NATIONAL ASSOCIATION OF URBAN HOSPITALS

Private Safety-Net Hospitals Caring for Needy Communities

Testimony Submitted to the House Energy and Commerce Committee by the National Association of Urban Hospitals

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The National Association of Urban Hospitals appreciates this opportunity to submit testimony to the House Energy and Commerce Committee regarding health care reform, the perspective of private, non-profit urban hospitals on health care reform, and the draft reform bill prepared jointly by the Energy and Commerce Committee, the Ways and Means Committee, and the Education and Labor Committee.

Introduction

The National Association of Urban Hospitals (NAUH) appreciates all that the House Energy and Commerce Committee has done, and continues to do, to bring health care reform to our nation. We appreciate the committee's hard and diligent work and the wide net it has cast in search of information and views that will enhance its ability to identify the best, most efficient, most economical means possible of making health insurance available to as many Americans as possible.

Aspects of the Reform Bill That NAUH Supports

NAUH finds a great deal to like in the tri-committee's draft health care reform plan. We would like to take this opportunity to identify those proposals and explain why we support them so that when this bill undergoes its inevitable review and amendment, the committee will understand why they are so important to private, non-profit urban safety-net hospitals.

Preservation of Current Medicare DSH and Medicaid DSH Payments

NAUH greatly appreciates that the tri-committee's draft health care reform plan does not call for immediate reductions in Medicare DSH and Medicaid DSH payments to hospitals. Others have proposed reducing these payments significantly and using the savings to help pay for health care reform. At the heart of such proposals is the assumption that if health care reform passes and all Americans are insured, hospitals that today care for many uninsured patients would have few, if any, such patients in the future and therefore would not need these DSH subsidies. NAUH would like to call to the committee's attention our experience that, contrary to what many people believe, Medicare DSH and Medicaid DSH do more than pay for care for uninsured patients.

Medicare DSH and Medicaid DSH help compensate hospitals for the additional costs they incur caring for their large numbers of low-income patients. The patients served by private urban safety-net hospitals tends to be older, sicker, and poorer than the typical hospital patient; have health problems they have neglected for years, if not for decades; have gone years with limited access to adequate food and housing; and have endured years with limited access to care. By the time they reach us, many of these patients have other medical problems caused by years of neglect of their health and require additional services for which Medicare and Medicaid do not pay – services like

additional care for medical problems other than their primary diagnosis (which is all Medicaid and Medicare pay for), transportation, non-prescription medications and supplies, nutrition counseling, assistance with social services, translation services, help with related behavioral health problems, and more. Private urban safety-net hospitals see many more of these patients than the typical American hospital, and DSH helps pay for these additional services.

Medicaid DSH payments also are used by states to help cover the shortfall in their Medicaid payments. Many states' Medicaid programs knowingly and intentionally reimburse hospitals for less than the cost of the Medicaid services they provide. States deliberately engage in such a practice, year after a year, precisely because they know Medicaid DSH payments will compensate for much – but not all – of their payment shortfalls. If Medicaid DSH payments were to disappear or diminish significantly, many high-volume Medicaid hospitals would suffer enormous financial shortfalls that their states, regardless of the condition of their economies, would never make up through fairer, more appropriate Medicaid payments.

In addition, even with near-universal insurance, many low-income Medicare and Medicaid patients will still not be able to afford their co-pays and deductibles. For hospitals such as ours that care for so many of these patients, such unpaid co-pays and deductibles can run into the hundreds of thousands or even millions of dollars a year. Medicare DSH and Medicaid DSH payments help compensate urban safety-net hospitals for this considerable lost revenue as well.

While NAUH shares the committee's hope that health care reform will benefit everyone, experience in Massachusetts suggests that reform will miss at least some people – and those people will continue to seek care when they are sick or injured. When they do, the hospitals to which they turn will be the same private urban safety-net hospitals that care for them now. Consequently, we applaud the committee's decision not to propose legislation that eliminates or phases out DSH payments based on the assumption that insuring most Americans will result in the virtual elimination of hospitals' uncompensated care costs. We much prefer the committees' proposed approach of studying the impact of reform on the need for DSH payments in 2016 instead of attempting to predict that impact before reform is even implemented.

