AUGUST 5, 2002

Skyline news

REPORTING ON NEW YORK'S HEALTH CARE NEWS

Senate Approves Drug and Medicaid Provisions but Postpones Action on Medicare

Last week, the U.S. Senate approved the Greater Access to Affordable Pharmaceuticals Act (S.812), sponsored by Senators Charles E. Schumer (D-NY) and John McCain (R-AZ), which is designed to close loopholes in the Federal Food, Drug and Cosmetic Act that allow brand-name drug companies to extend exclusive patents and keep equivalent, lower-cost generic drugs off the market. The bill, if enacted, is projected to save Americans billions of dollars in prescription drug costs over the next 10 years. The Senate also approved a provision, sponsored by Senator Byron Dorgan (D-ND), that would allow wholesalers and other pharmaceutical distributors to re-import outpatient pharmaceuticals from Canada, where drug prices tend to be much lower than prices charged in the United States.

Medicaid: As part of the bill, the Senate also approved an amendment offered by Senators Jay Rockefeller (D-WV) and Susan Collins (R-ME) that would provide substantial, temporary relief for State Medicaid budgets by increasing the Federal Medicaid matching rate, known as the "FMAP," by 1.35 percentage points for 18 months. Under the amendment, states would not be allowed to tighten

continued on page 2

Johnson Holds Hearing on Wage Index Issues; Experts Challenge "Conventional Wisdom"

On July 23, Congresswoman Nancy Johnson (R-CT), Chairman of the U.S. House Ways and Means Subcommittee on Health, held a hearing on the adequacy of Medicare's geographic cost adjustments used to adjust Medicare payment rates to reflect differences in costs across geographic areas. These adjustments include the hospital wage index, which is used to adjust Medicare prospective payment system (PPS) rates for hospitals, skilled nursing facilities, and other providers. The hospital wage index varies by metropolitan statistical areas (MSAs), as defined by the Office of Management and Budget. Providers that are not situated in MSAs are subject to a wage index calculated for providers in all non-metropolitan areas within a state. While expressing concern about the competitive disadvantage experienced by hospitals in Connecticut that are trying to recruit quality health care personnel and are situated very close to hospitals in other MSAs with higher Medicare payments, Chairman Johnson made clear that she did not believe that there are any easy solutions to perceived problems in the wage index methodology. "This is . . . one of the more complex and confusing [topics] that I have worked on as Chairman of this Subcommittee," she said. Despite testimony from over 30 members of Congress from all over the country, all seeking legislative reclassifications for hospitals in their districts into neighboring MSAs in order to receive higher Medicare reimbursements, Chairman Johnson pointed out that Medicare experts do not tend to agree that Medicare wage index areas should be

continued on page 3

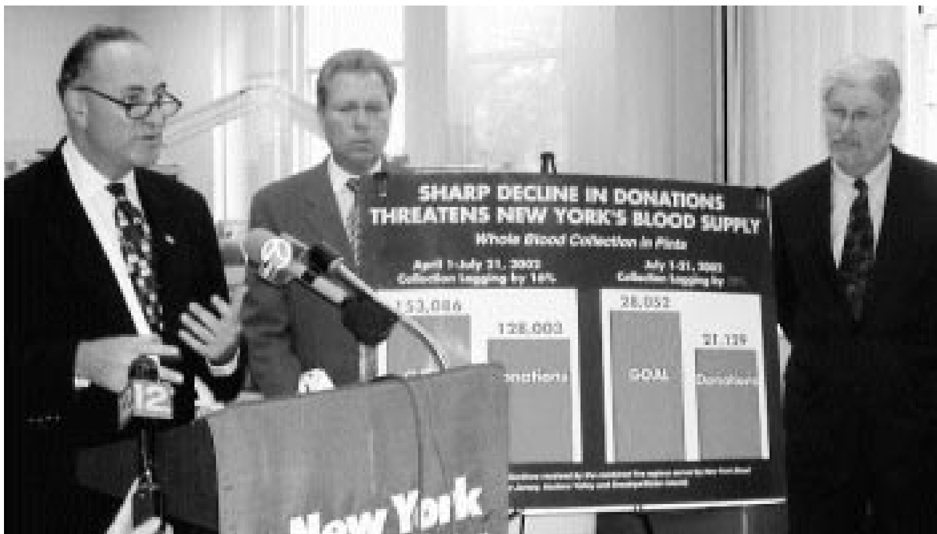
Nurse Reinvestment Act Is Passed

On July 22, the House and Senate passed the Nurse Reinvestment Act (S.1864/H.R. 3487) to help alleviate the nursing shortage. The language establishes a National Nurse Service Corps to increase the number of nurses eligible for scholarships in exchange for serving in critical shortage areas for two years, to be defined by the Secretary of Health and Human Services (HHS), which can include urban areas experiencing a nursing shortage. The bill establishes Faculty Loan Programs for schools of nursing to train graduate students who in turn join nursing faculties. The Act provides grants for health care facilities to recruit and retain nurses by expanding enrollment in baccalaureate nursing programs, developing internship and residency programs to encourage mentoring and the development of specialties, and providing education in new technologies. Priority funding will go to facilities providing care to under-

continued on page 4

Senator Schumer Calls on New Yorkers to Increase Blood Donations as Region Faces Summer Shortage

