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Skyline news

REPORTING ON NEW YORK'S HEALTH CARE NEWS

Congress Passes Major Health Care Legislation

Prior to breaking for its August recess, Congress passed major health care legislation reauthorizing the State Children's Health Insurance Program (SCHIP). The House package (H.R. 3162) also includes many Medicare and Medicaid provisions that directly affect hospitals. By a vote of 225–204,

the measure cleared the House on Aug. 1 largely along party lines, with 10 Democrats voting with Republicans against the bill, and five Republicans—including Reps. Frank LoBiondo (R-NJ), Michael Ferguson (R-NJ), and Chris Shays (R-CT) from the Greater New York area—joining Democrats in support. The Senate passed its SCHIP-only package on Aug. 2 by a vote of 68–31, one vote

above a veto-proof margin. Senator Tim Johnson (D-SD) did not vote.

House: The House bill—the Children's Health and Medicare Protection Act (CHAMP)—is much more costly than the expansion in the Senate bill. The CHAMP Act also provides eligibility expansions under SCHIP and Medicaid, incentives for States to cover more children and adults under both programs, and Medicare beneficiary improvements in benefits, including waivers of cost-sharing for preventive services, waivers of deductibles for colorectal cancer screenings, parity for outpatient mental health co-insurance under Medicare, and other beneficiary improvements under Medicare Parts A, B, C, and D. The bill also requires studies and demonstration projects under Medicare on health disparities and the need for Medicare to reimburse providers for translation services.

To pay for the SCHIP, Medicare, and Medicaid coverage and benefits expansions in the

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NYS Projects 9% Growth in Medicaid Spending Next Year

Projected 4% Increase in Enrollment to Drive Spending Increase

On July 30, the NYS Division of the Budget (DOB) projected the State government will end the current fiscal year with a balanced budget, while projecting that the State will end the next fiscal year—beginning on Apr. 1, 2008—with a deficit of \$3.6 billion. DOB estimated that Medicaid spending in New York by all governments—Federal, State, and local—would increase 9% next year, from an estimated \$32.4 billion in State fiscal year (SFY) 2007–08 to \$35.4 billion in SFY 2008–09 (excluding spending on administration, as well as programs administered by the Office of Mental Health and the Office of Mental Retardation and Developmental Disabilities). A large portion of this growth is attributed to a projected 4% increase in Medicaid enrollment, from 3.85 million New Yorkers this year to 4.01 million next year. Family

Health Plus (FHP) enrollment is projected to increase 3%, from 540,000 individuals in SFY 2007–08 to 556,000 in SFY 2008–09. General Fund Medicaid spending, which is financed exclusively by the State through general, non-dedicated revenues, is projected to increase at a much faster rate of 22%, primarily as a result of enrollment increases and financing changes, such as the continued State takeover of local Medicaid and FHP costs.

According to DOB, 50% of the projected \$2 billion in increased State Medicaid spending next year is a result of increases in enrollment, utilization, and inflation updates (\$1 billion); 20% of the increase is a result of the State takeover of local Medicaid and FHP costs (\$400 million); 15% is attributable to decreased financing through dedicated

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CMS Imposes Cuts Through Inpatient Final Rule

On August 1, the Centers for Medicare & Medicaid Services (CMS) released its final rule for payment policy changes in the Medicare inpatient prospective payment system (IPPS)

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Dr. Mark R. Chassin Named President of The Joint Commission

Mark R. Chassin, M.D., M.P.P., M.P.H. has been named President of The Joint Commission, effective Jan. 1, 2008. The Joint Commission evaluates and accredits nearly 15,000 health care organizations and programs in the United States, including more than 8,000 hospitals and home care organizations, and more than 6,800 other health care organizations that provide long term care, assisted living, behavioral health care, and laboratory and ambulatory care services. Dr. Chassin is currently the Edmond A. Guggenheim Professor of Health Policy and Founding Chairman of the Department of Health Policy at Mount Sinai School of Medicine and Executive Vice President for Excellence in Patient Care at The Mount Sinai Medical Center. He succeeds Dennis S. O'Leary, M.D., who has been President of The Joint Commission for 21

years and will become President Emeritus.

