NAUH
NATIONAL ASSOCIATION OF URBAN HOSPITALS

National Association of Urban Hospitals
Advocacy Agenda for 2017

2017 promises to be a year of major change in the health care world. The Affordable Care Act is expected to be repealed, in some manner, early in the year, with its eventual replacement bringing three major unknowns: when it will be replaced (and whether entirely or in pieces), what aspects of it will be replaced (and when), and what the nature of the various components of that replacement may be. This means 2017 will be a year during which NAUH will need to focus on protecting the ability of private, non-profit urban safety-net hospitals to serve their patients and their communities in an environment in which change could be swift and dramatic – and potentially damaging to access to health care for millions of Americans.

Urban Safety-Net Hospitals and Paying for Health Care

The nation's private, non-profit urban safety-net hospitals are heavily invested in the expanded access to health insurance that is the centerpiece of the Affordable Care Act. That law slashed Medicare payments to safety-net hospitals to help underwrite Medicaid expansion and insurance subsidies: cut their Medicare DSH and Medicaid DSH payments, cut their annual cost-of-living adjustments, and introduced new programs, such as the readmissions reduction and value-based purchasing programs, that had a disproportionate and negative impact on urban safety-net hospitals. These cuts and more were made in anticipation of safety-net hospitals serving fewer uninsured patients, so if repeal of the Affordable Care Act returns many low-income individuals to the ranks of the uninsured, these payment cuts must be restored so those hospitals will have the resources they need to care for these patients.

Ensuring Access to Health Care Services

NAUH believes that private insurance and Medicaid coverage aspects of the Affordable Care Act that are repealed must be accompanied at the time of their repeal by a plan to replace that coverage with equivalent access to health care. Patients who were covered by Medicaid expansion must remained covered until alternative, guaranteed access to care is established. Such repeal, moreover, must include the restoration of provider payment cuts that were implemented as part of the 2010 reform law. It is essential that urban safety-net hospitals and their patients have a complete understanding of the changes being imposed on them – what is being taken away and what is replacing it, including timelines for replacement – at the time such changes are adopted.

This is so important because urban safety-net hospitals are now serving many patients who benefit from aspects of the Affordable Care Act and whose access to care, and access to hospitals, may be affected by whatever replacement mechanisms are implemented. This also is important because urban safety-net hospitals generally do not have the resources of the typical community hospital and may need more time to make any necessary adjustments in how they serve their patients while remaining financially viable

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because ultimately, while individual aspects of the current health care system may disappear with a roll call of Congress and a presidential signature, the patients whom these hospitals serve will continue to turn to urban safety-net hospitals for care regardless of how federal health care laws treat them.

If the Affordable Care Act's Medicaid expansion is repealed but not replaced, many of the patients urban safety-net hospitals serve who benefited from that expansion will lose their insurance but not their need for care. Because Medicaid expansion and insurance subsidies for working-class families enabled millions of such individuals to obtain care and also reduced the amount of uncompensated care urban safety-net hospitals provided, any repeal of Medicaid expansion must be accompanied by the full restoration of the resources hospitals have long relied on to help them with their uncompensated care: pre-Affordable Care Act-level funding of Medicare DSH and Medicaid DSH. In addition, both DSH programs must be protected from any effort to redistribute their resources based on faulty data, such as uncompensated care data reported on hospitals' Medicare cost report S-10 worksheet.

Medicaid Policies

The Affordable Care Act added millions of Americans to the Medicaid rolls in 31 states and the District of Columbia. No matter what form it takes, Medicaid reform must not abandon these millions of people, the states that expanded their Medicaid programs, and the urban safety-net hospitals that serve so many of these beneficiaries. Any future Medicaid reform must require state and local governments to maintain their level of funding for Medicaid, to cover the same populations, and to provide a comparable level of benefits for those whom they cover. Abandoning current Medicaid recipients by reducing the current level of state commitment to Medicaid would impose an enormous and potentially unsustainable burden on urban safety-net hospitals.

If future Medicaid reform involves any kind of block grants for states, the baseline established for calculating those block grants must be predicated on current Medicaid enrollment and spending in the individual states – including states that expanded their Medicaid programs, as provided for in the Affordable Care Act. Such block grants cannot be based on pre-Affordable Care Act Medicaid enrollment and spending.

