

May 28, 2009

The Honorable Max Baucus
Chairman
Committee on Finance
U.S. Senate
Washington, D.C. 20510

The Honorable Charles Grassley
Ranking Member
Committee on Finance
U.S. Senate
Washington, D.C. 20510

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Dear Chairman Baucus and Ranking Member Grassley:

Trinity Health supports health care reform and is pleased that the Finance Committee is moving aggressively to achieve coverage and access for all in a cost-effective system of care. We appreciate the opportunity to provide you comments regarding the policy options contained in *Financing Comprehensive Health Care Reform: Proposed Health System Savings and Revenue Options*, released by the Senate Finance Committee on May 20, 2009.

Trinity Health is this country's fourth largest Catholic health system and is devoted to a ministry of healing. Our ministry encompasses 44 hospitals (32 owned and 12 managed), 379 outpatient clinics/facilities, 19 long-term care facilities, numerous home health and hospice programs and senior housing communities in seven core states. We employ more than 44,000 full-time equivalents, and our medical staff exceeds 8,000 physicians.

In 2006, Trinity Health developed a discussion document that includes the "Essential Elements" needed to achieve "coverage and access for all" in a cost-effective system of care. These Essential Elements are very similar to the eight principles that the Administration has committed to use as they work with Congress to transform and modernize America's health care system.

Using these Essential Elements, Trinity Health has been urging our nation's leaders to make comprehensive health care reform their top priority. Through our *Find a Way* Campaign, Trinity Health doctors, nurses and staff – those on the front lines of health care – have been asking Members of Congress and the Administration to ensure that everyone has quality, affordable health coverage in a coordinated, cost-effective system of care. *Find a Way* continues to build public support and momentum for comprehensive health care reform and emphasizes that everyone has a role to play. This effort has been coordinated with similar initiatives by the Catholic Health Association and the American Hospital Association.

We believe that "coverage and access for all" is both a moral and pragmatic imperative. Our work around health reform is reflective of our core beliefs that:

- Every person has inherent dignity and deserves respect
- Public policy should serve the common good
- Justice calls us to view health care as a basic human right
- Concern for the poor is a moral measure of society
- There must be a responsible stewardship of resources

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- Respect for pluralism should prevail for the religious and ethical values of patients and providers

We applaud your work to pursue responsible options to fund health care reform in a sustainable manner reflecting the principle of shared responsibility, where all stakeholders—government, providers, public and private payers, employers and consumers—are involved in the development of health care reform and assume a level of accountability in its success.

General Remarks

In our May 15 comments to the Committee regarding the Committee’s policy options paper on health care delivery system reform, Trinity Health expressed support for a number of quality-related reimbursement reform proposals designed to incentivize the provision of high quality care while reducing costs. In general, Trinity Health supports those concepts and has appreciated discussing our perspectives on these issues with Committee staff. Importantly, we believe that long-term, sustainable savings will be achieved through policies that produce incentives to improve performance and quality outcomes, not through discounting reimbursement.

Reducing payments to hospitals and health systems already in fiscal crisis will have far-reaching, negative consequences. In this time of recession, health care is a more stable employment sector than many others, and over the longer term, health care careers are an opportunity for displaced workers.

Trinity Health supports many of the Committee’s financing options to lower health spending or raise new revenue to fund health care reform. We commend the committee for evaluating proposals to look for new revenue streams, such as new lifestyle-related revenues and the tax exclusion for employer-provided health coverage, to fund needed investments in coverage and other health reforms. We also support the Committee’s proposals to expand the Medicaid drug rebate program and would encourage the Committee to extend that program to more hospitals and to inpatient services to lower the fast-growing pharmaceutical costs in hospitals.

However, we have concerns about a number of the proposals. Our financial margins have dropped significantly over the past eighteen months. Our average total Medicare margin for our hospitals is close to breakeven, and in many of our markets, our margins are negative. Significant cuts in Medicare reimbursement in any form would result in unintended and detrimental consequences for the communities served by Trinity Health hospitals.

Our hospitals are cutting services, scaling back or canceling projects including technological enhancements, and making tough decisions regarding reductions in staff. We are at a tipping point between how far reimbursement can be reduced and the continued capacity for hospitals to invest in the staff, programs, services, and infrastructure necessary to provide the quality care every community deserves.

