



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

**Testimony
of the
American Hospital Association
before the
Committee on Energy and Commerce
of the
U.S. House of Representatives**

"H.R. 5613, Protecting the Medicaid Safety Net Act of 2008"

April 3, 2008

Good morning, Mr. Chairman. I am Jim Buckner, administrator of Uvalde Memorial Hospital (UMH) in Uvalde, Texas. On behalf of the AHA's nearly 5,000 member hospitals, health systems and other health care organizations, and our 37,000 individual members, I appreciate the opportunity to share with you and your colleagues the hospital field's strong support for H.R. 5613, the "Protecting the Medicaid Safety Net Act of 2008." This much-needed legislation will prevent, for one year, the Centers for Medicare & Medicaid Services (CMS) from imposing regulations that would do harm to the health care services America's most needy people rely on.

My hospital is located in southwest Texas and serves five counties in the sparsely populated Edwards Plateau/brush country region. UMH has 66 beds with eight intensive care units; 11 maternity rooms with fetal monitoring equipment; surgical suites; an intermediate intensive care unit; and a 24-hour emergency department. We also provide a broad array of services in this rural area of Texas, such as pharmacy, hospice, rehabilitation and case management. The hospital recently added a triage area and four new fast-track emergency treatment areas. Each month we average 179 surgeries, 38 obstetrical deliveries, 1,200 emergency department visits, and 204 inpatient admissions. And, to the subject of today's hearing, 20 percent of our patients are covered by Medicaid. Moreover, 89 percent of our newborns are covered by Medicaid. So it is clear that any changes in Medicaid reimbursement will have a direct impact on our ability to serve the people who need us.



For more than 40 years, Medicaid has served as the nation's health care safety net, providing access to health services for millions who cannot afford private insurance. Today, more than 57 million children, poor, disabled and elderly people rely on Medicaid for care. The program now serves more people than Medicare. With the ranks of the uninsured growing, and the threat of an economic recession looming, the importance of Medicaid to so many people's lives and health is being magnified even as it is being jeopardized.

Hospitals like mine are the backbone of America's health care safety net, providing care to all patients who come through their doors, regardless of ability to pay. But, hospitals experience severe payment shortfalls when treating Medicaid patients. In 2006, Medicaid paid hospitals only 86 cents for every dollar it cost them to treat Medicaid patients. That same year, hospitals provided more than \$31 billion in care for which no payment was received. Despite these financial pressures, the Administration continues to call for further cuts in federal support for the Medicaid program.

THE FEDERAL BUDGET AND THE CMS REGULATIONS

Since early 2007, CMS has issued seven regulations, in either proposed or final form, that would significantly affect the Medicaid program's financial support for hospitals and Medicaid services provided to children, families, the elderly and the disabled. The Administration estimates that these rules would reduce federal spending by \$15 billion over five years. However, a report issued in March 2008 by the House Committee on Oversight and Government Reform estimates the fiscal impact of these rules at nearly \$50 billion over five years. CMS asserts that the majority of these regulations are necessary to address problems, particularly with the financing of the program. But, in the written justification for the regulations, CMS failed to identify any significant or widespread problems.

Despite concerns raised by Congress, states and providers, CMS has continued to move toward implementation of the regulations. Implementation would, among other things, limit payments for public hospitals and hospital outpatient services and reduce school-based services for children and case management for the disabled. The AHA has joined a broad-based coalition of 131 organizations, including advocates, labor, physicians and others who oppose these regulations. In addition, the National Governors' Association has called for a moratorium on the rules. The following are the regulations that directly affect hospitals.

REGULATIONS UNDER THE CONGRESSIONAL MORATORIUM

Congress has imposed a year-long moratorium, secured by P.L. 110-28, on two regulations: the proposed and final cost-limit rule; and the proposed graduate medical education (GME) rule. The existing moratorium on implementation of these rules expires May 25, 2008.

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 transfers (IGTs) and certified public expenditures (CPEs). It would also limit reimbursement for government-operated hospitals to the cost of providing Medicaid services to the program's 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 recognized – are in stressed financial circumstances and are most in need of enhanced payments. CMS estimates that the rules would reduce federal Medicaid support by \$5 billion over five years, cuts that would undermine states' and hospitals' ability to make sure Medicaid beneficiaries get the care they need. The cuts would also hurt states' and hospitals' substantial investments in 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.

The supplemental Medicaid payments that UMH has received through the Texas Rural Upper Payment Limit program have been essential to our ability to keep our hospital's doors open. In 2007, UPL payments provided \$1.6 million, or 3.2 percent, of our operating budget. UPL payments have made the difference in being able to invest in new technology and building improvements since the program started in FY 2003.

