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Skyline news

REPORTING ON NEW YORK'S HEALTH CARE NEWS

CMS Scales Back Proposed Medicare Payment Changes

Changes Will Substantially Reduce Payment Redistribution Among Hospitals

On Aug. 1, 2006, the Centers for Medicare & Medicaid Services (CMS) issued its final rule for the Federal fiscal year (FY) 2007 inpatient prospective payment system (IPPS), which goes into effect on Oct. 1, 2006. The final rule significantly modified changes that CMS had recommended in the proposed rule concerning the methodology for computing diagnosis related–group (DRG) weights and the algorithm for classifying patients into DRGs. The modifications will significantly reduce the payment redistribution among hospitals in FY 2007 from about $1.6 billion in the proposed rule to about $300 million in the final rule.

Much of the scaled-back redistribution results from CMS's decision to phase in the changes that will be enacted in FY 2007 over a three-year period. However, some of it results from CMS's decision not to implement two proposed changes: the Hospital-Specific Relative Value (HSRV) methodology for computing DRG weights and the Consolidated Severity-Adjusted DRGs (CS DRGs). The HSRV methodology was controversial because of research findings that it inappropriately compresses the DRG weights—that is, it reduces the range of weights among the DRGs. This would lead to severe underpayments for expensive, high-technology services, such as cardiac surgery. The CS DRGs were controversial because they do not sufficiently discriminate among cases based on resource consumption, they cannot accommodate non-Medicare populations (which are often

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Governor Pataki Signs Mandatory Vaccination Bills Into Law

On July 27, 2006, NYS Governor George Pataki signed a bill into law that requires hospitals to offer vaccinations against influenza and pneumococcal disease to inpatients age 65 and over, from September 1 to April 1 annually. The bill, S. 5087-A / A. 11236, sponsored by Senator Kemp Hannon (R-Nassau) and Assembly Member Crystal D. Peoples (D- Erie), requires each hospital to adopt an influenza and pneumococcal immunization policy that would include procedures on how to identify a patient age 65 or older and to adopt a "stand-

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Hospitals Conserve Energy During Heat Wave; GNYHA Assists From Its Desk at OEM

FROM ITS DESK AT THE NYC OFFICE OF Emergency Management (OEM), GNYHA—along with the NYC Health and Hospitals Corporation (HHC)—did its part to help the City cope with last week's heat wave. From OEM, GNYHA contacted its member hospitals to determine whether they needed assistance, focusing in particular on facilities located on Manhattan's east side between 40th and 14th Streets, where a number of high-voltage feeder cables had become disabled. At the request of the Mayor's office, GNYHA asked its members in the affected area to reduce all nonessential services, convert to generator power, and cancel elective procedures. Many members throughout the region had already begun to take such steps.

At a press conference held on Aug. 3 by Mayor Michael Bloomberg, OEM Commissioner Joseph Bruno said that his agency had been working around the clock to mitigate the effects of the heat wave and praised the City's hospitals for voluntarily cutting back on their use of power. He thanked HHC and GNYHA in particular for contacting the area's hospitals in an effort to help the City conserve power.

NYC Department of Health and Mental Hygiene Commissioner Thomas Frieden, M.D., M.P.H., reported an increase in respiratory complaints and hospital emergency department visits. He cautioned residents with respiratory or lung problems to be particularly careful.