Expansion of Medicaid Eligibility

NAUH enthusiastically supports the committees' proposal to revise Medicaid eligibility criteria to enable more low-income Americans to take advantage of this program. Every day our hospitals witness low-income working people struggling to pay for their health care. These are the very individuals and families whom universal insurance is most likely to miss because they simply would be unable to afford even modest, subsidized health insurance. We are pleased that the committees have proposed reaching out to such people in this manner.

We also appreciate the committees' decision to place financial responsibility for paying for this expansion of eligibility with the federal government rather than with the states because so many states have such a poor record of paying providers adequately for the care they deliver. Many states, moreover, currently are seeking to reduce their Medicaid obligation by cutting programs and cutting provider payments. With so many states already underpaying providers, NAUH urges the committee to consider adding to the bill a provision calling on states to make adequate payments to hospitals and other providers.

Improved Medicaid Payments for Primary Care

NAUH is similarly enthusiastic about the committees' proposal to improve Medicaid payments to primary care physicians. In the face of state Medicaid payments that range from mildly inadequate to insultingly miniscule, one of the biggest challenges that many Medicaid recipients encounter is finding primary care physicians willing to take them as patients. This proposal should help address that problem.

We should note, however, that inadequate Medicaid reimbursement is a problem that faces the broad spectrum of providers of care to the Medicaid population. For this reason, we urge the committees to consider directing similar improvements in Medicaid reimbursement for hospital inpatient care and services provided in hospital emergency rooms.

Recognizing the Special Needs of High-Volume DSH Hospitals

NAUH appreciates the committees' recognition that Medicare DSH hospitals may need additional financial help with the transition to some new service delivery systems. Specifically, we refer to the proposal that offers large Medicare DSH hospitals – those that receive at least $10 million a year in Medicare DSH payments – an opportunity to receive enhanced Medicare DSH payments to help them implement various quality measures. We are most grateful to see policy-makers acknowledge the very special role that private urban safety-net hospitals play in caring for low-income Americans – and acknowledge that our doing so has taken an unmistakable financial toll on these hospitals, leaving many of them so starved for resources by Medicaid and Medicare that they will need a financial helping hand to do their part to serve their urban communities in a reformed health care system.

Medicare Rates for the Public Plan Option

Creating a new health plan from whole cloth is a bold, ambitious, and challenging undertaking. The question of how such a plan would pay providers, especially in its earliest days, is a complicated one – and one fraught with anxiety and potential peril for those providers. For this reason, NAUH is cautiously optimistic about the tri-committee's proposal that the starting point for those payments will be current Medicare rates plus five percent. Based on our reading of the draft bill, we cannot tell whether this payment would include DSH, indirect medical education (IME), and capital payments and whether it also would include a wage index adjustment. If it does, this approach could offer a reasonable starting point for public plan payments; if it does not, however, those payments would be inadequate.

Concerns About the Reform Bill

As enthusiastic as NAUH is about the committees' draft health care reform bill, that bill does raise a number of concerns. We would like to outline those concerns briefly.

Future Public Plan Reimbursement

As noted above, NAUH is cautiously optimistic the bill's call for the public health insurance plan to start out paying Medicare rates plus five percent. Over time, though, we are concerned that if the public plan grows very large, its vast purchasing power and influence could lead it to attempt to impose Medicaid-like rates on providers – rates that in many states are well below providers' costs. This is especially a concern for private urban safety-net hospitals because, like many others, we expect enrollment in the public plan to be the last resort for many relatively low-income individuals and families – especially those employed by small businesses that do not offer health insurance benefits to their employees. We expect urban safety-net hospitals to serve a disproportionate numbers of public plan patients and are concerned about the potential impact of below-cost payments on the overall financial health of these hospitals. Alternatively, we are concerned that the public plan may even choose not to negotiate at all with some private urban safety-net hospitals, leaving us unable to serve large numbers of residents of our own communities. We hope the final version of the bill will address these concerns.

