



NATIONAL ASSOCIATION of PUBLIC HOSPITALS and HEALTH SYSTEMS

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June 9, 2004

Mark McClellan, Ph.D., Administrator
Centers for Medicare and Medicaid Services
US Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

Dear Dr. McClellan:

I am writing on behalf of the National Association of Public Hospitals and Health Systems (NAPH) in response to your letter of April 28, 2004 to Senator Charles Grassley. This letter announced the Centers for Medicare and Medicaid Services (CMS) apparent new policy on states' use of intergovernmental transfers (IGTs) and certified public expenditures (CPEs) to finance Medicaid expenditures.

Attached to this letter is an analysis prepared by NAPH's legal counsel, which outlines in detail why CMS's new policy contravenes established legal authority. In this letter, however, I want to convey to you the real world impact that CMS's new policy is having on safety net health systems and the vulnerable patients they serve. With all its imperfections, Medicaid has become our nation's primary vehicle for supporting safety net health systems. We are deeply concerned that CMS is on a path towards dismantling this system of support with no thought for replacing the lost funding or the lost access to care.

NAPH represents more than 100 of America's metropolitan area safety net hospitals and health systems. Our members provide health care services to all individuals, regardless of insurance status or ability to pay, including community-based primary and preventive care, hard-to-access specialty care and the full range of acute and tertiary care. In addition, NAPH members train many of our nation's physicians, nurses, and other health care professionals, and provide community-wide services like trauma care, burn care, and emergency preparedness relied upon by everyone.

A full *58 percent* of the patients served by NAPH members are either Medicaid recipients or patients without insurance. Medicare covers another 21 percent of their patients. Our members thus rely on governmental sources of financing to cover over three-quarters of their costs. NAPH members provide over 25 percent of the nation's uncompensated hospital care while representing only two percent of acute care hospitals in the country. Medicaid is a major source of essential financing for America's institutional health safety net – 38 percent of the net revenues of NAPH member hospitals are Medicaid revenues. Without adequate Medicaid support, most NAPH members simply would not survive.

Historically, public hospitals were created, owned and directly operated by state or local governments, which funded the substantial gap between the hospitals' costs, including the costs of caring for patients without insurance, and the revenues they received from third party payers. In more recent years, these governmental owners have sought to reduce the financial burden to their taxpayers of running these systems through the implementation of a variety of operational and structural efficiencies. Virtually all public hospitals are now expected to be completely competitive with their private counterparts in order to maximize the number of insured patients to help cross-subsidize uncompensated costs. They must operate

extremely efficiently to keep costs down, and aggressively bill and collect from all third party payers who owe them for care.

Moreover, many governmental owners have restructured their hospitals to provide more autonomy than a typical city, county or state agency might have, creating quasi-independent hospital authorities, public benefit corporations, hospital districts, etc. Though still unquestionably public, these governmental entities are freed from some of the bureaucratic “red tape” that had previously hindered their ability to compete with hospitals in the private sector. In some cases, the hospital has been converted to a completely private non-profit entity, although the former governmental owner may still financially support the indigent care provided by the now private hospital through a subsidy or contract. These moves by governmental hospital owners have all been viewed positively, as steps towards self-sufficiency on the hospital’s part rather than continued and unsustainable dependency on local or state taxpayers.

Until now, CMS’s new policy on intergovernmental transfers is discouraging the kinds of gains towards self-sufficiency and innovation that our members have been so proud of over the last couple of decades. By limiting intergovernmental transfers to public provider funds derived from tax revenues, CMS’s new policy encourages greater rather than lesser reliance on state and local taxpayers for support. CMS’s new policy is imposing costs (in the form of lost federal matching funds) on public hospital efficiency gains. CMS’s new policy fails to recognize that ***funds held by a public entity are public funds***, regardless of whether they were earned by reimbursement received for services provided or through subsidies granted from taxpayer funds.

In addition, CMS does not seem to recognize the extent to which public hospitals rely on IGT-funded Medicaid support payments, both within and outside of the Disproportionate Share Hospital (DSH) program, to provide critical – and irreplaceable – access to health care for the most vulnerable in their communities. Medicaid DSH, for example, covers 25 percent of the unreimbursed costs incurred by NAPH members. Our members, who currently manage to stay afloat with average margins that just barely put them in the black (0.7 percent average margins as compared to 4.5 percent industry-wide), would see their margins plummet to negative 9.2 percent if they did not receive Medicaid DSH payments. DSH quite literally permits our hospitals to stay in business and provide the care that they do, because no hospital could sustain the kinds of losses we would incur without DSH.

According to data collected by NAPH, our 100 members receive approximately \$3.5 billion in Medicaid DSH payments. They are also called upon by their states to provide approximately \$1.5 billion in intergovernmental transfers associated with those DSH payments. From their perspective, then, the DSH program provides \$2.0 billion in new Medicaid funding that they would not otherwise have available to support their substantial volumes of low-income care. (We do not have corresponding data about the extent of reliance of our members on IGT-funded Medicaid support payments provided outside of the DSH program, though we do know that it is extensive.)

There is nothing intrinsically wrong, abusive, inappropriate or illegal about intergovernmental transfers. The Medicaid statute has long recognized that local as well as state governments may pay for low-income health care services, and has provided federal matching funds for such publicly-financed care. When NAPH members provide \$1.5 billion in public funds for care for the poor, the Medicaid statute recognizes that contribution as a real contribution and commits the federal government to chip in an additional \$2.0 billion to help out. These are not devious “financing schemes” designed to defraud the federal government.

They are congressionally-approved mechanisms for allowing states to claim federal matching payments related to public funds spent on health care services to low income and vulnerable patients. NAPH members are spending a lot of public funds on Medicaid-eligible healthcare services and those funds are eligible for federal match.

Moreover, the reality is that unless such local contributions are matchable, in many states there will be no DSH or other types of Medicaid support payments for safety net systems such as ours. State government budgets are barely managing to keep abreast of the ever-growing costs of providing Medicaid coverage, and many simply will be unable to foot the bill to replace the non-federal share of additional support payments such as DSH for safety net providers to the extent that CMS is disallowing IGTs. Instead, these critical support payments will disappear. While that might result in federal savings, it will have a devastating impact on the health care safety net which has become completely dependent on Medicaid for survival. ***What is CMS's plan for ensuring that the millions of patients who rely on safety net health systems will have access to care after these IGT-funded payments are eliminated?***

CMS's actions are particularly puzzling in light of the Administration's recognition of the need to address the problem of the uninsured. Increasing funding for community health centers, while important and laudable, cannot begin to make up for the lost funding and lost access brought about by the new IGT policy. NAPH and its member hospitals have a critical role to play in expanding access to quality health care for the uninsured. But our ability to offer and implement effective solutions will be severely and irreparably hampered unless CMS rethinks and withdraws its new policy on IGTs.

NAPH respectfully requests an urgent meeting with you to discuss the serious ramifications of your new IGT policies on the health care safety net. While none of us would have designed from scratch a safety net support system that is so heavily reliant on IGT-funded Medicaid payments, it is the system we have. In designing new policies, CMS must recognize and account for that reality.

We look forward to meeting with you.

Sincerely,



Larry S. Gage
President

Attachment