May 27, 2009

THE
CATHOLIC HEALTH
ASSOCIATION
OF THE UNITED STATES

Senator Max Baucus
Chairman, Senate Finance Committee
U.S. Senate
Washington, D.C.

Senator Charles Grassley
Ranking Member, Senate Finance Committee
U.S. Senate
Washington, D.C.

Dear Chairman Baucus and Ranking Member Grassley:

On behalf of the Catholic Health Association of the United States, I am writing to you concerning the Senate Finance Committee's policy options paper, "Financing Comprehensive Health Care Reform: Proposed Health System Savings and Revenue Options." Let me first thank you for your leadership in the effort to improve health care in the United States and to ensure that quality, affordable care is available for everyone. We are grateful for the opportunity to offer our comments regarding the committee's financing of health care reform proposals.

The Catholic Health Association of the United States (CHA) is the national leadership organization of the Catholic health ministry, representing the largest group of not-for-profit providers of health care services in the nation:

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- 1 in 6 patients in the United States is cared for in a Catholic hospital each year
- All 50 states and the District of Columbia are served by Catholic health care organizations.
- Over 600 hundred hospitals and more 800 post-acute care organizations provide the full continuum of health care.

By pursuing the priorities of the ministry, CHA and it members - more than 2,000 Catholic health care sponsors, systems, hospitals, long-term care facilities, and related organizations - are working to create health care that serves everyone. CHA's *Vision for U.S. Health Care* lays out the Catholic health ministry's principles for reforming the health care system. As a central component of our vision, we believe that health care should be patient centered, addressing health needs at all stages of life through services that are coordinated and integrated all along the continuum of care, with accountability for health outcomes. We also call for health care reform to be sufficiently and fairly financed. The responsibility of financing a health care system that serves all should be shared by all stakeholders: government, employers, individuals, charitable organizations and health care providers.

We are pleased to see that these principles are reflected in many of the policy options included in the committee's paper. CHA would like to offer our comments on the committee's financing paper regarding the following sections:

Improving Payment Accuracy through Adjusting Annual Market Basket Updates—Skilled Nursing Facilities (SNFs)

The committee's option paper proposes to adopt the MedPAC 2010 recommendations to eliminate the update for SNFs. We support redesigning the SNF prospective payment system to better capture the cost of medically complex patients. However, we do not agree that the SNF update should be eliminated. We are concerned that until the redesign of the SNF prospective payment system is in place, limiting payments could create access barriers for patients who have complex needs.

Updating Payment Rates for Inpatient Services – GME and DSH Programs

The committee's paper offers several options to reform hospital GME and DSH payments. These options would restructure, combine, align or reduce GME and DSH payment levels for hospitals currently treating the low-income and uninsured and training medical residents.

GME Programs

Medicare subsidizes teaching hospitals for the costs of approved medical residency training programs through GME payments and most states make Medicaid GME payments to hospitals to help cover the costs of training new physicians. Thirty-seven percent of Catholic hospitals are teaching hospitals and depend on GME payments to compensate for the higher operating costs of running a teaching hospital and providing higher-intensity patient care. As the committee looks to increase the number of primary care physicians to meet the needs of a reformed health care system, teaching hospitals with medical residency training programs will become even more critical. We recommend that the committee delay any changes and/or reduction in Medicare and Medicaid GME payments until health reform is fully implemented and the dire need for additional primary care providers is met.

DSH Programs

The Medicare and Medicaid Disproportionate Share Hospital (DSH) payment adjustments were designed to compensate hospitals for treating a large share of low-income Medicare, Medicaid and uninsured patients, all of whom tend to be sicker and more costly to treat than other patients with the same diagnosis. The Medicaid DSH program is our nation's primary source of support for safety-net hospitals, including many Catholic hospitals that serve a disproportionate share of the most vulnerable low-income, uninsured and underinsured in their communities every day. Over sixty percent of Catholic hospitals qualify as Medicaid DSH facilities and many rely on Medicaid DSH payments to help keep their doors open and enable them to continue to provide essential care.

We recommend that the committee delay any changes and/or reductions in federal support for DSH programs until coverage expansions are implemented and there are demonstrable reductions in charity care and bad debt. Then, and only then, should DSH support be reduced.

We believe that even with a system designed for universal coverage, there will be populations that will remain uncovered. Hospitals will still need to provide for them, in addition to the continued cost to care for low-income Medicare and Medicaid patients as well as to provide other uncovered essential community health services. It needs to be clearly demonstrated that significant improvements in the amount and volume of charity care and bad debt have occurred before changes or reductions in Medicaid & Medicare DSH are considered.

