



National
Association
of Public
Hospitals
and Health
Systems

ECONOMIC RECOVERY:

ENSURING HEALTH CARE ACCESS & CREATING JOBS

Safety net health systems are critical elements of helping America survive, and solve, the economic crisis:

- Americans are losing jobs and, with it, employer-based health insurance. These individuals look to the safety net for care – in the past year, one urban safety net hospital alone reports uninsured care has increased by \$75 million. Quick investment in the safety net is essential to ensure that the uninsured have health care access.
- Major U.S. safety net health systems drive over one million jobs and more than \$133 billion in economic output. Assisting safety net health systems to rebuild and modernize their infrastructure will create jobs, ensure the continued ability of these systems to provide health services in times of economic crisis, and protect the long-term health of the nation.

To support the safety net and promote recovery, NAPH urges Congress and the new Administration to work together to accomplish three goals: 1) provide *immediate operating relief* to help safety net hospitals provide access to the increasing numbers of uninsured and out of work Americans; 2) provide *capital financing support* to allow safety net hospitals to move forward on urgent infrastructure projects both to ensure high quality health care and to stimulate local economies; and 3) complete work on several *outstanding issues* that remain unresolved from the 110th Congress. Below we offer ideas on approaches to accomplishing these three goals, but we are willing to work with Congress and the Administration to fashion the details of any proposals that will move forward. It is our hope that as the nation prepares to revitalize the American health care system, these solutions can serve as a bridge to a truly reformed system providing access to high quality care for all.

I. ENSURING HEALTH CARE ACCESS

The Kaiser Family Foundation estimates that for every percentage point increase in the unemployment rate, Medicaid and SCHIP enrollment increases by one million and the number of uninsured grows by 1.1 million.¹ By these figures and the Federal Reserve's most recent projection of the unemployment rate,¹¹ NAPH estimates that the number of uninsured individuals will have increased by 1.8 million to 3.3 million from the beginning of the economic recession to this time next year.



Public hospitals provide a safety net health system for the uninsured, but even in the best of times they operate with margins that are less than the hospital industry average; they also rely heavily on state Medicaid payments and local government support which are both at risk due to severely strained budgets. An immediate infusion of funding will provide assurance that the newly uninsured can access needed health care services, and that safety net hospitals remain stable and vital through the economic crisis. Such an investment will help boost sagging local economies while preserving the viability of essential providers on whom we will rely to play major roles in a reformed health care system.

Proposal: Create a direct pathway for the newly uninsured to receive health care

To meet immediate demand, it will be important for Congress to infuse new resources *quickly* and *directly* into safety net health systems. We suggest two alternative approaches to accomplish this goal: creating a Nationwide Uninsured Pool to fund direct federal payments to safety net health systems or increasing Disproportionate Share Hospital (DSH) allotments nationwide. We recommend a range of \$1.3 – \$2.5 billion on an annual basis in operating relief. This estimate maps to the number of newly uninsured individuals that the health care system may have to absorb based on Federal Reserve unemployment projections since the start of the recession in December 2007 and average hospital uncompensated care costs per uninsured individual.

Nationwide Uninsured Pool: Under this approach, Congress would set up a pool of funds against which eligible providers could submit claims for services provided to uninsured patients. In order to ensure that the limited pool of funds are targeted to providers with the least capacity to absorb the surge in uninsured, eligibility would be limited to hospitals with Low Income Utilization Rates, as defined in the Medicaid statute (Social Security Act, Section 1923(b)(3)), of 25% or more – this definition would include hospitals providing large volumes of care to Medicaid and charity care patients. Reimbursement would be based on costs – similar to support provided via Medicaid DSH and the safety net care pools established by Medicaid waivers – although additional incentive payments as described below could be made available to promote specific health policy priorities. If the capped funding is insufficient to cover all costs and incentive amounts, payments would be reduced on a pro rata basis.

Establishment of a Nationwide Uninsured Pool would serve longer term policy interests as well, by testing out a model of a dedicated funding pool tied directly to uninsured care. Congress could direct HHS to monitor the benefits derived from the pool payments (volume of care provided, regional demand for health care services and site of service) and assess whether the new payment mechanism adequately compensates safety net health systems for the cost of uninsured care. Additional incentive payments could be provided to safety net health systems for utilizing innovative care delivery techniques, providing care management, specifically demonstrating savings from emergency room diversions and/or targeting primary and preventive care to the newly uninsured.



