



October 31, 2006

Senator Charles E. Grassley
Chairman, Committee on Finance
United States Senate
Washington, DC 20510 -6200

Attn: Nick Wyatt
Nick_Wyatt@finance-rep.senate.gov

Dear Chairman Grassley,

I am pleased to have the opportunity to offer additional information and views as follow-up to the September 13 hearing on not-for-profit hospitals. The thoughtful questions submitted by Senators Santorum, Rockefeller and Bingaman reflect their appreciation of the challenges faced by today's faith-based and other not-for-profit hospitals.

Questions from Senator Santorum:

Question 1: I have talked with many of the hospitals in Pennsylvania and a number have charity care policies in place that provide free care to our most needy (under 200% of the federal poverty line), reduced care for those who have some ability to pay (above 200% but less than 400% of the poverty line), and even work with patients to qualify them for programs that will cover their medical expenses retroactively. However, to remain fiscally viable-even as a nonprofit-a medical facility has to make ends meet. The question then is how to balance the charitable mission of an organization with the need to remain financially stable to continue to serve your communities. How has your organization truck that balance? Is there a difference in how you reach that balance based on whether the nonprofit is a faith-based organization or a secular one? What is done with "margins"?

How does a medical facility balance its charitable mission of community service and the need for financial stability?

Senator Santorum is correct that hospitals must navigate a careful path between community service and financial stability. They must balance long-term viability with their daily mission of serving those in need and providing justice for employees in terms of fair wages, benefits and pensions. They must also consider the need for investment in technology and advanced treatments to maintain high quality of care as well as the need to reserve funds for future needs. This is a delicate balance that leaders of Catholic and other not-for-profit hospitals must strive to achieve in their facilities and their systems.

Some observers have described this phenomenon as hospitals needing to maintain two bottom lines, one measured in dollars, the other in service. These bottom lines are not an either/or scenario to the Catholic health ministry. Both are critically important because our mission of community service is the reason we began and continue our health and social service ministries, and we must have financial stability in order to continue to serve our communities and be equitable employers over the long term.

To specifically address Senator Santorum's first question, Catholic hospitals work hard to reach this balance in many ways, by measuring and monitoring financial and service performance and by utilizing billing and collection policies that will allow them to serve the greatest number of patients in a fair way while also keeping the organization itself healthy for the current period and into the future.

In addition, Catholic health care organizations are becoming increasingly innovative in responding to community need in cost-effective ways. For example:

- Some hospitals are using "global budgeting" for community benefit by taking funds budgeted for charity care and redirecting them to primary care services for uninsured persons to avoid preventable emergency room visits and inpatient admissions, thereby reducing the overall need for charity care.
- Hospitals in Cincinnati, Austin, Albany and other cities are "enrolling" uninsured persons in chronic disease management programs, helping them find donated primary and specialty medical care and providing ongoing management of their conditions. This strategy also reduces the charity care burden.
- Some hospitals maximize their community contribution by providing start-up funds for programs that community groups continue. We recently reported in our member newspaper, *Catholic Health World*, that Avera Health provided seed money to Communications Services to the Deaf (CSD) in Sioux Falls, South Dakota, to develop health educational materials for deaf and hard of hearing persons. With these start-up funds, CSD will sustain the program and make it available on a national basis.
- The use of volunteers also helps stretch community benefit dollars. In Ft. Lauderdale, for example, a Catholic hospital funds parish nurses who serve many parishes of various denominations, all with large numbers of low-income older persons. These nurses recruit, train and supervise community volunteers who make it possible to address the needs of a large number of older persons.
- Increasingly, our hospitals are turning to philanthropy to fund their community benefit programs. The Perry Family Health Center, for example, the source of primary care for very low-income and uninsured persons in northeast Washington, DC, is funded through monies raised by the Providence Hospital Foundation. (It is important to note that when funds are raised specifically for a community benefit program, the expense of the program is offset by the restricted donation and does not appear in the hospital's quantitative report of community benefit.)

Is this balance reached differently by faith-based organizations?

This "balancing act" between mission and financial stability is part of the tradition of the Catholic health ministry. The religious sisters who established our first hospitals and nursing homes were resourceful in finding ways to provide service and maintain financial viability. They begged, sold "shares" of health services (the original capitated managed care plans) taught the children of affluent families in order to serve the poor and used other strategies. Seeking creative solutions to funding community programs is part of our history and continues today. We also have been impressed with the ingenuity of other not-for-profit, community oriented health care organizations as well.

