



MAY 19, 2003

# Skyline news

REPORTING ON NEW YORK'S HEALTH CARE NEWS

## NYS Legislature Overrides Governor's Budget Veto; GNYHA Members Protected from New Cuts and Taxes

**O**n May 14, 2003, New York Governor George E. Pataki vetoed large portions of the budget bills passed overwhelmingly by both houses of the State Legislature. The following day, both houses of the New York State Legislature overrode all of the Governor's 119 budget vetoes. The Legislature's action means that its budget for State fiscal year 2003-04 is the law of the land, barring any litigation that may invalidate the Legislature's budget. This means that over \$600 million in new hospital cuts and taxes, \$400 million in new nursing home cuts, over \$70 million in home health cuts and taxes, a reduction in eligibility for the Family Health Plus program, and a variety of

other proposals that would have devastated New York's health care community will not be enacted this year. In addition, the Health Care Reform Act and all of its pools will be extended through June 30, 2005, without any major reductions in funding. Given the State budget deficit, this outcome is remarkable.

The health care community owes a deep debt of gratitude to Assembly Speaker Sheldon Silver and Senate Majority Leader Joseph Bruno, as well as the majorities in both houses, for their strong support throughout this debate. In addition, this outcome could not have been achieved without the strong advocacy of GNYHA

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## U.S. Senate Approves Medicaid Relief

**L**ast week, the United States Senate approved the Jobs and Growth Tax Relief Reconciliation Act of 2003 (S.1054), which, besides containing approximately \$350 billion in tax cuts over 10 years, contains \$20 billion in relief over 15 months for financially strapped state and local gov-

ernments. Specifically, S.1054 would provide \$10 billion in relief for states through a 2.95 percentage point increase in each state's Federal Medicaid matching rate for the last two quarters of Federal fiscal year (FY) 2003 (April 1, 2003, through September 30, 2003) and the

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## Medicare Releases Fiscal Year 2004 Proposed Rules

**T**he Centers for Medicare & Medicaid Services (CMS) has issued several proposed rules for Federal fiscal year 2004 prospective payment systems (PPS), including the general hospital inpatient PPS, inpatient rehabilitation facility (IRF) PPS, and skilled nursing facility (SNF) PPS. Key provisions of the rules are summarized below.

**Inpatient PPS:** A number of variables are affected by the proposed Inpatient PPS rule.

**Federal Rates.** The proposed FY 2004 operating PPS standardized amounts are 3.9% higher than the FY 2003 amounts (see Table 1 on next page), reflecting a market basket index of 3.5% and modest increases associated with diagnosis-related group (DRG) recalibration and geographic reclassifications. The proposed increase in the capital PPS standardized amount is 1.2%.

**Wage Index.** There are no significant changes to the wage index methodology in FY 2004, although NYC metropolitan area facilities should anticipate wage index reductions in FY 2005 due to implementation of an occupational mix adjustment and possible changes in labor market definitions based on the 2000 census. As in past years, member hospital corrections to underlying wage data will be reflected in the final rule.

**Outliers.** The high-cost outlier threshold proposed for FY 2004 is \$50,645 (51% higher than the current threshold) and is expected to

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**Table 1. Proposed Federal Inpatient PPS Rates**

Rate Type	FY 2003 (\$)		FY 2004, Proposed (\$)	% Change from 10/1/02
	As of 10/1/02	As of 4/1/03		
<b>OPERATING RATES</b>				
Large urban areas:				
Labor portion	\$3,022.60	\$3,022.31	\$3,139.26	3.9%
Nonlabor portion	1,228.60	1,228.48	1,276.01	3.9%
Total	4,251.20	4,250.79	4,415.27	3.9%
Other areas:				
Labor portion	2,974.75	3,022.31	3,089.56	3.9%
Nonlabor portion	1,209.15	1,228.48	1,255.81	3.9%
Total	4,183.90	4,250.79	4,345.37	3.9%
<b>CAPITAL RATE</b>	407.01	407.01	411.72	1.2%

decrease in the final rule based on CMS's new outlier methodology, which is expected soon.

**Discharges to Post-acute Care.** CMS proposes to add 19 DRGs to the current list of 10 DRGs that are reimbursed according to the transfer payment methodology when the case is discharged to post-acute care (see Table 2). GNYHA's analysis of 2001 Medicare billing data shows that New York hospitals have a higher-than-average proportion of "transfer cases" in these DRGs (43% vs. the national average of 37%); however, New York's proportion of cases that would be subject to the transfer payment penalty is lower than the national average (6% vs. 8%, respectively).

