



April 5, 2010

Skyline news

Reporting on New York's Health Care News

President Signs Health Reform into Law

After nearly a yearlong effort, Congress finally passed comprehensive health care reform legislation, and, in doing so, gave President Barack Obama his first major victory on his top domestic priority. The final legislation has been estimated to cost \$940 billion over the next ten years. Because the spending is offset by a set of cuts and revenue increases, the package is projected to reduce the Federal deficit by \$138 billion over the same period and by over a trillion dollars the following decade.

While the House passed its reform bill last November, and the Senate passed its version a month later, momentum on reaching a compromise between the chambers stalled in January when the Democrats lost their super majority (with Republican Scott Brown filling the late Senator Ted Kennedy's Massachusetts

seat and tipping the balance in the Senate to 59-41). It became clear to Senate leaders that passing final reform legislation would require a reconciliation strategy, which needs only a simple majority (51 votes) to pass the Senate. However, the reconciliation process mandates strict rules: provisions must either significantly save or spend revenue.

The Process After weeks of negotiating and increasing pressure from President Obama, the House and Senate reached a compromise on a reconciliation measure. The House then took up the Senate's underlying reform bill, and also considered a package of changes to the Senate bill included in the reconciliation measure. On March 21 the House passed both bills, the President signed the Senate bill into law on March 23, and the Senate passed a slightly modified reconciliation package on March 25

(the package was modified due to violations of the strict reconciliation rules affecting the student aid portion of the bill). The House completed final action on the reconciliation bill on March 25, and the President signed the reconciliation measure into law on March 30.

The Provisions The coverage provisions of the law are among the most notable pieces affecting hospitals. The law would extend health insurance to 32 million uninsured individuals by 2019 through a combination of Medicaid program expansions (to 133% of the Federal poverty level) and through tax credits and subsidies to enable the purchase of coverage through newly created state-based health in-

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New Budget Year Begins With No Budget

Unable to come to final agreement on a New York State budget for fiscal year 2010-11, the State Legislature last week sent Governor David Paterson emergency legislation providing appropriations for essential services, including Medicaid, through April 11, 2010. Due to religious holidays, Legislators left Albany March 29 and are not scheduled to return until April 7. It is expected

that Governor Paterson, Assembly Speaker Sheldon Silver, and Senate Democratic Leader John Sampson will try to negotiate an agreement before the emergency appropriations expire on April 11. If an agreement is not reached, more emergency legislation will be necessary to fund State operations after April 11.

Senate, Assembly Pass Resolutions Before leaving Albany, both houses passed budget res-

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Save the Date

Please reserve the following dates for the GNYHA Annual Meeting and the GNYHA Annual Reception and Awards Ceremony

2010 Annual Meeting

Tuesday, April 20, 2010

Keynote

Dr. David Blumenthal,
National Coordinator for HIT

2010 Annual Reception and Awards Ceremony

Thursday, May 27, 2010

UHC Abandons 24-Hour Notification Penalty

UnitedHealthcare (UHC) has announced that it will no longer seek to impose 50% reimbursement reductions on hospitals that fail to notify the plan of inpatient admissions within 24 hours. While UHC will still require notification within 24 hours, reimbursement reductions will not be applied unless notification is received more than 72 hours after admission. UHC has cited continuing concerns raised by hospitals as the reason for its decision to abandon reimbursement penalties for late 24-hour notifications.

UHC had been working to implement these substantial penalties for more than two years. The insurer did agree to a number of modifications to its admission notification protocol in response to the numerous concerns raised by the American Hospital Association and other hospital groups across the country. GNYHA, however, continued to argue that the underlying policy of imposing a 50% penalty for failure to meet an administrative requirement was unreasonable and confiscatory. The concerns raised by GNYHA led to an investigation by Attorney General Cuomo's office as well as the introduction of legislation in both the New York State Assembly and the Senate that would prohibit imposition of reimbursement reduction for late notifications. We greatly appreciate the responsiveness of the Attorney General, Assemblymen Richard Gottfried (D-Manhattan) and Joseph Morelle (D-Rochester) and Senator Neil Breslin (D-Delmar) on this issue.

While GNYHA has vigorously opposed the penalty aspect of UHC's admission notification policy, we do agree that notifying insurers of inpatient admissions in a timely manner is desirable whenever possible. UHC believes prompt notification can help shorten length of stay and reduce hospital readmissions. GNYHA has committed to working with the insurer on initiatives to shorten notification timeframes. ■

GNYHA Advocates for Statewide Perinatal Safety Strategy

GNYHA, in collaboration with the American Congress of Obstetricians and Gynecologists (ACOG) District II and the Healthcare Association of New York State (HANYs), recently responded to a request from the New York State Department of Health (DOH) to provide a consensus document to the State Health Commissioner outlining recommendations for a statewide strategy that promotes nationally recognized, evidence-based guidelines, interventions, and practices that can effectively improve perinatal care. GNYHA embraced this approach more than two years ago when it created its Perinatal Safety Collaborative in partnership with the United Hospital Fund (UHF).

