



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, the subsequent 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 the economic health of those communities also could suffer. As the second-largest private-sector source of jobs – 5 million nationwide – hospitals play a critical part in our nation's economy. Every dollar spent by a hospital supports more than \$2.00 of additional business activity in the community.

THE IMPACT OF THE ECONOMIC DOWNTURN ON HOSPITALS

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

- The credit crunch has increased the costs of borrowing needed funds, making it more difficult for hospitals to find the money for needed facility and technology improvements. Hospitals saw interest payments on borrowed funds increase by an average of 15 percent from July to September 2008 versus the same period last year.
- Many hospitals are reconsidering or postponing investments in facilities or equipment that communities rely on for care. These include: renovations or plans to increase capacity (56 percent); the purchase of clinical technology or equipment (45 percent); and investments in new information technology (39 percent).
- Many hospitals have noted an increase in the proportion of patients unable to pay for care. According to one AHA survey, uncompensated care increased 8 percent from July to September 2008 versus the same period last year.
- Among a sample of hospitals, total margins fell to *negative* 1.6 percent in the third quarter of 2008 versus *positive* 6.1 percent during the same period last year.
- Hospitals report that financial stress is forcing them to make or consider making cutbacks to meet their obligations. In one recent AHA survey, more than half of hospitals reported plans to reduce staff (53 percent) and more than a quarter of hospitals reported plans to reduce services (27 percent).

WHAT MUST BE DONE

HEALTH CARE COVERAGE FOR THE RECENTLY UNEMPLOYED

Some policy experts project that the unemployment rate could reach 10 percent. In that event, millions would lose job-based health care coverage. And many of these newly uninsured would not be eligible for public programs such as Medicaid and the State Children's Health Insurance Program (SCHIP) because of resource and asset restrictions. A number of options should be considered to ensure coverage for these individuals and their families, as well as assist the providers that serve them.

- **Expedited Medicaid/SCHIP Waivers:** After Hurricane Katrina devastated the Gulf coast, affected states were allowed to temporarily expand Medicaid and SCHIP coverage through an expedited waiver process established by the Centers for Medicare & Medicaid Services (CMS). Through these waivers, states also were authorized to create uncompensated care pools to reimburse providers for the cost of furnishing services to the uninsured who did not qualify for Medicaid or SCHIP. One hundred percent federally financed waivers administered through the Medicaid and SCHIP programs could be established to extend temporary coverage for the newly uninsured. Uncompensated care pools also should be established to help providers cover the cost of furnishing services to the uninsured who do not qualify for Medicaid or SCHIP. Funding could be provided through an enhanced federal matching rate.
- **Section 1011-like Program:** Under the *Medicare Modernization Act* (MMA), the Section 1011 program reimburses providers for uncompensated care provided to undocumented immigrants under the *Emergency Medical Treatment and Labor Act* (EMTALA). A similar program could be created and expanded to help providers cover the cost of furnishing services to the newly uninsured. New provider eligibility criteria could be developed for the expanded program. The funds supporting this program should flow directly from the federal government to the provider.
- **COBRA Temporary Expansion:** The *Consolidated Omnibus Budget Reconciliation Act* (COBRA) gives workers who lose their health benefits through the voluntary or involuntary loss of their jobs, and their families, the right to choose to continue group health benefits provided by their employer by allowing workers to pay the full premium and an administrative fee for up to 18 months. The federal government could subsidize a portion of the COBRA premium for the newly uninsured worker and the COBRA time period could be expanded from 18 months to 36 months.

MEDICAID FMAP INCREASE

The demand for Medicaid services increases during times of economic recession, requiring states to manage the increase in enrollment and subsequent funding pressures at a time when their budgets are stretched thin. Experts estimate that a one percentage point increase in unemployment increases enrollment in Medicaid and SCHIP by one million lives. Forty-four 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. States should be required to maintain their current eligibility and enrollment levels, benefit levels and provider payment rates through maintenance of effort criteria. Any FMAP increase should apply to disproportionate share hospital (DSH) payments, with a corresponding increase in DSH allotments to accommodate the enhanced federal match. These reforms are critical because states already have targeted their Medicaid programs in a search for savings through provider payment freezes or reductions, as well as through 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 will have severe, short-term, negative effects on the pension plans in which they participate, reducing benefits, undermining retirement security and likely leading to additional job losses 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 have to 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.

