

The LRHA Policy Corner

STATE & LOCAL ACTION:

**LSU and VA Consider Building A New Hospital In New Orleans*

Louisiana's charity hospital system and the U.S. Department of Veterans Affairs have begun negotiations specific to building a shared hospital in New Orleans to replace damaged facilities flooded by Hurricane Katrina.

- There are currently two charity hospitals - together known as the “Medical Center of Louisiana” – that have been struggling to recover financially and to chart a path for rebuilding since Katrina.
- The LSU-run system has been providing care out of temporary facilities and trying to work on a longer-term lease of facilities since the storm, but the hospital system has run into trouble in plans to build a new, replacement hospital for New Orleans.
- Based on estimates from engineers hired by LSU to do damage assessment, charity hospital officials say it would cost \$258 million to repair Charity Hospital and nearly \$118 million to repair University Hospital.
 - LSU officials have suggested building one new hospital, rather than replacing the outdated facilities they had as the first offer from the Federal Emergency Management Agency to help repair Charity Hospital was \$23 million - far short of what is needed to replace or repair either hospital.
- Working with the VA on a joint facility likely would help LSU tap into federal dollars set aside to help rebuild the New Orleans VA Medical Center.
 - The goal is to have a framework in place by June that would spell out the governing structure for a new facility, along with estimates on cost, a proposed location and other details.
 - One site being considered is the area bordered by Tulane Avenue, Canal Street, Roman Street and Claiborne Avenue, all dependent upon size.

**Schedule for the State Legislature*

Joint Committee Meetings


<u>Joint Legislative Committee on the Budget</u>	3/06/06	9:30 am	Room 5	Scheduled
<u>Legal Representation in Child Protection Cases</u>	3/06/06	9:00 am	Room 3	Scheduled
<u>Joint Education</u>	3/08/06	10:00 am	Room 1	Scheduled
<u>Foster Care Study Committee</u>	3/16/06	1:30 pm	Room 3	Scheduled

****Mental Health Group Gives Eight States Failing Marks***

The National Alliance on Mental Illness gave eight states — Iowa, Idaho, Illinois, Kansas, Kentucky, Montana, North Dakota and South Dakota — a grade of “F” for the overall quality of their mental health care, according to a report released March 1st by the mental health care advocacy group.

- The State of Louisiana received a grade of D-
- Five states — Connecticut, Maine, Ohio, South Carolina and Wisconsin — received grades in the “B” range. No state received an “A.”
- New York and Colorado both received “U” grades for refusing to respond to the surveys NAMI distributed.
- The study, “Grading the States: A Report on America’s Health Care System for Serious Mental Illnesses,” is the first state-by-state evaluation of mental health in 15 years, according to NAMI.
- The study individually evaluated each state on 39 different criteria, including, the state’s mental health care infrastructure, information access, services and recovery support.
 - Data is based on information gathered through surveys filled out by the state mental health leaders and by public information and NAMI contends that public mental health care systems across the nation deserve no more than a “D” grade on average and that governors must invest in cost-effective practices, increase funding and provide better access to information for the seriously mentally ill in their states. (See details below and/or view the entire report at: http://www.nami.org/gtsTemplate.cfm?Section=Grading_the_States&Istid=676)

➤ **Grading the States 2006: Louisiana**

	Report Card	
	Overall Grade: D-	Category Grades:
		Infrastructure: D
		Information Access: F
	Services: D-	

		National Rank
Per Capita Mental Health Spending	\$51.34	41
Per Capita Income	\$24,780	44
Total Mental Health Spending (in millions)	\$230	28
Suicide Rank		31

Recent Innovations

- Heroic response of individual providers and Office of Mental Health staff on the ground in the wake of hurricanes Katrina and Rita

Urgent Needs

- Restoration of Office of Mental Health's budget after recent state cuts
- Increased focus on developing and funding a community-based system

ON THE FEDERAL FRONT:

**MedPAC March Report Released - Doctor Pay Revisions Urged*

A report given to Congress on Wednesday, March 1st - by the Medicare Payment Advisory Commission (MedPAC) - discusses the method of calculating the yearly Medicare payment rate to doctors and the effect that the quality of a doctor's care should have on payment.

- The commission is urging changes in the way Medicare figures out how much to pay for one type of care compared to another. The technical procedure for doing that is assigning "Relative Value Units" (RVUs.)
- The units measure the amount of resources that are needed to provide a particular type of care.
 - For example, RVUs for heart surgery would be higher than RVUs for a much simpler procedure such as cataract surgery.
 - ❖ The higher the RVU, the higher the payment rate for the particular service involved. (RVUs are part of the Relative Value Scale (RVS).)
- The way RVUs are assigned leads to relatively low payment for primary care compared to various types of specialty care.
 - The concern is not just about income for today's primary care doctors but also about maintaining an adequate supply of primary care doctors in the United States

in the future. (The number of medical students seeking residences in primary care has recently seen a drop-off in recent years.)

