Communities in Charge: Financing and Delivering Health Care to the Uninsured

Addressing Key Constituencies for Generating Political Will Community Resources

Summary of October 10-11, 2001 Cluster Meeting
Cleveland, Ohio

On October 10-11, 2001, representatives from the fourteen communities receiving Phase Two *Communities in Charge* grants convened for the second of several planned cluster meetings. The purpose of the cluster meetings is to provide an interactive and educational forum for *Communities in Charge* project leaders to explore a single topic area. The communities select the topic to be discussed based on its relevance to the design and implementation of a coverage program for the uninsured.

Approximately twenty-one representatives from the Phase Two grantee communities gathered in Cleveland, Ohio on October 10-11, 2001 to discuss strategies for garnering political will and resources from key community leaders, including elected officials and health system executives.

This summary document presents the shared findings from the seminar and offers a brief summary of the issues discussed.

OVERVIEW

Given the demands that the average low income, uninsured citizen must contend with on a routine basis, it is difficult for this sector of the population to form a strong constituency and garner political representation. It is equally challenging for the uninsured to access the funds needed to hire knowledgeable advocates to work on their behalf within the political system. While many coalitions and advocacy groups representing low income, uninsured person may have the funds to hire lobbying talent, their attention is typically focused on helping the uninsured meet other daily challenges.

In order to access and engage key political stakeholders, advocacy groups for the uninsured must come together to lean how the political system works, identify the incentives that spur key stakeholders to action, and determine how to *get on* and *stay on* the political agenda.

The purpose of the cluster meeting was to address this learning process and to help the participants understand how to inform and influence key stakeholders. The cluster meeting was divided into three components:

?? A Political Simulation Game. An interactive, computer-based exercise which provided participants, working in small groups, with an appreciation of the decision-making challenges and trade-offs required when holding political offices.

?? Presentation by the panel of Elected Officials, Legislators and Key Aides listed below:

Representative Mary Lou Anderson
Kentucky State Representative

Ree Sailors
Executive Policy Advisor to the Governor of Washington

Jack Tighe
Communities in Charge National Advisory Committee Member and former Chief of Staff to the Governor of Pennsylvania

Tim Hogan
Former County Commissioner, Cuyahoga County (Cleveland), Ohio

?? Presentation by the panel of Senior Hospital/Health System Leaders listed below:

Dean Smith
Professor, Health Management & Policy – University of Michigan

Pat Hayes
Chief Executive Officer, Seton Health System – Austin, Texas

Warren Kessler
Former Chief Executive Officer, Maine General Medical Center, Augusta, Maine, Current Director, CarePartners, Portland, Maine

Doug Elwell
President, Marion County Health & Hospital Corporation, Indianapolis, Indiana

The following sections summarize key learnings from the meeting.

SUMMARY OF KEY LEARNINGS

1. **Develop a clearly articulated vision, strategy and a precise near and long-term plan before approaching a key political figure. Know and be able to concisely describe what it is that you want from a political figure and why. Recognize that substantial system change is often most effective and long-lasting when accomplished on an incremental basis.**

   The political process in the United States is defined by incremental transformation. Since change is slow, advocacy groups must develop a long-term vision and must outline the action steps for achieving their vision. In particular, an advocacy group must be prepared to answer the following questions when pushing for health care coverage expansion: 1) How much will be proposed program cost? 2) How will you pay for it – e.g., through a new tax or other revenue generating mechanism, or through re-allocating existing funding?

2. **Know how the political system and budgeting process works.**

Advocates for the uninsured must remember that healthcare is still considered a "giant killer." There are no easy answers for a politician to embrace, and there are numerous constituencies vying for representation. Education remains the number one priority on the political agenda and the voting public is willing to spend their dollars to this end. Therefore, advocacy groups for the uninsured must figure out a way to work within the established system to achieve their intended objectives.

Given that politician must address multiple worthy causes within a limited budget, the key for advocacy groups is to determine how limited funding can produce the greatest results. Part of this process is justifying the displacement of funds from other programs in order to fund the program under discussion.