Medicaid DSH Allotment Increases: DSH payments are the only Medicaid funding stream through which states are explicitly allowed to reimburse providers for care to the uninsured, and thus a clear mechanism for targeting funds to providers facing an increasing number of unemployed and uninsured patients. The DSH allotments set in statute are based not on need but on historical state spending levels at the time the allotments were set. Congress could more broadly address the sharp rise in the number of uninsured by increasing the Medicaid DSH allotments for all states on a temporary basis. Unlike other forms of Medicaid reimbursement, where payments grow as utilization grows, DSH spending has been artificially capped at a level that is not based on need or demand, and state DSH allotments (other than states with very low DSH allotments) have essentially been frozen in place since 2004. NAPH recommends one-time, temporary across-the-board increases in the current statutory allotments. The allotment increases should be fully federally funded (100% FMAP) to avoid further burdening states.

Such a one-time increase should be at a higher level for low DSH states. The DSH allotments in some states have for years been inadequate to cover the costs to hospitals of providing services to the uninsured even prior to this economic crisis.

II. CREATING JOBS; INVESTING IN INFRASTRUCTURE

Currently, safety net health systems serve as major economic engines in their communities – creating jobs; purchasing services, supplies and equipment from local vendors; and training the workforce to fill health care jobs around the country. As Congress considers infrastructure investments to stimulate the economy, it should include investment in health care infrastructure which is equally urgent and can have the same stimulus effect in local communities as investments in roads, bridges and schools. Targeted investment in safety net health care delivery systems works to rebuild the critical public health infrastructure and improve access to care for vulnerable populations. Below are proposed investment strategies targeted to safety net facilities, which can implemented as stand-alone programs or rolled into larger infrastructure policy programs considered by Congress.

Proposal: Invest in capital infrastructure and health information technology (HIT)

Immediate Relief: Over the years, safety net health systems have had limited access to capital and have been forced to defer increasingly urgent infrastructure needs. NAPH suggests offering a variety of mechanisms to support capital investments, with sufficient flexibility to allow local health systems to determine how to target the investment and best serve their communities, from facility modernization to neighborhood clinic expansions to HIT.

- **Grant Support:** For some safety net hospitals, the principle barrier to capital investment is the prospect of large new debt service burdens. With thin, or in some cases negative operating margins that are sure to plunge further downward in the recession, the ability to invest in modernized plants and equipment is beyond reach. Other NAPH members have taken steps to launch capital projects



that are now being put on hold because of their reduced ability to service the debt required. If these hospitals are to be prepared to provide access in a reformed system, they must make capital investments now. Direct grants can reduce the amount needed to be borrowed and facilitate quick implementation of these critical projects.

NAPH suggests using the framework established by the Hill-Burton program to funnel grants to safety net hospitals for these purposes. Title XVI of the Public Health Service Act authorizes grants for health care facility construction and capital equipment acquisition (including HIT), although the program is not currently funded. Since the post-war era, the Hill-Burton program has provided \$4.6 billion in grants to build and rebuild hospitals throughout the United States in exchange for a commitment to make the facilities available to all persons in the area and to provide a reasonable amount of care to those unable to pay for services. While the government stopped providing funds through the program in 1997, about 200 hospitals nationwide still have Hill-Burton service obligations, and the Health Resources and Services Administration (HRSA) still has a Hill-Burton office. Title XVI still contains the statutory framework for providing grants, and could provide the basis for a quickly implemented revitalized Hill-Burton program, with some modifications. One such modification that would help ensure swift implementation is to eliminate the requirement that grants be directed through states and allow for direct application by hospitals to HRSA.

To ensure that the grants are directed to those hospitals with the least ability to access capital without such assistance, eligibility should be focused on hospitals that are most reliant on public programs for funding – for example, hospitals meeting the criteria to be deemed Medicaid disproportionate share hospitals (Social Security Act, Section 1923 (b)). Recipients should be required to make a public service commitment, similar to the Hill-Burton commitments. Funding priorities should be established, including priorities for projects that will provide or improve the provision of critical health services (including accessible primary care, high-cost and under-reimbursed tertiary services such as trauma, burn and neonatal intensive care, HIT adoption, and rebuilding projects for antiquated facilities) and projects that will serve underserved populations, including low-income populations, ethnically, racially and linguistically diverse populations and rural populations.

- ***Loans and Loan Guarantees:*** Similarly, the Hill-Burton program provides a mechanism to provide loans or loan guarantees to eligible public and private hospitals for capital improvements. The program allocated \$1.5 billion in loans over the course of its history. The proposed loans and guarantees would provide more affordable interest rates for eligible hospitals while at the same time leveraging federal funds more efficiently. While some hospitals will not be able to move forward with their projects without grant support, others would benefit from loans and loan guarantees, or a combination of mechanisms. NAPH



recommends reviving the Hill Burton program for loans and guarantees as well as grants, under the terms described above.

