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THE LACK OF HOSPITAL EMERGENCY SURGE CAPACITY: WILL THE ADMINISTRATION'S MEDICAID REGULATIONS MAKE IT WORSE? DAY TWO

HEARING

BEFORE THE

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

SECOND SESSION

MAY 7, 2008

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THE LACK OF HOSPITAL EMERGENCY SURGE CAPACITY: WILL THE ADMINISTRATION'S MEDICAID REGULATIONS MAKE IT WORSE? DAY TWO

WEDNESDAY, MAY 7, 2008

HOUSE OF REPRESENTATIVES,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
Washington, DC.

The committee met, pursuant to notice, at 9:31 a.m., in room 2154, Rayburn House Office Building, Hon. Henry A. Waxman (chairman of the committee) presiding.

Present: Representatives Waxman, Cummings, Tierney, Norton, McCollum, Van Hollen, Murphy, Sarbanes, Davis of Virginia, Shays, Issa, and Sali.

Staff present: Phil Barnett, staff director and chief counsel; Karen Nelson, health policy director; Karen Lightfoot, communications director and senior policy advisor; David Rapallo, chief investigative counsel; Andy Schneider, chief health counsel; John Williams, deputy chief investigative counsel; Sarah Despres, senior health counsel; Steve Cha, professional staff member; Earley Green, chief clerk; Zhongrui "JR" Deng, chief information officer; Leneal Scott, information systems manager, Kerry Gutknecht, William Ragland, Miriam Edelman, and Jennifer Owens, staff assistants; Sheila Klein, office manager/general assistant to the staff director; Larry Halloran, minority staff director; Jennifer Safavian, minority chief counsel for oversight and investigations; Keith Ausbrook, minority general counsel; Christopher Bright, Jill Schmaltz, Benjamin Chance, and Todd Greenwood, minority professional staff members; Patrick Lyden, minority parliamentarian and member services coordinator; and Ali Ahmad, minority deputy press secretary.

Chairman WAXMAN. The meeting will please come to order. Today we are holding the second of 2 days of hearings on the impact of the administration's Medicaid regulations on the ability of our Nation's emergency rooms to respond to a sudden influx of casualties from a terrorist attack.

On Monday we heard from the leading experts that the emergency rooms in our Nation's premier trauma centers have little or no surge capacity. We learned from them that many Level I trauma centers do not have the capacity to respond to a terrorist bombing like the one that happened in Madrid in 2004. And we learned that the administration's new Medicaid regulations are expected to make these problems worse by cutting off crucial funding.

The hearing left us with a number of important questions, which we hope to answer this morning. Why would the Department of Health and Human Services, knowing that the Nation's emergency care system is already stretched to the breaking point, withdraw billions of Federal dollars from the hospitals that provide the most comprehensive emergency care to the most seriously injured? Why would the Department of Health and Human Services take this drastic step without first considering the impact of its actions on emergency preparedness, or consulting with the agency with lead responsibility for homeland security? Why would the Department of Homeland Security, which is the Federal agency with lead responsibility for protecting the Nation from terrorist attacks, stand by while local emergency surge capacity is compromised?

The impact of the Medicaid regulations on our health care safety net is not a partisan issue. Last month Republicans in the House joined with Democrats in passing bipartisan legislation that would postpone the regulations and give Secretary Leavitt and Secretary Chertoff an opportunity to reevaluate their implications for homeland security.

The issue we are considering today is one that concerns all Americans: how to ensure that we have a robust response capacity in our emergency rooms. If the unthinkable happens, and we have learned that the unthinkable can happen, lives will be lost unless emergency care is immediately available. If a major city experiences a terrorist bombing like the one that occurred in Madrid, there will be a golden hour, an hour in which the fate of those who are injured will be determined, whether the most severely injured survive or die. The Federal Government's job is to do everything possible to ensure that emergency care resources are ready during that golden hour.

Certainly our government should not be taking actions that undermine the prospect of an effective emergency response. That is why we are having this hearing today, and that is why I look forward to the testimony of the two men in charge, Secretary Chertoff and Secretary Leavitt.

[The prepared statement of Chairman Henry A. Waxman follows:]

Opening Statement of Rep. Henry A. Waxman
Chairman, Committee on Oversight and Government Reform
The Lack of Hospital Emergency Surge Capacity: Will the Administration's Medicaid Regulations Make It Worse?
Day Two
May 7, 2008

Today we are holding the second of two days of hearings on the impact of the Administration's Medicaid regulations on the ability of our nation's emergency rooms to respond to a sudden influx of casualties from a terrorist attack.

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If the unthinkable happens — and we've learned that the unthinkable can happen — lives will be lost unless emergency care is immediately available. If a major city experiences a terrorist bombing like the one that occurred in Madrid, there will be a "golden hour" that determines whether the most severely injured survive or die. The federal government's job is to do everything possible to ensure that emergency care resources are ready during that golden hour.

Certainly, our government should not be taking actions that undermine the prospect of an effective emergency response.

That is why we are having this hearing, and that is why I look forward to the testimony of Secretary Chertoff and Secretary Leavitt this morning.

Chairman WAXMAN. But before we go on, I want to recognize Mr. Davis for an opening statement.

Mr. DAVIS OF VIRGINIA. Well, thank you, Mr. Chairman. As you said, we are here today to discuss two issues, Medicaid reimbursement regulations and the hospital surge capacity in response to predictable, some say inevitable, mass-casualty events. And we are fortunate to have two very distinguished witnesses to inform our discussion. Welcome Secretary Leavitt and Secretary Chertoff. We appreciate their taking their valuable time to be with us today.

As we learned from Monday's testimony on these same subjects, the nexus between Medicaid payments to hospitals and emergency preparedness may seem intuitive, but it is not by any means proven. Extrapolating directly from daily emergency department utilization rates to catastrophic surge capacity overlooks complex and interrelated factors that differentiate single-facility financial management from the broader resources needed to mount a coordinated regional disaster response. But extrapolate the committee did in releasing a 1-day snapshot of hospital emergency room occupancy in seven major cities and concluding it painted a complete picture of surge capacity.

Consulting the issues of Medicaid reimbursement and terrorism preparedness simultaneously oversimplifies and obscures both issues. I happen to agree with Chairman Waxman: we ought to know more about the impact of the administration's proposed regulation changes before exacting further cost savings from an already stressed health care system. But wrapping that issue in the mantle of terrorism creates the false impression that solving the problem of emergency room capacity on Tuesday means we are ready for doomsday. It does not. As one peer-reviewed study put it, surge capacity planning involves ensuring the ability to rapidly mobilize resources in reaction to such a sudden, unexpected increase in demand, regardless of baseline conditions.

It is just too simple and fiscally untenable to say there can never be cost savings in Medicaid as long as we are not ready for a Madrid-style attack. Both Medicaid efficiencies and preparedness need to be pursued; not one pitted against the other. So I hope we can move beyond limited snapshots and talk about the dynamic range of factors, in addition to baseline facility funding, that make up real surge capacity: organization, leadership, standards of care, medical education and training, interoperable communications, transportation coordination and information technologies.

Finally, we appreciate the fact that our witnesses made a tough choice to be here today. As we speak, the Federal Government is conducting a national continuity of operations exercise, testing many of the response elements needed to treat a surge of trauma patients. I hope the exercise goes well in their absence, and trust the committee's approach to these issues will continue to be constructive and supportive of executive branch efforts to prepare the Nation for catastrophic events. Thank you.

Chairman WAXMAN. Thank you very much, Mr. Davis.

[The prepared statement of Hon. Tom Davis follows:]

HENRY A. WAXMAN, CALIFORNIA
CHAIRMAN

TOM DAVIS, VIRGINIA
RANKING MINORITY MEMBER

ONE HUNDRED TENTH CONGRESS
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Statement of Rep. Tom Davis
Ranking Republican Member
Committee on Oversight and Government Reform
"The Lack of Hospital Emergency Surge Capacity: Will the Administration's Medicaid Regulations Make it Worse?"
May 7, 2008

Thank you, Mr. Chairman. As you said, we're here to discuss two issues this morning: Medicaid reimbursement regulations and hospital "surge capacity" in response to predictable, some say inevitable, mass casualty events. And we're fortunate to have two very distinguished witnesses to inform our discussion. Welcome Secretary Leavitt and Secretary Chertoff. We appreciate their taking time to be with us.

As we learned from Monday's testimony on these same subjects, the nexus between Medicaid payments to hospitals and emergency preparedness may seem intuitive, but it is by no means proven. Extrapolating directly from daily emergency department utilization rates to catastrophic surge capacity overlooks complex and interrelated factors that differentiate single facility financial management from the broader resources needed to mount a coordinated regional disaster response.

But extrapolate the Committee did in releasing a one-day "snapshot" of hospital emergency room occupancy in seven major cities and concluding it painted a complete picture of surge capacity. Conflating the issues of Medicaid reimbursements and terrorism preparedness simultaneously oversimplifies and obscures both issues. I happen to agree with Chairman Waxman we ought to know more about the impact of the Administration's proposed regulation changes before exacting further cost savings from an already stressed health care system. Wrapping that issue in the mantle of terrorism, however, creates the false impression solving the problem of emergency room capacity on Tuesday means we're ready for Doomsday. It does not. As one peer-reviewed study put it, "Surge capacity planning involves ensuring the ability to rapidly mobilize resources in reaction to such a sudden, unexpected increase in demand, *regardless of baseline conditions*…." (emphasis added) It's just too simple, and fiscally untenable, to say there can never be cost savings in Medicaid as long as we're not ready for a Madrid-style attack. Both Medicaid efficiencies and preparedness need to be pursued; not one pitted against the other.

So, I hope we can move beyond limited snapshots and talk about the dynamic range of factors – in addition to baseline facility funding – that make up real surge capacity: organization, leadership, standards of care, medical education and training, interoperable communications, transportation coordination and information technologies.

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Chairman WAXMAN. Because of time constraints, we will leave the record open for all Members to insert an opening statement in the record.

But we will go right to our very distinguished witnesses, and we are privileged to have both capable Secretaries with us today with distinguished careers in public service.

Secretary Michael Chertoff served as the Secretary of Homeland Security since February 2005. That capacity is a challenge. He has a challenging and critical responsibility to lead the Nation's efforts to prepare for, protect against, respond to and recover from terrorist attacks, major disasters and other catastrophic emergencies, whether man-made or natural disasters, that affect our homeland. And before taking the helm at the Department of Homeland Security, Secretary Chertoff served as a judge on the Third Circuit Court of Appeals. Prior to that, he served as Assistant Attorney General of the Criminal Division at the Department of Justice.

Secretary Michael Leavitt has been the Secretary of the Department of Health and Human Services since January 2005. As Secretary of HHS, he is responsible for managing a daunting array of medical, public health and human services programs. HHS is the lead Federal agency for public health and medical preparedness and response. And before coming to HHS, Secretary Leavitt was the Administrator of the Environmental Protection Agency. He also served as Governor of Utah for three terms, and during his 11 years as Governor, Utah was recognized six times as one of America's best-managed States. We are pleased to have both of you here with us.

I don't know which one of you wants to go first. Secretary Leavitt—both of your prepared statements will be in the record in full. We would like to ask you to make your oral presentation to us now.

STATEMENT OF MICHAEL O. LEAVITT, SECRETARY OF HEALTH AND HUMAN SERVICES

Secretary LEAVITT. Good morning, Mr. Chairman. And thank you very much, Ranking Member Davis and other members of the committee. I am very pleased to discuss HHS leadership role in the public health and medical emergency preparedness efforts, as well as HHS and CMS efforts to ensure that Medicaid pays appropriately for services that are delivered to Medicaid recipients.

As you know, local, State and Federal agencies have a shared responsibility for ensuring that the Nation is prepared for emergencies. In that context, permit me to briefly discuss a few of the emergency preparedness efforts that are currently being led by HHS.

On October 18, 2007, President Bush signed the Homeland Security Presidential Directive 21 [HSPD–21]. It established a new national strategy for public health and medical preparedness. HSPD–21 mandates the development of an implementation plan. HHS chairs the interagency writing team that drafted the implementation plan that is currently in the process of being finalized.

As part of the implementation plan, HHS is implementing an Emergency Care Coordinating Center. This new center will serve as a coordinating focal point for emergency care as an enterprise.

The ECC, as we have come to know it, charter is being finalized, and we anticipate having the center up and running by the end of this year.

The National Response Framework Emergency Support Function, or ESF 8, titled the Public Health and Medical Services Function, provides a mechanism for coordinating Federal assistance to State, tribal and other local resources in response to a medical disaster.

The Secretary of Health and Human Services leads all of the Federal public health and medical response to public health agencies. The Secretary of HHS also coordinates, through his Assistant Secretary or ASPR, all of the ESF 8 preparedness, response and recovery actions. The National Disaster Medical System [NDMS], transferred from the Department of Homeland Security to HHS and remains the tip of the spear, if you will, as the Federal disaster health care response capacity.

Over the past 5 years, the Hospital Preparedness Program has provided more than $2.6 billion to fund the development of medical surge capacity at the State and local level. As part of our pandemic planning, we have asked grantees to report participating hospitals' ability to track beds electronically and to report to the grantee's emergency operations center within 60 minutes of a request.

From 2002 to 2007, the Public Health Emergency Preparedness Program has provided $5.6 billion to State, local, tribal and territorial public health departments. This program has greatly increased the preparedness capabilities of the public health departments.

Now turning briefly to Medicaid, it is important to remember that Medicaid is fundamentally a Federal-State commitment to provide health care for Medicaid beneficiaries. First and foremost, our responsibility is to assure that these low-income children, pregnant women and people with disabilities are able to receive high-quality and appropriate care when they need it.

The package of recent Medicaid regulatory activity will help enable, or to ensure rather, that Medicaid is paying providers appropriately for services delivered to Medicaid recipients, and that those services are effective, and that taxpayers are receiving the full value of the dollars that are spent through Medicaid.

GAO and the Office of Inspector General at HHS have provided policymakers with numerous reports on various areas in which States inappropriately engage in activities that maximize Federal revenues. These rules address these types of abuses head on. They address them by ensuring that the Federal Medicaid dollars are matching actual State payments for actual Medicaid expenses to actual Medicaid beneficiaries. Medicaid is already an open-ended Federal commitment for Medicaid services for Medicaid recipients. It should not become a limitless account for State and local programs and agencies to draw Federal funds for non-Medicaid purposes.

In conclusion, as I have mentioned earlier, HHS is working diligently to improve our Nation's emergency preparedness and our medical surge capacity, and we have made extensive funding available to hospitals through the States specifically to this end.

Medicaid, however, is fundamentally a partnership that relies on both States and the Federal Government to contribute their share of the cost of the program. Allowing for the continuation of abusive practices that shift costs to the Federal Government is not an appropriate way to ensure our Nation's preparedness. We are committed through our emergency preparedness efforts to continue to make progress and to make funding available to States, while acting through these Medicaid rules, to provide greater stability in the program and equity to the States. And I want to thank you for the opportunity of being here to testify.

Chairman WAXMAN. Thank you, Secretary Leavitt.

[The prepared statement of Secretary Leavitt follows:]

Testimony
Before the House Oversight and Government Reform Committee
United States House of Representatives

HHS Leadership in Federal Emergency Preparedness Efforts

Statement of
Michael O. Leavitt
Secretary
U.S. Department of Health and Human Services

For Release on Delivery
Expected at 10:00am
May 7, 2008

Good morning Chairman Waxman, Ranking Member Davis, and other distinguished Members of the Committee. I am pleased to discuss HHS leadership in Federal public health and medical emergency preparedness efforts, as well as HHS and CMS efforts to ensure that Medicaid pays appropriately for services delivered to Medicaid recipients, that those services are effective, and that taxpayers are receiving the full value of the dollars spent through Medicaid.

Emergency Preparedness

Local, state, and federal agencies have a shared responsibility for ensuring that the nation is prepared for emergencies. Before an event, government agencies at all levels work with the private sector to plan and exercise so they can be ready when a disaster occurs. During an emergency, local and state response agencies, including public health departments, are the first to respond. For multi-state or severe emergencies, the federal government may be asked to provide additional resources and coordinate response efforts across multiple jurisdictions. In that context, permit me to briefly discuss a few of the emergency preparedness efforts currently being led by HHS that involve working with our Federal, State, and local partners.

Homeland Security Presidential Directive (HSPD)-21

On October 18, 2007 President Bush signed Homeland Security Presidential Directive (HSPD)-21, "Public Health and Medical Preparedness," establishing a new National Strategy for Public Health and Medical Preparedness (the

Strategy). The Strategy aims to improve the Nation's ability to plan for, respond to, and recover from public health and medical emergencies at the Federal, State, Territorial, Tribal, and local levels. It calls for the continued development of a National Health Security Strategy, as well as a robust infrastructure -- including healthcare facilities, responders and providers -- which can be drawn upon in the event of an emergency. The Strategy also requires actions to ensure the adequate flow of information before, during, and after an event, including critical biosurveillance data and risk analysis. Finally, the Strategy calls for the development of resources at the community level to ensure that individuals and families are empowered to protect themselves in the event of an emergency.

