



Advocacy

ADVISORY

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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 ongoing federal and state issues related to patient access, covering the uninsured, and reimbursements. The CHRISTUS position is consistent that 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.

Putting Care Within Reach:

As one of the largest Catholic health care systems in the United States and because of our solid reputation among policymakers at all levels of government, CHRISTUS Health is uniquely positioned to lead in the effort to achieve meaningful and significant health care reform for this nation. Our efforts will be targeted at achieving objectives in support of the goal of universal coverage, and will include continuing to build effective relationships with legislators and members of the new Obama administration, equipping CHRISTUS leadership and associates with the tools needed to engage and participate in this important national debate, and working to build consensus and collaboration among other health care providers.

The national political scene promises change in 2009 and early indicators are that it will be a favorable time in which to work to achieve our goals. However, there remain significant challenges that CHRISTUS will work to help overcome as a primary feature of our campaign of “**Putting Care Within Reach.**” Success will require a profound commitment at every level of CHRISTUS Health, as we all work together in our individual communities and on a system-wide basis to promote a message of hope, change, and quality health care for every American.

Current Climate and CHRISTUS Position:

It is clear that health reform currently has the undivided attention of Congress. It is equally clear that the issue is divisive, not just between political parties, but also between regions of the country and providers and patients. CHRISTUS is excited about potential prospects for health care reform and we have been to Washington to express our support for this effort. We believe that the perfect should not be the enemy of the good in order to get a bill passed this year. Unfortunately, there is more attention being given to the differences under discussion, with very little attention to the similarities in all of the packages under consideration.

The CHRISTUS message regarding health care reform legislation includes emphasis on the following:

- **Oversight:** CHRISTUS believes that health providers must be accountable for demonstrating quality of care and cost effective care. Senator Rockefeller (D-WV) has proposed legislation which would expand MedPAC's authority to set payment rates for Medicare providers. And some have discussed an Independent Medicare Advisory Committee (IMAC) with authority to look at outcome measures and establish reimbursement systems that are aligned with cost effective care. CHRISTUS believes that the most important part of this discussion is not necessarily giving an entity authority to simply cut reimbursement rates, but giving some entity authority to look at the overall cost drivers in health care and determine what payment systems bring the most accountability for providing high quality care at the least cost. We agree with efforts to assign an agency with responsibility to make providers accountable.
- **Provider Collaboration:** CHRISTUS supports efforts to reduce barriers between physicians and hospitals so that more standardization exists in the provision of care and care is better coordinated among providers. Accountable Care Organizations (ACO's) came up in many of our meetings as one strategy to better coordinate care. The bills also include authority for demonstrations and pilot projects to expand medical homes and pursue similar initiatives.
- **Quality Measurement:** CHRISTUS reiterated its leadership among health systems to be transparent in terms of the cost and quality of care we provide. We agree with Congress that quality measures should be reported by all providers to ensure that we are accountable for the federal dollars we spend.
- **Workforce Initiatives:** CHRISTUS understands that an expansion of health coverage will require a workforce to meet the primary care needs of a larger population that previously avoided preventive care. We stand ready to do our part to work with federal agencies to ensure that we get this workforce trained. We are pleased that both the House and Senate are likely to include initiatives to bolster the primary care workforce with provisions to expand primary care residency slots for physicians and to provide incentives for nurses.
- **Information Technology:** CHRISTUS is working closely with federal policymakers within the Administration to ensure that the "meaningful use" standards under consideration will incentivize hospitals to embrace HIT. We met with the Office of the National Coordinator for Health Information Technology and shared our experience with HIT, and our belief that HIT will change the way we provide health care, especially by allowing patients to remain in their homes. The funding provided in the last stimulus bill in Congress will be made available to qualifying providers based on their ability to meet these new standards. CHRISTUS stands ready to be a leader in HIT and is eager to be an example for others.

