

Advocacy

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HOT TOPICS FOR ADVOCACY IN THIS ISSUE

THIS ISSUE of the Advocacy Advisory will focus on topics of current interest to health care, including the end of the battle over the \$555 billion budget, which was signed into law today by President Bush. This ends a lengthy dispute between the White House and Congress over spending levels and budget priorities. The CHRISTUS position is consistent that federal health care dollars must be preserved in programs such as Medicare and Medicaid, as both of these programs these serve a vital function as part of the health care safety net for the uninsured and underserved population.

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PRESIDENT BUSH SIGNS BUDGET; CONGRESSIONAL WRAP-UP

The battle over the 2008 budget has ended, with President Bush signing the \$555 billion omnibus spending bill passed last week by Congress, with the president still suggesting that he is looking for further ways to cut spending. “This legislation contains certain provisions similar to those found in prior appropriations bills passed by Congress that might be construed to be inconsistent with my Constitutional responsibilities,” Bush said in a statement issued by the White House. “To avoid such potential infirmities, the executive branch will interpret and construe such provisions in the same manner as I have previously stated in regard to similar provisions.” While the president praised Congress for ending their year on a high note with the approval of the budget package, he

expressed strong disappointment with what he called “wasteful spending.” The package includes considerable shifting of dollars to health care and other priorities supported by the Democrats.

For example, federal health agencies will see modest increases, but the numbers disappoint some groups who had hoped for much more. Approximately \$329 million was added to the budget for the National Institutes of Health, including money for a fund administered by the U.S. State Department to counter global AIDS and other epidemics. The Centers for Disease Control and Prevention (CDC) will see an increase of \$110 million; programs at the Substance Abuse and Mental Health Services Administration (SAMHSA) will rise by \$30 million; and programs for health professions at the Health Resources and Services Administration will receive an increase of \$466 million. Funding for graduate medical education programs at children’s hospitals will rise by \$4.6 million instead of the reduction requested by the Bush administration. Of special note, the bill includes an earmark for almost \$360,000 for CHRISTUS Santa Rosa’s Neonatal Intensive Care Unit. The bill also provides funding for some programs supported by Catholic health ministries, including a \$6.4 million increase in fiscal year 2008 for Title VIII nursing workforce development programs and an additional \$22.9 million in funding for the Older Americans Act nutrition programs.

In related news, as a result of the Medicare, Medicaid and SCHIP Extension Act of 2007, Congress provided a six month Medicare payment increase for physicians and extended funding for the SCHIP program through March 2009. The payment increase is effective through June 2008, and amounts to 0.5 percent increase, cancelling a 10.1 percent cut that was scheduled to take effect on January 1, 2008. However, this means that Congress will once again have to address the issue in mid-2008 to avoid yet another payment cut for physicians from taking effect on July 1. While the funding for SCHIP should be sufficient to preserve coverage for currently enrolled children, states will be hard-pressed to provide for any program expansions during this extension period. Also, the legislation failed to address an administration directive issued in August that would limit several state SCHIP programs by imposing income eligibility caps at 250 percent of the federal poverty level unless stringent guidelines were met.

Furthermore, Congress passed numerous provisions that extend the current Medicare payment policy as it affects the nursing home therapy cap exception. It also includes a permanent freeze at 60 percent of the compliance threshold for inpatient rehabilitation facilities and regulatory relief for long-term care hospitals. Specifically, the bill includes language that would permanently freeze the implementation of the 75% Rule at the 60 percent threshold level, and would allow patients' secondary medical conditions, or "co-morbidities," to continue serving as a basis for access to inpatient rehabilitation care and services. The legislation made no changes to Medicare policies affecting physician-owned hospitals.

Source: Catholic Health Association of the United States; the Associated Press, 12/26/07.

IRS REQUIRES CHANGES IN NON-PROFIT REPORTING

Non-profit hospitals will be required to report more bad debt information and that information will not be included in the community benefit reporting under the final 2008 Internal Revenue Service Form 990 for tax-exempt organizations. The instructions now explicitly state that bad-debt expense and Medicare shortfalls are not to be reported as part of a hospital’s community benefit. Rather, under a separate part of the schedule, not-for-profit hospitals will now be asked to describe in some detail how they calculate bad debt expense. Part 3 of the schedule has been revised from the draft, requiring a hospital to report aggregate bad debt expense at cost, provide an estimate of how much is attributable to people who qualify for charity care and also provide its rationale for what portion of the bad debt it receives constitutes community benefit. Hospitals also will be required to report whether they have adopted the Healthcare Financial Management Association’s Statement No. 15 and provide the text of their footnotes to financial statements that describe bad debt expense. The new Part 3 also collects Medicare shortfall information and gives a hospital the opportunity to describe what portion of Medicare shortfalls it believes should constitute community benefit.

