



DECEMBER 26, 2005

Skyline news

REPORTING ON NEW YORK'S HEALTH CARE NEWS

GNYHA Provides Assistance During Transit Strike and Continues Other Emergency Preparedness Activities

In order to ensure appropriate staffing levels during last week's strike of the Metropolitan Transportation Authority (MTA) Transport Workers Union, GNYHA members implemented their pre-existing contingency plans developed for such situations and successfully maintained normal operations in spite of the challenges posed by the strike. Plans included renting parking spaces for employees, facilitating carpooling, offering employees accommodations in the event that they needed to stay overnight at member facilities, and transporting employees by bus from certain locations. Before the strike occurred, GNYHA kept members informed of the potential strike situation and New York City's contingency plans, and provided suggestions for GNYHA members to consider when developing their own contingency plans. As is the case with all emergencies affecting the health care community, GNYHA representatives staffed GNYHA's desk at the NYC Office of Emergency Man-

agement Emergency Operations Center, to assist members with strike-related issues. GNYHA continues to be involved in the following emergency preparedness issues as well.

Pandemic Preparedness: On Nov. 30, GNYHA hosted a briefing with the NYS Department of Health (DOH), the NYC Department of Health and Mental Hygiene, and the New Jersey Department of Health and Senior Services to discuss the challenges posed by pandemic influenza. Representatives from the U.S. Department of Health and Human Services (HHS) and the three other agencies discussed the HHS pandemic influenza plan and their respective pandemic influenza activities. Lewis Rubinson, M.D., Ph.D., a critical care specialist, also discussed "Emergency Mass Critical Care," particularly as it relates to caring for patients during a pandemic. The materials from the Nov. 30

Health Care Workers Remain Dedicated Throughout the Strike

Like employees all over the metropolitan area, hospital employees awoke on Dec. 20 to the news of a transit strike and the challenge of getting to work. And get to work they did. They walked, bicycled, ferried, carpoled, road the rails, or hooked up with shuttle buses. They trekked over bridges, hiked for miles, sat in snarled traffic and crowded trains for hours so they could continue to provide care. They were there for 7:00 a.m. shifts, often leaving their homes at 3:00 or 4:00 a.m.; others slept at the hospitals. It took some four to five hours to get to work, but they got there—and GNYHA is proud of and grateful to them all. ■

briefing and other materials regarding pandemic influenza are available on GNYHA's Web site at www.gnyha.org/eprc/general in

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GNYHA Board Meets

The GNYHA Board of Governors met via conference call on December 22, 2005, and took the following actions:

- approved an application for Institutional Membership from Christ Hospital (Jersey City, NJ);
- was briefed on the latest developments concerning the New York City transit strike;
- approved the 2006 GNYHA budget;
- was briefed on GNYHA's advocacy plans in Albany for 2006; and
- was updated on the Federal budget. ■

Spending Reconciliation Bill Passes Narrowly in Congress; Procedural Snag Delays Presidential Review

Legislators in Congress last week scrambled to finish several large bills before breaking for the holiday recess. One of the most important bills they nearly completed was the spending reconciliation bill (S. 1932), which passed both chambers by a very narrow margin. A procedural issue will keep the measure from being sent to the President, as the report must now go back to the House

for a final vote following Senate Democrats' successful use of parliamentary rules.

Specifically, on Dec. 19, the House narrowly adopted the conference report by a vote of 212–206. All voting House Democrats voted against the measure, as did nine Republicans, including Representative John McHugh (R-NY) and Representative Christo-

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GNYHA Submits Comment Letters on Federal Policy

On Dec. 7, 2005, GNYHA submitted comments to the Office of Management and Budget (OMB) about the Hospital Consumer Assessment of Health Providers and Systems (HCAHPS) survey that the Centers for Medicare & Medicaid Services (CMS), in collaboration with the Agency for Healthcare Research and Quality, would like to implement. OMB had solicited comments regarding the cost burden of implementing the survey. On Dec. 9, 2005, GNYHA submitted comments to CMS on the wage index occupational mix survey that the Agency proposes to implement in 2006.

HCAHPS Survey: GNYHA endorsed moving forward with the survey because most hospitals already have a vendor contract to solicit patient satisfaction information. However, GNYHA expressed concern about the cost burden of implementing the survey on financially distressed hospitals that do not already have a vendor contract. In addition, GNYHA requested that CMS inform consumers if it posts results on its *Hospital Compare* Web site prior to data validation. Finally, GNYHA strongly urged that CMS create a beneficiary-encrypted database that qualified researchers could obtain through a data use agreement with CMS. The purpose of this request is to allow entities such as The Health Economics and Outcomes Research Institute (THEORI) at GNYHA to replicate CMS's methodology and composite scores and to prepare reports for its members that could be tailored to quality improvement.