- The Centers for Medicare and Medicaid Services review RVUs every five years, relying in large part on the recommendations of a private sector advisory group called the RVS Update Committee (RUC) - Formed by the American Medical Association, the RUC also recommends values for new services.
 - MedPAC concluded that the five-year process “does not do a good job of identifying services that may be overvalued.”
 - ❖ By relying too much on the RUC, “CMS has relied too heavily on physician specialty societies to identify services that are misvalued,” the report says. The work of the RUC tilts toward recommending higher values for specialty care.
 - ❖ Five-year reviews have led to “substantially more increases in RVUs than decreases, even though many services are likely to become overvalued over time,” MedPAC’s report says.
 - ❖ Because the process of assigning values is budget-neutral, increased values have to be offset in some way - some RVUs have become too high because medicine has found more efficient ways of providing the service involved. To the extent that excessive RVUs are identified and lowered, Medicare has less need for across-the-board reductions of all RVUs that lead to lower payment rates for primary care.
- ✓ To counter the problem, MedPAC urges the creation of “a standing panel of experts to help CMS identify overvalued services and to review recommendations from the RUC,” the report says.
- ✓ “The group should include members with expertise in health economics and physician payment, as well as members with clinical expertise.” (To view this MedPAC report and related news releases visit: <http://medpac.gov/>)

****S. 1955 – The Health Insurance Marketplace Modernization and Affordability Act of 2005***

Bill Sponsor: Senator Mike Enzi (R-WY) - Introduced: November 2, 2005

Official Title: A bill to amend Title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace.

- The bill would allow associations to independently pool their members to buy health coverage into association health plans (AHPs,) but would not allow them to establish self-insured plans.
- Pooled small business health plans would be able to offer coverage free from many, but not all, benefit mandates. (Those mandates currently in place in at least 45 states would continue, but pooled plan carriers would be permitted to offer plans that do not include other mandated benefits.)
- Under the bill, AHPs would be required to:
 - obtain federal certification;
 - be governed by a board of trustees with complete fiscal control;

- be established for more than three years for purposes other than pooling health care coverage;
 - and not condition association membership or coverage on health status.
- Regulatory oversight would be required of coverage issued to associations to remain with the states and not be transferred to federal control. (Rules would change to enact more uniform standards across state lines.)
- The Secretary of Health and Human Services would be required to determine how to certify small business health plans within six months of enactment.
 - A small business health plan would be required to pay a \$5,000 fee when filing an application for certification.
- Certain near-term changes in insurance regulation would be aimed at reducing costs and expanding access - those provisions would apply not just to association plans but also to policies sold to others.
- The National Association of Insurance Commissioners (NAIC) rating rules currently in effect in 24 states would become the interim standard for rating.
 - NAIC model rules dictate rating, and the amount that premiums can vary from an insurer's base rate, or average.
 - NAIC rules require that premiums charged when the policy is issued cannot vary more than plus or minus 25 percent from the base rate, and plus or minus 15 percent upon renewal.
 - Insurers licensed in a given state would be permitted to use the NAIC standard even if state law differs - a graduated transition process would apply for states that currently have rating bands significantly different from the NAIC model.
 - Requirements would begin in the first plan year following the issuance of final rules by the HHS Secretary under the National Interim Model Rating Rules and would remain in effect until harmonized national rating rules are promulgated and effective.
 - Within three months of enactment of this section, the HHS secretary would issue a list of benefits, service and provider mandates required to be provided by health insurance issuers in at least 45 states.
- To achieve uniformity, the legislation would create a harmonization commission under HHS to develop consistent standards for insurance regulation.
 - Members of the commission would consist of:
 - state insurance regulators, insurers, business and employer representatives, consumer advocates, agents, providers, high risk pool administrators and actuaries.
 - The commission would work with the NAIC and with states to issue model standards and would be required to address the following areas of insurance regulation:
 - rating, consumer protections and access to coverage, such as issuance and renewability standards.
 - After issuing those model standards, standards would be certified by the HHS secretary, and states would then have two years to adopt them - if a state failed to do so, an insurer would be permitted to sell insurance in that state following the harmonized federal rules, rather than the state's rules.

- ✓ This legislation has been cast as a 2006 priority with bipartisan support and has been referred to the Committee on Health, Education, Labor, and Pensions where it awaits further action.

****Fiscal Year 2007 Appropriations: Labor/HHS/Education***

U.S. Senate Appropriations - Labor, Health and Human Services, Education, and Related Agencies Subcommittee (Chairman Specter, R-Pa.) of Senate Appropriations Committee held hearings on fiscal 2007 appropriations for programs under its jurisdiction on March 1, 2006.

- This is one in a series of hearings to discuss the funds that will be distributed for fiscal year 2007.

U.S. House Appropriations - Department of Health and Human Services FY 2007 Budget Hearing for Labor, Health and Human Services, Education, and Related Agencies, will take place on March 8, 2006.

- Secretary Leavitt is scheduled to testify.

**The mission of the Louisiana Rural Health Association is to serve as a unified voice for the promotion of rural health care through advocacy, education, and leadership. The information above was provided in part by the National Rural Health Association and gathered from various publicly released documents of news related sources.*