On July 28, 2002, GNYHA participated in a press conference with Senator Charles E. Schumer, who called on New Yorkers to donate blood to compensate for a recent drop in local blood donations. According to the New York Blood Center, local collections were 25% below their usual level for the month of July, and 16% below normal collection levels for the period between April and July. Senator Schumer said that recent donor eligibility restrictions imposed by the U.S. Food and Drug Administration (FDA) have contributed to the current drop in local blood collections. The FDA decision stems from concerns about possible transmission of bovine spongiform encephalopathy (BSE, or the human form of "mad cow disease") in humans through blood transfusions. Despite no known cases of BSE transmission through blood transfusions, in May 2002 FDA guidelines became effective preventing anyone who spent more than three months in the United Kingdom from 1980 to 1996 from donating blood. On October 31, 2002, additional FDA guidelines will become effective, preventing anyone living in Europe for five years or more since 1980 from donating blood. According to the New York Blood Center, these restrictions will have a particularly devastating impact in metropolitan New York because approximately 25% of its blood supply is imported from European countries.



Left to right: Senator Charles E. Schumer, GNYHA President Kenneth E. Raske, and New York Blood Center President and CEO Robert Jones, M.D., M.B.A. at the press conference on the recent drop in local blood donations.

In an effort to stem the anticipated shortfall, Senator Schumer called on U.S. Department of Health and Human Services Secretary Tommy Thompson to direct the FDA to delay implementation of its decision to ban the importation of blood from Europe until the FDA can guarantee an alternative solution. At the press conference, Senator Schumer stated that a ban on "Euro blood" may have a devastating impact in the event we experience another terrorist attack. He said, "In light of the events of September 11 and the new risks and needs created by the ever-present threat of terrorism, New York's hospitals may now face the unthinkable task of deciding which victims of a trauma or terrorist attack will receive access to a limited, if not fully depleted, supply of blood, and which will not." ■

Senate Approves Drug and Medicaid Provisions but Postpones Action on Medicare *continued from page 1*

eligibility requirements during the period of the FMAP increase. The Rockefeller/Collins amendment, which was strongly supported by New York Senators Schumer and Hillary Rodham Clinton and New Jersey Senators Robert G. Torricelli and Jon Corzine, also temporarily increases Federal funding for the Title XX Social Services Block Grant, which provides funding for states for various social programs. If the bill is enacted, New York expects to receive over $1 billion in financial help. GNYHA strongly supported the Rockefeller/Collins amendment and is hopeful that the House will pass similar legislation, sponsored by Congressman Peter King (R-NY).

Medicare: The Senate was not able to muster enough votes to pass any of a variety of amendments to create a Medicare prescription drug benefit. The Senate also did not take action on proposals to spare health care providers from Medicare reimbursement rate cuts that are scheduled to take effect on October 1, 2002. These cuts include a Medicare indirect medical education (IME) cut that will reduce payments to New York and New Jersey teaching hospitals by $170 million in the coming year; the expiration of reimbursement rate add-ons for skilled nursing facilities (SNFs), which will cost SNFs nationwide approximately $1 billion in FY 2003; and Medicare payment reductions for physicians and home health agencies. The Senate Finance Committee now plans to consider provider legislation after the Senate's August recess. During Finance Committee deliberations, GNYHA will be working closely with Senator Torricelli, a member of the Finance Committee; Senator Max Baucus (D-MT), Chairman of the Committee; and Senators Schumer, Clinton, and Corzine to ensure that GNYHA members do not suffer any new Medicare cuts. Senators Torricelli, Schumer, Clinton, and Corzine have been extremely supportive of New York and New Jersey's hospitals and continuing care providers. ■