Even though the HCAHPS survey has been endorsed by the National Quality Forum, it is controversial because it would standardize the information collected through patient satisfaction surveys. This would require vendors to revamp their current surveys and would interrupt hospital trend analyses. Nonetheless, CMS and other organizations are seeking standardized information to incorporate into national performance measurement systems. Indeed, in its November 2005 report, *Performance Measurement: Accelerating Improvement*, the Institute of Medicine recommended

that HCAHPS data be incorporated into a baseline set of performance measures.

CMS intends to conduct training sessions on the HCAHPS survey in early 2006, to be followed initially by a "dry run" (during which the data will not be publicly reported), and finally by public reporting on its Web site.

Wage Index Occupational Mix Survey: The wage index adjusts provider reimbursement rates for regional differences in wage levels. Those differences reflect both wage rates and skill mix. The occupational mix adjustment aims to strip the effect of skill mix from the wage index in order to make it more like a price index. It is a statutory requirement that was first implemented in Federal fiscal year (FY) 2004 and is required to be updated in FY 2007. It was advocated by rural hospitals, which expected it to redistribute funding to them from large urban hospitals.

The first occupational mix adjustment was not uniformly beneficial to rural hospitals, however, or uniformly harmful to large urban hospitals. Indeed, it cut funding to roughly one-third of rural hospitals and increased funding in certain urban areas such as New York City. As a result—and purportedly because of flaws in the first data survey—it has been only partially implemented.

In order to correct the perceived flaws in the first survey, CMS proposed several changes in the second survey: it would collect salary data from all hospitals instead of

relying on a sampling of salary data from the Bureau of Labor Statistics; it would restrict the collection of occupational data to nursing, but would refine the nursing occupations; and it would implement the survey over a fixed time period for all hospitals (the first six months of 2006) rather than offering hospitals a choice of prospective and retrospective time frames. In addition, CMS would give hospitals only 30 days to prepare and submit the survey.

GNYHA supported the aspects of CMS's proposal that would make the survey easier to implement—that is, restricting the collection of occupational data to nursing—but opposed the aspects that would make the survey more difficult and expensive to implement—that is, collecting salary data and refining the nursing categories. The basis for GNYHA's comments was empirical research by THEORI that showed that the funding redistribution from some rural to some urban hospitals was not the result of a flawed initial survey, but a correct reflection of the occupational mix of the affected hospitals. Thus, GNYHA reasoned that the proposed survey would not yield sufficiently different results to justify its incremental cost burden.

In addition, to avoid future criticism of the survey—which could provide a rationale to continue only partial implementation—GNYHA recommended that CMS extend the study period for the next survey to all of 2006 and provide 90 days for hospitals to prepare and submit the survey. ■

Transit Strike *continued from page 1*

the "Emerging Public Health Issues" section under "Avian Influenza." In addition, on Dec. 12, GNYHA's Emergency Preparedness Coordinating Council met to continue discussing health care system preparations for a pandemic including addressing potential staffing and supply shortages. GNYHA also serves on the DOH workgroup that is revising DOH's pandemic influenza plan to incorporate guidance from the HHS plan.

RRC Meeting: On Dec. 5 and 6, GNYHA hosted a meeting attended by representatives of

DOH and the State's Regional Resource Centers (RRCs), NYS's eight designated trauma centers outside of NYC that coordinate emergency preparedness planning activities with other hospitals in their respective regions, local health departments, and local offices of emergency management. Topics discussed at the meeting included the Federal Health Resources and Services Administration (HRSA) requirements that all HRSA-funded training be "competency based," the regional preparedness councils that will be convened in each region, and DOH's plans for pharmaceutical stockpiling in NYS. ■

MedPAC Discusses Draft Recommendations for FY 2007

At the meeting of the Medicare Payment Advisory Commission (MedPAC) on Dec. 8–9, 2005, MedPAC staff presented draft recommendations for Medicare payment updates for fiscal year (FY) 2007, which begins on Oct. 1, 2006. The draft recommendations would cut Medicare payments in all service sectors compared with current law, as follows:

- inpatient and outpatient hospital services, market basket minus 0.45%;
- inpatient rehabilitation facilities (IRFs), one-half of the market basket;
- long term care hospitals (LTCHs), no update;
- skilled nursing facilities (SNFs), no update;
- home health (HH) agencies: no update.

