

Advocacy

ADVISORY

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In this edition:

- Medicare Report Warns of Financial Health
- Senate Bars Talk of Lower Medicare Drug Prices
- HHS Promotes Preventive Health for Beneficiaries
- Tobacco Tax Proposed as Way to Offset SCHIP
- Regional Updates

HOT TOPICS FOR ADVOCACY IN THIS ISSUE

THIS ISSUE of the Advocacy Advisory will focus on topics of current interest within the 110th Congress – including an examination of the outlook for health care issues:

- 1) The State Children’s Health Insurance Program (SCHIP) might be the most important piece of legislation to be addressed this year. SCHIP requires re-authorization during this congressional session. Unless Congress changes the budget baseline rules for SCHIP, funding will remain frozen at FY2007 levels for the long term. President Bush included a freeze in his proposed budget. Many states that were looking at increasing their coverage to more children are putting their programs on hold until additional funding is assured. In addition to the funding issue, many of the children who are eligible for coverage under SCHIP in many states did not get enrolled. Remediating this situation requires additional hearings and most likely, additional funding. There has been a recent proposal of using a tobacco tax to cover the increased expenditures expected.
- 2) The Medicare drug program is also on the table for discussion – some lawmakers believe that Medicare needs to be able to negotiate with drug manufacturers for best prices, but others believe that the best prices are available now and the introduction of formularies would work to increase costs. Most agree that there should be a move in the program to the use of generics. This issue was center-stage in Washington this past week as Republican lawmakers blocked a bill that would have permitted the federal government to negotiate Medicare drug prices.
- 3) Reimbursement rates for physicians are an important issue. The primary concern involves the annual effect of the Sustainable Growth Rate (SGR). Many on Capitol Hill believe this must be dealt with a long term manner rather than addressing the 5-6% deficits required under the SGR each year.
- 4) Health Information Technology – Congress is looking for a funding mechanism for hospitals and physicians to purchase HIT necessary to track quality measures, support electronic health records, and collect data that will be useful in determining new quality measures as time goes on.

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. Also under scrutiny at the federal level at this time are funding for stem cell research and right-to-life issues.

IN THIS ISSUE:

- MEDICARE REPORT CONTAINS WARNING ON FINANCIAL HEALTH
- SENATE BARS TALK OF LOWER MEDICARE DRUG PRICES
- HHS PROMOTES PREVENTIVE HEALTH FOR MEDICARE BENEFICIARIES
- TOBACCO TAX PROPOSED AS WAY TO OFFSET SCHIP EXPENDITURES
- NUMBER OF UNINSURED UPDATED
- REGIONAL UPDATES

MEDICAID REPORT CONTAINS WARNING ON FINANCIAL HEALTH

The upcoming report on Medicare's financial health is likely to contain a first-of-its-kind warning that will require President Bush to find ways to make the program more self-reliant. House Republicans came up with the idea for the warning when drawing up the Medicare drug benefit in 2003. Lawmakers say they were concerned the program's future growth would crowd out essential spending for defense, education and other purposes. "It's just one way of throwing some water in our faces so we look at this problem" said Rep. Paul Ryan (R-WI). The drug bill required that trustees issue a "Medicare funding warning" when they project in consecutive years that Medicare will rely on general revenues for 45 percent of its money. Last year's report contained such a projection for 2012. So this year's report, scheduled to be released Monday, could be the one that triggers the warning if the trend line holds for 2013. The warning could lead to such changes as payment cuts for health care providers or higher premiums for beneficiaries. Congress also could choose to ignore it. Some advocacy groups and congressional aides are expecting such a warning. Medicare's long-term financing trends have not changed dramatically over the course of the year. One part of Medicare, the drug benefit, is coming in under budget. "We are going to hit the 45 percent," Mark Hayes, chief health care adviser to Iowa GOP Sen. Charles Grassley, said late last year. "And the official sounding of that trigger, I think, will at least trigger its own discussion about entitlements and where we're going in this country with spending."

