

Safety-Net Association of Pennsylvania

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December 8, 2009

The Honorable Arlen Specter
U.S. Senate
Washington, D.C. 20510

Dear Senator Specter:

I am writing on behalf of the Safety-Net Association of Pennsylvania (SNAP), a group that represents private hospitals in Pennsylvania that care for especially high proportions of low-income patients, to share with you our views on selected aspects of the health care reform legislation currently under consideration in the Senate.

As providers of care to communities with large numbers of medically disenfranchised residents, we believe it is absolutely essential that we find ways to extend access to care to the more than 45 million Americans – among them more than one million Pennsylvanians – who today are uninsured and have little or no access to medical services. We also support efforts to enhance the effectiveness and efficiency with which providers of all types serve their patients.

Overall, we appreciate the general thrust of the reform legislation that you and your Senate colleagues are now debating. We do, however, have a number of concerns about certain aspects of this legislation, and we would like to take this opportunity to share our interest in four specific areas: the expansion of coverage to more Americans; the possible extension of the increase in the federal medical assistance percentage authorized in the American Recovery and Reinvestment Act of 2009 (ARRA); proposed reductions in Medicaid disproportionate share (DSH) payments to hospitals; and proposed reductions in Medicare DSH payments to hospitals.

In addition to these specific matters, we urge you to oppose any attempt to add to the Senate reform bill any measures that would further reduce government payments to safety-net hospitals in any way.

Expanded Coverage

SNAP enthusiastically supports making health care coverage available to more Americans. Every day, our hospitals encounter numerous low-income patients whose health and well-being have suffered from years – and in many cases decades – of neglect. If nothing else, making health care available to more Americans would be the greatest achievement of health care reform.

Extension of FMAP Increase

At the same time, it is important that providers be paid for the care they deliver, and for this reason, SNAP supports an extension of the increase in the federal medical assistance percentage (FMAP) authorized in this year's ARRA legislation. The purpose of this temporary increase was to help states through these extremely difficult economic times, and those hard times continue in Pennsylvania. State revenue remains down and appears unlikely to recover to pre-recession levels between now and the end of 2010, when the enhanced FMAP is scheduled to end. Even with this enhanced funding to support Pennsylvania's Medical Assistance program, the state slashed inpatient payments to hospitals this year by more than \$70 million and reduced supplemental payments (DSH, medical education, and others) another \$39 million – more than \$160 million in provider cuts in

all, including others, at a time when Medical Assistance enrollment and the number of uninsured Pennsylvanians is rising. Unfortunately, Pennsylvania's safety-net hospitals bore a disproportionate share of these cuts: even though safety-net hospitals constitute just 25 percent of the state's acute-care hospitals, we absorbed more than 80 percent of these cuts.

To keep its cuts as small as possible, the state took advantage of a number of one-time revenue sources – opportunities it will not have next year. As a result, in the absence of a full recovery of the economy or an extension of the enhanced FMAP, we expect next year's cuts to dwarf those imposed on us this year.

For this reason, we believe an extension of the temporary increase in FMAP is essential. Currently, the House health care reform bill calls for such an extension but the bill now before the Senate does not. We hope you will work with your colleagues to add this vital measure to the Senate's health care reform legislation.

Medicaid DSH Cuts

Medicaid DSH payments are incredibly important to safety-net hospitals like ours that care for so many low-income and uninsured patients. Medicaid DSH payments are intended to help hospitals that serve large numbers of uninsured patients and to help cushion the blow of the payment shortfalls that our hospitals suffer when they serve their many Medical Assistance patients. Those shortfalls, moreover, are considerable: Pennsylvania reimburses hospitals for only about 80 percent of the cost of the inpatient care they provide to their Medical Assistance patients and only about 50 percent of the cost of the outpatient services they provide to those patients.

