National Alliance of Safety-Net Hospitals

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Advocacy Agenda for 2019

Summary

In the coming year, NASH will:

- Address Medicare issues such as continuing threats to private safety-net hospitals' Medicare DSH payments, audits of the Medicare cost report's S-10 form, graduate medical education payments, potential cuts in bad debt, 340B, the participation of private safety-net hospitals in value-based purchasing and alternative payment model programs, and the expected national conversation about "Medicare for all."
- Address Medicaid issues such as the adequacy of Medicaid DSH payments, possible reductions in Medicaid eligibility and benefits, the implications of a new proposal to define whether new immigrants and their families pose a threat of becoming "public charges," the possible introduction of Medicaid block grants, and possible new restrictions on how states may finance their Medicaid programs.
- Work to protect private safety-net hospitals from federal spending cuts.
- Reintroduce itself to Congress and the administration.
- Seek to enhance its ability to help shape government health care policy in Washington by recruiting more members.

The Coming Year

With Democrats taking control of the House of Representatives but Republicans increasing their margin in the Senate, 2019 will bring divided government that will likely make law-making difficult for the next two years. The House and Senate can be expected to disagree about almost every aspect of health care policy, possibly resulting in relatively little policy change flowing from Congress to the president.

During the fall of 2018 Senate Republicans periodically spoke of reviving their attempt to repeal the Affordable Care Act; that talk died down when Democrats took the House, so any attempt to repeal the Affordable Care Act would mostly be symbolic. During the fall Senate Republicans also talked about entitlement reform, and that may be on their 2019 agenda – an objective they share with the White House. With Democrats controlling the House, however, it will be difficult for such efforts to succeed. In both cases, however – the Affordable Care Act and entitlements – it is possible that individual, incremental reform proposals could gain enough bipartisan support to come under serious consideration by Congress.

The administration will probably seek to step into this void by pursuing policy changes that can be made either through regulations or the introduction or repeal of programs for which congressional authority is not needed. The administration has proven adept at such policy-making over the past two years, as

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demonstrated by its implementation of changes in how hospitals account for their uncompensated care for the purpose of calculating their Medicare DSH uncompensated care payments; its implementation and quick expansion of Medicare 340B payment cuts; its approval of waivers to introduce work requirements into state Medicaid programs; its advancement of site-neutral payments for outpatient services, and more. These and other such efforts can be expected to continue in 2019.

Finally, late last year a federal court in Texas ruled the Affordable Care Act unconstitutional. This decision is being challenged and will begin to work its way through the appeals process this year.

Amid these various deliberations, the National Alliance of Safety-Net Hospitals (NASH) will work to advance and protect the interests of the nation's private safety-net hospitals and ensure their continued ability to serve their communities.

Tackling Medicare Challenges

Private safety-net hospitals face a number of Medicare challenges in 2019, including the continuing threat to their Medicare DSH payments, potential cuts of some Medicare payments, and a possible continuation of the recent effort to make Medicare outpatient payments entirely on a site-neutral basis. Other proposals may arise during the year as well.

An ongoing threat private safety-net hospitals face is reductions of their Medicare DSH payments. Targeted for reduction by the Affordable Care Act, the problem has long been the manner in which hospitals report the uncompensated care they provide – a critical factor in calculating their Medicare DSH uncompensated care payments. After years of delaying use of the Medicare cost report's S-10 worksheet for this purpose, CMS finally began phasing in its use in FY 2018, entered into a second year of that phase-in in the current 2019 fiscal year, and is now in the process of auditing the S-10s of a limited number of hospitals.

NASH is concerned about this auditing process, which appears to have a number of shortcomings: auditors are requesting enormous amounts of supporting data from hospitals and giving them little time to provide that data; it is not clear that the data auditors are requesting will help determine the accuracy of S-10 reports; the audits may be too limited in scope; it appears that the limited number of hospitals being audited are not adequately representative of the hospital industry as a whole and may exclude the very types of hospitals that past NASH analysis has found to be most likely to engage in questionable uncompensated care data reporting; and it is possible that CMS may, in the end, use this limited, flawed auditing as the basis for harmful – and inappropriate – changes in the Medicare DSH payments of private safety-net hospitals.