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HOUSE LEGISLATION MOVING FORWARD AGAIN WITH COMPROMISE MEASURE

The drive to enact health legislation gained momentum, as top House Democrats on Wednesday brokered a deal with White House backing to ease the impact on small business and pare back the cost of the sweeping bill. Democrats agreed to resume long-stalled deliberations in the House Energy and Commerce Committee, with prospects strong for the committee to approve the bill later this week. At the same time, they agreed to postpone any vote in the full House until September. In the Senate, Finance Committee Chairman Max Baucus (D-MT) said his effort to build a bipartisan bill is advancing. He cited an estimate by the nonpartisan Congressional Budget Office that the bill in the Senate Finance Committee would cost less than \$900 billion over a decade -- less than other versions of the health legislation in the House and Senate -- and ensure insurance coverage for 95% of Americans.

Together, the developments suggested that Democrats are likely to avoid their worst-case scenario -- a breakdown of talks before the August recess. But they are still far from agreement on the final contours of the legislation. Contrary to President Barack Obama's original deadline, neither the House nor the Senate will pass a health bill in the full chamber by the recess. Each chamber will have to reconcile internal differences in the fall. If successful, the House and Senate would then have to combine their separate versions into one. California Democratic Rep. Henry Waxman, chairman of the Energy and Commerce Committee, expressed confidence that the process is back on track. "Failure is not an option," said Mr. Waxman, whose panel is the last of three major House committees to act on the bill. The other two have passed it.

Among other things, the House deal, put together with heavy involvement by White House Chief of Staff Rahm Emanuel, would exempt more small businesses from a requirement to provide insurance to employees or pay a penalty. The deal would require that payments to health-care providers under a new public health plan not be pegged to Medicare, the health plan for the elderly. And it would also pare back the 10-year cost of the bill, estimated at roughly \$1 trillion, by \$100 billion. The cuts would be achieved in part by asking states to share in a planned expansion of Medicaid, which offers health insurance for the poor, and by requiring low-income people to pay higher premiums to purchase insurance. "We have reached an agreement that will allow health-care reform to move forward," said Arkansas Democratic Rep. Mike Ross, a leader of the centrist Blue Dog coalition who helped negotiate the deal.

The delay in a floor vote may be the most significant concession to the Blue Dogs by the House Democratic leadership, including Speaker Nancy Pelosi. With Congress on break for much of August, opponents will have an opportunity to raise public doubts. Republicans on Wednesday said even the revised bill would raise costs for small business and kill jobs. "It proves once again that the so-called Blue Dogs have no bite when they're forced to choose between their constituents and the radical leadership of their party," said Ohio Rep. John Boehner, the House minority leader.

On the Senate side, Mr. Baucus is close to securing agreement with three top Finance Committee Republicans. The emerging Senate package would expand coverage by creating a network of nonprofit cooperatives that would compete with private insurers. That contrasts with the House bill, which would create a government-run public health plan. In a statement, Mr. Obama said the developments represented "constructive" efforts to strengthen the legislation. However, liberal House lawmakers complained the changes would weaken the bill, in part by raising costs for lower-income people and diluting the strength of the public plan. "It's terrible and totally unacceptable," said Jerrold Nadler (D-NY). Reflecting the challenge for Democratic leaders in keeping the party united, Mrs. Pelosi met with a group of liberal lawmakers late Wednesday in an effort to calm tensions.

The deal exempts more small businesses from the mandate to provide insurance to workers. The original House bill exempted businesses with annual payrolls below \$250,000; the new deal would raise that threshold to \$500,000. Under the revised bill, companies with payrolls from \$500,000 to \$750,000 would face a penalty equivalent to 2% of payroll if they fail to offer insurance. Companies with payrolls above \$750,000 would pay an

8% penalty. After the changes, some 5.3 million employers would be exempt from the mandate, about 400,000 more than under the original House proposal, said the National Federation of Independent Business, a trade group representing small businesses. Even so, the federation said it believes the burden on small employers is too high. *Source: Wall Street Journal, 7/30/09.*