This is not to suggest that we oppose making the system more efficient. As we explained in our comments to the Committee on health care delivery system reform options, Trinity Health supports enhancing the efficiency of health system delivery through standardizing practices and improving quality and outcomes.

Trinity Health supports the comments submitted to the Committee by the American Hospital Association (AHA) on these and other policy options contained in the Committee’s financing policy options paper. AHA offered recommendations for savings beyond those put forward by the Committee, including recommendations related to Congressional Budget Office scoring methods, and administrative simplification. Trinity Health, too, supports these ideas.

Trinity Health’s comments will address the following policy options put forward by the Committee:

- Health system savings proposals;
 - Annual Medicare marketbasket updates;
 - Updating payment rates for inpatient services;
 - Graduate Medical Education payments;
 - Disproportionate Share Hospital payments;
- Tax-exempt hospital status; and
- Tax-exempt hospitals and health care reform.

Health System Savings Proposals

Annual Medicare Marketbasket Updates

One of the Committee’s policy options is to reduce or eliminate marketbasket updates to hospitals and continuing care providers. Trinity Health strongly urges the Committee to maintain full marketbasket updates to hospitals and continuing care providers, which are facing significant fiscal challenges in part because of inadequate Medicare reimbursement.

Annual Medicare marketbasket updates to hospitals and continuing care providers are designed to capture the rate of cost increase for certain categories of goods and services efficient providers must purchase for the provision of care. The update framework used by the Secretary of Health and Human Services to project the next year’s marketbasket adjustment and by the Medicare Payment Advisory Commission (MedPAC) in its analysis of the appropriateness of the update, does not adequately capture cost increases. The framework does not take into account the cost of the introduction of new goods or services; nor does it capture in a comprehensive fashion all necessary hospital and health system spending. Additionally, the update framework does not sufficiently address the astronomical costs associated with the procurement, ongoing maintenance, and necessary upgrades to health information technology (HIT) systems.

Trinity Health encourages the Committee to view the Medicare marketbasket update policy option in the more holistic way the Committee has approached the complex subject of health reform itself—by recognizing and accounting for the interconnectedness of key policy areas.

Medicare and the fiscal impact of its policies cannot be viewed in isolation. With Medicare margins approximating breakeven, representing more than 40% of all inpatient days, hospitals and health systems cannot sustain Medicare reductions. Such cuts would lead to serious, negative effects on communities across our seven states.

While the marketbasket update is intended to reflect cost increases, it has taken on more complex functions. In recent years, receipt of a full marketbasket update for hospitals and home health agencies is not simply related to increased costs for the provision of care. Per legislated changes, receipt of a full

update now also functions as a financial incentive related to quality reporting and will soon be linked to hospital adoption and use of HIT. Hospitals and home health agencies that fail to successfully submit quality data to the Centers for Medicare and Medicaid Services are subject to a two percentage point reduction in their marketbasket update. In 2015, hospitals that have not yet achieved the status of a “meaningful user” of HIT will have their marketbasket all but eliminated. In short, the marketbasket update functions no longer as an independent variable that can be altered to achieve budget savings—it is also a financial incentive to achieve quality and HIT goals.

Trinity Health believes the marketbasket update is necessary and should fulfill its original function: providing an increase in reimbursement to account for inflation in the costs associated with delivering care. Recently, the marketbasket’s purpose has evolved to become a tool to incentivize the adoption of valuable policy goals. Therefore, across-the-board marketbasket cuts would obfuscate the quality and HIT incentive goals.

Updating Payment Rates for Inpatient Services

Graduate Medical Education Payments

Our teaching hospitals rely on support from the Medicare and Medicaid Graduate Medical Education (GME) programs for the pursuit of the public good of training physicians and other health care providers. Within the seven states served by Trinity Health hospitals and across the country a dearth of physicians of many varieties—from primary care, to general surgery—threatens our ability to serve our communities. The character of the shortage varies by community, both urban and rural.

Projections show the physician shortage worsening over time. As coverage increases through comprehensive health reform, a greater need for physician services will take hold. Supporting the training mission of teaching hospitals and academic medical centers is more important than ever.