Already, many analysts believe the wake-up call will be greatly ignored. They say the trigger has nothing to do with the program's solvency, which refers to how long surpluses in the hospital insurance trust fund will last. Rep. Pete Stark (D-CA), chairman of the health subcommittee for the House Ways and Means Committee, said he will work this year to pass legislation that does away with the 45 percent rule. In any event, he does not intend to pay it much attention.

Absent legislation, Bush will be required to propose ways to reduce Medicare's reliance on the general treasury to below 45 percent. Bush's most recent budget has recommended an across-the-board cut of 0.4 percent for every Medicare provider when general funds pay for more than 45 percent of the program. Congress also will have to consider the president's recommendations next year on an expedited basis, but it can reject them. Several advocacy groups will encourage them to do so.

Source: the Associated Press, 4/19/07.

SENATE BARS TALK OF LOWER MEDICARE DRUG PRICES

A pillar of the Democrats' program tumbled this past week when the Senate blocked a proposal to let Medicare negotiate lower drug prices for millions of older Americans, a practice now forbidden by law. Democrats could not muster the 60 votes needed to take up the measure in the face of staunch opposition from Republicans. The opponents said private insurers and their agents, known as pharmacy benefit managers, were already negotiating large discounts for Medicare beneficiaries. Fifty-five senators, including six Republicans, supported a Democratic motion to limit debate and proceed to consideration of the bill; 42 senators voted against it. The Senate had a brief debate on the merits of the bill, which is a priority for the new Democratic majority in Congress.

Republicans framed the issue as a choice between government-run health care and a benefit managed by the private sector. The benefit is delivered and administered by private insurers under Medicare contracts. Senator John Cornyn (R-TX), denounced the bill as "a step down the road to a single-payer government-run health care system." Democrats said they were merely trying to untie the hands of the secretary of health and human services so he could negotiate on behalf of 43 million Medicare beneficiaries. A 2003 law prohibits Medicare from negotiating or setting drug prices or establishing a uniform list of covered drugs, or formulary. The House passed a bill requiring the secretary of health and human services to negotiate drug prices by a vote of 255 to 170 on Jan. 12, eight days after Congress convened. The Senate bill permits but does not require negotiations. President Bush had threatened to veto both versions.

The Congressional Budget Office said that the Senate bill, like the House measure, "would have a negligible effect on federal spending." "Without the authority to establish a formulary or other tools to reduce drug prices, we believe that the secretary would not obtain significant discounts from drug manufacturers across a broad range of drugs," the budget office said. Some Republicans prepared to filibuster the Senate bill, but that proved unnecessary. Their whip, Senator Trent Lott of Mississippi, said Republicans had blocked consideration of the bill because they did not want to dicker with Democrats over amendments on unrelated topics, "with no happy end in sight."

Source: *The Washington Post*, 4/19/07.

HHS PROMOTES PREVENTIVE HEALTH FOR MEDICARE BENEFICIARIES

Health and Human Services Secretary Mike Leavitt is scheduled to start a multi-state campaign to promote Medicare beneficiaries' use of preventive care. Leavitt will begin this campaign in New England, with visits to Rhode Island, Massachusetts, Maine and Connecticut during the first week. The effort is designed to encourage beneficiaries to take advantage of Medicare's no-cost pneumonia and flu shots, a physical when they enter the program and screenings for osteoporosis, diabetes and certain cancers. Most screenings require beneficiaries to pay 20% of the cost. Leavitt said that U.S. residents spend about \$3.8 billion for diabetes-related hospitalizations, about two-thirds of which could be avoided with appropriate preventive care. Leavitt said that about 50% of Medicare beneficiaries with diabetes do not have their blood sugar tested -- which is available at no cost -- in the course of a year. Beneficiaries also are entitled to no-cost supplies and training for managing diabetes. Leavitt said, "Because one chronic disease is often accompanied by complications, this effort will pay dividends for many years to come."

