

## State E-News Roundup

### A Compendium of Items from State, Regional, and Metropolitan Hospital Association Newsletters

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#### **Health Care Liability Reform**

##### **Ohio Hospital Association Health e-News Plus 2/9/09**

**ODH Sets 2009 Medical Record Copying Fees:** As required by Ohio statute, the Ohio Department of Health (ODH) has determined what hospitals can [charge](#) during 2009 for providing medical records. Total costs for providing medical records to a patient or patient's personal representatives may not exceed \$2.84 per page for the first 10 pages, 59 cents per page for pages 11 through 50, and 24 cents per page after page 50. For data recorded other than on paper, the maximum charge may be \$1.94 per page. The actual cost of postage may be charged.

For a request made by someone other than the patient or patient's representative, an initial fee of \$17.48 may be charged to compensate for the records search. With respect to data recorded on paper, a hospital may charge \$1.15 per page for the first 10 pages, 59 cents per page for pages 11 through 50, and 24 cents per page for pages numbering more than 50. Data recorded other than on paper may be charged at \$1.94 per page, and the actual postage cost may be charged.

##### **VHHA Capitol Report 2/27/09**

**Liability Issues to be Studied in 2009:** Both chambers have passed HB 2057 (Hamilton), expanding protection of providers expressing sympathy to patients by establishing that expressions of commiseration, condolence or compassion and apologies are inadmissible in malpractice actions. Any additional expansion of this protection depends on resolution of concerns about erosion of the privilege protecting materials related to provider quality and safety examinations from discovery and admissibility in lawsuits. During 2009, VHHA will continue to work with the Virginia Trial Lawyers Association, The Medical Society of Virginia and other stakeholders to resolve concerns raised by recent case law. The Joint Commission on Health Care's study of early disclosure of adverse outcomes and mediation, begun in 2008 with the Virginia Bar Association, also is expected to continue with a focus on these issues.

As previously reported, Senate leadership has directed VHHA, The Medical Society of Virginia and the Virginia Trial Lawyers Association to meet during 2009 to develop recommendations for the 2010 session regarding the form Virginia's cap on medical malpractice awards should take in the future. The study will include but not be limited to consideration of the approaches proposed in two Senate bills:

- SB 843 (Marsh), which increases the cap to \$2,750,000 on July 1, 2009, with subsequent annual increases based on a relevant U.S. Department of Labor consumer price index; and
- SB 1389 (Stolle), establishing a Patient Compensation Fund consisting of provider fees to pay compensation to patients for malpractice injuries over the \$2 million cap.

The patrons of these measures agreed to table them for this year to allow for study, and they have asked the stakeholders to prepare a study plan before the end of the 2009 session. VHHA supports maintaining the current \$2 million cap but will seek a thorough study of all available options for fair compensation of injured patients while maintaining Virginia's relatively stable liability environment. VHHA will report on the plans and progress of all these studies as they proceed.

## ***Health Information Technology***

### **Kansas Hospital Association Capitol Comment 2/2/09**

**Telemedicine Discussion Highlights Future Possibilities:** The House Vision 2020 Committee held its first of three days of hearings today on the current and future possibilities of utilizing telemedicine as a tool in the delivery of health care services to Kansans. Presenters today included the University of Kansas Medical Center, Preferred Health Systems and several Kansas community hospitals. Via Christi Regional Medical Center, Goodland Regional Medical Center, Horton Community Hospital and St. Luke's Health System shared examples of how their facilities incorporate telemedicine to enhance the medical services available in their communities. The [presenters](#) also identified the potential community benefits that are derived from using telemedicine services, including more convenience to the patient, better support to the local physician, and the ability to keep those health care dollars in the local community. Committee members seemed captivated by the use of the technology and the potential benefits that are available to the rural and underserved areas of the state. The committee will continue its hearings on Wednesday when Kan-ed, KHPA and the KVC Behavioral Healthcare share their perspective on telemedicine.

### **Idaho Hospital Association Weekly Bulletin 2/9/09**

**Regional Network Expands Bandwidth and Service Throughout Idaho:** In 2008, IHA's Board of Directors approved both a partnership and investment with the proposed [Idaho Regional Optical Network](#) (IRON). In just a little over a year, the network has been able to make significant strides in their mission to provide high speed internet access throughout the state, even to the most rural areas. This access to advanced networking with reliable bandwidth at significantly lower costs is dedicated primarily for health care, research, education and government uses.

The IRON system will be able to accommodate distance learning, video conferencing, telemedicine, public safety, large scale file sharing and many applications yet to be designed. For Idaho's community hospitals, it will be a key element as they continue to transform the landscape of healthcare with increased abilities to provide for EMRs, access to off-site expertise for Idaho's rural hospitals, and secure and quick transmission of data. Access to the IRON backbone may also provide significant savings as the cost for bandwidth is about \$25 per Mbps per month.

As one of IRON's first partners, IHA has been able to provide important insight into the needs of community hospitals as the group develops its strategic path. Additionally, IHA's Vice President of Operations and Registry Services, Stacey Carson, was elected to the IRON board of directors. "Having Stacey bring her considerable expertise to the IRON table continues to be a benefit for our members," said IHA President, Steve Millard. "Her involvement in developing strategic initiatives makes sure that our investment continues to pay dividends for our members."

Other members of the IRON board include David O'Neill, Executive Director for Information Technologies at Boise State University who will serve as President and CEO for 2009, and Mike Gwartney, Director of the Idaho Department of Administration, who serves as the Vice President. As IRON continues to expand access across the state, Stacey and the IRON board will be working with hospitals to help them find the most effective solutions. For hospital IT staff wanting to learn more about getting access, contact IRON General Manager, [Victor Braud](#) (760.294.1668).

### **Oklahoma Hospital Association Hotline 2/18/09**

**Quality Information Web Site Launched:** Eighty Oklahoma hospitals from across the state now provide information on the quality and safety of care they provide in their hospitals through the new [Web site](#) launched last week. The Web site will allow comparison of information between hospitals and will enable hospitals to examine their own quality improvement efforts and be aware of opportunities to explore best practices.

## California Hospital Association News 2/20/09

**New Report Focuses on Financing for Health Information Technology:** In its recently released report to the governor, the Health Information Technology Financing Advisory Commission found that rural and district hospitals face the greatest challenges to bridging the "technology gap" and applying technology solutions to operational problems, primarily due to limited resources. The report focuses on the extent to which limited capital is impeding the expansion and implementation of health information technology (HIT) in California. It also provides recommendations on how state government can address the challenges.

In addition, the report includes information on funding currently available to health care providers, including hospitals, for financing HIT as part of their strategic plans. The report recommends creating a public-private partnership to consolidate HIT resources, including dollars and expertise, and coordinating grants and loans. The report also provides an extensive listing of funding resources. For a copy of the report, visit the California Health & Human Services Agency website at [www.chhs.ca.gov/initiatives](http://www.chhs.ca.gov/initiatives), under "Health Information Exchange."

## *Hospital Billing, Charity Care, and Community Benefits*

### Michigan Hospital Association Monday Report 2/9/09

**New Report: Michigan's Health Care Safety Net In Jeopardy:** Record Medicaid caseloads, skyrocketing uncompensated care and a growing number of uninsured Michigan residents have pushed the state's 144 community hospitals to the brink of fiscal crisis. Last week, the MHA released a new report, *Michigan's Health Care Safety Net: In Jeopardy*, that has been broadly covered by the media, including the Detroit Free Press, The Detroit News and Crain's Detroit Business. This report examines the perfect storm that has hit Michigan hospitals, including negative margins, capital improvement delays, workforce layoffs, and chronic Medicaid underfunding. The report also quantifies how Michigan hospitals, patient care and health care jobs are being affected by the state and national recessions.

Based on available data, more Michigan citizens - in excess of 1.6 million - rely on Medicaid for health care than at any time in history. More uninsured Michigan residents are appearing at hospitals, usually in emergency rooms, to receive treatment for which they do not or cannot pay, resulting in debilitating uncompensated care levels at hospitals. U.S. Census Bureau data confirms this trend by showing that, between 1999 and 2007, the number of Michigan residents covered by private insurance plummeted by a staggering 727,000 people. These latest developments have collided with years of government underfunding of Medicaid to jeopardize the ability of Michigan community hospitals to carry out their missions. Copies of the report are being mailed to MHA members this week. For more information, contact Peter Schonfeld at the MHA.

### Kansas Hospital Association Capitol Comments 2/11/09

**Legislation Introduced to Assist in the Collection of Medical Debt:** [House Bill 2285](#) was introduced in the House Health and Human Services Committee and would allow any hospital or health care provider to submit a claim to the Kansas Department of Health and Environment for unpaid medical debt from an individual that was not covered by a health insurance policy or eligible to receive medical benefits under Medicaid or SCHIP. The Kansas Department of Health and Environment would then coordinate with the Kansas Department of Administration to determine if the debtor is entitled to any state refunds. If so, and the medical debt is at least 90 days old, the Kansas Department of Administration may transfer the amount of the refund to cover the debt owed to KDHE for disbursement to the hospital or health care provider minus an administrative fee. House Bill 2285 has been referred to the House Social Services Budget Committee.

## WVHA CEO Bulletin 2/16/09

### **WVHA Board of Trustees Approves Policy on Voluntary Discounts to the Uninsured:**

During last year's legislative session, Delegate Tim Manchin introduced legislation that would have required hospitals to annually report their charity care policies to the West Virginia Health Care Authority, and mandated the level of charity care or uninsured discounts to be provided by all hospitals. In anticipation of the re-submission of this legislation this year (in fact, introduced on Friday as H.B. 2364), the WVHA Board of Trustees voted to adopt the attached voluntary policy on the provision of charity care and discounts to the uninsured at its meeting on February 12th. Specifically, the Board supports the following:

- The submission of hospitals' charity care policies as part of the annual financial disclosure requirements;
- Provision of full charity care to the uninsured who are below 100% of the Federal Poverty Level (FPL); and,
- For those uninsured between 100% and 300% of the FPL, automatic discounts be provided of 15% for inpatients and 20% for outpatients, subject to certain conditions as articulated in the attached policy.

Delegate Manchin's bill, as submitted, would dictate that patients who are between 100% and 300% of the FPL receive a discount equal to the amount that Medicare patients receive. In order to avoid this more onerous mandate, the WVHA Board is encouraging its member hospitals to consider the adoption of the attached policy on a voluntary basis. Many hospitals may have already adopted internal policies which meet, at a minimum, the recommendations in the attached policy.

## Massachusetts Hospital Association Monday Report 2/16/09

**Guidelines Help Refine Hospital/Community Link:** Attorney General Martha Coakley last Wednesday released the much-anticipated new Community Benefit guidelines that hospitals and HMOs will use to create and report on programs that provide health assistance to the communities they serve. A 12-member task force, which Coakley chaired and which included MHA President Lynn Nicholas, FACHE, met for more than a year to refine the community benefits program, which the AG's office created in 1994.

Nicholas praised the AG and her staff for their focus on the issue, adding, "We believe the new guidelines will help ensure better planning and coordination of community benefits programs and will recognize some of the less visible contributions hospitals make to their communities, particularly in terms of participation and focus on statewide health initiatives." The new guidelines strongly recommend that hospitals undertake programs that are based on identified statewide priorities: addressing healthcare disparities, improving chronic disease management, promoting the wellness of an identified vulnerable population, and addressing the needs of the uninsured.

View the guidelines at [www.mass.gov/ago/communitybenefits](http://www.mass.gov/ago/communitybenefits).

## Ohio Hospital Association Health eNews Plus 2/19/09

**MetroHealth to Adjust Fees to Steer People Away From ER Visits and Expand Discounted Care:** [MetroHealth Medical Center](#) plans to introduce a new point-of-service fee next month, changing the way it charges uninsured patients for the first time in nearly two decades.