Johnson Holds Hearing

continued from page 1

enlarged, as many of the members of Congress testified. Referring to witnesses from the U.S. General Accounting Office (GAO), the Medicare Payment Advisory Commission (MedPAC), and the Urban Institute, Chairman Johnson stated, "These experts will tell us that the conventional wisdom may not be right—small rural hospitals are helped by the wage index and large teaching hospitals in the inner cities are disadvantaged." Indeed, William J. Scanlon, GAO Director of Health Financing and System Issues, testified that, because MSAs may extend over several thousand square miles, the hospitals within an MSA may need to pay varying wages to attract workers and may actually be in very different labor markets. "Hospitals in central counties of an MSA typically pay higher wages than hospitals in outlying counties," Scanlon stated. "Central county hospital wages ranged from 7% higher than outlying county hospital wages in Houston to 38% higher in New York City. In most of the MSAs with the highest population, the difference was from 11% to 18% in fiscal year 1997." Scanlon also pointed out that, because Medicare uses the same labor cost adjustment for all hospitals in the non-metropolitan areas of a state, which can be extremely large, hospitals in large towns, where average wages paid by hospitals are higher than those paid by hospitals in small towns or rural areas, are disadvantaged. Similarly, Glenn M. Hackbarth, J.D., MedPAC Chairman, testified that "MSAs and statewide rural areas are frequently too large to capture homogeneous labor markets for health care workers. . . . Hospitals in outlying suburban counties generally appear to face lower market wage rates than those located in the central core of the same MSA. Similarly, hospitals located in outlying rural areas appear to face lower wage rates than those located in counties adjacent to MSAs." Both Scanlon and Hackbarth testified that one solution may be to refine the methodology by dividing MSAs and non-MSA rural areas into smaller units that more accurately reflect labor markets.

The New York MSA: A number of members of Congress testified in favor of legislative reclassifications of hospitals outside the NYC MSA (which includes NYC and Rockland, Westchester, and Putnam counties) into the NYS MSA. Congresswoman Sue Kelly (R-NY) and Congressman Maurice Hinchey spoke in favor of reclassifying the hospitals in Dutchess, Orange, Ulster, and Sullivan counties; Congresswoman Marge Roukema (R-NJ) testified in favor of reclassifying hospitals in northern New Jersey into the New York MSA; and Congressman Christopher Shays (R-CT) testified in favor of reclassifying the hospitals in Fairfield County, Connecticut into the New York MSA. The American Hospital Association also submitted testimony stating that the current MSA system disadvantages rural hospitals. ■

News is Mixed in Medicare Hospital Inpatient PPS Final Rule

On August 1, the Centers for Medicare and Medicaid Services (CMS) published its final rule for fiscal year 2003 Medicare hospital inpatient prospective payment system (PPS) rates in the *Federal Register*. On the positive side, CMS did not expand the list of diagnosis-related groups (DRGs) in which patients discharged to post-acute care would be reimbursed as transfer cases. When a case is reimbursed as a transfer, it receives less than the full DRG payment if its length of stay is more than one day less than the geometric mean length of stay for the DRG. GNYHA had strongly advocated against an expansion as it would violate the principal tenet of the PPS, which is that paying hospitals an average amount for every case will generate surpluses for low-cost cases that hospitals can use to offset deficits incurred on high-cost cases. On the negative side, CMS established a cost outlier threshold for FY 2003 of $33,560, an amount that is 60% higher than last year's threshold, and $110 higher than the threshold in the proposed rule. Outlier payments are made for cases whose costs exceed their payments—that is, cases that generate losses for the hospital. The outlier *threshold* functions like a deductible in that the wage-adjusted threshold is subtracted from the loss before an outlier payment is made for the case. Increasing the outlier threshold will therefore make it much more difficult for hospitals to receive outlier payments for cases on which they incur substantial losses. To illustrate, the wage-adjusted threshold for NYC hospitals—the amount of loss per case that hospitals have to absorb—was $27,643 in FY 2002, but will increase to $44,092 in FY 2003. GNYHA and the American Hospital Association had sharply criticized the methodology that CMS used to derive the outlier threshold as being based on flawed economic theory. Other disappointing news was that CMS reneged on an agreement with the hospital industry to phase teaching data out of the area wage index over a five-year period, opting instead to cancel the last year of the phase-out . Lastly, CMS decided not to update the labor share of the PPS rate because its empirical analysis called for a slight increase that would disadvantage hospitals in low-wage index areas. This is the first time CMS has declined to make such an empirically derived change. With respect to specific payment parameters, the wage indices for the NYC and Long Island metropolitan statistical areas will be 1.4414 and 1.3357, respectively, and the update will be higher than originally proposed, 2.95% versus 2.75%, because the final rule market basket increase was 3.5%. The FY 2003 update is the market basket increase minus 0.55 percentage points, as stipulated by Congress. ■

Upcoming GNYHA Briefing

September 11th Fund Mental Health and Substance Abuse Program

Date: *Friday, August 9, 2002*

Time: *9:30 a.m. – 11:00 a.m.*

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

At this briefing, Steve Cohen of the September 11th Fund, Maggie Tapp of the American Red Cross, and Jerry McCleary from the Mental Health Association of New York will describe the September 11th Fund's Mental Health and Substance Abuse Program, to be launched in mid-August. The briefing will define criteria for participation, eligibility requirements, and program reimbursement. For more information contact Ellen Lukens, and to register contact Theresa Simon, at GNYHA. ■