This fall, the AHA joined with more than 100 other business groups to advocate for making technical corrections to the *Pension Protection Act of 2006* (PPA), including permitting full smoothing of unexpected losses, removing restrictions on asset smoothing, and allowing sufficient time to transition to the PPA's 100 percent funded target.

The *Worker, Retiree, and Employer Recovery Act of 2008*, H.R. 7237, which was signed by the President on Dec. 23, will provide pension funding relief for individual taxpayers and single-employer and multiemployer plans. Specifically, the bill:

- Suspends for one year the minimum required distributions in 2009 for taxpayers who are 70.5 years of age;
- Allows single-employer plans three years to phase-in pension funding target percentages under the PPA;
- Permits single-employer plans to temporarily adjust the PPA's plan contribution, distribution and projected earnings provisions;
- Allows multi-employer plans to elect a three-year extension of current amortization rules to help offset asset losses in 2008;
- Temporarily suspends limits on benefit accruals for participants in underfunded pension plans; and
- Makes technical corrections to provisions of the PPA affecting cash balance pension plans, asset smoothing, market rates of return for governmental plans and other issues.

H.R. 7237 will help many hospitals avert devastating burdens and the inevitable job losses arising from massive contribution increases, and the unavoidable benefit reductions that will be required to comply with those rules. However, more work needs to be done in this area in the 111th Congress to address needed relief for plans that are less well-funded and required to make significant contributions.

HEALTH INFORMATION TECHNOLOGY LOANS AND GRANTS

An immediate investment in health care information technology (IT) is critical to the sustainability and efficiency of our nation's health care system. This notion has strong bipartisan support and has been emphasized repeatedly by President-elect Obama. In his Dec. 6 radio address, he noted that increasing the use of health IT would "cut red tape, prevent medical mistakes, and help save billions of dollars each year." In a Dec. 22 *Washington Post* op-ed, Secretary of Health and Human Services Mike Leavitt also voiced his support for health IT, noting that "supporting health information exchange would be an infrastructure investment that would accelerate public-private cooperation in standards harmonization and certification." He cautioned that investments in infrastructure "should go only toward supporting exchanges of electronic health information that are compliant with nationally recognized standards."

IT is critical to creating the health care system of tomorrow, and robust federal financing is necessary if the benefits of IT are to be realized. Special funding for hospitals and regional health information exchanges should be made available through the Agency for Healthcare Research and Quality (AHRQ) or CMS, in partnership with the Office of the National Coordinator for Health Information Technology (ONCHIT). Many have concerns about how to invest effectively in health IT because of the lack of standard technologies and the difficulties in sharing information within and between hospitals and other providers. However, there are several key areas where immediate federal financing will help to stimulate improvements in health IT infrastructure development, adoption and use, and economic recovery.

Several critical investments in health IT should be made today to help bring about the vision of a modern health system. These investments would support our health IT infrastructure, ensure adoption of certified products and IT standards in all new IT efforts, expand connectivity within communities and assist physicians and other caregivers in re-engineering care processes to incorporate health IT in patient care. Specifically, spending should be targeted to achieve the following goals:

- **Infrastructure improvement:** Basic core IT infrastructure such as broadband access can pave the way for future information exchange, not only within the community but across the country. This would enable all health care organizations to realize the same benefits of time savings, greater efficiency, improved quality of care and patient involvement. For example, many rural hospitals still lack adequate connectivity resources to support health IT software and functions. Ensuring that all hospitals have adequate broadband access is an essential step toward an electronic health record for all Americans.
- **Acquisition and adoption of accepted standards and certified health IT:** Standards already have been established by the Healthcare Information Technology Standards Panel (HITSP) in many areas, and the Certification Commission on Healthcare Information Technology (CCHIT) already has certified many systems. Where standards have been recommended by the HITSP and certified by the CCHIT, they should be utilized and incentives to adopt these systems should be created. These certified clinical IT systems improve quality and patient safety. They include certain electronic health record systems, as well as systems that facilitate medication administration or bar coding of medications, access to current medication lists, allergy lists, electronic prescribing, digital imaging,

laboratory results, patient portals and personal health records, telemedicine, computerized physician order-entry or other decision-support tools.