The county-owned hospital, which is the region's safety-net health system, said about 37,000 people will be affected by the revamped payment policy.

MetroHealth leaders said they expect the new payment system to increase the number of people who get discounted care while at the same time encouraging those people away from the ER to less expensive forms of service, such as primary care physicians.

"We want to drive people to use the health care system the right way," said Dr. [E. Harry Walker](#), director of the [MetroHealth Center for Community Health](#). "Currently, if you want to show up to the emergency room to get your basic care, there is no economic incentive for you to choose one way or the other."

As the number of uninsured and underinsured in Cuyahoga County has risen in recent years -- and is expected to climb -- MetroHealth has been forced to respond to an increasing patient load. The hospital expects a 10 percent increase in uncompensated care this year. Under the new system, the poorest of the poor, who had previously received free care, will be asked to pay \$5 or \$10 co-pays for doctor's office and emergency room visits. At the same time, more people will qualify for discounted care. For example, the new system will cover uninsured individuals who earn up to \$43,320 annually, or 400 percent of the federal poverty level. Before only individuals who earned \$21,660, or 200 percent of the federal poverty level, qualified. The fee system also makes it more expensive to use the emergency room and less expensive to visit a primary care physician for preventive care. If the emergency room visit is determined not to be an emergency and the patient still wants to be treated there. Then, the cost will be \$75.

"Part of this is to help [patients] understand that it is better for [them] and better for us to help [them] use the system the correct way," Walker said.

Tim Walters, a community organizer for the [May Dugan Center](#), which serves the homeless and impoverished, said advocates will be watching the system to make sure it continues to provide access even when the poorest people cannot pay the \$5 or \$10 co-pays. But overall, he said, the new fee system is "a great improvement."

Definitely you are going to see more people coming in, more people getting health care that they've put off in the past," Walters said. "If this causes a 'run on the bank so to speak,' it's going to be because the need is there."

The program makes MetroHealth's payment policy for the uninsured more like those of [University Hospitals](#) and the [Cleveland Clinic](#), who for years have offered some discount for patients who are up to 400 percent of the federal poverty level. [Gary Benjamin](#), a community organizer with [UHCAN Ohio](#), hailed the new fee system as bringing MetroHealth "into the 20th century." Patients who have questions, can call the MetroHealth Line at 216-778-7878.

### GHA This Week 2/27/09

**Economic Impact Reports Mailed:** The Annual GHA Economic Impact Reports are ready and were emailed individually to each GHA-member CEO and public relations executive on Thursday, Feb. 19. If you did not receive your hospital's economic impact reports, please contact Robert Bolden at [rbolden@gha.org](mailto:rbolden@gha.org) or (770) 249-4505. The new reports, which contain 2006 economic impact data, show that Georgia hospitals collectively contributed more than \$33 billion to the state's economy while being responsible for more than 273,000 full-time jobs in Georgia. Every GHA member was sent its own hospital-specific economic impact numbers and is encouraged to share this positive message with its local media....([Read more](#))

### HARI CEO Briefing 2/27/09

**Uncompensated Care:** The Department of Health recently released "RI Uncompensated Hospital Care (2007)" detailing the amount of uncompensated care (charity care and bad debt) provided by hospitals, demographics of patients receiving charity care, and the financial burden on hospitals ... In 2007, the cost of charity care was \$36.5 million (a 32% increase from 2006), and the cost of bad debt was \$37.3 million (an 8% increase from 2006) ... The report confirmed the significance of increasing uncompensated care costs in Rhode Island while hospitals are experiencing declining operating margins.

### Wisconsin Hospital Association Valued Voice 2/27/09

**WHA Releases Special Report: Wisconsin Hospitals and the Current Economy:** Hospitals face historic financial challenges The seemingly recession-proof health care industry is reeling in today's economy. Wisconsin's community hospitals are treating an unprecedented number of patients who are either uninsured, receiving Medicaid benefits, or are unable to meet their deductibles. The symptoms are disturbing. Today, the Wisconsin Hospital Association released a special report on the impact the economy is having on Wisconsin hospitals. Included in this

week's packet, a limited number of hard copies of the Special Report are available to member hospitals. Download at: [www.wha.org/pubArchive/special\\_reports/WisHospitalsandEconomy2-2009.pdf](http://www.wha.org/pubArchive/special_reports/WisHospitalsandEconomy2-2009.pdf), and it is in the WHA Toolkit under "Economy," at [www.wha.org/toolkit/recession.pdf](http://www.wha.org/toolkit/recession.pdf).

The report details the impact that the recession is having on the hospital workforce, finances and charity care. The rise in unemployment has been accompanied by the loss of employer-sponsored health insurance. In turn, more people are relying upon safety-net programs, such as Medicaid or on hospitals' charity care programs for their health care. Hospital margins continue to fall as hospitals take action to cope with the economic recession. In a recent survey, WHA member hospitals indicated they are reducing or freezing staffing levels, modifying, delaying or cancelling capital projects, and considering cutting back existing programs or services.

In spite of the considerable challenges facing them, community hospitals continue to provide free health screenings, support free medical clinics, and subsidize important services, such as nursing homes. WHA President Steve Brenton said all these services become even more urgent in tough economic times.

"While the nation weathers one of the worst economic downturns that most Americans have ever experienced, Wisconsin hospitals continue to be positioned to serve the health needs of their communities," Brenton said. For information about the Special Report, contact Brian Potter, WHA, [bpotter@wha.org](mailto:bpotter@wha.org), 608-274-1820. To request copies contact Liz Schumann at [eschumann@wha.org](mailto:eschumann@wha.org).

## ***Limited Service Providers and Self Referral***

### **NJHA Newslink 2/5/09**

**Assembly Sends Physician Self-Referral Bill to Governor:** The Assembly voted along party lines today to approve a bill aimed at slowing down the proliferation of ambulatory surgical centers in New Jersey and regulating physician self-referral practices. S-787/A-1933, sponsored by Senate President Richard Codey (D-West Orange) and Assemblyman Herb Conaway (D-Delran), establishes limitations for practitioners who want to refer patients to certain surgical practices and ambulatory care facilities in which they have a financial interest. It also sets certification and data reporting requirements for single-room operating rooms.

Amendments to the bill secured by NJHA in the Senate and adopted today by the Assembly restrict future licensure of ASCs only to facilities "jointly owned by a general hospital in this state." This change was pursued actively at the request of the NJHA Board as a way to level the playing field with these for-profit entities. Radiation therapy pursuant to oncological protocol and lithotripsy services also will be subject to the self-referral prohibitions laid out in the bill.

This measure has been the subject of intensive debate since it began moving through the legislative process last year. The bill originally was written in response to the court ruling in *Garcia, et. al v. HealthNet of New Jersey, Inc. v. Wayne Surgical Center, et. al*, where the judge found that physicians who refer patients to ASCs in which they had a financial interest could be in violation of the Codey Act (N.J.S.A. 45:9 - 22.4). That law, passed in 1989, prohibited such referral practices.

The bill would create an exemption from the original Codey Act for referrals to existing ASCs under a very specific set of conditions. Exempted cases must fit all of the following conditions: the physician with a financial interest in an ASC refers the patient and also personally performs the procedure; the physician's financial interest is not related to the volume of patients referred to the facility; all clinical decisions are made by practicing physicians; and the patient is given prior written notice of the physician's financial interest.

Additionally, all single room OR operations now will be required to register with the state Department of Health and Senior Services on an annual basis and will be required to obtain certification by the Centers for Medicare and Medicaid Services as an ASC, or obtain accreditation from a CMS-recognized body. These facilities also will be required to report on an

annual basis patient encounter data parallel to the current reporting requirements of licensed ASCs. The bill will now go to the Governor for his signature.

### Montana Hospital Association Weekly News Report 2/13/09

**Panel Approves Modified Disclosure Bill:** The Senate Public Health Committee this week amended and then approved SB 51, sponsored by Sen. Terry Murphy (R-Cardwell), which would require health care practitioners to disclose their ownership, contractual or employee relationships when referring patients for additional services.

MHA opposed the amendments, arguing that disclosure should only be required for owners of health care facilities and services and that the bill will result in unnecessary and unhelpful paperwork for hospitals and clinics.

### Montana Hospital Association Weekly Report 2/20/09

**MHA's Specialty Hospital Bills Heard:** The Senate Public Health Committee on Wednesday heard two MHA bills aimed at resolving state policy over specialty hospitals. SB 446, sponsored by Senate President Bob Story (R-Park City), would allow development of specialty hospitals under certain restrictions.

These restrictions would include acceptance by the Department of Public Health and Human Services of a study that demonstrates the new facility would not harm the viability of existing community hospitals. In addition, all hospitals would have to provide 24-hour, seven-day-a-week emergency services and not discriminate in the selection of patients to serve.

In addition to MHA, the bill's proponents included the Billings Clinic, Bozeman Deaconess Hospital, St. Peter's Hospital in Helena, St. Vincent Healthcare in Billings and the Great Falls Clinic. The Montana Medical Association is neutral on the bill pending a meeting of its board of trustees on Saturday. The second bill, SB 439, also sponsored by Story, would extend the current moratorium on specialty hospitals for another two years. The committee is expected to take on both bills today.

### Illinois Hospital Association e-Update 2/27/09

**Step Up Opposition To Hostile Bills:** With a key legislative deadline approaching, it is critical that the hospital community keep up the pressure in opposing bills on nurse staffing ratios (**HB485**) and postsurgical recovery centers (**HB976/SB1407**). The deadline for House bills to move from committee to the House floor is March 12. The House Health Care Availability and Accessibility Committee is expected to hold a hearing on **HB485** and **HB976** as soon as Tuesday, March 3.

**HB485** would impose mandatory nurse-patient staffing ratios more stringent than those in California. It is critical that state representatives hear from their hospitals about the harm that would be caused by ratios and how they are engaged in many efforts to provide an excellent workplace environment for nurses and to promote patient safety. Also, share with your representative the positive effects of your hospital's implementation of the Nurse Staffing by Patient Acuity Act and emphasize that staffing by acuity is the right approach.

**HB976/SB1407** would allow any postsurgical recovery center to become a licensed hospital without a Certificate of Need permit and without meeting all the requirements that hospitals must meet under the Hospital Licensing Act. Please tell your state representative and senator that allowing postsurgical recovery centers to become hospitals would compromise patient safety and that those specialty facilities won't do their fair share to support the health care safety net. In addition, there is no need for additional hospital beds in the planning areas where postsurgical recovery center permits have been granted, which already have an excess of more than 850 beds in those areas.

## ***Medicaid, Hospital Payments, and Health Insurance***

### **UHA Legisletter 2/2/09**

**Good and Bad News on Medicaid Budget:** There is some good news for hospitals for fiscal year 2009. Essentially, Utah's hospitals will take a cut of \$1.1 million in state funds for their Medicaid reimbursement as the Legislature backfilled some of the cuts to hospitals for fiscal year 2009. This is good news because there were many additional cuts directly and indirectly on hospital funding that were discussed but not done by the Legislature. The bad news is that as of this point the Legislature has built in to the fiscal year 2010 base budget a minimum of a \$6 million state hospital reimbursement cut. This is just the state portion and adding the federal funding portion could mean hospital cuts in the tens of millions of dollars. UHA will continue to strongly oppose these large hospital Medicaid reimbursement cuts and will continue to strongly oppose any hospital tax. Other good news is that for fiscal year 2009, there will be no Medicaid eligibility reductions but these will still be considered for fiscal year 2010. The fiscal year 2010 budget debate is likely to play out until the very end of the session. There are a variety of options available to the Legislature to lessen the cuts to hospitals. UHA encourages all hospitals to contact their legislators to oppose these deep Medicaid hospital cuts and to oppose any hospital provider tax

### **Kansas Hospital Association Capitol Comments 2/3/09**

**Legislation Aims to Curtail "Most Favored Nations" Contract Provision:** Legislation ([SB 136](#)) was introduced in the Senate Financial Institutions and Insurance Committee that would prohibit an insurer from including in a provider contract any provisions which:

- Prohibits a provider from contracting with another health insurer to accept a lower reimbursement than the payment specified in the agreement;
- Requires the provider to accept a lesser reimbursement from the health insurer if the provider agrees with another carrier to accept the lower reimbursement for services;
- Terminates, renegotiates or grants the health insurer an option to terminate or renegotiate the agreement, if the provider agrees to accept a lower payment from a different carrier for services; or
- Requires the provider to disclose such provider's contracted reimbursement rates with other health insurers.