GNYHA believes a strategy that includes best practices used in the Perinatal Safety Collaborative will allow hospitals to initiate obstetrical quality improvement initiatives that are tailored to the specific needs of their

organizations and communities. With support from initiatives such as the GNYHA/UHF Perinatal Safety Collaborative, many hospitals across the State have already begun to implement these practices. GNYHA believes that these hospitals should not only be recognized for their efforts to advance the quality and safety of their obstetrical programs, but that DOH should continue to support and provide access to educational resources, which are essential to effective implementation.

Currently, 45 hospitals participate in the GNYHA/UHF Perinatal Safety Collaborative, striving to create a culture of safety by standardizing clinical practices and improving team work and communication. GNYHA will continue to assist member efforts to improve perinatal care and will continue to encourage DOH to promote this perinatal safety model statewide. ■

Health Reform *continued*

insurance exchanges. States like New York and New Jersey that have been national leaders in expanding their public programs would receive significantly enhanced Federal support for enrolling certain currently eligible individuals.

The law also implements health insurance reforms: prohibiting insurance companies from dropping coverage for enrollees who get sick, eliminating insurers' annual and lifetime coverage limits, and ensuring that individuals with preexisting conditions can access coverage. Plans will be required to spend more on providing care through increased medical loss ratios, and will have new rules on the rates they can charge enrollees. Most individuals will be required to have health insurance or face a penalty, and large employers will pay an assessment if their employees purchase insurance through the exchange. Parents will be able to keep dependents through age 26 on their health insurance plan.

With respect to hospitals, the law signifi-

cantly cuts disproportionate share hospital payments by a total of \$36 billion (\$22 billion for Medicare, and \$14 billion for Medicaid) starting in FY 2014 through 2019. Specifically, the Secretary would reduce Medicare DSH payments to 25% of the amount each hospital would otherwise receive in that year (a reduction of 75%). A portion of the 75% cut would be distributed back to hospitals based on each hospital's proportion of national hospital uncompensated care costs. The portion for uncompensated care is the remaining 75% of funds reduced by the percentage decrease in the uninsured share of the non-elderly population from FY 2013 to the payment year minus an additional 0.1 percentage point in FY 2014 and minus 0.2 percentage points for FYs 2015–2019.

Regarding Medicaid DSH cuts, the law requires reductions in State Medicaid DSH allotments as follows: \$500 million in FY 2014, \$600 million in FYs 2015 and 2016, \$1.8 billion in FY 2017, \$5 billion in FY 2018, \$5.6 billion

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GNYHA Co-Hosts Nursing Care Quality Protection Act Webinar

On March 26, GNYHA and the Healthcare Association of New York State (HANYS) co-hosted a webinar to address disclosure requirements, measurement criteria, and compliance expectations regarding New York State's Nursing Care Quality Protection Act (NCQPA). The NCQPA, which took effect March 15, requires hospitals and other health care facilities to provide, upon request, information related to nurse staffing levels and certain adverse events to members of the public or any State agency. The State is developing regulations to

implement the law; however, in two separate letters sent to hospital chief executive officers recently, DOH released guidance and outlined expectations regarding compliance with the NCQPA.

Next Steps A number of issues and questions regarding compliance remain unresolved, and GNYHA and HANYS are working with DOH to provide further clarification through the rulemaking process. GNYHA is also working with DOH to develop a "frequently asked questions" document to address many of the issues raised during the webinar. The document will

be posted to the DOH and GNYHA Web sites within the next few weeks. For more information, contact Lorraine Ryan (212-506-5416, ryan@gnyha.org) or Zeynep Sumer (212-258-5313, zsumer@gnyha.org). ■

PHSP Performance Improves

Based on financial reporting through the first three quarters of 2009, most pre-paid health services plans (PHSPs) appear to have rebounded from a poor financial performance in 2008. Net income totaled \$132 million, a total margin of 3%. In 2008, PHSPs had a combined loss of \$10 million through the third quarter, and a

The largest gains were reported by Fidelis (\$35.8 million), Metroplus (\$32.3 million) and Healthplus (\$29.9 million). The improved financial performance is largely attributable to the Medicaid managed care line of business, which showed gains of \$153 million. Plans did not fare as well on other lines of business, with losses of nearly \$25

million on Family Health Plus (including the employee buy-in program) and more than \$8 million on Child Health Plus. Medicare Advantage showed more promise: enrollment nearly doubled and net income increased to \$5 million, a 5% total margin.

