American Hospital Association

The Road to Economic Recovery:
A Proposal to Support Health Care in America

The economic recession gripping this nation calls for immediate and swift action. The ripple effects of the financial market crisis, rise in unemployment and the loss of job-based health care coverage has impacted hospitals' ability to continue to serve their communities. This pressure, coupled with other payment pressures, is leading to a decline in hospitals' financial health at a time when demand for health care services is growing.

Not only could the health of communities across the country be compromised if action is not taken now, but hospitals are a critical part of our nation's economy as the largest private sector source of jobs—5 million nationwide. Every dollar spent by a hospital also supports more than $2 of additional business activity in a community.

THE PLIGHT OF HOSPITALS

The American Hospital Association, through recent reports and surveys, has found:

- The credit crunch is increasing the costs of borrowing needed funds, making it more difficult for hospitals to find the money for facility and technology improvements. Hospitals saw interest payments on borrowed funds increase by an average of 15 percent from July to September versus the same period last year.

- The survey found many hospitals are reconsidering or postponing investments in facilities or equipment communities rely on for care. These include: renovations or plans to increase capacity (56 percent); delaying purchase of clinical technology or equipment (45 percent); and putting off investments in new information technology (39 percent).

- A majority of those hospitals surveyed noted an increase in the proportion of patients unable to pay for care, and uncompensated care increased 8 percent from July to September versus the same period last year.

- Among a sample of hospitals, total margins fell to negative 1.6 percent in the 3rd quarter of 2008 versus positive 6.1 percent during the same period last year.

- Hospitals reported that financial stress is forcing them to make or consider making cutbacks to meet their obligations. Over half of hospitals reported plans to reduce staff (53 percent) and over a quarter of hospitals reported plans to reduce services (27 percent).

WHAT NEEDS TO BE DONE

HEALTH CARE COVERAGE FOR RECENTLY UNEMPLOYED

Some policy experts are projecting that unemployment rates could go as high as 10 percent. Millions will lose job-based health care coverage. And many of these newly uninsured will not be eligible for public programs such as Medicaid and SCHIP because of resource and asset restrictions. There are a number of options that should be considered to get coverage for these individuals and their families as well as helping the providers serving them.

- **Katrina-like Medicaid/SCHIP Waivers:** Hurricane Katrina affected states were allowed to temporarily expand Medicaid and SCHIP coverage through an expedited waiver process established by the Centers for Medicare & Medicaid Services. Through these waivers, states were also authorized to create uncompensated care pools to reimburse providers for the cost of furnishing services to the uninsured that do not qualify for Medicaid or SCHIP. Federal financed waivers administered through the Medicaid and SCHIP programs should be established to extend temporary coverage for the newly uninsured as well as the establishment of uncompensated care pools to reimburse providers that furnish services to uninsured not qualifying for Medicaid or SCHIP. Funding should be through an enhanced federal matching rate.

- **Section 1011-like Program**: Under the Medicare Modernization Act, the Section 1011 program reimburses providers for EMTALA-related uncompensated care provided to undocumented immigrants. A similar program could be created to reimburse services furnished to the newly uninsured. New provider eligibility criteria could be developed for the expanded program. The funds supporting this program would flow from the federal government directly to the provider.

- **COBRA Temporary Expansion:** The Consolidated Omnibus Budget Reconciliation Act (COBRA) gives workers and their families, who lose their health benefits through the voluntary or involuntary loss of their jobs, the right to choose to continue group health benefits provided by their employers by allowing workers to pay their full premium and administrative fee for up to 18 months. The COBRA time period should be expanded from 18 months to 36 months and the federal government should subsidize a portion of the premium for the newly uninsured worker.

MEDICAID FMAP INCREASE

The demand for Medicaid services increases during a time of economic recession, requiring states to manage the increase in enrollment and funding pressures at a time when most of their budgets are stretched thin. Experts estimate that a one percentage point increase in unemployment increases enrollment in Medicaid and the State Children's Health Insurance Program (SCHIP) by one million lives. Thirty nine states have reported budget shortfalls for the current fiscal year or projected budget shortfalls for fiscal year 2010.

The AHA supports a temporary Federal Medical Assistance Percentage (FMAP) increase that would allow states to use such funds to support their Medicaid programs and, through maintenance of effort criteria, states should be required to maintain their current levels eligibility and enrollment levels, benefit levels, and provider payment rates. Any FMAP increase should apply to DSH payments, with a corresponding increase in DSH allotments to accommodate the enhanced federal match. These reforms are critical because states have already targeted their Medicaid programs in a search for savings through provider payment freezes or reductions, as well as benefits and eligibility changes. Such cuts will further weaken the already tenuous foundation of the health care safety net, dramatically harming the ability of providers to continue serving our most vulnerable patients.

