

NHA 2009 Legislative Issues At-A-Glance

Tax-exempt Status of Non-Profit Organizations

Nearly all NHA members are tax-exempt, non-profit or governmental hospitals. The loss of tax exemption would have a significant impact on Nebraska's hospitals and the patients they serve. Taxation, in addition to the community benefits already provided, would weaken the financial stability of Nebraska's hospitals.

Access to quality health care is predicated on the financial health of those who provide care. Payment from government sources, such as Medicare and Medicaid, and insurance companies, is often inadequate. Over the last twenty years, attempts have been made to repeal or limit the tax-exempt status of non-profit organizations, including efforts to allow local governments to levy payments in-lieu-of taxes.

On the federal level, hospitals have faced scrutiny and pressure to justify their tax-exempt status. Congress and the IRS have taken a greater interest in charitable organizations, from exploring the idea of requiring hospitals to provide a percentage of their operating expenses or revenue in charity care to qualify as tax-exempt to the development of the new Form 990 and its Schedule H, designated solely for tax-exempt hospitals.

Talking points

- In 2007 (based on 2006 data), Nebraska hospitals provided \$696 million of community benefits—programs and services that address identified community health needs and provide measurable improvement in health care access, health status and the use of health care resources.
- Urge the legislature to support an exemption from sales and use tax for non-profit rural health clinics and health care practitioner facilities that are owned by nonprofit hospitals.
- Urge the legislature to oppose legislation that imposes fees in-lieu-of taxes.

Health Care Workforce Development

Health care workforce development remains a top priority for Nebraska's hospitals. A significant gap between the workforce supply and demand remains a challenge for the health care field. A collaborative effort on behalf of the health care system, academic institutions and the public and private sector is needed to address the increasing demand for health care professionals in Nebraska.

There is, and will continue to be, a shortage of nurses, physicians, dentists, mental health providers, EMTs and other health care providers. The problem is more prominent in rural areas, as higher paying specialties in larger metropolitan areas attract a substantially higher percentage of medical school graduates.

Health care workforce diversity has also increased. Presently, a significant gap exists between minority populations and the number of professional health care positions they hold.

Funding for projects to alleviate Nebraska's health care workforce shortage continues to be a high priority for the Nebraska Hospital Association and its membership.

Talking points

- By 2014, Nebraska will be experiencing a severe workforce shortage in many professions throughout the state. A 2008 study by the NHA and Compdata predicts the following vacancies in just six years:
 - Registered Nurses = 14 percent
 - Occupational therapists = 14.5 percent
 - Physical therapists = 12.3 percent
 - Medical laboratory technicians = 11.1 percent
- Urge the legislature to address the health care workforce shortage by providing adequate reimbursement for services and by supporting programs, such as Nebraska's Nursing Faculty Student Loan Act, the Rural Healthcare Incentive Program, Area Health Education Centers and health care workforce development incentives.
- Urge all stakeholders to leverage state and federal funds with private money to develop innovative programs that will aid in the recruitment and retention of health care workers.

Medicaid Reform

Medicaid is designed to meet the needs of people with limited incomes who are generally sicker than the population served by private insurance plans. The need for Medicaid reform is based on the foundation that the program is not fiscally sustainable; however, evidence exists to show that the data previously used to support this premise is flawed. The recent average annual rate of Medicaid spending growth is less than the average rate of growth of General Fund revenues.

A provider rate increase of one percent has been included in the Health & Human Services' (HHS) 2009-2011 biennial budget request, which is below the cost of living increases that are being incurred in Nebraska. The Consumer Price Index (CPI) for the twelve months ended August 2008 was 5.4 percent. The latest Cost of Living Adjustment (COLA) used for Social Security benefits was 5.8 percent.

Incorporated in HHS' budget request is \$8.2 million in General Fund reimbursement cuts. The Medicaid program is funded with both federal and state dollars. Therefore, General Fund reductions of \$8.2 million will result in an additional reduction of \$12.7 million in federal funding. With a 2.1 Nebraska economic multiplier for hospital expenditures estimated by the American Hospital Association, a funding reduction of \$20.9 million will not only cause a burden to providers but would have an impact on Nebraska's economy of \$43.9 million. The total impact of these proposed cuts to Nebraska's providers and economy would be approximately \$64.8 million.

