March 26, 2009

William Corr
Deputy Secretary
Department of Health and Human Services
200 Independence Ave. SW, Room 120F
Washington, DC 20201

Dear Mr. Corr:

On behalf of the members of the American Hospital Association (AHA), the Association of American Medical Colleges (AAMC), the Federation of American Hospitals (FAH), the National Association of Children's Hospitals (N.A.C.H.) and the National Association of Public Hospitals and Health Systems (NAPH), we urge the Obama Administration to take swift action to ensure that harmful regulations issued in the final years of the Bush Administration do not take effect and/or are not further implemented.

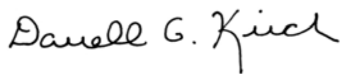
In particular, the following regulations are of most concern to hospitals:

- **Medicaid Outpatient Hospital Services Final Rule**
  73 Fed. Reg. 66,187 (Nov. 7, 2008). This rule narrows the definition of Medicaid outpatient hospital services to exclude many services currently reimbursed as hospital services by states, dramatically restricting payments.
- **Medicaid Disproportionate Share Hospital Audit and Reporting Final Rule**
  73 Fed. Reg. 77,904 (Dec. 19, 2008). This rule goes far beyond implementing the auditing and reporting requirements of the Medicare Modernization Act of 2003 to restrict the type and nature of the hospital costs that states can reimburse through DSH payments.
- **Elimination of Medicare Indirect Medical Education Adjustment for Capital Costs**
  42 C.F.R. § 412.322(d). This regulation eliminates Medicare capital indirect medical education (IME) adjustments, which ensure a stable revenue source for capital financing at our nation's teaching hospitals.
- **Proposed Rule Limiting Medicaid Payments for Public Providers to Cost**
  72 Fed. Reg. 2,236 (Jan. 18, 2007). This rule would limit reimbursement for government providers to a narrow definition of cost and restrict the definition of a unit of government eligible to contribute to the non-federal share of Medicaid expenditures.
- **Proposed Rule Eliminating Graduate Medical Education Payments Under Medicaid**
  72 Fed. Reg. 28,930 (May 23, 2007). This rule would eliminate the federal match for payments for graduate medical education (GME) costs and exclude direct GME payments from the calculation of the upper payment limit.
- **Proposed Rule Limiting Federal Medicaid Reimbursement for Certain Rehabilitative Services**
  72 Fed. Reg. 45,201 (Aug. 13, 2007). This rule would narrow the definition of Medicaid rehabilitative services to, among other things, exclude services that are "intrinsic elements" of programs other than Medicaid, such as foster care, child welfare, education, and child care.

The Medicaid program is a critical source of support for the safety net, ensuring the viability of hospitals providing access to care for low income and vulnerable populations. Public funding for graduate medical education, including the funding at risk in these regulations, is very important to our nation's teaching hospitals. If allowed to move forward, these regulations will result in many billions of dollars in reductions in federal funding for the safety net, with a significant impact on access to care. These rules will disrupt existing funding systems on which hospitals depend to provide care to Medicaid and uninsured patients, to provide access to specialty services to all members of their communities, and to train our future physicians and nurses. As a result, the hospital community, along with states and beneficiaries, have opposed these regulations, as expressed in the many comment letters CMS received. Congress has shared these concerns and temporarily delayed some of these rules, but the moratoria expire on April 1 and July 1, 2009.

On behalf of our members, we request that the Obama Administration take swift action, outlined in the attached white paper, to ensure that these regulations do not take effect and to provide adequate time for reevaluation of their underlying policies. Please contact Claudine Swartz, NAPH Assistant Vice President for Policy, at (202) 585-0103 if we can be of any assistance.

