UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ALAMEDA COUNTY MEDICAL CENTER,	)	
et al.	)	
Plaintiffs,	)	
v.	)	
THE HONORABLE MICHAEL O. LEAVITT, in his official capacity as Secretary, United States Department of Health and Human Services,	)	Case Number:
et al.	)	
Defendants.	)	

DECLARATION OF CHRISTINE CAPITO BURCH

I, Christine Capito Burch, make the following declaration pursuant to 28 U.S.C. § 1746:

1. I am the Executive Director of the National Association of Public Hospitals and Health Systems ("NAPH"). I submit this declaration in support of Plaintiffs' complaint and motion for a preliminary injunction in the above-referenced action against Defendants. I am of legal age and competent to testify.

2. This declaration is made on personal knowledge, information contained in NAPH's files upon which I normally rely, publicly available information, and other factual matters known to me.

3. I have served as Executive Director for NAPH for 18 years. Prior to that, I worked for the New York City Health and Hospitals Corporation, the largest municipal health care system in the country.

4. NAPH is a non-profit corporation incorporated under the laws of the District of Columbia. NAPH is headquartered in the District of Columbia.

5. NAPH represents its members' interests in matters before Congress, the Executive Branch, and the courts, as well as with other public and private entities.

6. NAPH is a trade association that represents more than 100 metropolitan area safety net hospitals. Our members fulfill a unique and critical role in the health care system, providing high intensity services—such as emergency and trauma care, neonatal intensive care, and burn care—to the entire community. In 2005, the latest year for which we have data, NAPH members provided 64 percent of all burn care beds in their communities and represented 54 percent of all Level I trauma centers.

7. NAPH members are also the primary hospital providers of care in their communities for Medicaid recipients and many of the more than 46 million Americans without insurance. NAPH hospitals represent only 2 percent of the acute care hospitals in the country, but provide 22 percent of the uncompensated hospital care provided across the nation. Based on the latest available data, 29 percent of the services provided by our members is to Medicaid patients and 20 percent to self-pay patients, the overwhelming majority of whom are uninsured or are covered by state and local indigent care programs.

8. Because of the services provided by NAPH members, they are highly reliant on federal funding sources to sustain their operations, and they are particularly reliant on Medicaid revenues. In 2005, more than two-thirds of revenues for public hospitals came from federal,

state, and local payment sources: 33 percent from Medicaid, 21 percent from Medicare, and 14 percent from state and local subsidies. An additional 25 percent of revenues came from commercially insured patients, while payments from self-pay patients accounted for 4 percent of net revenues. The remaining 3 percent of revenue were the result of payments from "other" insurance types such as Worker's Compensation and Veterans' Health Care.

9. Public hospitals and health systems, unlike other providers, are unable to shift cost to commercial payers because of their significantly greater amounts of uncompensated care and reduced commercial revenues. Thus, they rely to a much greater extent on Medicaid to help ensure access to care.

10. Public hospitals experience greater financial pressures than other hospitals nationally. In 2005, the average margin for NAPH members was 3.0 percent; this is 2.3 percentage points lower than the average margin of 5.3 percent for all hospitals in the United States. Hospitals with low margins are unable to finance working capital or reinvest in hospital infrastructure and new technology. Furthermore, 40 percent of NAPH members had negative margins, meaning that their expenditures exceeded their revenues in that fiscal year.

11. As the Medicaid program has evolved, States have established critical supplemental Medicaid payments to support safety net providers. These supplemental payments are targeted additional payments that states typically make above and beyond base Medicaid reimbursement to help support their mission or particular aspects of their mission. NAPH members rely heavily on supplemental payments for financial viability. Even with supplemental payments, the majority of NAPH members had margins lower than 2 percent in 2005. Without these payments, overall NAPH member margins would drop to negative (-) 7.8 percent. Public hospitals could

not long survive with such negative margins. They would be forced to curtail or close services on a large scale.

12. On January 18, 2007, the Centers for Medicare & Medicaid Services ("CMS") proposed the regulation, *Cost Limit for Providers Operated by Units of Government and Provisions To Ensure the Integrity of Federal-State Financial Partnership*, 72 Fed. Reg. 2236 ("Proposed Rule"), Ex. 16. Among other things, CMS proposed to upend decades of Medicaid law to 1) limit Medicaid payments for government-operated hospitals to the costs of providing Medicaid services to Medicaid recipients, and 2) narrow the definition of units of government eligible to contribute to the non-federal share of Medicaid expenditures.