SENATE FINANCE COMMITTEE MEMBERS ADDRESSING REFORM OPTIONS

The power to reshape the future of health care in the United States remained more than ever with six U.S. senators this week. Amid growing questions about their progress, the Senate Finance Committee's group of six was buoyed by news that its patience might be paying off. While majority Democrats in the House reached a deal, the three Senate Democrats and three Republicans, including Iowa's Charles Grassley, learned their emerging plan would cost less than any others in Congress. The development was a product of two-dozen private meetings since March, including three Wednesday, where a half-dozen politically diverse policy wonks have ploddingly and politely tried to tackle the nation's No. 1 domestic priority. What has given these six, representing 3 percent of the nation's population, such influence? Partly, it comes from their own reputations for seriousness of purpose and bipartisan legislative success, built from a combined 132 years in the Senate. It also stems from the structure of the Senate itself, which the founding fathers set up to accommodate deliberation and independence. The test of their work will be whether their peers, some annoyed by their pace, and the president, who has intimated differences on some provisions, will find it worth the wait. The team is anchored by Max Baucus (D-MT) the Finance Committee chairman, and Grassley, its ranking Republican.

In nearly 10 years, their partnership approach has led to major accomplishments, such as the 2001 tax cuts, the 2002 fast-track trade authority, and the 2003 Medicare prescription drug bill. Sen. Kent Conrad, D-N.D., who has attended nearly every session, said the others have built on Baucus' and Grassley's relationship out of a sense of responsibility. The dynamic inside Baucus' conference room, crowded to capacity with staff, is respectful and efficient, participants said. Baucus presides during the sessions, where press is barred, but shares the floor evenly around the conference table. Grassley is considered a fiscal conservative, but is also known to negotiate. Olympia Snowe, R-Maine, is a moderate known for collaborating with Democrats. Grassley described Snowe as meticulous.

Baucus called it encouraging Wednesday when the Congressional Budget Office estimated that the bill under development would cost less than \$900 billion over 10 years, less than rival House and Senate legislation. Baucus and Grassley said they were on the edge of an agreement, but work remained. Grassley noted that House legislation ceded to the secretary of Health and Human Services the authority to write rules; the Finance Committee is working to write them. What remains unclear is whether Obama, who has promoted inclusion of a government-run option but has stayed out of negotiations, will choose a bipartisan bill with less than he wishes. *Source: Washington Post, The Associated Press, 7/30/09.*

HEALTH BATTLE HAS TWO FRONTS: CAPITOL HILL AND THE AMERICAN PUBLIC

The battle of overhauling the health care system is being fought out on two fronts, on Capitol Hill and in the arena of public opinion, and when it comes to public opinion, a batch of recent polls show a desire for reform but rising concerns about the proposals moving through Congress. One consistent theme is the disparity between public belief that an overhaul is badly needed, and anxiety among Americans about what changes will mean to them personally. Here is a round-up of some of the latest surveys:

Wall Street Journal/NBC News : Plurality Disapprove Obama's Handling of Health Care

Forty-six percent of Americans disapprove of President Obama's handling of the issue of health care reform compared to 41 percent who give him positive marks, according to this poll conducted July 24-27. Thirteen percent are undecided. That compares to the 52 percent to 40 percent disapproval of former President Clinton's push for an overhaul in 1994. Forty-two percent say the plan Obama is pushing is a bad idea, 36 percent say it is a

good idea and 17 percent have no opinion. That compares to June when 32 percent said it was a bad idea, 33 percent labeled it a good idea and 30 percent had no opinion. Thirty-nine percent believe that under Obama's plan their health care will get worse, 29 percent say it will stay the same and 21 percent say it will get better. In April, 24 percent said it would get worse, 29 percent said it would stay the same and 22 percent said it would get better.

New York Times/CBS News : Concerns About Health Care Overhaul on the Rise

While most Americans believe that the nation's health care system needs fundamental changes or to be completely rebuilt, 59 percent of registered voters believe that the legislation now moving through Congress will not benefit them personally compared to 31 percent who think it will, according to the poll conducted July 24-28. Fifty-nine percent say from what they've read or heard of the legislation that it will increase costs for most Americans while 16 percent say it will have no effect and 15 percent believe it will reduce costs.