Respectfully,



Darrell G. Kirch, M.D.
President and CEO
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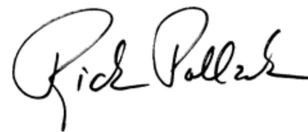
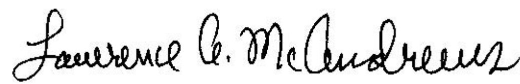


Rick Pollack
Executive Vice President
American Hospital Association

Chip Kahn
President
Federation of American Hospitals



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cc: Rima Cohen
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ADMINISTRATIVE ACTIONS REQUESTED TO PROTECT HOSPITALS AND THEIR PATIENTS

1. Rescind the Medicaid Outpatient Hospital Services Final Rule Before July 1, 2009.

This final rule narrows the definition of Medicaid outpatient hospital services to exclude many services currently reimbursed as hospital services by states, dramatically restricting payments.[1] CMS will no longer permit many services provided by hospitals to be reimbursed as outpatient hospital services (e.g., laboratory services, dental care, routine vision, psychiatric, observation, physician services, and provider-based FQHC services). We are aware of at least one state that, based on this rule, was refusing to pay anything to a hospital if the service was not unique to the hospital setting, despite contrary practice under Medicare. Such reductions in Medicaid outpatient hospital payments will undermine the critical role of hospitals in ensuring access to ambulatory care for uninsured and Medicaid patients in their communities.

In the 2009 American Recovery and Reinvestment Act (ARRA), Congress imposed a moratorium until July 1, 2009 on implementation of this rule, which became effective on December 8, 2008. States will begin or resume implementation of this rule on July 1 in the absence of administrative action.

While the federal court decision in *Alameda County Medical Center et al. v. Leavitt* invalidated the public provider cost limit final rule as violating a congressional moratorium, the ruling had no impact on the implementation of the outpatient hospital services rule.[2] Therefore, without swift rulemaking on the part of the Administration, this rule will take effect on July 1, restricting access to crucial primary and specialty outpatient care at a time when demand is at its height.

We request that the Administration use the rulemaking process to rescind the final rule prior to July 1, giving the new Administration the opportunity to consider these policies. This Administration is using a similar approach to rescind the provider conscience final rule.[3]

2. Postpone and Reconsider Further Implementation of the Medicaid Disproportionate Share Hospital (DSH) Audit and Reporting Final Rule Currently In Effect.

In 2005, CMS issued a proposed regulation implementing Medicaid DSH audit and reporting requirements included in the Medicare Modernization Act of 2003. The hospital community supports reporting and auditing requirements that help ensure that DSH payments are paid in accordance with federal rules. Such transparency will provide assurances to Congress, CMS, states and the public that DSH funds are being used to fulfill their intended statutory purpose to assist hospitals that serve a disproportionate share of low-income individuals.

The Medicaid DSH reporting rule, however, went far beyond reporting and proposed to restrict the type and nature of the hospital costs that states can reimburse through DSH payments. For example, the rule excludes uncompensated costs related to services furnished to patients with

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[1] 73 Fed. Reg. 66,187 (Nov. 7, 2008).
[2] *See Alameda County Medical Center et al. v. Leavitt*, 559 F. Supp.2d 1 (D.D.C. 2008)
[3] *See* Proposed Rule; Rescission of the Regulation Entitled ''Ensuring That Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law,'' 74 Fed. Reg. 10,207 (March 10, 2009).

insurance but no insurance for the service provided. It further excludes the uncompensated costs of physician services and pharmaceuticals provided and paid for by hospitals.

Although the proposed rule lay dormant for over three years, CMS finalized it in the waning days of the Bush Administration on December 19, 2008 (effective January 19, 2009) without addressing the substantial concerns raised by states and providers.[4] This final rule was not among the rules delayed in the ARRA, given the late date of its issuance.

The DSH program, over the years, has become the "lifeblood" of many safety net hospitals that provide essential access to care for the poor and uninsured. Policy changes in this program, particularly changes with significant economic impacts, directly affect their ability to provide this access. The Obama Administration should reevaluate the damaging policy changes implemented through this rule. **To do so, we request that the Administration take the following actions:**

- **Postpone the deadline for the initial audits and state reports.** Under the final rule, initial audits (for state rate years 2005 and 2006) must be completed by September 30, 2009, with reports due by December 31, 2009. Because states are already designating independent auditors and scheduling hospital audits, in order to have time to reconsider the policy decisions made in the final rule that impact the conduct of the audits, a necessary first step is to postpone the initial audit and reporting deadlines.
- **Issue guidance and begin a new rulemaking process to reconsider the policy changes of concern in the final regulations.** Some policy decisions regarding DSH were made in the preamble of the rule and can likely be reversed through guidance, while others will require a rulemaking process. The Administration should pursue both avenues, as appropriate, to establish its own approach to ensure that DSH may be used, as intended, to reimburse for appropriate uncompensated costs of providing hospital services to Medicaid and uninsured patients.

