American Hospital Association

Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

June 16, 2008

Cmdr. Melissa Sanders
Team Leader, Healthcare Systems Preparedness Programs
HSS/OS/ASPR
395 E Street, S.W.
10th Floor, Suite 1075
Washington, DC 20201

RE: Hospital Preparedness Program; Fed. Reg. Vol. 73, No. 96; May 16, 2008.

Dear Cmdr. Sanders:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 37,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Assistant Secretary of Preparedness and Response's (ASPR) proposal to require Hospital Preparedness Program cooperative agreement recipients to contribute non-federal matching funds beginning in fiscal year (FY) 2009.

Under this proposal, each of the 62 Hospital Preparedness Program awardees (comprised of the 50 states; the District of Columbia; the metropolitan areas of New York City, Los Angeles County and Chicago; and a number of other commonwealths and territories) would be required to make available, either directly or through donations from public or private entities, non-federal contributions in an amount equal to 5 percent of the award amount in FY 2009, and 10 percent of the award amount in FY 2010 and each successive year for the duration of the program. Non-federal contributions would be provided directly, or through donations from public or private entities, and could be in cash or in kind, fairly evaluated, including physical plants, equipment or services. This cost-sharing requirement would be implemented as a term and condition of the Hospital Preparedness Program award.

We oppose this proposal and urge ASPR not to finalize it. Congress clearly did not intend for this public health matching requirement to be applied to the Hospital Preparedness Program, and we urge ASPR to clarify its authority to impose such a requirement on the states. While the *Pandemic and All Hazards Act* amended Section 319C-1(i)(1)(C) of the *Public Health Service* (PHS) *Act* to require state matching for the Centers for Disease Control and Prevention's public health emergency preparedness program, it did not impose a similar requirement on for the Hospital Preparedness Program, which falls under PHSA Section 319C-2.

This proposal would allow the states to raise their matching funds through donations from public or private entities. Based on our experience with other programs that require state matching funds, such as in the Medicaid program, we are concerned that the states essentially would "tax" hospitals and other health care providers that participate in the Hospital Preparedness Program to raise the necessary funds, and could even make the awarding of Hospital Preparedness Program funds to a hospital conditional on whether the hospital makes a "donation" towards the match. In fact, the "maintenance of funding" provision of the PHS Act at section 319C-2(h) provides a powerful incentive for a state ***not*** to raise any of the matching funds directly from its coffers because it would then be required to continue to maintain such expenditures for as long as the Hospital Preparedness Program is in existence.

We urge ASPR to reconsider the likely consequences of its proposal. Already, more hospitals are electing not to participate in the Hospital Preparedness Program due to the combination of declining award amounts and increasing requirements and conditions for receiving funding. In the last several years, ASPR has added several burdensome requirements to the Hospital Preparedness Program that are perceived to be of little or no value by hospitals, including National Incident Management Systems education courses and Homeland Security Exercise Evaluation Program requirements. We are concerned that, if hospitals are now forced to contribute to the state matching amount, the exodus of hospitals from the Hospital Preparedness Program will accelerate, to the detriment of health care system preparedness for natural and manmade disasters. This will place communities at increased risk in the event of an emergency.

Therefore, we urge ASPR not to finalize this proposal. It is inconsistent with the intent of Congress and, considered together with the state maintenance of funding provisions, gives states the incentive to shift the entire matching amount to hospitals and other health care providers funded by the Hospital Preparedness Program program. Putting this burden on hospitals will have serious unintended consequences for public health and medical preparedness as hospitals elect not to participate in the program.

However, if the agency decides to move forward with this ill-conceived proposal, we recommend that a set of conditions be established to ensure that state matching funds are raised in a fair and equitable way.

1. The states must use a broad-based and fair system to raise the matching funds. Consistent with this approach:

    a. The state must submit its plan for meeting the matching requirements to ASPR for approval as part of its funding opportunity application (FOA), beginning in FY 2009.
    b. The state must bear some direct responsibility to raise the matching amount and may not shift the entire burden onto public and private sector entities through "donations" in cash or in kind.
    c. The state may not require hospitals or other eligible health care providers to make a donation in cash or in kind toward the match amount as a condition of receiving Hospital Preparedness Program funds or to base the amount of the Hospital

Preparedness Program funds awarded on whether (and how much) funds are donated towards the state matching amount.

d. Hospitals that receive Hospital Preparedness Program funding should not be the sole source the state turns to for providing the portion of the matching amount expected to be raised from public and private sector donations. Instead, states ought to evaluate which stakeholders benefit from the increased health care system preparedness, thereby developing a more community-based cost-sharing approach.

2. The plan and process for raising the state matching amount, including any development of state legislation, must be transparent and actively engage stakeholders. In particular, we strongly recommend that representatives from hospitals and from the state, metropolitan and regional hospital associations be included.

3. ASPR should define and further clarify in the FOA, and within a "frequently asked questions" document, what is meant by "in-kind" donations and how to determine the value of "in-kind" items. Eligible in-kind donations should include the types of physical plants, equipment and services hospitals provide to support community preparedness, such as emergency management committee meetings, education sessions, training and exercises, etc.

Thank you again for the opportunity to comment on this proposal. If you have any questions, please feel free to contact me or Roslyne Schulman, senior associate director for policy, at (202) 626-2273 or rschulman@aha.org.

Sincerely,

Rick Pollack
Executive Vice President