In essence, the legislation would prohibit the "Most Favored Nations" clause that is typically included in the Blue Cross and Blue Shield provider contracts. The legislation was introduced at the request of United Healthcare.

### **Indiana Hospital Association News 2/4/09**

**DSH Task Force Makes Recommendations:** IHA's Federal Leveraging Task Force met again last week to discuss the possible redesign of Indiana's supplemental payment programs. The Task Force concluded that while a new program is needed, this legislative session is not the time to support a hospital assessment. There were many factors cited in this decision, including the likelihood that the IGT mechanism will remain available in the short-term, the poor economic environment, uncertainty about the federal stimulus package, FSSA's plan to use an assessment to fund the existing HIP program, and a lack of consensus on how a redesigned system should be structured.

When discussing FSSA's Indiana Check-Up II Plan proposal, Task Force members voiced concern about a hospital assessment that would return less than 100 percent back to hospitals. In addition, members feel that the impact of the first HIP program must be better understood before Indiana surrenders any more of its DSH allotment. The Task Force's recommendation that a provider tax not be pursued has been communicated to key policymakers. FSSA Secretary Anne Murphy has assured IHA that unless we support a hospital provider tax, the major components of the Check-Up Plan II will not move forward this session.

The Task Force did direct IHA to continue working with FSSA on many elements of the plan including: improving the current HIP program, expanding coverage for more Hoosiers, and creating a transparent and equitable supplemental payment structure. While this work continues, IHA will engage with the funders of the current supplemental payment system and FSSA to plan an equitable distribution for 2009 payments.

### California Hospital Association News 2/6/09

**CHA Files Lawsuit Challenging Medi-Cal Reimbursement Reductions:** On Jan. 29, CHA filed a complaint against the state of California in federal district court seeking to halt implementation of Medi-Cal reimbursement cuts passed as part of the fiscal year (FY) 2008-09 state budget. CHA believes the state did not comply with federal Medicaid rules when making these cuts. CHA filed a lawsuit May 5, 2008, against the state of California in state court challenging the Medi-Cal reimbursement cuts that took effect July 1 as part of a mid-year, special session budget bill (see May 9, 2008, CHA News). This case is still proceeding.

CHA filed both lawsuits along with a coalition of other Medi-Cal providers, including the California Pharmacists Association, California Medical Association, California Dental Association, California Association for Adult Day Services, and several pharmacies and hospitals.

Several other lawsuits have been brought against the state challenging these Medi-Cal reimbursement cuts. The case of Independent Living Center v. Shewry resulted in a federal court issuing a preliminary injunction requiring the state to reimburse most of the providers at the full rate pending the outcome of the case. However, the plaintiffs were unable to show irreparable harm with respect to hospital services; thus, hospitals are currently receiving the lower reimbursement. The state has appealed the legality of this preliminary injunction; a hearing will be held before the Ninth Circuit Court of Appeal on Feb. 18.

Finally, a case has been filed in federal court by several non-California Medical Assistance Commission-contracting hospitals challenging the Medi-Cal inpatient rate cuts enacted by the mid-year special session budget bill and the FY 2008-09 state budget. A hearing will be held Feb. 20 on a motion for a preliminary injunction in this case.

### Ohio Hospital Association Health e-News Plus 2/13/09

**Law Denying Health Coverage to Patients Under Influence Repealed:** The Ohio legislature voted to repeal the state's Uniform Individual Accident and Sickness Policy Provision (UPPL) Law, which allowed insurers to deny health coverage to individuals injured while under the influence of alcohol. Gov. Ted Strickland signed the measure into law Jan. 5. Advocates of addiction screening and brief intervention programs have lobbied for the repeal of such laws across the U.S., saying the laws deter doctors from screening patients for alcohol problems out of fear their health care claims will be denied. Ohio is the 15th state to repeal its UPPL law. The UPPL repeal was included in a bill dealing with medical billing and the language was supported by OHA, the Ohio State Medical Association, the National Association of Insurance Commissioners and the National Conference of Insurance Legislators.

### California Hospital Association News 2/13/09

**The CHA Board Unanimously Approved the Following Motion:** In light of the state's financial crisis and catastrophic Medi-Cal payment shortfalls to hospitals, the CHA Board of Trustees endorses the general concept proposed by the Daughters of Charity Health System for a fee on hospitals for the purpose of increasing Medi-Cal payments to hospitals, provided that the proposal can be developed or modified under the leadership and management of CHA with full member participation to acceptably meet the five criteria adopted by the CHA Board in 2007 and made a part of this action, and provided further that such a proposal be brought back to the CHA Board of Trustees for consideration, including a complete evaluation of the model, permanent protections for hospitals, diversion of funds, agreements or other means to balance the program for hospitals.

### *Principles Governing a Hospital Tax*

- Hospitals must be permanently protected with respect to payments and the amount of the tax.
- Hospitals must be paid by Medi-Cal at the highest level allowed under federal law.
- The state must be required to ensure that criterion 2 is met, even if new General Fund (GF) money is required (state maintenance of effort).
- All of the money generated from the hospital tax must be used solely to benefit hospitals.
- Only the voters can change the program (that is, neither the Legislature nor the Governor could modify the program), however, the Legislature could modify the program by a super majority but only in furtherance of the program and its intent.

Implementation of this action will involve detailed discussions with the membership through Regional Association meetings, followed by recommendations from the Regional Association Boards to the CHA Board. Concurrently, CHA will work with legislators and Assembly Health Committee Chair Dave Jones, who has introduced a spot bill, reserving a legislative vehicle for a potential proposal.

### **SCHA Update 2/16/09**

**“The Many Faces of Medicaid” Video:** Medicaid is the key source of health care coverage for low income families, disabled and poor elderly South Carolina. Yet few people really understand how the Medicaid program works or who and what it covers and doesn’t cover.

The South Carolina Hospital Association is working to dispel the myths surrounding the program with its recently produced video entitled “The Many Faces of Medicaid.” The video, which can be viewed at [www.schamedicaid.org](http://www.schamedicaid.org), examines the program through the eyes of several South Carolinians, including parents who rely on Medicaid to help with their children’s healthcare bills. The program also sets the record straight regarding who does not qualify for Medicaid.

The Association emailed the video to more than 100,000 people last week inviting them to view the video and send it to others. In addition to the video, the SCHA website also includes a discussion guide and a brochure containing more information on Medicaid and the uninsured crisis in South Carolina.

### **Michigan Hospital Association Weekly Mailing 2/17/09**

**Medicaid Outpatient Uncompensated Care Disproportionate Share Policy Released:** Last week, the Medical Services Administration (MSA) released a final policy to implement the outpatient uncompensated care disproportionate share hospital (DSH) pool for fiscal year (FY) 2009 and subsequent years. This policy will distribute \$60 million of Medicaid outpatient uncompensated care DSH payments to eligible hospitals, split evenly between small and rural hospitals and large urban hospitals. The MSA anticipates that these payments will be distributed to hospitals by mid-March. Similar to the pool’s FY 2008 counterpart, this pool is funded by an expansion of the hospital provider tax, estimated at approximately \$30 million. Medicaid DSH-eligible hospitals located in a rural or micropolitan county or those with less than 100 acute-care beds would be eligible to receive funding from the small and rural component. All remaining DSH-eligible hospitals would be included in the large urban component.

Consistent with the FY 2008 policy, the MSA will allocate funds among hospitals based on each hospital’s proportion of outpatient uncompensated care relative to the sum for other hospitals in each component of the pool. This allocation process will use data from Medicaid cost reports from fiscal years ending between Oct. 1, 2006, and Sept. 30, 2007.

### **Wisconsin Hospital Association Valued Voice 2/20/09**

**Hospital Assessment Now Law:** Two years after it was first proposed, on February 19 Governor Doyle signed the hospital assessment into law. The assessment was one of several proposals included in the bill aimed at shoring up the state’s finances for the remainder of the 2007-09 biennium and taking the first steps toward stimulating the economy and heading off a projected \$5.7 billion deficit in the coming 2009-11 biennium.

"This is an example of what we can accomplish when we sit down and work through our differences," Doyle said to the media-packed room. "I want to acknowledge the willingness of the Wisconsin Hospital Association and hospitals across the state to get this done." The reworked hospital assessment is a marked improvement over the previous version debated during the past two years. It took months of work by WHA and state staff to craft the package that meets all of WHA's board-adopted principles for supporting a hospital assessment.

"The proposal signed into law today is a win for hospitals, our patients and the state," said WHA President Steve Brenton. "Not only will it result in a significant and much needed Medicaid payment increase for hospitals—the first in over a decade—it will help capture our fair share of federal health care dollars and allow the state to provide insurance coverage for uninsured, low-income childless adults statewide."

"Our members are being squeezed hard by increases in the number of uninsured patients coming to their doors," Brenton continued. "Charity care and bad debt increased by \$85 million (20 percent) just last year. The increased payments from the assessment will help fill this deficit and the extended coverage for childless adults will mean more people will have health insurance."

The assessment is slated to take effect retroactively back to July 1, 2008. Steps for implementation are underway, with a net \$200 million in higher Medicaid payments FY09 expected to start flowing next month and ahead of assessment payments. The first full year of implementation will begin July 1, 2009. As it has throughout the past two years, WHA will be scheduling member conference calls in the near future to discuss next steps in implementation of the new hospital assessment.

### California Hospital Association News 2/27/09

**CHA Leads Development of a Hospital Fee:** The CHA Board recently endorsed the general concept of a fee on hospitals for the purpose of increasing Medi-Cal payments to hospitals by claiming additional federal funds. The board instructed CHA staff to provide leadership and management over the process, and to pursue the development of a proposal, with full member participation, that meets the five criteria established by the board in 2007 (see Feb. 13 CHA News).

CHA is developing the legal, legislative and technical strategies to provide a framework for this project. CHA has retained Lloyd Bookman, Esq., of Hooper, Lundy & Bookman, and Michael Spivey, Esq., from the Spivey/Harris Health Policy Group based in Washington, D.C., to provide expert advice regarding hospital fee options and to ensure compliance with applicable federal laws. CHA is committed to a transparent and open process that will allow members to provide recommendations to CHA staff and to voice concerns. CHA is establishing a core group of hospital representatives to assist in creating policies and principles that will be used to develop a hospital fee proposal. This core group will include representatives from the spectrum of California hospitals.

CHA believes the most important element will be to develop proposals based on good public policy and strong principles. The framework must be developed first, followed by a financial model. Therefore, there is no financial model to share with hospitals at this time. The modeling will not be performed until the policies have been established, and the legal and regulatory parameters are understood.