The Need for Additional Resources to Fund Service Delivery Changes

NAUH appreciates the committees' recognition of the high cost of converting to new delivery systems and the need to provide additional resources to facilitate such transitions. NAUH would like to point out that in addition to the implementation of new quality initiatives for which the bill envisions support, a number of other new delivery system changes could impose considerable new costs on our hospitals. In these areas, too, we believe private urban safety-net hospitals will need supplemental assistance to enable us to implement such changes in a timely manner. We believe these mechanisms – including bundled payments, accountable care organizations, limited or no payments for avoidable hospital readmissions, and others – have a great deal to offer and would be welcome additions to the Medicare payment system. As useful as these mechanisms would be, however, they also pose undeniable challenges to urban safety-net hospitals, and we would like to take this opportunity to bring those challenges to your attention.

The common tie that binds these mechanisms is their requirement of a good deal of up-front investment by hospitals – an investment of funds that private urban safety-net hospitals generally do not have. For years, many of these hospitals have been starved of resources, especially by their state Medicaid programs. This leaves these hospitals without the resources they need to invest in new delivery systems.

Consider, for example, the concept of bundled payments. The hold-back of payments that are a key part of the bundled payment concept would take place at the same time that hospitals will need to spend money to develop the relationships necessary to deliver care through the bundled approach. What is needed, we maintain, is an adequate transition period from the current system to the new system – a transition long enough to enable private urban safety-net hospitals to find the resources needed to make that transition successfully. Alternatively, the federal government could finance the steps necessary for urban safety-net hospitals to make this transition.

We hope the committee will keep these challenges in mind as it works to reform the country's health care system and consider providing supplemental assistance to facilitate our efforts in these areas.

The Temptation to Cut DSH Payments

As noted above, NAUH is most grateful that the committees' health care reform proposal does not call for reducing Medicare DSH and Medicaid DSH payments as a means of generating revenue with which to pay for health care reform. At the same time, we recognize that this money will remain a large, tempting target as lawmakers grapple with how to finance reform. We know the temptation will be great, but we hope the committee will continue to resist – and will oppose – any effort to reduce Medicare DSH and Medicaid DSH payments to help pay for reform.

The Speed of Change

More than most providers, private urban safety-net hospitals are on the front lines in caring for low-income Americans, and we believe we have a better sense of the extent to which change is truly needed – and needed now. But many aspects of change come at a cost – a hard financial cost that hospitals will have to pay. Some hospitals will have relatively little trouble paying such costs, but many private urban safety-net hospitals – with their limited means, reduced income from investments in the current economy, and tight margins caused by years of under-reimbursement by government and caring for so many uninsured and under-insured patients – will struggle considerably to finance those costs and finance change. As noted, we hope that mandates for change will, whenever possible, be accompanied by the resources safety-net hospitals need to undertake such change. When they are not, however, we hope that the time-line for change will be reasonable so that hospitals that

already face such enormous financial challenges will not be overwhelmed by the cost of change – overwhelmed to the point where their financial health is jeopardized or they cannot comply with these new mandates in a timely manner.

About the National Association of Urban Hospitals

The National Association of Urban Hospitals advocates for adequate recognition and financing of private, non-profit, urban safety-net hospitals that serve America's needy urban communities. These urban safety-net hospitals differ from other hospitals in a number of key ways: they serve communities whose residents are much older and poorer; they are far more reliant on Medicare and Medicaid for revenue; they provide far more uncompensated care; and unlike public safety-net hospitals, they have no statutory entitlement to local or state funds to underwrite their costs. NAUH's role is to ensure that when federal officials make policy decisions, they understand the implications of those decisions for these distinctive private urban safety-net hospitals. NAUH pursues its mission through a combination of vigorous, informed advocacy, data-driven positions, and an energetic membership with a clear stake in the outcome of public policy debates.