New York State to Implement Mandatory Medicaid Generic Drug Program

Effective October 1, 2002, NYS will implement a new mandatory generic pharmaceutical program for clients in the Medicaid fee-for-service and managed care programs. Under the new program, brand name drugs will not be covered by Medicaid if an A-rated generic equivalent is approved by the U.S. Food and Drug Administration. Exceptions will exist for individual drugs that are exempted by the NYS Commissioner of Health, who is being advised by a Medicaid Pharmacy and Therapeutics Committee, and on a case-by-case basis for individual pre-authorized patients. The initial drug exemptions granted by the Commissioner are for Tegretol (to treat epilepsy and behavioral disorders); Clozaril (psychotic disorders and schizophrenia); Neoral, Gengraf, and Sandimmune (transplants); Lanozin (heart failure); Zarontin and Dilantin (epilepsy); and Coumadin (anti-coagulant). Medicaid will continue to cover these and other multi-source brand name drugs that are added to the exemption list. Prescribers who wish their patients to receive other brand name drugs rather than their generic equivalents will be required to complete a prior authorization process via telephone, after which the brand name prescription will be covered for up to six months, the maximum prescribing period under Medicaid. Patients without authorization will still be able to receive a three-day emergency prescription.

The NYS Department of Health (DOH) estimates that drugs subject to the new mandate represent 6% of all pharmacy claims to Medicaid and 8% of total pharmacy spending, estimated to reach $3.6 billion in 2002–03. DOH also estimates that 50% of current claims are for brand name drugs for which no generic equivalent exists, consuming 80% of total Medicaid pharmacy spending, and that 42% of claims are for generic drugs, or 13% of all spending. The State estimates total annualized Medicaid savings from the program at $20 million. Family Health Plus and commercial Child Health Plus enrollees are not affected. ■

Nurse Reinvestment Act

continued from page 1

served populations or high-risk groups, developing cultural competencies, and providing managed care or quality improvement skills. A separate component provides training and education support for geriatric nurse training programs. The Act also directs the HHS Secretary to create public service announcements promoting the nursing profession. Funding is authorized through fiscal year 2007. Members of Congress must still designate funds for the Nurse Reinvestment Act as part of the appropriations process. GNYHA would like to thank all the members of the New York Congressional Delegation for their support on this issue, in particular Representatives Sue Kelly and Eliot Engel and Senator Hillary Rodham Clinton, whose legislation contributed significantly to the final agreement. ■

CMS Clarifies Medicare Homebound Criteria

On July 26, the U.S. Department of Health and Human Services and the Centers for Medicare and Medicaid Services clarified the Medicare "homebound" criteria for home health agencies. The new instructions make clear that chronically disabled individuals who qualify as homebound should not lose home health services because they leave their home infrequently for occasions such as family reunions, graduations, and funerals. The instructions expand the examples of non-medical absences from home and note that the expanded list is not inclusive; make more flexible the list of conditions indicating that the patient cannot leave the home; and clarify that the determination of "homebound" should be made based on the patient's overall condition and experience over a period of time. The new instructions support Congress's earlier efforts to allow "homebound" patients to attend adult day care programs or religious services. ■

GNYHA Participates in CMS Listening Session

On July 19, GNYHA staff and members participated in two "listening sessions" for hospitals and continuing care providers sponsored by the regional office of the U.S. Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS). Organized by Deborah Konopko, HHS Secretary Tommy Thompson's Regional Representative, and moderated by Tom Barker, CMS Administrator Tom Scully's Senior Outreach Advisor, the session was part of a continuing effort by CMS to improve communication between providers and the agency. At the continuing care session, discussion centered around 1) publicly reporting performance data on nursing homes nationwide before the release of three validation studies; 2) publishing data for the public before facilities have a reasonable amount of time to confirm the data; 3) requiring facilities to spend significant amounts of time away from residents to complete the Minimum Data Set (MDS); and 4) shortfalls of the current survey and enforcement environment to effectively improve quality. GNYHA thanked HHS and CMS for extending the Medicare rate add-ons for selected RUG categories, streamlining the MDS assessment tool for certain submissions, and publishing the proposed rule to allow nursing homes to hire paid feeding assistants. During the hospital session, there was discussion of various Medicare rule proposals, including those that would create a new long term care hospital prospective payment system (PPS); significantly reduce hospitals' ability to receive payment for extremely high-cost cases, or outliers; and further reduce payments when hospitals transferred patients to other hospitals or settings. Also discussed were issues related to improving the efficiency of the hospital cost report audit process, aspects of the outpatient PPS, implementation of the inpatient rehabilitation facility PPS, the administrative simplification provisions of HIPAA, and other topics. GNYHA is grateful to Ms. Konopko and Mr. Barker for offering these listening sessions. ■