ALLIANCE of SAFETY-NET HOSPITALS

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The Honorable Cathy McMorris Rodgers
Chair, Energy and Commerce Committee
United States House of Representatives
Washington, DC 20515

The Honorable Virginia Foxx
Chair, Committee on Education and the Workforce
United States House of Representatives
Washington, DC 20515

The Honorable Jason Smith
Chair, Ways and Means Committee
United States House of Representatives
Washington, DC 20515

Dear Chair Rodgers, Chair Smith and Chair Foxx:

I am writing on behalf of the *Alliance of Safety-Net Hospitals* (ASH), a group of community safety-net hospitals that serve economically disadvantaged and underserved communities, to express our views on selected aspects of the Lower Costs, More Transparency Act (H.R. 2665).

First, we thank you for the provision in H.R. 2665 that would delay scheduled cuts in Medicaid disproportionate share hospital payments (Medicaid DSH) for two years. Medicaid DSH is a vital tool for helping community safety-net hospitals serve their low-income, uninsured, and underinsured patients, and between the continued rise in the cost of delivering health care and the expectation that many low-income Americans will lose their Medicaid coverage in the coming months, now is not a good time to reduce the federal commitment to helping safety-net hospitals cope with the cost of caring for such patients. We greatly appreciate the proposed two-year delay in the scheduled $16 billion in Medicaid DSH cuts.

Second, we would like to convey our opposition to a provision in H.R. 2665 that would introduce site-neutral Medicare payments for services provided in hospital outpatient departments. We ask you to modify this provision in a manner that would foster greater access to care for low-income Medicare and Medicaid beneficiaries who live in underserved parts of the country.

Mission-driven safety-net hospitals such as ours are fundamentally different from the typical American hospital: their priority is to go where the need is greatest, not where the revenue potential is most appealing. Typically, these hospitals can be found in economically disadvantaged and underserved

communities where most of the residents are insured by Medicare or Medicaid (or both) if they are insured at all. They do this in both rural and inner-city communities, reaching out to patients whom most providers find economically unfeasible to serve.

One of the best ways to improve access to care, whether it involves a sparsely populated rural area or a medically underserved inner-city area, is for hospitals to establish community clinics that function as an extension of a hospital. The challenge is that few physicians seek out such under-insured patients and choose to set up their private practices in the communities in which such individuals live, so the only way to serve many of these communities is for safety-net hospitals to establish medical practices directly in them: to build, equip, and manage clinics and to hire physicians and other health care practitioners to work in them. They need to pay these practitioners a competitive wage because as we have all witnessed in recent years, there is a shortage of almost every kind of health care professional in the U.S. today and such individuals can pick and choose where they work. Safety-net hospitals that establish community outpatient clinics give them a reason to choose to work in underserved rural and inner-city communities – and these hospitals are grateful that many such providers make this choice.

The investment needed to make such clinics possible is funded and then sustained in large part by the payments Medicare makes to hospital-based outpatient departments, which are greater than those Medicare makes to independent medical practices. Take away that additional funding, as H.R. 2665 proposes, and in many cases and in many places, both rural and urban, those facilities will no longer be feasible – not even for mission-driven community safety-net hospitals.

ASH recognizes the logic inherent in aligning Medicare payments for different sites of service. On the surface this seems only fair: taxpayers should not pay more for a given service when it is delivered in one location than they should when it is delivered in another.

But that logic, in ASH's view, is flawed – flawed because taxpayers, and Medicare, also have an interest in ensuring that everyone who needs care can find it, especially if those individuals are insured by Medicare or Medicaid. That is without question a challenge today, a challenge that in many places is little more than a dream, and reducing Medicare payments to some hospital-based outpatient departments would only make that dream less likely to be fulfilled. If we are starting with the premise that some areas do not have adequate access to care, reducing Medicare outpatient payments in the proposed manner would take us further from a solution to that problem, not closer.

Instead, ASH urges a more nuanced approach: an approach that recognizes that all providers are not the same, that some have a different, special mission, and that some need, and deserve, additional support from Medicare to ensure that they can fulfill that special mission.

One potential solution would be for Congress to amend the provision in H.R. 2665 equalizing Medicare outpatient payments to exclude objectively identified safety-net hospitals from such a policy. Further, we ask Congress to establish as the sole criterion for this exclusion all hospitals that meet the requirements of the current federal definition of a Medicaid disproportionate share (Medicaid DSH) hospital.

Across the country, community safety-net hospitals are doing more than ever to reach out to those who need access to quality, equitable health care. It is in the best interest of all of us that they continue to do so because if these hospitals do not create this access, that access will not exist. As currently written, H.R. 2665 would detract from their efforts and drive us further from our mutual objective, not closer. To address this concern, the Alliance of Safety-Net Hospitals urges you to amend the proposed legislation in the manner outlined above, and for the reasons presented above, to enable mission-driven community safety-net hospitals to continue doing their essential work in areas of great, unquestioned need.

We appreciate your attention to our views and welcome any questions you may have about them.

Sincerely,

Ellen J. Kugler
Director