### HANYS News 2/27/09

**HANYS' Report Debunks Medicaid Myths, Suggests Improvements:** HANYS issued a report on the state's Medicaid program this week that outlines strengths and weaknesses, and offers recommendations on how New York's Medicaid system can be improved. The report, [A Closer Look at New York State's Medicaid Program: Patients, Providers, and Policy Choices](#), also refutes several misconceptions about Medicaid, and offers a comparison between New York's program and other states.

"The details of New York's Medicaid system seem complex, but its purpose is very simple: it is the most important and effective avenue for millions of New Yorkers to receive the health care services they need," HANYS' President Daniel Sisto said. "For years, policymakers have worked hard to expand Medicaid coverage and provide critically needed services to more of New York's children, families, elderly, disabled, and chronically ill. But, unfortunately, discussions pertaining to proposed health care budget cuts and reform proposals often mischaracterize the intent, diminish the value, and ignore the original policy goals of the Medicaid program."

The Medicaid program will be even more vital as the economic downturn continues. As a growing number of individuals lose their employer-sponsored health coverage, many are unable to secure new coverage due to high costs or pre-existing health conditions. Governor Paterson's 2009-2010 budget proposal seeks to take away \$1.3 billion in funding from hospitals, nursing homes, and home health providers.

Highlights of the report include:

- Government policy drives Medicaid spending increases; just 2.1% of a projected Medicaid spending increase of 21% stems from provider cost increases.
- New York enrolls roughly 21% of the state population, compared to the national average of 13%. Per capita spending in New York is naturally greater because it covers more people.
- Special needs populations represent 20% of beneficiaries, but 75% of expenditures. To address growing Medicaid costs, policymakers must develop effective models of care delivery for the beneficiaries who need it most.
- Medicaid reform does not just mean payment reform--it includes decisions about the size and scope of the delivery system, quality initiatives, and efforts toward universal coverage.

## ***Miscellaneous Articles***

### **Nebraska Hospital Association Newlinks 2/19/09**

**Is it Time to Build Your Green Health Care Facility?** Building green isn't a new concept in the world of construction. The concept of building green has been slow to catch on in all areas of the construction industry, due to limited data and a lack of owner knowledge and education regarding the benefits of building green.

The following article will explore the major benefits of building green in the health care sector of construction including: Who should build a green building? What are the benefits to an owner for building green? What are some of the cost considerations of green health care building and finally, what are the construction benefits of green health care building? As a business owner/operator considering a green building, one should investigate if building green is right for his or her business.

According to The Business Case for Greening the Health Care Sector, a business owner/operator should look at three important factors: people, planet and profit. Exploring these three factors and their potential benefits, one is able to easily justify building green in health care because of:

- Improved patient and staff outcomes and reduced health risk "the people"
- Improved capacity and smaller facility requirements "the planet"
- Significantly reduce life-cycle costs and operating budget "profit"

[Continue reading article](#) written by NHA affiliate member, Dicon Corporation.

## Quality and Patient Safety

### Ohio Hospital Association e-Health News Plus 2/2/09

**Ohio Hospitals First in Nation to Team up in Fight Against C diff Infection:** More than 50 Ohio hospitals are teaming up to be the first in the nation to make a united effort to battle clostridium difficile, a dangerous and increasingly common infection often found in health care settings. OHA, The Ohio State University Medical Center (OSUMC) and the Centers for Disease Control and Prevention (CDC) launched the 18-month-long surveillance and reduction project last Friday. The initiative focuses on:

- Completing a statewide surveillance of C diff infections (CDIs) in Ohio.
- 2) Developing and implementing new evidence-based practices to assist in the reduction of C diff cases.
- The collaborative project will standardize how Ohio hospitals count CDIs, ensuring consistency with CDC definitions and improving public reporting. The project will then move on to testing ways to prevent the spread of the infection, implementing proven methods within the participating hospitals. Ultimately, the initiative seeks to reduce the number of C diff cases in Ohio.

This project is part of the [CDC's Prevention Epicenter Program](#), which began in 1997 as a way to work directly with academic partners to address important scientific questions regarding the prevention of health care-associated infections and antibiotic resistance. The Ohio State University Medical Center was named a Prevention Epicenter and Ohio is the first state to commit to participation in a surveillance and performance improvement initiative. Dr. Julie Mangino of the OSUMC Prevention Epicenter will be the lead physician on this project and OHA will serve as a data repository and a forum for participating hospitals to collaborate.

### SCHA Update 2/4/09

**South Carolina Healthcare Quality Trust (SC HQT):** SCHA, Health Sciences South Carolina and the Premier healthcare alliance have joined together to create the South Carolina Healthcare Quality Trust. The initial focus of the SC HQT will be to eliminate preventable healthcare associated infections. A news conference will be held in Columbia on Wednesday to announce the new partnership.

### WSHA Inside Olympia 2/4/09

**MRSA Legislation Proposed:** Last week, the House Health Care and Wellness Committee held a hearing on House Bill (HB) 1123, which addresses hospital-acquired infections, particularly Methicillin-Resistant Staphylococcus Aureus (MRSA). This morning, the Senate Health and Long Term Care Committee held a hearing on Senate Bill (SB) 5500, also addressing MRSA.

WSHA has been working with hospital infection control specialists and the bills' sponsors to create legislation that supports existing voluntary programs and institutes scientifically-validated and cost-effective patient safety practices aimed at stopping the spread of hospital infection.

After much research and discussion, WSHA has agreed to support legislation that:

- Requires screening for Intensive Care Unit (ICU) patients, which is supported by current science;
- Provides useful information to the public about hospital-specific MRSA transmission rates, while limiting reporting burdens by using existing data sources;
- Requires segregation of MRSA patients from other patients and requires notification when segregation is not possible; and
- Increases patient education. In general, both bills will advance patient safety and will be workable for hospitals. The one major area of contention that remains is whether MRSA screening for high-risk surgeries should be the responsibility of physicians or hospitals.

WSHA believes it should be a physician responsibility and part of the overall pre-surgical care the physician provides to allow enough time for patients to be decolonized prior to surgery. If the bills

are amended to make screening for these surgeries a physician responsibility, WSHA has agreed that emergency high-risk surgery patients will be screened in the hospital.

### **Kentucky Hospital Association CEO Briefing 2/6/09**

**MRSA Collaborative Benchmarking Program:** As part of the Kentucky MRSA Collaborative, KHA has developed a hospital MRSA Benchmarking Program to collect data confidentially from hospitals for the purpose of tracking improvements in hand hygiene, room cleaning and rates of MRSA infections. The Benchmarking Program will allow hospitals participating in the Collaborative to compare the success of hospital infection control activities against statewide and peer group performance.

KHA staff is sending, via e-mail, the username and password information to each hospital project lead, identified by the hospital on the MRSA Commitment Form. Hospitals are asked to submit minimal data on a monthly basis for an 18-month period. Hospitals will be able to run reports on performance to use internally to assist in improvement efforts. Additionally, KHA will be able to use aggregate information to demonstrate to the public and law makers that significant and successful activities are underway to control MRSA and other infections, and that mandatory public reporting is unnecessary. For more information on the MRSA Collaborative and Benchmarking Program, contact Elizabeth Cobb at KHA (502-426-6220 or 800-945-4542 or via e-mail at [ecobb@kyha.com](mailto:ecobb@kyha.com)).

### **Maine Hospital Association Friday Report 2/6/09**

**Legislature Considers Maine Health Data Organization Transparency Legislation:** The Legislature's Health and Human Services Committee voted "Ought to Pass as Amended" on [LD 101](#) "An Act To Extend the Operation of the Maine Health Data Processing Center and To Amend the Maine Health Data Organization Statutes," which would require hospitals to upon request provide the charge for any inpatient service or outpatient procedure.

The bill repeals the requirement for hospitals and ambulatory surgical centers to maintain lists of average charges for procedures specified by the Maine Health Data Organization through rulemaking. The bill replaced the price posting language with a requirement that hospitals provide charge information on inpatient, outpatient, and emergency department services upon request. In addition, the bill requires the Maine Health Data Organization (MHDO) to create an interactive website displaying average prices paid for specific procedures performed at all Maine hospitals.

At a public hearing on the bill this week, MHA emphasized that hospitals support transparency efforts. But MHA stressed that information provided to the public should connect both cost and quality data and encourage the state to link that data in their public reporting initiatives. Additionally, MHA requested that the original bill be amended to include the word "average" before "procedure charge" in the new requirement regarding disclosure of charge information to consumers upon request. The committee accepted MHA's amendment.

The bill also extends the life of the all-payer database and MHA told the committee that it supported the establishment of the database. The Association urged the committee and MHDO to look at opportunities to better capitalize on the database to guide health care policy decisions.

### **WSHA Inside Olympia 2/25/09**

**MRSA Legislation:** WSHA is working hard to ensure legislation intended to reduce hospital transmission of Methicillin-Resistant Staphylococcus Aureus (MRSA) is grounded in science and workable for Washington's hospitals. There are two different MRSA bills – HB 1123 and Senate Bill 5500. A version of the legislation is likely to be enacted into law this year; both bills have passed the initial policy committee. WSHA prefers the Senate bill.

Both bills require testing for patients in intensive care units, which some research has shown to be beneficial. In addition, HB 1123 includes a proposal to screen surgical patients, though WSHA successfully advocated for a narrowing of the definition of which surgeries should be screened.

There is currently no evidence that screening these patients reduces infections, and WSHA does not support screening patients prior to surgery.

WSHA is working closely with hospital infection control practitioners from rural and urban hospitals to develop our position on the bills. Thank you to our experts in infection control who have played an important role in educating legislators about MRSA.

## ***State Budget Issues and Legislative Agendas***

### **HANYS News 2/2/09**

**Sisto Challenges Administration on Health Care Cuts, Reform, and GME:** HANYS' President Daniel Sisto today [delivered testimony](#) on the Governor's proposed 2009-2010 state budget before a Joint Legislative Hearing of the Assembly Ways and Means and Senate Finance Committees. Mr. Sisto diverged from his written testimony to respond to the Paterson Administration's testimony, taking issue with its definition of health care reform, its proposals to shift resources away from Graduate Medical Education (GME), and its justification for the drastic cuts and taxes proposed by the Governor.

Mr. Sisto asked the Legislature to put aside the Administration's call to include Medicaid cuts in the deficit reduction plan being negotiated this week, insisting that legislators await events in Washington before agreeing to "gut our health system."

Mr. Sisto urged the State Legislature to ensure that any Medicaid funding New York receives from the federal stimulus package be used only for the Medicaid program. "This funding must be used to offset the cuts proposed in the Governor's Executive Budget. The Legislature should take no action on the budget until these forthcoming funding sources are identified and fully understood," said Mr. Sisto.

Mr. Sisto described the dangerously fragile financial condition and immeasurable human and economic value of our state's health care providers, and detailed the tremendous harm that will come to these providers and the New Yorkers they serve and employ if the Governor's cuts and taxes are enacted.

"The cuts and taxes on health care providers contained in Governor Paterson's state fiscal year 2009-2010 Executive Budget proposal must be rejected. In total, we face \$2.3 billion in cuts and taxes, and hundreds of millions more in redistributions. The magnitude of the cuts, taxes, and redistributions contained in his proposal will without doubt lead to hospital, nursing home, and home health care agency service and job reductions across the state, and in some cases, closures. In fact, right now two hospitals in Queens are poised to close due to their financial instability. Clearly, if this budget is passed, more will follow.

"Moreover, according to HANYS' analysis, the Medicaid cuts and taxes on all three sectors—hospitals, nursing homes, and home care providers—represent at least 51,000 jobs. These are jobs and services that the state can ill afford to lose at a time when the state and nation are looking to stimulate employment—especially when there is more than adequate new federal Medicaid funding to avoid it. Clearly, further cuts of this magnitude will only contribute to the economic downturn and make it that much harder for the state's economy to recover.

