



MAY 14, 2007

# Skyline news

REPORTING ON NEW YORK'S HEALTH CARE NEWS

## Report Ranks New York's Medicaid Program Among Best in Nation

In April 2007, the Public Citizen Health Research Group released a report that ranked state Medicaid programs based on their capacity to provide low-income residents with access to comprehensive quality health care. The report, *Unsettling Scores: A Ranking of State Medicaid Programs*, evaluates each state program on eligibility, scope of services, quality of care, and reimbursement.

The report ranked New York's Medicaid program as eighth best in the nation overall based upon a composite score that considered all four measures. New York's Medicaid

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—Public Citizen Health Research Group

program ranked first in “scope of services,” third in “eligibility,” thirteenth in “quality of care,” and—notably—second to last in “reimbursement.” The report noted that New York's anomalous ranking in reimbursement was largely the result of a sizable gap between Medicaid and Medicare payment levels for patients with equivalent health care needs, noting that New York's Medicaid provider payment levels amounted to only 45 cents for every dollar paid for similar patients by the Medicare program. The report raised specific

*continued on page 4*

## Public Health Council Withholds Approval of New Ambulatory Surgery Centers

At the Public Health Council (PHC) meeting on May 4, two applications for establishing freestanding ambulatory surgery center (ASC) projects were discussed and voted upon. Neither one received enough affirmative votes for approval.

**South Shore SC, LLC d/b/a Island Surgery Center:** Good Samaritan Hospital opposes this application due to concerns about its impact on the hospital. The State Hospital Review and Planning Council (SHRPC) Project Review Committee had voted on the application in January but there were not enough affirmative votes to approve the motion.

**Long Island Hand Surgery Center:** In 2004, SHRPC had voted to disapprove the certificate of need application for establishment of a physician-owned ASC in Huntington, and in 2005, the PHC followed suit. The application has been the focus of much debate among the PHC members and had come up for a vote at several prior PHC meetings. Hunting-

ton Hospital had opposed this application on the grounds that the physicians in question were currently performing surgical procedures at the hospital, that the hospital's operating rooms were not functioning at capacity, and that this ASC would harm the hospital financially. The applicant then requested a hearing before an administrative law judge, who recommended that the PHC Establishment Committee approve the application. After hearing testimony by counsel to the PHC and the applicant, the Establishment Committee did not have enough votes to approve the application at a prior meeting.

**DOH Commissioner's Comments:** Richard Daines, M.D., NYS Department of Health Commissioner, indicated that he was not persuaded that the proposed ASCs will harm hospitals and he believes that hospitals can manage the impacts of nearby ASCs. He also stated that patient satisfaction and choice, as

*continued on page 4*

## Medicare Inpatient PPS Proposed Rule Represents Back-Door Budget Cuts

The Health Economics and Outcomes Research Institute (THEORI) at GNYHA has completed a preliminary analysis of the Medicare inpatient prospective payment system (PPS) proposed rule for Federal fiscal year (FY) 2008 and has found that it would virtually cancel out the inflation updates provided during the next two years. Medicare provides inflation updates in line with anticipated increases in hospital input costs. As shown in the chart on page 3, the cumulative inflation update from FY 2007–09 would be 6.3%, while the cumulative increase in payments would be only 1.1%. Therefore, payments would increase by 5.2%, or \$5.7 billion, less than cost. The shortfall for

*continued on page 3*

# GNYHA Obtains Continued Exemption from “Official Prescription” Program for Hospitals with CPOE Systems

Hospitals in NYS that print prescriptions for non-controlled substances from computerized provider order entry (CPOE) systems can continue to be exempt from aspects of the NYS Department of Health’s (DOH’s) “Official Prescription” program, thanks to GNYHA’s efforts to secure the continued exemption. In order to obtain the exemption, facilities must complete an applica-

tion form and send it to DOH, which will notify facilities in writing if the applications have been approved. An emergency regulation became effective on Apr. 9, 2007, to implement the continued exemption.