In order to implement the actions outlined in the Strategy, the HSPD establishes an interagency Public Health and Medical Preparedness Task Force, led by the Secretary of Health and Human Services. In December 2007 an Assistant Secretary-level meeting of the 12 Departments that make up the Task Force was convened. Since then, HHS's Office of the Assistant Secretary for Preparedness and Response (ASPR) has chaired two interagency Action Officer level meetings to provide guidance on implementation.

HSPD-21 mandates the development of an Implementation Plan, which provides detailed information regarding how the Federal Departments and Agencies will execute these actions. HHS chairs the interagency Writing Team that drafted the Implementation Plan, which is currently in the process of being finalized.

Six workgroups have been established to oversee implementation of HSPD-21. Four workgroups are being chaired by HHS: (1) Medical Countermeasure Stockpiling and Distribution; (2) Biosurveillance; (3) Mass Casualty Care; and (4) Community Resilience. A fifth workgroup on Education and Training is co-chaired by HHS and DOD and a sixth workgroup on Risk Awareness is being chaired by the Department of Homeland Security.

HSPD-21 directed the establishment of two advisory committees. The National BioSurveillance Advisory Committee has been established as a subcommittee to the Centers for Disease Control and Prevention (CDC) Advisory Committee to the Director (ACD) and a Disaster Mental Health Advisory Committee is being established as a subcommittee under the National Biodefense Science Board (NBSB) which advises the HHS Secretary.

Emergency Care Coordination Center (ECCC)

Finally, HHS is implementing HSPD #21, including through the establishment of the Emergency Care Coordination Center (ECCC). This new center, an intradepartmental and interdepartmental collaborative effort involving the Departments of Defense, Homeland Security, Transportation and Veterans Affairs, will serve as the coordinating focal point for an Emergency Care Enterprise, coordinating with the Federal Interagency Committee on Emergency Medical Services. Its vision is exceptional daily emergency care for all persons of the United States and its mission is to promote Federal, State, local, tribal and

private sector collaboration to support and enhance the nation's emergency medical care.

The ECCC will assist the USG with policy implementation and guidance on daily emergency care issues and promote both clinical and systems-based research. Through these efforts, ASPR and its federal partners will improve the effectiveness of pre-hospital and hospital based emergency care by leveraging research outcomes, private sector findings and best practices. The ECCC will promote improved daily emergency care capabilities to improve resiliency of our local community healthcare systems. This will provide a stronger foundation on which to advance disaster preparedness efforts and strengthen our Nation's ability to respond to mass casualty events. Currently, the ECCC Charter is being finalized and we anticipate having the Center up and running by the end of the year.

Emergency Support Function 8 (ESF#8)

The National Response Framework (NRF) Emergency Support Function (ESF) #8 – Public Health and Medical Services – provides the mechanism for coordinated Federal assistance to supplement State, tribal, and local resources in response to a public health and medical disaster, potential or actual incidents requiring a coordinated Federal response, and/or during a developing potential health and medical emergency. The Secretary of Health and Human Services (HHS) leads all Federal public health and medical response to public health

emergencies and incidents covered by the *NRF.* The response addresses medical needs and other functional needs of those requiring medical care and other assistance during an emergency.

Except for the personnel and assets under armed forces command, the Secretary of HHS assumes operational control of Federal emergency public health and medical response assets, as necessary, in the event of a public health emergency. The Secretary of HHS, through ASPR, coordinates national ESF #8 preparedness, response, and recovery actions.

National Disaster Medical System (NDMS)

We are also continuously improving HHS's operational capabilities to respond to emergencies. The National Disaster Medical System (NDMS), transferred from the Department of Homeland Security to HHS, remains the "tip of the spear" as the federal disaster healthcare response capability, maintaining 6,200 medical and public health professionals and over 1,800 participating hospitals with approximately 32,000 beds. Since the transfer of NDMS last year, we have achieved a number of accomplishments aimed at improving the System including the integration of NDMS into the larger Emergency Support Function #8 (ESF-8) response framework and regionalization of NDMS response operations and caches to provide increased accountability and standardization for supplies as well as fiscal savings. Future goals for NDMS include enhancing readiness and

accountability through regionalization of NDMS response operations and enhancing equipment caches.

Hospital Preparedness Program (HPP)

We have made considerable investments in building the healthcare preparedness and response capabilities required during an incident resulting in mass casualties, and are committed to performance measurement. Over the past five years, the Hospital Preparedness Program (HPP) has provided more than $2.6 billion to fund the development of medical surge capacity and capability at the State and local level. As a result of HPP funds awarded to states and territories, hospitals and other healthcare entities:

- Increased their ability to provide needed beds during an emergency;
- Can now track bed and resource availability using electronic systems;
- Engaged with other responders through interoperable communication systems;
- Appropriately train their healthcare workers for all-hazards approach to emergencies,
- Protect their healthcare workers with proper equipment;
- Have installed equipment necessary to decontaminate patients;
- Have developed fatality management and hospital evacuation plans, and
- Coordinate regional exercises.

Pandemic and All-Hazards Preparedness Act (PAHPA)

Consistent with requirements contained in the Public Health Service Act, as amended by the Pandemic and All-Hazards Preparedness Act (PAHPA), HHS has updated the performance measures for our funding programs. Specific improvements include greater clarity in language, the use of definitions, and the addition of targets. For example, in FY 2006, HHS asked grantees to report participating hospitals' ability to track bed status electronically, and report it to the grantee's Emergency Operations Center within 60 minutes of a request. In 2007, the numerator and denominator were defined to improve clarity. For FY 2008, the target percentage of hospitals able to report was increased to 100 percent by the end of the end of the year.

HHS strongly supported the new accountability provisions included in PAHPA and is implementing these provisions. First, FY 2009 award funds will be based on the successful achievement of targets during the previous budget cycle. In addition, the matching provision will be applied to the Public Health Emergency Preparedness Program (PHEP) in FY 2009. We also intend, through notice and comment, to apply the matching provision to the Hospital Preparedness Program (HPP) in FY 2009. The audit and carryover provisions apply to both the PHEP and HPP programs currently; the withholding provision will be applied to these programs in FY 2009. The HPP and PHEP programs implemented the maintenance of funding provision in FY 2007.

Public Health Emergency Preparedness (PHEP) Program

From FY 2002- FY 2007, the Public Health Emergency Preparedness (PHEP) program has provided $5.6 billion to state, local, tribal, and territorial public health departments. This amount includes targeted supplements to prepare for smallpox (in FY 2003) and for an influenza pandemic (FY 2005 – FY 2007). This program has greatly increased the preparedness capabilities of public health departments:

- All states can receive and evaluate urgent disease reports 24/7, while in 1999 only 12 could do so.
- All states now conduct year-round influenza surveillance.
- The number of state and local public health laboratories that can detect biological agents as members of CDC's Laboratory Response Network (LRN) has increased to 110 in 2007, from 83 in 2002. For chemical agents, the number increased to 47, from 0 in 2001. Rather than having to rely on confirmation from laboratories at CDC, LRN laboratories can produce conclusive results. This allows local authorities to respond quickly to emergencies.
- All states have trained public health staff roles and responsibilities during an emergency as outlined in the Incident Command System, while in 1999 only 14 did so.
- All states routinely conduct exercises to test public health departments' ability to respond to emergencies. Such exercises were uncommon before PHEP funding.

Preserving the Medicaid Partnership

Medicaid, along with Medicare and other private payers, is an important source of funding for the American health care system. It is important to remember, however, that Medicaid is fundamentally a Federal-State commitment to provide health care for Medicaid beneficiaries. And, first and foremost, our responsibility is to assure that these low-income seniors, children, pregnant women, and people with disabilities are able to receive high quality and appropriate care when they need it.

The package of recent Medicaid regulatory activity will help ensure that Medicaid is paying providers appropriately for services delivered to Medicaid recipients, that those services are effective, and that taxpayers are receiving the full value of the dollars spent through Medicaid. As CMS and others have previously testified, there is a long and complicated history that is marked by States seeking to shift funding of the Medicaid program, to the greatest extent possible, to the Federal government. Federal recognition of this occurrence dates back to at least 1991 when Congress enacted prohibitions on provider taxes and donations.

Additionally, GAO and OIG have provided policymakers with numerous reports on various areas in which States engage in activities to maximize Federal revenues. Here are just a few examples:

- The GAO found several States "used several financing approaches to maximize federal Medicaid contributions without effectively committing

their share of matching funds. Under these approaches, facilities that received increased Medicaid payments from the states, in turn, paid the states almost as much as they received. Consequently, the states realized increased revenue that was used to reduce their state Medicaid contributions, fund other health care needs, and supplement general revenue funding."

- State agencies paid private facilities under a per diem rate for providing room and board, rehabilitation counseling and therapy, educational, and other services to children in State custody, and based their claims on facilities' estimated costs rather than actual costs. This resulted in an increase of $58 million in Federal Medicaid reimbursements.
- Medicaid is frequently billed for costs related to transporting children from home to school and back on a given school day despite the fact that children are transported to school primarily to receive an education, not to receive medical services. In a 2004 review of one state, OIG found that more than 90 percent of transportation claims to Medicaid, made on behalf of almost 700 schools and preschool providers over the September 1, 1993 through June 30, 2001 period, were not in compliance with Federal and State regulations.

These rules address these types of abuses head-on by ensuring that Federal Medicaid dollars are matching actual State payments for actual Medicaid services to actual Medicaid beneficiaries. Medicaid is already an open-ended

Federal commitment for Medicaid services for Medicaid recipients; it should not become a limitless account for State and local programs and agencies to draw Federal funds for non-Medicaid purposes.

When Medicaid funds are diverted to purposes not expressly authorized by law, legislatures have not had the opportunity to determine if such funding is warranted or desirable. As a result, the legislative decision-making process is weakened. This is especially true at the State level as Medicaid now typically accounts for one out of every five dollars spent by States. The Medicaid program should be based on transparency and trust, not on hidden funding arrangements that result in a "don't ask, don't tell" relationship with oversight agencies.

CMS is often asked why we cannot simply stop these practices through the audit and disallowance process. Audits and disallowances occur on the back end of the process. Obviously it would be better if there were no opening for practices that are inconsistent with the overall statutory and regulatory framework. The rules listed below would help eliminate perceived ambiguities and protect the federal-state financial partnership.

Final Medicaid Governmental Provider Payment Rule

The Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership rule requires that Medicaid payments to governmentally-operated health care providers not exceed

an individual provider's cost. This will ensure that the Federal government pays only its share for Medicaid services delivered by that provider. This reform is critical to strengthening program accountability, consistent with GAO and OIG recommendations.

To the extent that a provider is not governmentally operated, this rule does not impact Medicaid payments made to them by the State. The rule would simply offer further protection against States requiring non-governmental providers to assist in the funding of the Medicaid program as well as clearly stating that the provider must retain all of the Medicaid payments it receives. To the extent that a provider is governmentally operated, this rule stipulates that the provider is entitled to receive Medicaid payments up to their full cost of providing services to Medicaid eligible individuals.

The Federal government is not reducing, restricting, or limiting the Federal commitment to pay the full cost of providing medically necessary services to Medicaid recipients as long as the States are contributing their full share as well.

Proposed Rule on Graduate Medical Education

The proposed rule makes Medicaid graduate medical education (GME) payments and costs ineligible for Federal financial participation (FFP). Specifically, the proposed rule no longer allows States to include GME as a payment under the Medicaid State plan or as an allowable cost in determining

Medicaid payments. There is no explicit authorization under the Medicaid statute to subsidize the training of physicians. In a time of limited Federal and State resources, it is important to prioritize Medicaid spending and target it to its primary purpose.

Final Rule on Provider Taxes

This final rule (1) revises the threshold from 6 percent of net patient revenue to 5.5 percent under the first prong of the indirect hold harmless guarantee test as enacted by the Tax Relief and Health Care Act of 2006 (TRHCA, P.L. 109-432); (2) clarifies the standard for determining the existence of a hold harmless arrangement under the positive correlation test, Medicaid payment test, and the guarantee test; (3) codifies changes to permissible class of health care items or services related to managed care organizations (MCO) as enacted by the Deficit Reduction Act of 2005 (DRA, P.L. 109-171); and (4) removes obsolete transition period regulatory language. We believe that this rule faithfully reflects the intent of Congress in enacting the provider tax rules in 1991 and the minor revision in TRHCA.

Proposed Rule on the Clarification of Outpatient and Clinic Upper Payment Limit

The proposed regulation intends to clarify the current vague regulatory language in order to define the scope of Medicaid outpatient hospital services and the UPL for those services. The regulation intends to prevent an overlap between outpatient hospital services and other covered benefits. The potential overlap

could result in circumstances in which payment for services is made at the high levels customary for outpatient hospital services instead of the levels associated with the same services under other covered benefits.

The rule recognizes services paid under the Medicare outpatient prospective payment system or paid by Medicare as an outpatient hospital service under an alternative payment methodology as Medicaid outpatient hospital services. The scope of Medicaid outpatient hospital services may not include a service reimbursed under a distinct State plan payment methodology for another Medicaid covered service. The rule also limits the facilities that may provide outpatient hospital services to hospitals and departments of an outpatient hospital.

Final Rule on the Elimination of Reimbursement for Administrative Claiming and Transportation Costs for School-Based Services

This rule clarifies that administrative activities performed by schools are not necessary for the proper and efficient administration of the State Medicaid plan. The rule also specifies that transportation of students from home to school and back is not within the scope of allowable Medicaid-related transportation recognized by the Secretary. Therefore, under the rule, funding for the costs of these activities or services performed would no longer be available under the Medicaid program. States will continue to receive reimbursement under the Medicaid program for school-based Medicaid service costs under their approved State plans under current law.

Interim Final Rule with Comment on Targeted Case Management

The interim final rule clarifies the definition of covered case management services and implements Section 6052 of the Deficit Reduction Act of 2005, which redefined the scope of allowable case management services, strengthened State accountability, and required that CMS issue regulations. The work of GAO and the OIG was key to our understanding that some States were claiming case management expenditures that were not supported by actual activities to improve the health status of Medicaid recipients. It is important to remember that the point of the Medicaid program is to improve the availability of health services and the health status of program beneficiaries, not simply as a supplement for state and local budgets.

This interim final rule has a strong emphasis on ensuring that case management will be comprehensive and coordinated, to fully serve beneficiary needs. High quality case management should result in better outcomes for the individual and better value for the taxpayer.

Proposed Rule on Rehabilitative Services

In recent years, Medicaid rehabilitation services have increasingly become prone to inappropriate claiming and cost-sharing from other programs, because these services are so broadly defined as to become simply a "catch all" phrase. The proposed regulation clearly defines allowable services that may be claimed as "rehabilitative services."

This proposed rule will also include important beneficiary protections to improve the quality of care provided to the individuals who need these rehabilitative services. For the first time, rehabilitative services would be required to be furnished through a written plan of care that identifies treatment goals and methods. Our proposed rule contemplates that care will have a clear foundation in clinical practices, and will be designed and delivered in a patient centered environment.

Conclusion

These rules reflect the long-standing work of CMS and others, such as GAO and the OIG, to restore greater accountability to the Medicaid program, while safeguarding limited resources for actual services to those individuals who rely on the Medicaid program. As I have testified, HHS is working diligently to improve our nation's emergency preparedness and medical surge capacity, and we have made extensive funding available to hospitals through the states specifically toward this end.

Medicaid, however, is fundamentally a partnership that relies on both sides to contribute their share to the cost of the program, and allowing for the continuation of abusive practices of shifting costs to the Federal government is not the appropriate way to ensure our nation's preparedness. As Medicaid competes for resources at the State level against all the other demands that are present, an

erosion of confidence in the integrity of the Medicaid program ultimately is not good for Medicaid or for the people who rely on it.

We are committed through our emergency preparedness efforts to continue to make progress and make funding available to states, while acting through these Medicaid rules to provide greater stability in the program and equity among the States.

Thank you for the opportunity to testify today; I am happy to take any questions you may have.

Chairman WAXMAN. Secretary Chertoff.

STATEMENT OF MICHAEL CHERTOFF, SECRETARY OF HOMELAND SECURITY

Secretary CHERTOFF. Thank you, Mr. Chairman. Good morning, Ranking Member Davis and other members of the committee.

Let me just take a few moments now, since my full statement will be in the record, to put into perspective what the role of the Department of Homeland Security is with respect to the issue of preparedness and response, one dimension of which, but only one dimension of which, is the issue of mass care in the event of some kind of a terrorist attack or natural disaster. But I also underscore the fact that the planning and execution of a response to an attack, particularly with respect to the issue of mass care, would implicate not only HHS, but would also require the participation of the Department of Defense and Department of Veterans Affairs. They have a major role to play in furnishing the resources and capabilities necessary to respond to a medical emergency, and their capabilities are built into our plan. So it is not merely a matter of HHS.