"It would, therefore, be unconscionable to pass a Draconian state budget that will lead to wholesale services reductions, closures, and massive layoffs, without first factoring in these anticipated federal stimulus revenues," said Mr. Sisto. Mr. Sisto also admonished the Administration for reneging, in its budget proposal, on the state's nursing home rebasing agreement, and said the budget's home health payment reductions would harm access to care for the neediest New Yorkers.

## Connecticut Hospital Association Update 2/5/09

**Governor M. Jodi Rell Releases Her FY 2010 & FY 2011 Proposed Biennial Budget:** On Wednesday, February 4, Governor M. Jodi Rell released her [proposed biennial budget](#) for FY 2010 & FY 2011. In addressing the over \$6 billion two-year deficit, the budget proposal does not raise taxes and closes the projected budget deficits gap through a combination of budget cuts, stimulus funds, and rainy day funds.

The proposed budget:

- Preserves Medicaid rate increases passed in the last biennium.
- Preserves the Uncompensated Care Pool and the Urban DSH Pool.
- Preserves recent eligibility expansion to 185% of the federal poverty level (FPL) in the HUSKY A program and expansion of eligibility for pregnant women to 250% of FPL.
- Provides funding for significant caseload growth in the Medicaid program, including HUSKY A, Charter Oak Health Plan, and the State-Administered General Assistance Program.
- Implements non-payment for certain hospital-acquired conditions under Medicaid for an annual savings of \$1.7 million.

The budget will now be referred to the Appropriations Committee for its review and modification. CHA anticipates the projected budget to increase from the \$6 billion deficit upon which this budget is based. CHA will continue its aggressive advocacy to ensure that the final budget approved by the legislature funds and protects hospitals, along with the patients who rely upon them for care.

## GNYHA Skyline News 2/9/09

**HEP Launches “Protect Healthcare” Campaign:** At a press conference in Albany on February 2, the Healthcare Education Project, a joint initiative of GNYHA and 1199 SEIU United Healthcare Workers East, launched a comprehensive campaign to educate New Yorkers about the hugely destructive effect Governor Paterson’s proposed health care cuts—including \$2 billion in cuts to hospitals, nursing homes, and home health—would have on patients and communities across New York State. The “Protect Healthcare” campaign kicked off with a 30-second television ad that is airing statewide, and includes radio ads, direct mail to more than a million households, tens of thousands of patch-through calls to legislators, statewide door-to-door canvassing, and a Web site, [www.protecthealthcare.com](http://www.protecthealthcare.com). The press conference and campaign launch—which the New York Times covered in an exclusive story on February 2—was covered the next day by the Daily News, New York Post, Newsday, Buffalo News, New York Observer, Gannett newspapers, and New York public radio. The press conference featured GNYHA President Kenneth E. Raske and 1199 SEIU Political Director Kevin Finnegan. Two additional ads launched on February 9. To view any of the HEP television spots, visit the “Protect Healthcare” Web site or [www.gnyha.org](http://www.gnyha.org).

## HARI CEO Brief 2/13/09

**HARI Advocacy Plan** – A statewide economic impact report was released by HARI this week ... Highlights include:

- Employing 20,370 health care professionals – 5% of private sector employment in Rhode Island
- Paying \$1.6 billion in wages – 10% of the state’s private sector payroll
- Spending \$1 billion each year on goods and services
- Dedicating \$200 million to improving facilities and upgrading technology

Media coverage included WJAR-TV, the Providence Business News, Modern Healthcare and AHA News Now. Staff presented the advocacy plan to the St. Joseph Health Services Board of Trustees ... A similar presentation will be made at Roger Williams Medical Center’s upcoming board retreat ... A joint public relations and government relations executives meeting will be held on February 27, 9 a.m. at HARI ... The meeting will serve as an opportunity to discuss the governor’s FY 2010 budget.

## HANYS News 2/13/09

**HANYS Partners with State Rural Health Association for Legislative Advocacy:** On February 10, HANYS joined with the New York State Association for Rural Health (NYSARH) at the second annual rural health advocacy day in Albany. Rural health providers from across the state came to Albany to highlight to legislators and their staffs the health care services provided in rural areas of the state and the needs of rural New Yorkers. Leaders representing rural health networks and hospitals, including critical access hospitals, shared with more than 100 legislative representatives the essential services and important contributions that rural facilities provide to their communities. In addition to the main event, network and hospital leaders held numerous visits with individual legislative leaders and staff. There was a notable increase in interest from downstate legislators at this year's event. Later that day, Governor Paterson announced the award of rural health network grants and HEAL 9 grants, several of which were presented to rural health networks.

## AzHHA Insider Issue 2/13/09

**Economy and AHCCCS Rate Freeze Leading to Tough Times for AZ Hospitals:** This week, the Arizona Hospital and Healthcare Association (AzHHA) released two surveys, which demonstrate that the state's hospitals are experiencing turbulent economic times. The surveys reveal Arizona's hospitals experienced declines in their financial performance from the third quarter ending Sept. 30, 2008 as compared to the third quarter ending Sept. 30, 2007.

This decline coincides with worsening financial pressure following the Oct. 1, 2008 start of the Arizona Health Care Cost Containment System (AHCCCS) hospital payment rate freeze. This slashed hospitals' total reimbursement by \$37.5 million for FY 2009, including \$25 million in lost federal matching funds. Since the rate freeze took effect, AHCCCS payments only cover 82 percent of costs incurred by hospitals caring for AHCCCS patients. The cuts the legislature is considering in the FY 2010 budget would reduce AHCCCS payments to 75 percent of hospitals' total costs. Arizona hospitals already have shouldered \$93 million in funding cuts in the FY 2008 and FY 2009 state budgets. The legislature's FY 2010 proposed budget includes \$219 million in cuts to hospitals, which will result in a \$143 million loss of federal matching funds.

The AzHHA surveys revealed participating Arizona hospitals are addressing their economic challenges by:

- postponing construction and renovation projects (74 percent);
- delaying the purchase of clinical equipment (74 percent);
- increasing the hidden healthcare tax by shifting costs to businesses (59 percent);
- suspending information technology improvements (52 percent); and
- implementing hiring freezes (45 percent).

## NJHA Newslink 2/17/09

**Governor Announces New Round of Mid-Year Budget Cuts:** For the second time in the past two months, Governor Corzine today announced plans to reduce spending and implement cuts in the state's current fiscal year. While the new plan did not include any direct cuts to healthcare spending, there is a provision "eliminating forward funding of charity care" by \$25.5 million. In a conference call this afternoon with NJHA, State Treasurer David Rousseau and Health and Senior Services Commissioner Heather Howard assured hospitals there would be no delay or withholding of 2009 charity care payments. Instead, the July 2009 payment which was slated to come out of fiscal year 2009 will instead come out of next fiscal year's budget. Charity care has always been paid on an August-to-July time frame. This adjustment should be transparent from the hospitals' perspective and should not impact hospitals' cash flow. Legislation will be required to implement this plan, and NJHA will be directly engaged in the debate.

After announcing mid-year budget cuts in January of approximately \$800 million, today the Governor announced an additional \$472 million in cuts to offset a \$3.6 billion shortfall in the FY 2009 budget. This second round of cuts brings the total amount of mid-year trimming to \$1.3 billion. In total, \$65 million will be cut from the Department of Health and Senior Services

budget. The Governor outlined his plans at a press conference in Trenton this afternoon, citing the growing economic crisis. The critical factors leading to today's action include a \$2.8 billion decline in revenues coupled with a \$600 million increase in spending, including \$270 million to avoid an increase in the unemployment insurance tax on employers. The plan does account for an expected \$850 million from the federal stimulus package.

Gov. Corzine has stated that next year's revenues will be even lower than this year's, resulting in more painful cuts for the state. NJHA will continue to advocate for the appropriate level of charity care, graduate medical education and Medicaid funding in anticipation of the Governor's March 10 budget address.

### Utah Hospital Association 2/18/09

**Hospitals Cuts Lessened by Health and Human Services Subcommittee:** UHA has strongly lobbied the Health and Human Services Subcommittee to reduce the proposed cuts to hospitals Medicaid funding of \$32 million in state funds (a combined total of over \$110 million in state and federal reductions in hospital Medicaid reimbursement). In a final vote late last week, the subcommittee voted to reduce direct state Medicaid hospital cuts to \$11 million for fiscal year 2010. UHA also successfully lobbied the subcommittee to drop any reference to a hospital tax. These recommendations now go to the Executive Appropriations Committee. With the federal stimulus package estimated to bring an additional \$320 million in federal funds to Utah's Medicaid program over the next two years, we have an excellent opportunity to reduce or eliminate these hospital Medicaid cuts. Hospitals now need to lobby their legislators to tell them to use the additional federal stimulus Medicaid funding to stop these cuts to hospitals Medicaid funding. UHA will continue to strongly lobby legislative leadership to stop these hospital cuts now that the federal Medicaid stimulus money is a reality.

### Tennessee Hospital Association Legislative Bulletin 2/19/09

**THA 2009 Legislative Priorities:** THA has two top priorities for 2009: 1) urge the legislature to utilize the federal Medicaid stimulus dollars to make TennCare whole before allocating those dollars elsewhere; and 2) maintain a strong certificate of need (CON) program. These priorities are summarized below. For more information, read the [2009 THA Legislative Priorities](#) list.

According to the latest [projections by Tennessee Department of Finance and Administration Commissioner Dave Goetz](#), Tennessee will receive \$1.1 billion, instead of the originally projected \$1.6 billion, additional federal dollars over the next two years to offset potential Medicaid cuts. THA is working to verify those numbers. The association is urging the General Assembly to use this money to maintain the current level of disproportionate share hospital (DSH) and essential access hospital (EAH) payments before directing it to other state programs. Every dollar the state saves by cutting hospital payments costs hospitals three dollars due to the federal match. These cuts, if implemented, essentially would constitute a tax on Tennessee hospitals for providing services. Given the rise in unemployment and the growing number of uninsured Tennesseans, additional dollars should be allocated to TennCare from the stimulus to ensure financial viability in order to continue providing quality healthcare services to all Tennesseans.

THA also is working to extend the life of the Health Services and Development Agency (HSDA) and preserve the current CON laws. Legislation must be passed to extend the HSDA, which is set to terminate on June 30. A governmental entity is given an additional one-year wind down period before ceasing all activities. It is vital for hospitals that the CON program remains in tact.

Other priorities -- Corporate Practice of Medicine: THA introduced legislation that would allow, but not mandate, hospitals to employ hospital-based physicians: radiologists, anesthesiologists, pathologists and emergency room physicians. Currently, hospitals are prohibited from employing these physician groups. This legislation also includes a clear method for hospitals to give notice to patients that certain doctors are not employed by the hospital. This notice, when

given, effectively would limit the hospital's liability for these independent contractors, absent any negligence by the hospital. The Tennessee Supreme Court recently held hospitals liable for non-employee, hospital-based physicians in the [Boren](#) and [Dewald](#)

### Texas Hospital Association Health Care Advocate 2/20/09

**Senate State Affairs Interim Report Highlights Health Care Issues:** The Senate State Affairs Committee released its [interim report](#) earlier this week. The report includes a number of recommendations for improving transparency and efficiency in the health insurance market and reducing the number of uninsured Texans.