NYS’s “Official Prescription” program was scheduled to become fully effective on Apr. 19, 2006. However, after a series of discussions with DOH in 2005 and 2006, GNYHA obtained an exemption from the

requirements until Apr. 19, 2007, for all non-controlled substance prescriptions written in hospitals. At the request of members, GNYHA, together with the Healthcare Association of New York State, strongly advocated for a continuation of the exemption beyond Apr. 19, 2007, for hospitals that print prescriptions using CPOE systems. GNYHA’s request was put forward on the basis that those hospitals would either have to revert to handwriting prescriptions or unnecessarily expend significant sums for special equipment because CPOE systems vendors were not willing to develop the modifications needed to permit e-prescribing. DOH was initially reluctant to grant a continued exemption but, as a result of several discussions that GNYHA facilitated, the Department agreed to continue to exempt hospitals with CPOE systems provided that they affix serialized stickers, which DOH will make available, to their CPOE-generated prescriptions. DOH indicated that it did not want those hospitals printing prescriptions from CPOE systems to revert to handwritten prescriptions, particularly given vendors’ refusal to make the necessary modifications.

As of Apr. 19, 2007, prescribers in hospitals have the following options for writing prescriptions for non-controlled substances:

- 1) handwriting prescriptions on “Official Prescription” forms;
- 2) printing prescriptions from CPOE systems on serialized “Official Prescription” paper provided by DOH;
- 3) printing prescriptions from CPOE systems on regular paper with a special serialized sticker affixed once the stickers are available; or
- 4) transmitting the prescriptions electronically from practitioner computer to pharmacy computer or fax (e-prescribing).

The requirement that all controlled substances prescriptions be written on “Official Prescription” forms will continue. That phase of the “Official Prescription” program had been implemented as of Apr. 19, 2006.

For more information or to obtain an application form for the facility CPOE exemption, contact Doris R. Varlese at GNYHA. ■

## UPCOMING GNYHA MEMBER BRIEFINGS

### **WeRecycle! Inc.**

**Date:** *Wednesday, May 16, 2007*

**Time:** *2:00 p.m.–3:00 p.m.*

**Location:** *Web demo*

WeRecycle! Inc., a recently added GNYHA Services, Inc. contracted supplier, provides universal and electronic waste disposal and recycling services. In this second of two identical sessions, WeRecycle! will provide a comprehensive overview of its facilities, services, and special pricing for all GNYHA and Continuing Care Leadership Coalition members. To register and obtain log-in information, contact Barbara Green ([green@gnyha.org](mailto:green@gnyha.org)) or Andrea Giotopoulos ([agiotopoulos@gnyha.org](mailto:agiotopoulos@gnyha.org)), at GNYHA.

### **SunGard Availability Services: Planning and Documentation Seminar**

**Date:** *Tuesday, May 22, 2007*

**Time:** *10:00 a.m.–12:00 noon*

**Location:** *GNYHA Conference Center C, 555 West 57th Street, 15th Floor; and via live Webcast*

In this next of a series of seminars offered by SunGard Availability Services, a GNYHA Services, Inc. contracted supplier and leading provider of business continuity and disaster recovery solutions, a SunGard expert will discuss best practices for planning and documentation in the context of an enterprise-wide recovery plan, including detailing relationships among users and operational units, utilizing scenarios to develop integrated recovery plans, testing the plan through situational exercises, and other key topics. To register for this event either on-site or via live Webcast, contact Barbara Green ([green@gnyha.org](mailto:green@gnyha.org)) or Andrea Giotopoulos ([agiotopoulos@gnyha.org](mailto:agiotopoulos@gnyha.org)), at GNYHA.

### **Bluemark LLC**

**Date:** *Wednesday, May 23, 2007*

**Time:** *2:00 p.m.–3:00 p.m.*

**Location:** *Web-based demo*

Bluemark, LLC, a GNYHA Services, Inc. contracted supplier, provides a software application that assists

hospitals in meeting the reporting requirements for New York State’s charity care statute, along with determining patient eligibility for Medicaid and other financial assistance programs. In this second of two identical Web-based demonstrations, Bluemark will give interested member institutions a complete overview of its MAPSch™ software capabilities and favorable pricing for GNYHA members. To register and obtain log-in information, contact Barbara Green ([green@gnyha.org](mailto:green@gnyha.org)) or Andrea Giotopoulos ([agiotopoulos@gnyha.org](mailto:agiotopoulos@gnyha.org)), at GNYHA.