Reducing Geographic Variation in Spending

The committee's paper proposes several options to address observed geographic variation in Medicare spending. The paper notes several possible explanations for the differences; points out that none appear sufficient to explain the variation; and states that "policies to address this variation may warrant further review." CHA agrees that more review and analysis should be undertaken to understand and identify the causes of such geographic variation. Once more is known, it may be appropriate to develop policies to reduce unjustified geographic spending differences. However, we have concerns about the policy options mentioned in the paper. First, the proposal to simply reduce payments to hospitals in areas with higher spending than a national average, or to individual hospitals with spending higher than an area average, is too blunt an instrument. We do not know enough about the reasons for spending differentials, and should not risk the unintended consequences of reducing hospital payments in this manner. Such arbitrary reductions could lead to hospital avoidance or denial of care to the most clinically challenging patients. Second, implementing policy in this area is premature. Proposed system reforms such as value based purchasing proposals together with the knowledge that will be generated by comparative effectiveness research can help to explain and reduce these variations. Therefore, we urge the committee not to implement these proposals.

Requirements for Tax-Exempt Hospitals

Proposed Options to Modify the Requirements for Tax-Exempt Hospitals

The Catholic Health Association supports the community benefit standard and believes that legislation is not necessary especially with the new IRS reporting requirement on the 990 Schedule H, which standardizes the accounting and reporting requirements. We will have the opportunity for the first time to have data on hospitals' community benefit activities. A lot of time and effort when into the development and hospital use of the new IRS Schedule H and we need to wait for the data to be reported before making legislative changes to the current community benefit standard. We believe the new IRS reporting requirement for tax-exempt hospitals, in addition to existing law and current voluntary efforts, supports what the committee wants to achieve.

The Senate Finance Committee is considering policy options which would create new organizational and operational requirements for determining whether a hospital is a charitable organization for purposes of section 501 (c) (3) tax-exempt statuses. These include requiring not-for-profit hospitals to conduct a community needs analysis; to provide a minimum annual

level of charitable patient care; not to refuse services based on ability to pay; and to follow certain procedures before instituting collection actions against patients.

1. Conduct a community needs analysis

CHA believes that community needs assessment is at the heart of community benefit. Our *Guide to Planning and Reporting Community Benefit* says,

"*Community assessment helps the organization and its partners become aware of current needs and existing assets within the community that can respond to those needs. The process can help build relationships, educate communities and identify how resources can be used to meet needs."*

While we strongly support community needs assessment, we do not believe it needs to be mandated through legislation. The new IRS reporting requirement (Form 990 Schedule H) will encourage community needs assessment in two ways. First, the instructions to the Schedule H specify that "to be reported, community need for the activity or program must be established." Second, the Schedule H specifically asks hospitals to "describe how the organization assesses the health care needs of the communities it serves." (Part VI, 6.)

New and effective resources have also been made available to help hospitals conduct community needs assessment. In addition to CHA's *Guide*, the Association for Community Health Improvement, a division of the American Hospital Association, has a community assessment "tool kit" which is extremely popular and well-used (www.communityhlth.org).

2. Provide a minimum annual level of charitable patient care

We believe it is neither necessary nor advisable to set a national benchmark for charitable patient care for the following reasons:

- Charity care is neither the best nor the most efficient way to serve low-income persons in our communities. Charity care is often described as "reactive care." A person receiving charity care is often admitted to the emergency room with a condition that could have been treated earlier through proper primary care. The cost of charity care is often higher than primary and preventive care. The human cost is high as well, since people receiving charity care are often dealing with advanced stages of an illness or an improperly managed chronic illness.

- Setting a minimal level of charity care is premature. While there will still be persons in our communities who need help accessing needed care and services, the health reform measures that the committee enacts will have a distinct – but unpredictable - impact on how many persons will need charity care and for what services.

- Community need differs from state to state and from community to community—a sufficient charity and community benefit expenditure in one area may be insufficient in another. Medicaid, employment levels, insurance status, income and other socioeconomic factors all have a role in community need.

- Focusing on how much is spent on charity care and other community benefit activities diverts attention from the real health improvement issue. Low-cost programs can have more far reaching impact than higher cost programs. Facilities are working to avoid high-cost charity care in their emergency rooms by reaching out to patients before their conditions reach an acute stage and developing programs to manage chronic illness and prevent illness. Looking at charity care expenditures would not capture the value of these initiatives.