Specifically, the committee made the following recommendations:

- The Legislature should consider changes to current statutes prohibiting the employment of physicians. If lawmakers move forward with amendments to the Corporate Practice of Medicine doctrine, the committee noted that provisions should be included that expressly prohibit an employing corporation from “ever compromising or influencing the medical judgment of a physician. Protecting the integrity of a physician's diagnosis, treatment or medical decisions is of the utmost importance.” The committee also noted that it may be appropriate to limit changes to facilities in counties under a certain population, medically underserved areas or to certain specialties that practice solely in a facility setting.
- A state-funded reinsurance program in the small business market could establish reinsurance coverage for carriers and provide protection against unexpectedly high claims costs or high volume of claims. Reinsurance would establish a means of spreading risk in the small business market and help to provide predictability of claims for these enrollees. Though subject to available funding, these changes would reduce premium amounts for the covered population and decrease the number of uninsured, employed Texans.
- Subject to available general revenue funds, the Legislature should consider implementing a premium assistance program for certain, low-income enrollees in the state's High Risk Pool. Funding for such a program could be achieved with a direct GR appropriation or through an additional assessment on the insurance industry. Discussion surrounding this significant program change for low-income pool enrollees should include consideration of a financial/tax credit to the insurance industry for this portion of the pool costs.

The committee also studied the economic impact of the medical liability reforms passed by the Texas Legislature in 2003. The committee determined that the reforms have had a positive effect on Texas, and it made no recommendations for changes in current tort law.

### Minnesota Hospital Association Newsline 2/20/09

**MHA Creates Weekly Fact Sheets for Legislators -- Documents Meant to Inform Lawmakers of Hospitals' Contributions, Challenges:** The Minnesota Hospital Association (MHA) Monday issued the first of what will be its weekly fact sheets meant to inform state lawmakers of hospitals' community contributions and economic challenges.

Dubbed “Some cuts never heal,” the one-page documents will focus on various hospital issues, such as financing and enrollment in public health programs like MinnesotaCare. For example, this week's message explained that health care is no longer a recession-proof field. Next week's document will discuss how the Minnesota Health and Human Services budget, which channels funds from programs like Medicaid to hospitals, have shouldered a disproportionate share of state cost-cutting measures. The message goes on to say that the unfair practice must stop if hospitals are to remain the health care safety net for the sick and needy. View this week's issue here: [\[PDF\]](#).

### NJHA Newslink 2/25/09

**NJHA Releases Bankruptcy Primer; March 3 Webinar Planned:** NJHA today released its Hospital Closure Guidelines: A Bankruptcy Primer to assist member hospitals with bankruptcy issues that can arise in the closure process. This new resource was created in cooperation with a cross section of experienced lawyers from leading New Jersey law firms to help hospitals become more knowledgeable about various options and strategies to best position their institutions to

weather current financial difficulties. The guide provides information on how to navigate the bankruptcy process, should hospitals find it necessary.

In conjunction with the release of this document, NJHA will host a Webinar March 3 to discuss the Guidelines, examine different strategies for hospitals to overcome financial difficulties and ensure future stability and survival. Participants also will be able to ask questions of the presenters. [Click here](#) for more information or to register online for the Webinar.

### HANYS News 2/25/09

**State Legislators and Hospital Leaders Discuss Federal Stimulus:** Long Island's elected state representatives and hospital chief executive officers (CEOs) agree that the increased federal Medicaid funds in the economic stimulus package for New York should be used to offset the Governor's projected \$64 million in Medicaid cuts to Long Island hospitals. They agree that this would allow legislators and policymakers the time and funds to tackle health reimbursement reform in a logical and sustainable manner.

This approach to health budgeting and reform was shared by legislators on both sides of the aisle, as well as by hospital leaders, who attended a series of legislative/press briefings last week sponsored by Nassau-Suffolk Hospital Council (NSHC). "We need to use the federal funding to hold hospitals and education harmless," said State Senator Brian Foley (D-Blue Point). "Then we need to use money to reform health care [reimbursement] in the next few years. Then we'll have used our time and money well."

"Hospitals have already sustained two rounds of cuts in this fiscal year--about one billion dollars statewide," said Kevin Dahill, CEO of NSHC. "We're reasonably asking for an offset of the proposed cuts so that an industry that has proven itself to be an economic engine, offering stable, local jobs, can remain so."

"Everything you hear about the stimulus package is about creating jobs. You have an industry in this state producing billions in economic benefit. So, it appears that you would do what you should to avoid further catastrophe," said Joseph Quagliata, President and CEO of South Nassau Communities Hospital. "FMAP dollars [Federal Medical Assistance Percentage] are tied to Medicaid, so it makes sense to at least make hospitals whole."

### WSHA Inside Olympia 2/25/09

**Survey on Budget Impacts:** We are entering a crucial time as the Washington State Legislature grapples with the financial implications of the state budget deficit. In order to preserve funding for health care, it is critical we provide legislators with a clear picture of how reductions in hospital funding will affect the availability of health services.

Please take a few minutes to complete a short survey to help us identify types of hospital services that may be vulnerable if significant budget cuts are made. Your information will remain confidential. Your responses will be compiled and shared with legislators only in aggregate form. Our lobbyists need this information immediately. PLEASE RESPOND BY FRIDAY, FEBRUARY 27, 2009. The survey can be found at [www.tinyurl.com/impactsurvey](http://www.tinyurl.com/impactsurvey). Thank you for your help.

### Ohio Hospital Association Health e-clips Plus 2/26/09

**OHA Board Takes Stance on State Budget:** At its February meeting, the OHA Board of Trustees agreed that Ohio hospitals cannot accept the proposed Hospital Corporate Franchise Fee as proposed without the significant changes, which was the recommendation of the OHA Finance Committee, Task Force on HCAP Principles and Goals and OHA Executive Committee. The board expressed concern that hospitals cannot accept an assessment that will cost hospital employees their jobs, risk a reduction in vital services for patients and increase costs to Ohio employers. Further, the Board was concerned that reductions in health care workforce will negatively impact patient care, and added costs will be passed on to patients and their employers. Under the proposed fee, which is part of the state fiscal year 2010/2011 budget

proposal (House Bill 1), hospitals would pay \$597 million in additional assessments and only get \$187 million back through a modest increase in Medicaid reimbursement. OHA staff outlined to the Board the association's work with elected officials, business leaders, OHA members and members of the media to explain the budget proposal's potential negative impact on hospitals.

The Board also received a report on the administration's proposal to expand health insurance coverage for individuals, which would mandate dependent coverage up to age 29, extend state continuations coverage to 12 months and allow the Ohio Department of Insurance to order independent review of health claim denials, among other provisions.

### **HANYS News 2/27/09**

**HANYS' Online Advocacy Sites Mobilize New Yorkers:** Nearly 30,000 New Yorkers have joined a first-of-its-kind online campaign, launched earlier this year, to protect health care in their communities. These everyday New Yorkers visited [www.helpyourhospital.org](http://www.helpyourhospital.org) and its companion site, [www.helpyournursinghome.org](http://www.helpyournursinghome.org), where they took action to stop the Governor's proposed cuts and taxes, which threaten their local health care providers. Specifically:

- nearly 16,000 New Yorkers used the tools on the Web site to send letters to their state legislators; and
- more than 12,000 New Yorkers signed an online petition to lend their support to ensuring that the Medicaid dollars included in the recently adopted federal economic stimulus package are used for mitigating the Governor's proposed Medicaid cuts.

This outpouring of support for health care in New York is unprecedented. Using these unique online tools, HANYS has been able to mobilize a far greater number of New Yorkers than any of the Association's previous letter-writing campaigns. "We are delighted that New Yorkers have responded so enthusiastically to this online campaign, but we are not surprised," commented Daniel Sisto, President of HANYS. "When people understand that the Governor's cuts directly threaten health care in their own communities, they are eager to make a difference." Mr. Sisto noted that the positive response by New Yorkers confirms the results of a poll of New York voters recently conducted by Siena Research Institute on behalf of HANYS. The Siena poll shows that New Yorkers overwhelmingly support protecting health care providers from cuts.

## ***State Public Health Emergency Response Initiatives and Trauma Funding***

### **Ohio Hospital Association Health e-News Plus 2/9/09**

**Trauma Triage Creates New Category for Geriatric Patients:** Ohio's rules for trauma triage now have a separate category for geriatric patients, which became effective Dec. 29, 2008. A recommendation to treat geriatric patients, anyone 70-years-old or above, as a distinct population was made during the 2008 review required by the Ohio State Board of Emergency Medical Services (EMS). The main cause for the separation is that elderly patients have worse outcomes than younger trauma patients with similar injuries, and trauma patients have a better chance of recovery at a trauma center. Before the new distinction, age was only a factor in treatment.

OHA voiced concerns about over-triage and the lack of an accurate fiscal impact statement throughout the past year as the proposed rule moved through the rulemaking process. A copy of the complete trauma triage rules is available at [OHA's Web site](#) and more information on the changes can be found at [EMS' Web site](#). For comments or questions, e-mail [Timothy Erskine](mailto:Timothy.Erskine@ohio.gov), chief of trauma systems and research at the Ohio Department of Public Safety or [Bridget Gargan](mailto:Bridget.Gargan@ohio.gov), vice president of state policy and advocacy at OHA.

## Idaho Hospital Association Weekly Bulletin 2/13/09

**Trauma Registry Reports Valuable Data:** The 2009 [Idaho Trauma Registry \(ITR\) Annual Report](#) is now available. The report covers trauma cases submitted by 14 pilot hospitals between October 1, 2007 and September 30, 2008. This pilot project is a collaborative partnership between hospitals, public agencies, and safety officials to gather meaningful data on trauma incidents in Idaho.

Trauma cases submitted by pilot hospitals were linked, where appropriate, with motor vehicle collision reports (Idaho Transportation Department, Office of Highway Operations and Safety), patient care reports (Idaho Department of Health and Welfare, Bureau of Emergency Medical Services), and death records (Idaho Department of Health and Welfare, Bureau of Health Policy and Vital Statistics). Linking cases across data sources generates a single record for each injury incident. Analysis of de-identified, aggregate records provides the information needed to support performance improvement of emergency medical systems, policy change, and injury prevention.

Data analysis revealed:

- Falls were the leading cause of injury followed by motor vehicle collisions. These were also the leading causes of head injuries.
- Most injuries, with a known injury location, occurred in a home (34%) or on a public street or highway (31%).
- Of patients with a known discharge location, 61 percent (61%) were discharged home to self care. Of patients with head injuries, just 45 percent (45%) were discharged home to self care.
- Almost half (47%) of all fall injuries were sustained by those 65 years of age and older. More than one in four (28%) fall injuries was among females 65 years of age and older.
- Almost three-quarters (73%) of fall injury patients 64 years of age and younger were discharged home or to self care. Just one-quarter (25%) of fall patients aged 65 years and older were discharged home or to self care.
- Payer information was available for 23 percent (23%) of cases submitted by hospitals. At time of discharge just 29 percent (29%) were covered by private insurance, about one-third (32%) were covered by government insurance, and an additional 22 percent (22%) were reported as self-pay.

## Arkansas Hospital Association Notebook 2/16/09

**Cigarette Tax Passes; Trauma System A “Go”:** The Arkansas Senate gave its approval last Thursday for a measure to raise the state tax on a pack of cigarettes by 56-cents, paving the way for the state to finally establish a Trauma Care network, along with funding about 20 other healthcare programs. Taxes on other tobacco products will also go up, ranging from 32% to 68% over today’s rate. Twenty-eight of the 35 state senators voted in favor of the bill, one more than required for passage. The House passed the bill on February 5. Currently, Arkansas is the only state in the union that does not have a Level 1 Trauma Center, and one of only three that have no statewide trauma system in place.

The bill, which now awaits the Governor’s signature, will generate about \$85 million per year in additional state general revenues. During the first year, \$25 million is earmarked for the trauma system and \$28 million annually after that. The \$25 million for year one would include \$5 million for one-time grants to ambulance services for equipment and training. The balance of the monies, which could grow to \$175 million, including Federal matching dollars, will then go to a “trauma trust fund,” from which the Arkansas Department of Health and the state Board of Health will award grants to hospitals, rehabilitation facilities and other providers that choose to participate in the trauma system.