- ***Federal Mortgage Insurance:*** Infrastructure funding could also be leveraged by providing mortgage insurance for loans that would help to reduce interest rates to affordable levels. This mechanism would provide a similar impact as the Hill Burton loan guarantees, but could be executed via a currently operational program – the Federal Housing Administration's (FHA) Section 242 program – or a FHA look-alike program housed at the Department of Health and Human Services. The Section 242 program provides mortgage insurance for hospitals and, since its inception, has financed 360 capital projects totaling \$13.5 billion on a self-funded basis (i.e. revenues from the mortgage program have exceeded expenses over time, so that no federal appropriations are currently required). Access to the program for safety net hospitals – those with the least stable funding streams due to the large volumes of Medicaid and uninsured patients served – has been largely barred due to administrative and eligibility barriers imposed by the FHA. For example, the FHA requires hospitals to demonstrate three years of positive margins to qualify, but often the hospitals with the most need for such federal assistance are those which cannot rely on consistently positive margins due to their uninsured and low-income patient populations. Moreover, the program has been notoriously slow to approve financing. These barriers would need to be removed and streamlined to be effective in the short term. The FHA or HHS should be required to focus additional funding on safety net hospitals as opposed to those with access to private capital and firm deadlines for federal approval or disapproval would need to be enforced.

III. RESOLVING UNFINISHED BUSINESS

Even before the economic crisis, Congress was committed to ensuring that the safety net had the resources necessary to protect the uninsured. Key issues that remain unresolved from the 110th Congress should also be addressed as soon as possible.

Proposal: Invalidate or withdraw the pending Medicaid regulations

In 2007, CMS issued a series of seven Medicaid regulations that collectively would devastate the Medicaid program. Although these regulations were in various regulatory stages, Congress placed moratoria on six of the rules (or in some cases, portions of rules) through April 2009. Congress and the new Administration should work together to roll back all of these harmful regulations, by whatever means appropriate including by legislative invalidation, withdrawal of proposed regulations, and, if necessary, initiation of new rulemaking. Of particular concern to safety net hospital systems are the public provider cost limit rule, the graduate medical education rule, the Medicaid hospital outpatient regulation, and the Medicaid DSH rule. The outpatient regulation is not under a moratorium and is effective December 8, 2008 and requires immediate attention. The Bush Administration is about to finalize another Medicaid DSH rule in the near future that may also require attention.

**Proposal: Require fair pricing for inpatient hospital drugs**

The 340B program currently requires pharmaceutical companies participating in Medicaid programs to provide front-end discounts on outpatient drugs to certain safety net providers. Congress has considered, but not acted upon, expanding these discounts to inpatient drugs as well. Doing so significantly cuts the costs of providing prescription drugs to uninsured patients for safety net health systems. The 340B Program Improvement and Integrity Act of 2007 (S. 1376 / H.R. 2606), introduced by Representatives Rush and Stupak in the House and Senators Bingaman and Thune in the Senate, expands the discount to inpatient drugs.

Proposal: Initiate FMAP increase; Protect local governments by applying to DSH

As it has considered in the past, NAPH encourages Congress to increase the federal medical assistance percentage (FMAP) as part of an economic stimulus package. Any such increase, however, must also apply to DSH payments, with a corresponding increase in DSH allotments to accommodate the enhanced federal match – failure to do so could further shift the burden of funding uninsured care to local governments. Congress should also implement an automatic counter cyclical trigger to increase FMAP rates and should include a maintenance-of-effort requirement to ensure that current benefit levels and enrollment is maintained in state health programs.

Proposal: Reauthorize Section 1011 of the 2003 Medicare Modernization Act

Section 1011 of the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* (MMA) allocated \$250 million per year from the federal government to reimburse hospitals, physicians and ambulance providers for emergency services to undocumented immigrants. This program provides important relief to hospitals that shoulder significant uncompensated care burdens for this population. Congress should reauthorize the Section 1011 program, which expired on September 30, 2008, as soon as possible.

ⁱ “Medicaid, SCHIP and Economic Downturn: Policy Challenges and Policy Responses”, Kaiser Commission on Medicaid and the Uninsured, 2008.

ⁱⁱ Economic projections of the Federal Reserve governors and Reserve presidents at the October 2008 Federal Open Market Committee meeting.