



Skyline news

REPORTING ON NEW YORK'S HEALTH CARE NEWS

House Passes New BBA Relief Act; President Clinton Threatens to Veto

Last week, the House of Representatives passed a bill that would provide health care providers with relief from the damaging cuts contained in the Balanced Budget Act of 1997 (BBA); however, contending that the legislation provides more funding for Medicare managed care plans than warranted and does not provide enough funding for teaching hospitals, home health providers, and other direct caregivers, President Clinton has vowed to veto the bill. As *Skyline News* went to press, GNYHA was working with the Clinton Administration and Congressional Republicans and Democrats to ensure that the parties would begin to work together to ensure enactment of significant BBA relief legislation this year. GNYHA's priorities include ensuring that legislation protects New York State's Medicaid program against decreases that would result from proposed new Federal restrictions on inter-governmental transfers (IGTs). The bill, entitled the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000), is designed to build upon last year's Balanced Budget Refinement Act of 1999 (BBRA) by providing an additional year or two of relief for all providers. Following is a summary of the provisions that BIPA 2000 contains.

Teaching Hospitals: BIPA 2000 maintains the indirect medical education (IME) adjustment at the FY 2000 level of 6.5% in FY 2001,

and provides for a higher adjustment in 2002 (6.375%) than required under current law.

With regard to direct graduate medical education (DGME), BIPA 2000 raises the per resident amount "floor"—set by the BBRA at 70% of the geographically adjusted national average—to 85%.

Disproportionate Share Hospitals: BIPA 2000 reduces the Medicare payment reductions for disproportionate share hospitals (DSH) by one percentage point in 2001 and 2002. All DSH reductions expire after 2002.

Other Hospital Provisions: BIPA 2000 also enacts the following provisions for hospitals.

- Eliminates the inpatient prospective payment system (PPS) market basket update reduction for 2001, and spreads the update reduction in 2002 over two years, providing an update of market basket minus 0.55% in 2002 and 2003.
- Reduces the reduction in bad-debt costs that are allowable for Medicare reimbursement from 45% to 30%, effective FY 2001 and years thereafter.
- Grants the Department of Health and Human Services (HHS) Secretary the authority to adjust the average standardized amounts for the inpatient PPS, as well as the conversion factor under the outpatient PPS, to account for changes in case mix that the Secretary deems are not due to real case mix changes, but to coding or classifica-

tion changes only.

- Eliminates the outpatient market basket update reduction for 2001.
- Amends the implementation of the U.S. Health Care Financing Administration's (HCFA's) provider-based rule by providing a two-year grandfather provision for all facilities or organizations that were treated as

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New York State Proposes to Advance CHCCDP Funds

In a letter dated October 19, 2000, the New York State Department of Health (DOH) notified the U.S. Health Care Financing Administration (HCFA) that, pending HCFA's required review of certain formulas associated with the Community Health Care Conversion Demonstration Project (CHCCDP), DOH intended, under certain circumstances, to make advances of project payments to eligible institutions. CHCCDP is a part of the State's section 1115 Medicaid waiver, under which most Medicaid-eligible beneficiaries in the State will enroll in managed care plans over the coming years. The project is intended to

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provider-based on October 1, 2000. During the two-year period (October 1, 2000, to October 1, 2002), entities may apply for permanent provider-based status. HCFA must grant provider-based status for entities that apply during that time frame if they meet the geographic requirements of the HCFA regulation or they are located within a 35-mile radius of the main campus of the hospital with which they are affiliated.

- Provides that no copayment amount for an outpatient procedure in a year may exceed the amount of the inpatient hospital deductible for that year. In addition, the bill limits copayment amounts for outpatient procedures to specific percentages. In 2001, the copayment amount cannot exceed 60%; in 2002 and 2003, 55%; in 2004, 50%; in 2005, 45%; and in 2006 and years thereafter, 40%.

- Provides for a 2% increase in payments in FY 2002 for rehabilitation hospitals and units.

- Provides for incentive payments to psychiatric hospitals and units of 3% rather than 2% in FY 2001.

- Increases the national cap for long term care hospitals and units by 2% and increases targets for hospitals not subject to the national cap by 25%.

Skilled Nursing Facilities: BIPA 2000 affects skilled nursing facilities (SNFs) in a number of specific ways, as follows.

- Provides for a full market basket update under the SNF PPS for 2001, and an update of market basket minus 0.5% in 2002 and 2003.