Question 2: We have heard some contend that while a nonprofit hospital's charity care policy may be sound, patients are not aware of this policy and thus it is ineffective. At least in my state, that policies are required to be posted in key public areas, and generally a copy is given to the patient and conversations can be initiated by the patient or the hospital to determine if a patient is eligible any time in the payment or collections process. In addition, the Hospital Association of Pennsylvania put out guidelines on charity care and financial aid in July 2004 that includes a section on implementation such as communicating the availability of the policy, training staff on the policy and administering the policy fairly, respectfully and consistently. Without requiring every patient to be pre-screened for eligibility, what other specific points do you think should be added?

The Hospital Association of Pennsylvania guidelines described by Senator Santorum are excellent, as are the Healthcare Financial Management Association's *Patient Friendly Billing* guidelines, which we advise our members to implement.

It is clear that patients will use financial assistance only to the extent they are aware that a hospital offers such assistance. We are pleased to inform Senator Santorum and the committee that 95 percent of CHA's member health care systems have committed to posting the availability of their charity care and financial assistance policies in publicly accessible areas (and this figure is increasing as boards meet this fall).

In addition, other strategies our hospitals use include:

- Appointing "patient advocates" to work with patients in emergency rooms and with those who have been admitted or discharged. These patient advocates are responsible for helping patients enroll in coverage programs for which they are eligible and completing paperwork for the hospital's financial assistance program.
- Sending notices in all patient bills that financial assistance is available and providing guidance on how to apply.
- Running newspaper ads telling patients to contact the hospital if they have received a bill they cannot pay.
- Writing to all patients who have outstanding bills and informing them of the availability of financial assistance.
- Conducting in-service education programs for all billing and administrative workers on the hospital's policies and expectations that all patients are to be treated with the utmost dignity, regardless of their financial status.
- Instructing outside collection agencies to inform the hospital if they discover a patient is unable to pay his or her hospital bill and asking them not to pursue collection.

Question 3. How do you balance the desire to get patients enrolled in plans or qualified for the charity care policies without forcing patients to provide personal and financial information that they may not want to provide?

This is a significant problem for *all* hospitals, especially as they step up efforts to identify all persons eligible for charity care and remove them from bad debt rolls. We believe this is important, not only for more accurate hospital financial and community benefit records, but also for the peace of mind of persons unable to pay their medical bills.

At least four strategies are being used at Catholic hospitals. First, our facilities try to explain to patients and their families the advantages of enrollment. They train staff on how to approach the issues and they often ask multiple staff members to talk with the patient and family, establishing trust so the patient cooperates.

Second, new technology is becoming available to help our facilities gather information from various publicly available sources other than directly from the patient and has been of great help. Please let us know if interested in more information on how technology is assisting hospitals in this way.

Third, our organizations are learning how to make financial assistance determinations with less than perfect information. Financial assistance committees are being formed to assess whatever information is available (past hospital bills, income potential, housing situation) and to make the financial assistance determination based on it.

Finally, many of our hospitals provide charity care in collaboration with attending physicians. If the physician waives his or her fee because of medical indigency, the hospital does so as well.

Question 4: In the Commonwealth there is a requirement that nonprofit hospitals certify annually to the Department of Public Welfare that they have a charity care program, their efforts to seek collection of all claims and attempts to obtain health coverage for patients. If we continue to provide charity care above a certain level-such as 400% of the poverty level-does that not discourage the purchase and maintenance of health insurance?

It is important to realize that the reason Catholic hospitals provide charity care is because we believe that the human dignity of all persons depends on their ability to access needed health care. Persons seeking care without financial resources may be a worried parent, a patient who is sick and frightened, or a person in pain. They are our primary concern.

In response to Senator Santorum's question, this has been an issue the Catholic Health Association since we first began to concentrate on community benefit in the 1980's. The leaders who guided our early work were concerned that encouraging the establishment of free and discounted clinics and expanded charity care policies would mask the problem of millions of persons lacking health insurance. Our leaders worried that if America's not-for-profit hospitals address some of the problems faced by uninsured persons, there would be insufficient political will to address larger, systemic problems. Because of this, our number one advocacy issue is affordable and accessible health care for everyone.

Even more to the point raised by this question, we **are** concerned that some employers may drop health insurance if they believe their workers will be covered by financial assistance policies. However, hospital care is not the only or even the most important reason to have health insurance. Health insurance provides regular access to appropriate sources of care and helps keep people healthy, a benefit for both public health and systemic cost reduction.