In 2019, NASH will work with CMS to attempt to identify and address these and other audit-related problems and also hope that from this audit process will emerge new insight into how to refine the S-10's instructions in ways that will improve the quality and uniformity of the uncompensated care data hospitals report.

Another major Medicare challenge private safety-net hospitals face in 2019 is the desire of policy-makers to control or even reduce federal Medicare spending in the wake of the growing federal deficit. Public officials want to cut neither Medicare beneficiaries nor benefits, so historically, they have looked to provider payments for savings. Among the ways policy-makers have pursued Medicare savings in the past are to propose cuts in graduate medical education payments to academic medical centers and teaching hospitals – cuts that would hurt those safety-net providers and the low-income communities so

many of them serve. They also could seek to reduce Medicare bad debt reimbursement and pursue further cuts in 340B prescription drug payments. NASH will oppose such cuts – and any others that threaten the ability of safety-net hospitals to serve their communities.

NASH also will advocate that any continued movement toward paying for outpatient services on a site-neutral basis do so in a manner that ensures appropriate access to needed outpatient services in the low-income communities safety-net hospitals serve and appropriate reimbursement to providers for those services.

NASH will pursue its members' interest in participating in Medicare value-based programs and alternative payment models (APMs). To date, the manner in which these programs have been structured has made it difficult for safety-net hospitals to participate because, serving more challenging communities and patients, they often involve costs and obstacles that the typical community hospital does not face. In 2019, NASH will call for appropriate risk adjustment of new Medicare value-based purchasing and APM programs. Risk adjustment would help level the playing field and enable private safety-net hospitals to participate in these important endeavors. NASH also will urge CMS to include in these and other programs measures that seek to address social determinants of health – a major challenge in the communities private safety-net hospitals serve.

Finally, NASH will monitor the national conversation about "Medicare for all" and work to ensure that this conversation, which could develop into a major campaign issue in 2020, reflects an appropriate understanding of the needs of low-income patients and the private safety-net hospitals that serve them.

Addressing Medicaid Issues

Private safety-net hospitals face four distinct types of challenges to their Medicaid payments in the coming year: 1) cuts in their Medicaid DSH payments, 2) attempts to limit Medicaid eligibility, 3) attempts to reduce federal Medicaid spending, and 4) attempts to undermine the manner in which states finance their Medicaid programs.

One of the biggest Medicaid challenges private safety-net hospitals will face in 2019 is threats to the adequacy of their Medicaid DSH payments. The Affordable Care Act called for reducing Medicaid DSH payments. While millions of Americans have obtained health insurance in recent years, millions more still have not, the number of uninsured Americans is now rising again for the first time in years, and those uninsured individuals, when they need care, still turn most frequently to private safety-net hospitals. Three times in recent years Congress has recognized the problem that reducing Medicaid DSH payments would pose and – in response to advocacy by NASH and other hospital groups – delayed this cut's implementation. After numerous delays, these cuts are now scheduled to take effect beginning in FY 2020 – October of 2019 – and will result in Medicaid DSH allotments to states being cut $4 billion in FY 2020 and $8 billion every year from FY 2021 through FY 2025. Such cuts would significantly reduce the ability of states to help their safety-net hospitals and would unquestionably harm those hospitals and the communities and patients they serve, so in the coming year NASH will work with other hospital groups to urge Congress to delay Medicaid DSH cuts yet again and fashion a more appropriate approach to addressing the still-significant amount of uncompensated care private safety-net hospitals continue to provide to their low-income and uninsured patients.

Next, the administration and Congress could seek to introduce changes that would limit Medicaid eligibility and perhaps reduce the number of people who participate in the program. Medicaid was a major target of administration efforts in 2018 and appears likely to be so again in 2019. The

administration can be expected to continue encouraging states to introduce work requirements in their Medicaid programs – requirements that jeopardize the Medicaid eligibility of many residents in the communities private safety-net hospitals serve. The administration also could take steps to encourage states to tighten their Medicaid eligibility requirements or benefits – changes that, again, would disproportionately harm the kinds of communities private safety-net hospitals serve.