- Provides for a 16.66% increase in the nursing component of the case mix adjusted Federal PPS rate for services furnished on or after April 1, 2001, and before October 1, 2002. BIPA 2000 requires the General Accounting Office (GAO) to conduct an audit of SNF staffing ratios and the effect of the increase in the nursing component of the rate on SNF staffing ratios. The GAO report is due August 1, 2002. SNFs are also required to post daily the number of licensed and unlicensed personnel involved in direct resident care on each shift.

- Limits SNF consolidated billing require-

ments to Medicare Part B services provided pursuant to a Part A covered stay.

- Provides for a 6.7% increase in the adjusted Federal per diem rate for certain rehabilitation resource utilization groups (RUGs) from April 1, 2001, until the date on which a refined case mix classification system is implemented. The 20% increase provided to three specific rehabilitation RUGs (RHC, RMC, and RMB) under the BBRA will be removed effective April 1, 2001, and a 6.7% increase will apply to these RUGs instead. The 20% increase provided to the 12 extensive services, special care, and clinically complex RUGs under the BBRA is unchanged by BIPA 2000.

- Authorizes the HHS Secretary to establish a wage index reclassification system.

- Requires Medicare+Choice plans to provide for coverage of post-hospital care through a "home" SNF.

- Extends the moratorium on payment caps for therapy services for one more year, through the end of 2002.

Home Health Services: The following home health services provisions are contained in the relief legislation.

- An additional year delay in the 15% reduction in home health PPS rates, for a total delay of two years after the implementation of the home health PPS.

- Provides for a full market basket update to home health PPS rates in 2001.

- Grants the HHS Secretary the authority to adjust standard PPS amounts to account for

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BBA, BBRA, and BIPA 2000 Provisions for Hospitals and Continuing Care Facilities								
	1997	1998	1999	2000	2001	2002	2003	2004
HOSPITALS								
<i>Teaching hospitals: IME adjustment</i>								
BBA	7.7%	7.0%	6.5%	6.0%	5.5%	5.5%	5.5%	5.5%
BBRA				6.5%	6.25%	5.5%	5.5%	5.5%
BIPA 2000					6.5%	6.375%	5.5%	5.5%
<i>Medicare payment reductions for DSH hospitals</i>								
BBA	0%	-1%	-2%	-3%	-4%	-5%	0%	0%
BBRA				-3%	-3%	-4%	0%	0%
BIPA 2000					-2%	-3%	0%	0%
<i>Inpatient PPS update reduction</i>								
BBA	-0.5%	freeze	-1.9%	-1.8%	-1.1%	-1.1%	0%	0%
BBRA					-1.1%	-1.1%	0%	0%
BIPA 2000					0%	-55%	-55%	0%
<i>Reduction in bad debt costs for Medicare reimbursement</i>								
BBA	0%	-25%	-40%	-45%	-45%	-45%	-45%	-45%
BBRA				-45%	-45%	-45%	-45%	-45%
BIPA 2000					-30%	-30%	-30%	-30%
<i>Outpatient PPS update reduction</i>								
BBA				-1.0%	-1.0%	-1.0%	0%	0%
BBRA				-1.0%	-1.0%	-1.0%	0%	0%
BIPA 2000					0%	-1.0%	0%	0%
CONTINUING CARE								
<i>SNF PPS Update</i>								
BBA				-1.0%	-1.0%	-1.0%	0%	0%
BBRA				-1.0%	-1.0%	-1.0%	0%	0%
BIPA 2000					0%	-0.5%	-0.5%	0%
<i>Home health PPS updates</i>								
BBA				n/a	-1.0%	-1.0%	0%	0%
BBRA				n/a	-1.0%	-1.0%	0%	0%
BIPA 2000					0%	-1.0%	0%	0%

Network Regulations Become Effective

New Certificate of Need (CON) regulations recently became effective that permit, for the first time, the reallocation, relocation, or redistribution of acute care beds and certain pieces of major medical equipment from one hospital to another hospital within an "established Article 28 network." The regulations do not permit the movement of beds between acute care facilities and nursing homes in a network. The regulations define an "established Article 28 network" as an arrangement in which operating authority "is legally delegated to a corporation or other entity by hospitals participating in such arrangement and in which the corporation or other entity has received establishment approval" by the Public Health Council as operator or co-operator of the participating hospitals.