Before joining Mount Sinai, Dr. Chassin served as Commissioner of the NYS Department of Health. A board-certified internist, he practiced emergency medicine for 12 years. His background also includes service in the Federal government and many years of health services and health policy research. He is a member of the Institute of Medicine of the National Academy of Sciences and co-chaired its National Roundtable on Health Care Quality.

"Dr. Chassin has been a highly regarded member of the New York health care community for many years," said GNYHA President Kenneth E. Raske. "He will bring a great amount of expertise and professionalism with him to The Joint Commission, and we look forward to working with him."

In 2001, Dr. Chassin was recognized for

his contributions to the fields of quality measurement and improvement with several honors. He was selected in the first group of honorees as a lifetime member of the National Associates of the National Academies, and he received the Founders Award of the American College of Medical Quality and the Ellwood Individual Award of the Foundation for Accountability.

"I am very excited about the opportunity to lead The Joint Commission," said Dr. Chassin. "The Joint Commission is transforming health care through its accreditation process and other programs to help health care organizations provide safe, high-quality care for all Americans. I look forward to working with Dennis O'Leary to ensure a smooth transition. He has provided outstanding leadership to The Joint Commission for so many years." ■

NYS Projects 9% Growth in Medicaid Spending *continued from page 1*

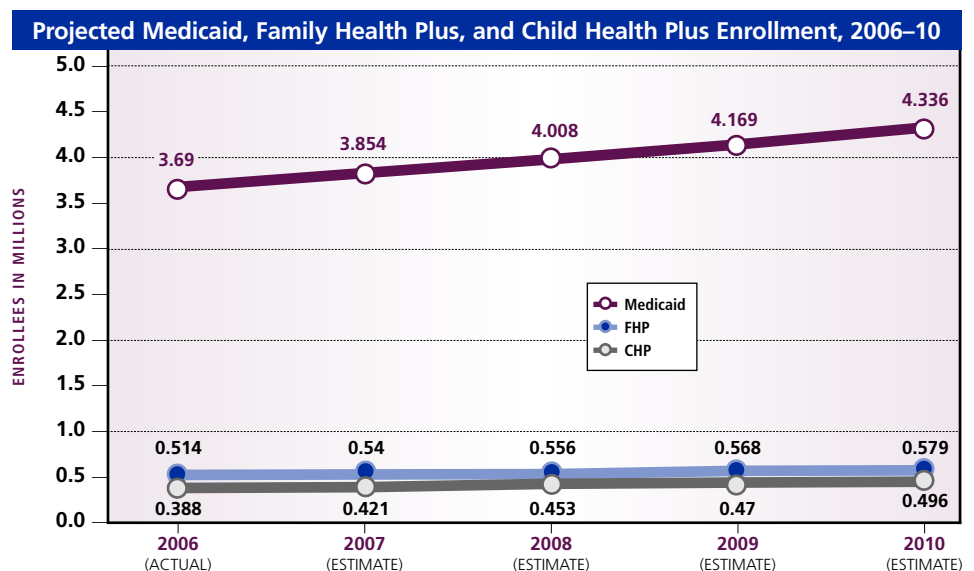
Health Care Reform Act (HCRA) revenues (\$300 million); 10% is attributable to the fact that some of this year's costs were "pre-paid" in the previous year (\$200 million); and 5% reflects a non-recurring collection of delinquent assessments owed by certain nursing homes, which offset current-year spending (\$100 million). Thus, fully half of the increase in General Fund spending is caused by financing issues as opposed to actual Medicaid program cost growth.

With regard to HCRA, which funds a variety of State programs including bad debt and charity care (BDCC) for hospitals and freestanding clinics, the State share of Child Health Plus (CHP) and FHP, the Elderly Pharmaceutical Insurance Coverage (EPIC) program, stem cell research, and other public health initiatives, the State projects a \$243 million surplus this year, dropping to a small \$10 million deficit in SFY 2008-09. After that, DOB projects much larger HCRA deficits of \$778 million in SFY 2009-10 and \$1.4 billion in 2010-11, primarily because of a sharp reduction in health insurance conversion proceeds (as a result of the end of funding from the conversion of Empire Blue Cross Blue Shield to a for-profit entity

replaced by much lower funding following the conversion of the much smaller Health Insurance Plan of New York) and increased spending for, among other programs, FHP, CHP, and stem cell research. Revenues from the 1% tax on hospitals are projected to increase from \$268 million this year to \$285 million in SFY 2008-09 and \$292 million in SFY 2009-10, while payments for hospital BDCC, funded partially by hospitals them-

selves through the hospital tax, are assumed to remain frozen at \$841 million annually.

