National Alliance of Safety-Net Hospitals

January 25, 2019

The Honorable Marco Rubio
United States Senate
Washington, DC 20510

Dear Senator Rubio:

Thank you for contacting the National Alliance of Safety-Net Hospitals (NASH) and inviting us to comment on the discussion draft of the SAFE Hospitals Act. We appreciate both your interest in our views on possible changes in the Medicaid disproportionate share program (Medicaid DSH) and your interest in Medicaid DSH itself.

As your attention to this issue reflects, Medicaid DSH is essential to private safety-net hospitals. Private safety-net hospitals' Medicaid DSH funding plays a vital role in helping these hospitals care for the low-income and uninsured residents of the communities they serve and it is not an understatement to suggest that for many of these hospitals, this Medicaid DSH revenue makes a difference in whether they are able to continue serving their communities in the manner those communities have come to expect – and in the manner we believe they deserve.

At this stage of consideration of the SAFE Hospitals Act, NASH believes the most useful contribution we can make to this conversation is to present a brief set of principles we believe should inform the development of any legislation that seeks to alter the Medicaid DSH program. These principles all begin with a very immediate concern: major change is coming to the Medicaid DSH program beginning in 2020 – with or without legislation. As mandated by the Affordable Care Act, the pool of federal money to distribute to states for Medicaid DSH will be reduced significantly beginning in FY 2020: $4 billion that year and $8 billion a year each in FY 2021, 2022, 2023, 2024, and 2025. Three times Congress has delayed implementation of these cuts – its recognition, we believe, that most Medicaid DSH recipients, including private safety-net hospitals, continue to serve significant numbers of low-income and uninsured patients, continue to provide significant amounts of uncompensated care, and continue to need the resources this program provides to ensure their ability to serve their communities. Any discussion about Medicaid DSH, we believe, must start with and reflect recognition of the major Medicaid DSH funding cuts that begin in FY 2020.

With this in mind, we offer the following three principles for reforming Medicaid DSH through the SAFE Hospitals Act or any other means.

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Principle #1:
Delay the Scheduled Medicaid DSH Cuts

NASH believes that first and foremost, the Medicaid DSH cuts scheduled to begin in FY 2020 must be delayed. The health care system in general, and Medicaid in particular, is in too great a state of flux to risk making major changes today that might unintentionally prove harmful and need to be undone tomorrow. Among the challenges Medicaid faces today are fluctuations in the number of uninsured people; instability in the private health insurance market; litigation involving the Affordable Care Act; a number of states either in the process of expanding their Medicaid programs or actively considering doing so; and the need for states to plan how to fund their share of Medicaid spending should legal challenges to the Affordable Care Act prove successful.

In NASH's view, any attempt to reallocate Medicaid DSH resources through legislation at the same time those resources are being cut would help feed this instability rather than improve it; there is no point to cutting a program at the same time you are trying to fix it. For this reason, the starting point of any attempt to reform Medicaid DSH should be to delay the pending Medicaid DSH cuts and to protect the program from further cuts.

Principle #2:
Any changes in Medicaid DSH must reflect the role Medicaid DSH plays in state Medicaid programs

Medicaid is a partnership between the federal government and the states. Congress created Medicaid and provided for the federal government to share its cost and for the states to develop their individual Medicaid programs to meet the distinct needs of their own residents, subject to compliance with federal legislative and regulatory parameters, while also paying a meaningful share of the program's cost – a partnership.

Over the years, state have built their Medicaid programs upon a foundation of legislative and regulatory guidelines. States decide who will be served by their Medicaid programs; what benefits those individuals will receive; how providers will be paid for caring for their Medicaid patients; and how the states themselves will finance their share of their Medicaid expenditures. They also have made decisions about the degree to which they want to use a fee-for-service approach and managed care to serve their populations. They have pursued section 1115 waivers from the federal government when they sought to innovate in ways not authorized by current legislation and regulations.

Among the many decisions they have made over the years, states have identified providers, such as private safety-net hospitals, that care for especially large numbers and proportions of Medicaid, low-income, and uninsured patients and directed supplemental payments – including but by no means limited to Medicaid DSH payments – to them to help ensure those hospitals' ability to serve their many Medicaid, low-income, and uninsured patients. While some people occasionally lament that the federal government often seeks to impose one-size-fits-all solutions on state Medicaid programs, the reality is that the 50 states have 50 different Medicaid programs, all tailored to their own individual needs.

In all of these decisions they must make – whom to cover, what benefits to provide, and how to pay providers for delivering and ensuring access to care – states have proceeded with a clear understanding of the federal laws and regulations that govern Medicaid and, significantly, the extent of the federal resources they will have at their disposal when they make these decisions. They understand the formula for determining the degree to which the federal government will match their own spending for Medicaid-covered services, which defines how much revenue they must generate themselves for their Medicaid

programs; they know the guidelines that govern how they may finance that spending; and they know the parameters that determine how much Medicaid DSH money they will receive.