Prior to the effective date of these new

regulations, projects to increase bed capacity or to acquire certain medical equipment, through relocation or movement, required a CON. The new regulations require that, prior to relocating the beds or equipment, the applicant submit a letter to the New York State Department of Health (DOH) Bureau of Architectural and Engineering Review advising DOH of the proposed movement of beds or equipment. DOH is required to notify the applicant within 30 days regarding whether or not the proposal is acceptable. If DOH determines that the proposal is unacceptable, the application will be deemed to be a CON application subject to either administrative review or full review.

Active Model/Corporate Merger: The term "established Article 28 network" includes the "active model," in which the network takes an active role in the functions and

operations of member facilities, and the corporate merger, in which a single, new entity is formed when two or more formerly independent entities are joined.

Passive Parent: Although it does not specifically use the term "passive parent," the Regulatory Impact Statement indicates that the new regulation does not apply to an arrangement between health care facilities if that arrangement does not involve delegating certain functions to the network entity; therefore the network does not play a significant role in the day-to-day operations of the facility. These arrangements are commonly known as "passive parent" arrangements. This is also indicated in the report of the State Hospital Review and Planning Council Workgroup on Network Development, released in 1998, which states that the term "established Article 28 network" does not include "passive parent" arrangements. For a copy of the regulations, call Olivia Segree at GNYHA. ■

Draft of Model Contract for HIV SNPs Nearing Completion

The AIDS Institute, New York State Department of Health (DOH), is in the process of completing a draft of the model contract that local social service districts will enter into with the eight HIV special needs plans (SNPs). HIV SNPs are managed care plans that will provide comprehensive health services to eligible Medicaid recipients who are diagnosed with HIV and/or AIDS. Within the next

several weeks, the completed draft contract will be circulated to interested parties for comment. DOH also indicated that the \$12 million in grants that is to be provided to the eight SNPs to assist with developmental needs and other costs has not been distributed yet, pending completion of the State contracting process with the SNPs. Voluntary enrollment in HIV SNPs is not expected before early 2001. ■

HCFA Releases Final Decision on Coverage of Clinical Trials

On September 19, 2000, the U.S. Health Care Financing Administration (HCFA) issued a final decision approving coverage of services provided to Medicare beneficiaries in clinical trials. Effective immediately, the coverage decision implements a directive issued by President Clinton in July requiring the U.S. Department of Health and Human Services (HHS) to cover many of the costs of clinical trials to encourage the inclusion of seniors in clinical studies.

The decision specifies that Medicare will cover the routine costs of clinical trials that meet qualifying criteria as well as reasonable and necessary items and services to diagnose and treat complications arising from participation in all clinical trials. Clinical trials qualify for coverage if they evaluate a Medicare benefit, have a therapeutic intent, enroll beneficiaries with a diagnosed illness, and meet certain scientific and clinical standards.

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assist hospitals serving high proportions of low-income patients in making the transition to a managed care environment without compromising services, including retraining their workforce as needed. While five years of funding totaling \$1 billion was authorized, only one year of grants attributable to 1997-98 has actually been distributed. DOH's plan would advance a portion of funds calculated to be owed after

application by hospitals and approval and monitoring by DOH, and subject to final formula modifications by HCFA. GNYHA and 1199/SEIU have written to HCFA as well as to others in the Administration voicing their strong support for this plan, which would help hospitals serving low-income communities cope with growing financial distress and cash shortages that have been exacerbated by the delay in CHCCDP. ■

MedPAC Considers Development of New Post-Acute Payment System

On October 20, 2000, the Medicare Payment Advisory Commission (MedPAC) met to discuss the development of a new payment system for post-acute services. During the previous MedPAC meeting in September 2000, the commissioners discussed the shortcomings of the minimum data set (MDS), the patient assessment tool used to determine the case-mix of residents, and the Resource Utilization Group-III (RUG-III) case-mix system under the skilled nursing facility (SNF) prospective payment system (PPS). MedPAC researchers analyzed

existing options to replace the RUG-III case-mix system for Medicare beneficiaries and concluded that the pursuit of a new post-acute payment system would be more efficient than testing current options. To develop the new payment system, MedPAC researchers plan to create two expert panels—a panel of physicians and a panel of hospital discharge planners—to identify what criteria are used to determine post-acute referrals to SNFs and to the community. In addition, MedPAC researchers intend to complete a quantitative analysis using the MedPAC

episode database to examine 1) beneficiaries' similarities and differences, 2) beneficiaries' use of multiple post-acute settings, and 3) whether APR-DRGs (all-patient-refined diagnosis related groups, which group patients according to the presence and level of comorbidities or complications) predict post-acute destination. MedPAC researchers will unveil the results of their analysis during the subsequent MedPAC meetings on November 16–17, 2000, and on December 14–15, 2000, in Washington, D.C. GNYHA will continue to closely follow the developments of the new payment system for post-acute care. ■

UPCOMING BRIEFINGS

ACGME Update

Date: Friday, November 3, 2000

Time: 9:00 a.m.–11:30 a.m.