The recommendation to cut hospital payments was based on a MedPAC analysis that concluded that while hospitals are projected

to experience a negative overall Medicare margin (includes inpatient, outpatient, and hospital-based SNF and HH services) again in 2006 (see table), at the national level, private payer margins are strong so that hospital total margins are positive. In addition, MedPAC staff noted that the aggregate negative Medicare margin was caused, in part, by hospitals with particularly low occupancy rates, higher-than-average cost per case and length of stay, and other indicators of inefficiency. The recommendations for IRFs, LTCHs, SNFs, and HH agencies were based on analyses that these sectors will continue to experience positive Medicare margins

Medicare Margins for Selected Service Sectors, 2002–04 and 2006

Service Sector	2002	2003	2004	2006 (est.)
Overall Medicare ^a	2.2%	-1.4%	-3.0%	-2.0%
Inpatient hospital	6.1%	2.0%	-0.3%	n/a
Outpatient hospital	-8.6%	-11.7%	-10.9%	n/a

n/a = not available.

^aIncludes inpatient, outpatient, and hospital-based SNF and HH services.

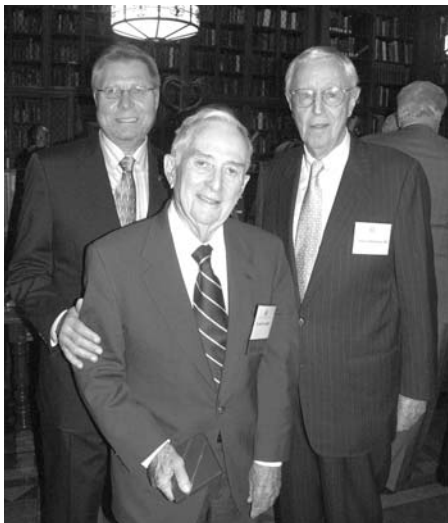
Source: Medicare Payment Advisory Commission.

through 2006.

GNYHA strongly opposes the recommendations to cut provider payments as they would accelerate the deterioration of providers' financial condition and imperil service quality and access for Medicare beneficiaries. Commissioners will formally vote on the recommendations at MedPAC's meeting on Jan. 10–11, 2006. ■

2005 Rudin New York Prize for Medicine and Health Awarded to Dr. John Laragh

On Dec. 14, 2005, John H. Laragh, M.D., Professor of Medicine in Cardiothoracic Surgery and Director of the Cardiovascular Center at NewYork-Presbyterian Weill Cornell Medical Center, was awarded the 2005 Lewis and Jack Rudin New York Prize for Medicine and Health in a ceremony at the New York Academy of Medicine.



Left to right: GNYHA President Kenneth E. Raske; 2005 Rudin Prize recipient John H. Laragh, M.D.; and New York Academy of Medicine President Jeremiah Barondess, M.D.

Dr. Laragh was honored for his research contribution used in the diagnosis and treatment of hypertension and other ailments.

At the ceremony, Dr. Laragh delivered a lecture entitled, "The Laragh Blood Pressure Equation: $BP = (\text{Body Salt}) \times (\text{Plasma Renin})$," in which he described his research that led to the discovery of the renin-angiotensin aldosterone hormonal system and its function as the major control center for co-regulating normal blood pressure and body sodium content. Dr. Laragh noted that his research shows that patients are often prescribed multiple medications when a course of monotherapy would serve them just as well or better.

Among Dr. Laragh's other honors are the 1969 Stouffer Prize of the High Blood Pressure Council of the American Heart Association, the Robert Tigerstedt Award of the American Society of Hypertension, the John Peters Award of the American Society of Nephrology, the Bristol-Myers Squibb Award for Distinguished Achievement in Cardiovascular Research, and the Distinguished Achievement Award of the American Heart Association. He is the past president of the International Society of Hypertension and a

past chairman of the Council for High Blood Pressure of the American Heart Association.

The Rudin Prize was established in 2003 as a forum for distinguished members of the biomedical community to receive recognition from the New York health care community and to share information regarding their innovative research for addressing pressing health care issues facing New Yorkers. The Rudin Prize is co-sponsored by GNYHA and the New York Academy of Medicine, and is supported by a grant from the May and Samuel Rudin Family Foundation. ■

Upcoming GNYHA Member Briefing

DOH Priorities for Medicaid Compliance

Date: Wednesday, January 18, 2005

Time: 1:00 p.m.–3:00 p.m.

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

This briefing will be led by Joan Johnson, Director of the NYS Department of Health's (DOH's) Division of Medicaid Fraud Control and Program Integrity. At GNYHA's request, Ms. Johnson will discuss high-priority areas on which providers should focus to facilitate continued compliance with the State Medicaid program. She urges hospitals to perform self-audits to identify potentially problematic areas. For more information contact Deborah Brown, and to register contact Cynthia Araujo, at GNYHA. ■

Congress Adopts Terrorism Risk Insurance Extension; President Signs Cord Blood Bill

On Dec. 19, the Terrorism Risk Insurance Extension Act of 2005 (TRIA) was presented to President George W. Bush for his signature. This action follows the adoption of the conference report by the U.S. Senate on Dec. 16, and by the U.S. House of Representatives on Dec. 17. GNYHA has lobbied extensively for the extension of this program, which

provides Federal stop-loss protection to insurers that cover terrorism risks. As the existing program is set to expire on Dec. 31, 2005, GNYHA expects the President to sign the bill (S. 467) imminently, extending the program for two years. The final bill's provisions are described in GNYHA member letter bulletin 248 (dated Dec. 20, 2005).