Interestingly, on the heels of the enactment in this year's State budget of an increase in CHP income eligibility levels from 250% of the Federal poverty level to 400% beginning in September, widely reported to provide access to CHP for an additional 400,000 children, DOB projects an increase in CHP enrollment from an estimated 421,000 this year to 453,000 in 2008-09, an increase of 32,000 children, or 7.6%. ■



Source: 2007-08 Financial Plan, First Quarterly Update (New York State Division of the Budget, July 30, 2007), p. 35.

The Children's Health and Medicare Protection Act (CHAMP)

Provider Updates: The CHAMP bill calls for inpatient and outpatient market basket cuts of minus 0.25% for FY 2008 only (but beginning Jan. 1, 2008). Skilled nursing facilities and home health providers would receive a 0% update for FY 2008 (also effective January). Inpatient rehabilitation facility providers would receive an update of only 1% for FY 2008. Physicians, who under current law would receive a 10% payment cut come January, would receive a 0.5% update in 2008 and 2009. Additionally, their payment formula is significantly reformed to prevent future reductions because of flaws in the current methodology.

Rehabilitation Policy Changes: CHAMP significantly revises the 75% rule and reduces payments for certain diagnoses by 1) permanently fixing the diagnosis threshold at 60%; 2) continuing to count patients with co-morbidities under the 60% threshold; and 3) reducing payments for unilateral knee replacements and unilateral hip fractures and replacements. Specifically, starting for discharges on or after April 1, 2008, the standardized amounts would be set in statute. Starting in FY 2009, a new methodology would be in place for payment of these three diagnoses: a blended rate that equals the skilled nursing facility (SNF) rate plus 25% of the difference between inpatient rehab rates and SNF rates for overhead costs and 33% of the difference between the rates for patient care costs. In addition, the bill calls for a study of inpatient rehabilitation services and reimbursement.

Wage Index Reclassifications: CHAMP extends the so-called Section 508 reclassifications for two years, through September 30, 2009, and reclassifies certain additional hospitals into higher wage-index areas.

Long Term Care Hospitals: CHAMP exempts long-stay cancer hospitals from the long term care hospital prospective payment system (LTCHPPS); reforms the LTCHPPS by creating criteria to clearly define LTCHs and the patients who belong there; expands medical necessity reviews; imposes a four-year moratorium on new LTCHs and the expansion of existing LTCHs; prevents the "25%" rule from applying to freestanding LTCHs; prevents the one-time budget neutrality adjustment and the regulation on short-stay outliers from taking effect; and provides no inflation update for FY 2008.

Managed Care: CHAMP renames the Medicare Advantage program "Medicare Part C" and reduces payments to plans over four years until they equal fee-for-service costs. Plans that cannot provide Medicare Part A and Part B services for less than 106% of fee-for-service costs in 2009 and 103% of fee-for-service costs in 2010 would be barred from enrolling new beneficiaries. The bill also contains many other revisions to the Medicare managed care program.

Dialysis: Starting in calendar year 2008, the CHAMP bill would equalize payments for dialysis services provided by hospital-based facilities and non-hospital-based renal dialysis facilities, which essentially results in a 3% cut for hospital-based services.

bill, the CHAMP Act would, like the Senate bill, increase tobacco taxes, but by only \$0.45 per pack, and looks to savings in the Medicare and Medicaid programs, including Medicare inflation update reductions for all providers and significant reductions in payments to Medicare managed care plans.