Any reductions in GME support for teaching hospitals and academic medical centers (many already deficit-fund the training of tomorrow’s physicians) would leave little incentive for these institutions to increase the physician pool. As we struggle to fulfill our mission of training physicians and providing sophisticated and safety net care to their communities, our teaching hospitals are on an unstable financial footing.

Trinity Health supports the concept the Committee put forward in a prior policy options paper of increasing the number of Medicare-funded Graduate Medical Education (GME) medical resident slots through the redistribution of currently unused slots to help address the shortage.

Trinity Health urges the Committee to reject any policy option that would reduce federal financial support for the Medicare and Medicaid GME programs. Indeed, the federal commitment to the public goods provided by teaching hospitals and academic medical centers is critical to our nation now and increasingly important as the Committee takes steps to expand health care coverage to more Americans. Health care reform cannot succeed without a sufficient number of well-trained health care professionals.

Disproportionate Share Hospital Payments

Trinity Health urges the Committee to maintain current DSH funding levels critical to ensuring that safety net hospitals are adequately supported, to provide comprehensive care to their most vulnerable patient populations and to continue to provide specialty services for all in their communities. DSH

payments are a lifeline for hospitals that provide significant levels of care to Medicare, Medicaid, and uninsured patients.

Even if significant coverage expansions are achieved through health care reform, there will be populations that will remain uncovered or underinsured, and hospitals will be asked to bear the burden of their health care and essential community services. Trinity Health recommends that the Committee reject reductions in federal support for DSH programs until coverage expansions are universal and fully implemented and Medicare and Medicaid payment shortfalls are addressed.

Tax-exempt Hospital Status

All Trinity Health acute care hospitals are Catholic, not-for-profit hospitals. Organized under Section 501(c)(3) of the tax code, not-for-profit hospitals are generally exempt from federal income tax, are eligible to receive tax-deductible contributions, have access to tax-exempt financing through state and local governments, and generally are exempt from state and local taxes. Since 1969, the Internal Revenue Service has applied a “community benefit” standard for determining whether a hospital meets its charitable, not-for-profit mission.

The Committee is considering policy options that create new organizational and operational requirements for determining whether a hospital is a charitable organization for purposes of section 501(c)(3) tax-exempt status. These include requiring not-for-profit hospitals (1) to conduct a community needs analysis; (2) to provide a minimum annual level of charitable patient care; (3) not to refuse services based on ability to pay; and (4) to follow certain procedures before instituting collection actions against patients.

All of these proposals are either redundant or premature. Next year, in an unprecedented national effort, the IRS will begin collecting information from not-for-profit hospitals on the benefits they provide to their communities and the policies and programs they employ to do so in a single document called “Schedule H.” That form will give policymakers much more complete information on which to make important decisions about whether the current requirements for tax-exempt status need to be updated. All of the areas encompassed in the Committee paper are contained in Schedule H.

1. Conduct a community needs analysis

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

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

2. Provide a minimum annual level of charitable patient care

Trinity Health believes it is neither necessary nor advisable to set a national benchmark for charitable patient care for the following reasons:

- Charity care is neither the best nor the most efficient way to serve low-income persons in our communities. Charity care is often described as “reactive care.” A person receiving charity care is often admitted to the emergency room with a condition that could have been treated earlier through proper primary care. The cost of charity care is often higher than primary and preventive care. The human cost is high as well, since people receiving charity care are often dealing with advanced stages of an illness or an improperly managed chronic illness.
- Setting a minimal level of charity care is premature. While there will still be persons in our communities who need help accessing needed care and services, the health reform measures that the committee enacts will have a distinct – but unpredictable - impact on how many persons will need charity care and for what services.
- Community need differs from state to state and from community to community—a sufficient charity and community benefit expenditure in one area may be insufficient in another. Medicaid, employment levels, insurance status, income and other socioeconomic factors all have a role in community need.
- Focusing on how much is spent on charity care and other community benefit activities diverts attention from the real health improvement issue. Low-cost programs can have more far reaching impact than higher cost programs. Facilities are working to avoid high-cost charity care in their emergency rooms by reaching out to patients before their conditions reach an acute stage and developing programs to manage chronic illness and prevent illness. Looking at charity care expenditures would not capture the value of these initiatives.
- The better question to ask is: What is the **impact** hospitals are having on the health of their communities? We believe that community benefit reports (which most hospitals prepare) and the new Schedule H will give hospitals opportunities to answer this question and to more fully describe the value they bring to their communities.

