

## MedPAC Declares: “We’re Not Responsible”

When MedPAC voted late in January to recommend to Congress a reduction in a planned increase in Medicare payments to hospitals, its chairman, Glenn Hackbarth, explained that “We should not use Medicare dollars to offset Medicaid losses.” He added that “I don’t see evidence to support the claim that our recommendation would impede access to care.”

But it would reduce access to care – as private, urban safety-net hospitals are keenly aware. Those hospitals count on Medicare disproportionate share payments to help cover the losses they suffer caring for Medicaid recipients and the uninsured. Without those payments, private, urban safety-net hospitals would simply receive less federal money for providing the same level of services.

With this statement, MedPAC appears to be signaling yet another step in the federal government’s retreat from its traditional role in financing health care for the poor. Congress initiated this withdrawal in 1997 when it repealed the Boren Amendment, which required Medicaid to cover the cost of services provided to Medicaid recipients. Since that time, the adequacy of Medicaid reimbursement has declined in many states.

Private, non-profit, urban safety-net hospitals have long been a key part of the solution to the problem of caring for the poor, but they cannot do it alone. They count on the federal government to help and can only wonder if the comments of MedPAC’s chairman mean that the federal government intends to pull back from or even abandon this responsibility, leaving it instead to individual hospitals – which have far fewer resources than the federal government. ♦

The National Association of Urban Hospitals advocates for adequate recognition and financing of the nation’s private, urban, safety-net hospitals, which serve America’s needy urban communities.

For further information about the Association, or the information presented in this document, please contact Ellen Kugler at 703-444-0989.

## Medicare, Medicaid “Reform” Proposed

In the days following the state-of-the-union address, the Bush administration began sharing some details of its plan to reform Medicare and Medicaid.

In response to rising costs and growing demand for a Medicare prescription drug benefit, the administration has proposed a larger role for the private sector in the delivery of Medicare services and will offer the inducement of prescription drug benefits to encourage more Medicare recipients to enroll in managed care plans.

The President’s Medicaid proposal would give states greater flexibility to tailor coverage for non-mandatory participants and provide funds to states through “annual allotments” based on a state’s 2002 Medicaid spending. Those block grants would include funds currently used to make Medicaid disproportionate share (DSH) payments to qualified hospitals, raising the possibility that some or even all states could choose to eliminate their Medicaid DSH programs and use those funds for other purposes. This could be a devastating blow to many safety-net hospitals.

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## NAUH Welcomes New President

John Day has been elected president of the National Association of Urban Hospitals. His term began on January 1 and runs through the end of the year.

Day is president and chief executive officer of Southcoast Health System, in Massachusetts.

Joining Day on NAUH’s new slate of officers is vice president Mark Richards, who is vice president of Thomas Jefferson University Hospital in Philadelphia. In addition, Javier Iruegas, president and CEO of Mercy Regional Hospital in Laredo, Texas, was elected NAUH secretary and Robert Walsh, senior vice president of Lutheran Medical Center in Brooklyn, was elected treasurer. ♦

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## **MedPAC Not Expected to Call for IME Cuts, New DSH Formula**

When MedPAC makes its recommendations to Congress next month, it is not expected to call for further reductions in Medicare indirect medical education (IME) payments or revisions in the formula for calculating Medicare DSH payments.

In the past, MedPAC had considered proposing a reduction in Medicare IME payments from the FY 2003 level of 6.5 percent to as little as 2.3 percent (these payments are scheduled to fall to 5.5 percent in FY 2004, but NAUH is still fighting for relief from this reduction). MedPAC also called for changes in the Medicare DSH formula for a number of years but is not expected to do so again this year; in the recent past, MedPAC has proposed changes in that formula that would have been detrimental to private, urban safety-net hospitals.

Congress is not bound by MedPAC's recommendations, so they do not constitute the final word on Medicare IME and DSH payments in 2003. This is especially important to keep in mind because in its report, MedPAC also is expected to tell Congress that hospitals are paid too much by Medicare. ♦

### **“Reform” Continued,**

NAUH will analyze these new proposals as more information becomes available and determine their implications for private, urban safety-net hospitals. NAUH also will develop positions in response to the proposals' specific provisions, prepare testimony to submit to congressional committees that hold hearings on the proposals, begin lobbying members of Congress, and identify other associations and advocacy organizations with which to work in pursuing common objectives. As appropriate, NAUH members may be asked to contact their elected officials to lobby selected provisions in the proposals.

NAUH members will receive separate correspondence on these proposals with a detailed summary and in-depth analysis. ♦

### **NAUH Welcomes New Members**

NAUH is pleased to welcome two new members: the Milton S. Hershey Medical Center, located in Hershey, Pennsylvania, and the New Jersey Hospital Alliance, a group of twelve urban safety-net hospitals in New Jersey. ♦

## **Failed Attempt to Limit Medicaid ER Visits: The Story Behind the Story**

When the Centers for Medicare and Medicaid Services (CMS) recently sent an advisory message to HMOs caring for Medicaid recipients that told them they could limit the number of paid emergency room visits their members could make each year, a firestorm of protest led to the new policy's repeal within days.

Underlying the idea of allowing Medicaid HMOs to limit emergency room visits, however, was a CMS philosophy that will not change as quickly as the ill-fated policy.

When asked about the new policy, numerous CMS officials publicly responded that they did not expect their policy to affect access to emergency care. Medicaid recipients, they said, would still be able to seek care in emergency rooms whenever they felt the need for such services. The only difference, they explained, is that hospitals and emergency room physicians would not be reimbursed for providing those services.

In effect, CMS had decided to shift financial responsibility for emergency care away from the federal government – and to shift it to hospitals rather than to the managed care plans that states pay to manage the care of Medicaid recipients. In making this decision, CMS officials fell back on provisions in EMTALA, the Emergency Medical Treatment and Labor Act, that require hospitals to provide the requested treatment regardless of the financial implications. Consequently, they chose to force hospitals – rather than the federal government or Medicaid managed care plans – to absorb this new, additional expense on their own.

Only the immediate and significant uproar over this new policy prevented the federal government from imposing yet another new, financially onerous responsibility on hospitals. While private, urban safety-net hospitals are grateful that the new policy was immediately repealed, its very creation is an ominous sign – and yet another reason for urban safety-net hospitals to work together to pursue their mutual public policy needs. ♦

*For further information about the news and views presented in NAUH Update, or to learn about membership, please contact Ellen Kugler, executive director, at 703-444-0989.*