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Skyline news

REPORTING ON NEW YORK'S HEALTH CARE NEWS

Congress Approves Medicare Bill

On November 22, 2003, the U.S. House of Representatives approved the Medicare Prescription Drug Improvement and Modernization Act of 2003 (H.R.1). The Senate followed suit on November 25. All New York Republican members of Congress voted for the bill, as did all Connecticut Republicans and all New Jersey Republicans except Congressman Scott Gar-

rett; all New York, New Jersey, and Rhode Island Democrats, including all six Democratic U.S. senators from those states, voted against it. Senators Lincoln Chafee (R-RI) and Christopher Dodd (D-CT) also voted against the bill. The President has promised to sign the bill into law.

H.R.1 creates a voluntary Medicare outpatient prescription drug benefit beginning in 2006. In the meantime, all Medicare beneficiaries will receive a drug discount card, and low-income seniors will receive \$600 worth of prescription drug coverage in 2004 and 2005. H.R.1 also reforms the overall Medicare program by encouraging private health insurers to offer Medicare products, including preferred provider options. The current

Medicare+Choice program would be reformed to increase payments to Medicare+Choice plans, which would be renamed "Medicare Advantage" plans. The bill would also experiment with market forces by creating a demonstration project beginning in 2010 in six metropolitan areas with Medicare Advantage penetration of at least 25%. Under the project, seniors would receive a certain amount of "premium support" with which they could choose between private plans and the traditional fee-for-service Medicare program. Beneficiaries who choose a plan that costs more than the premium support provided would have to pay the difference out-of-pocket. Beneficiaries who choose

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CMS Releases Psych PPS Proposed Rule—GNYHA Research Cited

On November 19, 2003, the Centers for Medicare & Medicaid Services (CMS) released its proposed rule for the inpatient psychiatric facility prospective payment system. While CMS refers to the rule as the IPF PPS, the industry is expected to continue to use the term "Psych PPS." Comments on the proposed rule are due to CMS by January 27, 2004. CMS will issue a final rule sometime after the comment period ends, and at this time expects that the final rule will go into effect for cost-reporting periods beginning on or after April 1, 2004. There will be what CMS is calling a three-year transition period, during which hospitals will receive a blend of their current and PPS payments; however, PPS cognoscenti would characterize the transition as four years, since pay-

ments based solely on the PPS would not be made until the fourth year. The payment parameters included in the final rule would pertain to the first 15 months of the Psych PPS—that is, from April 1, 2004, through June 30, 2005. The next update would take effect on July 1, 2005.

Proposed Methodology: The rule relies heavily on a payment methodology developed and presented to CMS by The Health Economics and Outcomes Research Institute (THEORI) at GNYHA in collaboration with the American Psychiatric Association (APA). The starting national rate is \$530 per day, and 36 possible adjustments can be used to determine each individual patient's per diem rate.

The facility-level adjustments include a

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Lobbying Efforts Continue on Medicare 75% Rule

The recent advocacy efforts of the rehabilitation provider community on Medicare's "75% rule" appear to have had an impact. In its Medicare Prescription Drug Bill conference report, Congress expressed its concern that "the rule, as written, would have severe consequences for access to inpatient rehabilitation hospital services." In addition, the conferees directed the General Accounting Office to consult with experts in the field to identify the conditions that are clinically appropriate for inclusion in the 75% rule and to issue a report on the subject. The conference language also urged U.S. Health and Human Services Secretary Tommy

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State COGME Holds Meeting on Minority Participation in Medicine

The NYS Council on Graduate Medical Education (COGME) held a special joint meeting on November 24 of its Subcommittee on Minority Participation in Medicine and its Subcommittee on GME Reform. COGME staff described various initiatives of the NYS Department of Health and COGME, including the State GME incentive pool program, which is designed to reward teaching hospitals for progress toward and achievement of State GME policy goals, as well as to address physician cultural competence and participation of minorities in medicine. Hospital representatives described their

use of funds awarded from the incentive pool program to support a health professional “pipeline” program for local high school students and for faculty to develop a cultural competency training curriculum. Other representatives described fellowships supported under the Empire Clinical Research Investigator Program, a component of the GME incentive pool program, to investigate the high prevalence of end-stage renal disease among African-Americans and to support increased cancer screening in collaboration with the Queens Public Library. COGME members also heard about the activities of New York’s Area Health Education Centers, which are

GNYHA Testifies at NYS Assembly Hearing on Translation Services

On November 25, GNYHA testified at a NYS Assembly hearing on hospital-provided oral and written translation services to patients with limited English proficiency (LEP) and with hearing impairments. The hearing was convened by the Committee on Health, the Legislative Task Force on New Americans, and the Legislative Task Force on People with Disabilities to examine three bills currently pending in the State legislature designed to expand these services in hospital settings.