13. NAPH timely filed comments with CMS, outlining our opposition to these new policies and their devastating impact on safety net hospitals and Medicaid beneficiaries' access to care. A true and correct copy of NAPH's comment letter from March 8, 2007 is attached hereto and made a part hereof as Exhibit D.

14. Based on our review, CMS received roughly 400 comment letters from stakeholders responding to the proposed version of the Rule. These commenters included hospitals, numerous State Medicaid agencies, national and State hospital associations, and other providers. None of these stakeholders wrote in support of the Rule, and the vast majority (over 300) called for CMS to withdraw or delay the Rule. The remaining comments requested that CMS amend or clarify the Rule's provisions.

15. We met several times with Administration and CMS officials to explain the concerns laid out in our comment letter and the potentially underestimated impact of this rule on public hospital systems, and to ask CMS to withdraw the Proposed Rule. Meetings occurred in February and May with officials from the White House and CMS.

16. NAPH and its members turned to Congress to pass a moratorium that would delay implementation of the Proposed Rule, to provide Congress the opportunity to fully consider the complex issues involved and to legislate as necessary. Members of both the House and the Senate expressed significant, bipartisan opposition to the rule. In February 2007, 43 Senators sent a letter to the Finance Committee Leadership (Exhibit B) and 226 Members of the House sent a letter to the Energy & Commerce and Ways & Means Committee leadership (Exhibit C) stating their opposition to the Rule and the negative impact it would have on public providers and their patients. In March 2007, 60 Senators (Exhibit G), 153 Representatives (Exhibit H), and the Texas delegation to Congress (Exhibit E) sent letters to Department of Health and Human Services Secretary Leavitt expressing their concerns. In December, 2007, 62 senators sent a letter to leadership of the Senate Finance Committee, House Ways and Means Committee, and the Energy and Commerce Committee, expressing opposition to the rule. (Exhibit A) Based on these letters, 263 members of the House and 69 Senators are on record in opposition of the Rule as of March 2008.

17. In March of 2007, Congress approved a one-year moratorium attached to an emergency supplemental appropriations bill that was vetoed for unrelated reasons. Two months later, Congress again included the one-year moratorium in the U.S. Troop Readiness, Veterans' Care, Katrina Recovery and Iraq Accountability Appropriations Act of 2007, which it passed on May 24, 2007. On May 25th, the President signed the legislation into law. Ex.11, U.S. Troop Readiness, Veterans' Care, Katrina Recovery and Iraq Accountability Appropriations Act of 2007, Sec. 7002(a) (Pub. L. No. 110-28).

18. CMS purported to issue a final version of the rule by putting it on display at the Federal Register on May 25, 2007. Ex.17, 72 Fed. Reg. 29748 (May 29, 2007) ("Rule") NAPH

submitted a comment letter on July 13, 2007 in response to the Rule. A true and correct copy of NAPH's supplemental comment letter is attached hereto and made a part hereof as Exhibit I.

19. As explained in detail in the attached NAPH comment letters, the Rule, if implemented, will in short order dismantle the intricate system of Medicaid-based support for America's health care safety net, seriously compromising access for Medicaid and uninsured patients. The result of this regulation will be a severely compromised safety net health system, unable to meet current demand for services and incapable of keeping pace with the fast-paced changes in technology, research and best practices that result in the highest quality care.

20. The President's budget for Fiscal Year 2008 estimates that this Rule will cut $5 billion in federal Medicaid participation between 2008 and 2012. Ex.15, FY 2008 Budget of the President of the United States.

21. The comment letters express our concern that a payment limit based on costs would be inefficient and burdensome, and a step back from efforts to bring cost-effective market principles into federal health programs. Prospective payment systems are structured to encourage health care providers to eliminate excess costs by allowing them to keep payments above costs as a reward for efficiency. Cost-based reporting and reimbursement will incentivize providers to increase costs and eschew efficiencies in order to preserve revenues. It will also impose enormous new administrative burdens on states and providers, as they engage in cost reconciliation processes that are not currently required and could last for years beyond when services are provided.