PENSION PROTECTION ACT TECHNICAL AMENDMENTS

The current financial crisis not only impacts workers today but also will have severe, short-term negative effects on the pension plans in which they participate, reducing benefits, undermining retirement security and likely leading to more job loss if action is not taken. The drop in the value of pension plan assets coupled with the current credit crunch has placed defined benefit plan sponsors in an untenable position. Many companies will divert cash needed for current job retention, job creation and business investments in order to meet pension funding requirements for obligations due many years after the current market conditions return to normal.

AHA urges Congress to consider making technical corrections to the Pension Protection Act of 2006 ("PPA"). Such provisions should include permitting full smoothing of unexpected losses, removing restrictions on asset smoothing, allowing sufficient time to transition to the PPA's 100% funded target, providing automatic IRS approval for certain funding elections to keep plans viable, clarifying end-of-year valuations, and permitting fixed interest rates to be used for Code section 415 limit purposes so as to avoid benefit reductions.

Employers who contribute to the more than 1,500 multi-employer defined benefit plans (more than 90% of which employ 20 or fewer employees), are also severely affected by the financial crisis. While these plans are subject to a separate set of funding rules, similar temporary relief designed to moderate the effects of the aggressive funding targets contained in the PPA is essential to avert devastating burdens and inevitable job losses arising from massive contribution increases and unavoidable benefit reductions that will be required to comply with those rules.

HEALTH INFORMATION TECHNOLOGY LOANS AND GRANTS

An immediate investment in health care information and technology systems (IT) is critical. Many hospitals and health systems have been pioneers in harnessing information technology to improve patient care and high quality medicine. Sophisticated clinical information technology is critical to the health care infrastructure and a strong federal financing role today is necessary for the benefits of IT to be realized throughout the health care system. Special funding for hospitals and regional health information exchanges should be made available through the Agency for Healthcare Research and Quality or the Centers for Medicare and Medicaid Services (CMS) in

partnership with the Office of the National Coordinator for Health Information Technology (ONCHIT).

- **Loans and grants for hospitals**. A program should be established to provide low-interest loans to hospitals and critical access hospitals (CAHs) for acquisition of certified, quality-enhancing, clinical health IT and its associated training and ongoing support. Grants – for essential, urban and rural safety net, and/or financially struggling hospitals – should be made for the acquisition of certified clinical information technology systems, training and ongoing support and maintenance of systems. Qualifying systems for both loans and grants would include currently certified electronic health record (EHR) systems and systems that provide medication administration or bar coding of medications, access to current medication lists, allergy lists, digital images, laboratory results or decision support tools.

- **Grants for health information exchange efforts**. These grants should be provided to organizations whose principal mission is to establish a secure, health information exchange network in a specified geographic area that allows the secure electronic sharing of health information among health care providers and other authorized users in the provision of care.

- **Payment adjustments under Medicare for hospitals using certified, quality-enhancing, clinical IT**. Hospitals currently using health information technology systems that improve patient safety or quality of care should receive a 1 percent increase in their Medicare inpatient and outpatient PPS payments. Qualifying systems would include certified EHR systems and systems that provide medication administration or bar coding of medications, access to current medication lists, allergy lists, electronic prescribing, digital images, laboratory results or decision support tools.

HOSPITAL ACCESS TO CAPITAL

Hospitals' ability to borrow money for needed construction, renovation, upgrades, and equipment has dramatically worsened in 2008. A November 2008 report by the rating agency Moody's stated, "The current credit crisis has limited access to the capital markets for hospitals in recent months, especially for long-term debt issuance. Access to capital is critical for hospitals and their communities given the increasingly capital-intensive and high-tech nature of modern health care. Ongoing capital investment is needed to assure quality of care and to remain competitive."

At the same time, Moody's notes, hospitals have experienced a "downturn in financial performance brought about by a weakening economy with increasing bad debt and charity care levels." Moody's concludes that the fundamental credit conditions for hospital borrowing are "pointing in a negative direction." Fitch Ratings on December 2, 2008, revised its outlook on not-for-profit hospitals to negative from stable. Fitch states, "Finally, hospitals' access to low cost capital is not expected to substantially improve over the near term. As a result, higher capital costs will be unavoidable for many institutions, as hospitals are forced to debt finance

committed projects at higher interest rates, and as liquidity enhancement for variable rate demand obligations remains scarce and expensive."

To provide the care their communities deserve, hospitals need to continually replace aging buildings and equipment, and upgrade technology to expand treatment options for patients. Hospitals need to plan for the future to ensure they have the needed facilities available to take care of a community as its population ages. To fund these investments, hospitals access financial resources through capital markets.

