GREATER NEW YORK HOSPITAL ASSOCIATION
GNYHA

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Skyline news

REPORTING ON NEW YORK'S HEALTH CARE NEWS

Governor Pataki Releases 2001–02 Budget Proposal; Includes Medicaid Cuts for Continuing Care Providers

On January 16, 2001, New York Governor George E. Pataki released his budget proposal for the fiscal year beginning April 1, 2001. In a move criticized by the bipartisan leadership of both houses of the State Legislature, the Governor proposed large new Medicaid cuts estimated to cost the State's nursing homes $328 million in Medicaid revenue in the coming fiscal year. Both Assembly Speaker Sheldon Silver and Senate Majority Leader Joseph Bruno view these new nursing home cuts as a violation of the Medicaid agreement reached when the Health Care Reform Act 2000 (HCRA 2000) was enacted. That agreement,strongly supported by GNYHA, called for no new Medicaid reimbursement rate cuts for all providers through March 31, 2003. GNYHA strongly opposes these new Medicaid cuts and will work hard to ensure that they are not adopted in the final 2001–02 budget.

Following is a brief summary of the Governor's health care budget proposals.

Medicaid: The Governor proposes $131 million in State share savings through new Med-

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New Data Show New York Hospitals Are Poor But Efficient

The newly released *2001 Almanac of Hospital Financial & Operating Indicators* by the Center for Healthcare Industry Performance Studies (CHIPS) shows that, in 1999, New York hospitals had the worst financial condition of any state's hospitals in the United States, but that they

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CHIPS Comparative Financial and Operating Indicators

Indicator	Median New York Result	Median U.S. Result	New York Rank	Total States Reporting	New York Quartile
Overall index of financial flexibility	(2.388)	2.009	43	43	4
Components of index					
Total margin	–0.3%	3.4%	42	45	4
Return on investment, inflation-adjusted	5.6%	8.5%	42	44	4
Replacement viability	6.8%	20.2%	39	44	4
Equity financing ratio	44.7%	59.6%	42	45	4
Days cash on hand,short-term	19.4	24.8	40	45	4
Cash flow to total debt	11.9%	21.3%	42	45	4
Average age of plant (in years)	10.93	9.31	43	44	4
Operating indicators					
Per discharge					
Adjusted net price	$4,367	$5,253	3	34	1
Adjusted cost	$4,523	$5,312	3	34	1
Per outpatient visit					
Adjusted net price	$185	$267	3	35	1
Adjusted cost	$181	$267	3	34	1

Congress Receives Committee Assignments

Over the last two weeks, the Congress assigned committee members and held Cabinet hearings in preparation for the start of the 107th Congress. New York Congressional delegates retained their previous health-related committee seats and gained one in the Senate.

Senate: Senator Charles Schumer remains

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MedPAC Makes Recommendations on Post-Acute Care and DME Payments

In recent weeks, the Medicare Payment Advisory Commission (MedPAC) made recommendations that will be included in its March 2001 report to Congress.

Post-Acute Care: On January 11, 2001, MedPAC finalized its recommendations related to post-acute care,including a recommendation to support the development of a new Medicare post-acute payment system. MedPAC recommended that, during the development of the new system, the current RUG-III case-mix system continue to be used for skilled nursing facilities (SNFs). At MedPAC's fall 2000 meetings, researchers outlined what they considered to be the primary shortcomings of the RUG-III system: 1) the minimum data set (MDS) assessment tool was designed for long term nursing home residents and lacks appropriate variables for higher-acuity Medicare residents in SNFs; 2) the RUG-III system uses staff time as the measure of resource utilization rather than the costs of providing SNF care; and 3) the MDS does not provide accurate assessment data for case-mix classification.