Mayor Michael Bloomberg noted that EMS had received 4,063 calls—the sixth busiest day in EMS history and 25% more than the number of calls received at this time last year. He thanked the City's hospitals, citing several facilities that had significantly reduced their consumption of electricity and were using power from their own generators. He also noted the high level of cooperation among City and State agencies, and the public and private sectors, throughout the heat wave. ■

CMS Scales Back Proposed Medicare Payment Changes

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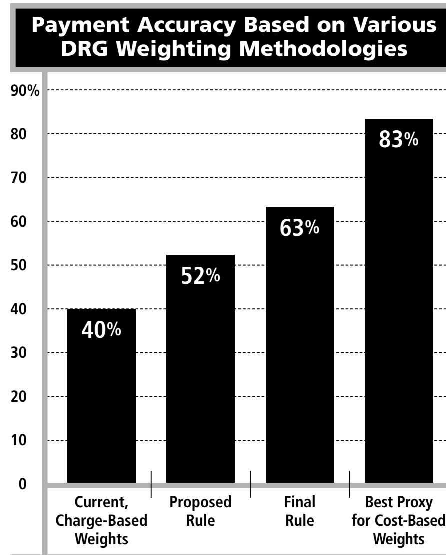
reimbursed based on the Medicare DRGs), and because they are a proprietary product of the 3M company.

The change that CMS did promulgate was to base the DRG weights on cost rather than charges. However, owing to major deficiencies in the accuracy of the data upon which the DRGs are based, the weights will not be based upon the real cost of providing services at the DRG level, but rather on a loose proxy for those costs.

In scaling back its DRG changes for FY 2007, CMS responded to concerns expressed in more than 2,300 comment letters, including letters from Senators Charles Grassley (R-Iowa) and Max Baucus (D-Mont.), the Chairman and Ranking Democrat on the Senate Finance Committee; Congresswoman Nancy Johnson (R-Conn.), the Chair of the Health Subcommittee of the House Ways & Means Committee; and a joint letter from more than 200 Congressional representatives, including



the entire New York delegation.

GNYHA's Role: GNYHA vigorously advocated for substantial changes to the proposed methodology based on an empirical analysis conducted by The Health Economics and Outcomes Research Institute (THEORI) at GNYHA. CMS proposed the changes to better match payments with cost at the DRG level; however, THEORI found that the changes improved payment accuracy only moderately, while modifications to the proposal that are similar to the ones that CMS ultimately promulgated, as well as using a better proxy for cost-based weights, would achieve superior results. THEORI concluded that the better proxy is the approach that New York State takes to estimate cost-based weights for the Medicaid program.

Payment accuracy is usually measured as the percentage of IPPS payments associated with DRGs that have a cost margin within the national average plus or minus 5%. The current charge-based methodology achieves about 40% payment accuracy, while CMS's original proposal achieved about 52%, the final rule methodology achieves about 63%, and the best proxy for cost-based weights achieves about 83% payment accuracy.

GNYHA believes that, ideally, real cost-based weights, rather than a poor or better proxy, should be used. Therefore, GNYHA has convened a workgroup to develop recommendations for correcting the deficiencies in the accuracy of the data upon which the DRG weights are based. ■

Health IT Bill Passes House

On July 27, 2006, the U.S. House of Representatives passed the health information technology (IT) bill—the Better Health Information System Act of 2006 (H.R. 4157)—by a vote of 270 to 148. Absent from the House bill was the proposed provision mandating price disclosure by hospitals, which the House leadership removed following advocacy by GNYHA and the hospital community. Sponsored by Ways & Means Health Subcommittee Chairwoman Nancy Johnson (R-Conn.), the passage of the bill by the House comes seven months after the Senate passed its version, the Wired for Health Care Quality Act (S. 1418). If enacted, H.R. 4157 would create important safe harbors for hospitals to provide IT to physician offices, establish timelines for coding system updates (including the implementation of the ICD-10, which spells out updated codes for providers to use on insurance claims), and give $30 million in matching grant funding to hospitals providing care to the uninsured, underinsured, and medically underserved. This legislation will now be reconciled against the Senate's health IT bill, sponsored by Senators Mike Enzi (R-Wyo.), Bill Frist (R-Tenn.), and Hillary Clinton (D-N.Y.), which does not include the safe harbors or the coding system updates, though it does authorize more significant grant funding for hospitals, among other providers. The material differences between the House and Senate bills will likely mean a difficult conference, which is expected to commence in September. ■