Senate: As reported in *Skyline News* on July

23, the Senate bill would extend and expand the SCHIP program, which is set to expire on Sept. 30, 2007, and would fund the program for five years, well above the President's request of \$5 billion. While the Senate originally approved a \$50 billion package in a budget resolution adopted earlier this year, its latest package is estimated to cost \$35 billion

and is fully funded through a \$0.61-per-pack increase in the Federal tobacco tax. The White House has threatened to veto the package and conservative Republicans have expressed their concerns, viewing the program's expansion as a harbinger of universal health coverage.

Next Steps: The House and Senate bills need to be conferenced prior to coming back before either chamber for final passage and sent to the President. Since the program is set to expire on Sept. 30 and since staff can begin pre-conference negotiations during the August recess, it is expected that conference work will be completed in September in time for the President to take action. GNYHA will work with lawmakers during this time to address the provisions that raise serious concerns for member hospitals, including market basket cuts and inpatient rehabilitation facility provisions (see sidebar). Also, GNYHA will be advocating for certain beneficial provisions to remain in any final conferenced bill and will advocate for the inclusion of a one-year Medicaid regulation moratorium that will protect teaching and public hospitals.

At issue will be the significant differences between the packages in terms of both size and funding. Additionally, it is unclear how Democratic leadership will reconcile the House package's inclusion of Medicare and Medicaid provisions that the Senate package does not include. Also, since the President has officially issued veto threats on both the House and Senate bills as they stand now, he is expected to formally reject the bill when it reaches his desk. The Senate has enough votes to overcome a veto of its bill (67 votes are needed), but the House does not have enough for its version (290 votes are needed). ■

CMS Releases Rehab PPS Final Rule for FY 2008

On July 31, the Centers for Medicare & Medicaid Services (CMS) released the final inpatient rehabilitation facility prospective payment system (IRF PPS) final rule for fiscal year 2008, which begins Oct. 1, 2007. While IRFs would receive a market basket increase of 3.2%, the aggregate payment increase to the IRFs would be 2.4% as the result of an increase in an outlier threshold from \$5,129 to \$7,362 in order to limit outlier payments to a target of 3.0%.

In addition, CMS had specifically asked the industry for comments on the appropriateness of continuing to consider patient comorbidities for determining compliance with the so-called 75% rule. Under current law, the 75% rule requires that a certain percentage of an IRF's admissions (65% beginning July 1, 2007) have a primary diagnosis that falls within one of 13 conditions. The rule is being phased in and, during the transition period, in addition to the primary diag-

nosis, patient comorbidities are considered in determining compliance. CMS rejected the industry's request and comments to continue to consider comorbidities once the transition period for the 75% rule is completed, and decided to maintain its current policy, stating that it believed that the principal diagnosis is the most accurate and appropriate way to identify the medical condition for which the beneficiary required intensive rehabilitation.

The Children's Health and Medicare Protection Act of 2007 has provisions for IRF services (see box above). ■

and for rates of payment in Federal fiscal year (FFY) 2008. Overall, the anticipated negative fiscal impact from several proposed changes will be less severe than expected in FFY 2008 but more severe than expected in FFY 2009. The most important provisions of the final rule pertain to implementation of a new, refined Medicare Severity Diagnosis-Related Group (MS-DRG) system, and implementation of cuts in capital-related payments to large urban and teaching hospitals.

Medicare Severity DRGs: Implementing a new DRG classification has two challenges. First, the new system will redistribute funding, which will cause dislocations for negatively affected hospitals. Therefore, while CMS proposed to fully implement the MS-DRGs in FFY 2008, in the final rule, the Agency said it would phase in the new system over two years. Thus, MS-DRGs will represent 50% of the DRG weights in FFY 2008 and 100% in FFY 2009. Second, in order to refine the DRG system, CMS overhauled the list of comorbidity and complication (CC) codes that will cause a case to be grouped into a higher-weighted DRG. Many of the most commonly used codes will no longer be used, while many newer codes not yet commonly used will become significant as of October 1, 2007. Because hospitals have not fully used the new CC codes, CMS expects that their adoption in the coming year will increase aggregate payments rather than merely redistribute them. Therefore, CMS proposed a cut to the Federal rates to maintain budget neutrality. In order to preserve the appropriate level of aggregate funding, hospitals will have to scrupulously use the new CC codes, which will require much education and training. Even then, however, hospitals with low average case-mix indices and tertiary hospitals that are already scrupulous about their coding will experience deep losses from the cuts. In its proposed rule, CMS estimated “overpayments” at 4.8% of total IPPS payments and proposed to avoid them by cutting the Federal rates prospectively by 2.4% in FFY 2008 and 2.4% in FFY 2009. Virtually all industry analysts believed CMS’s estimate—which the American Hospital Association said would cost the industry \$24