Three-quarters of those polled say they are very or somewhat concerned that a government plan to provide health care for all Americans will raise their taxes and about the same number worry that the cost of their own health care will go up. Sixty-nine percent believe that if the government creates a system of providing health care for all Americans, the quality of their own health care will get worse, compared to 53 percent who said so in June. Sixty-two percent worried that an overhaul would require them to change doctors compared to 53 percent in June.

Source: CQ Politics, 7/29/09.

BIPARTISAN GROUP EYES MEDICARE SAVINGS

A bipartisan group of senators agreed tentatively earlier this week on a plan to squeeze an additional \$35 billion out of Medicare over the next decade and larger sums in the years beyond, according to congressional officials, a step toward fulfilling President Barack Obama's goal of curbing the growth of health care spending. Under the plan, an independent commission would be empowered to recommend changes in Medicare annually, to take effect automatically unless Congress enacted an alternative. In addition to saving money, the proposal is aimed at turning the program for those age 65 and over into one that more clearly rewards quality, officials said. The commission would be required to recommend \$35 billion in savings over a decade from Medicare. There was no immediate estimate on the longer-term effects of the provision, the topic of exhaustive discussion among three Democrats and three Republicans groping for a compromise on legislation atop the administration's domestic agenda. The officials spoke on condition of anonymity, saying they were not authorized to discuss details of the private talks. The negotiations occurred as White House chief of staff Rahm Emanuel spent much of his day in the Capitol attempting to untangle a dispute that has stalled a companion bill in the House. Most of the variations under discussion have called for creation of a commission to issue annual recommendations for savings that would go into effect automatically unless the House and Senate blocked them. Currently, Congress must vote affirmatively to make any changes, a system that encourages individual lawmakers to seek favorable treatment for constituents or businesses in their districts or states. Any bipartisan compromise that emerges from the negotiations is also expected to include a number of cutbacks in planned payments to hospitals and other Medicare providers, totaling hundreds of billions of dollars. The bipartisan group is attempting to complete work in time for the Senate Finance Committee to vote on legislation next week.

Source: Associated Press, 7/29/09.

IDEA TO TAX INSURERS GAINING MOMENTUM

A proposal to tax insurance companies on their most-expensive policies appears to be gaining momentum in Congress and the White House, as lawmakers search for politically acceptable ways to fund a health overhaul. David Axelrod, senior adviser to President Barack Obama, suggested on CNN's "State of the Union" Sunday that the president found the idea "intriguing." "That was our big concern, that we not impose vast new burdens on the middle class," Mr. Axelrod said. Other comments by influential Republican and Democrat

lawmakers suggested that the idea has broader appeal than some other funding plans that have been floated, such as taxing individuals on their employer-provided health plans, or imposing a surtax on the wealthiest Americans. A main sticking point to passing Mr. Obama's plan to overhaul the health-care system and expand coverage to the nation's uninsured is how to cover the cost, estimated at upward of \$1 trillion over 10 years.

Underscoring the challenge, the Congressional Budget Office on Saturday issued a report finding that relatively little savings would be realized by one of the few deals reached between party leaders and moderate Democrats who want to change the health bill: an agreement to create a panel to find cost savings in Medicare. The report said the proposal, which the White House is pushing as a crucial, cost-saving change to the legislation, would save \$2 billion over 10 years. In recent days, Sen. John Kerry (D-MA) and others have floated the idea of targeting high-end insurance plans as a way to help cover the costs of a health-care overhaul. Mr. Kerry has publicly offered few specifics, but congressional staffers have suggested that options being discussed include taxing insurance companies or employers that offer such plans. It wasn't immediately clear how much tax revenue such an approach would generate.