The better question to ask is: What is the impact hospitals are having on the health of their communities? We believe that community benefit reports (which most hospitals prepare) and the new Schedule H will give hospitals opportunities to answer this question and to more fully describe the value they bring to their communities.

3. Not to refuse services based on a patient's ability to pay

Current law prohibits hospitals from turning away any patient in need of emergency services, who is medically unstable or in active labor. (EMTALA Regulations: 489.24 -- Special responsibilities of Medicare hospitals in emergency cases). Therefore, a new requirement is not needed for emergency care and we do not recommend that hospitals be required to offer unlimited services in the most expensive care setting, an emergency room.

We do believe however that a not-for-profit hospital should have written charity care policies, approved by the governing body and updated periodically. The CHA *Guide* offers a checklist for charity care/ financial assistance policies. Another resource for hospitals is the Health Care Financial Management Association Principles and Practices Board Sample Hospital Charity Care Policy and Procedures. (www.hfma.org)

4. Follow certain procedures before instituting collection actions against patients

Over the last five years, hospitals and health care systems throughout the country have reassessed and revised their billing and collection policies and procedures. Guidance by national organizations, especially HFMA's Patient Friendly Billing Initiative, has been extremely effective in improving these policies and procedures.

Again, many of the options proposed in this section of the paper are addressed by the new IRS Form 990 Schedule H, including billing and collections practices. In Part II, 9b the form asks: "Does the organization's collection policy contain provisions on the collection practices to be followed for patients who are known to qualify for charity care or financial assistance? Describe." We believe that mandating standardized collection procedures beyond this requirement is not needed, and urge Congress to review the Schedule H data before moving forward with any potential legislation.

Tax-exempt hospitals and health care reform

In addition to commenting on the options presented by the Senate Finance Committee, CHA would like to take this opportunity to respond to a question raised during the committee's financing health care reform roundtable discussion: Will there still be a need for tax-exempt hospitals after health care reform is passed? We believe the community benefit provided by tax-exempt hospitals offers several reasons why these institutions will still be needed, and in fact will serve a unique role in helping to implement health reform efforts.

First, the current community benefit standard is more than charity care for persons who cannot afford health care. It includes a rich array of services that respond to unmet community health needs and that will still be necessary after reform makes health care affordable. Community hospitals provide services that promote health, prevent disease and manage chronic conditions. These services are not only better uses of community benefit resources but also result in improved quality of life for members of the community by helping them avoid or mitigate the health, emotional and financial consequences of dealing with a serious illness. In addition to charity care, the IRS definition of community benefit includes other important ways hospitals respond to community need by:

- Participating in public means tested programs for low-income persons. Community benefit includes serving Medicaid patients and users of other means-tested public programs because these programs pay providers significantly below cost. Without this benefit, enrollees of these public programs could experience problems accessing the health care system and the care they need.

- Providing services that improve community health, such as health education (disseminating information on diseases and healthy lifestyles), community-based clinical services (mobile clinics, immunization programs), and health care support services (case management, enrollment in public programs).

- Educating health professionals, through basic and graduate educational programs for medical, nursing, and other health professionals and contributing to the knowledge of health professionals throughout the community.

- Subsidizing services needed in the community by continuing (OR offering) needed programs and services despite a financial loss. Research at the University of Michigan Law School has demonstrated that unprofitable services are much more likely to be provided by nonprofit tax exempt organizations. These include emergency psychiatric and other mental health services, HIV/AIDs treatment, alcohol and drug treatment, burn units and trauma services. ("Making Profits And Providing Care: Comparing Nonprofit, For-Profit, And Government Hospitals by" Jill R. Horwitz, J.D. PhD, *Health Affairs*, May/June 2005.)

- Conducting research to improve clinical care, health care delivery or community health. This would include research sponsored by government or nonprofit entities.

- Addressing the root cause of health problems. A person's socio-economic status and environment has a greater impact on his health than direct medical care. Community benefit programs impact other factors that contribute to health when they address problems related to housing, poverty, environmental hazards, the availability of nutritious food and other determinants of health.

Second, the community benefit role of hospitals is a critical factor in accomplishing the goals of health care reform: access to health care, improved population health and cost containment. Not-for-profit, tax-exempt hospitals can contribute to each of these goals:

Access to Health Care: Tax-exempt community hospitals focus on improving access to health care by assessing gaps in service and working with community partners to plan and deliver programs and services. This commitment to health care access will continue even when universal coverage is available, especially for:

- Persons who have difficulty navigating the health care system because of language, cultural or other barriers.
- Persons who, because of their life circumstances, do not seek out preventive services or case management that could improve their health outcomes.
- Persons who need services that are not covered or not completely covered. This may include services such as dental, substance abuse treatment and mental health care and prescription drugs.