A.5431-B, sponsored by Assembly Member Adriano Espaillat (D-NYC), would impose new and expanded State requirements on hospitals to provide language assistance services to LEP patients in all hospital settings. While clearly supporting the intent of the legislation to expand the availability of language assistance in hospitals, GNYHA opposes this legislation because the funding to allow hospitals to meet the expanded

requirements that would be imposed under the bill will never be available. Because there are existing Federal statutory and regulatory requirements, as well as requirements in existing State regulations, GNYHA instead called for collaborative efforts to identify low-cost but meaningful ways to help hospitals address the needs of their diverse communities. This bill has already passed the Assembly; a similar bill by NYS Senator Olga Mendez (R-NYC) has been introduced and referred to the Senate Health Committee.

During the hearing, GNYHA expressed support for A.8049-A by Assembly Member Richard Gottfried, Chairman of the Assembly Health Committee, and co-sponsored by Assemblyman Espaillat, which provides Medicaid reimbursement for oral and written translation services.

GNYHA will continue its advocacy related to these bills, including the exploration of other options designed to expand the current range of services hospitals currently provide to LEP and hearing-impaired patients. ■

collaborating with organizations to increase the diversity of the health workforce, and initiatives of the W.K. Kellogg Foundation. ■

GNYHA Comments on OIG Proposal to Limit Provider Charges to Medicare

GNYHA urged the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services to withdraw a proposed regulation that would limit provider charges to government programs, including Medicare and Medicaid, to 120% of the provider’s average negotiated payments “per item or service” with private health plans as well as charges or payments applicable to other private patients. The OIG sought to define what it means for a provider to submit charges to governmental programs that are “substantially in excess” of its “usual charges,” an action that would subject the provider to program exclusion for three years. This statutory language was promulgated in 1987, or prior to the development of most of the prospective payment systems (PPSs) that now prevail in Medicare. In its comments, GNYHA noted, among other things, that the rule should not apply to PPS-based and cost-based reimbursement systems; that, to the extent there might be flaws in payment policies, it is the role of the Centers for Medicare & Medicaid Services, not OIG, to correct them; that the proposal greatly exceeds OIG’s jurisdiction by imposing a charge cap tied to negotiated payment rates as a condition of participation in Medicare and Medicaid; that the rule would be extraordinarily difficult and costly to implement, if it could be implemented at all; that Congress has chosen to introduce market factors into Medicare through Medicare+Choice expansions; and that negotiated rates, which reflect business trade-offs and considerations, are not comparable to fee-for-service government payments. The proposal is notable in its definition of “usual charges” as negotiated payment rates and its definition of “substantially in excess” as 120% of that benchmark. OIG has made prior attempts to define these phrases. ■

Insurance Instability and Coverage Gaps Affect Millions of Americans

A November 2003 study by The Commonwealth Fund that followed people's health coverage between 1996 and 1999 reveals that 85 million individuals, or 38% of the U.S. population under age 65, were uninsured at some point during those four years—nearly double the 43.6 million Americans recently estimated to be without coverage in 2002. The study, *Churn, Churn Churn: How Instability of Health Insurance Shapes America's Uninsured Problem*, further revealed that most of the individuals spent a

significant amount of time without coverage. More than half of those who had a gap in coverage, or 45 million individuals, lacked health insurance for more than a cumulative total of one year during the four years, and 29 million had no insurance for more than two years. Two-thirds of those leaving Medicaid or other public insurance programs became uninsured—a problem that has plagued New York's health insurance programs. Overall, "churning" contributed to an average 2 million people losing their health coverage each month during the study period. The report notes that churning can drive up the costs of

running insurance programs and can undermine efforts to provide effective health care. Recent studies show that those who are uninsured for even short periods often forgo needed care and face difficulties paying medical bills. This problem disproportionately affects low-income Americans, minorities, and young adults. The study concludes that public policies should emphasize retention of insurance when individuals' jobs, family circumstances, or incomes change. ■

Psych PPS *continued from page 1*

wage index, which for the first 15 months of the Psych PPS would be the fiscal year 2003 hospital wage index; a 16% increase for hospitals located in rural areas; and an indirect medical education (IME) increase of one plus the hospital's ratio of interns and residents to its average daily census (IRADC), raised to the power of 0.5215.