If the Medicaid cost-limit rule is implemented, Texas hospitals overall expect an 80 percent reduction to the Texas Rural UPL program in which UMH participates. We would struggle to fill that budget gap and would be forced to immediately consider deferring acquisitions of technology, especially in areas like electronic medical records, and deferring renovations to our 35-year-old hospital. Also, a number of services we provide to improve the quality of life for our rural residents could be eliminated. They include our hospice program and a diabetic outreach program. Furthermore, the community and the medical staff count on the hospital to recruit primary care physicians and specialists to our community to improve the medical safety net. UPL dollars help make initial support of these physicians possible.

Intergovernmental transfers have been utilized for at least two decades in Texas. Public hospitals have been putting up the match that our state does not provide because of budget constraints. The Texas Rural UPL program has operated very openly and with no abuse of the system. As best as I can determine, rural Texas public hospitals have only been able to keep from closing their doors thanks to two major funding interventions: the Texas Rural UPL program and the Critical Access Hospital program. As a result, rural, needy, and Medicaid-eligible Texans have retained access to their rural safety net hospitals.

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 recognizing GME as medical assistance. This rule would cut nearly \$2 billion in federal support for the Medicaid program. The finalization of this new policy would throw many safety-net hospitals into financial jeopardy, ultimately harming the most vulnerable of our citizens.

REGULATIONS NOT CURRENTLY UNDER CONGRESSIONAL MORATORIUM

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 when calculating the hospital outpatient UPL. Under the proposed rule, the types of services that might not be reimbursed through hospital outpatient programs include: 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 attempts to justify this dramatic policy shift by citing a 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. Despite these differences, CMS proposes to narrowly define Medicaid hospital outpatient services in order to achieve its goal of aligning Medicaid with Medicare. The effect of aligning the hospital outpatient policies for these two programs would be to limit Medicaid federal support for hospital outpatient programs and state Medicaid programs overall, and to ultimately limit the services needed by Medicaid patients.

Provider Tax Rule. This final rule would change Medicaid policy on health care-related taxes that are used by 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 to determine the existence of hold-harmless arrangements. These 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.

IN THE COURTS

With the May 25 deadline looming, the AHA and others are also pursuing a litigation strategy. The AHA, National Association of Public Hospitals, Association of American Medical Colleges and the Alameda County (CA) Medical Center, with the support of several other hospitals and the National Association of Children's Hospitals, filed suit in U.S. District Court for the District of Columbia to reject CMS' policies, specifically asking the Court to prevent the administration from implementing the Medicaid regulation that would cut some \$5 billion in funding by restricting how states fund their Medicaid programs and pay public hospitals. The grounds of the suit are these:

- CMS has overstepped its authority in dictating to states the governmental status of entities within their jurisdiction;

- Congress has barred the agency from imposing a cost limit on Medicaid payments to governmental providers;
- CMS improperly issued the rule on the very day – May 25, 2007 – that a congressional moratorium took effect to block the rule for one year.

Alameda County (CA) Medical Center, the lead plaintiff in the case, estimated in the court filings that the Medicaid cost-limit rule alone would result in a loss of approximately \$85 million in supplemental Medicaid payments. That is a 19 percent loss in the hospital's operating budget, a number that threatens the hospital's very existence. Cutbacks in critical services like trauma care, acute psychiatric care and outpatient specialty clinic services, as well as staff downsizing, might not be enough to make up for the resulting gap in their financial operating budget.

Hurley Medical Center in Flint, Michigan, also joined the lawsuit as a declarant. Hurley noted in court documents that they expect to lose anywhere from \$6 million to nearly \$13 million in Medicaid supplemental payments because of the rule's policy changes. The hospital, which provides 66 percent of the uncompensated care provided in its region, is already operating at a deficit. It would not be able to sustain this magnitude of payment cuts.

CONCLUSION

Mr. Chairman, we applaud your leadership, and that of your colleague, Rep. Tim Murphy (R-PA), in introducing H.R. 5613, the "Protecting the Medicaid Safety Net Act of 2008." By extending until March 31, 2009, the moratorium on several Medicaid regulations and including other regulations as part of the moratorium, your bill would prevent some \$20 billion from being stripped from Medicaid. It accomplishes this by delaying implementation of regulations affecting CPEs and IGTs; GME; rehabilitation services for people with disabilities; outreach and enrollment in schools and specialized medical transportation to school for children covered by Medicaid; coverage of hospital outpatient services; case management services that allow people with disabilities to remain in the community; and state provider tax laws.

As you well know, many in Congress have expressed their opposition to the CMS rules. Legislation introduced earlier in the year to extend the moratorium on rules specific to hospitals has strong bipartisan support in the House and Senate.

The weight of these new regulatory policy decisions is hurting hospitals and state Medicaid programs that already are reeling under many other pressures, from a costly workforce shortage to higher demand for services, and from higher costs due to the onset of a recession. Yet, Congress and the general public have been largely excluded from CMS' decision-making process. The agency's regulatory budget-cutting policies will have a devastating effect on America's poor children and mothers, disabled and elderly, and the caregivers who want to help them.

We again thank you for your leadership on this issue, and we urge all of your colleagues to support your legislation to delay implementation of these harmful policy changes.