Improved Population Health: Another goal of health reform is to promote health and prevent disease and injury in America's communities. Not-for-profit, tax-exempt hospitals work with other providers and agencies to address such public health problems as diabetes, obesity, asthma, sexually transmitted diseases, and immunizations at the local community level.

Cost Containment: Not-for-profit, tax-exempt hospitals help to reduce health care costs by:

- Tapping community and other philanthropic resources to fund community health programs and provide capital for needed projects.
- Keeping resources in the community by using any excess revenue to provide services and make facility improvements. The IRS Revenue Rule 69-545 refers to this benefit when it describes a hospital whose "excess funds are generally applied to expansion and replacement of existing facilities and equipment, amortization of indebtedness, improvement in patient care and medical training, education and research."
- Promoting health and disease prevention. For example, many not-for-profit hospitals are tracking the occurrence of ambulatory sensitive conditions, which are those ailments that could have been treated earlier if primary care services were available. Hospitals use this information to form community partnerships that deliver primary care, preventive services and case management to people in the community that need them. This effort not only improves the lives of those without adequate access to primary care but also helps to reduce health care costs.

- Addressing the root causes of community health problems and preventing the need for emergency and acute care services. As discussed earlier, this includes health promotion and disease prevention programs, increasing access to primary care, and activities addressing social determinants of health such as poverty, education, a clean environment and housing.

Lastly, mission-driven hospitals will continue to provide characteristics that strengthen and benefit our communities, including:

- Values: The values of not-for-profit health care organizations shape the way they conduct operations and are reflected in their decision-making process such as determining the mix of services and activities to provide. These values focus on commitment to vulnerable persons and for the welfare of the community and are often different from those of the marketplace.
- Governance and Accountability: How organizations are governed and to whom they are accountable also shape decisions and behavior. Nonprofit hospital boards are responsible for making decisions in the best interest of communities, for upholding their organizations' mission, and for being accountable to their communities.
- Long-term Commitment: Not-for-profit, tax-exempt hospitals are community-oriented and have a long term focus on community need and staying power rather than a short-term market focus. While not always possible, they will try to continue needed programs despite financial hard times.
- Voluntarism and Philanthropy: Not-for-profit organizations were established and are sustained by the involvement of community members. Tax-exempt organizations offer opportunities for volunteers and donors to help others in their community with their time and/or financial contributions. Tax-exempt not-for-profit hospitals help make a community a community.

Speaking before the Harvard Business School Club of Chicago in January of 1995, the late Cardinal Joseph Bernardin said:

Health care is fundamentally different from most other goods and services. It is about the most human and intimate needs of people, their families and communities. It is because of this critical difference that each of us should work to preserve the predominantly not-for-profit character of our health care delivery….throughout the country.

In a reformed health care system, tax-exempt hospitals will be needed because the presence of these organizations historically has had a positive influence on health care in our communities and will continue to do so.

Additional Financing Sources for Health Care Reform

In addition to suggesting health system changes to reduce spending as a means of financing health care reform, the committee also suggests looking to new sources of revenue. While health care reform measures will generate savings, CHA strongly agrees with the committee that additional, upfront investment will be needed for health care reform to succeed. Considering the many options, including modifying the tax treatment of employer contributions to health care and raising revenue while encouraging healthy lifestyles, makes sense if done appropriately. For example, care must be taken not to introduce tax code changes that could disrupt the provision of employer-provided health care, which the committee's coverage paper assumes would continue to be the source of health care coverage for millions of Americans.

CHA also suggests the committee reconsider how savings from health care reform proposals will be evaluated by the Congressional Budget Office. The longer-term impact of system changes should be reflected through longer scoring windows. This is especially important given that the short term investments likely necessary to implement reform could mask the potential long term savings. Cost and savings estimates should consider improvements in economic activity and productivity, as well as reductions in health care utilization such as reducing avoidable emergency room visits and hospitalizations.

Thank you again for the opportunity to provide comments on these proposed financing options and for all the efforts of the Senate Finance Committee to improve the health care system. If we at CHA can provide any clarifications of these comments or be of any further assistance, please do not hesitate to contact me or a member of our advocacy staff.

Sincerely,

Sr. Carol Keehan, DC
President and CEO