ASSOCIATION OF SAFETY-NET COMMUNITY HOSPITALS

Written Testimony

SENATE SPECIAL COMMITTEE ON MEDICAID REFORM

December 14, 2010

The Association of Safety-net Community Hospitals submits the following written testimony to the Senate Special Committee on Medicaid Reform.

Our Association was organized to increase the understanding by government entities and elected officials of the specific mission and needs of safety-net community hospitals in Illinois. Our mission is critical because, with very limited exceptions, we serve only the neediest members of society. Our institutions are also critical to the economy of our service areas where, in almost all cases, we are the largest employer and the economic engine.

The members of our Association are respected healthcare providers committed to making important investments in clinical service lines, technology and standards of care as we continue to excel in the Chicago market. Collectively, our hospitals have been recognized for excellence in healthcare services and service delivery, including: Primary Stroke Center Certification, Chest Pain Center Accreditation, Magnet recognition from the American Nurse's Credentialing Center, Stage 6 designation for the HIMSS Analytics EMR Adoption Model, American College of Radiology Certification for CT and Digital Mammography, Recognition for Excellence by the American Diabetes Association and many others.

Within the City of Chicago, safety-net hospitals account for 37% of all Medicaid days. If public charity hospital services are excluded, our percentage of Medicaid days increases to 43%. Individually, some of our members are over 60% Medicaid. Clearly, by any definition, we serve a "disproportionate" share of our State's Medicaid clients.

Our safety-net hospitals are themselves needy because we have limited opportunity, if any, to cross subsidize with commercial business; yet we face daunting financial pressures from rising costs (principally labor, pharmaceuticals, and malpractice coverage), significant charity care, an aging infrastructure, and the need to keep pace with technology.

Among the critical issues safety-net hospitals face are the following:

1. Lack of capital for facility, technology, life safety, and equipment improvement and/or replacement;
2. Increasing numbers of uninsured and underinsured patients;
3. Disparity of cost vs. payment in Medicaid and Medicare funding;
4. Difficulty in recruiting and retaining staff physicians due to low payments and high malpractice;
5. Increased incidence of disease and complications due to lack of primary care access;
6. Difficulty in recruiting and retaining staff due to financial, benefit, and community safety conditions;
7. Cook County Health Services diminishment/fragility;
8. Increased cost of leveraging funds (negative bond outlook);
9. Increased mortality and morbidity due to lack of specialty care referrals;
10. Cost of providing cultural and language appropriate treatment and care management;
11. Increased education, medication, and follow up needs due to lower community health indexes; and

12. Decrease in or total inability to cost shift from better payment insured patients.

We have always worked closely with the State in a collaboration that has produced significant results, including the Hospital Assessment programs, the hospital capital program included within the 2009 capital bill and the hospital stimulus funding program passed in the 2009 veto session. From the assessment alone, we estimate that there has been a $5 billion boost to the State's economy over the past seven years, with over $1 billion in direct benefit to the State's General Revenue Fund.

We suggest that the following issues be considered in any reform to Medicaid:

1. The State's Medicaid system cannot continue to function effectively within the bounds of the current fiscal condition. Hospitals have greatly benefitted from certain provisions of the federal stimulus program that mandated timely payment in exchange for increased FMAP. But, as that program phases out in early 2011 and concludes on June 30, there will be an additional and significant hole in the Medicaid budget. The "usual" fixes include either cuts, payment delays, or both, and neither is acceptable.

   At the present time, the State only funds 32% of the hospital line, with the balance coming principally from Federal match and the Hospital Assessment program (the "Assessment"). The Assessment also annually contributes a residual of $130 million to GRF and separate healthcare related funds. But, even with these extraneous funding sources, reimbursement to hospitals is well below cost.

   Our association has publicly stated its support for an appropriate income tax increase and we are prepared to work to support any such initiative. No serious conversation about Medicaid Reform should occur without discussion of a tax increase.

2. The State's reimbursement methodology for hospitals has not been updated in almost 20 years. If and when the State revises its base rate structure, it must also protect the delicate balance of the entire reimbursement methodology. Without funding from quarterlies and the Assessment, most of our members will close their doors. In addition, the key is not to blindly reduce payment per unit of service, but to reduce the episode of care through coordination, communication and improved access to specialists. While we are supportive of and understand the need for rate restructuring, we also caution that no change in reimbursement can be abrupt and that a shadow rate system should be in place for at least one year to insure the integrity and predictability of any new system.

3. The current Assessment has a state imposed sunset, but no sunset at the federal level. Accordingly, it is important to protect the assessment by removing the State's sunset. It is essential from both an operating and capital budgeting/funding perspective to have well understood, consistent revenue streams. In these difficult recessionary times, this is particularly important for ongoing relationships with banks and bondholders.

4. The current cost of malpractice coverage for our hospitals is unsustainable. In addition, we are often forced to cover the physician's risk before they will agree to serve the

hospital. Many of our member institutions have been forced to self-insure all or a significant portion of the malpractice risk. This places many hospitals one significant verdict from having to significantly curtail services or face closing.

Please know that our insurance cost pressures are not the result of inferior quality. There is often a perception that the quality of care at inner-city community hospitals is inferior. This is not true. We are monitored for quality and consistently earn high marks. To the extent there is any disparity, it generally lies with the difficult populations we serve, particularly including rapidly growing caseloads needing mental health and substance abuse treatment. This problem has been exascerbated by the State's failure to adequately serve this population, causing them to present at our hospital emergency rooms.

5. Unfortunately, our revenues do not afford sufficient opportunity for facility, technology, life-safety, and equipment improvements and/or replacements. Further, the Federal Affordable Care Act ("ACA") imposes "meaningful use" standards for technology that must be in place by 2014 or financial penalties begin to accrue. The cost per institution for meeting these standards runs into the millions, with one of our members facing an investment in excess of $4.5 million. While these expenditures address important updates that will enhance quality and efficiency, they also put pressure on tight capital budgets. To that end, it is important for the State to release the capital funds dedicated to various safety-net hospitals pursuant to Public Acts 96-37 and 96-39.

6. ACA will also increase the Medicaid population by an estimated 700,000 lives when fully implemented. Yet, many workforce issues and pressures have not been addressed. As an example, we already suffer from a severe nursing shortage. Any reform to the Medicaid system must address workforce supply issues or quality and access could suffer.

7. We believe there are opportunities to ferret out fraud through investigations targeting payments for referrals and passive enrollment.

Thank you for your consideration of our testimony. We look forward to continuing our longstanding working relationship with the State, specifically including the Department of Healthcare and Family Services. It is our continuing goal to be "part of the solution."

Please contact either of our Co-Chairpersons, Mark Newton from Swedish Covenant Hospital and Sister Sheila Lyne from Mercy Hospital, for additional information or to address any questions. Mark can be reached at 773-970-1000, and Sister Sheila can be reached at 312-567-2019