### **United Outreach Solutions**

**Date:** *Thursday, May 24, 2007*

**Time:** *2:00 p.m.–3:00 p.m.*

**Location:** *Web-based demo*

United Outreach Solutions (UOS), a GNYHA Services, Inc. contracted supplier, assists hospitals in developing and operating laboratory outreach programs designed to provide laboratory testing services for hospital-affiliated, community-based physicians. At this Web-based demonstration, a UOS representative will discuss the company’s complete turnkey solution, including how these services can help hospitals better utilize lab capacity and generate significant new revenue. To register and obtain log-in information, contact Barbara Green ([green@gnyha.org](mailto:green@gnyha.org)) or Andrea Giotopoulos ([agiotopoulos@gnyha.org](mailto:agiotopoulos@gnyha.org)), at GNYHA.

### **Medicare GME Policy**

**Date:** *Monday, June 4, 2007*

**Time:** *2:00 p.m.–4:00 p.m.*

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

At this briefing, staff from the Centers for Medicare & Medicaid Services will review Medicare GME policy issues, including the reimbursement for resident training time in nonhospital settings (see related story in this issue, page 3), the treatment of “didactic” time, and the treatment of vacation and sick time. For more information, contact Tim Johnson ([tjohnson@gnyha.org](mailto:tjohnson@gnyha.org)), and to register, contact Hilary Demby ([hdemby@gnyha.org](mailto:hdemby@gnyha.org)), at GNYHA. ■

# CMS Proposes FY 2008 Update for Rehab PPS; Requests Comments on 75% Rule

On May 2, the Centers for Medicare & Medicaid Services (CMS) released its inpatient rehabilitation facility prospective payment system (IRF PPS) proposed rule for fiscal year (FY) 2008, which begins on Oct. 1, 2007. Comments on the rule are due to CMS by July 2, 2007.

CMS estimates that payments to IRFs would increase by about 2.4% under the proposed rule. The agency did not propose any changes to case-mix groups or the low-income facility, teaching, or rural facility adjustments, but did propose to increase the outlier threshold from \$5,129 to \$7,522 in order to limit estimated outlier payments to a target of 3.0% of aggregate payments. The proposed rule also continues the phase-in of the “75% rule,” which currently requires that 60% of an IRF’s admissions have a diagnosis that falls within one of 13 conditions. On July 1, 2007, the compliance threshold will increase to 65%. During the transition, in addition to

the primary diagnosis, patient comorbidities are considered in determining compliance. When the transition period ends on July 1, 2008, the required compliance percentage will jump to 75% and, under the current regulations, patient comorbidities will no longer be considered. CMS is requesting comments on the appropriateness of continuing to consider patient comorbidities when determining a facility’s compliance after the transition.

GNHYA is working with Congress to pass H.R. 1459—introduced by Rep. Nita Lowey (D-NY), John Tanner (D-TN), Kenny Hulshof (R-MO), and Frank LoBiondo (R-NJ)—which would maintain the current 60% threshold and require CMS to work with the rehabilitation industry to develop appropriate admissions criteria for inpatient rehabilitation services. To date, 24 members of the New York delegation have signed on as co-sponsors. GNYHA is very grateful for their continued support on this important issue. ■

## Medicare Finalizes GME Nonhospital Rule

Last week, the Centers for Medicare & Medicaid Services (CMS) finalized its policy to create an alternative methodology for teaching hospitals to use in demonstrating that they are entitled to count resident training time in nonhospital settings for Medicare reimbursement purposes. Under the Balanced Budget Act, training in these settings is allowable and countable for teaching hospitals for both direct graduate medical education (GME) and indirect medical education reimbursement if certain requirements are met. CMS had proposed the alternative methodology in response to concerns raised that this nonhospital training was being disallowed on audit as a result of unclear requirements for counting the time and onerous documentation requirements.

