November 21, 2005

The Honorable Charles E. Grassley
Chairman
Committee on Finance
U.S. Senate
Washington, DC 20510

The Honorable Joe Barton
Chairman
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

The Honorable Max Baucus
Ranking Member
Committee on Finance
U.S. Senate
Washington, DC 20510

The Honorable John D. Dingell
Ranking Member
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

Dear Committee Chairmen and Ranking Members:

I am writing on behalf of the National Association of Public Hospitals and Health Systems (NAPH) to provide you with NAPH’s comments and concerns as you work to craft a conference agreement on the FY 2006 Deficit Reduction Act. First and foremost, we ask you to bear in mind the importance of protecting Medicaid recipients and the uninsured and the ability of America’s safety net providers to deliver care to these vulnerable populations. NAPH represents more than 100 of America’s metropolitan area safety net hospitals and health systems, whose mission is to provide health care services to all individuals, regardless of insurance status or ability to pay. Medicaid helps reimburse hospitals for the uncompensated costs of providing care to the uninsured, which amounted to nearly $6 billion for NAPH member hospitals in 2003.

We respectfully request that conferees consider the following critical issues during conference negotiations in order to ensure that the final FY 2006 Deficit Reduction Act protects Medicaid enrollees and the providers that serve these patients as well as the nation’s 46 million uninsured.

In summary, NAPH urges conferees to:

- Accept the Senate position on cost-sharing and benefit flexibility, which retains current federal Medicaid policy on cost-sharing and benefits. Reject the cost-sharing increases and enforceability provisions in Sections 3121-3123 of the House Deficit Reduction Act (H.R. 4241) and the benefit flexibility provisions in Section 3124 of the House bill.
- Accept the House version of Hurricane Katrina relief provisions (Section 3201).
- Reject the reimbursement restrictions on out-of-network emergency department services proposed in Section 3147 of the House bill.
Accept the increases in drug rebate percentages included in Section 6002 of the Senate Deficit Reduction Omnibus Reconciliation Act (S. 1932) to ensure that safety net hospitals can continue to provide access to prescription drugs.

**Medicaid Cost-Sharing**

During final negotiations leading up to its floor vote, the House made significant improvements to the cost-sharing provisions in H.R. 4241 by limiting permissible increases in nominal cost-sharing amounts. However, NAPH remains concerned about the cost-sharing increases and enforceability provisions contained in the bill (Sections 3121-3123). In particular, Section 3121 would permit states to increase cost-sharing beyond nominal amounts for certain populations and would allow providers to deny services to individuals who do not meet their cost-sharing obligations. States could also terminate eligibility for individuals who fail to pay required premiums for 60 days or more. Sections 3122 and 3123 would permit states to raise cost-sharing for non-preferred prescription drugs and for non-emergency use of the emergency room, respectively.

While some populations will be exempt from these changes, the enforceability provisions will apply to most adults and to some children. Because states will be permitted to charge non-nominal cost-sharing for many groups (including optional children) over 100 percent federal poverty level, it is very likely that these enrollees will not be able to meet their cost-sharing obligations. Even with the recent revision to limit allowable increases in nominal cost-sharing, these provisions will reduce access to services and raise uncompensated costs.

NAPH members disproportionately serve vulnerable populations such as poor children, pregnant women, and people with disabilities. Many of these individuals would be especially at risk if states were to impose new cost-sharing on Medicaid recipients and make premiums and co-payments enforceable. Because providers would be permitted to deny services for individuals who cannot meet cost-sharing obligations, many Medicaid beneficiaries may delay necessary care. Cost-sharing enforceability could, therefore, lead to more costly hospital interventions once a disease or condition has progressed and become more difficult to treat. At the same time, providers could also experience an increase in uncompensated care if beneficiaries who are terminated from Medicaid due to failure to pay required premiums continue to present needing hospital care.

The burden of these costs would fall disproportionately on public hospitals that, by legal mandate or explicitly-adopted mission, cannot and do not turn patients away. NAPH members are already struggling with low (and sometimes negative) margins, and many simply cannot bear increases in uncompensated care. *Therefore, we strongly recommend that the conference committee accept the Senate position which retains current federal Medicaid policy on cost-sharing. Moreover, we encourage conferees to reject the House position, which would permit states to impose additional cost-sharing on certain Medicaid enrollees.*
Medicaid Benefit Flexibility

NAPH recognizes the importance of providing states with more flexibility to shape their Medicaid programs to meet unique state needs. However, we are concerned that the benefit flexibility provisions in Section 3124 of the House bill do not contain adequate protections for certain Medicaid enrollees. Section 3124 would eliminate current federal standards governing Medicaid coverage for certain groups of Medicaid recipients by permitting states to vary and reduce the traditional benefit package without seeking waivers of federal requirements. Instead, States would be permitted to offer limited “benchmark” coverage that meets certain minimum criteria. These benchmark packages are designed for a different population and do not take into account the unique needs of low income and vulnerable populations. Nonetheless, the benefit package changes could be applied to both mandatory and optional Medicaid enrollees, unless they fall into an exempt category.