The economic environment and ongoing credit crisis is limiting or preventing access to the debt markets for hospitals The federal government should step in to support hospital capital financing in the following ways.

- **Section 242**: The current Federal Housing Administration's Section 242 Hospital Mortgage Insurance construction loan program (section 242) helps hospitals meet their borrowing needs. The 242 program, administered by the Office of Insured Health Care Facilities (OIHCF), insures mortgage loans for the construction, rehabilitation, replacement, and equipping of hospital facilities, as well as refinancing of related existing debt. Since the program began in 1968, more than 360 financings totaling over $13.5 billion have been insured in 40 states. The program maintains one of the best claims records in the FHA portfolio with mortgage insurance revenues significantly exceeding total insurance claims costs over time. In addition, OIHCF estimates the projects they have assisted in FY 2008 alone provide an economic stimulus of $1.65 billion and support over 5,500 total jobs in the hospitals' communities during construction. These projects, when complete, are projected to provide an annual economic stimulus that could reach up to $526 million and create 3,200 new jobs in the hospitals and their surrounding communities. As hospitals find it increasingly costly or impossible to access the capital markets, the OIHCF, given adequate resources and flexibility, can better support necessary investment in hospital renovation, construction and upgrades.

  The AHA believes that legislation is necessary to reduce costs and increase flexibility in mortgage insurance for hospitals under the 242 program through the following changes in the law:
  - Expand eligibility to cover the full array of facilities and services offered by today's hospitals and health systems.
  - Exempt hospitals from the 80% real property requirement so that borrowing for expensive new technologies (such as MRI, CT scanners) can be insured using Ginnie Mae real estate mortgage investment conduits, significantly reducing financing costs.
  - Provide federal matching funds to help hospitals meet 242's mortgage reserve requirements.
  - Permit hospitals to refinance existing obligations without linkage to a construction or renovation project.
  - Increase funding for the OIHCF and clarify that the office qualifies for FHA Modernization Funds.

- **New Construction Grant Program**: Establish a new construction grant for those hospitals currently unable to meet eligibility requirements under the 242 program.

Financing under this new program would be separate and distinct from the existing Hospital Mortgage Insurance Fund. Qualified institutions would include essential community hospitals as well as hospitals providing critically needed tertiary state-of-the-art care, research, or training.

- **Bond Default Reissuance Support**: Some hospitals are finding it difficult to make payments on existing debt. Other institutions find they are in default of a bond issuance because they can no longer meet certain bond covenants such as requirements pertaining to days cash on hand, days in accounts receivables, or operating margin. When a hospital cannot meet a bond covenant, they are considered in default and required to pay the debt in full. Historically, hospitals have gone to the market and reissued new bond financing. Recently, the ability to remarket existing debt has been severely restricted and expensive, with minimal availability for bond insurance and the collapse of the auction rate market. The federal government, using funding from the Troubled Assets Relief Program (TARP) or the liquidity facility announced by Secretary Paulson on November 12, should step in with federal backing of these debts so they can be restructured.

- **Incentives to Purchase Tax-Exempt Bonds:** The stimulus package should include tax reforms to reinstate incentives for banks to buy tax-exempt hospital bonds. The Tax Reform Act of 1986 severely curtailed banks' participation in the tax-exempt bond market by automatically disallowing deductions for interest expense whenever those bonds are purchased. The Act left an exception only for bonds purchased from smaller municipalities, those selling no more than $10 million of bonds each year. In contrast, non-bank corporations are permitted to hold up to 2% of their total assets in tax-exempt bonds (regardless of the size of the issuer) without jeopardizing interest expense deductibility.

  Given the severe challenges affecting the municipal bond markets, now is the time to modify these limitations and help channel additional capital to critical infrastructure projects. First, any stimulus legislation should extend the 2% de minimis rule to banks, placing them on the same footing as other corporate investors. Second, a package should raise the $10 million small issuer exception to $30 million. Because the $10 million level was not indexed to inflation, its purchasing power has eroded significantly since 1986, leaving many smaller governments either to defer projects to comply with this low limit or find non-bank purchasers. Most importantly, the small issuer limit should be made applicable at the individual hospital level. This will allow a hospital to issue bonds through a statewide authority that also issues bonds for other purposes to additionals organizations and municipalities.

  Taken together, these steps promise to significantly boost the demand for municipal bonds, adding liquidity to the market. Additional demand will enable hospitals across the nation, and particularly those in small and rural communities, to finance critical health care projects that play an important role in growing and stabilizing our national economy.