MedPAC researchers stated that the U.S. Health Care Financing Administration's (HCFA's) development of the new post-acute payment system should take part simultaneously with the development of assessment

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NYS Announces $500 Million in Transition Funds for Medicaid Managed Care

On January 9, 2001,Governor George E. Pataki announced that the process for distributing $500 million in managed care transition funding to 89 hospitals that treat high proportions of Medicaid and uninsured patients would begin. The funds are available through the Community Health Care Conversion Demonstration Project (CHCCDP), a component of New York's section 1115 mandatory Medicaid managed care waiver. In all, CHCCDP will provide $1.25 billion over the years of the waiver to eligible hospitals for purposes of making the transition to managed care and to train their employees to accommodate these changes. The $500 million represents two years of funding attributable to program years 1998 and 1999. CHCCDP hospitals must undertake programmatic goals,including developing needed primary care services to ensure the success of Medicaid managed care,and related initiatives.

Under the terms of the 1115 waiver, eligible hospitals include those that had at least 5,000 inpatient discharges in a base year, at least 20% of which were for Medicaid and uninsured patients. The base year is updated with each award cycle. The formula, which increases funding as the hospital's level of Medicaid and uninsured services as a proportion of total services increases, produced individual hospital award amounts ranging from $166,232 to $22,615,197. Hospitals and worker retraining entities in New York City will receive 87% of the total amount,including 35% that the New York City Health and Hospitals Corporation will receive. The State's rules require that hospitals spend between 10% and 25% of their CHCCDP amounts on worker retraining. Of the $500 million total, at least $123 million will be spent for such purposes. The table below shows how the funds were distributed. ■

Distribution of CHCCDP Funds to NYS Hospitals

Distribution	Number of Hospitals	CHCCDP Allocation	Percent of Total	Worker Retraining Portion
NYC	43	$433.5 M	86.7%	$108.2 M
Rest of NYS	46	$66.5	13.3%	$14.5 M
Total	89	$500 M	100%	$122.7
Public[a]	18	$196.0 M	39.2%	$48.9 M
Voluntary	71	$304.0 M	60.8%	$73.8 M
Total	89	$500 M	100%	$122.7 M

[a] Includes municipal and State public hospitals.

1999 HCRA GME Incentive Pool Recipients Announced

On January 10, 2001, Governor George E. Pataki announced the recipients of funds from the 1999 Graduate Medical Education (GME) Incentive Pool, which was included as part of the Health Care Reform Act (HCRA) of 1996. The incentive pool rewards hospitals and GME consortia for meeting State policy goals in the areas of downsizing residency programs, increasing primary care training, maintaining and promoting quality, and increasing the number of underrepresented minorities in GME training. Sixty-six hospitals in New York State,including 20 hospitals in three GME consortia, will receive $54 million in funding. This amount represents the final distribution of GME incentive pool funds authorized under HCRA 1996.

The GME incentive pool was continued in HCRA 2000, but with modifications to the requirements and at a lower funding level of $31 million. The New York State Department of Health (DOH) is currently reviewing the exact requirements for the HCRA 2000 GME incentive pool. In September 2000, GNYHA sent detailed recommendations to the Commissioner of Health regarding the new requirements, and requested an interim payment system for future incentive pool distributions. DOH is investigating the possibility of implementing such a system for the HCRA 2000 GME incentive pool funds. ■

Governor Pataki Releases 2001–02 Budget Proposal *continued from page 1*

icaid cuts for nursing homes. When the Federal and local shares are added, the entire cut to nursing homes from the Governor's proposals total about $328 million. The Governor's specific Medicaid cuts for nursing homes include:

- eliminating the 2001–02 inflation increase for a State savings of $50 million (cost to nursing homes statewide: $125 million);
- eliminating the Medicaid reimbursement adjustment for nursing homes with more than 300 beds for a State savings of about $24 million (cost to nursing homes statewide: $60 million);
- eliminating Medicare data from the case mix cap calculation used to determine Medicaid reimbursements for a State savings of approximately $46 million (cost to nursing homes statewide: $115 million);and
- eliminating payments related to return on equity for proprietary nursing homes for a State savings of approximately $11 million (cost to proprietary nursing homes statewide: $28 million).