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

David Leach, M.D., Executive Director, and Cynthia Taradejna, Executive Director, Institutional Review Committee, both of the Accreditation Council for Graduate Medical Education (ACGME), will provide an update on ACGME's current initiatives and activities, as well as new institutional requirements. The program, for GNYHA members only, is intended for hospital administrators and physicians who have responsibility for residency training. For more information, call Tim Johnson, and to register, call Barbara Marino, both at GNYHA.

Immigration Employment Issues

Date: Monday, November 6, 2000

Time: 2:00 p.m.–4:00 p.m.

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

This GNYHA member briefing will provide information on the various H1 visa programs and green card status under which hospitals can employ staff, including resident physicians. The briefing will include a brief overview of GNYHA's action plan on workforce issues, followed by a presentation on the H1 visa programs by Stephen Perlitsh, Esq., who specializes in immigration law. To register, call Barbara Marino at GNYHA.

Reducing Medication Errors

Date: Friday, November 17, 2000

Time: 9:30 a.m.–12:30 p.m.

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

This briefing, for GNYHA members only, will cover the findings of national research on strategies to reduce medication errors, and will highlight strategic opportunities and initiatives undertaken by hospitals. David Bates, M.D., Medical Director of Clinical and Quality Analysis at Partners Healthcare System, Inc., will discuss the research and programs he has carried out to

reduce medication errors, evaluating interventions that rely on information system technology and non-technological solutions. Dr. Bates will also discuss the findings of his national work on the potential cost savings for hospitals of reducing medication errors. Arthur Klein, M.D., President of the New York Presbyterian Health Care Network, together with Mark Callahan, M.D. and Mary Cooper, M.D., will speak about the initiatives undertaken at both the New York Presbyterian Hospital and within the New York Presbyterian Healthcare System. Frank Saya, the Director of Pharmacy at Cedars-Sinai Medical Center in Los Angeles, will discuss the programs his hospital has implemented to tackle medication errors. The briefing is designed for GNYHA member medical directors and other physicians involved in quality improvement, pharmacy and nursing directors, directors of quality improvement/assurance, and health information system specialists. Pre-registration is required; please call Barbara Marino at GNYHA.

Reminder:

GNYHF-UHF Symposium on Health Services Research on November 9

Greater New York Hospital Foundation (GNYHF) and United Hospital Fund (UHF), in collaboration with major health services research centers, are sponsoring the Eleventh Symposium on Health Services Research on Thursday, November 9, 2000. This year's program features a keynote address on health services research trends by John M. Eisenberg, M.D., Director, Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, and a special afternoon plenary session with Lauren Leroy, Ph.D., President and Chief Executive Officer, Grantmakers in Health. In addition, the symposium features individual sessions on the following topics: access to health care for persons with HIV, issues in continuing care, preventive and ambulatory care, immigrant health issues, home care services, research methods, organization of health services, and guidelines and practice. Registration information is available from Brenda Lamb at UHF or Cynthia Benchemmar at GNYHA. ■

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changes in case mix that the Secretary deems are not due to real case mix changes, but to coding or classification changes only.

- Provides for a two-month extension of periodic interim payments.

- Requires the Comptroller General to conduct a study on variations in prices paid by home health agencies for nonroutine medical supplies.

- Clarifies that neither the time nor distance between a parent office of a home health agency and a branch office shall be the sole determinant of a home health agency's branch office status.

- Clarifies the definition of "homebound" so home health agencies can better understand which beneficiaries are eligible for coverage.

Medicaid Provisions: BIPA 2000 increases amounts that all states can spend on Medicaid DSH for 2001 and 2002; increases public hospital DSH limits for 2003 and 2004, a move that mitigates other limits on IGTs; and makes it possible for the State to share in unspent monies to support its Child Health Plus program. ■

Coverage of Clinical Trials

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A copy of the decision and a program memorandum providing detailed information about handling claims from clinical trials is available at HCFA's Web site, www.hcfa.gov/quality/8d.thm. ■