Any repeal of Medicaid expansion or even any changes in Medicaid policy that result in fewer people covered by Medicaid or fewer services available to Medicaid beneficiaries must be accompanied by full repeal of the Medicaid DSH cuts that are scheduled to begin in January 2018 and those Medicaid DSH resources must be protected from any further reductions in the future. Any attempt to redistribute DSH resources based on how much uncompensated care hospitals provide must not be based on flawed uncompensated care data such as that currently produced by the Medicare cost report's S-10 worksheet.

Any meaningful change in who is eligible for Medicaid, how Medicaid services are delivered, or what services Medicaid covers must include a transition period to help beneficiaries, providers, and the states adjust to those changes without suffering undue harm. This is especially important for urban safety-net hospitals because most such hospitals lack the resources to absorb the potentially significant costs providers might incur as part of such changes – especially if reform leads to fewer insured people and fewer benefits for Medicaid beneficiaries.

Finally, as policy-makers consider giving states new, possibly unprecedented flexibility to decide how to structure and operate their Medicaid programs in the future, they also should enable states to retain their current level of flexibility for financing those same Medicaid programs through established mechanisms such as provider taxes, intergovernmental transfers, certified public expenditures, and others.

Medicare Policies

Urban safety-net hospitals serve especially large numbers of Medicare beneficiaries and, in particular, especially large numbers of low-income Medicare beneficiaries, so they have special needs that must be taken into consideration and addressed as part of any attempt to change the federal role in helping to meet the health care needs of the country's seniors. Reform must recognize that urban safety-net hospitals serve more low-income elderly and uninsured patients and more patients with complex medical needs than the typical community hospital, that such patients often require more resources to serve than the typical hospital patient, and that urban safety-net hospitals often bring fewer resources to their efforts than those other hospitals.

The federal government has long supplemented the Medicare payments it makes to safety-net hospitals to help bridge the gap between what Medicare pays urban safety-net hospitals and the resources those hospitals expend caring for their low-income elderly and uninsured patients. Any attempt to reform Medicare must include restoration of the most important of those resources, Medicare DSH payments, to their pre-Affordable Care Act level. Medicare DSH resources should not be combined with Medicaid DSH resources into a single, nation-wide uncompensated care pool. Any attempt to redistribute Medicare DSH or Medicaid DSH resources based on how much uncompensated care hospitals provide must be based on reliable, verifiable uncompensated care data and not, as has been proposed by some, the data currently reported on the Medicare cost report's S-10 worksheet, which NAUH has demonstrated to be inaccurate and misleading.

Many urban safety-net hospitals also are teaching hospitals, and those teaching programs, in addition to enhancing the ability of these hospitals to serve the low-income residents of their communities and training our next generation of physicians, also help recruit young professionals to urban medical practice. Any attempted Medicare reform must reflect the importance of medical education programs by protecting graduate medical education payments and ensuring their adequacy now and in the future.

If repeal and replacement results in fewer people covered by Medicaid, hospitals will find themselves providing more uncompensated care to low-income seniors. For this reason, Medicare bad debt reimbursement should be retained at its current level.

While NAUH supports continued innovation in the delivery and reimbursement of Medicare services, future innovations must reflect the very real differences between types of hospitals and the types of patients and communities those different hospitals serve. Urban safety-net hospitals, for example, serve communities with large numbers of patients whose socio-economic status brings with it numerous challenges that other hospitals do not face, so the manner in which innovation programs are structured in the future and the manner in which participating providers are paid by those programs must reflect the additional staffing, resources, and services urban safety-net hospitals often must bring to their efforts to achieve the quality goals such programs demand.

No Additional Payment Cuts

Urban safety-net hospitals have already absorbed significant payment cuts to underwrite the cost of Medicaid services and private insurance for low-income and working-class Americans. They can afford no more such cuts in the future.

The changes expected in the coming year will almost certainly be considerable and will just as certainly make new, significant demands of urban safety-net hospitals: demands associated with ensuring continued access to care for the residents of their low-income, medically vulnerable communities, and in particular, access for individuals who may lose health care coverage as a result of these changes. The

financial challenges associated with this role will be great, and for this reason, it is essential that the changes to come include no reductions in Medicare or Medicaid payments to safety-net hospitals and no other policy changes that result in a decline in the resources these hospitals have traditionally received, and that they need, to ensure access to care for the people who will turn to them for care in the coming year.