Source: Modern Healthcare, Associated Press, 12/20/07.

GAO EXAMINES MEDICARE DRUG BENEFIT; SCHIP FOR ADULTS

Summaries are provided below of two reports on the Medicare prescription drug benefit and SCHIP recently released by the Government Accountability Office:

- Medicare prescription drug benefit: CMS might have made almost \$90 million in questionable payments to contractors hired to help launch the Medicare prescription drug benefit, according to a report released recently by GAO. According to the report, CMS paid about \$735.4 million to more than 250 contractors, but 16 contractors received most of the payments. The report found that some of the payments did not comply with terms of the contracts. In some cases, payments exceeded caps included in the contracts, and in other cases, CMS did not obtain adequate documentation to confirm costs billed, the report found. CMS spokesperson Jeff Nelligan said that the agency disagrees with the conclusions of the report and that the launch of the Medicare drug benefit required some contract decisions outside of standard policy.
- SCHIP: States that cover adults under SCHIP are more likely to experience funding shortfalls than those that do not, according to a report released last week. For the report, GAO examined 10 of the 14 states that cover adults under SCHIP. According to the report, adults accounted for 54% of combined SCHIP expenditures in the nine states for which GAO had fiscal year 2006 data. Individually, adults accounted for 1% of SCHIP expenditures in one state, 32% to 42% in three states and more than 50% in five states, the report found. The report also found that six of the 10 states had SCHIP funding shortfalls at some point during the 2005-2007 period, compared to 10 of the 41 states that did not cover adults under SCHIP. Jocelyn Guyer, deputy executive director of the Center for Women and Families at Georgetown University, said states expanded coverage to adults under SCHIP because "they were encouraged to by both the Clinton and Bush administrations," and the states that did so were in some cases those "that had already expanded coverage for children to modest-income families."

Source: Kaiser Daily Health Policy Report, 12/21/07.

PATIENT ACCESS: EMERGENCY DEPARTMENTS REPORT DIFFICULTY WITH RETAINING ON-CALL SPECIALISTS

Hospital emergency departments nationwide are increasingly unable to find and retain specialists to help treat seriously injured and ill patients at a time when EDs are already struggling with overcrowding and growing patient loads. A nationwide survey by the American College of Emergency Physicians in found that 73% of 1,328 ED directors said they had a problem with inadequate on-call coverage by specialists. "The historic relationship between physicians and hospitals is unraveling," said Dr. Ann O'Malley. She is a physician and senior researcher who co-authored a new study regarding emergency department coverage for the Center for Studying Health System Change. Experts and observers attribute this trend in large part to the increasing number of physician-owned specialty hospitals, which reduces the need for doctors to work on-call hours in EDs in exchange for use of a hospital's facilities for their private practices. Other factors include fear of malpractice lawsuits and the growing number of uninsured patients. Compounding the problem is the increasing number of patients seeking ED care. According to the Centers for Disease Control and Prevention (CDC) the annual number of ED visits increased by 18% from 1994 to 2004. During the same time period, the number of hospitals operating 24-hour EDs decreased by 12%. Some hospitals have begun hiring full-time or part-time ED specialists, while others have begun covering fees for physicians treating the uninsured and paying doctors daily or monthly stipends for on-call work.

Source: The Washington Post, 12/21/07.

REPUBLICANS HOPE HEALTH CARE ACTION CAN BENEFIT POLITICALLY

Senior Senate Republicans finessing their election-year message are calling on the Senate Republican Conference to stress health care issues to help win over independent voters in their attempt to regain a majority in 2008. Sen. Bob Bennett (R-UT), a close adviser to Minority Leader Mitch McConnell (R-KY), said health care "has replaced Iraq as the No. 1 item of anxiety and concern." Sen. Lamar Alexander (R-TN), the incoming conference leader, said, "From a Republican point of view, we want to put together four words that don't usually go together -- universal access and private sector." The issue of health care -- on which voters trust Democrats more than Republicans, according to polls -- is particularly sensitive for the GOP following President Bush's earlier vetoes of two bills to renew and expand SCHIP. "I think Democrats will use that as an issue," Sen. Orrin Hatch (R-UT) said, adding, "I think most Republicans want SCHIP, but they wanted it to work right."