**Counting Residents in Non-hospital Sites.** The proposed rule would establish additional requirements for counting residents training at non-hospital sites. Hospitals may claim graduate medical education payments for such training if they incur all or substantially all of the costs of that training. The proposed rule would require hospitals claiming residents in non-hospital settings to demonstrate that they had been bearing those training costs continuously as of Jan. 1, 1999. For other training programs, hospitals would be asked to demonstrate that they had borne those training costs from the inception of training.

**Clinical Base Year.** The proposed rule did not, as had been expected, clarify CMS's policy setting direct medical education payments for residents training in specialties that require a year of broad-based training prior to entering the specialty part of the program.

**Available Beds and Patient Days.** The proposed rule seeks to define available beds for purposes of calculating indirect medical edu-

cation and eligibility for disproportionate share hospital (DSH) payments, as well as for defining patient days for computation of DSH payments, including stricter definitions of what constitutes an available bed and characterizing dual-eligible days as Medicaid days under certain circumstances and not counting Medicare+Choice days as Medicare days.

**IRF PPS:** CMS proposed no changes to the payment parameters in the IRF PPS other than to announce a 3.3% increase in the Federal rate. CMS proposes to reinstate enforcement of the existing "75% rule" for cost-reporting periods beginning on or after Oct. 1, 2003, which requires hospital rehab units

to demonstrate that at least 75% of their inpatient population requires intensive rehabilitative services for the treatment of one of 10 conditions (stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, hip fracture, brain injury, polyarthritis, neurological disorders, and burns). These criteria were promulgated in 1984, have not been modified since, and have been criticized as being out of step with more recent clinical innovations in rehabilitation for cardiac and pulmonary conditions in particular.

**SNF PPS:** The most noteworthy proposal in this rule was not to update the area wage indices. This proposal would benefit GNYHA members in FY 2004 because the hospital wage index is expected to decrease. The proposed rule would ensure a full 2.9% market basket increase in payment rates for SNFs for FY 2004. SNFs will also benefit from a CMS decision to delay implementing case-mix refinements to the SNF PPS until a later fiscal year, which would ensure the continuation, through FY 2004, of a 20% rate add-on for 15 selected resource utilization groups (RUGs) and a 6.7% add-on for all rehabilitation RUGs. CMS also indicated that it intends to identify a list of high-cost services that are used infrequently in SNFs to be added to the existing list of services excluded from consolidated billing under the SNF PPS. ■

**Table 2. New DRGs That Would Be Reimbursed as Transfer Cases**

DRG	TITLE
12	Degenerative nervous system disorders
24	Seizure and headache, age >17 with CC
25	Seizure and headache, age >17 without CC
89	Simple pneumonia and pleurisy, age >17 with CC
90	Simple pneumonia and pleurisy, age >17 without CC
121	Circulatory disorders with AMI and major complications, discharges alive
122	Circulatory disorders with AMI without major complications, discharges alive
130	Peripheral vascular disorders with CC
131	Peripheral vascular disorders without CC
239	Pathological fractures and musculoskeletal and connective tissue malignancy
243	Medical back problems
277	Cellulitis, age >17 with CC
278	Cellulitis, age >17 without CC
296	Nutritional and miscellaneous metabolic disorders, age >17 with CC
297	Nutritional and miscellaneous metabolic disorders, age >17 without CC
320	Kidney and urinary tract infections, age >17 with CC
321	Kidney and urinary tract infections, age >17 without CC
462	Rehabilitation
468	Extensive O.R. procedure unrelated to principal diagnosis

Note: CC = complications or comorbidities. AMI = acute myocardial infarction. O.R. = operating room.

## NYS Legislature Overrides Governor's Budget Veto *continued from page 1*

members and their support for the Health-care Education Project, a joint effort of GNYHA and 1199 SEIU. Through the Project, GNYHA was able to mount an

unprecedented television, radio, direct mail, and phone banking campaign that made all the difference and was unmatched by any other group in the State. ■

## U.S. Senate Approves Medicaid Relief *continued from page 1*

first three quarters of FY 2004 (October 1, 2003, through June 30, 2004). The other \$10 billion in relief would be provided to states and local governments for more general budget needs and would be allocated to states based on each state's share of the national population. According to preliminary estimates, this provision would make available more than \$1.4 billion in new Medicaid funding for New York State, and another \$600 million in general budget relief. In addition, S.1054 provides \$48 million to states and health care providers to help defray the costs of providing care for undocumented immigrants. GNYHA has been working for over a year, along with a coalition of providers, unions, consumer groups, and governors, including New York State Governor George E. Pataki, to encourage Congress to enact a Medicaid matching rate increase so that the New York State government would not feel pressured to reduce Medicaid spending during the current economic

downturn. Indeed, the Healthcare Education Project, a joint project of GNYHA and 1199 SEIU, has contributed heavily to an advertising and phone banking campaign in key districts around the country to encourage members of Congress to enact fiscal relief for states. GNYHA is pleased that New York's Senators, Charles E. Schumer and Hillary Rodham Clinton, have been strong supporters of providing more Federal funding for New York's Medicaid program. Bill S.1054 will now have to be reconciled with the House-passed version of the President's economic plan, which does not contain fiscal relief for states. Several Republican members of the New York Congressional Delegation, including Congressmen Peter King and Tom Reynolds, are working with House conferees to ensure that the Senate's fiscal relief for states is contained in the final version of the bill. GNYHA is grateful for the support of Congressmen King and Reynolds on this important issue. ■