Basically what I would like do is describe the role that we play in any kind of a response and, therefore, what role we play in planning in the lead-up to the possibility of a response. As you know, under the National Response Framework and the National Incident Management System, the Department of Homeland Security plays the role of incident coordinator/incident manager. That does not mean that we are exercising command and control over other departments and agencies. That would be prohibited as a matter of law.

What we do is bring to the table the agencies that will play a role. There is a lead agency designated for particular functions; in the case of mass terrorists, the Department of Health and Human Services. That is a designation that is both prescribed by statute as well as by HSPD 5 and HSPD 21. Our role then would be to coordinate and deconflict the various capabilities that we bring to the table and the roles and responsibilities of the lead agency and other agencies. For example, in the case of an attack, let's say a conventional attack, we would obviously have to coordinate the law enforcement response, although the lead agency there would be the Department of Justice. There might well be a security response, in which case we would be coordinating with the Department of Defense and the National Guard. And to the extent there was a mass casualty response, the mission assignment for carrying that out would be to HHS, but there would be support provided by the Department of Veterans Affairs and the Department of Defense. This is all done under the rubric of what we call Emergency Support Function 8, and the actual undertaking would be coordinated through the National Response Coordination Center.

As part of the preparation for this, we engage in a variety of planning exercises. And with respect to the issue of mass care, again we look to the Department of Health and Human Services to take the lead with respect to identifying what the gaps are with respect to potential surge capability, what the available resources are, and what are the most efficacious ways to provide those resources. That is done with the understanding that the initial re-

sponse obligation lies upon State and local public health officials. Therefore, they must participate in the planning, and it is their responsibility to make sure that they are planning in a way that is synchronized with us.

We also recognize, however, that these capabilities would likely be overwhelmed in 24 hours, or maybe 48 hours. That is why we have capabilities such as the National Disaster Medical System, which is run by HHS. We would look to the Department of Defense to provide mobile field hospitals and other kinds of medical capabilities, which we would move into the arena as quickly as possible. The National Guard would obviously play a major role. And, again, if there were some particular issue like a chemical attack or a dirty bomb attack, there would be specialized capabilities by the military that would be called into play.

So that is the general role that we play in coordinating these issues. We have engaged in planning, strategic planning, on a number of scenarios, including some with medical dimensions, again looking to HHS as the principal lead in identifying what the requirements are, identifying where the gaps are, and formulating a way in which those gaps can be plugged.

Thank you, Mr. Chairman.

Chairman WAXMAN. Thank you very much.

[The prepared statement of Secretary Chertoff follows:]

Statement for the Record

The Honorable Michael Chertoff

Secretary
United States Department of Homeland Security

Before the
United States House of Representatives
Committee on Oversight and Government Reform

May 7, 2008

Introduction

Good morning Chairman Waxman, Ranking Member Davis, and Members of the Committee. Thank you for the opportunity to participate in this hearing to discuss issues surrounding medical surge capacity and the effect of Medicaid regulations on the ability to respond in the event of a major disaster or other catastrophic incident.

I will address medical surge capacity within the scope of overall emergency preparedness and response capabilities, including national incident management doctrine. In particular, I will discuss the roles and responsibilities of the Department of Homeland Security (DHS), and highlight key areas of coordination between DHS and the Department of Health and Human Services (HHS).

It is important to note that the Department of Health and Human Services is the lead Federal agency for public health and medical preparedness and response issues and consequently coordinates and provides the actual health care and medical response in a major disaster or other catastrophic incident. The Department supports HHS in their mission.

Department of Homeland Security Responsibilities

The Department of Homeland Security's mission is to lead national efforts to prepare for, protect against, respond to, and recover from terrorist attacks, major disasters and other catastrophic emergencies whether manmade or natural disaster that affect the homeland. Should a catastrophic incident occur, DHS leads overall incident management activities.

Incident management, by definition, incorporates a variety of Departments across the Federal government, as well as State and local government and law enforcement; the actors involved depend on the type of incident. In turn, each department or agency, whether at the Federal or State and local level, has a particular role and mission. It is our role to coordinate and integrate all of those individual activities into an effective, coordinated, and timely response.

Medical surge capacity is a critical element of our local, state and national resiliency. When a large-scale natural or manmade disaster occurs, the ability to provide urgent and life-saving medical care, provided by resources from the local, state and federal levels, will have a direct correlation to the ability to save lives.

For example, if an improvised nuclear device or radiological dispersal device (i.e., a "dirty bomb") goes off in the middle of Manhattan or a biological agent is released in our Nation's capital, the capacity to handle a large number of causalities will be essential to managing the overall crisis and providing the necessary urgent care to those in need.

Many of our nation's medical facilities, including emergency departments and trauma centers, would be overwhelmed with individuals suffering from illnesses and injuries, ranging from relatively minor to life-threatening. HHS serves as the lead agency for coordinating the health response activities. It is our responsibility to facilitate that effective medical response within the

context of all the other demands of the event, such as the law enforcement, environmental, intelligence-gathering, public safety, communications, and search and rescue aspects.

In the event of a dirty bomb detonation, there will likely be numerous patients with multiple injuries from the bomb itself and related blast debris, such as glass, concrete and metal. This scene would also require additional care to address the issue of radiation contamination.

If a biological agent, such as an aerosolized form of anthrax, were disseminated over a wide area such as the Washington, D.C. metropolitan area, the city's medical capabilities would be severely tested. There would be little visible evidence of life-threatening injury, illness or other physical symptoms in the immediate aftermath of an anthrax release. We expect that many people will show up at local emergency departments to seek medical treatment, including those who have not been contaminated but are concerned they may have been exposed.

In this scenario, the Department's National Biosurveillance Integration Center (NBIC) would work with the intelligence community both before and after an event to identify the potential for a release and to help characterize the biological event if it did occur.

The fact that there may be little indication of a biological agent release early on is the reason a system of environmental sensors such as the DHS BioWatch program is critical to identifying that release before people become clinically symptomatic. Reaching exposed persons and providing them with appropriate antibiotics before they become clinically symptomatic is critical to saving lives.

Incident Management and Command

Homeland Security Presidential Directive (HSPD)–5 provides the framework for the Federal government's incident management system. HSPD-5 directs DHS to coordinate the Federal response in a major disaster or terrorist attack. The roles and responsibilities of Federal, state and local governments, law enforcement and the private sector are outlined in the National Response Framework (NRF) and in the 15 Emergency Support Functions (ESF), which include transportation, communications, health, law enforcement, and critical infrastructure.

Based on the National Incident Management System (NIMS), DHS is responsible for integrating the Federal response capabilities with our partners at the state, local and private sector levels to ensure a strong and interoperable national response. This system provides for a command, control and accountability structure among the multiple jurisdictions and disciplines that have to respond to large-scale events.

At the Federal level, response activities are coordinated by FEMA's National Response Coordination Center (NRCC). All of the lead agencies for the various Emergency Support Functions will have representatives present at the NRCC, including HHS as lead for ESF – 8 activities (*Public Health and Medical Services*). The NRCC includes representatives from FEMA and Office of Health Affairs (OHA), who interact directly with their counterparts from HHS to facilitate the necessary coordination for an effective medical response. Information from the NRCC is routinely fed to the National Operations Center where it is combined with

information from other agencies and open source media outlets to provide a common operating picture of an incident, thus giving full visibility to senior decision makers.

To be successful in fulfilling the DHS mission as the overall incident commander, we have to support others' abilities to fulfill their respective roles and responsibilities. For instance, we rely on the Department of Transportation to obtain key transportation-related information and provide appropriate resources to maintain transportation infrastructure. We rely on the Department of Defense and Army Corps of Engineers to provide support in coordinating and facilitating the delivery of their services and assessing public infrastructure and other resources. The Department of Justice is responsible for the characterization of a terrorist incident and to determine the source to prevent subsequent attacks. HHS is responsible for public health and medical issues.

It is not the responsibility of the Department of Homeland Security to direct our Federal partners to perform their specific roles and responsibilities when managing a major incident – for example, telling Health and Human Services specifically how to provide medical surge. It is the Department's responsibility to ensure that each of the agency roles and responsibilities are being met and coordinated in a major incident response.

Coordination with the Department of Health and Human Services

The authorities for mass casualty events are enumerated in several places, including the National Response Framework (NRF), Emergency Support Function (ESF) – 8: *Public Health and Medical Services*, HSPD-21 and the Public Health Service Act, and other statutory authorities. According to the NRF, HHS is the lead Federal agency in preparing, deploying and providing health and medical care to the public in the event of a disaster or other emergency.

Within DHS, the Office of Health Affairs and FEMA both work closely with the HHS Office of the Assistant Secretary for Preparedness and Response (ASPR) and the Centers for Disease Control and Prevention (CDC) on a daily basis to address the issues that affect our Nation's ability to effectively prepare for and respond to a major emergency.

State and Local Response

It is also important to highlight the essential role that state and local responders play in the immediate aftermath of a catastrophic event. Using the National Incident Management System (NIMS) model, these responders are required to manage on-scene activities from the moment of the event until Federal resources are able to arrive and become operational. Depending on the magnitude of the event, the response activities (including personnel, equipment and supplies) will expand from local health resources, to surrounding regions, to state resources, to adjoining state resources to Federal resources. Plans in place around the country incorporate these expanding assets.

DHS is committed to ensuring that the Federal response, whether it is a medical, environmental, or law enforcement response, for example, is well-coordinated with state and local officials to

ensure a seamless and integrated response. The role of the Federal government is to supplement the state and local efforts and to provide assistance when it is needed.

FEMA and the Office of Health Affairs work closely HHS and with states and local regions to assist in developing inter-state and multi-state agreements to provide supplies, hospital beds, medical professionals during a catastrophic event. These partnerships are important to ensure medical surge capacity.

Conclusion

Mr. Chairman, these are all very important issues. Medical surge capacity is a significant part of any effective national emergency preparedness and response capability. We are committed to working with our partners to ensure that these missions are fulfilled. I would be happy to answer any questions.

Thank you.

Chairman WAXMAN. Without objection, we are going to begin questioning with 10-minute rounds, first controlled by the Chair and second controlled by Mr. Davis. After that we will go back to the 5-minute rule.

I am going to start off the questions myself.

Secretary Leavitt and Chertoff, we are here to answer the very simple question—if we had a terrorist attack like what happened in Madrid, with conventional bombs or suicide bombers, which most terrorist experts say is most likely, not the unthinkable weapons of mass destruction, but if the unthinkable, unlikely terrorist attack using conventional weapons occurred, would we be prepared to deal with it?

Now, many experts have told us that if we had something like an attack on a commuter train where, as in Madrid, 177 people were killed and more than 2000 were injured, we wouldn't have the surge capacity in some of our major cities to deal with those people in the Level I trauma centers or even in the emergency rooms.

Secretary Chertoff, do you think we have the capacity to deal with such an attack?

Secretary CHERTOFF. I do, Mr. Chairman. Now, I want to note that HHS is currently engaged in a systematic survey of capacities and plans across the country, so there is going to be a definitive answer to this. And there is no doubt some communities are better prepared than others. But I don't have to speculate about it.

I remember we had a bridge collapse in Minneapolis some months ago. That was exactly the kind of event that you are talking about. It was not a terrorist event, but it was one which certainly posed challenges to casualties. My understanding is that in Minneapolis things worked very well.

Chairman WAXMAN. Thirteen people went to the emergency room under those circumstances. We could have hundreds, if not thousands, of people rushed into emergency rooms.

Secretary CHERTOFF. We have had air crashes, we have had other disasters. I can't give you a definitive statement with respect to a particular city. What I can tell you is I am not sure that the day-to-day capacity rates of emergency rooms is a prediction of the capability of the emergency system to deal with a disaster.

Chairman WAXMAN. Have you delegated that to HHS?

Secretary CHERTOFF. HHS has a principal responsibility, to my understanding.

Chairman WAXMAN. Well, let me read to you what your Chief Medical Officer Jeff Runge told the House Appropriations Committee last month. He said, "I don't think anybody who has looked would be under the mistaken notion that we are adequately prepared for a hospital surge. We have squeezed all the capacity out of the hospitals' budgets, and it's just not there."

He went on to say, "We frankly don't have a lot of solutions for it. Surge capacity does just not exist in the world of hospitals."

Mr. Runge did say the Federal assets could be brought to the scene of a bombing, as did you earlier, but that could take some period of time, maybe a day or more, which may be too long for many critically injured victims.

So your own expert does not think we are prepared. Why, do you disagree with Dr. Runge's assessment?

Secretary CHERTOFF. I wasn't here for the testimony. I think it depends on the number of people. If there are—I can certainly imagine an attack of a dimension that would overwhelm local resources. That is the very premise of what our position is with respect to planning. It is the recognition that the Federal Government would have to step in and surge. And obviously since we are doing a gap analysis, I am going to be the first person to tell you there are undoubtedly gaps that need to be plugged, some of which are planning, and some of which are capability gaps.

What I can't tell you is that this is simply a matter of emergency rooms. I think it is a much more complicated issue than that. I will also obviously acknowledge I am awaiting more precision in the results of the HHS study with respect to the country as a whole.

Chairman WAXMAN. Well, I don't doubt it is more complicated than one factor or another, but what I fear, and what the experts told us a couple days ago, is if we go ahead with these Medicaid cuts, withdrawing billions of dollars from hospitals that have Trauma I centers and emergency rooms, we will be making the problem worse. We will make it less sure that we can even meet the response that we found so inadequate in our survey on March 25th. At that time the staff called Los Angeles, and three of the five Level I hospitals that were so overcrowded, they simply shut their doors. There wasn't even a terrorist attack. They shut their doors and said divert these people somewhere else. And Washington, DC, both Level I trauma centers surveyed are over capacity and treating patients in hallways and waiting rooms.

So if, in the middle of this inadequate capability of our emergency rooms to deal with ordinary problems, we had a terrorist attack, I just think that if we go ahead with the billions of cuts in Medicaid funds for those institutions, we are making the problem worse. The first thing at the Federal level is at least not do any harm. I think a lot of people can ask how is it possible that 6 years since 9/11, nearly 3 years after Hurricane Katrina, we have spent billions of taxpayer dollars on homeland security, and yet our emergency systems are not in place?

I don't doubt that you have very good intentions and a lot of helpful initiatives, but the problem is that the positive effect of these programs, which involve grants of millions of dollars, are going to be overwhelmed when we pull out billions of dollars in some of these Medicaid cuts.

We were told Monday that the Medicaid regulations will cripple hospital emergency rooms. The head of Virginia's emergency response program said if you take away significant Medicaid funding, it is going to be disastrous. An expert from UCLA said the regulations would cripple emergency care in Los Angeles.

Secretary Leavitt, do you think these experts are wrong?

Secretary LEAVITT. Mr. Chairman, I think we are dealing with two fundamentally different assumptions. They are fundamentally different assumptions in two areas. The first is the way surge capacity works, and that we would have to rely on hospitals as the bed for surge capacity. The second is that the mission of Medicaid is the assurance of emergency preparedness.

Let me deal with the first one, surge capacity and the way it works.

Chairman WAXMAN. I am asking about the Medicaid, the Medicaid cuts by these new regulations. I know we contacted you and your Department, and we asked for every document that you might have that would indicate that you—if you—did an analysis to find out what the impact would be of these Medicaid regulations. And I think we might have even sent the same request to the Department of Homeland Security. And we found that there was not a single analysis of the effects of the Medicaid regulations on our Nation's emergency rooms. If that is the case—maybe we haven't received it, but if that is the case, no analysis has been done. I just think that is irresponsible.

Secretary LEAVITT. Mr. Chairman, we have exercises on a regular basis, and the people from CMS sit at the same table as those from our Assistant Secretary for Preparedness and Response. Medicaid's mission, however, is not emergency preparedness; it is to provide health care to people, not to support institutions. Now, at HHS we have a very important Assistant Secretary for Preparedness and Response who is tasked with that responsibility. We have made substantial investments in developing surge capacity.

Chairman WAXMAN. Did he do an analysis of what the impact would be of the Medicaid regulations that withdraw money from these institutions?

Secretary LEAVITT. He manages emergency response, not Medicaid. The analysis on Medicaid was based on the fact that the funds were being drawn for purposes that we believe were inappropriate under the mission of Medicaid, which we believe to be helping people, not supporting institutions.

Chairman WAXMAN. Well, they help people by supporting institutions. Our public hospitals are absolutely dependent on the Medicaid dollars. They have so many people that come into emergency rooms that have no insurance, and the hospitals then have to shift the cost. And then if they find that Medicaid is not going to pay them for graduate medical education or other functions that they serve, they just have to give up the expensive things like Level I trauma centers. That is what they are telling us. But it looks like they never told you because they were never asked the question of what the impact would be with these Medicaid cuts.