Bennett and Sen. Ron Wyden (D-OR) are trying to build support for the Healthy Americans Act, which would require individuals to enroll in private health plans. Under the bill, the government would subsidize premiums for lower-income families, and insurance companies would be prohibited from denying coverage or raising premiums because of pre-existing conditions. Bennett said, "Republicans don't use the language of universal health care because it's code for a single-payer government-run system." He continued, "Now, I'm perfectly willing to embrace universal coverage as long as it's understood that it's not a single-payer government-run system, because I do endorse the goal of every American (being) insured." Wyden believes the measure appears to be more politically palatable next year than SCHIP for Republicans. He said, "It gives Republicans the private-sector role for health care they are looking for, at the same time allowing Democrats to say everybody is going to be covered." Also, Sen. Jim DeMint (R-SC) last week proposed an expansion of access to low-cost health care without a government mandate.

Source: The Hill, 12/21/07.

Of Physician Interest

PHYSICIAN PAYMENT CUTS: TROUBLES NOT OVER

Last week, Congress passed legislation that replaced a schedule 10.0 percent cut in 2008 Medicare physician payments with a 0.5 percent increase through June 30, 2008. The good news is that this legislation will ward off the cut for six months, giving Congress another opportunity to avert a disastrous situation of issues of patient access to care. The adoption of this Medicare package also refused to address limits on physician-owned hospitals and further regulation of imaging services. The bad news about the bill is that will mark over six years that Medicare payments have not covered physician practice costs – a proposition that will likely continue to trouble most physicians and seniors. It also creates continued uncertainty about the future of Medicare payments and leads to a natural question in the minds of many observers – why has there not yet been a dedicated long-term solution to this problem? This year, the American Medical Association led a \$3 million grassroots campaign to avert the 10.1 percent cut in physician payments, with aggressive advocacy efforts and advertising resulting in over a half a million contacts to Congressional members. The AMA has said this effort will continue for a solution that fully funds Medicare payments in a way that covers practice costs and ensures access to care for those who depend on Medicare. In the meantime, the AMA is suggesting that physicians review their Medicare participation options, because officials at CMS have stated they would extend the participation deadline for 45 days if Congress passed legislation on Medicare physician payment.

Source: American Medical Association, 12/26/07.

Of Regional Interest

LOUISIANA

New Census Data Shows Louisiana Rebounding. Louisiana appears to be rebounding from the devastation of Hurricane Katrina, gaining 50,000 residents in the year ending July 1, according to new Census Bureau state population estimates released last week. After the storm hit in August 2005, the bureau estimated the state lost 250,000 residents. Despite the most recent gain, the state is far from returning to its pre-Katrina population level of 4.5 million. The Census Bureau estimate is reached by measuring births, deaths and migration into and out of each of the 50 states, the District of Columbia and Puerto Rico. In Louisiana, the Census estimates a net increase of people moving into the state from other states of 29,000, accounting for more than half the jump. California remains the nation's most populous state with about 37 million people. It gained about 300,000 new residents, second to Texas numerically, but 25th fastest by rate of growth, the same ranking as last year. The total U.S. population was estimated at 301.6 million last July 1. The bureau will release county (parish) population breakdowns in the spring, which should give a clearer indication of exactly how many residents have returned to the parishes in and around New Orleans. Earlier this month, the urban planning consultancy firm GCR & Associates, estimated New Orleans' population at 300,000, or about 65 percent of its pre-Hurricane Katrina size, which was around 455,000. GCR chief executive and New Orleans native Greg Rigamer said people have been coming back to the city at a rate of 3,000 to 4,000 per month, which includes in-state migration. Things are looking up, but the city still suffers from failing infrastructure, poor health care and educational services and a "horrific" criminal justice problem.

Source: The Associated Press, 12/26/07.

TEXAS

Medicaid Reform Plan Would Help Poor Get Coverage. The state of Texas submitted a plan to the federal government in December that would increase health coverage for low-income adults, though with benefits perhaps less generous than what Medicaid offers. Texas wants federal rules to be suspended so it can take some money traditionally funneled to hospitals that treat a lot of poor and uninsured patients and instead help financially strapped adults buy private health insurance plans. The policies might offer leaner benefits than Medicaid, the nation's main health care program for the poor. They also would charge co-payments, and possibly premiums, that Texas isn't allowed to charge its 2.7 million Medicaid recipients. "We're redesigning the Texas health care system to reduce the reliance on expensive, hospital-based care by making primary and preventive care affordable for the working poor," said Albert Hawkins, Health and Human Services commissioner. If federal officials approve the plan, poor and working-poor Texans who are 19 or older could apply for subsidized coverage next fall. It would be offered by private insurance companies through a new state-administered Health Opportunity Pool. If applicants are eligible for coverage at work, but unable to afford it, the state could help them buy those policies. Mr. Hawkins insisted that under the plan, the state's big-city, safety-net hospitals would not lose any federal payments for seeing large numbers of indigent patients. He said lawmakers last spring approved an extra \$150 million of state spending to increase reimbursements next year for hospitals that treat Medicaid patients. The increase will generate \$246 million in federal matching funds. Mr. Hawkins said the additional federal money can be used to pay for the Health Opportunity Pool, without reducing the \$1.5

