



NOVEMBER 14, 2005

Skyline news

REPORTING ON NEW YORK'S HEALTH CARE NEWS

Medicare and Medicaid Bill Passes Senate

On Nov. 3, the U.S. Senate passed the Deficit Reduction Omnibus Reconciliation Act of 2005 (S. 1932), which includes over \$10 billion in cuts to both the Medicare and Medicaid programs. On Nov. 10, the U.S. House of Representatives postponed the vote on their version, the Deficit Reduction Act of 2005 (H.R. 4241), which

includes over \$11 billion in savings solely from the Medicaid program.

The Senate Bill: As reported previously in *Skyline News*, the Senate bill does not contain any Medicare reimbursement rate cuts for hospitals, and does contain several provisions that are strongly supported by the hospital community, including a delay in the so-called

75% rule for rehabilitation hospitals and units and a permanent moratorium on physicians' ability to refer patients to new specialty hospitals in which they have a financial interest. The bill would achieve one-time Medicare savings from hospitals, however, by delaying payments to hospitals (and other providers) in two ways. First, it would create a pay-for-performance (P4P) pool by, in effect, diverting a portion of outlier pool funds starting in 2007. Payments to hospitals from the P4P

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NYS Commissioner of Health Praises Hospitals' Efforts to Improve Quality

On Oct. 28, more than 300 participants attended the 2005 Quality Symposium, *Institute for Healthcare Improvement Best Practices and Innovative Solutions*, sponsored by GNYHA, NewYork-Presbyterian Healthcare System, the Healthcare Association of New York State, and regional hospital associations. NYS Commissioner of Health Antonia Nov-

ello, M.D., M.P.H., Dr.P.H., praised the hospitals for their commitment to the 100,000 Lives Campaign, and challenged them to continue to adopt new health care models, emphasizing the critical role of leadership in motivating and supporting staff to reach sustainable improvement. Roger Resar, M.D., Senior Fellow at the Institute for Healthcare Improvement (IHI), emphasized the impor-

tance of individual responsibility in saving lives. Other highlights included opening remarks from Herbert Pardes, M.D., Chief Executive Officer at NewYork-Presbyterian Healthcare System, and Kenneth E. Raske, President, GNYHA, who spoke about the GNYHA and United Hospital Fund (UHF) Central Line-Associated Bloodstream Infections (CLABs) Collabo-

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HHS Pandemic Influenza Plan Provides Useful Tools for Providers

On Nov. 2, the U.S. Department of Health and Human Services (HHS) released its Pandemic Influenza Plan, which provides a blueprint for preparing for and responding to a possible pandemic. The release of the plan coincided with President George W. Bush's Nov. 1 announcement regarding the nation's strategy and his request for \$7.1 billion in funding from Congress to prepare for a possible pandemic.

While HHS has been criticized for some aspects of its plan, GNYHA believes the plan provides useful guidance to the health care community. Most helpful are the planning checklists, decision-trees, and specific recom-

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Left to right: Arthur Klein, Chief Operating Officer, NewYork-Presbyterian Healthcare System; Antonia C. Novello, M.D., M.P.H., Dr.P.H., Commissioner, NYS Department of Health; Herbert Pardes, M.D., Chief Executive Officer, NewYork-Presbyterian Healthcare System; Kenneth E. Raske, President, GNYHA; and Daniel Sisto, President, Healthcare Association of New York State.

Medicare and Medicaid Bill

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pool would not begin until 2008. Second, the bill would postpone payment of claims that would otherwise be made during the period from Sept. 22 through Sept. 30, 2006, until Oct. 2, 2006, thus pushing \$5.2 billion in spending from one fiscal year to the next.

The House Bill: Bearing little resemblance to the Senate bill, the House bill includes significant cost-sharing and premium increases for Medicaid clients. While it does not contain any Medicare reimbursement rate cuts for hospitals, it would allow Medicaid managed care plans to limit the amounts they pay hospitals for out-of-network emergency services provided to a Medicaid managed care beneficiary; thus, in New York, hospitals would be paid only the \$95 Medicaid fee-for-service rate for patients who are not admitted to the hospital. GNYHA strongly opposes this provision. Additionally, states would be permitted to impose copayments for non-emergency services provided to an individual in a hospital's emergency department if the person has access to an alternative, non-emergency services provider. Under this provision, hospitals must inform the patient, after conducting the initial screening, that the hospital may require the patient to pay the copayment before the service is provided, and that the hospital can refer the patient to an alternative, non-emergency services provider that will not require the copayment. The copayment would be limited for the poorest beneficiaries.