Talking points

- Urge the legislature to move carefully and cautiously on the proposed budget cuts to Medicaid; ultimately, the cost of unpaid medical bills will be shifted to the private sector, forcing the cost of health care to increase substantially.
- An \$8.2 million cut in state Medicaid expenditures will cause a chain reaction with significant consequences:
 - Nebraska's most needy will not get necessary health care.
 - Charity care, bad debt expenses and undercompensated care will increase.
 - Providers will lose \$20.9 million due to lost federal funds.
 - At a minimum, Nebraska's economy will suffer a loss of nearly \$65 million.
- Urge the legislature to support overall Medicaid reform initiatives to ensure the program is operating efficiently; meeting the needs of the people it was designed to serve; and providing adequate reimbursement to those who provide the services.

- Due to increased costs of living and providing services, increasing reimbursement rates by only one percent equates to a reimbursement cut of four to five percent for providers.
- Medicaid reimbursements do not cover the cost of health care, let alone the full charge of each service provided. Medicaid reimburses hospitals approximately 70-75 percent of the cost to provide services.
- According to Health Care State Rankings 2008, 11.8 percent of Nebraskans were enrolled in Medicaid in 2006.
- Urge the legislature to exercise more oversight over the administration and reimbursement of Nebraska's Medicaid program to ensure more efficient and effective use of our state's resources.

Unfair Trade Practices by Insurance Companies

Health care providers across the country have reported significant administrative difficulties and delays in securing payments from health insurers and managed care organizations. Providers are in the position of caring for the patient and then seeking to collect from the insurer, with whom the provider may have little bargaining power.

Talking points

- In 2007, the NHA membership was surveyed regarding potentially unfair trade practices by insurance companies and many issues identified were related to untimely and incorrect payments from commercial and Medicare Advantage insurers.
- Insurance companies must be responsible business partners, working to help patients and hospitals receive payments in a timely manner.
- Urge the legislature to consider the impact that unfair trade practices by insurance companies have on Nebraska's hospitals, including increased administrative costs that add to the overall cost of care.

Uninsured, Underinsured and Access to Care

As the number of people without health insurance or who are underinsured rises, there is a negative financial impact on providers of health care services. The ability of the uninsured to access health care services in a timely manner, as well as the long-term health status of those individuals, is also impacted.

In 2007, the American Hospital Association (AHA) released a framework titled, "Health for Life," for improving health and health care in America. The program identifies five essential elements of reform:

- A focus on wellness
- The most efficient, affordable care
- The highest quality care
- The best information
- Health coverage for all, paid for by all

The NHA continues to work with the AHA, policymakers at the state and federal level, along with many other public and private stakeholders to develop meaningful solutions to the growing number of uninsured and underinsured.

Talking points

- Nearly 1 in 9 Nebraskans are uninsured.
- In 2006, approximately 217,000 Nebraskans were without health insurance.
- Over 60 percent of the uninsured in Nebraska are either self-employed or work for a small employer.
- Approximately 68 percent of the small employers in Nebraska do not currently offer health insurance.
- The cost of providing care to the uninsured and underinsured is shifted to taxpayers and the privately insured.
- Urge the legislature to fully fund the Kids Connection program in order to cover more children in "at risk" situations.
- Educate policymakers about the growing number of uninsured, the cost and lack of insurance availability, and the impact of the uninsured on the health care delivery system.

- Urge the legislature to create more incentives for employers to provide health insurance.

Recovery Audit Contractors (RACs)

The challenges hospitals face in today's health care environment are enormous. The constant struggle to obtain fair reimbursement for services provided and to comply with the tremendous amount of regulations, at both the federal and state levels, seems to be never ending. Beginning in 2009, Nebraska hospitals will transition into the Recovery Audit Contractor (RAC) program.

While being implemented to assure that Medicare payments are made correctly, this federal program will create additional challenges for Nebraska's hospitals.