In addition to the healthcare providers, the trauma care funds will help to improve communications between hospitals and emergency responders to ensure that patients in need of trauma care get to the best facility to handle their conditions. Supporters noted during the campaign backing the legislation that having a trauma system in place with designated Level I and Level II trauma centers will save between 200 and 600 lives per year, along with millions of

dollars now spent in lifetime disability and rehabilitation costs. Governor Beebe will hold a bill signing ceremony February 17.

## ***Workforce, Staffing and Employee Relations Issues***

### **Nevada Hospital Association Hospital Healthlink e-Newsletter 2/5/09**

**Nevada Academy of Health:** Senate Bill 171 of the 74th Session of the Nevada Legislature established the Nevada Academy of Health. The Academy is charged by statute to study issues related to health care, and one specific task is to analyze and evaluate data relating to health care. Along this line, the Academy has compiled a "Scorecard" of health indicators. The Scorecard is a compilation of outside research and studies that offer context to Nevada's position among the states on health-related issues. As is evident from the document, Nevada usually ranks poorly when compared with other states on these health indicators. The Academy's desire in creating the Scorecard is not to highlight our shortcomings, but rather to offer a snapshot of where Nevada stands on many key health issues that are generally considered indicative of our level of health.

It is the Academy's hope that policy makers will use the Nevada Health Scorecard to provide context to health care debate, identify areas of critical need and help frame legislation and policy that relates to health, wellness and the delivery of medical care in our state. Please also be mindful that the Scorecard is constantly in motion. New reports are published regularly, and the Nevada Health Scorecard will be updated to incorporate these studies. The online version of the document is available through the Nevada Department of Health and Human Services Web site, and each ranking offers a hyperlink to the source material whenever it's available. Accessing these source materials will often provide greater detail on certain issues, particularly demographic information, including racial disparities.

Of the many health-related issues that have gained prominence in Nevada over the past year, none is more striking than the Hepatitis C outbreak in southern Nevada. This crisis has led to a broader review of the health system in our state, where it fell short before, and what must be done to correct our deficiencies.

The Nevada Academy of Health has reviewed work done by the State Health Division staff, under the direction of acting state health officer Dr. Mary Guinan, of the health system that identifies key issues and a framework for creating a full systems response to prevent blood borne infections in medical facilities in Nevada.

While this review and the resultant document titled Framework for System Reengineering is the property of the State Health Division, the Academy salutes the work of Dr. Guinan and Health Division staff to outline how all components of the health system interact during a crisis like the Hepatitis C outbreak. It is the belief of the Nevada Academy of Health that a comprehensive, systems-based approach is the best way to develop stronger working relationships between the many arms of our health system and improve the quality of care across the system.

More must be done to ensure controls are in place to prevent health outbreaks and ensure networks exist to respond promptly when something does occur. The Academy believes that developing a systems approach in this manner is in the best interest of public health. For more information and to view the Scorecard visit [http://dhhs.nv.gov/Academy\\_Health.htm](http://dhhs.nv.gov/Academy_Health.htm).

### **Illinois Hospital Association e-Update 2/6/09**

**Nurse Staffing Ratios Proposed Again:** Bills that would impose mandatory nurse staffing ratios have surfaced in both the Illinois Senate and House. Senate Bill 224 and House Bill 485 are nearly identical to ratio bills that have been introduced over the past several years. The bills would impose ratios more stringent than those in California's law and would allow IDPH to prescribe even more stringent ratios in the future beyond those specified in the bills. Members are urged to tell their state legislators that nurse staffing ratios would be harmful to hospitals and

patients. Also share with legislators the positive impact that your hospital's implementation of the Nurse Staffing by Patient Acuity law has made.

### Illinois Hospital Association e-Update 2/6/09

**Host a Mini-Residency With Your Legislators:** The success of IHA's advocacy agenda relies on the contacts that hospital leaders establish with their legislators at the grassroots level. With a new Governor and General Assembly, IHA invites you to redouble your efforts to build or strengthen your relationships with your elected officials. Through IHA's mini-residency program, you can give your legislators a first-hand look at the contributions your hospital makes, the challenges it faces and the impact of potential legislation. IHA has resources and materials ([click here](#)) to help you arrange a successful mini-residency that will serve as the foundation for a continuing relationship

### VHHA FYI Weekly 2/6/09

**Virginia Board of Nursing Considering Continued Competency Options for Licensure:** The Virginia Board of Nursing is working to develop recommendations for continued competency requirements for registered, practical and nursing aide licenses. The issue was last addressed in 2002 without resolution – except rules promulgated for advance practice registered nurses. The Board's goal is to advance a system that is not onerous or duplicative to practitioners, facilities or the Board and does not limit nurses' practices as their roles and responsibilities change from bedside to nontraditional settings. VHHA, VNA, VONE and AARP met with the Board to discuss options on January 27. Hospital representatives asked that competency training done to meet hospital accreditation requirements be considered one avenue for meeting a nurse's Board competency requirements. The nursing organizations also requested that the Board consider several options for meeting competency requirements for licensure to address the variety of settings that employ nurses and skills that nurses use. The Board of Nursing will study systems in other states and report back to the group this summer.

### Texas Hospital Association Health Care Advocate 2/6/09

**Nursing Coalition Requests Funding; Educates Legislative Staff:** At a [news conference](#) this morning at the Texas Capitol, members of the Texas Nursing Workforce Shortage Coalition called on legislators to appropriate an additional \$60 million in special-item funding to increase the annual production of registered nurse graduates in Texas. The coalition – led by the Texas Hospital Association and Texas Nurses Association – is a broad-based group that includes health care providers, business groups and education leaders working together to solve the nursing shortage in Texas.

“Despite the current budget situation, our coalition believes an investment in nursing education must be a priority,” said Dan Stultz, M.D., FACP, FACHE, president/CEO of the Texas Hospital Association and chairman of the coalition. “We know that if the Legislature doesn't make this investment now, Texas will never be able to close the supply-demand gap.”

Other speakers at the event – which attracted strong media attendance – included Susan Sportsman, RN, Ph.D., president of the Texas Nurses Association; Paulette Burns, RN, Ph.D., dean of the Harris College of Nursing and Health Sciences at Texas Christian University; and Bill Hammond, president of the Texas Association of Business.

Following the news conference, the coalition hosted a “Lunch 'n Learn” for legislative staffers at THA headquarters to educate this important audience about the nursing shortage and the coalition's proposed solution.

Under the coalition's proposal, the additional \$60 million in funding would enable nursing schools to:

- Increase capacity. Nursing schools cite the lack of faculty as the biggest barrier to enrolling more students.

- Improve efficiency. State dollars should be used to create incentives for nursing schools to admit and graduate more registered nursing students within a reasonable time.
- Assist nursing students. Financial aid and other incentives should be available to nursing students to encourage enrollment and graduation.
- Nursing schools that receive funding will be held accountable for producing additional graduates. Under the coalition's proposal, schools with records of producing year-over-year increases in the number of graduates or achieving high graduation rates would be given upfront funding to build on their proven successes. Schools with lower graduation rates still would have an opportunity to request funding based on a contract to produce additional graduates and would be required to meet specified benchmarks.

More details are available on the Texas Nursing Workforce Shortage Coalition's Web site at [www.TexasNeedsNurses.org](http://www.TexasNeedsNurses.org).

### WSHA Weekly Report 2/6/09

**New Residency May Improve Retention of Nurses in Rural Facilities:** Rural nurses must have more breadth and depth of knowledge than other specialty nursing fields. The demands mean early burnout and high turnover rates when compared with urban nurses. However, residency programs can reduce the turnover of new and transitioning nurses. In response, Idaho State University (ISU), Pocatello, in partnership with health organizations throughout the Northwest, has developed the Northwest Rural Nurse Residency (NWRNR) program.

Participants in the NWRNR receive all of their training (64-hours of seminars and a 104-hour supervised clinical experience) 'at home' in their own facilities and communities, using new technologies at no cost to participants. Program faculty and staff provide support and information for preceptors, residents and nurse administrators in this 12-month program. The second cohort of NWRNR residents will start in early May and space is limited. Applications are accepted on a first-come, first-served basis. For details call the ISU Office of Professional Development at (208) 282-2982, or visit the NWRNR website at [www.isu.edu/nursing/opd/nwrnr.shtml](http://www.isu.edu/nursing/opd/nwrnr.shtml).

### WSHA Weekly Report 2/6/09


**Health Work Force Institute Connects Hospitals to Welcome Back Center:** The Health Work Force Institute brought together human resources directors from 10 Puget Sound area hospitals and other health care organizations to discuss an innovative solution to expanding the pipeline for new employees and increasing diversity in area hospitals. The meeting centered around the Puget Sound Welcome Back Center based at Highline Community College, Burien. Welcome Back assists immigrants trained in health care in their country of origin to navigate their way to licensure, and a return to work in health care, in this country. The goal is to help these professionals re-enter the health care work force, even at an entry level, and gain the additional training and licenses needed to move up. For details, go to <http://welcomeback.highline.edu/>.

The group identified several areas for collaboration and partnership, including the creation of a database of internationally trained workers and their skill sets for use by hospital recruiters. The Highline program is the first of its kind in Washington, and there are efforts in place to expand Welcome Back Center services across the state. The hospital participants expressed excitement about the program because these are skilled workers who are already dedicated to the health care field. The Health Work Force Institute may offer additional regional forums to engage hospitals across the state in the implementation of innovative programs to address the health care work force crisis.

### California Health Care Foundation Briefings Newsletter 2/11/09

**Assessing the Impact of California's Nurse Staffing Ratios on Hospitals and Patient Care -- UCSF Center for California Health Workforce Studies:** In 2004, California began requiring that acute-care hospitals maintain certain minimum ratios between nurses and patients, making it the first state in the nation to do so. However, little is known about what effects the staffing ratios have had, either on the hospitals themselves or the quality of care they provide. This issue brief

examines how California's nurse staffing regulations affected different types of hospitals in order to probe what strategies were used to meet the ratio requirements; whether the ratios influenced hospitals' financial performance; and what effect they had on improving patient care. The research combined quantitative and qualitative analysis, including interviews with executives and other management staff at 12 acute-care hospitals. The results show that while the legislation has increased the use of registered nurses, the ratios have had no clear impact on the quality measures that are associated with nursing care. The study also found no relationship between the staffing regulations and the overall decline in hospital operating margins that occurred after the law went into effect. The full issue brief is available under Document Downloads below.

 [PDF Assessing the Impact of California's Nurse Staffing Ratios on Hospitals and Patient Care](#)  
(269K)

### **Kansas Hospital Association Capitol Comment 2/12/09**

**Health Care Pricing Transparency Bills Introduced:** Two bills have recently been introduced relating to health care pricing transparency. [House Bill 2288](#) would require a health care provider, upon a written request, to provide an estimate for the cost of any elective or non-emergency health care service. The proposed bill also allows the health care provider to include a disclaimer stating that the actual amount billed for the health care service provided may differ from the estimated cost provided. In addition, [HB 2290](#) was introduced in the House Taxation Committee. This bill would require health care providers and health insurance carriers to make available certain health care information. Each health insurance carrier would be required to release its negotiated medical rates with Kansas health care or medical care service providers. House Bill 2290 also would require each health care provider to make available its provider charges based upon the lowest insurance negotiated rate. Neither bill has yet been scheduled for a hearing.