3. Restore the Medicare Indirect Medical Education (IME) Adjustment for Capital Costs for FY 2010 and Beyond.

CMS's FY 2009 IPPS rule eliminated capital IME adjustments, consistent with phase-out provisions included in the FY 2008 IPPS rule. *See* 42 C.F.R. § 412.322(d). CMS justified eliminating the capital IME adjustment by explaining that teaching hospitals are receiving "excessive payments levels." However, teaching hospitals' capital margins will be ***negative*** if the IME payments are eliminated. This would occur on top of already slim or negative Medicare overall margins. According to MedPAC's March 2009 report, Medicare overall margins for major teaching hospitals are only 1.1 percent and are -6.4 percent for other teaching hospitals. Teaching hospitals rely on Medicare capital payments to ensure a stable revenue source for capital improvements. The unpredictable and often insufficient revenue streams associated with running teaching programs make it otherwise difficult for some teaching hospitals to access affordable capital financing. Moreover, many teaching hospitals provide critical services that are otherwise unavailable in their communities – including advanced trauma care, burn care services and pediatric and neonatal intensive care –and are the first receivers during catastrophes such as

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[4] Medicaid Disproportionate Share Hospital Audit and Reporting Final Rule, 73 Fed. Reg. 77,904 (Dec. 19, 2008).

chemical spills, fires, disease outbreaks, and natural disasters. A reasonable and steady stream of Medicare capital payments is crucial in ensuring that these hospitals can maintain the necessary readiness infrastructure. Congress restored that funding for FY 2009 only in the ARRA, § 4301, with the expectation that "the hospital community [would] seek a permanent fix in the annual IPPS rulemaking cycle." Conference Report No. 111–16, page 754.

We request that the Administration use the FY 2010 IPPS rulemaking cycle to restore the capital IME adjustment for fiscal year 2010 and beyond under 42 C.F.R. § 412.322(d).

4. Withdraw the Proposed Rules Limiting Medicaid Payments for Public Providers to Cost, Eliminating Graduate Medical Education Under Medicaid, and Limiting Federal Medicaid Reimbursement for Certain Rehabilitative Services.

The implementation of these rules would be devastating to the Medicaid program and the safety net hospitals that depend on these payments. They would cut billions of dollars from the program, seriously compromising the future ability of safety net hospitals to serve Medicaid patients and the uninsured, to train our health care system's future physicians and nurses, and to provide many essential, community-wide services.

The public provider cost limit rule would limit reimbursement for government providers to a narrow definition of cost and restrict the definition of a unit of government eligible to contribute to the non-federal share of Medicaid expenditures.[5] Only governmental hospitals would be subjected to this lower payment limit; regulations would continue to permit payments to other categories of providers up to what Medicare would pay in the aggregate for the category. In effect, public safety net hospitals would face dramatic cuts to supplemental payments that acknowledge the special services provided by safety net providers and the burden of serving vulnerable, low-income populations. The Centers for Medicare and Medicaid Services (CMS) finalized this rule on May 29, 2007, but the federal court in *Alameda County Medical Center* determined it was finalized in violation of a congressional moratorium.[6]

Contradicting longstanding interpretations of authority contained in the Medicaid statute, the graduate medical education (GME) rule would prohibit federal matching funds for state payments to providers for GME costs and exclude direct GME payments from the calculation of the upper payment limit (UPL) for inpatient and outpatient services.[7] Medicaid is a significant funding source for graduate medical education, and many programs have evolved in reliance on that financial support. The rule would likely leave teaching hospitals in an untenable position; they would be forced either to cut back on their teaching programs, depriving the next generation of Medicaid recipients (and all Americans) of a sufficient number of health care providers, or to stop offering other essential services to the communities in which they are located.