In the Medicare Modernization Act of 2003 (MMA), Congress directed the United States Department of Health and Human Services (HHS) to conduct a three-year demonstration project utilizing RACs to determine whether improper payments were being made within the Medicare program. In later legislation (Tax Relief and Health Care Act of 2006), Congress took things further by requiring the HHS to implement a permanent RAC program nationwide by January 1, 2010.

Talking points

- Centers for Medicare and Medicaid Services (CMS) should invest in education to help hospitals understand its complex rules and guidelines so claims are paid correctly the first time.
- Medicare systems corrections should be made to proactively minimize errors.
- RACs should be required to expand the role for physicians, especially regarding medical necessity reviews.
- CMS should establish a reliable process for re-billing claims denied by a RAC (waiving timely filing limits).
- A three year look-back period is too long; a 12-month look-back period is more appropriate.
- CMS should develop a centralized system that would provide the status of RAC audits and appeals.

- CMS should require RACs to implement a more balanced approach on overpayments and underpayments.
- RACs should be required to reimburse all providers for copying and shipping medical records.

Patient Safety and Quality Oversight

Included in the NHA's designed future, is the goal that "Nebraska is home to healthy communities where hospitals are known as leaders in quality initiatives."

Assuring the safety of patients who enter the health care system continues to be a top priority of Nebraska health care providers. NHA members have been directly involved in the implementation of the Patient Safety Improvement Act, signed into law by Governor Heineman in April 2005.

The Nebraska Coalition for Patient Safety has been formed as the patient safety organization in Nebraska. The coalition is actively enrolling hospital members and reporting has begun. Participating in the coalition is one way in which hospitals can learn from each other to prevent the occurrence of adverse events in their facility. Grants, membership fees and sponsorship opportunities continue to be the main source of funding for the coalition.

Talking points

- Nebraska hospitals are voluntarily participating in the Nebraska Coalition for Patient Safety by reporting adverse patient events, which ultimately reduces the risk of reoccurrence.
- The NHA and Nebraska's hospitals participate in the NHA's Care Compare Web site, www.nhacarecompare.com, which provides the public with online information about quality, average charges and length of stay for inpatient hospitalizations.
- The NHA's member hospitals approved guidelines for the development of a hospital policy regarding no expectation of payment for serious, preventable adverse events. A draft model policy will be prepared during the first quarter of 2009.
- Nebraska hospitals demonstrate their commitment to being "leaders in quality" by sharing best practices featured on the Quality and Patient Safety page of the NHA Web site.

Health Information Technology

Health Information Technology (HIT) is one component of the puzzle to improve patient safety, quality and performance. Nebraska's collaborative nature can work to establish a model that is effective and efficient.

An Executive Order issued by President Bush after the passage of the Medicare Modernization Act of 2003 created the Office of the National Coordinator for Health Care Information Technology (ONCHIT), charged with ensuring that Americans have access to an electronic health record within ten years.

Talking points

- To evaluate the feasibility for a statewide electronic health record, the Nebraska Health Information Initiative (NeHII) was formed.
- A significant portion of IT cost is borne by hospitals, while the financial benefits are experienced by other providers, payers and employers. All stakeholders should share the cost of those investments.
- Maintenance costs are significant. Adoption of HIT is more difficult for smaller hospitals because they likely have a less developed infrastructure and less staff support. Increased Medicare payments to support the ongoing costs of HIT, as well as low-interest loans and grants to support both hospitals' initial investments in IT and health information exchange projects are necessary.
- The multiplicity of privacy rules from local, state and federal governments, accrediting bodies and other organizations makes compliance difficult and can interfere with patient care. A single set of privacy rules is needed to facilitate the use of HIT and ensure access by health care providers to information at the point of care.
- Information exchange should be promoted as a public resource. Improved care comes when the right information is available to the right provider at the right time. Data belongs to the patient and cannot belong to an organization, physician or vendor.
- A lack of standards is not the problem. The problem is that we need to select a single set of standards and get consensus among health care stakeholders to use those standards.