Other provisions include reducing payments for prescription drugs, allowing states to vary benefits among beneficiary groups, requiring citizenship verification for new applicants, tightening eligibility rules related to asset transfers for long term care services, increasing provider taxes to private managed care organizations, and allowing states to establish a non-emergency medical transportation brokerage program. The Secretary would also be required to conduct several demonstration projects involving "cash and counseling" programs as alternatives to home care and personal care; "money follows the person" rebalancing programs in lieu of institutionalization; and "health opportunity accounts" (similar to health savings accounts.)

Next Steps: These spending cuts are part of

Medicare Finalizes Outpatient Payment Increase for 2006

On Nov. 2, the Centers for Medicare & Medicaid Services (CMS) announced an average 2.3% payment increase for hospital outpatient prospective payment system (OPPS) services in 2006. (This increase excludes cancer hospitals and children's hospitals that are held harmless under OPPS.) While CMS provided a 3.7% market basket increase for OPPS services, the overall payment increase is significantly less, primarily because of the expiration of a provision in the Medicare Modernization Act of 2003 that established a payment floor for certain drugs. GNYHA estimates that its members will experience only a 0.2% increase in payments because of the expiration of the payment floor, as well as other policy changes such as the end of the wage index transition blend that was provided in 2005 and the implementation of a 7.1% adjustment for rural sole community hospitals (hospitals that are at least 35 miles from the next nearest hospital or meet other criteria to establish that they are a community's sole source of care). Other major policy decisions included in the final rule are summarized below.

• **Outlier payments.** CMS finalized its proposal to reduce the outlier payment pool from 2.0% of total outpatient PPS payments to 1.0%. In 2006, the outlier thresholds will be as follows: 1) the cost of the service must be at least 175% of the ambulatory payment classification (APC) payment rate, and 2)

the cost of the service must exceed the APC payment rate by a fixed dollar threshold of \$1,250. The outlier payment will be 50% of the cost above the 175% threshold.

- **Payments for drugs.** CMS established the payment rate for separately payable drugs at the average sales price (ASP) plus 6%, as was proposed; however, the agency decided not to finalize its proposal to provide a 2% add-on to these rates for handling and administration costs because it believes that the payment rate of ASP plus 6% adequately reimburses hospitals for these costs.
- **Collection of pharmacy overhead and drug-handling costs.** CMS will not implement its proposal to require hospitals to collect data on pharmacy overhead and drug-handling costs, but rather will work with the industry to find an alternative approach to gather those data. CMS agreed with GNYHA and other industry organizations that the proposal was unduly burdensome and administratively unfeasible for hospitals to implement.
- **Discount on multiple imaging services.** CMS did not finalize its proposal to implement a multiple procedure discount for imaging services. The agency had proposed to pay the full APC payment for the highest paid imaging service and 50% of the APC rate for all other imaging procedures rendered within the same "family" of procedures during the same session.

The rates will be effective for services provided on or after January 1, 2006. ■

larger budget cuts included in the \$54 billion package in the House and the \$35 billion savings package in the Senate. The votes in the Senate were predominantly along party lines, at 52-47. If the House passes its version next week, the Conference Committee will have

the challenging task of reconciling these vastly different bills. GNYHA will continue to monitor all Congressional reconciliation activity closely and continues to urge the removal of the two hospital provisions included in H.R. 4241. ■

AROUND

John N. Kastanis, F.A.C.H.E., has been named Interim President and Chief Executive Officer of Southampton Hospital. He replaces **Annette Leahy**, who has stepped down after three years. Mr. Kastanis was most recently President and Chief Executive Officer of The Hospital for Joint Diseases Orthopaedic Institute, where he had been since 1996. He has also held senior management positions at Bayley Seton Hospital and the Manhattan Eye, Ear, & Throat Hospital. ■

CLABs Collaborative Makes News

The GNYHA/United Hospital Fund Central Line–Associated Bloodstream Infections (CLABs) Collaborative, which is working to eliminate CLABs in GNYHA member hospitals, was featured in the NYC media last week. On Nov. 9, Dr. Max Gomez of WNBC-TV’s “NewsChannel 4,” featured Beth Israel Medical Center’s participation in the CLABs Collaborative and interviewed Brian Koll, M.D., Beth Israel’s Direc-

tor of Infection Control, who explained how the program’s protocols had resulted in the elimination of CLABs in the hospital for five consecutive months. On Nov. 10, a *Daily News* editorial on making New York hospitals safer said the CLABs Collaborative “demonstrates that small changes in health care can prevent patient deaths,” and that, by participating in the project, “some of the hospitals have eliminated this type of infection altogether for sev-

eral months.” A total of 38 GNYHA member hospitals are participating in the CLABs Collaborative, which began earlier this year. The participating hospitals follow a series of protocols, including standardizing the supplies used to insert a central line via custom packs to ensure that all the supplies are always easily accessible and available at the patient’s bedside, avoiding femoral line placement, creating a central line certification program for new residents, and authorizing nurses to halt the insertion of a central line if a protocol is not being followed. ■

Pandemic Plan *continued from page 1*

mentations for steps to be taken by providers before and during pandemic alert periods.