On Dec. 20, the President signed into

law the "Stem Cell Therapeutic and Research Act of 2005" (H.R. 2520). Introduced by Rep. Christopher Smith (R-NJ), this law will encourage the collection of stem cells from the placentas and umbilical cords of newborns to use in treatment and research. The bill authorizes Federal support to collect and store stem cells from umbilical cord blood by establishing a transplantation program, to establish a database to help physicians and researchers access the cells and bone marrow, and to follow the outcomes of patients receiving such transplants. ■

Spending Reconciliation Bill

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phers H. Smith (R-NJ) from the Greater New York area. The conference report then moved to the Senate, where, after successfully raising a point of order, Senate Democrats forced three provisions to fall out of the report. One provision would have granted hospitals immunity from liability in the event they refused to treat low-income Medicaid beneficiaries for non-emergency care in their emergency departments if their State government required a copayment for such services and the patient refused to pay. Another provision would have required the U.S. Department of Health and Human Services (HHS) and the Medicare Payment Advisory Commission to submit reports to Congress on a hospital pay-for-performance (P4P) program.

The Senate adopted the bill officially on Dec. 21, 2005, with all Democrats voting against the measure, as did five Republicans including Senators Gordon Smith (R-OR), Olympia Snowe (R-ME), Susan Collins (R-ME), Lincoln Chafee (R-RI), and Mike DeWine (R-OH). Vice President Dick Cheney cast the tie-breaking vote to pass the measure (51-50). However, since the package was modified from the recently passed House version, the report must now go back to the House for a final vote before the President can sign it into law. With many members of the House already having left Washington for the holidays, it is unclear at this time whether they will be called back prior to their officially scheduled return on Jan. 31, 2006.

The conference report includes \$11.2 billion in cuts to both the Medicare and Medicaid programs. Highlights of the bill's Medicare

provisions affecting hospitals are as follows:

- *Expands requirements for hospital quality reporting.* Starting in fiscal year (FY) 2007, in order to receive a full inpatient Medicare inflation (or "market basket") update, hospitals will be required to report on 1) complications, 2) comorbidities upon admission, and 3) the incidence of two hospital-acquired infections. The reportable, preventable infections will be identified by the Centers for Disease Control and Prevention, specialty societies, and others based on evidence-based guidelines. These reporting requirements will be in addition to the current reporting requirements under the CMS Hospital Quality Initiative. Hospitals that fail to report will have their market basket update reduced by two percentage points. Additionally, HHS will be required to develop a plan to implement a value-based purchasing program for hospitals to commence in FY 2009. It is important to note that hospital payments are not lagged as in previous proposals. Earlier versions of the bill would have created a value-based purchasing pool by diverting funding from the current outlier pool, and value-based payments would not have been made until at least a year after the diversion of funds from the outlier pool to the new pool. GNYHA expressed great concern about the payment lag, and is pleased it is not contained in the final version of the bill. Earlier versions of the bill would also have required the implementation of a P4P program for physicians; however, the final bill does not.
- *Codifies CMS's existing "75% Rehab Rule" and adds an additional year to the transition period,* whereby the inpatient rehabilitation facility classification criteria threshold will

be 60% in 2006, 65% in 2007, and 75% in 2008; *extends the physician-owned specialty hospital moratorium* and requires HHS to develop a strategic plan to address uncompensated care and the provision of care to low-income beneficiaries; and *codifies current Federal regulations regarding the definition of Medicaid days* that may be included in the Medicare disproportionate share hospital formula as they pertain to certain expansion populations covered under Section 1115 Medicaid demonstration waiver programs.

- *Establishes two hospital-related demonstrations,* one aimed at studying costs and outcomes across various post-acute care settings following hospitalization from calendar year (CY) 2008 to 2011, and the other establishing a Medicare gainsharing program at six institutions beginning in CY 2007; *freezes Medicare physician reimbursement rates* for CY 2006 for physicians rather than the 4.4% cut that was scheduled to take effect; *freezes Medicare home health payments* at 2005 rates; and *permanently cuts Medicare bad debt payments for skilled nursing facilities* from 100% to 70%.

The final bill also includes a Medicaid provision that caps hospitals' emergency services charges at the Medicaid fee-for-service rate for out-of-network Medicaid managed care enrollees, and another one that allows states to impose copayments for non-emergency services provided in emergency rooms for Medicaid enrollees. Some other Medicaid provisions allow states to increase copayments for their Medicaid populations, tighten long term care eligibility rules around asset transfers, and impose home equity limitations. ■