Secretary LEAVITT. Mr. Chairman, it probably won't surprise you that I hear similar expression from those who run schools, who say, we need to have more money for our schools, and if we can find a way to get Medicaid money to support our school effort, it will help our schools. I hear a similar thing from those who run child welfare programs; if we could just get some Medicaid money, it would help us, and they stretch it over to health care. Medicaid was not intended to be our emergency response mechanism.

Chairman WAXMAN. It wasn't intended, but, in fact, it is.

Secretary Chertoff, you are head of the Homeland Security. You have designated this issue of health care functioning to HHS, and yet they are saying that they don't know what the impact is going to be of these cuts.

Congress always holds hearings after the fact. After Hurricane Katrina and that disaster, we held hearings, and we asked, how could this happen? This is a hearing to find out if we are prepared. I don't want it on my conscience years after a terrorist attack, God

forbid, that we realize that we didn't do what was necessary because the bureaucracies weren't functioning the way they should, the planning wasn't taking place, that there was money being withdrawn so that the whole system, which is all very fragile in this country for health care, wasn't able to function when it came to emergency care or preparedness for a surge of victims of a terrorist attack. I don't want it on my conscience.

Do you feel that you can tell us today that your conscience would say that we are doing all that we need to do, Secretary Leavitt and Secretary Chertoff?

Secretary LEAVITT. Mr. Chairman, I share with you the worry about surge capacity. It is a responsibility that I have and we have at HHS. I also worry about the long-term sustainability of Medicaid. Medicaid was not designed nor intended to be the source of money that we use to design an effective surge capacity strategy in this country. We do have a means by which that should be done. If Congress in its wisdom believes that more money is needed for more surge capacity, we need to use the intended vehicle. We need to apply it to a logical, thoughtful strategy. That logical and thoughtful strategy will not include emergency rooms being the only place where surge capacity takes place. There is not an emergency room in America for which you can't build a scenario that will blow the doors off in a very short period of time.

Chairman WAXMAN. So you feel good about the situation?

Secretary LEAVITT. No, that is not what I said at all, Mr. Chairman. I said I don't feel good about the situation, but I don't believe Medicaid is the way to solve it.

Chairman WAXMAN. And you think we ought to give other money, but we haven't been asked to give other money for this purpose.

Secretary Chertoff, how do you feel?

Secretary CHERTOFF. I actually agree with Secretary Leavitt on this. I think that I am the last person to tell you I think we are done. I think that we aren't—and I have been involved in more specifically looking at the issue of emergency response in the Gulf States. But more generally I think we need to be identifying gaps based on planning done at a Federal, State and local level. And then if we need to plug the gaps with money, the money ought to be targeted to plug the gaps.

Although I am seeing a bit of a disconnect, I have no reason to believe that giving more Medicaid money to hospitals is going to result in that money being spent specifically on those items which would be required to deal with a surge situation. Nor is it obvious to me that the only solution in this surge situation is the emergency rooms.

So the question to me would be, do they need to have additional beds in storage? Do they need to have additional ventilators or medication or things of that sort? And if, in fact, there is a gap, that ought to be directly funded, but with the understanding that money is going to be spent on those issues. I have no reason to believe that Medicaid funding in a hospital is necessarily going to be dedicated to emergency response as opposed to something else.

Chairman WAXMAN. A lot of it is being dedicated to this now, and that money is going to be withdrawn, and it is a sizable amount of money.

I have taken up 13 minutes, and I am going to give 13 minutes to Mr. Davis.

Mr. DAVIS OF VIRGINIA. Thank you, Mr. Chairman.

Secretary Leavitt, let me start with you. Thanks for being here. Regardless of one's views on the regulation, I am concerned about using Medicaid reimbursement to support emergency medical preparedness because it is an imperfect financial tool. In my experience, hospitals use additional revenues created through reimbursement policy. They can be reinvested in ways that may not improve emergency capacity, as Secretary Chertoff just noted. For example, hospitals may more regularly reinvest in expanding capacity for profitable services, orthopedics for example.

Do you think that additional Medicaid reimbursement necessarily results in improved emergency surge capacity?

Secretary LEAVITT. There is no evidence that it does.

Mr. DAVIS OF VIRGINIA. Thank you very much.

I mean, Medicaid is the fastest-growing part of the Federal budget. It is the fastest-growing part of States' budgets as well. And to allow this to continue without tampering and looking at ways that we can improve service, but at the same time cut back costs means there won't be money for a lot of other things in the budget downstream.

Let me ask you this, Secretary Leavitt. For the Homeland Security Presidential Directive 21, it is my understanding that there is a stakeholder group that is working on the different financial levers available to improve preparedness. The group is looking at Medicare, Medicaid, private payer, grant funding and market forces. How does this group's work inform future funding decisions made at the Department?

Secretary LEAVITT. That group is looking at that question as well as many, many others to inform this question. Until I receive their report, I don't know what they will say. I think it is clear that homeland security is everyone's second job. We all have a primary job. The job of Medicaid is to take care of people who are poor or indigent or disabled, and States are using ambiguities in the law to try and tap that fund for many different reasons.

Mr. DAVIS OF VIRGINIA. Because it is the largest part of their budget?

Secretary LEAVITT. And they have determined——

Mr. DAVIS OF VIRGINIA. Even in economic downturns when their revenues are less, the Medicaid costs are going up.

Secretary LEAVITT. In fact, Mr. Davis, I would make the point that Medicaid is the single greatest influence on State budgets right now.

Mr. DAVIS OF VIRGINIA. I agree.

Secretary LEAVITT. And if you wanted to see why States were not investing and why they were looking for ways in which they could divert Federal funds into schools and to child welfare and to public health and public safety, it is because Medicaid is pushing all those things out and crowding them out. Their capacity to do that is being compromised by the fact that the program is growing so fast.

Mr. DAVIS OF VIRGINIA. And understand this, 10, 12 years ago it was really not a factor in State governments the way it is today.

Secretary LEAVITT. I was elected Governor in 1993, and I would have to check this, but I believe it was in the neighborhood of 6 percent of the State budget. Today, again, I would have to check, but I am guessing it is like every other State in that it is close to 20 percent. That means every one of those dollars is crowding out education, it is crowding out higher education, it is crowding out public response and preparedness, all of the things we are talking about.

Mr. DAVIS OF VIRGINIA. So in point of fact, putting more money into this may have the opposite effect?

Secretary LEAVITT. Well, it has had the opposite effect.

Mr. DAVIS OF VIRGINIA. The Homeland Security Presidential Directive 21 requires that the group review financial incentives that improve preparedness without increasing health care costs. There are economic reasons that hospitals have not increased emergency department capacity or the number of inpatient beds. How does the health system increase capacity without increasing costs?

Secretary LEAVITT. Well, I want to emphasize in this process the whole concept of an all-perils response. Everything we do to prepare, for example, for a pandemic helps us for a bioterrorism event. Anything we can do that will use the same assets for multiple things allows us to expand capacity without expanding costs. The idea of sharing assets.

The way our surge capacity is designed to work, we know that there is a scenario for every hospital, no matter how big, no matter how well funded, no matter how sophisticated, that the capacity will exceed their ability to deal with that. And therefore every hospital and every community needs to have a surge capacity plan that allows them to use schools that may, in fact, have been mothballed. Or I have seen plans where shopping centers are converted into surge capacity. I have actually witnessed during Katrina convention centers being turned into hospitals, and very good hospitals, in the context of 24 hours.

So surge capacity is about using existing assets to convert to hospital capacity very quickly. It is not simply using the emergency room. If you were to look at any emergency room in this country, you would see that at least half of what is there at any given moment would not be considered absolutely critical. And if we turn into an emergency, those will be moved away or asked to be deferred, and we will have substantial capacity that would not have been evident in the snapshot that was taken that the chairman referred to.

Mr. DAVIS OF VIRGINIA. Thank you.

I would like to ask unanimous consent that a Wall Street Journal article, Nonprofit Hospitals Once for the Poor Strike It Rich, be included in the hearing record.

Chairman WAXMAN. Without objection.

[The information referred to follows:]

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April 4, 2008

PAGE ONE

Nonprofit Hospitals, Once For the Poor, Strike It Rich

With Tax Breaks, They Outperform For-Profit Rivals

By JOHN CARREYROU and BARBARA MARTINEZ
April 4, 2008; Page A1

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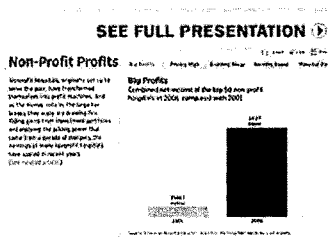
Nonprofit hospitals, originally set up to serve the poor, have transformed themselves into profit machines. And as the money rolls in, the large tax breaks they receive are drawing fire.

Riding gains from investment portfolios and enjoying the pricing power that came from a decade of mergers, many nonprofit hospitals have seen earnings soar in recent years. The combined net income of the 50 largest nonprofit hospitals jumped nearly eight-fold to $4.27 billion between 2001 and 2006, according to a Wall Street Journal analysis of data from the American Hospital Directory. AHD, an information-service company, compiles data that hospitals report to the federal government.



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The Cleveland Clinic swung from a loss to net income of $229 million during that period. No fewer than 25 nonprofit hospitals or hospital systems now earn more than $250 million a year. One nonprofit hospital system, Ascension Health, has a treasure chest of $7.4 billion -- more than many large, publicly traded companies.

Nonprofits, which account for a majority of U.S. hospitals, are faring even better than their for-profit counterparts: 77% of the 2,033 U.S. nonprofit hospitals are in the black, while just 61% of for-profit hospitals are profitable, according to the AHD data.

At some nonprofits, the good times are reflected in new facilities and rich executive pay. Flush with cash, Northwestern Memorial Hospital in Chicago has rebuilt its entire campus since 1999 at a cost of more than $1 billion. In October, it opened a new women's hospital that features marble in the lobby, birthing rooms with flat-screen televisions, 1,000 works of art and a roof topped with 10,000 square feet of gardens. In 2006, Northwestern Memorial's former chief executive officer, Gary Mecklenburg, received a $16.4 million payout.

But Northwestern Memorial has been frugal in its spending on charity care, the free treatment for poor patients that nonprofit hospitals are expected to provide in return for the federal and state tax breaks they receive. In 2006, Northwestern Memorial spent $20.8 million on charity care -- less than 2% of its revenues and a fraction of what it received in tax breaks. By comparison, the hospitals run by Cook County, where Northwestern Memorial is located, spent 14% of revenues on charity care.

WSJ's John Carreyrou provides a tour of Chicago's non-profit Northwestern Memorial Hospital, which underwent a renovation costing more than $1 billion.

Northwestern Memorial says that in addition to charity care, it provides other benefits to its community, such as pioneering research in obstetrics and other areas that improve standards of care nationally.

To be sure, some nonprofit hospitals, particularly ones in inner cities that handle large numbers of uninsured patients, remain under financial strain and are struggling to keep their doors open.

But the growing gap between many nonprofit hospitals' wealth and what they give back to their communities is raising questions about the billions of dollars in tax exemptions they receive.

BACKSTORY

• Read more about how[2] nonprofit hospitals went from charity and tax breaks to healthy profits.

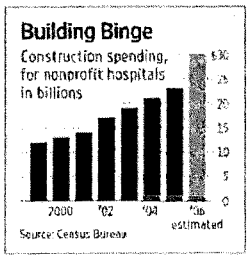
"Some nonprofit hospitals seem to forget that their operations are subsidized with generous tax breaks. They allow their priorities to get out of whack," says Sen. Charles Grassley. The senior Republican on the Senate Finance Committee threatened last year to introduce legislation forcing nonprofit hospitals to provide a minimum amount of charity care.

Nonprofit hospitals account for about 60% of the more than 3,400 hospitals in the U.S. The rest are either for-profit or government-owned.

In a report issued in December 2006, the Congressional Budget Office estimated nonprofit hospitals receive $12.6 billion in annual tax exemptions, on top of the $32 billion in federal, state and local subsidies the hospital industry as a whole receives each year.

Community Benefit

In return for not paying taxes, nonprofit hospitals are supposed to provide a "community benefit," a loosely defined requirement whose most important component is charity care. But many hospitals include other expenses in their community-benefit accounting to the Internal Revenue Service, including unpaid patient bills. Often, hospitals also include the difference between the list prices of treatment they provide and what they are paid by Medicaid and Medicare, the government programs for the poor, disabled and elderly. Excluding those other expenses, many hospitals spend less on charity care than they get in tax breaks, studies by various counties and states show.



One nonprofit hospital system, St. Louis-based BJC HealthCare, counts the salaries of its employees as a community benefit. BJC, which runs 14 hospitals in Missouri and Illinois, says on its Web site that it provided more than $1.8 billion in benefits to various communities in 2004. Its payroll, including its CEO's $1.8 million compensation, accounted for $937 million of that figure, while charity care represented $35 million, according to BJC.

"The impact that any organization that's job-producing and buying goods has on a community is of benefit to that community," says BJC HealthCare spokeswoman June Fowler. However, she says BJC won't count its payroll as a community benefit in the future because of new standards adopted by the IRS.

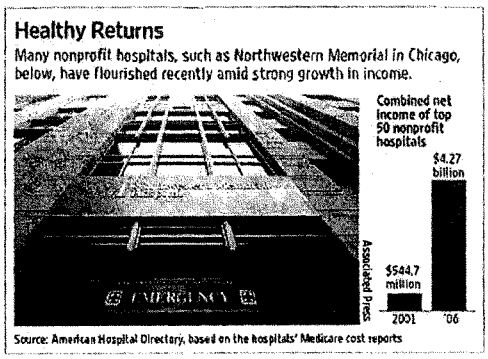
The new standards, due to take full effect in 2009, will require nonprofit hospitals to break out specifics of their community-benefit contributions. But they won't require the hospitals to provide any minimum amount of charity care.

The size of nonprofit hospitals' tax exemptions is coming under scrutiny in part because their incomes have risen so sharply in recent years, and because they represent such a big chunk of America's health-care spending. Thirty-one cents of every dollar spent on medical care is spent on hospitals.

One reason for hospitals' soaring profits is a gradual increase in Medicare

reimbursements after federal budget cutbacks during the 1990s. By merging and gaining scale, many hospitals also gained leverage in price negotiations with health insurers.

However, much of the industry's profit growth comes from strategies it honed to increase profits. Among them: demanding upfront payments from patients; hiking list prices for procedures and services to several times their actual cost; selling patients' debts to collection companies; focusing on expensive procedures; and issuing tax-exempt bonds and investing the proceeds in higher-yielding securities.



Untaxed investment gains have greatly increased some hospitals' cash piles. Ascension Health, a Catholic nonprofit system that runs 65 hospitals, mostly in the Midwest and Northeast, reported net income of $1.2 billion in its fiscal year ended June 30, 2007, and cash and investments of $7.4 billion. That's more cash than Walt Disney Co. has.

Ascension says it needs to maintain a sufficient amount of cash to pay for charity care, to keep the interest rates it pays on its debt low, to provide retirement benefits to its 106,000 employees, and to make capital and technology investments at its hospitals.

At the University of Pittsburgh Medical Center, which runs 20 facilities, cash and investments totaled $3.35 billion at the end of last year. UPMC says the money goes toward producing "world-class health care, education and research," citing the $1 billion it spent over five years to create electronic medical records for patients and an additional $500 million to build a children's hospital and a network of cancer centers.

But some of UPMC's expenses are only tenuously related to medicine. In its 2006 fiscal year, UPMC also spent $10 million on advertising, including $1 million on ads in the New York Times. Wendy Zellner, a spokeswoman for the hospital, says the ads enable UPMC "to better compete with other leading hospitals."

UPMC paid its CEO, Jeffrey Romoff, $3.3 million in fiscal 2006. Mr. Romoff also received $36,995 from the hospital to cover a car allowance, spousal travel and

legal and financial counseling. Ms. Zellner says what UPMC pays Mr. Romoff is in line with "nonprofit and for-profit organizations of comparable scope and complexity."

Some nonprofit hospital executives enjoy other perks. Royal Oak, Mich.-based Beaumont Hospitals says it paid $10,795 for the country-club membership of the president of its foundation last year. A spokeswoman for Beaumont says it pays for the membership to provide the executive "a venue with access to potential donors."

The Cleveland Clinic continued to pay its former CEO, Floyd Loop, more than $1 million a year for two years after he retired in April 2005. The Cleveland Clinic says part of that was deferred compensation and vacation pay and the rest was for consulting services.