Of Physician Interest

AMA NATIONAL HEALTH INSURER REPORT CARD SHOWS IMPROVEMENT

Health insurers have made important improvements in the twelve months since the American Medical Association (AMA) called for an overhaul of the industry's billing and collection process, but there is a tremendous opportunity for improving efficiency in the nation's multi-payer health care system. This is the key finding of the AMA's National Health Insurer Report Card. This is the second year in a row that the AMA has released its report card to diagnose the strengths and weaknesses of the claims processing systems used by eight of the nation's largest health insurers. "We are encouraged that health insurers took the AMA's initial report card findings seriously and made improvements, but this year's new report card shows there is still work to do," said AMA Board Member William A. Dolan, M.D. "Each insurer uses different rules for processing and paying medical claims that results in confusion and inconsistency in claims processing. Simplifying the administrative process through standardized processing and payment requirements is needed as part of comprehensive health reform legislation this year. It will reduce unnecessary costs in the health system and eliminate the variability that requires physicians to maintain a costly claims management system for each health insurer." The inefficient and inconsistent claims process adds as much as \$200 billion annually to the health-care system. One recent study estimated physicians spend the equivalent of three weeks annually on health insurer red tape. To keep up with the administrative tasks required by health plans, physicians divert as much as 14 percent of their revenue to ensure accurate payments from insurers.

Key findings from the 2009 National Health Insurer Report Card include:

Denials. The inconsistency found among health insurers in 2008 continues to be demonstrated in 2009. The wide variation in how often health insurers deny claims, and the reasons used to explain the denials, indicates a serious lack of standardization in the health insurance industry.

Timeliness. Prompt pay laws continue to appear effective in encouraging insurers to respond to physician electronic claims with relatively quick payment transmittals. Five of eight insurers showed a slight improvement from last year in reducing the median time necessary to respond to a physician claim.

Accuracy. While there remains room for improvement, health insurers made progress in eliminating unnecessary reporting discrepancies from the payment process. Private health insurers correctly acknowledged the expected contracted rate to physicians upon fee 72 to 93 percent of the time in 2009, compared with 62 to 87 percent of the time in 2008.

Transparency. Payers have made improvements since 2008 in their efforts to disclose vital policies and information to physicians through their Web sites. Almost every insurer provides physicians with at least some access to a range of payment policies, with the notable exception of policies related to prior-authorization of services.

Of Regional Interest

ARKANSAS

Federal Stimulus Funds Come to State. It's been six months since passage and implementation of President Obama's \$787 billion economic stimulus package, projected to pump nearly \$3 billion in federal funds into Arkansas over the next two to three years. But some are already questioning whether the infusion of federal funds is actually creating jobs in Arkansas, as promised, and others are expressing disappointment over not receiving funds they thought they would get. The state is receiving and distributing stimulus funds. Officials say the money is helping many businesses stay afloat in tough economic times, and that as many as 300 new temporary state jobs are being filled to help make sure programs receiving stimulus funds — from jobless benefits to food stamps other social services — are properly administered. State officials closely monitoring the stimulus program say it will take time for the funds to create jobs. A committee of the Legislative Council, the legislative body that oversees state government between legislative sessions, is to discuss the stimulus funding and the state jobs it has created at an August 4 meeting. Also, the state must present a report on its stimulus spending to the federal government by October 10. About \$954.4 million of the estimated \$2.9 billion the state is to receive is expected to be spent on Medicaid and other human services, according to Recovery.Arkansas.Gov, a Web site set up by the governor's office to track the stimulus spending. Another \$475.5 million is to go to education and higher education, \$454.3 million to housing and labor, \$443.9 million to fiscal stabilization and \$379.5 million to transportation.

Another \$87.9 million is slated for energy and weatherization, \$50.3 million for water and environment and \$34.4 million for safety and community services. Additionally, the U.S. Department of Labor this month released nearly \$60 million in stimulus money to extend jobless benefits in Arkansas. The state also is applying for funding to expand broadband access in rural areas of the state. The bulk of the new state government jobs, about 200, are in the Department of Human Services with 200, according to the state finance office. Of those, 112 are temporary family support specialists. The jobs will last through the end of 2010, when the stimulus funding stops, and pay about \$27,000 a year, said DHS spokeswoman Julie Munsell. The Department of Workforce Services is hiring 107 new employees, mostly work force services specialists, at salaries ranging from \$25,000 to \$43,000.