Question 5: Community benefit is a concept that will vary greatly from hospital to hospital and area to area. I understand that some have argued that all community benefit should be limited to charity care or specific standardized items. In my experience the community benefit of the Children's Hospital of Pennsylvania offering training for parents on how to properly use child safety seats in cars and the low-income health clinics by our research hospitals both serve the community. How do we continue to ensure there is community benefit but take into consideration the differences between types of hospitals, charitable missions, size and location?

It is our firm belief that community benefit is multidimensional, extending well beyond charity care. We identify the following categories of community benefit:

- **Charity Care**
- **Shortfalls** from government indigent care programs, such as Medicaid and SCHIP (but not Medicare).
- **Community Health Services:** clinics, support groups, support services, and prevention and health promotion activities.
- **Health Professional Education:** training for physicians, nurses, and other health professionals to address unmet community needs.
- **Subsidized Services:** trauma services, hospice and palliative care programs, and behavioral health.

- **Health Research:** clinical research, and studies on community health and health care delivery.
- **Donations:** cash, grants, and in-kind services.
- **Community-Building Activities:** neighborhood improvements, housing programs, coalition building, and advocacy for community health improvement.

This classification, we believe, takes into consideration differences not only in hospitals but in community needs as well.

Questions from Senator Rockefeller:

Question 1: I think the real issue facing all hospitals, but primarily nonprofit hospitals, is the problem of the uninsured. The Census Bureau just reported last month that, in 2005, the number of uninsured adults rose to 46.6 million. And, the number of uninsured children rose for the first time since 1998 to 8.3 million.

As I understand it, nonprofit hospitals have a hard time trying to shoulder the uncompensated health care burden caused by lack of health insurance. In West Virginia, nonprofit hospitals had \$442 million in uncompensated health care in 2005. By comparison, the uncompensated health care burden of WV's for-profit hospitals was only \$64 million.

With the added costs of Medicare and Medicaid cuts as well as cuts to health professions training programs, many nonprofit hospitals struggle to keep their doors open. And, their tax exempt status is the only thing that allows them to stay afloat.

Sr. Keehan, Mr. Duke and Mr. Lofton, can you talk a little bit about the challenges faced by your hospitals because of the lack of health insurance? You can't just move costs around, can you?

It is accurate that the nation's hospitals "shoulder the uncompensated health care burden caused by the lack of health insurance." An important part of the mission of our organizations is to help maintain the health care safety net until our nation adequately addresses the need for everyone to have health care coverage.

As Senator Rockefeller suggests, however, there is never enough. Hospitals cannot compensate for the more than 46 million persons who have no health insurance. In fact, the growing number of uninsured and underinsured persons is the primary challenge facing our institutions today. Growing uncompensated care burdens take their toll on our programs, our ability to expand and upgrade services and to maintain a stable workforce with fair compensation for our employees. Particularly at risk are programs used in high volumes by uninsured patients: emergency and trauma services, some maternity programs and mental health services which must be subsidized by hospitals. Eventually, we fear, the problem of the uninsured will weaken the health care infrastructure.

It is important to point out that the problem of the uninsured is not just a practical problem, but a moral problem. It is a national disgrace that more than 15 percent of persons in this country do not have health insurance. We also believe that shifting costs from one group of patients to another is an irresponsible way to finance healthcare. This cost shift is increasingly progressive and is reaching intolerable levels. We urge this committee to make insurance coverage for everyone a priority in the next Congress.

Senator Rockefeller also cites Medicare and Medicaid cuts as a source of financial distress for hospitals. Such cuts hurt hospitals that rely on these dollars to treat elderly and low-income

populations, which often comprise the majority of patients in not-for-profit hospitals. When these programs are scaled back or under-funded, it is not only the hospitals that are impacted, but patients and communities as well. It is unacceptable that some patients are unable to find a physician who will accept Medicare or Medicaid because of low reimbursement levels, when we have made a public policy commitment to cover these patients.

Question 2: It has been suggested by some that the 1969 IRS Community Benefit standard for determining tax exempt status is too broad and was wrongly decided. However, it is true that nonprofit hospitals contribute to their communities in a variety of ways. Some nonprofit hospitals focus almost exclusively on providing charity care.