Source: *Daily Health Policy Report*, Associated Press, 4/20/07.

TOBACCO TAX PROPOSED AS WAY TO OFFSET SCHIP EXPENDITURES

House Majority Whip James Clyburn (D-SC) on Tuesday said that Congress should consider increasing the federal tobacco tax to offset a proposed \$50 billion expansion of SCHIP over five years. Clyburn, whose constituency includes tobacco farmers, said that the farmers benefited from a \$9.6 billion tobacco buyout in 2004 to help them transition out of the industry. Clyburn said, "Who would be hurt if we had an increase? The tobacco farmers got a great deal, so all we're talking about is people who choose to smoke cigarettes." House Budget Committee Chair John Spratt (D-SC) declined to comment on whether he would support a tobacco tax increase, and House Energy and Commerce Committee Chair John Dingell (D-MI) likely would prefer to offset SCHIP with cuts to Medicare Advantage reimbursements. Meanwhile, the Senate Finance Committee during the next several weeks will be drafting an SCHIP proposal that might include a tobacco tax increase, according to committee Chair Max Baucus (D-MT). "Everything is on the table," Baucus said.

Source: Kaiser Daily Health Policy Reports, 4/19/07.

CMS: MEDICARE FRAUD COSTS BILLIONS EACH YEAR

Medicare fraud costs billions of dollars each year, according to testimony from federal officials at a hearing this week of the House Energy and Commerce Subcommittee on Health. Acting CMS Administrator Leslie Norwalk said, "The fraudulent business practices of unscrupulous durable medical equipment, orthotics, prosthetics and supplies suppliers continue to cost the Medicare program billions of dollars," adding that CMS "has seen a marked increase in fraud and abuse activities over the past few years that can be directly tied to provider enrollment issues." Examples of fraud include paying kickbacks to physicians who prescribe high-cost wheelchairs when lower-cost equipment would be effective and filing Medicare claims for equipment never delivered or not needed. Medicare and fraud prosecutions have resulted in \$11 billion in fines and settlements since 1997, according to the testimony of Daniel Fridman, senior counsel to the attorney general. The HHS Office of Inspector General recently investigated Miami-Dade County, Fla., which has the highest concentration of equipment suppliers per Medicare beneficiary. Investigators conducted inspections of 1,581 sites and uncovered fraud that resulted in 286 suppliers losing Medicare eligibility. At the hearing, federal officials also testified that the rate of mistakes by Medicare that result in overpayments or other errors is dropping. Norwalk said new figures will indicate that the effort to reduce billing and other errors "has been a success." The error rate is on target to reach 4.3% in 2007, compared with 5.2% in 2005.

Source: Congress Daily, 4/19/07.

Of Physician Interest

PHYSICIANS SHOULD BE ABLE TO REVIEW PERFORMANCE RATINGS PRIOR TO RELEASE

A policy paper and principles assuring that physicians are given the opportunity to comment on performance ratings that they believe are inaccurate were adopted this week by the American College of Physicians (ACP) at its annual meeting. The principles, part of the paper *Developing a Fair Process Through Which Physicians Participating in Performance Measurement Programs Can Request a Reconsideration of Their*

Ratings, also address performance ratings that do not take into account the characteristics of the practice or patient population being treated prior to the release of ratings to the public.

Accurate reports of physician performance will allow physicians to effectively assess and improve their performance, and enable consumers and purchasers to make informed decisions concerning treatments, coverage and the quality of care. The principles, ACP says, should be considered in tandem with other organizational principles on developing measures; sharing, aggregating, and reporting data; and the ethics of physician performance measurement. ACP has stated in previous position papers that programs measuring physician performance should operate in a fair, objective and scientifically sound manner. Performance data should be used for public reporting or to determine physician payment only after data are fully adjusted for case-mix composition, including age, severity of illness, co-morbidities, and other features of a physician's practice and patient population that may influence the results.

