessment. In other words, those hospitals would lose the entire amount of their assessments.

It is important to remember that the amounts available for eligibility expansion are not limited to the total of one or both HCAP funding pools. For instance, whether all of the HCAP funds or only the federal share is used to expand coverage, it might also be in the interest of policymakers to first repay some portion of the existing uncompensated care before expanding

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[24] A federal block grant potentially would not obviate a state's responsibility to provide state funds for such a purpose. The structure of block grant funding can vary greatly. The important point to note is the extent of the possible coverage expansion.

[25] Prior to FY 1997, no "managed care savings" was incorporated into the rate setting process.

[26] Various issues surround the 75 percent enrollment rate. First, based on their assumption that the costs of covering the new eligibles would be similar to the less costly Medicaid eligibles (those who are not pregnant, disabled, et cetera), the Department of Human Services used relatively low capitation rates in estimating the costs of covering the new eligibles. However, if only 75 percent of the newly eligible individuals enrolled, those who enrolled would likely be the sickest (and most costly). Because many Medicaid eligibles are enrolled through their application for cash benefits, the pool of Medicaid eligibles includes a more even mix of the healthy and sick. In addition, what about the 25 percent who do not enroll? Would they be retroactively enrolled in HMOs — thus driving up capitation rates — or would they generate uncompensated care or create the need for fee-for-service payments?

[27] It is assumed that about 65 percent of the capitation rate would go to the hospitals because the amount used for inpatient hospital services to set the FY 1997 capitation rates represented about 47 percent

(cont'd. on page 12)

coverage. If policymakers felt it was necessary to reimburse hospitals for their Medicaid shortfall (the difference between a hospital's actual costs and the amount Medicaid reimburses), the total pool of funds used to expand coverage could first be reduced by that amount.

Further Options Related to Eligibility Expansion — Potential Means of Cost Control

Additional "managed care savings," the introduction of copayments, and service reductions all have significant potential for cost control.

If policymakers are interested in expanding eligibility beyond the capacity of either the federal share or the total funding pool, or if they simply want to contain costs for the previously discussed expansions, quite a few possibilities exist in terms of cost containment. Additional "managed care savings," the introduction of copayments, and service reductions all have significant potential for cost control.

The FY 1997 capitation rates are based on the costs of providing care through a fee-for-service reimbursement system, less six percent. The department felt it was reasonable to include the six percent savings because of the widely known ability of HMOs to control costs. If even more individuals (expanded eligibles) were to be enrolled through these managed care plans, it is quite likely that rates could be negotiated to include savings of greater than six percent.[28] This would be because of the economies of scale from covering more individuals. The savings would also spill over into the costs of covering the existing Medicaid population.

Although HCFA rejected the notion of cost-sharing by the expanded eligibles in the OhioCare proposal (those at or below 100 percent of the poverty line), block grants may not include such restrictions. Furthermore, it is possible that any restrictions would only apply to individuals below 100 percent of poverty (or some other level) — thus, some of the expanded eligibles could possibly be required to make copayments. Of course, the introduction of cost-sharing requirements could generate unreimbursed care for providers if individuals enroll but are either unable or unwilling to make their copayments, or it could lead to lower enrollment if individuals do not enroll to avoid having to make copayments. Both possibilities would likely lead to higher costs: the former because providers likely would demand higher rates and the latter in ways discussed in the next section.

Another option for cost containment, but one which may have less appeal for many, is the reduction of the services provided. Ohio's Medicaid program is often referred to as a "Cadillac" insurance program because, in many cases, it covers more services than are covered by many private plans. For instance, dental services and some chiropractic care are provided. While reducing the services provided to the expanded eligibles (and even the existing population) could lead to considerable cost savings, the savings may occur only in the short-run if covered services were not selected wisely. If medical problems are left untreated, the costs of treatment in the long-run can be much greater. In addition, since HMOs place a great deal of emphasis on preventive care, it is unclear how willing they would be to enter into contracts that do not provide extensive preventive services.

Additional Issues Regarding Eligibility Expansion

While this paper has addressed many of the cost issues associated with expanding eligibility, little reference has been made to the feasibility of such an initiative. Two such issues include

[27] *(cont'd.)* of the total rate, while outpatient hospital services represented about 18 percent. However, the contracts made between HMOs and providers could alter this amount. Based on the same assumption, about $221.1 million would go toward hospital care if eligibility were to be expanded to 100 percent of the poverty line.

[28] This reduction would likely lead to a proportionate reduction in the amounts received by hospitals from the HMOs.

the difficulty of enrolling all of the new eligibles and problems with HMO coverage in rural areas.

One issue that must be addressed when expanding eligibility is how to enroll all of the new eligibles. OhioCare assumed that only 75 percent of the new eligibles would voluntarily enroll. Not only does the problem of adverse selection exist with a partial enrollment scenario — most of the new enrollees would be the sickest, which would drive up the cost pool — uncompensated care could be generated when those who are not enrolled need services. Unless those individuals either could be retroactively enrolled in HMOs (a highly unlikely scenario which would defy the basic premise of managed care) or unless they were covered on a fee-for-service basis, both of which would result in higher costs, uncompensated care would still be present among the expanded population.

Before expanding the Medicaid population through the use of HMOs, it is also necessary to consider the feasibility of using HMOs to provide health care to individuals in rural areas. If rural Ohioans must continue to receive coverage on a fee-for-service basis, the costs associated with their care would likely be higher than those individuals in managed care plans. It would not be possible to cover as many people at any level of funding as could be covered if all were in HMOs.[29] Such a study of the feasibility of HMOs or other managed care mechanisms in rural areas is best left for further research.

Summary

Since federal mandates in the 1980s led to the creation of hospital DSH programs, the federal fiscal burden created by the already costly Medicaid program has been greatly exacerbated. In an attempt to contain the growing costs of DSH programs, the federal government has attempted to restrict their use. This has led many to believe that further tightening may come in the near future, which could require Ohio and other states to change or abolish their DSH programs.

Ohio already has received federal approval to expand Medicaid eligibility using HCAP funds through the OhioCare proposal. Estimates in this paper indicate that those funds could cover up to 400,000 individuals who are currently neither privately nor publicly insured.

Recent discussions of a balanced federal budget have included the possibility of reforming the Medicaid program. If the federal government were to decide to give states their share of federal Medicaid funds in the form of a block grant (and especially if DSH funds were included), reform possibilities would not be limited to eligibility expansion. Among other options, reimbursement rates to Medicaid providers could be increased, covered services for current eligibles could be expanded, or refinements could be made to existing DSH programs.

Whatever option is chosen, restructuring a program of such magnitude would have tremendous effects on all those involved. Expanding eligibility could provide better care for those currently uninsured, and increasing provider reimbursement rates could provide better access to care for those who are currently eligible for Medicaid. One thing is certain, any alteration of HCAP would have significant fiscal effects upon the entities responsible for funding the state share of the program — Ohio's hospitals.

... it is also necessary to consider the feasibility of using HMOs to provide health care to individuals in rural areas.

... any alteration of HCAP would have significant effects upon ... Ohio's hospitals.

[29] It is possible that the additional costs of covering individuals in rural areas (who are unable to enroll in HMOs because of their geographic location) through fee-for-service arrangements would not be significantly greater, on aggregate, than covering them through HMOs. That is because there are few individuals, relative to the total, who would fall into that category. Almost 60 percent of the state's ADC and Healthy Start Medicaid eligibles live in 17 Ohio counties in which HMO programs are now in place; and, almost 80 percent live in 40 metropolitan and surrounding counties in which HMO enrollment is currently deemed possible.

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