Hospitable Pay

Some of the best paid nonprofit hospital CEOs

CEO	Hospital	Total accrued compensation, in millions	Year
Gary Mecklenburg*	Northwestern Memorial Hospital	**$16.4**	2006
Floyd Loop†	Cleveland Clinic	**7.5**	2006
Mark Neaman	Evanston Northwestern Healthcare	**5.4**	2006
Lloyd Dean	Catholic Healthcare West	**5.3**	2006
Philip Incarnati	McLaren Health Care Corp.	**5.2**	2006
Joseph Trunfio	AHS Hospital Corp.	**5.0**	2005
Alan Brass	ProMedica	**4.1**	2005
Herbert Pardes	New York-Presbyterian	**3.5**	2006
Jeffrey Romoff	UPMC	**3.3**	2006
Douglas French‡	Ascension Health	**3.3**	2004

*Retired on Sept. 1, 2006; total includes a retirement payout and deferred compensation †Retired in April 2005; $6.4 million of the $7.5 million is a split-dollar life insurance policy, the rest is deferred compensation, vacation pay and consulting fees ‡Resigned in May 2004

Sources: Forms 990 filed to the IRS; the hospitals

The University of California San Francisco Medical Center provided its CEO and chief operating officer low-interest mortgage loans of more than $1 million each, according to the University of California's executive compensation reports. A UCSF spokeswoman says such loans help recruit and retain executives, given the area's high cost of housing.

Catholic Healthcare West, a hospital system based in San Francisco, forgave a $782,541 housing loan it made to its CEO, Lloyd Dean. Counting the forgiven loan, Mr. Dean's total accrued compensation in 2005 was $5.8 million. Catholic Healthcare West says his compensation reflects his skill in turning the hospital system around financially.

One nonprofit hospital executive who has benefited from the industry's good fortunes is Mr. Mecklenburg, the former CEO of Chicago's Northwestern Memorial. The hospital says it paid him $5.45 million in salary, bonus and deferred compensation in its fiscal year ended Aug. 31, 2006, and an additional $10.95 million when he retired the next day. The hospital also awarded five other executives a combined $13.3 million in total compensation in fiscal 2006, according to its filings to the IRS.

Mr. Mecklenburg, now a partner at Chicago private-equity firm Waud Capital Partners LLC, declined to comment, referring questions to the hospital and to the former chairman of its compensation committee, James Denny.

Stellar Results

Northwestern Memorial says a big part of Mr. Mecklenburg's $16.4 million payout represents retirement benefits and deferred compensation accrued over his 21-year tenure. Mr. Denny, who chaired the hospital's compensation committee from 1995 to January 2008, says Mr. Mecklenburg delivered stellar results, nearly quintupling the hospital's patient revenues. "Our view of it is: This is the best deal we've ever made," he says.

Critics argue that Mr. Mecklenburg's compensation is excessive for a charity organization that gets tens of millions of dollars a year in tax breaks. Northwestern Memorial sits on property on the Gold Coast, Chicago's most affluent neighborhood, abutting Lake Michigan. The Center for Tax and Budget Accountability, a Chicago nonprofit organization, estimates the value of the hospital's annual property-tax exemption at $37.5 million. Northwestern Memorial is also exempt from $12.5 million in sales tax for a total of $50 million in annual tax exemptions, not counting the taxes it doesn't pay on its investment gains, the center estimates.

"The hospital's tax benefit is more than two times greater than the charity care provided," says Heather O'Donnell, the center's health-care policy director.

Northwestern Memorial says it hasn't calculated the value of its tax exemptions. Robert Christie, the hospital's vice president for government relations, notes that the Center for Tax and Budget Accountability receives funding from the Service Employees International Union, which represents numerous hospital employees and frequently clashes with hospitals in labor disputes. Ms. O'Donnell says her organization receives funding from many foundations besides SEIU.

Peter McCanna, Northwestern Memorial's chief financial officer, says the hospital's contribution to its community should be judged more broadly. "We fundamentally disagree with narrowing [the definition of] our community-benefit contribution to charity care," he says. He says Northwestern Memorial's research and education expenses should also be counted. The hospital is the primary teaching hospital for Northwestern University's Feinberg School of Medicine.

Taking into account educational and other expenses, such as bad debt and unreimbursed Medicaid costs, Northwestern Memorial values its total community-benefit contribution at $230 million for fiscal 2006.

Room Service

Around Chicago, Northwestern Memorial is known as a hospital that attracts the well-heeled. It's a short walk from the Magnificent Mile, the famous thoroughfare lined with expensive shops and restaurants. At Northwestern Memorial's new Prentice Women's Hospital, expectant mothers can watch TV or browse the Internet on 42-inch flat-screen televisions, order room service 24 hours a day and page nurses and doctors via a wireless system. Some birthing rooms have views of Lake Michigan. Only 6% of Northwestern Memorial's patient revenues come from Medicaid.

By comparison, Sacred Heart Hospital, a small for-profit hospital in a poor neighborhood on the west side of the city, gets 62% of its revenues from Medicaid and pays several million dollars a year in taxes, according to its president, Edward Novak. Parts of Sacred Heart date back to 1928, when the hospital was founded. Another wing was built in 1950. Mr. Novak says he would like to replace the aging hospital with a new facility, but is struggling to figure out how to pay for it. He says his compensation is less than $220,000 a year.

At John H. Stroger Jr. Hospital -- formerly known as Cook County Hospital -- 56% of patients don't have any insurance when they are admitted, says John Cookinham, the hospital's chief financial officer. At Northwestern Memorial, the percentage of uninsured patients is less than 5%. Stroger's chief operating officer earned $204,485 in 2007, according to Cook County budget records.

In recent years, some nonprofit hospitals have decided to stop using the courts to collect from patients who owe them money. But Northwestern Memorial pursues patients such as Iris Ayala who haven't paid their bills. While running an errand for her employer, the 50-year-old Ms. Ayala fainted and collapsed in the street one day in 2006. A friend rushed her to Northwestern Memorial's emergency room.

Ms. Ayala says her insurer paid for the bulk of her 24-hour hospital stay, but she was responsible for a $1,035.39 co-pay. Working only part-time because of health issues and with a daughter in college, she says she couldn't afford her portion of the bill.

After representatives for Northwestern Memorial repeatedly called her to ask for payment, Ms. Ayala says she promised she would settle the bill once she got her annual tax refund. But Northwestern Memorial sued her in Cook County Circuit Court in July 2007. To make the lawsuit go away, Ms. Ayala says she borrowed the money and paid the hospital. "They didn't want to hear my sob story," she says.

Northwestern Memorial declined to discuss Ms. Ayala's case, citing patient privacy laws. Mr. McCanna says the hospital sued only 82 patients in 2006 and 2007, a number he says is small compared with the more than one million accounts it billed over that period. He says the hospital tries to determine whether patients who are

behind on bills qualify for assistance, but some can't be reached or refuse to volunteer information about their finances. "Absent of information, a lawsuit is sometimes the only recourse," he says. Mr. McCanna adds that, in some cases, the hospital has waived patients' bills after later learning that they did qualify for aid.

Northwestern Memorial says its strong balance sheet allows it to provide outstanding care and conduct innovative research. As of Aug. 31, 2007, its cash and investments totaled $1.82 billion, making it one of richest individual nonprofit hospitals in the country. With such a treasure chest, it could operate for a year and two months without any revenue -- a gauge of financial strength Mr. McCanna highlights in presentations to bond investors and analysts.

"Nonprofit is a misnomer -- it's nontaxable," says Sacred Heart Hospital's Mr. Novak. "When you're making hundreds of millions of dollars a year, how can you call yourself a not-for-profit?"

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Mr. DAVIS OF VIRGINIA. Thank you.

The majority staff report on the status of emergency departments looked at 34 hospitals and found that many were operating at or above capacity. Three hospitals were diverting ambulances, including one hospital that is undergoing a major expansion that includes the recent purchase of 3 million pounds of travertine imported from Tivoli, Italy, and 569 flat-panel TVs. Another hospital that, according to the majority report, had patients in overflow spaces and borders has also undergone a significant expansion that included a new women's hospital with marble in the lobby, and flat-screen TVs, and birthing rooms. Both of these hospitals are nonprofits and it appears that they have sufficient resources to invest in marble and TVs, but not enough to invest in emergency departments.

Is this typical, and is this appropriate in your view?

Secretary LEAVITT. Well, it is not appropriate, in my mind. I don't know how typical it is. I think the point you are making is a good one, and that is many times the lack of emergency room capacity is because the administration of the hospital has chosen not to invest there because it didn't, in fact, assist their business model.

Mr. DAVIS OF VIRGINIA. And, in fact, raising Medicare reimbursement and diverting that money to pay for marble floors and flat-screen televisions really doesn't go anywhere to solve this problem, does it?

Secretary LEAVITT. You made the point earlier that there is no assuredness or no guarantee that money coming from Medicaid would go into emergency preparedness, and there is no direct link.

Mr. DAVIS OF VIRGINIA. The question is, if we want to look at surge capacity, perhaps Medicaid is not the best way to look at that.

Secretary LEAVITT. Indeed, Mr. Davis, it is not. I want to emphasize I believe that there are deficiencies in our surge capacity. I just don't believe Medicaid dollars is the source of funds that ought to be directed or looked to to link to that solution.

Mr. DAVIS OF VIRGINIA. Thank you.

Secretary Chertoff, thanks for being with us today. Does DHS have the expertise to determine the appropriateness of any of the following matters as it relates to Medicaid? Let me go through them. Whether public providers should be limited to cost in Medicaid reimbursement.

Secretary CHERTOFF. No, we rely on HHS. Frankly, the whole issue of Medicaid is not actually within our purview. So the short answer is no, we don't have the expertise.

Mr. DAVIS OF VIRGINIA. Do you have the expertise to determine the appropriateness of the definition of unitive government for health providers that treat Medicaid patients?

Secretary CHERTOFF. No.

Mr. DAVIS OF VIRGINIA. How about the appropriateness of graduate medical education payments in Medicaid?

Secretary CHERTOFF. No.

Mr. DAVIS OF VIRGINIA. How about the scope of rehabilitation services?

Secretary CHERTOFF. No.

Mr. DAVIS OF VIRGINIA. How about the appropriateness of the administrative claims for schools?

Secretary CHERTOFF. No.

Mr. DAVIS OF VIRGINIA. The definition of the scope of outpatient services?

Secretary CHERTOFF. No.

Mr. DAVIS OF VIRGINIA. The definition of the scope of targeted case management services.

Secretary CHERTOFF. No.

Mr. DAVIS OF VIRGINIA. Thank you.

The National Response Framework encompasses a broad array of functions and entities.

Secretary CHERTOFF. Correct.

Mr. DAVIS OF VIRGINIA. For example, transportation, communication, roads, utility and public work infrastructure may all be heavily used in an emergency; however, these facilities also have important functions unrelated to disaster response or homeland security. Therefore it seems imprudent to describe any service that might have a role in an emergency as a homeland security activity.

How do you determine what functions are primarily related to homeland disaster compared to those that are tangentially related?

Secretary CHERTOFF. Well, I agree with you. The key philosophy is what is directly related, and the way we go about that is we put together a plan. We analyze what are the core capabilities that we have to have to respond effectively. We then identify and survey whether there are gaps in those capabilities, and then we determine what is the best way to plug those gaps.

Mr. DAVIS OF VIRGINIA. Thank you.

Mr. Shays.

Mr. SHAYS. Thank you both for being here, and thank you, Mr. Chairman, for having this hearing.

I am wrestling with the fact that I think we are really dealing with two issues. We are dealing with the health care issues and the needs of our hospitals, and we are dealing with a potential catastrophic event and a surge capacity. I would like to know from each of you who has the responsibility? First, has there been a study done that looks at the entire United States to say how many Trauma I, Trauma II and Trauma III centers we need and ideally where they should be located?

Secretary LEAVITT. Mr. Shays, with respect to emergencies, we are currently doing a study right now under the matter that was referred to earlier.

Mr. SHAYS. Can you move the mike a little closer?

Secretary LEAVITT. Yes. We are currently doing a study under HSPD 21, the group that was referred to earlier. However, I can also tell you that we are asking and requiring grantees of HHS for pandemic preparedness to give us information about their surge capacity plan. Between those two, we will have a very good idea in the future as what the capacity is and where our gaps are.

I would also like to make the point——

Mr. SHAYS. When do you think that would be done?

Secretary LEAVITT. We expect it to be done by the end of this year so that we can make the report before the end—conclusion of this term.

But I would like you to know that we already have the capacity at any given moment to determine where rooms and beds are available anywhere in the country within a reasonably short period of time. During Katrina I was constantly updated as to how many beds we had anywhere in a region that we could move patients to. This is an important part of the way surge capacity works. We are discussing surge capacity today as to what you can put into an emergency room at any given hour. That is not the way surge capacity works.

Mr. SHAYS. I want to make sure that my colleague has time. I would like a brief comment from both of you as to who is ultimately responsible for this issue, because it seems to me like when two people are, no one is.

Secretary LEAVITT. I think we both agree HHS has responsibility for any matter related to medical response in a disaster.

Mr. SHAYS. And so it would be your job, not DHS, to determine how many Trauma I, II and III units we need around the country.

Secretary LEAVITT. Well, it will be our determination to determine how many we have, what our gap is and how best to respond to that.

Mr. SHAYS. Thank you.

Mr. ISSA. Thank you.

Governor, I will continue along that line. With 259 trauma centers in the country, 5 in San Diego, 4 in Utah, it is very clear that in San Diego we have as much capacity for our 2 million people in a relatively small area as Utah has in a huge area. For all practical purposes, in the case of disasters of any sort, take the Northridge earthquake, aren't we essentially always assuming for homeland security that they are going to be in high-risk areas, where ultimately the people of Utah or Oklahoma or Wyoming could just as easily have a huge disaster affecting thousands of people over an area that could not possibly concentrate the types of hospitals that we have in Los Angeles or San Diego? So ultimately isn't the planning for major disasters more about the essential planning and training and ability to move people than it ever will be about having operational extra spaces in one location?

Secretary LEAVITT. Yes. There is no one area of the country capable of handling their own surge in an event of sufficient size to require that kind of capacity.

Chairman WAXMAN. Mr. Davis, your time has expired.

Ms. McCollum.

Ms. MCCOLLUM. Mr. Chairman, the report conducted by the committee highlights serious challenges confronting hospital emergency rooms, and crowding is a serious problem. The American College of Emergency Physicians released a report last month that addresses the crowding issue. The report asks what causes crowding, and it responds, "Over the years the reasons for crowding have included seasonal illnesses, visits by the poor and the uninsured who have nowhere else to turn except the safety net provided by emergency departments. This country can continue to expand the capacity of emergency rooms, to serve as a provider of last resort for the uninsured and the mentally ill, or Congress can work to provide universal health care for all Americans. The choice is ours."

Mr. Chairman, I don't know about the situation in New York, Washington, Chicago, Houston, Denver or Los Angeles. I have never visited an emergency in any of those cities, so I will take this report's findings as accurate. But I live in Minnesota, and I need to set the record straight.

First, the report inaccurately states that Minneapolis is hosting the 2008 Republican Convention. The convention will take place in St. Paul, MN, my congressional district, with Minneapolis accommodating many of the visitors. This distinction is important, especially for the St. Paul officials, first responders, health care professionals involved in preparing to meet the needs of 40,000 visitors, including the President of the United States and Republican nominee for President.

Second, the report examines Hennepin County Medical Center, which is an excellent hospital and a Level I trauma center located in Minneapolis. In the event of an emergency at the national Republican convention, Regions Hospital in St. Paul, an excellent facility, will be the primary responder, with the hospital examined in the report providing support.

What concerns me about this report is it examines Minneapolis solely as the presence of the national convention, yet it evaluates emergency room capacity on a random day, March 25, 2008. During the 4 days in September when the Republicans gather in St. Paul, there will be significant additional resources available to ensure a safe, enjoyable convention. There will also be an emergency plan and considerable assets in place to respond to any foreseen event.

The Department of Homeland Security designated the national party conventions as a national special security event. This Congress appropriated $50 million to each host city to ensure coordination is seamless between Homeland Security, Secret Service, local and State law enforcement and their first responders.

Finally, while I fully understand the use of Madrid terrorist attacks as a standard for assessing casualty preparedness, real American tragedies like the Oklahoma City bombing, Hurricane Katrina, Virginia Tech shooting could also have been used as models.

In the Twin Cities we don't need to investigate emergency room capacity using a telephone survey. Our first responders were forced to respond to an emergency in real time. Only 9 months ago on August 1, 2007, at 6:05 during rush hour, 8 lanes of traffic on Interstate 35W, the bridge, it collapsed into the Mississippi River. That night 13 people died, many my constituents. And more than 110 patients required emergency and medical attention. The bridge collapsed due to structural failure. It just as easily could have been the result of a terrorist attack, but the disaster tested the very hospital in the committee's report.

Hennepin County Medical Center and hospitals from the entire Twin Cities metropolitan area responded heroically, professionally and efficiently. Their response was not a simulation or a blind phone survey, it was real. And people are alive today because of that response.