Plan Assumptions: The HHS plan clarifies for providers the demands they may face in terms of patient visits; staffing, supply, and bed needs; and potential lack of external infrastructure support. For this purpose, the plan assumes that 25–30% of persons in a community will become ill during a 6–8-week outbreak. At the peak of an epidemic, about 10% of the workforce in general will be absent. This estimate does not take into account, however, potential significant absenteeism associated with people who stay home because they fear infection. HHS models estimate increases in hospitalization and intensive care unit demand of more than 25% during even a moderate pandemic. As a result, the plan recommends that providers anticipate undertaking response activities for several weeks or months.

Provider Recommendations: The HHS checklists build on the types of guidelines that many providers in the New York region already have in place, and anticipate the significant stress on the health care system in the event of a pandemic. The following recommendations are among the most notable.

- **Surveillance and Communication.** Providers need mechanisms for detecting increases in flu-like illnesses, tracking visits, and updating data needed to manage the response.
- **Triage, Clinical Evaluation, and Admission Procedures.** Hospitals should develop strategies for triage, diagnosis, and isolation of influenza patients including providing phone triage, assigning separate waiting and evaluation areas, assigning a triage coordi-

John H. Laragh, M.D. to Be Awarded Rudin Prize for Medicine and Health

John H. Laragh, M.D., Professor of Medicine in Cardiothoracic Surgery and Director of the Cardiovascular Center at NewYork-Presbyterian’s Weill Cornell Medical Center, will be awarded the Third Annual Lewis and Jack Rudin New York Prize for Medicine and Health on Dec. 14, 2005, in a ceremony at the New York Academy of Medicine. Dr. Laragh is being honored for his research contribution used by clinicians in the NYC area and around the world in the diagnosis and treatment of hypertension and other ailments. To register for the event, log on to www.nyam.org/rudin.

The Lewis and Jack Rudin New York Prize for Medicine and Health was established to provide a forum for a distinguished member of the metropolitan New York community to receive recognition from colleagues and the public at large. The prize, which is co-sponsored by GNYHA and the Academy, is supported by the May and Samuel Rudin Family Foundation. ■

nator, and reviewing evaluation and admission procedures.

- **Staffing.** Hospitals should determine how they will meet staffing needs and should consider re-assigning clinical administrators, recruiting retired personnel, using trainees, increasing cross-training of personnel, using volunteer corps, identifying essential support personnel, and working collaboratively locally to obtain staffing. Hospitals should also plan for needed supplies of personal protective equipment and undertake staff education and training.
- **Bed Capacity.** Hospitals should develop policies to expedite discharges, consider at-home follow-up care, develop triggers for canceling elective procedures, and plan to expand bed capacity through various methods.
- **Occupational Health.** Hospitals are advised to have plans for protecting workers from exposures in the health care setting through the use of recommended infection control measures, evaluating and managing symptomatic and ill personnel, and distributing and administering antiviral drugs and vac-

cines to workers and their families.

- **Infection Control.** The plan provides extensive guidelines on basic infection control principles, management of infectious patients, infection control for health care personnel, and occupational health. With respect to hospitals specifically, the plan recommends steps that should be undertaken in emergency departments, including posting visual alerts, providing separate waiting rooms, and reinforcing source control measures such as adherence to respiratory hygiene and cough etiquette in waiting areas.
- **Regional Planning:** HHS recommends communitywide planning to support local public health efforts and health care facility planning. In this regard, GNYHA has been working through its Emergency Preparedness Coordinating Council and in collaboration with State and local agencies. Its next planning meeting will be held on Nov. 30, 2005 (see “Upcoming GNYHA Member Briefings” on page 4). To assist members, GNYHA has also developed materials on influenza that can be accessed at www.gnyha.org/eprc. ■

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relative. (See related story on page 3.)

The panel discussion, moderated by Mary Reich Cooper, M.D., J.D., Vice President and Chief Quality Officer at NewYork-Presbyterian Healthcare System, focused on practical approaches to implementing programs for rapid response teams, CLABs, glucose control, and ventilator-associated pneumonia. The attendees, who included executive leadership, physicians, nurses, and other health care professionals, found the discussion to be practical as well as replicable, which is critical in all successful quality improvement initiatives. Many of the attendees invited the panelists to visit their hospitals and present their projects at grand rounds. Attendees also received a compendium of NYS hospitals' IHI successes, which was compiled and published by the quality leadership at NewYork-Presbyterian Healthcare System.