"A fair and accurate reconsideration process is yet another way to minimize unintended consequences that may compromise the care of the patient," said ACP President Lynne M. Kirk, MD, FACP. "These principles reflect the importance of balancing stakeholders' urgent need for useful information with the need for due diligence to ensure that the information provided is valid, reliable, and useful." Voluntary payer utilization of the general guidelines are designed to ensure a fair and accurate process through which physicians participating in a performance measurement program can request a reconsideration of performance ratings prior to public release. The 11 principles included in the paper are listed below:

1. Prior to public release of performance ratings to the public or use of ratings to determine payment, physicians should be given the opportunity to review the ratings for accuracy, and at the physician's request, initiate reconsideration of their individual ratings. The payer should employ all possible means to ensure that no adverse determination regarding physician performance be made without prior review by the rated physician, and, when requested by the physician, ratings should be reconsidered by an appropriate and objective group of reviewers.
2. At the time of enrollment in a performance measurement program, and when ratings are first distributed for internal review, payers should provide physicians with a clear explanation of all program facets, including: the clinical guidelines and evidence that is graded upon which measures are based; the analytical methods used to aggregate, rate, and report data; the physician's right to an objective, timely, and expeditious reconsideration and appeals process; and a clear description of the reconsideration and appeals process, including the grounds for challenging ratings.
3. Payers should have a well-defined and distinct mechanism for responding to physician inquiries and requests for reconsideration. Practical time frames must be established to ensure timely resolution of the contested matters and to minimize the delay of public reporting.
4. In submitting a request for reconsideration, physicians should be given an opportunity to clearly identify the grounds for challenging the ratings. Physicians should be able to challenge the accuracy and fairness of the application of performance measures. Ratings may be challenged on a variety of factors, including: the validity, reliability, appropriateness, and applicability of the measure and its evidence base; the appropriateness of the statistical methods used to aggregate the data, including the size of the sample; the effectiveness of statistical adjustments (or lack of) used to account for confounding factors, including care attributable to the individual physician, case-mix composition, co-morbidities, severity of illness, and patient non-adherence; the suitability of the measure implementation process; and the accuracy of the reporting format.
5. Submitting a request for reconsideration should not create an undue administrative burden on physicians to the extent that it discourages physicians from challenging ratings. Similarly, user fees and penalties should not be imposed on physicians who challenge performance rating decisions.
6. Fairness must be integral to methods used by payers to evaluate requests for reconsideration. Decisions about the appropriateness of ratings should be thorough and responsive to the concerns of the physician. In responding to physicians with the results of a reconsideration appeal, payers should state their findings and the clinical basis for their findings as clearly as possible.
7. The payer should establish unambiguous parameters to determine when a dispute cannot be resolved through an internal review process, and instead warrants consideration by an independent, external review or appeals board. These parameters should be set high enough to minimize the delay of public reporting and to preserve the goals of transparency.
8. If the physician still contests a rating after all mechanisms for reconsideration have been exhausted, the physician should be permitted to include comments adjacent to the disputed rating in the public report.

9. Payers should provide a central source for collecting, monitoring, and analyzing all inquiries and requests for reconsideration in order to enhance accountability, ensure that concerns are adequately addressed, and improve processes through the identification of recurrent issues and concerns.
10. If the physician successfully challenges an erroneous rating, he/she should receive full payment from the third party payer. Any "withholds" that may have occurred from physician reimbursement during the period of appeal should be paid within sixty days to the physician along with interest based on the medical Consumer Price Index.
11. Recognizing the importance of educating physicians about the potential difficulty and associated expenses of a performance measurement auditing process, the College will educate its membership about the appeals process and encourage its membership to use it judiciously to avoid frivolous appeals. ACP is willing to engage in a multi-stakeholder process to promote an appeals process that is fair and reasonable for both physicians and health care payers.

Source: American College of Physicians, 4/20/07.

