



National Association of Public Hospitals and Health Systems

# OurView

DECEMBER 2008

1301 Pennsylvania Avenue, NW, Suite 950  
Washington, DC 20004

202 585 0100 tel / 202 585 0101 fax  
www.naph.org

Larry S. Gage / PRESIDENT  
Christine Capito Burch / EXECUTIVE DIRECTOR

## SAFETY NET SOLUTIONS: ENSURING HEALTH CARE ACCESS & JOBS

### CRISIS

America's health care safety net is answering the call to care for a surge of new patients during the economic recession. Safety net hospitals across the country are reporting an influx of patients who are newly uninsured, under-insured or unable to pay out-of-pocket expenses.

Prior to the current recession, NAPH member hospitals represented only 2 percent of the acute care hospitals in the country, but provided 20 percent of the nation's uncompensated hospital care. As more people seek care and states make drastic Medicaid cuts, uncompensated care is on the rise.

In the last few months, NAPH members report spikes in their uncompensated care at the same time they face massive cuts from state and local governments. One urban safety net hospital alone reports uninsured care is projected to increase by more than \$75 million from last year. As a result, they are confronting the prospect of major

service cuts in their communities at a time when services are most in demand.

### SAFETY NET SOLUTIONS

The safety net is committed to helping America survive the current economic crisis, but will require an immediate investment of federal assistance to meet increasing demand and ensure access to care. NAPH proposes the following solutions to address these needs:

#### Proposal #1: Relief for Costs of Caring for the Uninsured

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. To ensure that they have access to care, NAPH recommends that Congress and the Obama Administration include \$1.3 - \$2.5 billion in immediate operating relief on an annual basis to safety net hospital systems in an economic recovery package for the additional costs of caring for the newly uninsured.

There are several options for this relief, including:

□ **Creating a Nationwide Uninsured Pool** to fund direct federal payments to safety net health systems serving high volumes of uninsured patients. Under this approach, Congress would set up a pool of funds to be paid to eligible health systems for services provided to uninsured patients. Only high-volume providers of low-income care would be eligible for the pool payments.

□ **Increasing Medicaid Disproportionate Share Hospital (DSH) allotments** to states on a temporary basis to fund additional costs to providers of serving uninsured patients. The Medicaid DSH program is a mechanism that is already in place to help fund costs of care for the uninsured. Although less direct than a nationwide uninsured care pool, across-the-board increases in state DSH allotments would be a simple means of directing enhanced funding to safety net hospitals. Higher DSH allotment increases should be provided for "low DSH" states. The DSH allotment increase should be funded entirely with federal dollars to avoid further burdening states.



### Proposal #2: Jobs and Infrastructure

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. In fact, major U.S. safety net health systems generate over one million jobs in their communities and provide services that result in more than \$133 billion in economic output. However, over the years, safety net health systems have had limited access to capital and are increasingly being forced to defer urgent infrastructure projects.

As Congress considers infrastructure investments to stimulate the economy, health care investment – from facility modernization to neighborhood clinic expansions to health information technology (HIT) – is equally urgent and can have the same stimulus effect in local communities as investments in roads, bridges and schools. Below are some suggested investment strategies that would address these needs:

□ **Grants and Loans:** The old Hill Burton program, which remains in federal statute, could be revitalized to spur infrastructure investment. The program can be a vehicle to provide grants, loans and loan guarantees for capital and HIT investments to health systems in exchange for a commitment to provide care to those unable to pay for services.

□ **Federal Mortgage Insurance:** Infrastructure funding could be leveraged by providing mortgage insurance for loans that would help to reduce interest rates to affordable levels. The program

could be executed via 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 Program would need to be modified to expand eligibility to hospitals, like many safety net hospitals, that have more volatile financial performance, as well as streamlined to make it easier to apply.

### Proposal #3: 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. The following key issues that remain unresolved from the 110th Congress should also be addressed as soon as possible:

□ **Withdraw proposed Medicaid regulations and invalidate final Medicaid regulations:** The Bush Administration issued seven Medicaid regulations that collectively would devastate the Medicaid program. Congress placed moratoria on six of the rules through April 2009. The new Administration should withdraw or roll back all six of these rules. The one Medicaid regulation that was not protected by a moratorium – the regulation that limits Medicaid funding for hospital outpatient services – was recently finalized. Congress should invalidate that rule as soon as possible. The Bush Administration is about to issue another final regulation on Medicaid DSH that may also require attention.

□ **Require fair pricing for inpatient hospital drugs:** Congress has considered, but not acted upon expanding 340b drug discounts to inpatient drugs. Doing so significantly cuts the costs of providing prescription drugs to uninsured patients for safety net health systems. This proposal saves the federal and state governments money because the discount would apply to Medicaid as well.

□ **Initiate FMAP increase; Protect local governments by applying to DSH:** As part of the economic recovery package, Congress should increase the federal medical assistance percentage (FMAP). 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 include DSH in this crucial relief measure could further shift the burden of funding uninsured care to local governments.

□ **Reauthorize the Section 1011 program:** 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. The program, which expired on September 30, 2008, needs to be reauthorized as soon as possible to ensure that providers who care for this population do not incur higher losses on their care. ■