Others, such as teaching hospitals, focus more on scientific research that will lead to treatments and cures for diseases. Other nonprofit hospitals provide invaluable education services to their communities.

We have a Children's Health Van at Marshall University in West Virginia, which I helped create, that provides vital health education services to children and their families. Most of these families would have no contact with the health care system otherwise. I think that is a huge community benefit.

Don't you agree that nonprofit hospitals benefit communities in a variety of ways-from charity care to scientific research to capital investment and infrastructure development?

We agree with Senator Rockefeller that not-for-profit hospitals benefit communities in a ways that extend well beyond charity care. We are convinced that the 1969 IRS Community Benefit Standard was and continues to be appropriate because it encourages tax-exempt hospitals to address the greatly different needs in various communities with the unique expertise and capabilities of different hospitals. We believe that hospitals enjoy a unique perspective on the health needs of their communities that the IRS could not be expected know.

As we said earlier, it is our firm belief that community benefit is multidimensional, extending well beyond charity care. Therefore we identified the following categories of community benefit:

- Charity Care
- Shortfalls from government indigent care programs
- Community Health Services
- Health Professional Education
- Subsidized Services
- Health Research
- Donations
- Community-Building Activities

Who else is going to make the investment in health care that we are going to need as our population ages?

As the nation's population ages, we believe that the not-for-profit health sector will be needed more than ever. We partner with a number of nonprofit organizations dedicated to serving older persons such as the Alzheimer's Association and other groups addressing specific

conditions and population, homes and services for the aging, and other voluntary service organizations,

It is the tradition and commitment of the nonprofit service sector to provide and adapt services as community needs change. With the growing numbers of older and frail person, our health and aging service organizations will be increasingly involved in chronic care, senior housing, home and community based services, and programs for serving persons with dementia.

These are needs that the market alone is unlikely to address adequately. We believe that our country will need a robust not-for-profit service sector with health and human service providers who will adapt to changing needs over time, find creative solutions to emerging problems, and be advocates on behalf of older persons and other vulnerable populations who cannot speak for themselves.

Question 3: It is my understanding that nonprofit hospitals are required to participate in Medicare as a condition of training tax exempt status. However, from year to year, nonprofit hospitals experience shortfalls in Medicare reimbursements as well as Medicaid reimbursement. In West Virginia, the underpayments by state and federal governments for treating Medicaid patients cost hospitals an additional \$100 million annually.

My question, Sister Keehan and Mr. Lofton, is why shouldn't shortfalls in Medicare and Medicaid reimbursement-assuming they can be accurately calculated-be included in a nonprofit hospital's community benefit calculation?

CHA's community benefit guidelines and standard definitions identify Medicaid shortfalls but not Medicare shortfalls as community benefit.

Medicaid: As a poverty program, Medicaid is designed to help meet the health needs of lowest income persons in our communities. Nearly every provider participating in the Medicaid program does so knowing that program reimbursement is unlikely to cover costs. In some cases, such as cancer treatment, the program leaves significant deficits for health care providers. Participation in Medicaid is most certainly community benefit, and shortfalls should be counted as such.

Medicare: By contrast, Medicare was originally designed to fairly reimburse efficient providers. Participation in Medicare does not distinguish not-for-profit hospitals, and when a loss is experienced it may be viewed more as the cost of doing business than community benefit. Therefore, we recommend that Medicare shortfall not be counted as community benefit.

At the same time, we realize that many efficient hospitals continually experience Medicare shortfalls. This is especially true for hospitals that: 1) offer services that are under-reimbursed by Medicare, 2) serve patients whose costs of care are not adequately recognized by the Medicare payment system and /or 3) are in areas of the country where the wage adjustment is inadequate.

For these hospitals, we recommend reporting and explaining the financial loss of the Medicare shortfall, but not calling that loss community benefit. We also strongly recommend that the Senate Finance Committee look into the issue of inadequate Medicare funding for hospitals and other providers.

Questions from Senator Bingaman:

Over the past several years, attention on the issue of how hospitals handle charitable care and community benefits has clearly had a positive impact, as hospitals across this country have revised their policies and made those very policies more transparent to the public.

This hearing was rightly focused largely on issues around "charitable care" and "community benefits" and the "tax-exempt status" of certain hospitals in the country.

I would like to bring to the table another issue that is of importance to my state and those of the Chairman and Ranking Member and that has to do with the Medicaid and Medicare disproportionate share hospital (DSH) programs. These programs are also under the jurisdiction of the SFC, and I think that we should also think carefully about the billions of dollars spent on those programs and the impact they have on charitable care and community benefit.