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

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

Trinity Health, along with CHA, do believe however that a not-for-profit hospital should have written charity care policies, approved by the governing body and updated periodically. The CHA *Guide* offers a checklist for charity care/ financial assistance policies. Another resource

for hospitals is the Health Care Financial Management Association Principles and Practices Board Sample Hospital Charity Care Policy and Procedures. (www.hfma.org)

4. Follow certain procedures before instituting collection actions against patients

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

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

Tax-exempt hospitals and health care reform

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

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

- Participating in public means tested programs for low-income persons. Community benefit includes serving Medicaid patients and users of other means-tested public programs because these programs pay providers significantly below cost. Without this benefit, enrollees of these public programs could experience problems accessing the health care system and the care they need.
- Providing services that improve community health, such as health education (disseminating information on diseases and healthy lifestyles), community-based clinical services (mobile clinics, immunization programs), and health care support services (case management, enrollment in public programs).

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- Educating health professionals, through basic and graduate educational programs for medical, nursing, and other health professionals and contributing to the knowledge of health professionals throughout the community.
- Subsidizing services needed in the community by continuing (OR offering) needed programs and services despite a financial loss. Research at the University of Michigan Law School has demonstrated that unprofitable services are much more likely to be provided by nonprofit tax-exempt organizations. These include emergency psychiatric and other mental health services, HIV/AIDS treatment, alcohol and drug treatment, burn units and trauma services. (“Making Profits And Providing Care: Comparing Nonprofit, For-Profit, And Government Hospitals by” Jill R. Horwitz, J.D. PhD, *Health Affairs*, May/June 2005.)
- Conducting research to improve clinical care, health care delivery or community health. This would include research sponsored by government or nonprofit entities.
- Addressing the root cause of health problems. A person’s socio-economic status and environment has a greater impact on his health than direct medical care. Community benefit programs impact other factors that contribute to health when they address problems related to housing, poverty, environmental hazards, the availability of nutritious food and other determinants of health.

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

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

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

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

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

- Tapping community and other philanthropic resources to fund community health programs and provide capital for needed projects.
- Keeping resources in the community by using any excess revenue to provide services and make facility improvements. The IRS Revenue Rule 69-545 refers to this benefit when it describes a

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hospital whose "excess funds are generally applied to expansion and replacement of existing facilities and equipment, amortization of indebtedness, improvement in patient care and medical training, education and research."

- Promoting health and disease prevention. For example, many not-for-profit hospitals are tracking the occurrence of ambulatory sensitive conditions, which are those ailments that could have been treated earlier if primary care services were available. Hospitals use this information to form community partnerships that deliver primary care, preventive services and case management to people in the community that need them. This effort not only improves the lives of those without adequate access to primary care but also helps to reduce health care costs.
- Addressing the root causes of community health problems and preventing the need for emergency and acute care services. As discussed earlier, this includes health promotion and disease prevention programs, increasing access to primary care, and activities addressing social determinants of health such as poverty, education, a clean environment and housing.

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

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

Concluding Remarks

Trinity Health applauds the Committee's work on health care reform. It is our belief that legislation needs to address the interrelated components of health reform in order to achieve coverage and access for all in a cost-effective system of care. As legislation is advanced through the normal channels to Congressional approval, we would encourage you to ensure that final legislation is both comprehensive and integrated – and that it achieves the imperative for a health system that meets the needs of all Americans.

We will be doing our part, too, by engaging our grassroots network to reach out to members of Congress representing more than seven states and multiple Congressional districts. Trinity Health has been advocating for systemic health care reform for over two years and we believe that our voice is more important than ever.

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We welcome the opportunity to work with the Senate Finance Committee and its staff to strengthen the ideas presented in its series of option papers. Please let us know if we can provide any additional information based on our efforts to reform health care locally while we advocate for reform nationally.

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