NATIONAL ASSOCIATION of PUBLIC HOSPITALS and HEALTH SYSTEMS
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Statement

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Good afternoon. My name is Charles Luband and I am a counsel to the National Association of Public Hospitals and Health Systems (NAPH). NAPH member hospitals are safety net hospitals that provide care to our most vulnerable populations – the poor elderly, disabled, and many of the more than 45 million Americans without insurance.

I would like to take this opportunity to talk with the Commission briefly about the importance of Medicaid to safety net hospitals and the communities they serve and in particular focus on the importance of supplemental payments such as Medicaid disproportionate share hospital (DSH) payments and other payments, including so-called Upper Payment Limit (UPL) payments.

I would also like to reiterate a request to the Commission that NAPH, along with the American Hospital Association (AHA), the Association of American Medical Colleges (AAMC), and the National Association of Children's Hospitals (N.A.C.H.), recently made to the Commission requesting a formal opportunity to present regarding this complex payment system and how it supports care for the uninsured while ensuring access for Medicaid beneficiaries.

I. The Importance of Medicaid to Safety Net Hospitals

Medicaid is of tremendous importance to safety net hospitals. For NAPH member hospitals, Medicaid comprises the single largest patient category; 32% of our patients are Medicaid patients. The next largest category is self-pay, meaning uninsured, patients, which represent 24% of our patients. Medicaid is by far the largest payer for NAPH members, comprising 37% of NAPH member net revenues. A substantial portion of these revenues is derived from special supplemental Medicaid payments often directed to public and safety net hospitals.

The most important of these payments is Medicaid disproportionate share hospital (DSH) payments. Through Medicaid DSH, states may reimburse hospitals for the unreimbursed cost of serving Medicaid patients and patients without insurance. It is the only Medicaid payment for the cost of care to uninsured persons.

Medicaid DSH is strictly limited. No hospital can receive more than its cost of serving Medicaid patients and patients without insurance. States have statutory limits on the amount of federal dollars that can be used each year. Due in part to the limits referenced above, DSH has been

decreasing as a total share of Medicaid spending and has not contributed to Medicaid's recent cost growth. DSH is currently only 5 percent of total Medicaid spending.

Safety net hospitals also typically receive other types of supplemental payments through Medicaid, including payments to support graduate medical education, trauma care, burn care, neonatal intensive care and the like. Many states provide supplemental payments to rural hospital providers, pediatric hospitals, sole community providers. Through these supplemental payments, Medicaid has become an integral source of support for the various critical roles that safety net providers play in their communities. All of these supplemental payments are subject to Medicaid upper payment limit regulations and are often therefore referred to as "UPL payments." In some quarters, the term "UPL" has taken on a pejorative meaning, bringing to mind some state abuses of Medicaid financing mechanisms. But for thousands of communities across the country, UPL payments provide the essential lifeblood that supports a robust safety net health system that can meet the many demands placed upon it.

As you consider reforms to the Medicaid program, NAPH urges you to keep in mind the often overlooked but critical role that Medicaid plays in financing the safety net. DSH and UPL payments enable safety net hospitals to ensure access to care not only for low income Medicaid patients, but for the nation's 45 million uninsured. To put this in perspective, NAPH hospitals represent only 2% of acute care hospitals nationally but provide twenty-four percent of the uncompensated care. Public and safety net hospitals also provide highly specialized, often undercompensated services, such as trauma, neonatal intensive care, burn care, and emergency psychiatric services, that often no other hospital in the community is able or willing to provide. NAPH members also serve critical emergency preparedness and response roles on the front lines in the case of any man-made or natural emergency or disaster.

And these hospitals accomplish all of this on the slimmest of margins. Average NAPH member margins are a mere 0.5 percent, as compared to a 4.8 percent average margin for hospitals nationwide. Take away our members' Medicaid DSH payments, and these margins drop precipitously to negative 11.4%. And while I don't have the data to quantify the impact of the loss of UPL payments on margins, it's probably not necessary to do so, because at negative 11.4% a hospital has long since shut its doors.

II. A Request to the Commission

Because of the importance of these payments to our members' ability to serve the uninsured and Medicaid patients in their communities, NAPH, along with the American Hospital Association (AHA), Association of American Medical Colleges (AAMC), and the National Association of Children's Hospitals (N.A.C.H.), has made a formal request to present to the Medicaid Commission regarding the hospital perspective on Medicaid, including a discussion of Medicaid DSH payments and other supplemental payments.

Last month, Medicaid DSH was discussed in the Commission proceedings a number of times. We were extremely concerned that there may have been some confusion and misunderstanding regarding these payments, in particular some confusion between Medicare and Medicaid DSH, which are two distinct and quite different programs. We would like the opportunity to describe these payment mechanisms to the Commission, which we think will enhance the discussion and recommendations emerging from the group.

Safety net hospitals such as NAPH members rely on Medicaid DSH and other supplemental payments. Without these payments, many safety net hospitals would surely close.

Medicaid's role in supporting safety net hospitals is extremely important. Please do not adopt proposals that could harm the vulnerable populations that safety net hospitals serve.

We look forward to an opportunity to formally present our issues.