- **Assisting physicians and other caregivers in re-engineering care process to incorporate health IT in patient care:** Installing health IT alone is not a solution. Making effective use of health IT requires changing both basic processes and an organization's culture. Successful conversions from paper-based systems to clinical IT systems have required evaluation of clinical processes and re-engineering. This was then followed up by physician and caregiver training to allow a smooth transition and efficient use of systems. Ongoing training is essential for successful IT adoption.

Specifically, the AHA supports the following steps for investment:

- **Low-interest Loans for Hospitals:** A program should be established to provide low-interest and/or government-backed loans to hospitals, including critical access hospitals, for expansion of basic IT infrastructure and acquisition of certified, quality-enhancing, clinical health IT. Hospitals that have already invested heavily in health IT but need upgrades or modifications to standardized or certified systems should be eligible for funding as well.
- **Grants for Financially Struggling Hospitals:** Health IT systems are very costly and accessing resources to fund IT projects can be difficult for essential, urban and rural safety-net and/or financially struggling hospitals. AHRQ should develop a grant program for hospitals having difficulty qualifying for loans or retiring loans.
- **Grants for Early Adopters:** As new standards are accepted for use, they should be added to the set of standards used to qualify for incentives. Hospitals using systems that were developed prior to the current certification process, or that were developed internally, should receive incentives to modify their systems to adhere to current interoperability standards.
- **Expand Funding and Ease Disbursement Rules for FCC Broadband Program:** The Federal Communications Commission (FCC) maintains several programs to provide broadband access and other infrastructure to rural hospitals. Specifically, Congress should increase funding for the FCC's Rural Health Care Pilot Program and extend the program for another five years. In addition, the FCC should be required to quickly review and revise its processes to ensure that they cause no undue delays nor create any unforeseen obstacles for eligible providers to get connected. As part of this review, the FCC should include provisions to allow hospitals to provide access to emergency medical facilities, private physician offices and clinics, and nursing homes and other long-term care facilities, as each of these is part of the continuum of care and a basic, networked community.
- **Payment Adjustments under Medicare for Hospitals Using Certified Quality-enhancing, Clinical IT:** The fastest and easiest way to stimulate additional jobs and expansion of health IT is by increasing Medicare payment for hospital services. Hospitals currently using health IT systems that support patient safety or quality of care should receive a temporary 1 percent increase in their Medicare inpatient and outpatient

prospective payment system payments. Hospitals purchasing certified health IT systems also should qualify for the bonus payment.

- **Grants for Health Information Exchange Efforts:** AHRQ should provide grants 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.

HOSPITAL ACCESS TO CAPITAL

Hospitals' ability to borrow money for needed construction, renovation, upgrades and equipment dramatically worsened in 2008. A November 2008 report by the rating agency Moody's stated that the current credit crisis "has limited access to the capital markets for hospitals in recent months, especially for long-term debt issuance." It added, "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 noted, hospitals have experienced a "downturn in financial performance brought about by a weakening economy with increasing bad debt and charity care levels." Moody's concluded that the fundamental credit conditions for hospital borrowing are "pointing in a negative direction." Fitch Ratings on Dec. 2 revised its outlook on not-for-profit hospitals to negative from stable. Fitch stated, "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 continually need to replace aging buildings and equipment, and to upgrade technology to expand treatment options for patients. To fund these investments, hospitals frequently access financial resources through capital markets.

However, 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:

- **Bolster the FHA Section 242 Program:** The current Section 242 Hospital Mortgage Insurance construction loan program (frequently referred to as Section 242) helps hospitals meet their borrowing needs. The Section 242 program, administered by the Federal Housing Administration's (FHA) Office of Insured Health Care Facilities (OIHCF), insures mortgage loans for the construction, rehabilitation, replacement and equipping of hospital facilities, as well as the 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 that the hospital projects it assisted in fiscal year 2008 alone provided an economic stimulus of \$1.65 billion and supported

more than 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. As hospitals find it increasingly costly or difficult 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 Section 242 program. Specifically, changes should be made to:

- Expand eligibility to cover the full array of facilities and services offered by today's hospitals and health systems.
 - Exempt hospitals from the 80 percent real property requirement so that borrowing for expensive new technologies can be insured using Ginnie Mae real estate mortgage investment conduits, significantly reducing financing costs.
 - Provide federal matching funds to help hospitals meet Section 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, which are used within the agency to improve operations.
- **Create a New Construction Grant and Credit Subsidy Program:** A new construction grant and credit subsidy program should be established in FHA's OIHCF for those hospitals currently unable to meet eligibility requirements under the Section 242 program. Financing under this new program should 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 or research and training.
 - **Bolster Bond Default Reissuance Support:** In the current economic environment, some hospitals are finding it difficult to make payments on existing debt. Other organizations find they are in default of a bond issuance because they no longer can 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, it is 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 Term Asset-Backed Securities Loan Facility (TALF)¹, should step in with federal backing of these debts so that they can be restructured. Taking this action would result in an orderly and functioning market for hundreds of billions of dollars of assets currently frozen on the balance sheets of banks, broker-dealers and investors. Hospital auction rate securities and variable rate demand note issuers would be freed

¹ The TALF was announced by the Federal Reserve on November 25, 2008 and is partially funded under the *Emergency Economic Stabilization Act of 2008*.

from high penalty and maximum rates on their “failed” securities, and variable rate demand note issuers would be spared from forced accelerations.

- **Create Incentives to Purchase Tax-exempt Bonds:** The economic recovery 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 percent 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 to help channel additional capital to critical infrastructure projects. First, any stimulus legislation should extend the 2 percent *de minimis* rule to banks, placing them on the same footing as other corporate investors. Second, the \$10 million small issuer exception should be raised to \$30 million. Because the \$10 million level is 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 would allow a hospital to issue bonds through a statewide authority that also issues bonds for other purposes to additional organizations and municipalities. Legislation (H.R. 6333, S. 3518) was introduced during the 110th Congress by Reps. Neal and Frank and Sens. Bingaman and Crapo to accomplish these goals.

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.

WORKFORCE

The demand for registered nurses (RNs) and other health care personnel will continue to rise with the growing health care needs of the 78 million “baby boomers” who will begin to retire in 2010. The Department of Health and Human Services estimates that, by 2020, our nation will need 2.8 million nurses – 1 million more than the projected supply. The Department of Labor in 2006 ranked RNs as the occupation with the highest demand rate. In fact, hospitals reported 116,000 RN vacancies as of January 2007. Almost 88,000 qualified applicants – one in three – were turned away from U.S. nursing programs in 2005-2006, largely due to the lack of prepared nursing faculty. In addition, the Bureau of Labor Statistics projects severe shortages for many allied health professions. Without decisive intervention, these trends will have a serious impact on hospitals’ ability to care for patients and communities.

Two proposals could be included in an economic stimulus package to create jobs and infrastructure:

- **Enhance the Domestic Supply of Nurse Faculty through Capitation Grants to Eligible Schools of Nursing:** To receive a capitation grant, a school of nursing must use the grant to increase the capacity of nursing faculty and students at the school. Grants would be dispersed by formula depending on enrollment of full- and part-time students. Capitation legislation introduced in the 110th Congress (S. 446 and H.R. 772) could address the multiple needs of nursing programs by increasing the number of nursing faculty, supporting the retention of current faculty, and allowing for the purchase of needed equipment to enhance, build or expand clinical laboratory space and infrastructure.
- **Establish a Nurse Training and Retention Demonstration Grant Program:** The program would enable hospitals to develop programs within the work environment designed to retain nurses in the profession. Recent studies of the costs of nurse turnover have reported results ranging from about \$22,000 to more than \$64,000² (U.S.) per nurse turnover. Furthermore, nursing research has shown that investment in programs that support professional nurses in hospitals is associated with lower Medicare mortality rates, higher levels of patient and nurse satisfaction, and lower turnover rates.

In addition, the federal government should fully fund the Nurse Loan Repayment and Scholarship Program. In 2008, neither section of the program had sufficient funds to meet the demands of nursing students seeking support. Students who apply for the Nurse Loan Repayment and Scholarship Program are individuals who are enrolled or accepted for enrollment in schools of nursing. The federal government has the opportunity to ensure that these nursing students continue their education, meet the health care needs of the nation and help stimulate the economy. Based on the funding level in 2008 (\$31.51 million) and the number of students supported (604), the federal government could provide support to nearly 4,000 nursing students if both sections of the Nurse Loan Repayment and Scholarship Program received a total of \$200 million.