Mr. Chairman, I have statements from Hennepin County Medical Center, Regions Medical Center, St. Paul's chief of police, Minnesota Hospital Association, and there are more to come that I will

submit to the record later. And I would like to have the committee's permission to enter these into the committee report.

Chairman WAXMAN. Without objection, that will be the order.

[The information referred to follows:]

Hennepin County Medical Center response to Surge Capacity Snapshot

Prepared: May 6, 2008

Hennepin County Medical Center encourages caution when interpreting the information contained in the Snapshot of Emergency Surge Capacity in Minneapolis. This report assesses daily operating capacity, but does take into account the surge capacity and capability that has been developed in the metro area. The progress has been significant and the system performed well when tested recently by a community event. This level of preparedness, however, is only possible with continued funding and, as the Snapshot report concludes, would be in jeopardy if federal funding is reduced.

Hennepin County Medical Center worked with 28 other metro hospitals to develop a comprehensive surge capacity plan that has been tested as recently as August 1, 2007, when the I35W Bridge collapsed.

At the time of the collapse, three ICU beds were available at Hennepin County Medical Center. Within 45 minutes, by putting the surge capacity plan into action, Hennepin was able to make 25 ICU beds available and the Emergency Department was able to open two thirds of its capacity.

Similar plans are in place at other Twin Cities hospitals that would produce 2500 – 3500 surge beds, with appropriate equipment, able to take patients in the event of a disaster. A community surge plan, including opening an offsite care facility, is also in place and has been exercised.

Continued funding at the current level, or even additional funding, would ensure that the system in Minnesota stays strong. All hospitals today are forced to operate at or near daily capacity. Hospitals are not able to "over staff" for disasters on a daily basis.

Think of it like a rubber band. More funding means a thicker rubber band (hospital emergency system) better able to stretch to respond to disasters. Less funding means a thinner, more brittle rubber band less able to stretch to respond to emergencies.

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Regions Hospital response to surge capacity snapshot

Regions Hospital in St. Paul, Minn., is a 427-bed, Level I Trauma Center and teaching hospital that has served Minnesota and western Wisconsin for more than 130 years. As a Level I Trauma Center, Regions is equipped to handle the most complex injuries and illnesses. Regions also has a burn center, verified as a regional burn center by the American Burn Association through the American College of Surgeons.

Regions trauma and emergency departments work closely with the hospital's Emergency Medical Services program. Regions also houses the East Metro Medical Resource Control Center (MRCC), which coordinates the care and transportation of patients in the area so that those with critical conditions receive the treatment they need from a hospital with the capacity to best serve them. In addition, Regions works in close collaboration with other hospitals in the Twin Cities, including the other Level I Trauma Centers: Hennepin County Medical Center and North Memorial Medical Center.

While Regions is prepared to care for the injured in the event of a Mass Casualty Incident (MCI), hospitals such as Regions serve as the safety net for a disproportionate number of uninsured and Medicaid patients. It is unrealistic to expect that these hospitals will be able to continue to respond effectively, as well as provide care for the uninsured/underinsured, should further cuts to the Medicaid program be made. Some hospitals across the nation have been forced to close their Level I Trauma Centers because of lack of reimbursement, which weakens these safety net hospitals and their ability to respond to MCIs should they occur.

As the only Level I Trauma Center and largest emergency department in the east metro, Regions is uniquely positioned to coordinate emergency medical services for the upcoming Republican National Convention. Preparations at Regions have been underway for more than a year with collaboration among departments internally and partnerships forming externally with hospitals, first responders, police, fire and other local entities. For our part, Regions expects to see as many as 300 patients a day in its emergency department during the RNC, up from 150 from what is considered normal activity. We will markedly increase staffing and equipment to accommodate this heightened demand.

Should our community be faced with an MCI, Regions and the other hospitals in the area will respond, as we do now, and care for whoever comes to our doors. We must ensure that the ability to respond to this need never disappears from our community by keeping our hospitals healthy and vibrant.

Regards,

Ralph Frascone, M.D.
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Senior physician, Emergency Center
Regions Hospital
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DEPARTMENT OF POLICE
John M. Harrington, Chief of Police

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May 6, 2008

Congresswoman Betty McCollum
1714 Longworth Bldg.
Washington D.C. 20515

Dear Congresswoman McCollum:

Thank you for providing me with an opportunity to respond to the City of Saint Paul's emergency preparedness leading up to the 2008 Republican National Convention in Saint Paul, Minnesota.

I would like to clarify for the Committee that while both the cities of Minneapolis and Saint Paul are hosts to the Republican National Convention from September 1 through September 4, the convention will take place in the Xcel Energy Center, located in downtown Saint Paul, Minnesota. The Saint Paul Police Department (SPPD) is the lead local agency in charge of security planning.

I recently became aware of a survey of level 1 trauma centers around the country. I found it more than a little disconcerting to find that the level 1 trauma center at the epicenter of this year's Republican National Convention was not one of those mentioned and, apparently, not evaluated.

One of the selection criteria that caused the City of Saint Paul to rise to the top was Regions hospital and its excellent trauma center along with an outstanding paramedic service provided by the City. As an example I would cite the recently published US Fire Administration Technical Report on the I-35W Bridge collapse response (USFA, 2008), Emergency Management was highlighted as one of the strengths of the successful response. Regions hospital and Saint Paul Fire Paramedics was a part of that response. Regions Hospital has been a close partner to the SPPD and the USSS in emergency preparedness in general and convention security planning in particular. In fact, the Regions Hospital EMS Medical Director, R.J. Frascone, has been a member of our planning subcommittees from the very beginning.

Thank you again for the opportunity to address this oversight.

Sincerely,

John M. Harrington
CHIEF OF POLICE

Statement from Bruce Rueben, President
Minnesota Hospital Association
May 6, 2008

"Minnesota hospitals are ready. Whether natural disaster or man-made emergency, hospitals have equipment and plans in place to best handle the unexpected. In the Twin Cities, hospitals have developed a coordinated response, working together to share resources and provide care.

While hospitals can't predict the scope and scale of a disaster, they can have thorough preparedness plans in place. Our plans were tested last August when the Interstate 35W bridge in Minneapolis collapsed into the Mississippi River. Hospitals were ready, treating more than 110 patients at twelve different hospitals across the city. National leaders praised Minnesota's quick and efficient response where patients were triaged at the scene and sent to the appropriate level of emergency department care."

Chairman WAXMAN. The gentlelady's time has expired. We will be pleased to have the rest of her statement in the record.

[The information referred to follows:]

I 35W Bridge Collapse Emergency Response Summary

Narrative summary

On Aug. 1, the 8-lane, 2000 foot I 35W interstate highway bridge collapsed into the Mississippi causing multiple injuries and deaths.

Hennepin County Medical Center's response and the performance of other hospitals and first responders validated resources put into careful and continual emergency planning and exercising that Hennepin County Medical Center has been leading for many years.

Hennepin County Medical Center is the Regional Hospital Resource Center for 29 hospitals in the 7-county metro area. Upon confirming the information from the first 911 call, the Medical Resource Control Center in the hospital's EMS dispatch center activated the web-based MN-Trak system to notify other hospitals and first responders and coordinate resources on a metro-wide basis.

Within two minutes of the initial reports from the dispatch center, Hennepin's lead emergency room physician declared an "Alert Orange" at the hospital, which activated our emergency operations plan throughout the institution.

Next steps included:
- creating room for patients by opening beds in the emergency department
- opening the Emergency Operations Center to manage hospital operations
- opening a labor pool to make staff available throughout the hospital

In short order we had:
- adequate physician, nursing, and support staff available throughout the hospital
- 10 operating rooms staffed and ready to go
- 3 CT scanners staffed and ready to go
- 25 open ICU beds ready for patients

Hennepin County Medical Center received 25 patients that night from the collapse. Six required emergent intubation.

EMS dispatch center coordinated ambulance response and all patients were transported from that very unstable scene to Hennepin and other hospitals in approximately two hours. Hennepin EMS also continued to provide full service coverage to the rest of its primary service area without "giving away" any calls throughout the night.

Other hospital operational responses:
- the Security Department locked down the buildings to control access to provide privacy for victims and their families and officers also provided increased patrol coverage and service
- Social Services, Chaplaincy, and other departments opened a family support area to provide comfort and information to families of victims and to those looking for family-members that evening
- physician leaders and the Public Relations department provided external communications to the large number of media that showed up instantly and transmitted information live around the world throughout the evening and for the next few days
- support departments including Facilities Management, Environmental Services, Information Technology, and many others responded to the immediate needs as a result of the incident and in the days following
- Critical Incident Stress Management services were provided to staff directly involved in the incident and other support services were made available to staff in the hours and days following the incident.

After-action information
Including patients who walked in for care over the next two days with injuries from the collapse, we received **31** patients from the incident. Metro hospitals treated a total of **126** victims from the event.

We have received, and continue to receive, an outpouring of support and recognition from the community in response to our work that night. From offers of food and volunteers, to posters from kids that say thanks, to mentions in editorials and letters to the editor, it has been gratifying to see that our response, and the work and resources that made such a response possible, are understood and valued by the community.

Media coverage was intense, both during and after the event. According to Nielsen research, TV stories and interviews that mention or include Hennepin County Medical were seen by 62-million people through last Friday. That does not include print, radio, or Internet coverage.

Chairman WAXMAN. Mr. Sali.

Mr. SALI. Thank you, Mr. Chairman.

Secretary Chertoff, border security is an important issue affecting Idahoans, and the need for secure travel documents I think they consider equally as important. Do you have any security concerns specifically with the use of matricula consular cards, passport cards, NEXUS and Sentry and PASS cards?

Secretary CHERTOFF. First, Mr. Chairman, I guess I do have to observe when I was invited here, I thought the topic was going to be medical surge. It is hard for me to see the correlation here, so I have to ask you whether you want me to answer this. But if you do, I will go ahead and answer.

Chairman WAXMAN. Well, the rules allow each Member to ask questions.

Secretary CHERTOFF. On any topic.

Well, the short answer is I think certainly our NEXUS cards and Sentry cards, our PASS cards which are about to be issued by the Department of State are secure. They reflect a substantial step forward in improving the security of our documentation. Likewise our laser border-crossing cards.

The matricula consular is not an American-issued card, so I can't warrant or vouch for the security of that. We don't rely upon that for purposes of allowing people to come across the border.

Mr. SALI. I think there is a relation here. I hear concerns for many areas of the country that part of the problem in hospitals is that they are overrun with illegal aliens in specific places. And part of the problem in dealing with the problem of illegal aliens is making sure that we have legal ways for people come to our country that are secure in fact.

Was there a recall on the NEXUS, Sentry or PASS cards during the last year or two?

Secretary CHERTOFF. Not that I am aware of.

Chairman WAXMAN. Mr. Sali, it is your time to ask questions, but you are off the topic for which we have invited the Secretaries to speak, I guess Secretary Chertoff will have to decide whether he is prepared to respond. But——

Mr. SALI. Well, Mr. Chairman——

Secretary CHERTOFF. I could find out. I didn't come prepared to talk about it.

Mr. SALI. Perhaps the Secretary would be willing to respond to some of these questions in writing——

Secretary CHERTOFF. Sure.

Mr. SALI [continuing]. If I submit them to the committee.

[The information referred to follows:]

BILL SALI
1ST DISTRICT, IDAHO

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May 12, 2008

The Honorable Michael Chertoff
Secretary
United States Department of Homeland Security
Washington, DC 20528

Dear Secretary Chertoff:

Thank you for your testimony and participation at the Committee on Oversight and Government Reform's May 7, 2008 hearing, "The Lack of Hospital Emergency Surge Capacity: Will the Administration's Medicaid Regulations Make It Worse?"

Pursuant to our dialog during the hearing, let me ask that you answer the following questions for the official hearing record:

1) Border security is an important issue affecting Idahoans and the need for secure travel documents is paramount.

    a) Does the Department of Homeland Security (DHS) have any concerns specifically with the use of the Matricula Consular card, Passport card, and the Nexus, Sentri and FAST cards?

    b) If so, what specific security concerns does the DHS have and what is the Department doing to rectify its concerns with these travel identification cards?

2) As you know, I signed onto a bipartisan letter dated April 25 that was sent to Secretary Rice and you regarding the security of Western Hemisphere Travel Initiative travel documents. Part of that letter addresses the security of the Passport card and the Nexus, Sentri, and FAST cards among other things.

    a) Were the Nexus, Sentri, and FAST cards ever recalled last year?

        i. If so, what prompted the U.S. Customs and Border Protection to issue a recall of these cards?

    b) Are the Passport cards ready for distribution?

c) If not, what is the reason for the delay in not issuing these cards?

d) Does the current Passport card have any key electronic components made overseas?

e) What countries are involved in the manufacture and assembly of the key components used in the Passport card?

3) Many Idahoans have expressed concern that a proposed Mexican consulate in Boise will foster the continued presence of illegal aliens there.

a) Do the facts support that the Matricula Consular cards, as issued by Mexican consulates in the United States, present national security concerns?

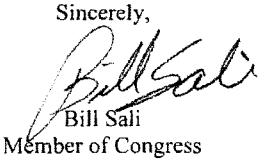
i. If so, what are the Department of Homeland Security's national security concerns with the Matricula Consular cards?

b) Are you aware of any situations where illegal aliens gain access to government programs, banking, housing, and health care benefits with the Matricula Consular card?

i. If so, could you please provide details of when illegal aliens used Matricula Consular cards to obtain government benefits?

Please provide my office with your responses no later than 30 days. If you have any questions regarding this letter, please contact Rick Podliska at (202) 225-6611.

Sincerely,



Bill Sali
Member of Congress

Mr. SALI. And if I may continue, do you share the concern that the presence of illegal aliens in our country is affecting the ability of our hospitals to respond in a surge situation?

Secretary CHERTOFF. Well, I don't know if I would connect it to a surge, but I would agree that I am aware that the presence of people who are in this country illegally does strain emergency rooms on a day-to-day basis, because often these people don't have health care through their employers, so they are relying on the emergency room as a kind of primary care facility. And that is one of the things we hoped to address when we took up the issue of comprehensive immigration reform, but as everybody now knows, that didn't take off in the Senate. So in the meantime our approach is to enforce the existing laws as vigorously as possible.

Mr. SALI. Secretary Leavitt, let me ask you the same question. Do you share that concern about the presence of illegal aliens, overwhelming at times, on the emergency room and hospital capabilities in our country, and if you do, what is your office doing to relieve that situation?

Secretary LEAVITT. Again, there is no connection necessarily between surge capacity. But there is little question that many of those who go to emergency rooms to be treated are here without proper documentation. Our Department does provide substantial assistance to hospitals to pay for those, but there is no question about the fact that it is a big part of the problem.

Mr. SALI. How much does your agency pay for treatment for illegal aliens each year?

Secretary LEAVITT. That is not a number I have off the top of my head. It is a big number.

Mr. SALI. You will get that for me, though?

Secretary LEAVITT. I would be happy to respond in writing, to the degree we have that information.

Mr. SALI. I have heard both of you say today that the presence of illegal aliens is not directly related to the surge, and yet both of you have said that illegal aliens use emergency rooms as their primary care doorway, if you will, into the health-care system.

Secretary LEAVITT. This is an important point, and I want to clarify it. On a day-to-day basis, in an emergency room, there are many people who are there for what essentially could be a clinic, not necessarily an emergency. In such a setting, they would be asked to take their health-care problem or defer it for another time, and that capacity would be used for the surge. Virtually any emergency room would have somewhere between 30 to 50 percent of its capacity used in that way.

So when we say that they are overflowing, they are not overflowing necessarily with people who are in life-and-death situations. Surge capacity would clear those out in the kind of emergency we are talking about, to be treated in another way or on a different day.

Chairman WAXMAN. The gentleman's time has expired.

Mr. Sarbanes.

Mr. SARBANES. Thank you, Mr. Chairman.

On that last point, we had testimony on Monday that suggested that a relatively small percentage of the ED volume is from nonurgent kinds of care. So I think that is a red herring. We are really

talking about people coming into emergency rooms that need emergency care.

We had a number of hearings on the effect of these Medicaid regulations. Going back last year, in June, we were told by a panel of experts that the emergency rooms are at the breaking point and the ability of emergency department personnel to respond to a public health disaster is in severe peril.

In November, the American College of Emergency Physicians said that if the regulations we are discussing today went into effect, "The Nation's public hospitals and emergency departments will sustain a devastating fiscal blow from which recovery may be impossible."

And the National Association of Public hospitals—and, by the way, public hospitals are the ones really getting hit between the eyes. We had a description of a nonprofit hospital engaged in some purchases, which I am not sure I would necessarily defend myself, but let's not get off on that tangent. We are talking about the impact largely on public hospitals, which are the ones that would suffer the most from implementation of this regulation. The Association of Public Hospitals said, "These regulations have the potential to devastate essential safety-net hospitals and health systems in many parts of the country."

