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Statement for the Record
of the
American Hospital Association
before the
Committee on Oversight and Government Reform
of the
U. S. House of Representatives

"The Administration's Regulatory Actions on Medicaid:
The Effects on Patients, Doctors, Hospitals, and States"

November 1, 2007

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 37,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to submit this statement for the record for the committee's hearing to examine the administration's recent Medicaid regulatory actions. The committee is rightfully concerned that these regulatory actions amount to significant policy changes that may have a negative effect on state Medicaid programs, the hospitals and physicians serving this vulnerable population and, most importantly, the patients themselves.

Since late December 2006, the Centers for Medicare & Medicaid Services (CMS) has issued half a dozen regulations in either proposed or final form that will significantly affect the Medicaid program's financial and administrative support for hospitals. The majority of these regulatory actions have been described by CMS as necessary to root out problems, particularly with the financing of the program. However, in the written justification for these regulations, CMS suggests that no significant or widespread problems have been identified. Yet, CMS continues to move forward in the face of significant concerns raised by Congress, the states and the provider and advocacy communities.

REGULATIONS UNDER CONGRESSIONAL MORATORIUM

Cost-limit Proposed and Final Rules: Of critical importance are two regulations upon which Congress has imposed a year-long moratorium, as secured by P.L. 110-28. The first regulation restricts payments to financially strapped government-operated hospitals, narrows the definition of hospitals qualifying as public hospitals, and restricts state Medicaid financing through intergovernmental transfers and certified public expenditures. It limits reimbursement for government-operated hospitals to the cost of providing Medicaid services to Medicaid recipients. In addition, the rule restricts 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 will have significant practical implications for public hospitals, particularly those that have restructured to achieve gains in efficiency. This regulation is effectively a cut in funding for those public hospitals and safety-net providers that – as CMS has recognized – are in stressed financial circumstances and are most in need of enhanced payments. These cuts will undermine the ability of states and hospitals to ensure quality of care and access to services for Medicaid beneficiaries, as well as to continue their substantial investments in health care initiatives to promote the Department of Health and Human Services' policy goals, including adoption of electronic health records, reducing disparities in care provided to minority populations, and enhancing access to primary and preventive care.

GME Rule: The second rule subject to the Congressional moratorium proposes to eliminate any federal Medicaid support for graduate medical education (GME). This regulatory action represents a substantial departure from long-standing Medicaid policy by no longer permitting matching federal dollars for hospitals' GME costs. CMS claims this rule is a clarification, when in fact it reverses over 40 years of agency policy and practice recognizing GME as medical assistance. The agency's recent action will result in a cut of nearly $2 billion in federal funds from the program. Finalizing this new policy will put many safety-net hospitals in financial jeopardy, ultimately harming the most vulnerable Medicaid beneficiaries served by these hospitals.

OTHER REGULATIONS

Outpatient Rule: CMS recently issued a proposed rule that substantially departs from long-standing Medicaid policy regarding the definition of Medicaid outpatient hospital services and how costs for such services are treated for the purposes of calculating the hospital outpatient UPL. Under the proposed rule, the types of services 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 therapy; outpatient clinical diagnostic laboratory services; ambulance services; durable medical equipment; and outpatient audiology services. CMS says this dramatic shift in policy is needed to align Medicaid and Medicare outpatient polices, despite the fact that these programs serve very different populations – Medicaid serves a largely pediatric population, while Medicare serves an elderly population. The effect of "aligning" the Medicaid policies with

Medicare would be to limit overall Medicaid federal spending for hospital outpatient programs and state Medicaid programs.

Provider Tax Rule: The proposed provider tax rule makes changes to Medicaid policy on health care-related taxes used by the states to help support their share of Medicaid expenditures. The AHA specifically objects to CMS' changes to the standards for determining whether an impermissible hold-harmless arrangement exists within a health care-related tax. The rule represents a substantial departure from long-standing Medicaid policy by imposing largely subjective, overly broad standards for determining the existence of hold-harmless arrangements. These proposed policy changes will 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 will unduly limit states from implementing legitimate provider tax programs that are consistent with the Medicaid statute and congressional intent.

Drug Rebate/NDC Reporting Rule: CMS, in issuing regulations implementing the Medicaid Drug Rebate program provisions of the *Deficit Reduction Act of 2005*, has chosen to expand a requirement imposed on state Medicaid agencies to collect National Drug Code (NDC) numbers. This regulation expands the NDC reporting requirement for "physician administered" drugs to drugs administered in hospital outpatient settings that are properly exempt. The underlying statute is clear that drugs administered by a medical professional in most hospital outpatient clinic settings are exempt from the Medicaid Drug Rebate program and the new NDC reporting and collection requirements. This policy change is inconsistent with the statute and will result in costly and burdensome reporting requirements for hospitals already straining under tight financial resources.

CONCLUSION

Hospital and state Medicaid programs are hard hit by these new regulatory policy decisions, and Congress and the general public have often been excluded from these policy decisions. The impact of CMS' policies is to limit federal spending and affect access to needed services. And the most significant impact will be felt by the poor children and mothers, the elderly and the disabled that are served by the Medicaid program.