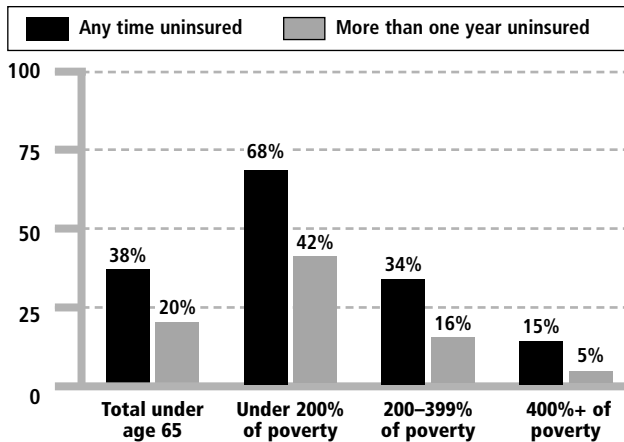
The patient-level adjustments include a 13% increase for patients aged 65 or over; an adjustment for one of 15 Inpatient PPS DRGs; and an increase for up to 17 comorbidities, which are defined based on ICD-9-CM codes.

The proposed rule also includes per-diem adjustments based on each day of the patient's stay including a 26% increase for day one of the stay; a 12% increase for days two through four of the stay; and a 5% increase for days five through eight of the stay.

The proposed rule reserves 2% of aggregate Psych PPS payments for outlier cases.

Work Plan, Resource Center: GNYHA will hold a briefing on the proposed rule for member hospitals, followed by a luncheon and a clinical workgroup (see "Upcoming GNYHA Briefings"), which will review the comorbidity adjustments that CMS included in the proposed rule. GNYHA will also provide a case-level fiscal impact analysis to each of its members. Non-member hospitals can obtain a fiscal impact analysis by subscribing to the Psych PPS Resource Center by logging onto www.theori.org and clicking on "Psych PPS." ■

Percent Uninsured, U.S. Population Under Age 65, 1996–99



Source: *Churn, Churn, Churn: How Instability of Health Insurance Shapes America's Uninsured Problem* (The Commonwealth Fund, November 2003).

Medicare Bill *continued from page 1*

a plan that costs less than the premium support provided would share in the savings, thus providing an incentive for beneficiaries to choose lower-cost plans. Medicare+Choice penetration in the NYC metropolitan area currently stands at just under 22%. The penetration is much lower in New Jersey, Connecticut, and Rhode Island.

Provider Provisions: For hospitals, H.R.1 provides for a full Medicare inpatient market basket update for the next three years, provided hospitals give the Centers for Medicare & Medicaid Services (CMS) quality data under CMS's quality initiative. Hospitals that do not provide the data requested would have their updates reduced by 0.4 percentage point. For teaching hospitals, H.R.1 would increase the indirect medical education (IME) adjustment

from the current 5.5% for every 10% increase in the ratio of interns and residents to beds to 6.0% on April 1, 2004; 5.8% on October 1, 2004; and 5.55% on October 1, 2005. This will provide teaching hospitals in NYS with approximately \$100 million more than current law would provide during that time period. Teaching hospitals in New Jersey would receive \$22 million more, Connecticut teaching hospitals would receive \$22 million more, and Rhode Island teaching hospitals would receive \$5 million more. On October 1, 2006, however, the IME adjustment would be reduced to 5.35%. On October 1, 2007, the IME adjustment would return to the current level of 5.5%. Other teaching hospital provisions include a 10-year extension of the current-law freeze on direct graduate medical education (DGME) payments for teaching hospitals with DGME per resident amounts

in excess of 140% of a geographically adjusted national average; and the redistribution to rural hospitals of 75% of the number of unused residency positions a teaching hospital had below its Medicare resident cap in the most recent cost-reporting period for which a cost report has been submitted by Sept. 30, 2002, or 2003 under certain circumstances. Participants in residency reduction demonstration projects would be exempt. H.R.1 also provides \$250 million per year for hospitals serving large numbers of undocumented immigrants. For home health care providers, the bill provides a market basket update of market basket minus 0.8 percentage point in FY 2004–06. For physicians, the bill eliminates the 4.5% reduction in 2004 and provides a 1.5% update in 2004 and 2005. ■

Assemblyman McLaughlin Holds Roundtable Discussion on Hospital Preparedness; DOH Holds Blackout Preparedness Workgroup

On November 18, NYS Assemblyman Brian McLaughlin (D-Flushing) convened a group of hospital executives and labor leaders to identify hospital emergency preparedness needs as well as to discuss potential funding and educational opportunities for hospitals as they relate to the August 2003 blackout. David Rosen, CEO of MediSys Health Network, and Stephen Mills, CEO of the New York Hospital Medical Center of Queens, shared their experiences during the blackout and expressed the need for funding to better prepare hospitals for emergency situations. Also at the roundtable were Joint Commission on Accreditation of Healthcare Organizations President Dennis O'Leary, M.D., and Joe Capiello, Vice President, Accreditation Field Operations. GNYHA emphasized that hospitals in NYC have been granted only \$125,000 each to enhance preparedness, but have spent, incrementally, on average \$5.5 million each since September 11, 2001. GNYHA also stressed that hospitals are the first line of defense during emergencies, yet they are not recognized federally as first responders. Assemblyman

McLaughlin urged that the group work together to make the case for more hospital funding. GNYHA would like to thank Assemblyman McLaughlin and will continue to work with him and other officials to secure needed funding for hospital emergency preparedness.