The rehabilitative services rule would restrict the definition of rehabilitative services eligible for federal Medicaid funding, threatening access to important services in the community for

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[5] *See* Proposed Rule Limiting Medicaid Payments for Public Providers to Cost, 72 Fed. Reg. 2,236 (Jan. 18, 2007).
[6] Note that the decision in this lawsuit invalidated only the public provider cost limit final rule, and does not apply to any of the other rules described in this letter.
[7] Proposed Rule Eliminating Graduate Medical Education Under Medicaid, 72 Fed. Reg. 28,930 (May 23, 2007).

vulnerable populations and support for the providers of those services. [8] The proposed definition would exclude services that are "intrinsic elements" of programs for non-Medicaid populations, such as foster care, child welfare, education, and child care. Due to a lack of resources, some of these other programs will not be able to pay for these services without Medicaid as a partner. The rule would further prohibit the use of federal Medicaid funds for therapeutic foster care, designed for children with serious mental illness, and prohibit states from using the rehabilitative services option to fund day habilitation services for persons with developmental disabilities.

HHS is prohibited from finalizing these rules before April 1, 2009, as a result of a congressional moratorium, and the ARRA expressed the Sense of Congress that the Administration should not finalize these regulations. *See* ARRA, Div. B, § 5003(d).

We request that the Administration take the following actions:

- **Withdraw these regulations through a Notice of Withdrawal of Proposed Rulemaking.** Although these regulations are only in proposed form, a formal notice of withdrawal will helpfully clarify administration policy. HHS has used similar methods to withdraw rules in the past. *See, e.g.,* HHS Office of Inspector General, Notice of Withdrawal of Proposed Rulemaking, 72 Fed. Reg. 33430 (Jun. 18, 2007) and 67 Fed. Reg. 72896 (Dec. 9, 2002).

- **Direct the Government Printing Office (GPO) to remove the public provider cost limit rule changes from the Code of Federal Regulations (CFR).** Despite the fact that the public provider cost limit rule was never effective, the CFR includes these changes, resulting in substantial confusion. The GPO should be directed to revise the CFR to reflect the actual state of the regulations.

5. Rescind Portions of the Final Rule Restricting Allowable Provider Taxes.[9]

The provider tax rule imposes a more stringent interpretation of a hold-harmless test outlined in federal law and could hinder the ability of states to fund their Medicaid programs in an already dire budgetary environment, ultimately decreasing funding to crucial providers and threatening access to care.[10] Without administrative action, this rule will become effective upon the expiration of the current congressional moratorium on July 1, 2009.[11] *See* ARRA § 5003.

We request that the Administration use the rulemaking process to rescind portions of this regulation[12] before expiration of the moratorium on July 1, 2009.

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[8] Proposed Rule Limiting Federal Medicaid Reimbursement for Certain Rehabilitative Services, 72 Fed. Reg. 45,201 (August 13, 2007).

[9] Note that similar action could be taken related to similarly situated Portions of the Final Rule Restricting Federal Reimbursement for Case Management Services, 72 Fed. Reg. 68,077 (December 4, 2007), and the Final Rule Restricting Federal Reimbursement for Costs of School Administration and Transportation Services, 72 Fed. Reg. 73,635 (December 28, 2007), both of which would also weaken the Medicaid program significantly, although their direct impact on hospitals would be less pronounced.

[10] Portions of the Final Rule Restricting Allowable Provider Taxes, 73 Fed. Reg. 9,685 (February 22, 2008).

[11] Unlike the provider tax rule, the school administrative services rule, *supra* note 9, never went into effect; therefore, CMS could choose to extend its effective date beyond July 1 (as contemplated in the Memorandum issued by Rahm Emanuel on January 20, 2009), allowing more time to complete the rulemaking process to rescind it.

[12] The portions of the regulation of concern are those identified in the language of the existing moratorium.