Any attempt to alter the formula for determining the allocation of Medicaid DSH funds to states could threaten to undermine the foundation upon which states have made all of these decisions, and in so doing, potentially threaten the effectiveness of their Medicaid programs. This is not to say Medicaid DSH does not need to be addressed; NASH recognizes that the current DSH allocations were established a quarter of a century ago and acknowledges that they could be revisited. At the same time, however, we believe any such undertaking must first understand and then take into consideration the broader implications of altering states' Medicaid DSH allotments and must include measures that ensure that any changes in the methodology for calculating Medicaid DSH allotments does not threaten to undermine or even destroy the fragile foundations upon which 50 states have been spending the past 50 years shaping their individual Medicaid programs.

Principle #3:
Any changes in Medicaid DSH must preserve states' flexibility to use Medicaid DSH resources in the manner they believe best serves their individual Medicaid programs

As noted, the 50 states today have 50 different Medicaid programs. No two are alike. This is an essential part of the federal-state Medicaid partnership and it is a part we know that many members of Congress value and espouse. NASH believes it is important that the SAFE Hospitals Act, no matter how it may evolve from the current discussion draft, ensure that states retain, among many other prerogatives, the right to direct Medicaid DSH payments to the hospitals that, in their estimation, play a critical role in serving their Medicaid, low-income, and uninsured populations. This reflects one of the very ideas expressed in the materials that accompanied distribution of the discussion draft of the SAFE Hospitals Act: the importance of protecting funding for hospitals in communities of need – the very communities private safety-net hospitals serve. Medicaid DSH has been one of the most important tools in doing exactly this, with decisions about how to use these resources made on a state-by-state basis rather than directed by federal laws or regulations.

The desire to address what are perceived as shortcomings in the program while still giving states reasonable flexibility to design their own Medicaid programs is a real challenge, and there is a very fine line between appropriate and harmful intervention. Changes in the Medicaid DSH program will have to walk this fine line very carefully, and two examples from the discussion draft illustrate the challenge this poses.

First is the proposal to alter the criteria for hospitals to qualify for Medicaid DSH payments by raising the minimum Medicaid inpatient utilization rate required to receive such payments. While there may be some justification for addressing these criteria, NASH is concerned that a new, federally dictated standard may deprive states of important flexibility. For example, there may be hospitals in some states that currently receive Medicaid DSH payments not because they serve especially large numbers of Medicaid patients but because they are the sole provider of certain services, such as behavioral health or delivering babies, in a certain geographic area. In such situations, a state Medicaid program may choose to make Medicaid DSH payments to such hospitals to ensure access to such services in that area, but new federal criteria might eliminate that important prerogative.

Second are the proposals to 1) establish four tiers of hospitals among those that are eligible for Medicaid DSH and for states to address and treat each tier differently, and 2) have CMS dictate the DSH payment methodology in states with fewer than 15 DSH hospitals. As an association that represents private safety-net hospitals, NASH believes it is important that these hospitals receive an appropriate share of Medicaid DSH funding and we appreciate your attempts to target such funding more directly to safety-net hospitals

and others that care for especially large numbers of Medicaid, low-income, and uninsured patients but as of this writing we cannot tell whether this proposal would accomplish this goal and are in the process of examining this question more closely. Ultimately, it is unclear to NASH at this time whether the proposed tiers would benefit state Medicaid programs, beneficiaries, and the private safety-net hospitals that serve so many of those beneficiaries or harm them and our primary concern is that they could hinder access to care in some areas. This aspect of the proposal would benefit from careful analysis and data modeling before it is included in future legislation.

There is a wide belief today that states need a reasonable measure of flexibility to design and operate their own Medicaid programs. This requires a delicate balance between federal regulation and state prerogative, and we question whether this discussion draft strikes that balance at this time.

About the National Alliance of Safety-Net Hospitals

The National Alliance of Safety-Net Hospitals advocates for adequate recognition and financing of private safety-net hospitals that serve America's neediest communities. These private 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 dependent 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. NASH's role is to ensure that when federal officials make policy decisions, they understand the implications of those decisions for these distinctive private safety-net hospitals. NASH 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. Until 2019 NASH was known as the National Association of Urban Hospitals, or NAUH, and its evolution into NASH reflects its members' recognition that private safety-net hospitals can be found serving communities not only urban but also rural and suburban across the country.

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NASH appreciates your interest in Medicaid DSH and your willingness to consider our views on a program of great importance to all of the nation's private safety-net hospitals. As the process of reviewing, discussing, and revising the discussion draft of the SAFE Hospitals Act continues, we hope you will share with us your future plans and invite us to comment on them as well. We also would welcome an opportunity to sit down with you or your staff to elaborate on the basic principles we have outlined above and share our thoughts and ideas on Medicaid DSH in much greater detail.

Sincerely,

Ellen J. Kugler
Executive Director