22. This cost-based limit on government-operated providers will eliminate billions of dollars of support payments that have traditionally been used to ensure that the nation's poor and uninsured have access to a full range of primary, specialty, acute and long term care, without any

plan for replacement funding. The cuts will restrict funding that has ensured that our communities are protected with adequate emergency response capabilities, highly specialized but under-reimbursed tertiary services (such as trauma care, neonatal intensive care, burn units and psychiatric emergency care), and trained medical professionals.

23. Individual NAPH members estimate millions and even hundreds of millions of dollars in lost federal funding. This magnitude of lost funding will have significant impacts on our members' operations, if they are even to remain viable. For example, members have reported that they will have to: dismantle significant components of our ambulatory care system and scale down emergency departments; cut services and increase the time that patients wait to get treatment; reduce primary and preventative services, resulting in a much greater downstream cost to all; close nursing units or eliminate inpatient beds, which would have a direct impact on services to the residents; and close down teaching programs, jeopardizing the training of physicians who serve in their communities. Representatives of beneficiary advocate groups in letters to Congress have asked Congress to stop this rule (along with other Medicaid rules issued by CMS) to avoid reducing access to care for Medicaid patients and the uninsured which they state would be seriously harmed by these rules.

24. NAPH understands that in testimony before Congress during the week of February 25, governors asked Congress to stop the regulations, noting the severe impact on states and their ability to fund their Medicaid programs, particularly in light of the worsening economy. Based on communications between NAPH members and their state Medicaid agencies, it is our understanding that states will be unable to make up the shortfalls caused by the lost federal funds. Many of our members are in states that are already facing fiscal crises. For example, California is now facing a budget deficit of at least $16 billion.

25. The comments further explain that the Rule's severely constrained definition of a unit of government eligible to contribute funds to the non-federal share of Medicaid expenditures is overly restrictive and inconsistent with the language and statutory framework of the Medicaid statute, Title XIX of the Social Security Act.

26. Our membership includes safety net hospitals with a wide range of governmental structures that are not included under the restrictive new definition of a unit of government under the Rule. Some of our public hospital members, many of which were originally created as part of the state or county government, have modified their governance structures to gain the flexibility needed to more efficiently provide care. These public hospitals nevertheless retain their public mission, often as specifically directed by state or local law, and continue to possess many attributes of governmental status, despite not having taxing authority or direct access to tax revenues.

27. The NAPH members excluded from this definition will no longer be eligible to fund the non-federal share of State Medicaid expenditures. The loss of this funding and the resulting federal matching funds will reduce, if not eliminate, supplemental Medicaid payment programs, as such supplemental payments are frequently possible only when a local public entity is willing to provide at least a portion of the non-federal share of funding. NAPH members will be particularly impacted by this change in policy because of their dependence on supplemental payments.

28. The comments also contain our concern that CMS did not provide sufficient data to support its estimated savings from the spending cuts in the Rule. In its Regulatory Impact Analysis, CMS asserts that the Rule will not have a significant impact on providers for which relief should be granted, and it projects "this rule's effect on actual patient services to be

minimal." It estimates $3.9 billion in federal savings from the Rule from 2007 to 2011, but provides no detail on how it derived this estimate or how a reduction of $3.9 billion could result in a "minimal" effect on patient services. The President's Budget for Fiscal Year 2008 estimates that the Rule will cut $5 billion in federal Medicaid participation between 2008 and 2012. Ex. 15.

29. NAPH has surveyed its members, about the impact of the Rule on providers, on patients and on total federal Medicaid funding provided to states. Based on NAPH data assessing impact to public hospitals in these States, the estimated statewide loss of federal dollars is $932 million in Florida, $550 million in California, $103 million in Georgia, $235 million in Tennessee, and $480 million in Texas.

30. NAPH continues to advocate on behalf of its members to prevent implementation of this Rule. Members of Congress have shown significant report for extending the existing moratorium. NAPH members testified before the House of Representatives Committee on Oversight and Government Reform regarding the impact of this Rule and a string of additional Medicaid rules issued by CMS over the last year that would cut billions of dollars more from the Medicaid program.

31. NAPH is authorized by its Executive Committee to bring this suit on behalf of its members.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on: March 11, 2008
Washington, DC

(Signature): _____

Christine Capito Burch
Executive Director
National Association of Hospitals
and Health Systems