REVERSING COURSE ON BAD REGULATIONS

- **Rescind CMS payment cuts to teaching hospitals:** Reductions to Medicare capital indirect medical education (IME) payment, which went into effect on October 1, will eliminate $1.3 billion over five years from teaching hospitals. Despite numerous comment letters – from the AHA, 210 members of the U. S. House of Representatives and 51 members of the U.S. Senate – CMS moved forward and began implementation. As a result, teaching hospitals in 2009 will receive half their capital IME adjustment, and in 2010 and beyond, the adjustment is eliminated. These unnecessary cuts ignore how vital these capital improvements are to investment in the latest medical technology and ongoing maintenance and improvement of hospital facilities. AHA believes Congress should reverse these cuts.

- **Medicaid Outpatient Rule:** This rule, which took effect December 8, substantially departs from long-standing Medicaid policy regarding the definition of Medicaid outpatient hospital services. Under the 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 would 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.

  In addition to the 333 state and local governments, providers and health care associations that submitted comments to CMS, Congress has spoken repeatedly in bipartisan opposition to the rule. Two Senate bills (S. 2460 and S. 2819), that included a moratorium on the Medicaid outpatient regulation, received strong support from members of both parties. By a vote of 349-62, the House overwhelmingly passed legislation (H.R. 5613) that included a similar moratorium. The outpatient moratorium and others contained in H.R. 5613 were part of the *Supplemental Appropriations Act of 2008*, but the outpatient regulation was dropped during negotiations between the White House and House leadership. Given the bipartisan support for preventing the outpatient regulation from moving forward, the AHA believes Congress should institute a moratorium on this rule.

- **Medicaid Regulations Subject to the Moratorium:** The following regulations would severely restrict Medicaid funding. They have been blocked by legislation through a

moratorium that expires on March 31, 2009. AHA, along with other health care providers and state Medicaid program officials, believe these rules should be withdrawn so as not to negatively affect the Medicaid program during this health care crisis.

- **Medicaid Cost-limit Rule**: The cost limit rule would restrict payments to financially strapped government-operated hospitals, narrow the definition of "public" hospitals, and restrict state Medicaid financing through intergovernmental transfers and certified public expenditures. It would also limit reimbursement for government-operated hospitals and restrict the ability of states to make supplemental payments to providers through the Medicaid Upper Payment Limit. It would cut funding for public and safety-net providers that are in stressed financial circumstances and are most in need of adequate payments.

- **Medicaid Graduate Medical Education (GME)**: The proposed rule would eliminate any federal Medicaid support for GME. While CMS claims that this rule is a clarification, it is in fact a reversal of more than 40 years of agency policy and practice, would cut nearly $2 billion in federal support, and puts safety-net hospitals in financial jeopardy.

- **Medicaid Provider Tax Rule**: The Medicaid provider tax rule would change Medicaid policy on health care-related taxes. Specifically, the rule's hold-harmless changes would make it difficult for states to adopt or implement health care-related tax programs with reasonable assurance that they are compliant with federal rules. The vaguer and broader standards CMS proposes would limit states from implementing legitimate provider tax programs that are consistent with the Medicaid statute and congressional intent.

PHYSICIAN SELF REFERRAL

Self-referral to physician-owned hospitals encourages the selection of healthier, less complex and insured patients for higher reimbursement. This shifts patient care away from community hospitals, and harms the safety net for our nation's most vulnerable populations. Self-referral to physician-owned hospitals threatens community hospitals' ability to provide services such as emergency departments, neonatal intensive care units and burn units.

The Congressional Budget Office has recognized how self-referral affects patient care and Medicare reimbursement in its budget estimates and has concluded that an enactment of a ban on physician self-referral would lead to significant cost savings. Numerous independent and government agencies have studied the impact of physician self-referral in the hospital setting. Research identified several behaviors of physician-owned hospitals that threaten the financial status of the Medicare program, access to services in communities, patient safety and the continued viability of full-service community hospitals. Furthermore, research shows that physician ownership and self-referral significantly increases utilization and does not lead to improved outcomes.

Most recently, a January 2008 report by the Department of Health and Human Services' Office of the Inspector General found that two-thirds of physician-owned hospitals use 9-1-1 as part of

their emergency response procedures and, even more concerning, more than a third of these hospitals use 9-1-1 to obtain medical assistance to stabilize a patient – a practice that violates Medicare conditions of participation. This study was prompted by two separate deaths in physician-owned hospitals where neither hospital had a physician on duty at the time of the emergency, and the staff on duty could not handle post-operative complications.

The AHA believes that the ability of physicians to self-refer presents a clear and significant conflict of interest and needs to be addressed through legislative action. Enactment of a ban on self-referral to physician-owned hospitals is long overdue and necessary this year, to address the clear concerns over conflict of interest and the burden that it places on community hospitals.