According to the final rule, as of cost-reporting periods that begin on or after July 1, 2007, teaching hospitals may use proxies as support to demonstrate that the hospital has incurred appropriate costs for training at the nonhospital setting. These proxies would also

need to be included in any written agreements between the hospital and the nonhospital setting. For example, teaching hospitals may utilize national physician salary data from the American Medical Group Association instead of specific physician salary information, and may utilize a presumed standard of three hours per week spent by supervising physicians in nonpatient care activities instead of conducting individual physician studies. In addition, teaching hospitals may utilize a 90% threshold for demonstrating that the teaching hospital is incurring all or substantially all of the training costs at the nonhospital setting. Previously, the expectation from CMS was that the teaching hospital should demonstrate that it was essentially incurring all the direct GME costs at the nonhospital setting.

GNHYA will be hosting a member briefing with CMS staff on June 4 at which this Medicare GME policy issue and several others will be discussed; see “Upcoming GNYHA Member Briefings” on page 2 for more information. ■

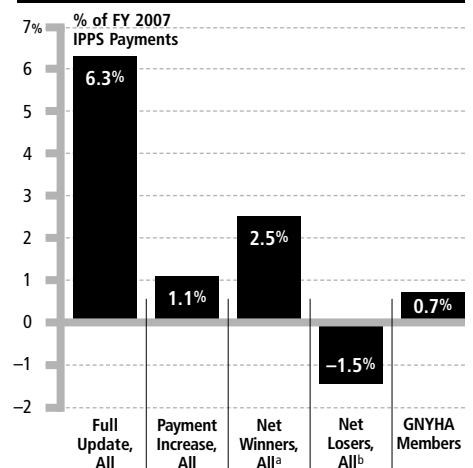
## Medicare Inpatient PPS Proposed Rule *continued from page 1*

GNHYA members would be roughly \$440 million.

The bulk of the losses would be associated with a 4.8% decrease in the Federal operating and capital rates, which would be phased in over two years. The Centers for Medicare & Medicaid Services (CMS) is proposing this decrease to ensure budget neutrality after implementing its proposed Medicare-severity diagnosis-related groups (MS-DRGs). The CMS actuary determined the magnitude of the decrease after reviewing a study by 3M Health Information Systems of the effect on case mix of the change in Maryland from the State’s former rate-setting methodology to 3M’s All Patient Refined DRGs. Maryland’s former rate-setting methodology relied less on complete diagnosis coding than the new system. Therefore, when the hospitals began coding more accurately, their aggregate case-mix index increased significantly. The budget-neutrality cut is referred to as a “behavioral offset.”

THEORI believes that the experience in Maryland cannot be extrapolated to New York—and possibly to other states—because New York’s DRG system already relies on complete and accurate diagnosis coding. Therefore, the change in Medicare’s DRG system would not significantly increase the hospitals’ case-mix indices, and CMS’s proposed 4.8% behavioral offset would constitute nothing more than a cut in New York. GNYHA is vigorously opposing the behavioral offset. ■

### Two-Year Fiscal Impact of the Medicare IPPS Proposed Rule



<sup>a</sup> 63% of total. <sup>b</sup> 37% of total.

# CMS Proposes Inflation Increases for Skilled Nursing Facilities and Home Health Agencies

**O**n Apr. 30, the Centers for Medicare & Medicaid Services (CMS) published proposed rules regarding the prospective payment systems (PPSs) for skilled nursing facilities (SNFs) for fiscal year (FY) 2008 and for home health agencies for calendar year (CY) 2008. **Skilled Nursing Facilities:** CMS proposes to increase payments to skilled nursing facilities by a full market basket (inflation) factor of 3.3%. This adjustment will increase annual Medicare payments by a projected \$690 million nationwide. CMS also proposes to revise and rebase the components of the market basket, which currently reflects data from FY 1997, to reflect data from 2004.

**Home Health:** CMS proposes to increase payments to home health agencies by a full home health market basket factor of 2.9%. CMS also proposes to make significant changes to the home health case mix system. Most notably, CMS is proposing, in response to case-mix increases that it believes are associated with changes in coding and documentation practices rather than the treatment of more resource-intensive patients, to reduce the national standardized 60-day episode payment rate by 2.75% per year for three consecutive years, starting in 2008. The proposed rule also

seeks to increase the number of case-mix groups from 80 to 153. Further, CMS proposes to replace the current therapy threshold of 10 visits per episode with three new therapy thresholds of 6, 14, and 20 therapy visits.