We commend the House for exempting children and pregnant women in mandatory eligibility groups, dual-eligibles, terminally-ill hospice patients, and other particularly vulnerable groups from these benefit changes. However, although some very low-income beneficiaries would remain protected, Section 3124 eliminates the Medicaid Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit for non-exempt optional children. Although Section 3124 is similar to SCHIP, it is notable that SCHIP beneficiaries frequently have higher incomes than the Medicaid groups that could experience benefit reductions while simultaneously being exposed to higher cost-sharing under the House bill.

Especially when combined with the cost-sharing changes included in the House bill, we are concerned that reducing benefits will decrease access and increase uncompensated care costs for safety net providers. In addition, in the future, states would only be permitted to expand Medicaid eligibility if they provide new eligibility groups with the traditional, more expensive Medicaid benefit package. This limitation on flexibility for new eligibility groups is likely to deter states from expanding eligibility and virtually ensures that states will not undertake efforts (outside of the Section 1115 process) to reduce the number of uninsured by expanding Medicaid. This, too, will contribute to rising uncompensated care costs for public hospitals and health systems. Therefore, NAPH strongly recommends that the conference committee accept the Senate position, which preserves current federal Medicaid benefits requirements. We encourage conferees to reject the House position, which would permit states to impose benefit limitations on certain Medicaid enrollees.

Hurricane Katrina Relief

NAPH is pleased that both the House and Senate bills include Hurricane Katrina relief for states bearing an increased burden of caring for Katrina survivors. Although neither package fully addresses health care needs in the Katrina-impacted areas, NAPH believes the House position (which would provide $2.5 billion in relief to the affected areas) is more favorable than that of the Senate. To help states shoulder the increased need for Medicaid in the wake of Hurricane Katrina, both bills would increase the FMAP to 100 percent for program spending in specified areas of Alabama, Louisiana, and Mississippi through May 15, 2006. The House provision applies the 100 percent FMAP not just to Katrina evacuees but also to any individual residing in...
a Katrina-impacted area; the Senate only extends the provision to Katrina evacuees. *We therefore urge conferees to support the Hurricane Relief provisions in Section 3201 of the House bill.*

**Medicaid Managed Care Payment for Out-of-Network Emergency Department Care**

We are also concerned about Section 3147 of the House bill, which dictates the rates Medicaid managed care plans will pay for care delivered in the emergency departments (ED) of out-of-network hospitals. The House proposes to pay only the fee-for-service rate to any out-of-network provider of emergency services. Hospitals that are not part of a managed care plan’s network deserve the right to negotiate their payments for ED care and should not be subject to rate setting that will excuse the plans from their obligation to provide access to care for their patients. *To assure fair hospital reimbursement, we urge conferees to oppose the reimbursement restrictions in Section 3147 of the House bill.*

**340B Drug Pricing Program**

Finally, the House and Senate bills include provisions relevant to hospitals participating in the 340B drug discount program. Although neither bill included provisions that would extend 340B prices to the inpatient setting, the Senate bill does include a measure (Section 6002) that would increase the Medicaid drug rebate percentage for both brand name and generic drugs, which could lead to a decrease in 340B prices. *NAPH urges conferees to retain the increases in drug rebate percentages included in Section 6002 of the Senate bill to ensure that safety net hospitals can continue to provide access to prescription drugs.*

NAPH is also concerned that provisions in both bills (Sections 6004 in Senate bill and 3102 in House bill) – relating to the submission of billing information for “physician-administered drugs” to state Medicaid agencies for purposes of collecting rebates from pharmaceutical manufacturers – could create a duplicate discount problem for manufacturers and the 340B community if this term is interpreted to include drugs purchased through the 340B program. *NAPH recommends language clarifying that “physician-administered drugs” shall not include drugs subject to discounts under the 340B program.*

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NAPH recognizes that Medicaid can and should be reformed. NAPH looks forward to working with Congress on long-term reforms to strengthen the Medicaid program. However, we strongly oppose efforts to produce savings in ways that will harm beneficiaries or shift costs to states and providers. Hurricane Katrina highlighted the importance of public hospitals to Medicaid beneficiaries and the uninsured. Particular care must be taken to ensure that budget reconciliation does not harm beneficiaries or the providers who serve them.
Thank you for working to ensure that the conference agreement include these key hospital issues. NAPH and its members appreciate your efforts to support America’s safety net providers, and we look forward to continuing to work with you in the future to reform and sustain Medicaid.

Sincerely,

Larry S. Gage
President