REVERSE COURSE ON BACKDOOR BUDGET CUTS

A number of regulatory decisions were promulgated over the last two years that, if finalized, will have a devastating effect on hospitals' financial well-being. It is critically important, particularly in these times of great economic uncertainty, that these rules, which amount to nothing more than backdoor budget cuts, not be allowed to stand.

FINAL RULES THAT SHOULD BE OVERTURNED

- **Payment Cuts to Teaching Hospitals:** Reductions to Medicare capital indirect medical education (IME) payments, which went into effect on Oct. 1, will eliminate \$1.3 billion over five years from payments to 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 with implementation of this rule. As a result, teaching hospitals in 2009 will receive half their capital IME adjustment; in 2010 and beyond, the adjustment is eliminated. This unnecessary cut ignores how vital capital improvements are to investment in the latest medical technology and ongoing maintenance and improvement of hospital facilities. Congress should overturn this cut.

² Advisory Board, 1999; Jones, 2005; OBrien-Pallas et al., 2006.

- **Medicaid Outpatient Rule:** This final rule, which took effect Dec. 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 is narrowly defining Medicaid hospital outpatient services to align Medicaid with Medicare. The effect will 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 this 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 moratorium was part of the *Supplemental Appropriations Act of 2008*, but it was dropped during negotiations between the White House and House leadership. Given the bipartisan support for preventing the outpatient regulation from moving forward, Congress should overturn this rule.

- **Medicaid DSH Reporting and Auditing Regulation:** On Dec. 19, CMS issued a final rule implementing the Medicaid DSH reporting and auditing requirements contained in the MMA. The rule will go into effect on Jan. 19. While the AHA has long advocated for greater transparency in the operation of the Medicaid DSH program and more consistent federal standards, the final rule fails to achieve these goals and makes substantive policy changes that clearly exceed congressional intent. The rule alters the definition of uncompensated care to largely exclude both bad debt and physician services, despite the fact that the MMA left the underlying law governing DSH limits in place, and that Congress expressed no concern about the calculation of uncompensated care costs. The policy changes to the Medicaid DSH program, which is a lifeline for many safety-net hospitals across the country, will have a significant negative impact on these organizations. The rule should be withdrawn.
- **TRICARE Outpatient Prospective Payment System (OPPS) Rule:** The Department of Defense (DoD) on Dec. 8 released its TRICARE outpatient prospective payment system (OPPS) final regulation, which adopts most of the Medicare OPPS payment weights, rates and policies. TRICARE provides health insurance for active-duty military service members, retirees and their families. This final rule will reduce hospital revenues by \$458 million in its first year of implementation, beginning May 1, 2009.

In order to buffer the significant decrease in payments, DoD will implement a transition that is woefully inadequate. The loss of \$458 million in hospital outpatient revenues in the first year alone – a 25 percent cut from pre-OPPS levels – is unsustainable. Additionally, the first year cuts are a harbinger of even greater annual losses over the course of the transition period. DoD rejected the AHA’s recommendations for an annual 15 percent stop-loss payment reduction limit for all TRICARE OPPS services for network hospitals that would remain in place until TRICARE rates are in line with Medicare rates. DoD also ignored concerns expressed in writing by 57 senators urging TRICARE to provide a crucial broad and effective transition that covers all services, similar to what Medicare included when it adopted the OPPS or what TRICARE included when it transitioned physicians to the Medicare physician fee schedule. This is not the time for payment reductions to hospitals and a new regulation with adequate transitional policies should be proposed and adopted. The rule should be withdrawn.

MEDICAID REGULATIONS CURRENTLY SUBJECT TO MORATORIUM

The following regulations would severely restrict Medicaid funding. They have been blocked by legislation through a moratorium that expires on March 31, 2009. The AHA, along with other health care providers and state Medicaid program officials, believes that these rules should be withdrawn so as not to negatively affect the Medicaid program during this health care crisis.

- **Medicaid Cost-limit Rule:** This final 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 also would 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) Rule:** This 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 that would cut nearly \$2 billion in federal support for training physicians when the demand for health care professionals is high. It also would place safety-net hospitals in financial jeopardy.
- **Medicaid Provider Tax Rule:** This final 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 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 the 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 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.