## GNYHA HIPAA Workgroup Receives Special Designation; Allows for Larger Role in National Debate

The GNYHA Health Insurance Portability and Accountability Act (HIPAA) Transactions Workgroup has been designated as a Workgroup for Electronic Data Interchange (WEDI) Strategic National Implementation Process (SNIP) Affiliate for HIPAA Implementation. This designation will enable the group to have a stronger voice in the national debate regarding HIPAA standards. The regulations governing the implementation of the HIPAA transactions require the Secretary of Health and Human Services to consult with WEDI before adopting or modifying a HIPAA standard.

GNYHA's HIPAA Transactions Workgroup, which began meeting in 2002, currently includes more than nine payers and 50 providers. The workgroup has identified on behalf of the health care community a number of important recommendations to ensure minimal cash flow disruption post-implementation and to ensure that the full benefits of HIPAA are achieved.

Since the current activities of the GNYHA HIPAA Transactions Workgroup are aligned with the WEDI organizational requirements, the workgroup will continue in its current form under a WEDI SNIP designation. ■

## Upcoming GNYHA Briefings

### **Nursing Magnet Recognition Standards**

**Date:** Tuesday, May 27, 2003

**Time:** 1:30 p.m.—4:30 p.m.

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

The current shortage of qualified nurses, along with an aging labor pool, have created significant challenges for nurse recruitment and retention. The Nursing Magnet Recognition Program, which was developed by the American Nurses Credentialing Center to recognize health care organizations that provide the very best in nursing care, has been shown to attract, retain, and develop workforce excellence. This briefing is a follow-up to the briefing on the Magnet Recognition Program held at GNYHA on December 10, 2002, and will focus on the interpretation and updates of the standards for Magnet Recognition. GNYHA encourages VPs of nursing, nurse managers, nurse recruiters, shift supervisors, medical directors, human resources staff, and hospital administrators to attend this session. For more information contact Terri Straub, and to register contact Barbara Marino, at GNYHA.

### **GNYHA/DOH HERDS Drill**

**Date:** Tuesday, June 3, 2003

**Time:** 9:00 a.m.—12:00 noon

**Location:** At your institution

On June 3, 2003, GNYHA and the New York State Department of Health (DOH) will conduct a drill of the Hospital Emergency Response Data System (HERDS). All GNYHA member hospitals are encouraged to participate. During the drill, participating hospitals will be asked to conduct actual assessments of their current surge capacity and submit this information via HERDS. For more information contact Susan Stuard, and to register contact Meg Figley, at GNYHA.

### **Craneware, Inc.**

**Date:** Tuesday, June 10, 2003

**Time:** 9:30 a.m.—11:30 a.m., lunch following

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

At this briefing, Craneware, Inc., which recently entered into a strategic alliance with GNYHA Ventures, Inc., will present its *Active Chargemaster Professional Toolkit*, a software solution that helps health care facilities keep their Charge Description Master Files current, accurate, and compliant. Keith Neilson, Craneware's President and CEO, and Nora McNeil, Craneware's head of Research and Development, will discuss the value of Craneware's solution and give a demonstration of its key features. For more information contact Gayle White, and to register contact Sahar Zodeh, at GNYHA. ■

# Guidelines for Managing SARS in Hospitals Reviewed at GNYHA Briefing

At a briefing held at GNYHA on May 12, 2003, the New York City Department of Health and Mental Hygiene (DOHMH) and the New York State Department of Health (NYSDOH) put forward guidelines for the management of potential cases of Severe Acute Respiratory Syndrome (SARS). Drawing upon the guidelines developed last year to address the management of potential smallpox cases, the SARS guidelines emphasize the importance of rapid identification, triage, and isolation of possible cases; strict adherence to infection control procedures; and close coordination with public health authorities. These steps are essential to minimizing the possible transmission of SARS in health care settings, given that many of the secondary transmissions that have occurred in other countries have involved health care workers. In order to rapidly identify and isolate possible cases, the guidelines recommend that providers inquire about a patient's symptoms (fever and cough or shortness of breath) and travel history, or contact with a known SARS patient, as promptly as possible. To minimize the possibility of transmission in waiting areas, DOHMH has made available signage in several languages that directs patients to identify themselves to triage or reception if they have certain symptoms and travel history. Patients having these symptoms are to be placed immediately in an airborne infection isola-