Medicare Finalizes FY 2007 Update for Rehab PPS

On August 1, 2006, the Centers for Medicare & Medicaid Services (CMS) released its inpatient rehabilitation facility prospective payment system (IRF PPS) final rule for fiscal year 2007, which begins on October 1, 2006. The provisions in the final rule will result in an average payment increase for rehabilitation facilities of only 0.8%. While the regulation provides a 3.3% market basket increase to the IRF PPS rates, this increase is mitigated by an adjustment of –2.6% to remove what CMS perceives as the effect of coding improvements—rather than a true increase in patient acuity—since the implementation of the IRF PPS. In addition, CMS revised the case-mix group weights and patient comorbidity adjustments, and increased the outlier threshold from $5,129 to $5,534. Although CMS raised the outlier threshold, aggregate outlier payments are expected to increase by 0.1%. CMS did not make any changes to the low-income facility, teaching, or rural facility adjustments. ■

CMS Affirms GME Payment Policy But Addresses Documentation Burden

On August 1, 2006, the Centers for Medicare & Medicaid Services (CMS) issued its final rule regarding the hospital inpatient prospective payment system (IPPS) for 2007. In its final rule, CMS reaffirmed the controversial policy stated in the IPPS proposed rule that allows Medicare direct graduate medical education (GME) reimbursement only for patient care activities in nonhospital settings and Medicare indirect medical education (IME) reimbursement only for patient care activities regardless of setting. In particular, CMS affirmed that so-called didactic or scholarly activities are not reimbursable activities except for Medicare direct GME and unless they occur in the hospital setting. However, in response to strong advocacy by GNYHA and others, CMS did establish a "one workday" threshold for documentation, effective October 1, 2006. This administrative policy may ameliorate some of the most troubling aspects of the policy.

GNYHA had expressed great concern regarding this statement of longstanding policy after it had been presented in the IPPS proposed rule. One of the main points GNYHA made in its comment letter was that, in the context of GME, it is often difficult to distinguish between patient care activities and nonpatient care activities. Picking up on several examples mentioned in the discussion accompanying the proposed rule, GNYHA noted that a resident's day-to-day, if not moment-to-moment, activities often involve a variety of activities that cannot be easily categorized. In response to these comments, and in order to provide further clarification, CMS added a definition of "patient care activities" to the direct GME regulations. A conforming statement was made to the IME regulations reflecting CMS's statement that its policy "limiting the IME count to only time spent in patient care activities is rooted in the purpose and creation of the IME adjustment."

While reaffirming its general policy position, CMS also outlined an administrative and documentation policy regarding nonpatient care activities. CMS noted in response to comments about the associated administrative requirements of its policy that "it is not our desire to impose unreasonably complicated and time-consuming recordkeeping requirements." According to CMS, regardless of what kind of department schedule is currently being used, a teaching hospital must be able to indicate full days that are devoted to nonpatient care activities. If an entire day during which a resident is working consists of nonpatient care activities, a teaching hospital must ensure that that fact is noted as part of the rotation schedule and the time must be excluded from the resident full-time equivalent employee (FTE) count.

GNYHA will continue to press for administrative relief for its members and will continue to advocate with Congress and CMS for support of all aspects of GME, including important educational activities. ■

SHRPC UPDATE

At its meeting on Aug. 3, 2006, the State Hospital Review and Planning Council (SHRPC) approved (in some cases with conditions or contingencies) the following GNYHA member projects: **Phelps Memorial Hospital**, construction of a five-story, 750-space parking garage; **North Shore University Hospital**, renovation project to add 24 medical/surgical beds; **Long Island Jewish Medical Center**, certification of a second dedicated electrophysiology studies laboratory within a renovated cardiac catheterization suite; and Good Shepherd Hospice, removal of Nursing Sisters Home Care, Inc. as co-operator and sole corporate member, and appointment of **Catholic Health System of Long Island, Inc.** as the sole corporate member.