So what is it that these experts understand that the two of you don't understand about the impact these regulations are going to have?

Secretary LEAVITT. Mr. Sarbanes, let me describe for you, as a former Governor, what is happening with respect to public hospitals and where I believe we ought to be turning to remedy this.

It is not unusual at all, in our public hospital setting, we agree to pay public hospitals an increment more than what we do normal hospitals. Many States are taking that increment more and essentially taking it off the table, putting it into their general revenues, and then using that increment more to pay the match that they are supposed to be paying for Medicaid.

This is essentially a dispute between partners. We are saying to the States, we want you to put up real dollars, not our dollars recycled, so that you don't have to put up as much money.

Mr. SARBANES. Let me take that line of thinking and move it slightly in a different direction.

First of all, I want to challenge a premise that I thought I heard in your testimony, that perhaps hospitals are not at the center of any kind of disaster response. And you talk about these other things, convention centers being set up on a short-term basis or schools or so forth.

But you both agree that when there is an emergency or a disaster, hospital emergency rooms are where people go, are they not?

I mean, I represented hospitals for 16 years. Any kind of disaster or occurrence in the community that created pressure, the first place they come, the first place they come, because they can't think of any other place to go, is to the emergency room. True?

Secretary LEAVITT. Mr. Sarbanes, there is no hospital in America that can keep enough spare capacity warm all the time just in case we have a major catastrophic event.

Mr. SARBANES. Let me ask you this question.

Secretary LEAVITT. You can develop a scenario that will blow the doors off any emergency room in America——

Mr. SARBANES. The doors are already blown off. This is the thing. There is this notion that we are waiting for these surge situations. But as a practical matter, we have a surge already. When you look at the boarding that is going on, the diversions that are going on, the fact that the beds in the hospitals for inpatient admissions are completely full, we are talking about a surge happening right now.

Now, let me ask you this question: If a hospital is underfunded, understaffed and underequipped in its main operations and main functions, is it better or less prepared for a surge, in your view?

Secretary LEAVITT. This question ought to be directed to those who administer and invest in the hospital. Most of the hospitals——

Mr. SARBANES. I am just asking your personal opinion. If a hospital in its core function is underfunded, underequipped and understaffed, is it better or less prepared for an emergency in a surge?

Secretary LEAVITT. Obviously they are less prepared.

Mr. SARBANES. They are less prepared. Well, that is the situation many of the hospitals are in.

So this fascinating but, I think, largely false distinction between funding that is going just for a surge as opposed to funding that is going to what Medicaid core functions should be, it is sort of—this is a red herring, at best.

And we have to strengthen the underlying core function and structure and infrastructure of our public hospital system and other parts of our health-care system if we are going to be able to respond to this surge.

Thank you.

Chairman WAXMAN. And we shouldn't be cutting money out of it if they are already not prepared to deal with the problems.

Mr. Issa, you are recognized.

Mr. ISSA. Well, thank you, Mr. Chairman.

And I certainly think that it has been good to wait a little while to go today, because I think Mr. Sali's questions, although they seemed to start on a tangent, finished pretty cogently.

Secretary Chertoff, the link that you did agree exists between our inability to either stop illegal immigration or the absence of their having an alternate insurance plan that would put them into the normal front-door of hospital and urgent care and other places rather than emergency rooms and trauma centers is a significant part of the overcrowding and the underfunding today.

From your side, Homeland Security, you seem to very much agree that part of the problem you face when looking at surge capacity today is can you get those centers freed up in time of emergency?

So my question to you is, do you feel comfortable that even though a nonscientific, partisan telephone survey found that, lo and behold, these seven trauma centers were overcrowded on a given day, or emergency rooms, that those would be reasonably free-upable for the kind of catastrophic emergencies we might have in the case of a dirty bomb or some other terrorist attack?

Secretary CHERTOFF. Well, I agree with Secretary Leavitt. My understanding—of course, the expertise really resides with his De-

partment, but it certainly makes sense to me. My understanding is that, in a true emergency, people who are in the emergency room using it for primary care or for something less than an emergency would be asked to leave, and many of them would.

I also agree with Secretary Levitt there is probably some point at which no emergency center, no matter how well-funded, is going to be able to handle what would be a truly mass event. And that is why we have these backup systems in place.

There is no question that a catastrophic event is going to be bad. It is not going to be pleasant. But I think that we would expect the emergency room to clear out all but the priority cases in order to handle them.

Mr. ISSA. I certainly agree. And certainly there are doctors who have been serving in capacities other than urgent care whose experience in surgery and other areas would quickly be brought in post-triage to do it.

Governor Leavitt, you know, the title of this hearing today I think is significant, because it starts off and it says, "The Lack of Hospital Emergency Surge Capacity: Will the Administration's Medicare Regulations Make It Worse?"

Yesterday, or the day before yesterday, I asked the panel—who all felt that overcrowding was a problem and so on but differed on whether they could handle emergencies. Virginia said, "We did handle emergencies. We believe we are well-organized, even here in the District," while other areas did not.

One of the interesting things was, I said, "Here is a billion dollars. How would you spend it? Would you spend it on training and preparation for an emergency, or how else would you spend it?" To a person, the panel said, "I would spend it on day-to-day, routine costs. I would simply absorb a billion dollars."

Governor, certainly you have the background to understand that $1 billion is a lot of money. But the cost of injuries in America today is estimated to be $300 billion in medical costs. A billion, $2 billion, $3 billion, if it is not used for preparation training, emergency facilities and planning, even $3 billion or $4 billion added into the system, will it in fact increase surge capacity if it is simply spent on a daily basis?

Secretary LEAVITT. Our significant concern with moneys that we give to States is that they are focused on increasing surge capacity. We have put nearly $7 billion, through different departments other than Medicaid, into emergency preparedness and specifically into surge capacity. And I believe that if we were just to send Medicaid money, it would be absorbed into the hospital overhead.

Mr. ISSA. And, Governor, following up, because the time is limited, essentially aren't we dealing exactly with that here today? That if, in fact, we don't carefully make sure that these funds do not get diverted and do not cover up for problems, including illegal immigration, to quote the other Member, but all kinds of problems of the underinsured, aren't we, by definition, making ourselves less capable if we don't take action to ensure that it goes into planning and training and preparation, rather than absorbing what clearly appears to be an everyday problem in America that was neither created by September 11th nor would be rectified by a few billion more dollars here or there?

Secretary LEAVITT. Every community needs a plan, every community needs to train, every community needs to exercise. And that is what much of our money goes to, and should.

Mr. ISSA. Governor, my time is short, but you did deal with the problems of illegal immigration. You dealt with the problem of your emergency rooms and the impact of the underinsured.

Isn't that a separate issue that we should concentrate on finding solutions for but not mix it with today's hearing on surge capacity directly related to 9/11-type events?

Secretary LEAVITT. We have dealt with three specific and different issues today: surge capacity, the effect of illegal immigration, and Medicaid regulations. All three are separate. All three are important issues.

Mr. ISSA. Thank you.

Thank you, Mr. Chairman.

Chairman WAXMAN. Secretary Leavitt, could you furnish for the record how that $7 billion you claimed is going to help the hospitals?

Secretary LEAVITT. What I said, Mr. Chairman, was we have spent nearly $7 billion on local and emergency preparedness, including surge capacity in hospitals. And, certainly, we can provide how that has been spent.

Chairman WAXMAN. And how much of that has been surge capacity?

Secretary LEAVITT. That is not a figure I have.

Chairman WAXMAN. If you could give it to us for the record, we would appreciate it.

We now have Mr. Murphy.

Mr. MURPHY. Thank you very much, Mr. Chairman.

Welcome, Secretary Leavitt and Secretary Chertoff.

For the last 4 years, before I came to Congress, I was the chairman of Connecticut's Public Health Committee in our legislature charged with this very issue, making sure that we had appropriate surge capacity and everyday capacity in our hospitals.

And, Mr. Leavitt, I was reading through your testimony, and it is dazzling, at some level, the amount of bureaucracy and commissions that we have created around this issue: ACD, NVSB, ECCC, ASPR, NRF. And I am sure these are worthy commissions; I am sure they are looking at important questions. But as somebody who is doing this on the ground floor, this is all new to me.

As a State policymaker, we knew that Medicaid was not just about supporting people, it was about supporting institutions as well. They are one and the same. You can't help people unless you have institutions that are there and willing to do the work. So the distinction, I guess, is a little bit troubling to me.

But we also didn't know too much about these grants that were coming to us, because we really knew that in order to keep these hospitals up and running, in order to keep capacity working, we needed Medicaid. We couldn't do it with grants alone.

Mr. Leavitt and Mr. Chertoff, if the staff has it ready, I would like to just draw your attention to a chart. And this, I think, gets at Chairman Waxman's question about the amount of money that is going to hospital preparedness grants. This is, I think, a fair representation of, over the last several years, the amount of money

that has been going into hospital preparedness grants, starting at $498 million in 2003, dropping now to a proposed $362 million in the proposed budget for the coming fiscal year—a pretty sharp decrease. And $362 million over 50 States spreads pretty thin.

The real rub here is when you compare it to the Medicaid cuts, if we can put that chart up now. Now, this is the grant money that States are getting, $362 million proposed in the next year, compared to the impact of the Medicaid cuts.

Now, this is the State Medicaid director's estimates. If you take the CBO estimates, you are still talking about five times the amount of Medicaid cuts as you are talking in grant money to hospitals. And I think every State appreciates that grant money, but it is a drop in the bucket compared to what hospitals are going to face with regard to these Medicaid cuts.

I guess I ask this to you, Secretary Leavitt. Do you have concerns that these grants, dwindling year by year, are going to be dwarfed by the size of these cuts? And though those cuts are going to obviously see their way through the entirety of a hospital's operation, no doubt much of it is going to end up in the emergency room.

Do you have a concern that these cuts, these Medicaid cuts—you say they are to support individuals; they inevitably have to support institutions in order to support the individuals—are going to dwarf those grants?

Secretary LEAVITT. Mr. Murphy, the distinction on institutions and people is not one that we have arbitrarily made. It is in the statute.

Over time, States have inappropriately claimed Medicaid dollars in a number of categories, which had the direct impact—I know you know this as a State legislator—of crowding out all of the other activities, including the development of public health and emergency systems.

Medicaid was not designed, nor is it intended, to support institutions. Money should be directed to people. We support people. We support poor people, pregnant mothers and the disabled. This is not intended to be a hospital entitlement.

Now, I understand that they have come to rely on it, in some cases. That is precisely the reason that we are pushing back to the fee-based consultants who are driving this on the basis of their getting a piece of the action to push Medicaid into every area of State government. It is not just emergency preparedness. It is in schools. It is in child welfare. It is in all the places that the States are not adequately funding, they are trying to get a garden hose into the Medicaid fund.

Mr. MURPHY. But we are not talking about those places today. We are talking about institutions that are indisputably linked to health care, which are hospitals.

And the fact is you say it is about supporting individuals, but the money doesn't go to individuals. It goes to institutions. It goes to doctors. It goes to hospitals. It goes to outpatient clinics. Because we know we need those places up and running.

So let me just shift to a related question, and this is building off of Mr. Sarbanes's questions.

You talk about the fact that ultimately this isn't going to happen in emergency rooms. If something enormous happens, you are

going to have to build something outside of the emergency room. But doesn't that capacity, whether it exists in the physical confines of the emergency room or not, rely on the assets that exist right now in those emergency rooms?

If we are gutting the capacity of hospital emergency delivery systems, in terms of equipment, in terms of personnel, in terms of expertise, it seems to me, Mr. Leavitt and Mr. Chertoff, that this directly impacts your ability to then move that capacity offsite, even if it isn't onsite at the hospital grounds.

Secretary LEAVITT. Again, this is a very important point, Mr. Murphy. We are bringing capacity in. In the first 24 hours of an emergency, we are dependent upon local assets. And that is where you clear out the emergency room, you take anyone who is nonessential out of the hospital. You make capacity.

Within 24 hours, we have the NDMS system there. We have as many as 6,000 beds we can bring from all over the country. We then go to another phase where we start taking patients into capacity. At any given moment, we know how many hospital beds are available in the area.

We are not dependent upon the hospital facilities, except for that 24-hour period. And that is why we exercise and train for all of the other aspects on surge capacity.

Mr. MURPHY. And I appreciate that. I know enough about how these things work to know that they still do draw upon local resources, they still do draw upon other hospitals, upon other capacity in the system. And, as Mr. Sarbanes and others have suggested here today, we have maxed out both the emergency and nonemergency capacity of our health-care systems to the point that extra capacity, even in the 48 and 72-hour window, simply doesn't exist.

Now, you can fly it from in from all over the country, but I think this problem exists across the board. Our medical technicians, our emergency medical personnel, are working 24/7 just to handle existing capacity right now, never mind being able to move over to an emergency when it does happen.

My time has expired, Mr. Chairman.

Chairman WAXMAN. Thank you, Mr. Murphy.

Mr. Duncan.

Mr. DUNCAN. Thank you, Mr. Chairman.

Secretary Leavitt, I have to be very quick because they have a vote going on. But a few days ago, we were given figures that, in the 10 years leading up to 2006, Medicaid payments to Tennessee hospitals went up from $245 million to $607 million.

I am sure that you have no idea of what those exact figures are, but do you think that every State has received similar-type increases, more than doubling over the last 10 years?

Secretary LEAVITT. Well, States have clearly seen dramatic increases. We have seen a dramatic increase in the overall program. Tennessee may have been somewhat unique because of TennCare.

Mr. DUNCAN. And would it be fair, then, to say that, in those 10 years, inflation has averaged around 3 percent a year, so those payments to hospitals have gone up several times above the rate of inflation? Do you think that is fair?

Secretary LEAVITT. Medicaid is growing at two to three times inflation.

Mr. DUNCAN. Two to three times the rate of inflation. So payments to the hospitals have gone way up over the past 10 years?

Secretary LEAVITT. The Medicaid money going to hospitals has dramatically increased over the past decade.

Mr. DUNCAN. All right. Thank you very much.

Chairman WAXMAN. Mr. Tierney.

Mr. TIERNEY. Thank you, Mr. Chairman.

Thank you, gentlemen, for being here today.

Secretary Chertoff, I want to ask you a little bit about your role or your involvement in these Medicaid rules that were issued. In your testimony, you said that, "Medical surge capacity is a critical element of our local, State and national resiliency."

But I don't see any evidence, I don't think we have been able to find any evidence of your Department expressing any concern about these Medicaid rules to anybody, and particularly with respect to the impact they might have on emergency rooms or the ability to respond to an attack or a natural disaster.

Did you consult with Secretary Leavitt about these rules before they were issued?

Secretary CHERTOFF. No, because I don't think that these Medicaid rules are particularly closely connected to the question of whether there is surge capacity necessary to meet an emergency.

Mr. TIERNEY. So you were aware of them but just chose not to get involved, or you weren't even aware that they were being considered?

Secretary CHERTOFF. I don't think I was particularly aware of it, nor would I have expected to be made aware of it.

Mr. TIERNEY. The staff interviewed Dr. Runge from your staff, your Chief Medical Officer. It is his role, apparently, to coordinate between the Department of Health and Human Services, to make sure that hospitals and the medical system are prepared for a disaster or for an incident.

They asked Dr. Runge if he had reviewed or commented on the regulations, and he also said he had no communications with anyone at HHS about it. And he said that there was no discussion within the Department of Homeland Security about the rules.

That is pretty consistent with your testimony, as well, on that?

Secretary CHERTOFF. It is.

Mr. TIERNEY. If he supposed to be the point person for medical preparedness, I just don't understand how he completely ignores rules which are certainly going to have some impact? Or is it your position they are absolutely going to have no impact at all on emergency rooms?

Secretary CHERTOFF. Here is where I think we are having some disagreement. Everything has impact on everything. So, in some sense, the economic health of the country has an impact on homeland security. But if I used that logic, I would be involved also in the subprime mortgage crisis, because that affects State budgets; I would be involved in gas tax and gasoline prices, because that has an impact. Even for a Department which has sometimes been accused of having too broad mandate, that goes several bridges too far.

Our focus, with respect to working with HHS, is to assure that there is a planning effort under way, that we are identifying gaps, and that we are coming up with specific measures that will plug the gaps.

And I have to say I agree with Secretary Leavitt; I don't think that Medicaid funding and reimbursement rules have anything more than a very indirect connection with this issue. And if I took the position that every indirect impact on homeland security made it my business, we would become the Office of Management and Budget instead of the Department of Homeland Security.

Mr. TIERNEY. I do think there is a disconnect between what we are talking about here. I have a difficult time thinking that you don't see a more direct relationship between the status of our hospitals' capacity and emergency rooms' capacity to deal with these things than a mortgage. There is a bit of a difference there between the two, and I would hope you would get that distinction.