### **LHA Impact Weekly 2/13/09**

**LHA Opposes the Employee Free Choice Act:** The LHA Board this week joined numerous other business leaders opposing The Employee Free Choice Act. Hospitals are under increasing pressure from federal and state governments, private insurers and consumers to ensure that the highest quality healthcare is delivered in the most cost-effective manner. Enactment of The Employee Free Choice Act would impose significant and unnecessary challenges for hospitals attempting to meet these goals. First, the bill would strip hospital employees of an American icon - the secret ballot. Second, the bill could lead to a government entity dictating the terms of a contract between the hospital and its employees – a harmful move for employer-employee relations. For more information, visit [www.MyPrivateBallot.com](http://www.MyPrivateBallot.com). The LHA will be sending updates and alerts to members in the coming weeks on this important issue.

### **Hospital Council of Northern and Central California February Council Connect 2/19/09**

**Report on the Laboratory Workforce Shortage in California:** The Healthcare Laboratory Workforce Initiative (HLWI), led by the Hospital Council, has released a new report, "California's Other Healthcare Crisis: The Laboratory Workforce Shortage."

In November 2007 the HLWI surveyed California hospitals about the shortage, its impact and how they are coping. More than 140 hospitals responded. The report analyzes the survey data and compares it to relevant state and national sources of information.

Here are the key findings from the report:

- The laboratory workforce shortage is persistent and severe. The vacancy rate for clinical laboratory scientists (CLS) in California hospitals is approximately 30 percent. It takes hospitals an average of six months to fill a CLS vacancy.
- California is not producing enough CLS graduates. In 2007, there were 119 CLS graduates in California. In 2008, the number was expected to increase to 125. It is estimated that in order to meet current demand, California would have to increase the number of new CLSs by 800 per year, a significant increase.

- California has a small number of training programs and a lack of capacity to train large numbers of students. California has only 13 CLS training programs and two approved medical laboratory technician (MLT) training programs, with class sizes of two to 30 students.
- There are too few hospitals engaged in training. According to the HLWI survey, hospitals that provide CLS training report retaining 50 percent to 100 percent of trainees. Yet, only 21 percent of hospitals actually have an existing relationship with a program.

The report recommends that hospitals take the following steps to help alleviate the laboratory workforce shortage:

- Provide clinical experience for students.
- Work with community colleges and universities to support and develop new CLS and MLT training programs,
- Educate our state legislature on the need for more state funding for training, and
- Help to increase public awareness and interest in laboratory science as a career option.

[Click here](#) for a full copy of the report.

### LHA Impact Weekly 2/20/09

**LHA Sends Letter Opposing Employee Free Choice Act:** LHA President & CEO John Matessino this week sent a [letter](#) to our congressional delegation opposing the Employee Free Choice Act (EFCA). This bill severely undermines long standing principles of balance and fairness in federal labor law. The legislation is a dramatic assault on the rights of employees and employers that threatens any chance for a constructive dialogue on labor law reform.

The EFCA bill has not yet been filed in Congress, but when it is filed, this bill will likely have broad support in the House and will come down to a very narrow margin in the Senate. Sen. Landrieu is a key senator on this issue, and we need to urge her to vote AGAINST cloture. Cloture is the only procedure by which the Senate can vote to place a time limit on consideration of a bill or other matter, and thereby overcome a filibuster. To end debate, the Senate needs 60 votes, and the unions have 58 or 59, depending on what happens in the Minnesota Senate race. The LHA will continue to update members on this important issue.

### California Hospital Association 2/20/09

**Applications Now Accepted for Health Professions Scholarships:** The Health Professions Education Foundation (HPEF) is currently offering several scholarship and loan repayment programs for students and professionals in the health care field.

The Associate Degree Nursing (ADN) Scholarship Program offers up to \$10,000 in funding for students accepted or enrolled in an accredited ADN program in California. The Allied Healthcare Scholarship Program offers up to \$4,500 per academic year in scholarships to students who are accepted or enrolled into the fields of diagnostic medical sonography, medical imaging, medical laboratory technology, occupational therapy, physical therapy, respiratory care, social work, pharmacy, pharmacy technician, surgical technician and ultrasound technician.

The deadline to apply for the scholarship programs is March 24. For more information, visit the HPEF website at [www.healthprofessions.ca.gov](http://www.healthprofessions.ca.gov), then "Applications."

## Oklahoma Hospital Association Hotline 2/25/09

**Workforce Center Launches New Web Site:** The Oklahoma Health Care Workforce Center launched a new permanent [Web site](#) this week. The Web site will be a valuable resource to all hospitals. If you have suggestions for ways the OHCWC can further enhance the site's usefulness, contact the Center's new project coordinator, Shayla Austin, shayla@ohcwc.com, (405) 319-8694.

## WSHA Inside Olympia 2/25/09

**Nurse Staffing Bills:** Last week, the House Commerce and Labor Committee passed two bills addressing hospital staffing:

- House Bill (HB) 1642 requires health care facilities to have scheduled, uninterrupted meal and rest breaks for employees. This is a significant change from the current practice of using intermittent rest breaks. No exceptions are included in this proposed legislation, even for patient emergencies. The bill also creates escalating penalties up to \$5,000 per violation. If enacted, the bill would be the first Washington State law dictating meal and rest breaks for any industry.
- HB 1680 amends the hospital mandatory overtime law to significantly limit the use of pre-scheduled on-call services. The bill also adds radiologic, cardiovascular, and surgical technologists and technicians to employees covered by the existing mandatory overtime law.

WSHA strongly opposes both bills and is concerned about the many adverse impacts the bills would have on patient care and hospital finances. We will continue to work to defeat them.

## Texas Hospital Association Capitol Update 2/27/09

**Lawmakers Urged to Invest in Nursing, Physician Education:** THA President/CEO Dan Stultz, M.D., FACP, FACHE, testified before the education subcommittees of the Senate Finance and House Appropriations committees this week. As chair of the Texas Nursing Workforce Shortage Coalition, Stultz explained the need for additional funding to increase registered nurse graduates. With the almost \$15 million in the base budget and an additional \$60 million investment, Texas could double the number of nurse graduates by 2013. Stultz pointed out that nursing jobs are "recession proof."

The coalition proposes to allow nursing schools with a proven record of increasing graduates to receive up-front funding. Other nursing schools could contract with the Texas Higher Education Coordinating Board to produce a specified number of new graduates, with funding linked to achieving specific benchmarks.

THA Board member Kirk Calhoun, M.D., president of the University of Texas Health Science Center at Tyler, testified regarding the need to increase/restore Medicaid funding for Graduate Medical Education. He pointed out that Texas is losing medical graduates to other states because of an inadequate number of residency slots at teaching hospitals.

## Texas Hospital Association Capitol Update 2/27/09

**Union-Backed Ratio Bill Filed; Nurse Days Planned:** At the request of the California Nurses Association/National Nurse Organizing Committee, the Hospital Patient Protection Act of 2009 has been filed in both chambers. Sen. Mario Gallegos (D-Houston) filed [Senate Bill 1000](#), and Rep. Senfronia Thompson (D-Houston) filed [House Bill 1489](#). The companion bills establish a mandatory nurse to patient ratio; the legislation is modeled on the staffing ratio law in California. CNA/NNOC is planning a nurse day at the Capitol on March 4.

The Texas Hospital Association and the Texas Nurses Association support [Senate Bill 476](#) by Sen. Jane Nelson (R-Flower Mound) and its companion, [House Bill 591](#) by Rep. Donna Howard (D-Austin). The legislation would put the existing nurse staffing regulations into statute, and require that a hospital's governing board ensure that the hospital has a policy, a nurse staffing committee and receive its reports at least twice a year.

[Senate Bill 476](#) is posted for a hearing in the Senate Health and Human Services Committee on March 3. The Texas Nurses Association will hold its nurse day at the Capitol on March 3. All of the activities next week are likely to generate media attention to the nurse staffing issue.

### Illinois Hospital Association e-Update 2/27/09

**Step Up Opposition To Hostile Bills:** With a key legislative deadline approaching, it is critical that the hospital community keep up the pressure in opposing bills on nurse staffing ratios (**HB485**) and postsurgical recovery centers (**HB976/SB1407**). The deadline for House bills to move from committee to the House floor is March 12. The House Health Care Availability and Accessibility Committee is expected to hold a hearing on **HB485** and **HB976** as soon as Tuesday, March 3.

**HB485** would impose mandatory nurse-patient staffing ratios more stringent than those in California. It is critical that state representatives hear from their hospitals about the harm that would be caused by ratios and how they are engaged in many efforts to provide an excellent workplace environment for nurses and to promote patient safety. Also, share with your representative the positive effects of your hospital's implementation of the Nurse Staffing by Patient Acuity Act and emphasize that staffing by acuity is the right approach.

**HB976/SB1407** would allow any postsurgical recovery center to become a licensed hospital without a Certificate of Need permit and without meeting all the requirements that hospitals must meet under the Hospital Licensing Act. Please tell your state representative and senator that allowing postsurgical recovery centers to become hospitals would compromise patient safety and that those specialty facilities won't do their fair share to support the health care safety net. In addition, there is no need for additional hospital beds in the planning areas where postsurgical recovery center permits have been granted, which already have an excess of more than 850 beds in those areas.

### Wisconsin Hospital Association Valued Voice 2/27/09

**Proposed MOT Legislation Fails to Address Key Issue: Employee Fatigue:** Worker fatigue is an issue that crosses many industry sectors, including health care, utilities, airline and transportation. In the health care industry, concern centers on patient and employee safety when employees work very long hours or very many hours. Wisconsin hospitals are working closely with their employees to develop evidence-based strategies to address the issue of fatigue. There is a growing amount of research on the topic which shows long hours and fatigue can impair judgment, put employees at risk of injury and patients at risk for errors.

"Our members are engaging their staff in discussions and developing policy on work schedules, the importance of arriving at work rested, allowing adequate time between shifts and taking scheduled lunch and breaks," according to Judy Warmuth, WHA vice president of workforce. "All are important strategies to address the issue of fatigue," she added.

The issue of fatigue, whether the cause is "mandatory" or voluntary hours (including long hours resulting from multiple jobs at different employers) demands an open conversation and creative solutions from all stakeholders, not narrowly-focused legislation or mandates, according to Warmuth. WHA supports constructive dialogue aimed at finding evidence-based strategies that ensure patients are cared for by staff that have not worked long hours, have had adequate time between shifts/jobs and can come to work rested, alert and safe.

WHA is concerned because a bill to ban mandatory—often unavoidable—overtime is now being circulated and will likely be introduced in the Legislature. If passed, this bill will restrict hospitals' ability to care for patients in circumstances of very high census or acuity, or unexpected/unanticipated staff absences, while failing to address the underlying concerns of employee fatigue. WHA has sent a memo to Wisconsin legislators on this issue. A copy of the memo is available at [www.wha.org/workforce/pdf/MOTlegMemo2-26-09.pdf](http://www.wha.org/workforce/pdf/MOTlegMemo2-26-09.pdf). WHA does not

believe mandatory overtime is an appropriate, or frequently used routine staffing strategy. However, in order to protect patients it must remain an option in 24/7/365 health care settings.

"Hospitals must have the tools to respond to unanticipated/unexpected patient care situations—our patients deserve nothing less. This legislation will make it more difficult to manage their care," according to Warmuth. WHA is a member of the Wisconsin Safety Partnership, a cooperative group of agencies and organizations, including OSHA, insurers, employers and the Department of Workforce Development, focused on worker safety. The partnership is working to educate employers and to develop strategies for a safer workplace for patients and employees. The WHA Board of Directors has endorsed a position that outlines the responsibilities of both employers and employees relative to fatigue ([www.wha.org/toolKit/fatigue.pdf](http://www.wha.org/toolKit/fatigue.pdf)). WHA has provided and will continue to provide education for its members on this topic.