

**Statement
of the
American Hospital Association
before the
U. S. Senate Committee on Finance**

**“Strengthening America’s Economy: Stimulus That Makes Sense”
January 24, 2008**

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 submit this statement for the record as the Committee on Finance examines the need for a short-term economic stimulus legislative package to stave off a deep economic recession.

A weak economy means fewer jobs with employer-based health care coverage and, consequently, greater numbers of uninsured individuals and families. Medicaid is *the* public program designed to assist vulnerable populations in times of economic hardship. As state revenues decline and Medicaid enrollment increases, state governments will struggle to meet the health care needs of their residents. It is estimated that over the next two fiscal years 24 states will face budget shortfalls. A fiscal relief package for states is important before the economy worsens and should include two critical health care initiatives: an extension of the moratorium on several Centers for Medicare & Medicaid Services’ (CMS) regulations that would drastically cut federal funds to state Medicaid programs; and a temporary increase in Medicaid’s federal medical assistance percentage (FMAP).

The temporary FMAP increase should allow states to use such funds to support their Medicaid programs and maintain their current levels of enrollment. States also should not be forced to radically transform their programs in order to receive such fiscal relief.

In addition to increasing FMAP, states should not be subjected to budget-cutting regulatory policy changes. Since early 2007, CMS has issued a half dozen regulations, in either proposed or final form, that, if implemented, will significantly affect the Medicaid program’s financial support for hospitals and, ultimately, the patients we serve. The majority of these regulations have been described by CMS as necessary to root out problems, particularly with the financing



of the program. However, in the written justification for these regulations, CMS failed to identify any significant or widespread problems. Despite concerns raised by Congress, the states and the provider and advocacy communities, CMS continues to take steps to implement these regulations.

REGULATIONS UNDER CONGRESSIONAL MORATORIUM

Of critical importance are two regulations upon which Congress has imposed a year-long moratorium secured by P.L. 110-28: the cost-limit proposed and final rule, and the graduate medical education (GME) proposed rule.

Cost-limit Rule. This regulation would restrict payments to financially strapped government-operated hospitals, narrow the definition of “public” hospitals, and restrict state Medicaid financing through intergovernmental transfer and certified public expenditures. It would limit reimbursement for government-operated hospitals to the cost of providing Medicaid services to Medicaid recipients. In addition, the rule would restrict states’ ability to make supplemental payments to providers with financial need by setting the Medicaid upper payment limit (UPL) for government-operated hospitals at the individual facility’s cost. The rule’s restrictive definition of government-operated hospitals would have significant practical implications for public hospitals, particularly those that have restructured to achieve gains in efficiency. This regulation effectively amounts to a cut in funding for those public and safety-net providers that – as CMS has recognized – are in stressed financial circumstances and are most in need of enhanced payments. These cuts would undermine the ability of states and hospitals to ensure quality of care and access to services for Medicaid beneficiaries, as well as to continue their substantial investments in health care initiatives to promote the Department of Health and Human Services’ policy goals, including adoption of electronic health records, reducing disparities in care provided to minority populations, and enhancing access to primary and preventative care.

GME Rule. This proposed rule would eliminate any federal Medicaid support for GME. CMS claims this rule is a clarification, when, in fact, it is a reversal of over 40 years of agency policy and practice recognizing GME as medical assistance. This rule will result in a cut of nearly \$2 billion in federal funds from the Medicaid program. The finalization of this new policy would put many safety-net hospitals in financial jeopardy, ultimately harming the most vulnerable of our citizens covered by the Medicaid program and served by these hospitals.

The net impact of the implementation of these two rules would be a reduction in Medicaid funding of \$700 million over the next year, according to the Congressional Budget Office. The existing moratorium on implementation of these rules expires May 25.

REGULATIONS THAT SHOULD BE UNDER A MORATORIUM

In addition, the AHA believes two other CMS proposed rules should be placed under moratoria: the proposed outpatient and provider tax rules.

Outpatient Rule. This proposed rule substantially departs from long-standing Medicaid policy regarding the definition of Medicaid outpatient hospital services and how costs for such services are treated for the purposes of calculating the hospital outpatient UPL. Under the proposed rule, the types of services that are at risk for not being reimbursed through hospital outpatient programs include Medicaid's: early and periodic screening and diagnostic treatment dental services for children; physician emergency department services; physical, occupational and speech therapies; outpatient clinical diagnostic laboratory services; ambulance services; durable medical equipment; and outpatient audiology services. CMS stated that it based its dramatic shift in policy on the need to align Medicaid outpatient policies with Medicare outpatient policies. However, these programs serve very different populations. Medicaid serves a largely pediatric population, while Medicare serves an elderly population. Yet despite these differences, CMS proposes to narrowly define Medicaid hospital outpatient services to align Medicaid with Medicare. The effect of aligning the hospital outpatient policies for these two programs would be to limit Medicaid federal spending for hospital outpatient programs and state Medicaid programs overall and, ultimately, the patients served by Medicaid.

Provider Tax Rule. This proposed rule would make changes to Medicaid policy on health care-related taxes used by the states to help support their share of Medicaid expenditures. The AHA specifically objects to CMS' changes to the standards for determining whether an impermissible hold-harmless arrangement exists within a health care-related tax. The rule represents a substantial departure from long-standing Medicaid policy by imposing largely subjective, overly broad standards for determining the existence of hold-harmless arrangements. These proposed policy changes would create great uncertainty for state governments and providers making it difficult for them to adopt or implement Medicaid health care-related tax programs with reasonable assurance that they are compliant, leaving them unreasonably open to after-the-fact challenges. In addition, the vaguer and broader standards CMS proposes would unduly limit states from implementing legitimate provider tax programs that are consistent with the Medicaid statute and congressional intent.

CONCLUSION

Hospital and state Medicaid programs are reeling under the weight of these new regulatory policy decisions, and Congress and the general public have been largely excluded from the decision making process. The effect of these regulations will be to limit federal spending rather than to protect access to much-needed services. The most significant impact of the agency's actions will be felt by the poor children and mothers, the elderly and the disabled that are served by the Medicaid program.

The AHA believes that the current fiscal crisis faced by states demands immediate and meaningful federal support. The combination of no federal fiscal relief and CMS' unrelenting regulatory budget-cutting policies will have a devastating effect on state Medicaid programs, the hospitals and physicians serving this vulnerable population and, most importantly, patients themselves. Meaningful federal support should include extension of the current moratorium, as well as the application of additional moratoria to rules resulting in deep reductions in Medicaid spending and an increase in the federal Medicaid matching percentage.