OBAMA'S TAKEDOWN OF HEALTH CARE

The U.S. Public Hospital System Is Being Destroyed

by Marcia Merry Baker

Nov. 16—The extent of downsizing and closures underway and pending in the U.S. medical system, centered on hospitals, is threatening to end public hospital service for huge parts of the nation, and upping the death rate for mass numbers of people—genocide.

Below is a short list of some of the multiple areas of Wall Street/insurance company/Obama assault on what remains of the U.S. hospital system, as summarized from current fact sheets by the American Hospital Association (www.aha.org).

Also noted are several of the many bipartisan expressions of protest against the devastation underway, which will go nowhere without getting Obama out of office, reinstating Glass-Steagall, and building an economy, with a real health-care system.

The immediate cause of crisis in hospital and related services—logistics, staff, diagnostics, treatment, and training—are the cuts in Federal funding mandated by Obama's 2010 Patient Protection and Affordable Care Act (ACA/Obamacare), focussed on, but not limited to, cutting care for the old and poor, that is, Medicare and Medicaid. Some of these cuts went into effect last year, some are going into effect right now (FY 2014, which began Oct. 1), and more are set to take effect in the coming months.

The contrived excuse given in 2009-10 is that there would be "universal coverage"—health care for all, paid for by cutting $500 billion over 10 years from Medicare payments to hospitals and doctors, and another $200 billion in additional cuts—which, it was asserted, would come from ending "excessive" care and "overtreatment."

The designers of the ACA—the Wall Street insurance sector and the White House—knew that they were imposing a corporatist system, in which the government and the private sector join forces to loot what remains of health care, and kill people at the same time. They called it health-care "reform."

These Obamacare cuts in resources come on top of prior years of erosion of the U.S. medical system, over the decades of damage from so-called private "managed care," (starting in 1973), deregulation to allow for-profit financial groups to buy up non-profit hospitals (starting in the 1970s), and finally the culmination in corporatism—as seen in the Federal government/private insurance "sign ups" scheme, even if HealthCare.gov is a fiasco.

The number of community hospitals today is below 5,000, which itself is below the 5,800 a generation ago. There are far fewer beds per 1,000 residents than modern standards of medicine require, and lower ratios of scanning, infusion, and other facilities.

Each week there are announcements of hospital staff and program reductions, and closings. Examples:

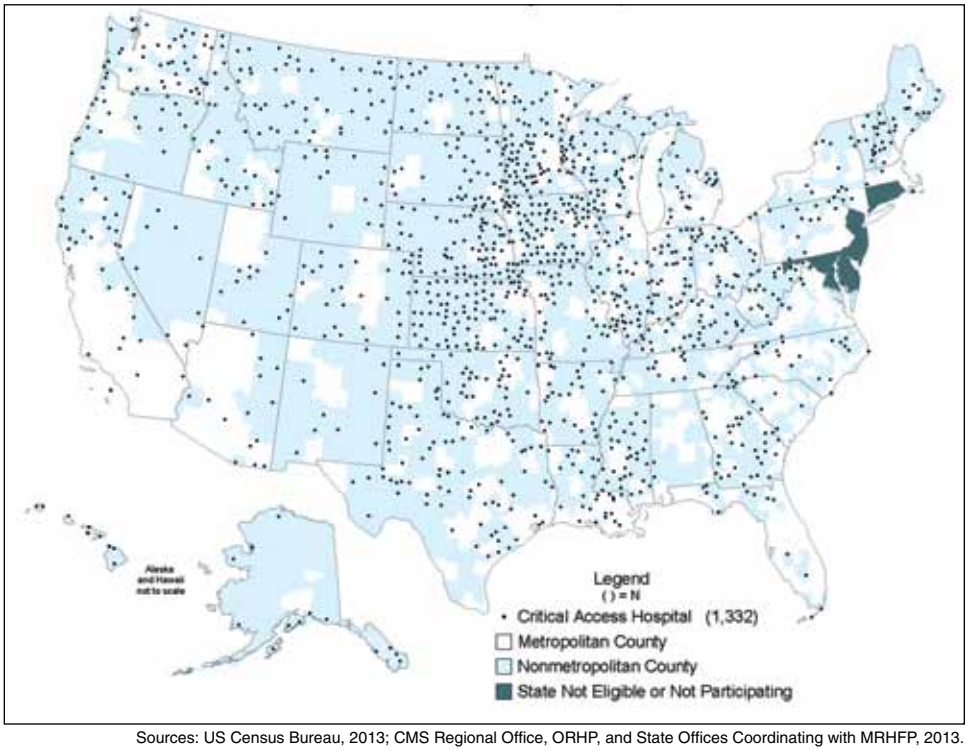
Washington, D.C. The for-profit Medstar Washington Hospital Center announced 300 staff cuts the week of Nov. 12.

New York. In the western part of the state, a desper-

ate scramble is on, for how to keep the Lake Shore Healthcare Center open (in Irving), scheduled to shut this Winter. The hospital was bought up, then dumped by the University of Pittsburgh Medical Center (UPMC), technically non-profit, but part of the new globalist medical operations. Lake Shore is the main facility for a community which includes the Seneca Nation's Cattaraugus Territory.

These are just two examples from dozens nationwide. Overall, an estimated $95 billion worth of reductions in Federal payments for Medicare and Medicaid services by hospitals, has been imposed since 2010.

FIGURE 1
Location of Critical Access Hospitals
(Information gathered through June 30, 2013)



Sources: US Census Bureau, 2013; CMS Regional Office, ORHP, and State Offices Coordinating with MRHFP, 2013.