It is wise for advocacy groups to understand the difference between "cost savings" and "cost avoidance." Most government officials are concerned with "cost savings" – understanding how money saved from a particular program can be utilized in some other area. Since all levels of government, and most not-for-profit health systems, are caught in a budget crisis, funding is of primary concern among political figures. Therefore, while many leaders may agree with an advocacy group in principle, the bottom line is program funding. Hospitals, however, support "cost avoidance." For example, the emergency room and intensive care unit are the most utilized and most expensive departments in a hospital. They are also where most uninsured patients end up. "Emergency room relief" involves cost avoidance and, thus, motivates hospital executives.

3. **Understand what motivates targeted community leaders and identify their particular "issues."**

Paul Gionfriddo, the Executive Director of Indigent Care Coalition (ICC) in Austin, Texas, facilitated the Political Simulation Game. The objective of this game was to help the participant's understand the policy process from the perspective of the elected leader, recognize his/her conflicting roles, and encourage the group to appeal to the leader's particular bent.

All hospital chief executives typically want to have a seat at the table and to have their voice heard. It is important for an advocacy group to recognize that the executive of a hospital is primarily concerned with the time commitment necessary to make the proposed initiative work, as opposed to the amount of money that the project requires. Time is the most valuable commodity.

4. **Advocacy groups have a responsibility to educate community leaders and the general public.**

Most elected officials have limited knowledge of health care policy and need experts to clarify their understanding of issues. An advocacy group will carry more weight if it can find ways to help the elected official and aid in his/her understanding of the "big picture."

From a practical standpoint, it is important for advocacy groups to present ideas in a straightforward and clear manner. The proposal should not exceed one page in length and graphics can be sued to enhance text. The groups should be sure that the document is easy to read given a politician's limited time.

5. **Start educating an elected official as early as possible. Get the leader's attention – contact, contact, contact!**

   It is important for the advocacy group to get the issue on the candidate's platform as early as possible. If the group starts early enough, it may be able to assist the politician (who earns credit for developing the program) *and advance* its own mission. Once the politician is in office, the advocacy group can hold the official to his/her promise. If the advocacy group waits until the politician is in office, it is often difficult to push the issue through given the politician's increasing constituent demands.

   Also, the advocacy group should not wait to approach an elected official. By the time the legislative session begins, the decisions have already been made. Legislators can be influenced when the discussion is still in committee – not immediately preceding the floor vote.

6. **Pull together multiple constituents to develop a strong coalition.**

   Advocacy groups have a tendency to "preach to the choir" and simply talk to one another, as opposed to pooling each other's resources and exercising more political clout. It is essential that groups engage in the tough dialogue with those holding differing opinions because compromise is an essential part of passing legislation. While a coalition of advocacy groups might have to compromise on some points, collectively the groups will be able to wield greater political power.

   Finally, encourage other advocates to support the particular cause, such as a newspaper editor or local official. Additional voices strengthen the group's position.

SUMMARY OF KEY LEARNINGS SPECIFIC TO HOSPITAL CONSTITUENCIES

1. **Recognize that hospitals operate within a challenging fiscal environment.**

   It is important to recognize that hospitals face fiscal constraints that impact their ability to support programs for the uninsured. Hospitals are not "cash cows" that have unlimited funds for new program creation. They face real fiscal pressures that result in lower operating margin, tight cash flow and limited available funds to support new coverage initiatives.

   In recent years, the following factors have influenced hospital financial stability:

   - ?? Hospital "profits" are down – national studies estimate a reduction in operating margin from almost 7% in 1998, to 3.5% in 2002. Government payers and regulators have generally accepted this trend, since reimbursement cuts are largely responsible for the decreasing profits.
   - ?? Running a hospital is a tough, low-margin business. Revenues are down due to cutbacks resulting from the Federal Balanced Budget Act, costs associated with Y2K systems updates, significant expenses for compliance with the Health Insurance Portability and Accountability Act, and increasing professional and administrative expenses.

