

CMS Directive Restricts SCHIP Coverage

On August 17th, the Centers for Medicare and Medicaid Services (CMS) issued a directive to State Children's Health Insurance Program directors bypassing the legislative process and altering the practices that have governed SCHIP for the last ten years. The directive introduces eight new restrictions and conditions on states' abilities to cover children over 250% FPL and limits the flexibility states have to design their programs effective August 17, 2008.

The directive asserts that states meet several conditions before they can cover children in families with incomes above 250 percent of the federal poverty level. One condition is that states must prove they are covering 95 percent of the children whose families are at 200 percent of poverty level—\$42,400 for a family of four. A second condition asserts that private employer-based coverage in the state has not declined by more than 2% over the last five years.

If states can satisfy these two requirements, they may provide coverage to children over 250% FPL. However, a second layer of the directive imposes two additional conditions: (1) children must be uninsured for an entire year before they are permitted to enroll and (2) out-of-pocket costs must equal the maximum allowed by SCHIP (5% of family income) or no less than they would pay for private coverage minus 1% of family income.

Implications for California

If the directive were to be met in California, approximately 34,000 kids could lose coverage. The directive may also affect the state's ability to expand coverage to thousands of children up to 300% FPL, as supported by the Governor and other key policymakers. It is also unclear whether California could meet the 95% participation rate provision as the August 17th letter did not indicate what data standard would be utilized. Additionally, enrollment levels fluctuate throughout the year and are impacted largely by changes in the economy. The requirement that 95% of eligible children must be enrolled is unrealistic. Studies have shown that in a given year over 10%—more than 300,000 children—fall off the Medi-Cal program, only to return a short time later (see

Churning and Racial Disparities in Medi-Cal available through www.calendow.org). The Governor's cuts to last year's budget for outreach and enrollment services in California made it even more difficult to sign up eligible, but unrolled children to meet the 95% participation condition. Finally, the directive will result in increased administrative costs at the state and local levels. The costs of making the necessary changes to enrollment systems, applications and eligibility would be significant.

The Push Back

Children and families are counting on Congress to fix this problem by suspending the implementation of the CMS directive. Several lawsuits have already been filed on behalf of states and advocates are being urged to contact their representatives. For more information, please visit www.mrmib.ca.gov/MRMIB/SchipBackground.html.

Medicaid Regulations Cost California

In 2007, CMS issued seven key regulations that would impact federal Medicaid policies and payment. The new federal rules could reduce funding for California services by nearly \$11 billion dollars over the next 5 years. Along with the \$16 billion California budget deficit, the new regulations have the potential to devastate the fragile healthcare and safety net system that thousands of people statewide depend on for healthcare. Many of the temporary bills Congress passed to delay the effective date of some regulations will expire in May or June 2008. Two new bills were recently introduced (HR 5613 and S 2819) that are also intended to postpone or block the regulations.

Under the regulations, providers and schools would lose significant funding for vital health services. The proposed rules would cut preventive outpatient care at hospitals and clinics, payments to safety net hospitals, and coverage expansion programs in 10 counties. In all more than \$1 billion per year would be lost by clinics, schools, and hospitals to provide care to Medi-Cal and the uninsured. These cuts would be disastrous to the healthcare system and could force hospital closures, increased ER usage, and higher healthcare costs. \$540 million annually for improving the quality of and access to nursing homes and centers for the developmentally disabled would no longer be available.

Other beneficial programs and services would also be hit hard. More than \$1 billion annually would no longer be available for prenatal care, alcohol and drug treatment, adult day healthcare, dialysis, mental health, and independent rehabilitative centers. Over \$100 million would be lost for Medi-Cal outreach and enrollment and medical transportation at schools.

The California Department of Health Care Services has prepared a matrix that analyzes the program and fiscal impacts of the seven regulatory packages proposed by CMS on California Medicaid programs. The matrix is available through LA Health Action at http://lahealthaction.org/index.php/library/full_entry/1535/

Legislation to Watch

Healthcare Quality and Access

AB 2400: Hospitals: closure. (Price)

AB 2400 is intended to help address the problem of hospital closures. This bill would require that prior to closing a general acute care or psychiatric hospital or prior to eliminating the level of health services provided, a hospital would provide notice regarding the proposed changes to the public and the applicable administering department. The bill would also require that 18 months after implementing any changes, the hospital would report their impact. *Status:* Re-referred to the Assembly Committee on Health to be heard on April 15th.

AB 2741: Hospitals: management requirements. (Torrico)

This bill requires hospital transactions not regulated by the Attorney General to undergo a health impact analysis by the Department of Public Health. The analysis would determine the impact on accessibility of healthcare services to the surrounding community and if the transaction is in the public interest. The law would apply to for-profit and district hospitals. *Status:* Passed the Assembly Health Committee and referred to the Appropriations Committee on April 2nd.

AB 2942: Hospitals: community benefits. (Ma)

This bill will would eliminate existing California law on hospital benefit reporting (SB 697) and replace it with law that requires reporting for all hospitals and certain non-profit clinics. The bill eliminates Medicare shortfalls and bad debt as community benefits, requires broader consultation with the community, and requires computation of the value of “free” and discounted care. *Status:* Re-referred to the Assembly Health Committee on April 3rd.