In addition, the following GNYHA member hospitals were approved as Designated Stroke Centers: **Cabrini Medical Center**, **Long Beach Medical Center**, **Nassau University Medical Center**, **North General Hospital**, and **St. Luke's Cornwall Hospital**.

STATEWIDE PERINATAL DATA SYSTEM REGULATION: At the meeting, SHRPC adopted a regulation that would implement the Statewide Perinatal Data System (SPDS), an Internet-based system that is designed to provide the New York State Department of Health (DOH) and health care providers with data for public health promotion and health care quality improvement. Hospitals would be required to report to DOH data elements for all parturient women and newborns in New York State, including data elements relating to demographics, risk factors, and health outcomes. The regulation will become effective upon publication of a Notice of Adoption in the *State Register*. However, the New York City Department of Health and Mental Hygiene (DOHMH) expects to submit a waiver to DOH so that the regulation would not become effective for hospitals located in New York City until January 2008. This delay would enable DOH and DOHMH to coordinate reporting systems so that hospitals located in New York City will continue to report birth certificate data to DOHMH. GNYHA had strongly advocated that hospitals in New York City not be required to reconfigure their reporting systems to comply with the regulation.

INTERPRETATION SERVICES REGULATION: In addition, SHRPC adopted a regulation regarding language interpretation services in hospitals. The regulation, which will become effective upon publication of a Notice of Adoption in the *State Register*, is designed to provide hospitals with additional guidance on the expected components of their language assistance programs for patients with limited English proficiency. DOH will be working with GNYHA and its members throughout the fall to provide guidance on compliance with the new regulations. GNYHA will also be working with DOH to make sure that more State-required forms are translated into additional languages.

NEW MEMBER: Michael Sloma, President and CEO of Apollo Health, has been appointed to SHRPC. ■

Physicians Ask for Help at Emergency Care Hearing

Responding to a recently released series of reports on emergency care by the Institute of Medicine (IOM), which found that the U.S. emergency health care system is at a breaking point in terms of capacity, the Ways & Means Health Subcommittee held a hearing on July 27 that focused on the status of emergency care. Chairwoman Nancy Johnson (R-CT) announced that the goal of the hearing was to better understand the demands placed on health care providers and the reason for those demands, in order to explore potential solutions.

Gail Warden, President of the Henry Ford Hospital and Chair of IOM's Committee on the Future of Emergency Care in the U.S., testified as to the findings and recommendations of the report. These included supporting a vision for the future of emergency care, involving a national network of regionalized, coordinated, and accountable emergency care systems; improving efficiency and patient flow; increasing funding; and taking into account the needs of pediatric patients. The witness panel also included Alan Kelly of Scottsdale Healthcare, who underscored the impact of the Emergency Medical Treatment and Labor Act requirements and the growing number of uninsured and undocumented immigrants. Kelly referenced the shortage of on-call and pediatric specialists, fragmented technology systems, and a lack of disaster preparedness as key issues in emergency care.

While Alan Levine, CEO of a public hospital system in Florida, cited an aging population and nurse staffing shortages as contributing to emergency department overcrowding, he pointed to medical liability concerns, physician shortages, and an increase in non-hospital alternatives for specialists as the major contributors. Frederick Blum, M.D., President of the American College of Emergency Physicians, reviewed similar areas of concern and urged the Federal government to take steps to improve resources and keep the doors of emergency departments open. Specifically, Dr. Blum urged members to support H.R. 3875 / S. 2750, the Access to Emergency Medical Services Act, which would provide liability protections, increase payment, and create incentives to move patients out of the emergency room. Larry Bedard, M.D., of California Emergency Physicians, rounded out the hearing by highlighting the availability of on-call physicians and calling for an "ultimate solution" of universal health coverage. ■