billion a year in federal payments to safety-net hospitals for treating a disproportionate share of the uninsured poor. This year, the Legislature passed Medicaid reform that required Mr. Hawkins to seek federal permission to give poor patients financial incentives to quit smoking and lose weight and discourage them from seeking routine care in emergency rooms. He was also told to ask for rules waivers so the state could offer current Medicaid recipients tailored benefit packages and subsidize private coverage of uninsured, low-income adults. Most of the 760,000 adults on Medicaid in Texas are elderly or disabled. Income limits for other adults – if they are not pregnant women – are among the tightest in the nation. A working parent with two children has to make \$308 or less a month to qualify. A working parent of two could earn up to \$2,862 a month and still be eligible for the proposed subsidies from the Health Opportunity Pool. Mr. Hawkins said an estimated 2.1 million adults would be eligible, though the pool would not be a Medicaid-like entitlement, where assistance is guaranteed by federal law to all who qualify. Mr. Hawkins said applicants would be helped on a “first-come, first-served basis” until funds budgeted by the state run out.

Source: The Associated Press, 12/16/07.

UTAH

Governor Wants Health Insurance for All. Gov. Jon Huntsman Jr. wants to make a \$30 million "down payment" on a comprehensive, three-year proposal that would require all Utahns to be insured. That money, which would expand eligibility for Medicaid and the Children's Health Insurance Plan (CHIP), is a significant first step toward implementing sweeping health-system reform in the state, Huntsman said. "The way we go about handling health care is economically unsustainable," he said recently, pointing out that health care costs in Utah grew at more than double the rate of inflation last year. Fewer than 60 percent of businesses now offer health insurance to their employees. Huntsman said a blueprint of his confidential plan won't be rolled out until the Legislature's caucuses can review it - which could be a few weeks away, but a working draft of the plan is in circulation. "This is an effort that is driven by the Legislature, by our office, by the business community and certainly by many advocates as well," he said. "So this is an all hands on deck effort and one we're taking very, very seriously." The main crux of the plan is to cover more individuals by extending existing programs. The \$30 million, included in the governor's budget recommendations for fiscal year 2009, would expand eligibility for Medicaid to those earning up to 200 percent of the federal poverty guidelines, up from 133 percent. For CHIP, children in families earning up to 250 percent would qualify, up from 200 percent, Huntsman said. The next part of the plan would include devising a way to subsidize working families who don't qualify for these programs and can't afford private insurance; and creating consequences that force those who can afford health insurance to buy it. One possibility, for instance, is to require Utahns to have a basic level of health insurance before they could apply for a job or register for higher education, according to the working draft. The idea, said David Sundwall, director of the Utah Department of Health, is that if every Utahn were insured, health care costs would be contained. "If everyone is covered there is not that opportunity for cost shifting," said Sundwall, who is involved in the health reform effort. "The sad thing is now we have people with no health insurance - but with very high health care costs - and they're what make the costs go up." In a state such as Utah, he added, "the private insurance-based approach is the way to go right now."

Source: Salt Lake City Tribune, 12/16/07.

OKLAHOMA

Oklahoma Medicaid Beneficiaries Lose Coverage and Access. More than 5,800 Oklahoma residents were dropped from the state's Medicaid program because they could not meet federal proof-of-citizenship requirements. The guidelines are intended to prevent undocumented immigrants from enrolling in the program. The Oklahoma Health Care Authority did not report the immigration status of those who were dropped from Medicaid, called SoonerCare in Oklahoma. However, OHCA CEO Mike Fogarty said, "This leads us to speculate, if not conclude, that this has become a requirement that some people have had difficulty overcoming," adding, "There has not been a problem with an invalid case load." Of the beneficiaries dropped from the program, 62% were children, 58% were white, 18% were black, 13% were American Indian, 10% were Hispanic and 1% was Asian-American. Those percentages are in line with those for the program as a whole, Fogarty said. According to OHCA, each SoonerCare beneficiary is notified at least four times of the proof-of-citizenship requirements, but many do not understand or do not have the necessary documentation. According to the *World*, an additional 5,500 to 6,000 Oklahomans are expected to be dropped from SoonerCare on Jan. 1, 2008. Also, Fogarty reported that the number of uninsured children in the state decreased by one-third over the past decade, largely because of increased enrollment in SoonerCare. About 343,000 children were enrolled in the program in November -- more than twice the number enrolled 10 years ago.

Source: The Tulsa World, 12/15/07.

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