First, due to historical nature of the DSH program, there are profound differences in the amount of federal Medicaid DSH dollars that go to provide assistance to hospitals that care for a disproportionate share of low-income Medicaid and uninsured patients based on state boundaries. States such as New Mexico, Iowa, Montana, Arkansas, Oregon, ND, Idaho, UT, and Wyoming receive less than an estimated \$82 per uninsured individual in DSH funding compared to over \$650 per uninsured individual in NH, LA, RI, ME and MO. In other words, federal Medicaid DSH dollars are flowing to certain states to help hospitals deal with the uninsured at more than eight times the level than nine states represented on the SFC.

For the information of Mr. Hartz, Virginia also receives less than \$100 per uninsured individual from the federal Medicaid DSH program.

What should the SFC do to improve the fairness within the Medicaid DSH program and the equity in funding that goes to help hospitals address uncompensated care in their communities and states?

Medicaid disproportionate share hospital (DSH) payments are vital to institutions - including those in our membership - that are committed to the care of all patients regardless of their ability to pay. Catholic hospitals have a long and distinguished history of service to the poor. Our institutions provide essential health care services to millions of Medicaid and uninsured patients every year.

Since 1981, Medicaid DSH payments have recognized the unique circumstances of hospitals serving a 'disproportionate number' of low-income patients - both Medicaid and uninsured patients. Payment rates have been adjusted to help these institutions remain financially viable and ensure access for vulnerable populations. As you know, legislative changes since 1997 have imposed caps on the amount of DSH payments to an individual hospital and on the total amount of federal matching funds available for DSH payments (the state DSH allocation).

As a result, the distribution of federal DSH dollars varies greatly across the states, essentially reflecting the size of a state's DSH program in 1991. These 15-year old circumstances are not, in our view, a sound basis for the allocation of federal DSH funds. CHA supports a change in federal policy to increase the allotment that states receive under the DSH program that reflect recognition of the growing number of uninsured patients as well as the unreimbursed costs of care provided to Medicaid beneficiaries. .

All hospitals -- such as those in our membership with significant uncompensated care -- should be fairly compensated under a federal DSH policy regardless of their location or form of organization.

Should DSH funds follow the uninsured patient so that hospitals are not what some might call "double-dipping," by both collecting DSH funding and then billing the uninsured patient separately?

CHA has comprehensive guidelines for reporting uncompensated care that would not permit hospitals to claim uncompensated care costs for patients from whom they are able to collect

payment. The majority of Catholic hospitals have discount and charity care policies that provide free care for patients with income and resources up to 200 percent of the Federal Poverty Level and discounted care for patients with higher incomes. Based on our survey, since the majority of our hospitals do not require patients below 200 percent of FPL to pay for the cost of their care, the possibility of "double-dipping" is unlikely. Unfortunately, it is not possible for the Medicaid DSH program to absorb or pay for all of the costs of serving the 46 million uninsured in our country, so DSH is unable to reimburse for the full cost of treating the uninsured. We believe it is time for Congress to address the growing number of uninsured and work to ensure everyone in our country has access to affordable health care coverage.

On a related matter, the Medicare DSH program has a formula that has the paradoxical effect of, while intended to target money to safety net and charitable hospitals, of actually reducing funding to hospitals as they provide more and more uncompensated care. The formula is flawed in that uncompensated care is not reflected in the numerator but only in the denominator. Thus, for every increase in uncompensated care at the hospital, the formula has the perverse effect of actually reducing Medicare DSH dollars to that hospital.

"The DSH payment formula rewards hospitals that treat poor patients who have health insurance but penalizes hospitals for treating patients who do not have health insurance," says Sean Nicholson at AEI in a report entitled Medicare Hospital Subsidies. "Ironically, the structure of the DSH payment formulas may...reduce the supply of hospital care to the (low-income) uninsured, the group that arguably faces the greatest barriers to medical care." Mr. Samuelson estimated that, in addition to losing revenue through uncompensated care on uninsured patients, hospitals lose an additional \$171 per uninsured admission, on average, due to reductions in Medicare DSH payments.