On the Chopping Block

These are a few of the types of deliberate reductions and cancellations in support for the U.S. hospital system, under the Obama Administration:

1. Reduce Medicare payments to hospitals' outpatient services. Any service to over-65-year-olds in a hospital is to be paid the same as for the same services given in a physician's office, according to a new MedPAC recommendation before Congress. This will reduce the hospital payment between 65% and 80% for 10 of the most common outpatient hospital services.

Money goal: Reduce Medicare spending by $900 million a year, that is, $9 billion over 10 years.

Impact: Services available nowhere else but in a hospital outpatient department, for low-income patients and for persons with multiple conditions, will be threatened with termination. According to MedPAC's own data, hospitals are already 11% in the red for Medicare outpatient services.

2. Cap Medicare payments for a list of 66 outpatient services (Ambulatory Services Classification, ASC) provided at a hospital, according to a recommendation by MedPAC, under consideration by Congress.

Money goal: Reduce Medicare spending by $900 million a year.

Impact: Access to services may be entirely shut; among the 66 procedures are nerve injections and neuropsychological testing.

3. Reduce Medicare payments to defray the bad debt hospitals took on to treat low-income Medicare patients who could not afford their deductibles. Historically, Medicare paid 100% of such bad debt, until the 1990s through today, when payments were reduced.

Money goal: These payments were reduced last year for most hospitals to 65%, and they will be reduced over three years for small, rural Critical Access Hospitals (CAHs), down to 65%. Total "saved": multi-millions.

Impact: The death rate will rise in rural areas, as the Critical Access Hospitals must close. Care for inner-city urban poor likewise will be drastically lessened.

4. Cut graduate medical education. Obama's FY 2014, now in effect, reduced payments to teaching hos-

pitals, by reducing the Graduate Medical Education (GME) program.

Money goal: Cut $11 billion over 10 years. The Simpson-Bowles Commission wanted a reduction of $22 billion by 2025.

Impact: The severe shortage of physicians will worsen. As thing are now, the deficit of doctors is expected to top 120,000 within 10 years.

5. Reduce payments to providers of Medicaid, medical services for the poor, in various ways. For example, the Federal match rate for disaster-recovery, Federal Medical Assistance Percentages (FMAP), was reduced in 2012 from 71.92% down to 65.51% in Louisiana, eliminating multi-millions of dollars to pay for Medicaid in the state,

Money goal: Cut $11.2 billion over 10 years. The Simpson-Bowles proposal is to cut $44 billion by 2020.

Impact: More will die. Medicaid right now covers 1 in 3 children, 1 in 3 births, 8 million persons with disabilities, and 1 in 4 non-elderly adults.

6. Reduce support for small and rural hospitals. Cuts are in effect or planned for whole classes of smaller hospitals, in particular, hitting Medicare Dependent Hospitals (MDH), of which there are 200 nationwide, a program called adjustment for Low Volume Hospital (LVH), and aimed at 1,332 CAHs in rural areas. In August, the Obama Administration announced its intention to re-categorize more than 850 of the 1,332 CAHs in a way to deprive them of the means to continue.

Money goal: Cut tens of billions of dollars.

Impact: If the CAH proposal goes through, 70 of Iowa's 80 rural CAHs could shut; in Wisconsin, 53 out of 58; in Texas, 50+ out of 80; with a similar pattern in other states.

Protest: A bipartisan group of lawmakers is skirmishing to try to save small and rural hospitals, and those serving a population in which at least 60% are enrolled in Medicare. They include Rep. Morgan Griffith (D-Va.) and many others. A joint letter defending the CAHs was issued by Reps. Ron Kind (D-Wisc.) and David McKinley (R-W.Va.). In the Senate, Tammy Baldwin (D-Wisc.) led a group of 20 Senators demanding the protection of rural hospitals, including Iowans Chuck Grassley (R) and Tom Harkin (D), whose state has 80 CAHs, 70 of which are threatened by Obama shutdown.

7. Reduce support to hospitals to defray their uncompensated care for charity patients. This is called the Medicaid and Medicare Disproportionate Share Hospital (DSH) program, referring to a high share of the hospital's cases being low income, uninsured, and underinsured.

Money goal: The ACA reduces the Medicaid DSH payments by an estimated $14.1 billion from FY 2014 (now) through FY 2019; and Medicare DSH payments by $22.1 billion from FY 2014 through FY 2019.

Impact: Care is cut back; programs and hospitals must shut; people will die.

8. Impose new restrictive hospital admissions policies—the "two midnights" rule—for Medicare and Medicaid patients. The Centers for Medicare and Medicaid Services (CMS) ordered this into effect Oct. 1, to drive down the numbers of patients in the hospital for "observation"—that is, for analysis and care. Chaos and misery are the result. The CMS will pay a hospital for an inpatient case that spans at least two midnights; but if a patient is treated for a shorter stay, the hospital will be paid on the much lower outpatient basis, no matter how clinically severe the case is.

Money goal: Billions diverted away from hospitals.

Impact: Diagnosis and treatment are compromised; the judgment of doctors and hospital staff is overridden; patients—even with Medicare and supplemental insurance, find themselves socked with huge bills.

Protest: 105 members of Congress appealed to the Obama Administration to delay the Oct. 1 start date of the "two midnights" rule, which was ignored. The CMS conceded to a delay for three months in when to start financial penalties on hospitals for non-compliance.

9. Penalize hospitals for "excess" readmissions. This began on Oct. 1, 2012. The first year, a "too high rate" of readmissions was monitored for heart attack, heart failure, and pneumonia. In 2015, readmission rates will be additionally monitored for chronic obstructive pulmonary disease and for total hip or knee replacement.

Money goal: Billions. Last year (FY 2013), hospitals were fined 1% of their Medicare base payments. This is being increased to 3% by FY 2015.

Impact: Masses of people are sicker and likely to die.

marciabaker@larouchepub.com