DOH Workgroup: On November 24, the NYS Department of Health (DOH) held its first Blackout Preparedness Workgroup meeting at GNYHA. The workgroup, which includes GNYHA as well as other organizations representing hospitals and continuing care facilities, GNYHA member facilities, and the NYC Office of Emergency Management, is charged with reviewing current standards for health care facilities in the area of power issues, as well as developing recommendations for improving future response capabilities. The workgroup discussed issues such as providing priority power restoration for health care facilities and whether end-stage renal dialysis facilities and adult homes should be required to have emergency generators. DOH expects that the workgroup will release recommendations by the first quarter of 2004. ■

Lobbying Efforts Continue on Medicare 75% Rule *continued from page 1*

Thompson to delay enforcing the 75% rule until the report is finished. It is significant that these recommendations mirror those of the Medicare Payment Advisory Commission and the rehabilitation field. Although not binding, the conference language reflects an important step in garnering legislative action on the issue.

These legislative developments are especially important because, as *Skyline News* went to press, it was still uncertain whether the Centers for Medicare & Medicaid Services (CMS) would publish a final regulation on the 75% rule by December 1, 2003—CMS's deadline for issuing a final regulation with an effective date of January 1, 2004. GNYHA understands that the regulation is in the final stages of clearance and contains only minor changes to the provisions put forth by the agency in the proposed rule. Final adoption

of those provisions would financially decimate rehabilitation providers in New York and severely impair access to needed inpatient rehabilitation services for patients.

GNYHA spoke with Secretary Thompson to convey its significant concerns about the devastating impact that the proposed 75% rule would have on its members with inpatient rehabilitation facilities and their patients. The Secretary assured GNYHA that he would personally consider the matter. GNYHA also provided the Secretary with its analysis of the adjustments to the 75% rule that are needed in order for patients in New York to maintain access to rehabilitation care. GNYHA also offered to convene a group of experts to discuss its recommendations with the Secretary.

GNYHA will continue to advocate for formal legislative action on the 75% rule and will apprise its members of developments. ■

Upcoming GNYHA Briefings

State Education Department Blue Ribbon Task Force on the Nursing Shortage

Date: Tuesday, December 2, 2003

Time: 10:00 a.m.—1:00 p.m.

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

This briefing will address the survey report recently released by the NYS Education Department and the NYS Board of Regents on the nursing shortage. Barbara Zeital, R.N., Ph.D., Executive Secretary of the NYS Board for Nursing, will be the keynote speaker, and will discuss the highlights of the report. The briefing will highlight Volumes I, II, and III of the survey results, which include responses from over 12,000 nurses from NYS. For more information contact Terri Straub, and to register contact Rosanne Denaro, at GNYHA.

LTC Emergency Preparedness Workshop

Date: Monday, December 8, 2003

Time: 10:00 a.m.—12:00 noon

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

This workshop is intended to assist members of the Continuing Care Leadership Coalition (CCLC) in understanding emergency preparedness regulations and developing and sustaining effective emergency preparedness systems. The workshop will feature representatives from the Office of Health Systems Management from the NYS Department of Health, the NYC Office of Emergency Management, the CCLC membership, and GNYHA. The workshop is designed for CEOs/Administrators as well as staff involved with emergency management. The content is tailored specifically to nursing facilities. For more information contact Roxanne Tena-Nelson at (212) 506-5412, and to register contact Jenifer Fergusson at (212) 258-5330, at CCLC.

Psych PPS

Date: Monday, December 15, 2003

Time: Executive Briefing, 10:00 a.m.—12:00 noon; Luncheon, 12:00 noon—1:00 p.m.;

Clinical Workgroup, 1:00 p.m.—3:00 p.m.

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

GNYHA has scheduled a briefing, luncheon, and clinical workgroup meeting on the new Medicare Psych prospective payment system (PPS), which will apply to psychiatric hospitals and psychiatric units within general hospitals that are exempt from the general hospital inpatient PPS and are, instead, currently reimbursed under the rules of the Tax Equity and Fiscal Responsibility Act of 1982. The briefing is recommended for psychiatric administrators and clinicians, as well as directors of financial planning and reimbursement, in these facilities. The clinical workgroup is recommended for psychiatric administrators and clinicians. For more information contact Karen Heller, and to register contact Theresa Simon, at GNYHA. ■