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Why a multibillion-dollar funding program is dividing hospitals

Some safety-net hospitals say the state's allocation system shortchanges them.

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The state's $3.5 billion hospital assessment program is up for renewal soon. But hospitals disagree about how the next iteration should allocate funds. The issue even divides "safety-net" facilities that treat large numbers of low-income and uninsured patients. Some larger, busier hospitals get more money under the current program, but some smaller hospitals with lower patient volumes get less, even if a higher percentage of their patients are on Medicaid or uninsured.

State legislators are running out of time to revamp the current assessment program. For some hospitals, another year without additional funding could mean cutting service lines—or closing altogether—as medical costs and uncompensated care rise.

"Roseland Community Hospital was almost wiped off the map" when the program changed in 2018, costing the safety-net facility about $6.6 million, says CEO Tim Egan.

More than 200 Illinois hospitals pay into the fund, triggering additional contributions from the federal government. The money is then redistributed to hospitals to offset the cost of treating patients on Medicaid. The joint federal and state health insurance system pays hospitals less than Medicare and commercial insurance.

The latest version shifted away from fixed payments that safety nets like Roseland have come to rely on to cover recurring costs like payroll and medical supplies. Instead, it adopted a "follow the patient" model, in which more funds are tied to Medicaid claims, which can be unpredictable. Designed as a Medicaid funding mechanism, the program doesn't compensate hospitals for treating indigent patients with no insurance coverage at all.

The program was intended to be a "Robin Hood tax," pulling funds from wealthier hospitals that treat larger numbers of patients with private insurance, which pays hospitals more than government programs. In some cases, however, major medical centers such as University of Chicago Medicine also attract comparatively large numbers of Medicaid patients. They get more money under the current allocation system, even though Medicaid patients represent a smaller share of their overall patient base, making them less financially dependent on the program than a small safety net like Loretto Hospital.

Bigger hospitals offering a wider array of specialty services and medical education also qualify for supplemental payments under the hospital assessment program. Smaller safety nets typically don't have the capabilities needed to get such payments.

A bipartisan legislative work group led by state Rep. Greg Harris, D-Chicago, needs to get a compromise bill passed this month in order to get approval from the federal Centers for Medicare & Medicaid Services before the current program expires June 30.

The only measure on the table so far would give a larger share of the pot to hospitals in underserved areas that treat a higher proportion of Medicaid patients, including safety nets, rural critical access facilities and many community hospitals. Backed by the Service Employees International Union, the bill was drafted with now-shuttered MetroSouth and Westlake Hospital in mind—both of which lost assessment funding as patient volumes dwindled.

LOSSES

According to an SEIU analysis, the two dozen community hospitals in the state with a Medicaid patient population of about 30 to 50 percent lost a total of $30 million under the current assessment program, says Anne Igoe, director of SEIU Healthcare Illinois' health systems division. More than half a hospital's patients must be on Medicaid for it to be considered a safety net.

The hospital industry says assessment program funds are needed by all hospitals—regardless of size and payer mix—to support Illinois' severely underfunded Medicaid system. The state spent an average of $5,436 per Medicaid beneficiary in 2015, less than all but one other state—Nevada, according to the latest data from the Illinois Health & Hospital Association. The nationwide average was $7,556.

"Everybody would love to go back to a decade ago when we all got a check, reliably, every two weeks with those static payments. It was easier to plan for your operations that way," says Sinai Health System CEO Karen Teitelbaum. "But we as a hospital industry need to adjust our operations to match the care we're giving."

Teitelbaum says four-hospital Sinai, Chicago's largest safety-net chain, got $9.4 million more money under the current assessment regime, partly due to offering expensive services like trauma care and a graduate medical education program.

The current allocation was driven by the evolving health care landscape, including shifts to outpatient and value-based care, as well as federal rules requiring that fixed payments be phased out by 2028, says state Sen. Heather Steans, D-Chicago, a member of the legislative work group.

But without fixed payments, safety nets have less money to treat the growing ranks of uninsured patients, says Jose Sanchez, CEO of Norwegian American Hospital. Sanchez says the Humboldt Park safety net spent $16.3 million last year treating more than 4,400 patients without insurance—up from about 4,200 the year earlier.

Sanchez says he hopes the new hospital assessment program will recognize that safety nets "are a unique and different set of hospitals that address the poor and the indigent in our communities. . . .Who is going to serve them the day we close?"

Inline Play