Source: Arkansas Democrat-Gazette, 7/28/09.

LOUISIANA

Insurance and Federal Payouts Create Medicaid Problem in Louisiana. Louisiana Gov. Bobby Jindal says post-storm damage payments from insurance settlements and Louisiana's Road Home program following Hurricanes Katrina and Rita are contributing to a \$1 billion Medicaid shortfall for his state Louisiana's impending dramatic decrease in federal funding is due to what the governor says is a faulty calculation of sources of income in the state, including insurance and Road Home payments after the 2005 storms. From 2005 to 2007, according to the Bureau of Economic Analysis, Louisiana's per-capita income is reported to have increased by 42 percent - a dramatic, sudden increase which will drop the state's federal Medicaid funding, according to the governor's office. Jindal says Louisiana's reimbursement rate will drop from as high as 73 percent to 60 percent - forcing cuts to either public health or higher education. Within the next year, Louisiana will face the largest decrease of federal Medicaid funding in the nation - a decrease almost twice that of the state with the next largest decrease, North Dakota, the governor's office said. Louisiana's Medicaid funding, which would normally be 72 percent, is temporarily enhanced by the federal stimulus. This coming October, it will decrease to 67 percent, and then will decrease to 63 percent in October 2010. The drop from 72 to 63 percent will cost the state an estimated \$700 million per year. The state will start seeing this loss of funding this October, with the full impact starting January 2011.

Source: Associated Press, 7/27/09.

NEW MEXICO

Ranking Improves in Kids Count, But Remains Near Bottom. New Mexico's ranking in the well-being of its children has improved, but the 2009 Kids Count report still shows a mixed picture. The state's overall ranking improved from 48th last year to 43rd this year - but remains in the bottom five states in 4 of the report's 10 key indicators. The state ranks 49th in teen birth rate, 48th in percentage of children living in single-parent families and 47th in the child poverty rate. In addition, New Mexico ranks 44th in the percentage of children in families in which no parent has a full-time, year-round job. Officials of the Annie E. Casey Foundation, which publishes the databook each year, noted the latest report does not reflect information from the height of the economic downturn. *Source: Associated Press, 7/29/09.*

OKLAHOMA

Officials Expect \$2.5 Billion in Additional Federal Stimulus Funding. Oklahoma can expect to see between \$2.5 billion and \$3 billion in federal stimulus money, an analyst for a state think tank said Wednesday. Paul Shinn -- the former budget director of the Oklahoma House of Representatives turned analyst for the Oklahoma Policy Institute -- told members of the Oklahoma JumpStart coalition the state was in line to receive stimulus money over the next year. "There are things the stimulus will do and things it won't do," Shinn said. "The goal of the American Reinvestment and Recovery Act (the ARRA) is to help maintain essential public services, help those who are most at risk in the economic downturn and spur spending for jobs." Yet, despite the massive influx of federal spending, Shinn said the recovery package would not prevent Oklahomans -- or Americans -- from "suffering the long-term effects" of the economic downturn. "Unless we see 5 percent growth next year, it will be 2013 before state and local budgets are back to their 2008 level," he said. "I believe 2012 and 2013 will be difficult, painful years." Shinn said the \$2.5 billion is "only about one-tenth of all government spending (state, federal and local) in Oklahoma." He said a large portion of the package was designed to keep state budgets stable while other funds were earmarked for "enhancements" to Medicaid. "The ARRA allows for federal Medicaid percentage to go from 65 percent to 75 percent," he said. Other areas set to receive stimulus funds include the federal food stamp program, Head Start, Early Head Start, Pell Grants and transportation programs. "The additional funding will allow 40,000 more Oklahomans to receive food stamps," he said. Currently, Shinn said about 500,000 of the state's 3.5 million residents receive food stamps. Along with poverty-related funding, Shinn said more than \$600 million would be spent on infrastructure. "Those funds will go for projects including highway construction, water plants, waste-water plants and others," he said. "All of those projects create jobs." Additionally, Shinn said he hoped the ARRA would help increase transparency in government. "Oklahoma is not very good at government transparency," he said. "I hope the stimulus package sets helps to set a higher standard for transparency." *Source: Norman Transcript, 7/30/09.*