GNYHA and UHF continue to take the lead in eliminating CLABs through their CLABs Collaborative, in which participating hospitals are reporting dramatic reductions in CLABs and significant cost-savings as a result. The CLABs Collaborative has also identified various models and strategies to engage staff in quality improvement efforts and to create models for future initiatives. ■

CMS Issues Final e-Prescribing Standards

On Nov. 7, the Centers for Medicare & Medicaid Services (CMS) issued a final rule adopting standards for electronic prescribing (e-prescribing) transactions under the Medicare Modernization Act. The rule mandates that Part D plan sponsors establish and maintain an e-prescribing program employing these standards by Jan. 1, 2006, and requires that any e-prescribing conducted by providers after Jan. 1 be undertaken using the standards set forth in the rule.

The regulations define e-prescribing as the transmission, using electronic media, of prescription or prescription-related information between a prescriber, dispenser, pharmacy benefit manager, or health plan. In a notable departure from the proposed rule, CMS expanded the scope of coverage for e-prescribing transactions from individuals enrolled in a Part D plan to any individual who may be eligible for Part D benefits. The specific standards address three areas: 1) new prescriptions, renewals, cancellations, changes, ancillary messages, and administrative transactions; 2) eligibility queries between prescribers and Part D sponsors; and 3) eligibility inquiries between dispensers and Part D sponsors. The named standards are from the National Council for Prescription Drug Programs and the Accredited Standards Com-

mittee. CMS also notes that there are not established standards in the areas of formulary and medication history transmission, and will test standards in those areas as part of its 2006 e-prescribing pilot project.

Exemptions to the required use of these standards fall into three categories. First, so as not to create incentives for a return to the use of paper faxes, CMS will not require computer-generated faxes containing prescription or prescription-related information to use these standards. Second, for prescriptions transmitted within a legal entity, the entity may use the e-prescribing standards or may continue to use HL7 transactions that are commonly employed within "closed" networks. Finally, when a non-prescribing provider must be involved in the prescription transaction, the parties are not required to use the e-prescribing standards. This exemption addresses the complexities of prescribing in the long term care setting, where the nursing facility is required by law to conduct concurrent and retrospective Drug Regimen Review.

GNYHA will continue to monitor the piloting and testing of these standards and will keep members informed regarding the safe harbors for e-prescribing that were proposed recently by CMS and the Office of the Inspector General. ■

Upcoming GNYHA Member Briefings

Medicare Part D Prescription Drug Benefit

Date: Friday, November 18, 2005

Time: 10:00 a.m.–1:00 p.m.

Location: GNYHA Conference Center, 555 West 57th Street, 15th Floor

At this briefing, representatives from the Centers for Medicare & Medicaid Services New York Regional Office and the NYS Department of Health will discuss implementation issues for the Medicare prescription drug benefit. The focus will be on available resources for hospital personnel to use in counseling patients on the new benefit, the relationship to NYS programs, and implications for dual-eligible and low-income individuals. The program will also include a presentation by representatives from Montefiore Medical Center on educating hospital clinical and administrative staff about the new benefit. For more information contact Tim Johnson or Elisabeth Wynn, and to register contact Theresa Simon, at GNYHA.

Planning for Pandemic Influenza

Date: Wednesday, November 30, 2005

Time: 2:00 p.m.–5:00 p.m.

Location: NYC Department of Health and Mental Hygiene, 125 Worth Street, 2nd Floor Auditorium, New York, NY

This meeting will be held by GNYHA in conjunction with the NYS Department of Health, the NYC Department of Health and Mental Hygiene, and the NJ Department of Health and Senior Services. Representatives from the U.S. Department of Health and Human Services (HHS) and the three other agencies will discuss the HHS plan (see story on page 1) and regional planning activities for pandemic influenza. Lewis Rubinson, M.D., Ph.D., a critical care specialist, will discuss "Emergency Mass Critical Care," particularly as it relates to pandemic influenza planning. The meeting should be of interest to critical care, respiratory therapy, and emergency

medicine staff. For more information contact Doris Varlese, and to register contact Laurie Sangirardi, at GNYHA.

Self-Disclosure Practices in Relation to Federal and State Enforcement Agencies

Date: Wednesday, November 30, 2005

Time: 2:30 p.m.–4:30 p.m.

Location: GNYHA Conference Center, 555 West 57th Street, 15th Floor

This briefing will focus on processes that health care providers should use to identify and self-report internal fraudulent activities to appropriate governmental entities. Laurence Freeman and Laura Laemmle of Patton Boggs LLP will discuss the process for self-disclosing to the U.S. Department of Justice, and Edward Kornreich of Proskauer Rose LLP will address voluntary disclosure with respect to state agencies. For more information contact Deborah Brown, and to register contact Cynthia Araujo, at GNYHA. ■