In November the administration proposed a regulation that would redefine eligibility for entry into the U.S. based in part on whether the applicant or members of an applicants' family might become "public charges" – that is, individuals who might need assistance from various public benefit programs, including Medicaid – in the coming years. Depending on how such a regulation is structured, such a policy might discourage legal low-income immigrants from applying for Medicaid for fear that doing so might jeopardize the ability of members of their family to immigrate legally to the U.S. – and in the process possibly leave private safety-net hospitals that care for such individuals unpaid for their efforts. NASH will work to include much-needed protections for safety-net hospitals in any such regulation that might be adopted.

If the policy focus shifts from participants to spending, an effort could be undertaken to attempt to introduce a major Medicaid change that has been much-discussed in the past: Medicaid block grants. Block grants, whether based on individual states' Medicaid enrollment or on their past Medicaid spending, could impose unreasonable limits on Medicaid spending that could potentially leave private safety-net hospitals unreimbursed for care they provide to legitimately eligible individuals. NASH will work to ensure that any new approach that involves Medicaid block grant continues to give states the ability to pay safety-net hospitals adequately for the essential services they provide to the low-income residents of the communities in which those hospitals are located.

Finally, another approach the administration and Congress might take to reducing federal Medicaid spending in 2019 would be to attempt to address the manner in which states finance their Medicaid programs. Provider taxes used to help pay the state share of Medicaid costs have come under scrutiny in the past, and in the coming year so might other funding mechanisms states use, such as intergovernmental transfers and certified public expenditures. The administration also might seek to limit how states calculate their Medicaid upper payment limits and determine their rate range room and also might more carefully examine Medicaid waiver applications to ensure that they are budget-neutral. Whether through regulations or legislation, any such efforts could pose a potential threat to private safety-net hospitals if they limit the ability of state governments to fund their Medicaid programs. NASH will closely monitor legislation and regulations that attempt to introduce these or other such money-saving policy changes and work to oppose any that threaten the ability of safety-net hospitals to serve their communities.

Protecting Safety-Net Programs From Spending Cuts

As noted, it is possible there will be an appetite for spending cuts in Washington in 2019 – cuts to pay for other congressional priorities or to address the federal budget deficit. Over the years, Congress has often looked to health care when seeking to cut spending or pay for other needs.

Such efforts could arise in a number of contexts in 2019: as part of negotiations to raise the federal debt limit, which will be needed sometime in March; as part of deliberations to raise the spending limits (also often referred to as budget caps) instituted through the Bipartisan Budget Act of 2015 to provide relief from the budget sequestration enacted in 2011; as part of ordinary budget negotiations; as a way of finding savings to offset spending for an infrastructure bill that appears to be of interest to both House Democrats and the Trump administration; and possibly under other circumstances as well. Regardless of

the context, NASH will work to protect Medicaid and Medicare from further spending cuts that might jeopardize the ability of private safety-net hospitals to serve their communities.

Using Data and Research to Support Advocacy

NASH always seeks to support its policy positions with data. The best recent example of this has been NASH's work addressing the challenges posed by the anticipated use of the S-10 in calculating hospitals' Medicare DSH uncompensated care payments. For years NASH has analyzed the S-10 data of hospitals throughout the country in search of anomalies and trends that suggested problems in how hospitals complete their forms, using what it learned to inform its interaction with CMS and its advocacy of both improvements in the S-10's instructions and delays in its use until those instructions can be improved and the results of data reporting can be audited. As has been the case on numerous occasions over the years, the use of data and the credibility that data earns when interacting with policy-makers has enhanced NASH's advocacy on its members' behalf. In 2019 NASH will continue to use data to identify problems and support its advocacy on behalf of private safety-net hospitals.

Reaching Out

Recognizing that safety-net hospitals can be found serving communities across the country, our organization, previously the National Association of Urban Hospitals, evolved into the National Alliance of Safety-Net Hospitals in late 2018. In 2019, NASH will reach out to private safety-net hospitals across the country with the message that the best way to address their policy needs in Washington is to supplement their existing hospital association involvement with a group that focuses solely on issues unique to private safety-net hospitals and does not regularly subordinate their specific needs to those of a membership group in which they are an unmistakable minority.

At the same time, NASH will reintroduce itself to Congress and the administration, seek to educate public officials about the vital role private safety-net hospitals play in the American health care safety net, and advocate the development and implementation of federal policies that help private safety-net hospitals fulfill their mission of service to the low-income residents of the communities in which they are located.