AB 2967: Healthcare cost and quality transparency. (Lieber)

This bill would create the California Health Care Cost and Quality Transparency committee to collect medical data to assess the quality of care provided by hospitals, physicians, healthcare providers, and health insurers. The quality assessments would be framed in the context of the providers' charges. The Committee would develop a plan to improve medical data collection and reporting practices. The bill would also require the Committee to implement strategies to improve healthcare quality and meet related requirements. *Status:* Set to be heard in the Assembly Health Committee on April 8th.

SB 1058: Health facilities: bacterial infections. (Alquist)

SB 1058 requires hospitals to collect information about infections, report their infection rates and screen patients for MRSA, a dangerous antibiotic resistant infection. The bill would require health facilities to implement procedures to screen every patient scheduled to undergo an inpatient or outpatient surgery, or who is admitted to an intensive care unit, burn unit, or other unit at high risk for the presence of MRSA. The bill would require additional information on wound care and ways to prevent the spread of MRSA to patients who test positive for an infection to stop its spread to other patients and from moving into the community. *Status:* Passed Senate Health Committee and referred to Appropriations on April 2nd.

SB 1522: Healthcare coverage: coverage choice categories. (Steinberg)

SB 1522 would require the departments of Managed Health Care and Insurance to sort health insurance policies into five coverage categories that meet specific requirements, ranging from “comprehensive” to “catastrophic.” Organization of plans into these categories would enable consumers to better track premiums, benefits and cost-sharing, and make it easier for consumers to compare plans. It would also set minimum benefit standards and therefore protect consumers from plans that do not provide adequate coverage. *Status:* Re-referred to the Senate Health Committee and set for hearing on April 9th.

Community Health

SB 1420: Food facilities: nutritional information. Menu Labeling. (Padilla)

This bill requires each food facility in the state that is part of a chain to provide nutritional information as part of their menus. *Status:* Passed the Senate Health Committee

and scheduled for a hearing in Senate Appropriations on April 14th.

AB 2572: Menu labeling. (Parra) Oppose

This bill codifies existing menu labeling practices into law. Chain restaurants would be allowed to provide nutritional information to consumers in ineffective formats such as brochures, tray liners and electronic kiosks. The bill would pre-empt local government from enacting local menu labeling ordinances and would also nullify any existing menu labeling ordinances. *Status:* Set for hearing in the Assembly Health Committee on April 8th.

AB 1472: Public health: California Healthy Places Act. (Leno)

This bill would charge the California Department of Public Health to provide technical assistance and grants to local public health agencies and community organizations to evaluate land-use planning decisions to ensure that they create communities that promote health. *Status:* In Senate Appropriations and held under submission.

AB 2474: Obesity prevention. (Galgiani)

AB 2474 requires the Department of Health to establish a program to implement recommendations for improvement identified in the California Obesity Prevention Plan (requirements of DHS in 2005), which would establish a systematic approach to tracking the health impacts of obesity and evaluating prevention programs. *Status:* Passed out of Assembly Health to Appropriations on April 2nd.

SB 1165: Environmental protections. (Kuehl)

This bill requires local government agencies to make available to the public early drafts of environmental reports. It requires additional environmental review and public comment for any environmental impact report more than 5 years old. *Status:* Re-referred to Senate Environmental Quality on March 28th.

City of Los Angeles

Fast Food Interim Control Ordinance (Perry/Parks):

Prohibits establishment of new fast food restaurants for up to 2 years in Council Districts 8 and 9. *Status:* Legal counsel review.

Pacific Hospital Heads List to Operate MLK

Supervisor Yvonne Brathwaite Burke recently told the *LA Times* that Pacific Hospital of Long Beach is the leading candidate to operate King-Harbor Hospital when it

reopens in February 2009. Pacific's proposal is to initially open MLK with 77 beds.

The *Times* reported that three obstacles remain to finalizing the contract:

- the number of uninsured patients the hospital would take and how much the county would pay for treatment
- the role the University of California system would play at the hospital
- whether Pacific, a non-union hospital, would be required to hire union workers.

Community Criteria

CHC, together with advocates from community- and faith-based organizations, clinics and physicians, has also asked that potential operators demonstrate their ability to maximize funding; carry out a mission closely matched to former MLK Hospital's to serve poor, uninsured, and underserved residents needing healthcare; provide culturally competent, quality healthcare services and accountability standards with which to measure performance; make a long-term commitment to provide care; and establish a community advisory board. It is also recommended that the Board of Supervisors allow the community to participate in the selection of the operator/owner and define the governance structure for communication and ensuring accountability between the Board and operator/owner.

Services Report

LA Health Action on March 28th released their report that detailed the decline in medical services for South LA and offered several recommendations to ensure an adequate supply of needed primary and specialty services. The recommendations include using Public Private Partnership (PPP) clinics to fill the current outpatient gap; allocating expanded resources to community clinics; improving outpatient-care data gathering and reporting. The full report, "Examining County-Funded Outpatient Service Declines in South Los Angeles," is available in their Issues Library at <http://www.lahealthaction.org/>.

**FOR MORE INFORMATION, CONTACT
COMMUNITY HEALTH COUNCILS
323.295.9372 • INFO@CHC-INC.ORG**