tion room (AIIR), or negative pressure room, and health care workers and visitors having contact with the patient are to follow standard, airborne, and contact precautions. While most hospitals generally have negative pressure rooms, the guidelines also outline potential alternatives for isolation purposes and how to achieve negative pressure if an AIIR is not available. The guidelines also recommend that hospitals have in place certain overriding measures to support any form of emergency including a functioning incident command system; disaster plans; redundant communication systems; plans for increasing surge capacity; security plans; and employee health and safety protocols, including disease surveillance among health care workers. Although the guidelines were reviewed for the purpose of addressing possible SARS cases, it is expected that they will be released in a final form that will be broad enough to encompass planning for and responding to highly communicable diseases in general. GNYHA will continue to work with DOHMH and NYSDOH to implement the guidelines and to plan for possible surge capacity needs.

**Low Number of Potential SARS Cases in NYC Region:** The number of suspect and probable SARS cases in the New York City region remains low, with NYSDOH reporting a total of 47 possible cases throughout the State. Twenty-one of these cases have

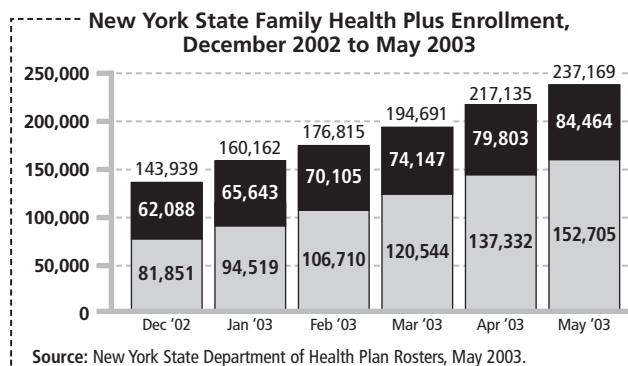
been reported in New York City. Of the 47 cases reported Statewide, only seven are considered probable—meaning in addition to fever, respiratory symptoms, and a certain travel history, these seven patients also have pneumonia. However, all cases have been mild, all have recovered or are recovering, and none involved a community or secondary transmission. In New Jersey, the current number of cases includes three suspect cases and one probable case.

**GNYHA Web Site:** To help members plan for potential SARS cases, GNYHA has created a page on its Web site, [www.gnyha.org](http://www.gnyha.org), which brings together guidelines issued by DOHMH, NYSDOH, the New Jersey Department of Health and Senior Services, the Centers for Disease Control and Prevention, and the World Health Organization. The page also provides updated charts on the numbers of SARS cases reported, fact sheets and signage in several languages, and guidelines for management of SARS in a number of settings, including health care settings, the general workplace, and schools. ■

## Family Health Plus Enrollment Tops 230,000

The Family Health Plus (FHP) program, which was enacted as part of the Health Care Reform Act of 2000, provides comprehensive health coverage to low-income adults. As with Medicaid, local social service districts accept and process FHP applications, and enrollees may select from FHP managed health plans available in their county.

Enrollment data from the New York State Department of Health demonstrate the considerable growth in the Family Health Plus program over the past six months. New York State estimates that, when fully implemented, this program will benefit 600,000 low-income New Yorkers. ■



### Legislative Digest

The NYS Legislature considered the following health care bills over the last several weeks:

**ECT Emergency Resources and ECT Reporting:** Bill A.5943, which would require electroconvulsive therapy (ECT) providers to have access to resources for the treatment of medical emergencies, passed in the Assembly. GNYHA is not aware of any ECT provider that does not have access to emergency resources and suggests that this requirement could be established through licensing and recertification rather than legislation. The Assembly Mental Health Committee approved A.7906, requiring ECT providers to report the use of ECT on a quarterly basis. Existing regulations already capture data through the Statewide Planning and Research Cooperative System (SPARCS) data bank. GNYHA opposes further duplicative reporting. • **Language and Hearing Interpretation Services:** The Assembly Health Committee approved A.5431-A, which would require hospitals to provide language interpretation services to patients with limited English proficiency. GNYHA supports the intent of the legislation, but opposes A.5431-A on the basis that it duplicates existing State regulations and Federal guidelines. The Assembly passed A.6614 to require hospitals to provide language interpretation services to patients who are hard of hearing. GNYHA believes hospitals already meet this requirement through existing State regulation. ■