Physician Self-Referral

Physician self-referral leads to over utilization, higher costs and often initiates patient “steering” and loss of freedom of choice.

Since the repeal of the Certificate of Need program, physician-owned ambulatory surgery centers and other outpatient services have rapidly expanded. This trend allows physicians to “cherry pick” profitable hospital services, undermining the community hospitals’ ability to provide a full range of needed services. Physician-owned hospitals do not provide unprofitable emergency services, costly neonatal services or trauma care. Quality and safety suffer when increasingly complex procedures are performed in unlicensed, largely unregulated settings.

Several attempts have been made at the federal level to limit physician self-referral. To date, they have been unsuccessful.

- CMS issued the proposed fiscal year 2008 physician fee schedule rule, which contained proposed changes to the physician self-referral or “Stark” rule, narrowing the existing exceptions that CMS believes are not adequately covered under the existing rule. The proposed rule was not finalized.
- In 2007, the U.S. House of Representatives approved the Children’s Health and Medicare Protection (CHAMP) Act. Included in that bill was a provision that limited physician self-referral to hospitals in which they have ownership; however, the self-referral language was subsequently dropped.
- In 2008, the House approved a physician self-referral ban in a mental health parity bill and the Senate included a similar provision in its version of the supplemental appropriations legislation for Iraq and Afghanistan. The language was dropped before final approval of each bill.

Talking points

- Urge policymakers to support the critical changes to current federal law and regulations identified by the American Hospital Association (AHA).
- Congress must ban self-referral to new limited-service hospitals to prevent conflict of interest, preserve patient care and promote fair competition.

Hospital Billing Practices

The mission of community hospitals is to serve the health care needs of people in their communities 24 hours a day, seven days a week. Their task, and the task of their medical staffs, is to care and to cure.

Negative publicity concerning hospital collection practices has generated debate about hospital charging, collections and charity care policies. Media coverage often depicts hospitals as overcharging the uninsured and using overly aggressive methods to collect from patients with a limited ability to pay. Unfounded allegations that hospitals are profiting from the uninsured and poor undermine the public support of community hospitals.

In 2004, lawsuits were filed accusing hospitals of overcharging uninsured and underinsured patients and using inappropriate collection practices to obtain payment. Though the federal and state courts dismissed most cases, this issue is still receiving national attention.

Payments from government sources and insurance companies are often inadequate, forcing hospitals to cover the cost of providing patient care, maintaining essential public services and providing uncompensated care and other community benefits.

Talking points

- NHA formed an Issue Strategy Group (ISG) to develop a recommended framework for charity care policies in Nebraska hospitals.
- The ISG created and the NHA Board approved a document titled, "Principles and Guidelines for Financial Aid Practices in NHA Member Hospitals." This publication promotes uniformity among Nebraska hospitals in billing and collection practices of low-income and uninsured patients. The NHA continues to encourage all of its members to use the principles and guidelines outlined in this publication.
- The NHA continues to actively participate in the NHA Care Compare Web site, www.nhacarecompare.com that provides information on quality, average charges and length of stay.
- Urge policymakers to oppose state and federal legislation that would reduce hospitals' rights to collect unpaid balances.

Sales and Use Tax Exemption for Non-Profit Certified Rural Health Clinics and Health Care Practitioner Facilities

The mission of non-profit certified rural health clinics (CRHCs) and health care practitioner facilities is to provide a benefit to the communities they serve.

Recently, the Nebraska Department of Revenue called into question the tax-exempt status of the non-profit clinics and facilities, and is now conducting random audits. In some instances, the Department of Revenue has issued sizable assessments.

These non-profit clinics and facilities have been created to improve access to health care at costs lower than provided in the for-profit arena. They are integral parts of the non-profit hospitals that own them. Taxing them is inconsistent with the tax treatment of their owners.

In 2008, LB 949 was introduced, providing a sales and use tax exemption to non-profit CRHCs and health care practitioner facilities. LB 949 was indefinitely postponed by the Revenue Committee.

Talking points

- Taxing CRHCs and health care practitioner facilities is inconsistent with the tax treatment of the hospitals that own them.
- Urge the legislature to support legislation in 2009 that would exempt CRHCs and health care practitioner facilities from sales and use tax.