TEXAS

State Officials Worry Stimulus Funding Might Not Go to Quality Projects. The federal stimulus package has deluged some Texas agencies with so much money that state officials are worried the funding might not be spent on quality projects, according to a government report issued this week. The Texas Department of Housing and Community Affairs, which manages home weatherization funds, has \$327 million to spend on work for which it's typically given \$5 million a year. The Texas Workforce Commission's added haul requires it to find summer jobs for at least 14,420 young people -- nearly 15 times the number that found jobs through the program in 2008, according to the federal Government Accountability Office. "Anytime you receive that sort of an exponential increase in funding and corresponding increase in required activity levels, you are concerned [about] how you are

going to marshal the resources to address it," said Tim Irvine, chief of staff and board secretary for the Texas Department of Housing and Community Affairs.

Texas relies entirely on federal funding to weatherize the homes of low-income people. It has a backlog of about 14,000 households that want assistance, which can include conducting home energy audits, improving insulation and replacing inefficient heating and cooling systems, Irvine said. Last year, the program weatherized 4,100 homes, department officials said. With stimulus funds, the state thinks it could address about 48,000 homes. The department has more money than it can spend directly, so it's sending funds to large entities, such as Dallas County, which are familiar with federal grant procedures. "These are well-orchestrated, well-overseen and well-managed programs," Irvine said. The GAO report found the overall impact of stimulus funds on Texas' budget remains unclear. Congress said the stimulus would create millions of new jobs and prevent states from having to cut services and workers. But Texas didn't have to grapple with a budget deficit. The report credited additional Medicaid funding – \$2.5 billion – with helping cover a shortfall in Texas's Medicaid budget for 2009. The boost also helped absorb growth in Medicaid enrollment, which grew 5.1 percent from October 2007 to May 2009. Nearly 3 million Texans now use the program, which provides health benefits for the poor and disabled. But the state does not have many new jobs to show for its stimulus investment, which totals \$14.4 billion over several years.

State and federal policymakers have been feuding over how Texas intends to spend another large injection of stimulus cash – more than \$3 billion that goes to support public education. U.S. Rep. Lloyd Doggett, D-Austin, has accused state Republicans of backing money out of the state budget and replacing that money with stimulus funds. Gov. Rick Perry says the Legislature appropriately programmed stimulus funds. However, Texas school districts remain confused about how they are allowed to spend the money.

Source: Dallas Morning News, 7/18/09.

UTAH

Utah Hospitals Score Above Average. The Utah Department of Health's 2009 Hospital Consumer Satisfaction Report, which evaluated patient satisfaction at 34 hospitals in the state, was recently released. The Health Department extrapolated the state's information from a survey by the Centers for Medicare and Medicaid Services. Called the Hospital Consumer Assessment of Healthcare Providers and Systems, it contains 27 questions about a patient's recent hospital visit. Most respondents --- 73 percent-- said they would recommend their hospital to family and friends. The state's hospitals received their highest ratings in providing good discharge information and communication with doctors. Ratings in areas involving communication with nurses, room cleanliness and explaining medications to patients before discharge were rated lower than national averages. Overall, Utah scored above national averages on seven out of 10 publicly-disclosed measures. Sam Vanous, the Health Department's HMO health program manager, said the information is important because "we feel all Utahns should have as much information as possible when choosing a hospital." Every individual is different, he said, "and every hospital is different. We feel, with this tool, they can find a hospital that is most appropriate for them." Within six weeks of being discharged, patients were asked by the hospitals to complete the survey, either on paper or via phone, and that information was then sent to CMS, Vanous said. While CMS released its first batch of survey data in March 2008 -- gathered as part of what was then a pilot program -- this is its first full-scale release of patient satisfaction scores, he said. The data will be updated and re-released every quarter.

Source: Salt Lake City Tribune, 7/30/09.

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