billion over 10 years—was too high. Therefore, the U.S. House of Representatives approved a provision forbidding CMS to use appropriated funding in FFY 2008 to implement the cut and MS-DRGs. GNYHA and other commenters strongly urged CMS to determine and recoup any overpayments retrospectively to guard against excessive cuts. In its final rule, CMS rejected this recommendation and maintained its estimate of overpayments and the associated cut at 4.8%. CMS did reduce the impact of the cut, however, by phasing it in over three years instead of two: 1.2% in FFY 2008, 1.8% in FFY 2009, and 1.8% in FFY 2010. The attenuated cut creates an opportunity for the health care community to work with CMS to correct its damaging policy.

Capital: CMS had proposed two cuts to urban hospitals, including elimination of the inflation update for FFY 2008 and elimination of the 3% add-on for large urban hospitals. In the final rule, CMS decided to provide the inflation update for all hospitals, but it will eliminate the large urban add-on. In the proposed rule, CMS also requested comments on whether it should maintain the indirect medical education (IME) and disproportionate share hospital (DSH) adjustments in the capital PPS. GNYHA and other

commenters provided a strong empirical defense of these adjustments; however, in the final rule, CMS announced that it would eliminate the IME adjustment over two years, starting in FFY 2009. (It was silent on the DSH adjustment.) CMS implied that it would eliminate the capital IME adjustment in order to reduce overall IME payments, which it believes are too high in the operating PPS. CMS does not have the authority to reduce the operating IME adjustment. Since CMS did not propose to eliminate the capital IME adjustment in the proposed rule, it will accept comments on this new policy during the next 90 days and in the comment period on the FFY 2009 IPPS proposed rule, creating an opportunity to preserve the capital IME adjustment, which is so crucial to GNYHA member hospitals.

Graduate Medical Education: In response to strong opposition from the teaching hospital community, CMS decided not to finalize its proposed policy regarding removing vacation and sick time from the calculation used to determine hospital resident counts. According to the preamble, commenters—including GNYHA—gave numerous reasons why this policy would be administratively difficult to implement. Although CMS stopped short of adopting the policy, it invited comments regarding alternative methods of addressing this issue. ■

SHRPC UPDATE

JEFFREY KRAUT APPOINTED NEW SHRPC CHAIR

At the August 2 meeting of the State Hospital Review and Planning Council (SHRPC), NYS Department of Health (DOH) Commissioner Richard Daines, M.D. announced that **Jeffrey A. Kraut** was appointed as its new Chair. Mr. Kraut is Senior Vice President, Strategic Planning and Program Development, at **North Shore–Long Island Jewish Health System** and a valued member of the GNYHA community. GNYHA looks forward to working with him in his new capacity.

Also at the August 2 meeting, the following GNYHA member projects were approved (in some cases with conditions or contingencies): **Mount Sinai Diagnostic and Treatment Center** and **North General Diagnostic and Treatment Center**, approval for permanent life for a project that previously received approval for three-year limited life; Alliance for Health Improvement, LLC, approval to become the established co-operator of **North General Diagnostic and Treatment Center** and **Mount Sinai Diagnostic and Treatment Center**; **Beth Abraham Health Services Health Care**, approval to expand its long term home health care program capacity in Staten Island, Nassau County, and Suffolk County; and **New York Downtown Hospital**, approval as a designated stroke center.

AIA GUIDELINES: At the July 19 Planning Committee meeting, DOH presented for discussion revisions to the construction regulations for health care facilities in the New York State Health Code. The regulation would adopt the 2000 *Guidelines for Design and Construction of Health Care Facilities* issued by the American Institute of Architects (AIA) and the U.S. Department of Health and Human Services. DOH regulations currently incorporate the 1997 edition. ■