Mental Health, Substance Abuse and Behavioral Health Services

Psychiatric patients access services through every hospital's emergency department under EMTALA. The obligation to provide service has significant cost to the hospital and, most importantly, the quality of care for patients. The state's regional centers do not have sufficient capacity to provide access to mental health services, causing both hospitals and patients to suffer.

The final report of the Behavioral Health Oversight Commission, formed in 2004, was issued in 2008 regarding the implementation of LB 1083, the Nebraska Behavioral Health Act.

The Commission found that apart from improvements under the reformation of the behavioral health system, there are many areas which must be addressed. The commission report includes examples of perpetuating inadequacies in the system, including lack of transparency by the Nebraska Department of Health and Human Services (DHHS) in the reporting of financial information to the Commission, the current and future roles of the state's regional centers are undefined and the costs of services provided at the Hastings Regional Center are excessive and unjustified.

Talking points

- Urge policymakers to develop appropriate rate methodologies for providers and adequate funding streams.
- Urge the legislature to support reforms in accordance with the findings and recommendations of the Behavioral Health Oversight Commission.
- Urge policymakers to develop incentives and provide funding to cultivate a behavioral health care workforce.

Health Care Provider Safety

The potential for violent behavior by a patient to a health care provider is increasing. The U.S. Department of Labor has indicated health care workers are at a much higher risk of violent crimes at work than other workers.

Laws in other states provide for criminal prosecution for violent crimes on specific workers.

Many legislative attempts have been made in recent years to address this issue, with the most recent attempt being LB 787, introduced in 2008, which would increase penalties for assaults on emergency service and health care providers. Similar to previous attempts, LB 787 failed to come out of committee.

Talking point

- Urge the legislature to support legislation that increases penalties for assaults on health care workers.

Harmonize Nebraska's SCHIP with the Federal SCHIP

As uninsured and underinsured rates rise, financial pressures on providers rise, levels of charity care and bad debt increase, and the ability of the uninsured/underinsured to access health care is also impacted.

The State Children's Health Insurance Program (SCHIP), called "Kids Connection" in Nebraska, is an important, cost-effective program, providing access to health care for many children who do not qualify for Medicaid or do not have insurance.

Current federal law allows states to enroll children who live in households earning up to 200 percent of the federal poverty level (FPL) in this program. In Nebraska, SCHIP provides coverage for children in households earning up to 185 percent of the FPL.

Talking points

- Urge the legislature to support efforts designed to harmonize Nebraska's SCHIP program with the federal SCHIP.
- Providing coverage for these children will decrease the number who seek more costly care in hospital emergency departments.

Union Organizing

A top priority for organized labor in 2009 is the Employee Free Choice Act (S.1041/H.R. 800), which would replace private ballots in union elections with a "card check" process that recognizes a union if a majority of workers sign a card in the presence of union organizers.

This bill would impact businesses of all sizes by abolishing secret ballot elections during union organizing drives—taking privacy, power, and choice away from America's employees. The bill would require mandatory arbitration by government-appointed arbitrators if the union and employer could not agree on terms of a first contract within 120 days. Employers found in violation would face increased penalties.

Talking points

- The NHA opposes the Employee Free Choice Act.

- The existing democratic process utilizing a secret ballot to form a union should be protected.
- Urge the legislature to oppose the “Fair Share” legislation at the state level.

Resources

Nebraska Unicameral

For up-to-date information on the Nebraska Unicameral, including senator’s contact information and a weekly schedule, visit the Legislative Home page:

www.nebraskalegislature.gov/

Nebraska’s Congressional Delegation

Visit the NHA’s Web site for a complete list of Nebraska’s Congressional delegation and their contact information:

www.nhanet.org/advocacy/ne_cong_delegation.htm

NHA Advocacy Resources and Contacts

Many of the resources your Advocacy Team can utilize are located on NHA Web site, including the Advocacy Center and tips on effective advocacy:

www.nhanet.org/advocacy/action_center.htm

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