The Governor also proposes to cap Medicaid payments to certified home health agencies (CHHAs) for administrative costs, for a State savings of $2 million and a cost to CHHAs statewide of $5 million. As previously announced by the Governor, the budget also contains a proposal to increase the New York State Department of Health's long-term care surveillance activities including a greater number of on-site inspections. The Governor also announced that he will propose legislation that includes criminal background checks for nursing home and home care employees who provide direct care, and increased fines for noncompliance. The revenues gained from the fines will be placed in a "Quality of Care Incentive Account and will be reinvested in quality improvement programs for nursing homes." In addition,the Governor has proposed the following Medicaid changes:

- maximizing revenues through the use of hospital intergovernmental transfers;
- allowing disabled individuals with incomes up to 250% of the Federal poverty level to buy in to the Medicaid program;
- allowing women with incomes up to 250% of the Federal poverty level who have been diagnosed with breast or cervical cancer through the Centers for Disease Control's screening program to receive Medicaid benefits;
- requiring Medicaid managed care enrollees to pay the same copayments for prescription drugs that are required of fee-for-service beneficiaries;and
- establishing an interagency group on Medicaid fraud and instituting a rapid response audit team.

The budget document also says that New York City will continue to phase in mandatory managed care by zip code in five phases, one every four months, beginning in the last quarter of fiscal year 2000–01. The Governor estimates that this schedule will provide 796,000 Medicaid managed care enrollees by the end of 2000-01 and 1.1 million by the end of State fiscal year 2001–02 (March 31, 2002). He also reiterates the State's intention to begin implementation of HIV special needs plans in 2001–02.

Other Health Initiatives: The Governor has also proposed the following new health initiatives: extending the Child Health Plus program, which is due to expire this year, through June 30, 2003; providing $5.8 million in additional funds to implement the Health Information and Quality Improvement Act of 2000,including the physician profiling and syringe access programs; providing $5 million to implement the newborn hearing screening program; and providing $216.8 million to counties and New York City for public health services, including a 30% increase in funding for the State's response to the West Nile virus.

Biomedical Research: The Governor has proposed adding $31.5 million to begin the implementation of the plan described in the State of the State address to utilize $283 million in State funds over the next five years to invest in university research facilities, provide funding to secure new Federal matching research grants,create new business incubators and business parks, train and recruit highly skilled employees, and increase support for emerging and growing high-tech firms. The proposed $283 million in State funds are expected to leverage over $700 million in combined Federal,university, and private funds to create a total program of $1 billion over five years for high technology and biotechnology. The $283 million would be used to support three "centers of excellence" already under development in Buffalo, Rochester, and Albany. Additionally, the Governor proposes expanding the centers of excellence to other areas of the State,including medical schools, health centers, and research institutions in New York City. ■

HCFA Delays Implementation of Inpatient Rehab PPS

The U.S. Health Care Financing Administration (HCFA) has announced that it cannot implement the inpatient rehabilitation prospective payment system (PPS) on April 1, 2001, as previously scheduled. The new implementation date will be announced in the final rule. Comments on the proposed rule are due February 1, 2001. ■

New York Hospitals Are Poor But Efficient *continued from page 1*

scored well on efficiency indicators. This finding confirms what New York hospital administrators have known for years: their financial problems are the result of insufficient revenue rather than high costs. Furthermore, the CHIPS data show that the financial condition of New York hospitals began to deteriorate in 1997, the first year of deregulation, and continued to deteriorate in 1998 and 1999 as a result of the Medicare payment policy cuts in the Balanced Budget Act of 1997. CHIPS measures a hospital's overall financial condition with the "financial flexibility index," which is a composite of seven financial indicators representing profitability, liquidity, capital structure,and other financial ratios. The table on page 1 summarizes New York's comparative performance on these indicators as well as several efficiency indicators. ■

MedPAC Makes Recommendations Affecting Post-Acute Care and DME Payments *continued from page 2*

instruments with common core elements for acute, post-acute, and outpatient care required under the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). Pursuant to BIPA, HCFA must consult with both the Agency for Health Care Research and Quality and MedPAC during the development of the assessment instruments. With respect to the proposed inpatient rehabilitation prospective payment system, or PPS (not used for SNF rehabilitation), MedPAC recommended that the Functional Independence Measure be used to assess patients, that the proposed outlier policy be studied, and that the disproportionate share adjustment be reexamined. For the provision of home health care services, MedPAC recommended that the Secretary monitor performance of the home health PPS, paying particular attention to the use of "significant change in condition" payment adjustments and payments for patients with wound care needs.