The U.S. today has a vast, multi-part health care safety net. Among the major participants in this safety-net are public and children's hospitals; federally qualified health centers and other government-sponsored clinics; sole-community, Medicare-dependent, and critical access hospitals; and others. Urban safety-net hospitals are a vital part of this health care safety net as well. These private, non-profit, mission-driven institutions are key providers for many uninsured, under-insured, low-income, and Medicare- and Medicaid-dependent residents of urban areas throughout the country. Without urban safety-net hospitals, millions of Americans would have very limited access to medical care.

Typically, private urban safety-net hospitals serve alongside public hospitals in their communities, providing the same services to the same patients for the same reimbursement – if they are paid at all. Most urban communities do not have any public hospitals, leaving private urban safety-net hospitals standing alone as the providers of last resort for people who have nowhere else to turn for care.

Urban safety-net hospitals benefit the entire nation. Many have teaching programs through which they train our next generation of physicians. They also are deeply involved in medical research, playing a pivotal role in developing the medical breakthroughs that will improve the quality of life for millions in the years to come.

Hospitals generally only provide individual types of services if they feel they can make money on those services – but not private urban safety-net hospitals. These hospitals routinely provide money-losing services – maternity and neonatal intensive care, behavioral health and substance services, care for AIDS patients, burn and trauma services, and more – simply because their communities need these services and no one else is willing to provide them. Their emergency rooms are among the busiest in the country, serving vast numbers of emergency patients who have no way to pay for the care they receive.

Many urban safety-net hospitals are more than ordinary community hospitals: they are tertiary-care institutions that offer cutting-edge treatment that takes advantage of the latest in medical knowledge. They are pioneers in new treatments and are the hospitals to which other hospitals transfer their most complicated cases. For these reasons, they attract patients from well beyond the borders of their own communities, making them a vital resource for entire regions of insured and uninsured patients alike.

While caring for disproportionate numbers of low-income and disadvantaged patients, urban safety-net hospitals regularly provide services that no payment system in the world recognizes and for which no payment system in the world will compensate them. Their patients benefit greatly from help with transportation, social work services, on-site translators, child care, instruction in nutrition, visits and telephone calls to the homes of young,

pregnant women from nurses and other health care professionals, classes on raising children, special programs for low-income seniors, and much, much more.

Private urban safety-net hospitals are almost always the economic engines that drive their communities – a key source of jobs for residents, customers and contracts for small businesses, and tax revenue for local governments. They often are the only institution of great size in their communities – communities that other businesses have long abandoned for more lucrative markets elsewhere.

While many suggest that "the market" should be left to address access to care, time has proven that there is no market for providing health care to people who have no insurance and no means of paying for care. Time and time again, however, mission-driven private urban safety-net hospitals have stepped into this void and gone where markets never go, providing care to the low-income residents of their communities because others have abandoned those communities and because the residents who remain and need care have nowhere else to turn. Urban safety-net hospitals recognize that they do so at their own peril and that they are risking their financial viability and perhaps their very futures. They do it anyway.

Conclusion

The National Association of Urban Hospitals enthusiastically supports health care reform and sees a great deal of merit in the health care reform bill developed jointly by the House Energy and Commerce Committee, the House Ways and Means Committee, and the House Education and Labor Committee. We hope we have given you insight into the needs of America's private, non-profit urban safety-net hospitals, thank the committee for the significant accomplishment this draft bill represents, and welcome any questions you may have about our organization and our views on the issues addressed above or any other health care reform-related matters.

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For additional information about the views expressed in this testimony, please contact Ellen Kugler, executive director of the National Association of Urban Hospitals, at 713-444-0989 or at ellen@nauh.org.