Governor Signs Mandatory Vaccination Bills

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ing order" program for immunization. Standing orders authorize licensed practitioners to administer vaccinations without the need for a physician's order. Hospital-based immunization is seen as highly effective in increasing immunization rates and is strongly recommended by the Centers for Disease Control, the Centers for Medicare & Medicaid Services, the National Vaccine Advisory Committee, and the General Accounting Office. Despite Medicare coverage, according to the NYS Department of Health, immunization rates in New York remain well below the *Healthy 2010* goal of 90% among the elderly who are age 65 and older. As of 2002, that population's rate of immunization was at 64.7%. The law allows the NYS Commissioner of Health to waive the requirement if there is a vaccine shortage. This law will take effect in October.

Another vaccination bill signed into law by the Governor, S. 8341-A / A. 8761-B, requires immunization against pneumococcal disease of every child in New York State born on or after January 1, 2008, beginning with enrollment in any public, private, or parochial child care center, day nursery, day care agency, or nursery school. ■

LEGISLATIVE DIGEST

In the past weeks, NYS Governor George Pataki has taken action on hundreds of bills. The following health-related bills were among those monitored closely by GNYHA.

Gov. Pataki signed the following bills into law: **Use of "Nurse" Title.** S. 6326-A / A. 5816-A limits the use of the title "nurse" to individuals who are licensed by the State. • **Colon-Prostate Treatment Act.** Under A. 6763a / S. 4691a, uninsured people diagnosed with colon or prostate cancer in NYS who earn too much to qualify for Medicaid but too little to afford health insurance will now have their treatment covered through Medicaid. NYS is the first state in the country to have such coverage for colon cancer treatment. • **Radiologic Technology Licensure.** S. 5606-A / A. 4882-B updates existing law by creating licensure requirements for radiography, radiation therapy, and nuclear medicine technology, as well as providing intravenous contrast administration certification for radiology technologists. GNYHA strongly supports this law. • **Medical Assistance Resources.** S. 4691-A / A. 6763-A extends medical assistance to persons with breast, cervical, colon, or prostate cancer provided that they have an income of 250% or less of the Federal poverty line. • **Alternate Forms of DNR.** S. 6365-A / A. 9479-A permits alternative "Do Not Resuscitate" (DNR) forms to specifically include "Do Not Intubate" orders and would exclude people with mental illness from using such alternative DNR forms. GNYHA supports this law. • **Nursing Home Criminal History Check.** S. 6630 / A. 9979 makes technical corrections to the laws that established the criminal history record check system for prospective employees in nursing homes and home health agencies. This new law allows the Division of Criminal Justice to submit fingerprints to the FBI, to provide that all determinations are made promptly, and to change the effective date to Sept. 1, 2006. The measure also clarifies the process for reimbursing providers under the system. • **Hospital Water Charges—Extension.** S. 7048 / A. 10291 extends for an additional two years the establishment of certain water charges for hospitals and charities in NYC. GNYHA strongly supported this bill and urged its enactment. • **Hospital Refinancing.** S. 7717-A / A. 10915-A authorizes certain not-for-profit hospitals to incur outstanding refinancing indebtedness. • **Mandatory Vaccines.** See page 1 in this issue.

The Governor recently vetoed the following bills: **Death Certificates Signed by NPs.** S. 4797-A / A. 5220-A would have permitted nurse practitioners (NPs) to sign death certificates in like manner as physicians and imposed upon NPs the same duties that physicians have. • **Palliative Education and Training Program.** S. 7458-A / A. 11162-B would have provided grants for medical school education in palliative care that may be used for faculty development and recruitment, and teaching at hospital-based ambulatory care settings and hospices, including personnel, administration, and student-related expenses. • **Geriatric Chemical Dependence Act.** S. 7930 / A. 11243 would have made grants available to providers for developing and implementing innovative approaches to serving older New Yorkers with chemical dependence problems as well as providing outreach and education to combat stigma and ageism and to provide chemical dependence–specific training for seniors. ■