**Impact:** CMS projects that the net impact of its proposed refinements and updates in the proposed rule will result in an estimated \$140 million in additional Medicare payments to home health agencies in 2008. Under the rule, not-for-profit HHAs and government-sponsored HHAs will receive increases of 3.56% and 3.04%, respectively (relative to 2007), while for-profit HHAs are expected to experience a 1.90% reduction in payments.

While the Continuing Care Leadership Coalition (CCLC) is pleased that CMS has proposed to provide SNFs and home health agencies with a full market basket increase despite the President's Federal budget proposal to freeze SNF and home health rates for 2008, the group is deeply concerned about the proposed changes to the home health case-mix system that would result in a 2.75% reduction in payments. CCLC is further assessing the proposed changes in the PPS in preparation for the submission of comments to CMS. ■

## Public Health Council

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well as physician choice, are "public goods" that should be protected.

**GNYHA's Position:** GNYHA has consistently called for a moratorium on new freestanding ASCs when a hospital believes that the ASC will have an adverse impact on it. This position is based on concerns that freestanding ASCs do not serve the broader community, as hospitals do, and do not provide needed services such as trauma and emergency services. GNYHA notes that out-migration of patient care to freestanding ASCs is a key reason for hospitals' financial difficulties in NYS, and believes that compensation for care should account for varying levels of services between full-service hospitals and freestanding ASCs.

**DOH Counsel's Office:** Susan Regan, PHC Establishment Committee Chair, expressed her concerns about the applicants' inability to move forward with their projects. She made a motion, and the PHC agreed, to ask the DOH Counsel's office for advice about how to address the number of votes needed for approval. Currently, the PHC determines that number based on the number of members of the full PHC as indicated by the PHC statute, even if there is a vacancy (in contrast to the number of members currently on the PHC, or the number of members voting). DOH will confer with the Attorney General and provide its analysis to the PHC. ■

## New York's Medicaid Program

*continued from page 1*

concerns that Medicaid cost-containment efforts in NYS could potentially undermine the strengths of its Medicaid program and cause Medicaid provider reimbursement levels in New York to lag further behind those of the Medicare program.

"The size of its population and the number and importance of its medical institutions," the report stated, "make New York a bellwether state in health trends. With almost three million enrollees, Medicaid has a strong multiplier effect throughout the economy and is therefore important financially and politically as well as in terms of health."

Copies of the report, are available at [www2.citizen.org/hrg/medicaid](http://www2.citizen.org/hrg/medicaid). ■

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**Jeffrey Menkes** has been named President and CEO of New York Downtown Hospital and began his service on May 7, 2007. He replaced **Bruce D. Logan, M.D.**, who resumed his position as Chief of Medicine. Mr. Menkes has more than 30 years of experience in health care and has been a key member of senior administrative leadership at several hospitals and health systems, including Continuum Health Partners, Inc., The Mount Sinai Hospital, North Shore-LIJ Health System, and NewYork-Presbyterian Hospital. • **Neil P. Benjamin** has been appointed the new Director of the Division of Health Facilities Planning (DHFP) at the NYS Department of Health (DOH), where he will manage the Certificate of Need program; administer the Health Efficiency and Affordability Law for New Yorkers (HEAL-NY); develop or review legislation and policy for ensuring access to health care services, high-quality patient outcomes, and the role of publicly traded companies in health care delivery; and review health care utilization patterns. At DOH, Mr. Benjamin has served as Sr. Health Care Fiscal Analyst, Associate Health Care Fiscal Analyst, Unit Head and then Director of the DHFP Bureau of Financial Analysis, and Assistant Director of DHFP. • President George Bush has nominated **Kerry Weems** as the next Administrator of the Centers for Medicare & Medicaid Services. Mr. Weems, who is currently the Deputy Chief of Staff to Secretary of Health and Human Services (HHS) Secretary Michael Leavitt, has held various positions in HHS over the past 24 years and is known for his budget expertise. Previously, he served as Acting Assistant Secretary for Budget, Technology, and Finance and as Chief Financial Officer for HHS. • **Tevi David Troy** has been nominated by President Bush as HHS Deputy Chief of Staff, to succeed Kerry Weems. Mr. Troy serves currently as a Deputy Assistant to the President for Domestic Policy. He has also served as the President's Special Assistant and as Deputy Cabinet Secretary. ■