In recognition of this problem, the Medicare Payment Advisory Commission (MedPAC) has made several recommendations in the past regarding revising the Medicare DSH formula, including:

- **The low-income share measure should reflect the cost of services provided to low-income patients in both inpatient and outpatient settings. This, of course, would help rural hospitals greatly, as they provide a larger volume of their care in such settings.**
- **In addition to Medicare SSI and Medicaid patients, the low-income share measure should include uninsured and underinsured patients represented by uncompensated care and also other patients sponsored by other state and local indigent care programs. This would help eliminate disparities in Medicare and DSH payments caused by differences in Medicaid eligibility rules across states.**
- **Medicare DSH should be concentrated among hospitals with the highest shares of low-income patients. A minimum threshold should be established below which a hospital receives no DSH payment but there should be no "notch" that would provide substantially different payments to hospitals just above and below the minimum threshold.**

Mr. Nicholson argued that the MedPAC proposals "correct most of the problems with the structure of the DSH program. The more inclusive measure of care provided to the poor would direct more DSH funds to hospitals that provide a substantial amount of uncompensated care but have a relatively low volume of Medicaid and Medicare/SSI patients...The proposed index would also eliminate the perverse incentive that currently exists of penalizing hospitals that increase the number of uninsured patients they treat. Under the recommended formula, admitting more uninsured patients would increase rather than decrease DSH payments."

As such, when the federal government is investigating the issue of charitable care and community benefit provided by hospitals, should the federal government also reassess a funding formula in the Medicare program that actually has the perverse incentive of penalizing hospitals for caring for uninsured and underinsured patients?

The failure of the Medicare DSH policy to fully take into account the value of services rendered to patients who are unable to pay for their care is a long-standing inequity for the hospitals bearing this burden. As Senator Bingaman points out in this question, it is not just that the hospitals bearing these uncompensated care costs do not receive an increase in their Medicare DSH payment. Because of flaws in the funding formula, the hospital's DSH payments actually are reduced. Similar to our comments on Medicaid DSH, the Medicare program must recognize the costs of the growing number of underinsured and uninsured patients.

We hope that Congress will address the Medicare DSH formula issue, and urge that any changes in Medicare policy is focused on offsetting the charity care obligations that hospitals currently incur. .

In addition, what do the witnesses think about the recommendations made by MedPAC in 1998, 1999, and 2001 and summarized in the bullets above to revise the Medicare DSH formula and do they agree with Mr. Nicholson that they would improve the Medicare DSH formula?

CHA shares MedPAC's goal of improving Medicare DSH payments. While there is not at this time broad agreement on the design of a new Medicare DSH formula, including the MedPAC recommendations referenced above, we believe this issue must be addressed. Given Medicare's very significant role in financing care in private hospitals, any change in the DSH formula must not impede hospitals' ability to continue to provide care to those without insurance or the means to pay for their care.

As recommended by MedPAC, we believe that the cost of services provided to low-income patients in both inpatient and outpatient settings should be considered. Large numbers of low-income patients are served in outpatient settings, and these costs should not be ignored. Additionally, we believe that all hospitals providing uncompensated care above a minimal level should continue to be eligible to receive Medicare DSH payments, and not be cut off by an arbitrary threshold.

In summary, it is essential that any modification to the Medicare DSH formula take into account the financial vulnerability of all hospitals caring for low income and uninsured patients. In our view, this calls for recognizing the critical role that is played by the nation's private, nonprofit hospitals as safety net providers. DSH payments should be based on an accurate measure of a hospital's costs to serve uninsured and low-income patients, as well as the scope of services provided to those patients. CHA looks forward to working with the Finance Committee and MedPAC to ensure equitable hospital payments under the Medicare DSH program.

And finally, to what extent should DSH funds be targeted on core safety net providers that are financially vulnerable?

As we have stated above, hospitals that are bearing significant costs for serving low-income Medicare, Medicaid and uninsured patients are in our view financially vulnerable. We believe it is essential to consider the entire financial commitment of hospitals that provide access to vital health services to their communities. We believe this means recognizing the critical role that is played by the nation's private, nonprofit hospitals as safety net providers. Again, DSH funds should be based on an accurate measure of a hospital's uninsured and low-income patients as well as the scope of services provided to those patients.

We appreciate the opportunity to provide these responses to your questions, and I will be happy to provide any further information should you require it.

Sincerely,

A handwritten signature in cursive script, appearing to read "Sr. Carol Keehan".

Sr. Carol Keehan, DC
President and CEO

cc: Senator Rick Santorum
Senator Jay Rockefeller
Senator Jeff Bingaman