Of Regional Interest

LOUISIANA

Push Is On to Get Health Care for Children. Some 68,000 children in the New Orleans area lost their health-care coverage after Hurricane Katrina, but state health officials estimate that about a third of them remain eligible for government-funded health insurance. So, the Louisiana Department of Health and Hospitals and a host of local partners launched a weeklong effort in Orleans and St. Bernard parishes this past Tuesday to try to reconnect as many of those children as possible to either the Louisiana Children's Health Insurance Program or traditional Medicaid. Ruth Kennedy, director of DHH's LaCHIP, said the department wants to make sure that "when it comes to health care, no child is left behind."

"Health care for children matters," she added during a press conference at the Children's Defense Fund headquarters in New Orleans. The LaCHIP "outreach blitz" that kicked off Tuesday runs through Sunday and will target not only families whose children have lost their LaCHIP/Medicaid health care coverage for any reason post-Katrina but also families who never have received coverage before and are unaware they qualify for the programs. DHH employees and volunteers from across the state will be stationed across the New Orleans area, distributing information about various health coverage programs and setting up mobile units of DHH eligibility workers. They will process LaCHIP/Medicaid applications, renew coverage for families who need to update their contact information, and provide immediate eligibility determinations whenever possible.

Enrollers will be stationed in retail stores, schools, churches, community centers and other places throughout Orleans and St. Bernard.

DHH is conducting the outreach initiative in partnership with the "Cover the Uninsured" campaign, which is sponsored by the Robert Wood Johnson Foundation.

"We want to keep kids healthy. That's our focus on this," Dr. George Sterne with the Louisiana chapter of the American Academy of Pediatrics, one of DHH's local partners, said. Increased participation in LaCHIP will help decrease overcrowding at hospital emergency rooms and take pressure off limited in-patient facilities, he added. Kennedy said some 611,000 children are enrolled in public health coverage in the state. When LaCHIP started in 1998, Louisiana had the fifth-highest percentage of uninsured children at more than 31 percent, she said, but that figure dropped to 12.5 percent last year — 10th-lowest in the country. More Louisiana children now are eligible for LaCHIP because of the annual federal poverty level increase this month, Kennedy added. Now, for example, children in a family of four with up to \$41,304 annual income can get free health coverage if they don't already have it. The old income limit was \$40,000. The threshold income for a family of three is now \$34,344.

Source: *The Advocate*, 4/18/07.

TEXAS

Medicaid Reform, Health Incentives Pass Texas Senate. A bill approved by the Senate on Tuesday and now headed to the House would subsidize private health coverage for working-poor adults and nudge the poorest Texans to lose weight and quit smoking by providing financial incentives. Republican leaders hailed the measure, passed unanimously, as the first step in a multiyear overhaul of Medicaid, the state-federal health insurance program for the poor, elderly and disabled. But many safety-net hospitals fear the bill could siphon millions in special federal payments they get from Medicaid for treating so many uninsured poor people.

Lt. Gov. David Dewhurst has said he anticipates additional federal payments that would allow the hospitals – even after some of the money is used for other purposes – to come out unscathed. Mr. Dewhurst said it's urgent that the state experiment with programs that might slow growth in – and wring more benefit from – Medicaid's \$18 billion annual budget. Medicaid accounts for about 25 percent of state spending.

Mr. Dewhurst and Sen. Jane Nelson, R-Lewisville, the bill's sponsor, said Texas should exploit latitude that all states were given more than a year ago by President Bush and Congress, then controlled by the GOP. "It's important that we get this legislation out and we get it approved," Mr. Dewhurst said, so that approvals can be obtained next year from "the current [federal] administration." He and other state leaders discussed their plans with U.S. Health and Human Services Secretary Mike Leavitt last winter.