Some people assume that greatly expanding access to health insurance will eliminate the need for Medicaid DSH payments, but we know that is not true. First, despite our best efforts, some people will still not be insured, and when they are sick or injured, they will continue to turn to hospitals for care – and most of them will continue to turn to safety-net hospitals like ours. Second, hospitals will still face considerable Medicaid shortfalls – and safety-net hospitals will suffer the biggest shortfalls of all. In fact, since the current reform proposals in both the Senate and the House call for adding nearly 15 million Americans to the Medicaid rolls, we expect safety-net hospitals under health care reform to care for even more Medicaid patients than they currently do and to experience even greater Medicaid shortfalls than they currently suffer. And third, because so many Medicaid patients have neglected their health for years, they generally are much more difficult and costly to treat, and to restore to good health, than the typical hospital patient.

Despite this, the reform bills currently before both the House and the Senate call for significant future cuts in Medicaid DSH payments to hospitals. While we prefer the proposed Senate methodology for calculating such cuts, we are greatly troubled that the Senate's Medicaid DSH cuts, if implemented, would be more than twice as great as those proposed by the House. We also disagree with the idea that so-called high-DSH states should be cut more than low-DSH states. High-DSH states are high-DSH states for a reason: their hospitals care for more Medicaid patients and they generally use higher DSH payments to compensate for lower Medicaid payments so they can put more Medicaid resources into the hands of hospitals that care for more low-income patients.

Consequently, we urge you to support the Senate methodology for calculating future cuts in Medicaid DSH payments to hospitals; to advocate a reduction of those proposed cuts to the level proposed in the House bill rather than the much more damaging level of cuts proposed by the Senate; and to work to eliminate the burden of additional cuts to be borne by high-DSH states like Pennsylvania.

Medicare DSH Cuts

Like Medicaid DSH, Medicare DSH payments are vital to safety-net hospitals: they are intended to help preserve access to care for Medicare beneficiaries by providing additional resources to hospitals that care for large numbers of low-income patients, including Medicaid patients, and Medicare beneficiaries who also receive SSI benefits. Pennsylvania's private safety-net hospitals care for large numbers of low-income Medicare patients who cannot

afford their co-pays and deductibles and whose care is often more costly than the typical Medicare patient; they care for large numbers of Medicaid patients for which they are seriously underpaid – and would care for many more Medicaid patients under the current reform proposals; and they care for many other under-insured and uninsured patients as well. These hospitals count on their Medicare DSH payments to help defray these costs.

The current Senate bill, however, would automatically reduce Medicare DSH payments to hospitals by 75 percent, with hospitals to receive some of that money back in the form of an adjustment for the uncompensated care they provide.

This cut would be harmful to Pennsylvania's safety-net hospitals and would leave them underpaid for the additional costs associated with treating their low-income Medicare patients. Instead of deciding now how much Medicare DSH payments should be cut, we believe it would be more appropriate for reform legislation to call for a rigorous quantitative analysis of the reduced financial burden on hospitals to be performed three to five years after reform is introduced. At that point, any necessary reductions in Medicare DSH payments could be based on actual experience rather than projections developed before a final version of the bill is even passed.

About the Safety-Net Association of Pennsylvania

The Safety-Net Association of Pennsylvania represents the interests of private, acute-care hospitals that play the leading role in caring for the poor, the disadvantaged, and the uninsured residents of the commonwealth. Safety-net hospitals are the 25 percent of hospitals in Pennsylvania that care for the highest combined proportion of uninsured patients, Medical Assistance recipients, and Medicare SSI recipients and that therefore constitute the state's health care safety net. These 37 hospitals are located in eastern, central, and western Pennsylvania, in urban, suburban, and rural areas, and in 19 of the state's 67 counties. As a result of the patients they serve, safety-net hospitals face a significant, continuing, disproportionate challenge to their financial health.

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We appreciate your consideration of these perspectives on health care reform and welcome any questions you may have about SNAP, our members, or our positions on these issues.

Sincerely,



Michael Chirieleison
President