Elimination of the Resident Count Weighting Factor for DME Payments: On January 12, 2001, MedPAC approved a recommendation to eliminate the weighting factor used to determine the resident count for calculating Medicare direct graduate medical education (DME) payments. Under the current policy, a resident who is in the initial residency period (IRP) is counted as 1.0 full-time equivalent employee (FTE), and a resident who is beyond the IRP is counted as 0.5 FTE. The IRP is defined by Medicare as the minimum number of years required to achieve Board eligibility in a speciality. Medicare's DME payment is calculated per FTE, and the current formula essentially halves DME payments for subresidents training in specialties such as cardiology or pediatric gastroenterology.

MedPAC's recommendation would allow all residents to be counted as 1.0 FTE. The provision would be implemented in a budget-neutral manner, thereby redistributing DME payments to providers that train subspecialty residents. The proposed change would have no effect on the resident count used to determine Medicare indirect medical education payments. MedPAC's recommendation is consistent with recent reports of a growing shortage of specialty physicians. ■

JCAHO to Pilot a Process to Assess Staffing Effectiveness

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has announced plans to test an approach to assess the effectiveness of staffing in health care organizations, including acute care hospitals and long term care facilities. JCAHO notes that it is taking this step in recognition of the fact that effective staffing is a significant concern among health care professionals and the public.

Based on a search of the literature and the recommendations of a "broad-based panel of experts," JCAHO has identified a set of measures thought to be sensitive to staffing effectiveness and known to encompass data that most organizations already collect. The measures will include clinical indicators (patient falls, medication errors, skin breakdown, pneumonia after surgery) and human resource indicators (overtime, staff satisfaction, patient complaints, nursing care hours, staff turnover rates). The approach is designed to emphasize the relationship between human resources and clinical outcomes, and calls for multiple indicators to be examined in combination, based on the premise that no one indicator alone is likely to reflect staffing effectiveness. JCAHO defines staffing effectiveness as the number, competency, and skill mix of staff related to the provision of needed services.

Following approval of the staffing standards by JCAHO's Professional and Technical Advisory Committees and JCAHO's Survey and Procedures Committee, the model will be subject to pilot testing and field review, at which time providers will be given the opportunity to comment and make recommendations regarding the assessment model and process. Implementation is targeted for 2002. ■

Congress Receives Committee Assignments *continued from page 1*

on the Judiciary Committee, which has oversight on immigration issues. He also sits on the Banking, Housing, and Urban Affairs Committee, and received a new appointment to the Committee on Energy and Natural Resources. Senator Hillary Clinton was appointed to the Health, Education, Labor, and Pensions (HELP) Committee, which has jurisdiction over issues such as public health and children and families, and has debated the patient's bill of rights. Senator Clinton attended her first hearing as a member of the HELP Committee on January 19, when the committee considered the nomination of Governor Tommy Thompson to be Health and Human Services Secretary. At the hearing, Senator Clinton expressed interest in working to enact a long term care (LTC) tax credit to help families afford LTC and a strong, enforceable patient's bill of rights, and to extend the State Children's Health Insurance Program to cover entire families. Senator Clinton was also appointed to the Budget Committee (which reviews tax expenditures, duties of the Congressional Budget Office and the overall budget process) and is on the Committee on Environment and Public Works.

House: New York Congressional delegates retained their positions on House health care committees. Congressmen Amo Houghton, Michael McNulty, and Charles Rangel will hold their positions on the Ways and Means Committee, which has jurisdiction over Social Security, Medicare, and Medicaid. Congressman Rangel is the ranking minority member on Ways and Means. Congressmen Vito Fossella, Edolphus Towns, and Eliot Engel were appointed to the newly merged Energy and Commerce Committee, which has jurisdiction over Medicare Part B, Medicaid, and the State Children's Health Insurance Program. Congresswoman Nita Lowey will remain on the Labor Health and Human Services Appropriations Subcommittee, which funds the department responsible for Medicare and Medicaid payments. ■