Also under the bill passed by the Senate on Tuesday, Texas would seek federal permission to design benefit packages tailored for different categories of Medicaid recipients and use hospitals' uncompensated-care money to create a low-income insurance purchasing pool. In addition, the state Health and Human Services Commission would conduct a health savings account pilot program. In the pilot, part of an adult Medicaid recipient's benefit would be placed in an account, under his control, which is a pet idea of conservative health care experts. Only the 900,000 adults on Medicaid could choose the option. Medicaid recipients who go to hospital emergency rooms for routine care would have to pay a penalty – either a \$5 or \$15 co-pay, depending on income. The co-payments would be required only of people with incomes above the poverty line. Sen. Nelson said she's proudest of the bill's emphasis on preventing disease. The bill requires a second pilot – in a region of Texas to be later specified – that would offer Medicaid recipients who complete smoking-cessation and weight-loss programs such financial incentives as cheaper prescription drugs.

The largest, the Texas Hospital Association, said its 500 member hospitals accept Ms. Nelson's assurances the state will seek more federal uncompensated-care money for hospitals. Certain local and state expenditures aren't being matched by Washington, said John Hawkins, the association's lobbyist.

But a group that represents 17 nonprofit hospital systems, including Parkland and Children's, said it's not sure that Texas can draw down more federal money.

"Is there a chance for new federal money? We don't know," said Steve Svadlenak, executive director of the Texas Association of Public and Nonprofit Hospitals.

If no new federal funds come to Texas, he said, "there's at best no gain to hospitals."

That's because some funds would be diverted, to do things like pay part of the premium so more low-income adults could buy health policies through their employers.

The state's safety-net hospitals receive more than \$2 billion a year for treating a disproportionate share of the uninsured – and to offset low Medicaid reimbursements, at least to the level of those paid by Medicare, the federal program for seniors and the disabled.

That still leaves hospitals \$4.5 billion short, Mr. Svadlenak said.

Some advocates for the poor fear the customized benefit packages for different groups of Medicaid recipients could lead to denial of care, as more enrollees are placed in managed care plans that are sometimes accused of denying coverage of needed services.

Sen. Carlos Uresti, D-San Antonio, persuaded colleagues to accept an amendment that says the state couldn't "reduce the scope of benefits." Sen. Nelson said she agreed to another amendment, creating a six-legislator oversight panel, to make sure recipients are not denied care.

Source: the Dallas Morning News, 4/18/07.

UTAH

Utah Children Who Lack Health Insurance Up 26%. The number of uninsured Utahns continues to grow, though at a slower pace - except among children. According to estimates recently released by the Utah Department of Health, 306,500 Utahns didn't have insurance in 2006. The number of uninsured grew about 5 percent over the previous year, compared with double-digit increases in the past several years. But children continue to suffer when it comes to adequate coverage. There were 89,500 children up to age 18 without insurance in 2006. That's a 26 percent increase in one year and a 63 percent jump from 2001. Last week, a Health Department press release incorrectly put the increase among children at 4.7 percent. "It's worrisome because children are one of the most vulnerable populations," said Norm Thurston, a health economist with the Utah Department of Health and member of Gov. Jon Huntsman Jr.'s Initiative on Health Insurance for the Uninsured. "The fact we're seeing an increase of children going without health insurance is problematic to us," he said. He attributes the jump to Utah's growing population, along with the skyrocketing cost of health insurance, which forces companies to cut back on coverage or pass on price increases to employees who can't afford it. According to the Utah Health Policy Project, premiums for job-based family health insurance grew 66 percent over the past decade, faster than the national average. Most of Utah's uninsured children could qualify for Medicaid or the Children's Health Insurance Program (CHIP). CHIP enrollment in Utah was halted in September because of a lack of funds. Enrollment will resume July 2, thanks to a \$4 million boost from the Legislature earlier this year. That will add about 12,000 children to the insurance rolls. The Utah Health Policy Project is also advocating that Congress adequately fund CHIP and Medicaid - at \$50 billion to \$60 billion over the next five years - as it debates re-authorization of CHIP this year.

Source: Salt Lake City Tribune, 4/17/07.

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