Secretary CHERTOFF. No, I don't say that I don't think emergency care and the health-care system isn't more connected. I think that Medicaid reimbursement, which is not specifically targeted to putting money away for emergencies, is, I think, several degrees of separation from the kinds of much more specific issues that we are focused on, in terms of getting ready for emergencies.

Mr. TIERNEY. But I find it interesting that your Department didn't even look at the prospect that reducing Medicaid funding might have an impact on hospitals' overall operations, including the impact on emergency rooms and capacity in case of a surge incident. I would think that is the type of thing that you are assigned to do and Dr. Runge is assigned to do, to at least raise the issue and think about it and move on from there.

The staff asked Dr. Runge how he justified this lack of communication with HHS about the rule. What he said was, "We are focused on threats that can kill hundreds of thousands, not hundreds." A little insensitive, I would think, to——

Secretary CHERTOFF. Well, I wasn't there for the interview; I can't read his mind. But I think what he was trying to draw a distinction between is the very real issue of day-to-day capability of the medical system to deal with day-to-day kinds of issues, which is a perfectly important and significant matter but not one that falls within the purview of my Department, as compared to dealing with the issues that do rise to the level or do specifically involve homeland security, like a pandemic flu or a major catastrophe, where we do focus on the issue of surge.

But our main focus is on those matters that have a direct relationship. Are we stockpiling enough? Do we have a plan? Do we have a delivery mechanism? Do the localities have a plan? And there we do interface with HHS, not only Dr. Runge, but I personally talk to Secretary Leavitt about these issues. But much more tightly related to the specific need to have an emergency preparedness capability than Medicaid funding, which has to do with the overall economic health of the medical system, which is, frankly, a much broader issue than my Department's focus.

Mr. TIERNEY. Well, I guess it could be seen that way, but it could be narrowed down to when there is a serious, severe cut in financing, it will affect the operations of a hospital, including those that

you are directly concerned with. I would like to think your Department gets involved at that capacity. That is not indirect; that is pretty direct.

My time is up, and I yield back. Thank you.

Chairman WAXMAN. The gentleman's time has expired.

Ms. Norton.

Ms. NORTON. Thank you, Mr. Chairman.

I want to thank both these witnesses for being here.

I am particularly grateful for this hearing, because I am afraid I am more deeply implicated than some because of my representation of the District of Columbia. I have worked closely, of course, in my work on the Homeland Security Committee with Secretary Chertoff.

Secretary Leavitt, I worked with your predecessor on something called ER–1. I am particularly concerned about this place, not only because I represent 600,000 people here, but because all of official Washington is here, 200,000 Federal workers, and because this is a prime target for terrorism.

This discussion about trying to separate out Medicaid from other money is important because we want money used for what it is intended. But you certainly can't treat a hospital as if it were not an organism with core functions that treat private and poor patients alike, as if you could collapse the part that treats Medicaid patients. And I think that is what some of us have been trying to get at.

I want to ask you about the hospitals here. We have three trauma centers here. Two of them were surveyed in this survey, and they were extensively above capacity. No available treatment spaces in the hospital. Only six had intensive care unit beds. One could not participate in the survey because it was so overcrowded that it had to stop taking, accepting new patients at all.

My good friends on the other side of this dais cite the Washington Hospital Center emergency room as a model for the country. It is a very good emergency room. That is what I worked with on so-called ER–1. I will get to that in a minute.

But since they cite the Washington Hospital Center, I went to the head of the emergency room, Dr. Mark Smith, and Dr. Smith confirmed the findings of the survey and, in addition, said he had twice as many patients as he did treatment spaces. They are putting them in the corridors and administrative offices. They are putting them in waiting rooms. And he said he had a major problem with preparedness.

Now, I understand triage. I also hope we are not ever in the position of what I would believe would be chaotic triage, if everybody surged in one place. For that reason, here in the Nation's Capital, I have been working with the administration—actually we have almost gotten it through several times—on at least one hospital that would have surge capacity, so that everybody would know in advance, don't put all these Federal workers close to the nearest hospital. This is the one that is prepared. It has huge capacity—it would have a huge capacity. A lot of private money would go into this, some Federal money.

Now, my question is this: If you cut billions of dollars of what amounts to safety-net funding from hospitals, you are also includ-

ing these trauma centers here in the Nation's Capital. Can you assure this committee that, even with such very severe Medicaid cuts, the hospitals in the Nation's Capital are prepared for a mass event here and to accept patients in the event of a mass event here?

I would further ask Secretary Leavitt if he supports ER–1.

First, I want to know, are you saying to this committee, in the face of a survey that you are aware of, that in the event of a major or mass event here, that the hospitals, even with the cuts that are on the table, could, in fact, manage that event?

Secretary LEAVITT. Ms. Norton, I will tell you that the Washington, DC, area engages in regular planning exercises I think as well as any place in the country. I want to restate: Am I saying that surge capacity is acceptable everywhere in the country? No.

Ms. NORTON. I am not asking about that. I am asking about the place where Members of Congress, the President of the United States, where members of the Cabinet, where 600,000 residents are here, where 200,000 workers are here, three traumas centers—I am being very specific. I am not focusing on elsewhere. I am focusing on target No. 1.

Can you say you are prepared?

Secretary LEAVITT. I am not the person to answer that. The person in my Department would be Rear Admiral Vanderwagen, who was not invited to the hearing today. And I am sure he would be happy to meet with you and give you his reaction to the preparedness.

Ms. NORTON. I have to indicate that, as the Secretary, I would think you would know whether or not the Nation's Capital is prepared for a mass event.

Secretary LEAVITT. I live here, just like you do, and I am anxious for that to be the case.

Ms. NORTON. And that troubles me, both as a member of the Homeland Security Committee and as a member of this committee, that you cannot answer that question.

Do you support ER–1 surge capacity?

Secretary LEAVITT. Is the project at George Washington?

Ms. NORTON. It is the project at Washington Medical Center.

Secretary LEAVITT. I am aware of the project by title. I do not know enough about it to respond at this hearing. If you would like, I would be pleased to respond in writing.

Ms. NORTON. I very much appreciate it.

And thank you, Mr. Chairman.

Chairman WAXMAN. Thank you, Ms. Norton.

Mr. Cummings.

Mr. CUMMINGS. Thank you very much, Mr. Chairman.

Secretary Leavitt, perhaps the thing that most confuses me about your actions is why you did not consider the impact of your Medicaid regulations on emergency preparedness.

Last June, the committee had a hearing on the state of emergency medical care in the United States. At the hearing, concerns were raised about the effect of the Medicaid regulations on hospital emergency rooms. As a result, the committee wrote to the Centers for Medicare and Medicaid Services to ask whether CMS, which issued the rules, had consulted with the Assistant Secretary for

Preparedness, who is the official in your Department in charge of emergency response.

Astonishingly and unbelievably, CMS responded that it, "did not specifically request input from the Office of the Assistant Secretary for Preparedness because that office is not likely to have expertise in Medicaid financing."

The committee wrote you again in November. In this letter the committee specifically requested, "all documents relating to the potential impact of the Medicaid regulations on emergency care and trama services." In February, the Department responded to the committee's request. I want to read to you from this letter. And it says, "The Department has not found responsive documents."

According to this letter, your staff searched for responsive documents in five different parts of the Department: the Office of the Secretary, the Office of the Assistant Secretary for Preparedness, the Health Resources and Services Administration, the Centers for Disease Control, and CMS. Yet not one of those offices had done any analysis of the impact of the regulations on emergency care.

Secretary Leavitt, how can you possibly explain this? Hospitals across the Nation are telling us that your regulations will devastate their emergency rooms, yet you did not even consider this issue, according to what I just read.

Secretary LEAVITT. The rule change we are proposing is not about surge capacity or hospital health. It is about States who have been claiming inappropriately funds that they are using to recirculate to pay their fair share with Federal funds.

Medicaid is not a program to support hospitals. Medicaid is a program to support people who are poor, people who are pregnant and people who are disabled. It was not intended nor is its purpose, nor should it be managed, to be the source of funds for surge capacity.

Mr. CUMMINGS. Let me just go a little bit further. You were specifically asked to consider the impacts of your rules on trauma centers and emergency rooms. Over a year ago, Chairman Waxman and over 150 other Members of Congress wrote to you to urge you to consider these issues.

Let me read to you from our letter: "We are writing to request that you withdraw the proposed rule. The proposal would threaten the capacity of safety-net hospitals to deliver critical but unprofitable services, such as trauma centers, burn units and emergency departments."

Yet, still, you prepared no analysis. This appears to be a case of willful blindness. Perhaps it would be better stated if I said it appears to be "eyes wide shut." It seems that you are deliberately ignoring the impacts that your rules will have on emergency care and preparedness in our Nation. That is irresponsible, and, to be frank with you, it is quite dangerous.

Secretary Leavitt, the preamble to the proposed Medicaid regulations read, "With respect to clinical care, we anticipate this rule's effect on actual patient services to be minimal. While States may need to change reimbursement or financing methods, we do not anticipate that the services delivered by governmentally operated providers or private providers will change."

In response to these regulations, your Department received over 400 written comments, all of which expressed opposition to the rule or to portions of the rule. And I would like to read just a sample of one of those. It is from the Society of Academic Emergency Medicine.

And it says, "This proposal will jeopardize the viability of public and other safety-net hospitals. It will also jeopardize the viability of our emergency medicine teaching programs, which has long-reaching downstream effects on the quality of emergency care in this country. We believe that Medicaid cuts of this magnitude projected under this proposed rule will adversely affect access and the viability of our Nation's safety-net providers."

So I am just wondering, do you have a comment on that?

Secretary LEAVITT. Yes, I do. This rule is about States not paying their fair share, and it is a dispute between partners. We are mutually committed. If States will step up and do their share, we will ours. But this is about paying for people, not for institutions.

We are following the law. We are trying to push back where people or States and other programs within State governments are trying to make up for deficiencies that have occurred in State governments by tapping Medicaid funds. And someone needs to do it, because the Medicaid program is unsustainable in its current course; I made the point earlier.

Many of the programs in States are being crowded out by Medicaid. And it is being crowded out because we continue to use it for virtually every aspect of State government. Anyone in State government who thinks they can find some connection to Medicaid is attempting it. And we have to do this in a way to keep the integrity of the fund, so that we know we are paying for health care for people, not for institutions, and we are not making up for States who aren't doing their share.

Mr. CUMMINGS. I see my time is up.

Chairman WAXMAN. Secretary Leavitt, with all due respect, I think you are ignoring reality. You are saying that you want to cut back on a system that is getting Federal dollars inappropriately, and they should make up the money at the State and local level. They are not going to be able to make up that money in a recession. The income is not coming into the States.

And you never asked your partners, the States, what the impact would be to make these kinds of withdrawals of the Federal share of the Medicaid funds that go to the institutions, especially public hospitals that are funded exclusive by the taxpayers. At the minimum, I would have thought that you would have wanted to ask the question of what the impact would be, so you would know.

You insist that is not going to have this kind of impact. Yet, when you put our rules, the Society for Academic Emergency Medicine said, "This proposal will jeopardize the viability of public and other safety-net hospitals. It will jeopardize the viability of our emergency medicine teaching programs."

Parkland Hospital in Texas said they received Medicaid payments of $90 million annually and that, without this funding, Parkland may be forced to drastically scale back their services in the Trauma I center, the level Trauma I center.

You have all these others—the president of the University of California, the University of California academic medical centers. You have all these comments. And we looked at the rulemaking record; the fact is you ignored these comments. You didn't adjust the policy in response to these comments in the final rule, and you did prepare an analysis to the effect of the Medicaid regulations would be minimal impact on care being provided by the States.

How can that be? Isn't that irresponsible?

Secretary LEAVITT. Mr. Chairman, it is responsible for me to follow the law and assure that the States are doing their job. Otherwise, we are not being a wise steward of limited Medicaid funds.

This is a dispute between partners, between the Federal Government and the States. And the Federal Government is saying, you can't take money we have given you extra for these hospitals, put them back into your general fund, and then use them to pay your share. Just give us real money, give us value, give us—for real patients.

This is not about surge capacity. It is about a relationship between the States and the national Government——

Chairman WAXMAN. The consequences will be the institutions that provide the safety net to the very poor in our society will not be able to continue to function and provide those services.

It just seems to me you are judging your actions on an ideology without having established the record. You didn't come to Congress and ask for those changes. You are trying to put them into effect on your own.

Fifty Governors have asked us to at least put a halt on this so they can be studied, which they should have been studied before they were put into place. An overwhelming majority of the House of Representatives has put a hold on these regs until we can look at them further.

I think that you ought to withdraw these regulations and let's see what the impact will be. Let's know that we are not doing any harm to the ability for hospitals around the country to deal with the problems that they may face, not just day to day, but in a terrorist attack.

Secretary LEAVITT. It is not surprising to me that you can unite 50 Governors around the proposition that the Federal Government should pay their share. And that is essentially what this amounts to.

Many States have improperly used money that has come from the Federal Government for the purpose of supporting the hospitals we are talking about, have taken it off the table, and then used it to pay their share.

This is about States not paying their fair share. And I would think we would all be united in saying, if we are going to have a partnership, then everyone ought to pay real dollars for real value for real patients.

Chairman WAXMAN. Did you consult with Secretary Chertoff to tell him that there may be some impact around the country on the ability to deal with a terrorist attack?

Secretary LEAVITT. This is a dispute between the Federal Government and the States on Medicaid financing.

Chairman WAXMAN. You didn't inform Secretary Chertoff of that?

Secretary LEAVITT. We regularly consult on the larger strategic issues related to our joint mission. This is not one of them.

Chairman WAXMAN. Did you do an evaluation to know what the impact would be on these hospitals if these regs went into place?

Secretary LEAVITT. Medicaid is not intended to support institutions. It is intended to support people.

Chairman WAXMAN. But it does support these institutions, because people without insurance go to these hospitals. People who are injured go to these hospitals. If you withdraw the money from the hospitals because you have a theory that the States ought to come up with more money, it means, as we were told by Dr. Roger Lewis, who is an emergency room physician at UCLA, a nationally recognized expert in hospital emergency preparedness, he said, "Those of us who work on the front lines of the medical care system believe it is irrational that an emergency care system that is already overwhelmed by the day-to-day volume of acutely ill patients would be able to expand its capacity on short notice in response to a terrorist attack." He said, "If a bomb went off in Los Angeles and injured hundreds or thousands, LA would not have the emergency room capacity to care for the wounded."

In your statement to the Congress, you emphasize the support the Federal Government is giving States and localities to improve this emergency preparedness. And we asked Dr. Lewis, and he said they were getting $433,000 in a preparedness grant, and he was very grateful for it, but the cost of these Medicaid changes would mean they would go without $50 million. He said that is 100 times more than the Medicaid cuts they would get on these preparedness grants, and they are going to be in very, very sad shape.

Do you take what he had to say seriously? Do you think he is just fronting for the States because they want to rejigger their money around?

Secretary LEAVITT. Mr. Chairman, over the course of the last 3 years, I have been in virtually every State and met with the emergency community, and the record is replete with my statements of concern about surge capacity. It is not at the level we want it to be. We have many areas in which we can improve. But Medicaid is not the source of funds to do that.

If the Congress of the United States views that there is a need for more dollars, we have ways in which we can funnel directly to the hospital funds that are necessary to improve their surge capacity.

Medicaid was intended to be for people, not for institutions. And every institution I know would like to drag a garden hose over into the Medicaid fund and be able to tap it, because their fund isn't what they would like it to be.

We need to be disciplined. We need to ensure that these disputes are resolved between the States and the Federal Government so that we have a true partnership, not just one that relies entirely on the Federal Government.

Chairman WAXMAN. Well, I must say, with all due respect, your actions make absolutely no sense. The tiny grants you are giving to hospitals can't possibly offset the impact of cutting billions of dollars from those programs.

I must say, as we conclude this hearing, I find it very discouraging. We know the Nation's emergency rooms are already at the breaking point. We know a terrorist bombing is a predictable surprise. We know that local emergency room capacity is critical to saving lives in that golden hour following an attack. We know that public and teaching hospitals operate many of our Nation's most critical emergency rooms and trauma centers.

We know that the Medicaid regulations will reduce funding to these institutions by hundreds of millions of dollars each year. We know that these cuts will further undermine the ability of these hospitals to respond to a terrorist bombing. We know that these regulations will go into effect in 3 short weeks.

And yet the Secretaries that are in the position to avoid this harm will not take any action. I think it is regrettable.

I must say, this is not just a disagreement. I think it is a substantial breach in what I think is our mutual responsibility to make sure that we can deal with a homeland security attack, which could amount to a tragedy.

I thank you both for being here. We hear the bells; there is a vote on the House floor.

I do want to ask unanimous consent that the record be held open for Members to ask further questions and get responses in writing.

We stand adjourned.

[Whereupon, at 11:15 a.m., the committee was adjourned.]

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