?? In recent years, pharmaceutical expenses have gotten the most press coverage for having the highest growth rates in cost and expense. However recent national data demonstrates that hospital costs account for *the* highest medical cost inflation rates.
?? Like most individuals whose retirement investment accounts have suffered as the stock market has "adjusted" downward and the national recession has grown, hospital investment income (on which most institutions rely for significant resources) has also declined.
?? The market economy and the elimination of several "Certificate of Need" review and approval procedures have resulted in the growth of freestanding surgery centers – an 18% increase in the past two years. As for-profit entrepreneurs develop these delivery centers, these facilities tend to take away profitable niche markets from hospitals.
?? The growth of managed care (even though it is ebbing in recent years has placed significant pressures on hospitals to reduce costs, shorten length of stays, eliminate licensed but empty beds, and reduce staffing levels. The result has been a decrease in revenues and lower profit margins.
?? The impact of nursing shortages has increased staffing costs since hospitals must maintain existing levels of services.

2. Understand that hospitals face growing administrative challenges.

Hospitals continue to confront increased regulatory oversight. The amount of paperwork that must be completed for administrative and regulatory purposes has increased. It is estimated that one hour of emergency room services requires one hour of follow-up paperwork, and forty minutes of paperwork for each hour of inpatient care provided.

3. Consider promoting the concept of community benefits reporting.

Most hospitals are organized as non-profit corporations and are eligible for various forms of tax relief since they also qualify as charitable 501 (c) (3) corporations. Consistent with the historical origins of hospitals as almshouses for the impoverished sick, the IRS initially required hospitals to provide free care "to the extent of their financial ability." Over time, the IRS has loosened its requirement that hospitals provide free indigent care. Hospitals' "promotion of health" was recognized as a charitable purpose and automatically qualified them for tax-exempt status. Several recent legal challenges and IRS opinions have tightened standards for charity care. Consequently, hospitals are increasingly being required to provide evidence that they serve a "community benefit" by delivering services to the indigent.

In a March 9, 2001 memorandum, the IRS decided that a hospital's stated policies to provide health care services to the indigent were not enough to satisfy the charity care requirement of the community benefit standard. Instead, the IRS required that hospitals show the actual health care services provided to the indigent. While this did not establish specific "community benefit" reporting requirements, it did provide guidance for tracking the charitable care policies and activities of a hospital. The following are criteria used to evaluate a hospital's level of charity care.

?? Does the hospital have a specific written plan for the indigent care, and does it broadcast the terms and conditions of its charity care policy to the public?

?? Does the hospital maintain and operate a full-time emergency room for all persons regardless of their ability to pay?
?? Does the hospital maintain separate detailed records about the number of times and circumstances under which it provides free or reduced-cost care to the poor?
?? Does the hospital maintain separate accounts on their books that segregate the cost of providing free or reduced care to the poor?

In response to the concerns of patients and local advocacy groups, some states have taken an aggressive approach to ensuring that not-for-profit hospitals provide community benefits and a minimum amount of free care to the poor. In doing so, the hospital then qualifies for tax-exempt status. Several states are passing "community benefit reporting" legislation that requires private, non-profit hospitals to assess community needs, develop plans to address priorities, and report on community benefits.

One example is California's Hospital Community Benefit Program, the result of legislation passed in 1994. The enabling legislation stated that private, non-profit hospitals "assume a social obligation to provide community benefits in the public interest" in exchange for their tax-exempt status. Under the community benefit legislation, a private non-profit hospital in California is required to:

?? Conduct a community needs assessment every three years
?? Develop a community benefit plan in consultation with the community
?? Submit a copy of its plan to the Office of Statewide Health Planning and Development on an annual basis

4. The first, second and third issues for success – Personal Relationships.

Much like working with elected officials, it is critical to develop, build and maintain relationships with key officials of hospital systems (including senior management and members of Boards of Trustees).

5. Take advantage of existing programs.

Before trying to influence hospital system leaders to support new programs or contribute resources, be sure to get what you can out of the current system. Nationally, Medicaid and S-CHIP enrollment levels are too low. Current studies indicate that as many as 40% of individuals eligible for coverage in existing public programs are not enrolled. Therefore, community consortia can conduct outreach efforts to complement the enrollment work of hospital systems, as opposed to requesting additional resources. Such an approach may foster a solid working relationship, which may lead to future initiatives.

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