	PHSP		Commercial	
	2008	2009	2008	2009
Total	(\$10)	\$132	\$88	\$71
State Gov't	(\$9)	\$125	(\$113)	\$13
Medicare	(\$3.4)	\$5.5	\$146	\$120

loss of \$22 million through the full year.

Membership increased 6% from third quarter 2008 to more than 20 million member months. All but two of the 11 plans reported positive net income, a sharp contrast to the third quarter of 2008 when fewer than half of the plans were profitable. However, performance did vary across plans, with Affinity reporting \$5.8 million in losses for 2009, down from \$12.7 million in losses in 2008.

Commercial plans also reported improved performance on the State programs they participate in, with a net gain of \$13.2 million through third quarter 2009, compared to a \$113 million loss for the same period in 2008. Medicare Advantage continues to be a source of significant income for commercial plans with surpluses of \$120 million in 2009, down slightly from \$146 million in 2008. ■

Budget *continued*

olutions reflecting the differing budget priorities of each chamber's majority parties. Where health care is concerned, each proposal has significant differences. For instance, the Senate rejected all of the health care provider tax increases Governor Paterson proposed, while the Assembly accepted the hospital, nursing home, and home health tax increases. Unlike the Governor, the Assembly made the tax increases "reimbursable costs" by the Medicaid program, meaning the portion of the tax attributable to Medicaid beneficiaries would be covered. The portion of the tax covered, then, varies depending upon each provider's Medicaid caseload. The reimbursement applies only to Medicaid fee-for-service cases, not to Medicaid managed care cases.

For Medicaid, the Assembly and Senate both accepted the Governor's proposed elimination of the reimbursement rate inflation update, or "trend factor" for the remainder of calendar year 2010 for all Medicaid providers. While the Assembly rejected the Governor's proposed Medicaid hospital readmissions penalties altogether, the Senate lessened the penalties by 75% by exempting readmissions associated with mental health and substance abuse diagnoses.

With regard to charity care reimbursement cuts, the Assembly lessened the Governor's proposed \$187 million annual cut to non-public hospitals to \$73 million, a 60% funding restoration. The Assembly also accepted a modified version of an industry proposal to transfer funding from the bad debt and charity care pool to regular Medicaid, thus allowing public hospitals access to more Federal disproportionate share hospital funding. The Senate budget resolution was silent on charity care;

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Health Reform *continued*

in FY 2019, and \$4.0 billion in FY 2020. The structure of the cut was revised to ensure specific savings targets each year, which effectively eliminates the “trigger” included in the Senate bill which had tied reductions to gains in insurance. The savings allocation methodology, to be determined by the Secretary, would impose the largest reductions on states with the lowest percentages of uninsured individuals during the most recent year and those that do not target DSH payments to hospitals with high volumes of Medicaid patients and uncompensated care, excluding bad debt.

Hospitals also face Medicare reimbursement rate inflation, or “market basket update cuts” totaling over \$100 billion over the next ten years (starting on April 1, 2010, through 2019). Specifically, for inpatient acute care, inpatient rehabilitation, inpatient psychiatric care, and outpatient services, the market basket cut reductions are: 0.25% in 2010 and 2011; 0.1% in 2012 and 2013, 0.3% for 2014, 0.2% for 2015 and 2016, and 0.75% in 2017, 2018, and 2019. Productivity cuts start in payment year 2012, and essentially represent an additional cut to the market basket based on the productivity factor generated by the Bureau of Labor Statistics to capture the reduced cost of doing business resulting from increased efficiencies. The average productivity factor over the past ten years has been 1.3%. Among the various revenue-generating provisions, the law also imposes fees on health insurers and pharmaceutical manufacturers, and an excise tax on device manufacturers as well as high-cost health plans. The law also raises taxes on high income individuals and families.

The law includes a number of delivery system reforms aimed at increasing the quality of care while reducing costs. Specifically, it implements: a readmissions policy in 2013 that would penalize hospitals for having higher-than-expected readmission rates; a hospital-acquired condition (HAC) policy in 2015 that would penalize hospitals with high rates of HACs; a value-based purchasing program in 2013; a bundling pilot program in 2013 where payments for acute and post acute providers are “bundled” together to better align incentives; accountable care organizations in 2012 to allow hospitals to better work together with physicians to improve care management; and

an innovation center in 2011 to test innovative payment models.

The law includes a number of graduate medical education provisions. It creates a national workforce commission, facilitates rotating residents to non-hospital settings, and clarifies that certain non-patient care activities can be included as part of a resident’s training. Resident slots from hospitals that have closed (as of two years prior to enactment) would now be preserved in the same

geographic area. Also, the law expands the types of entities eligible to participate in the 340B outpatient drug discount program, but does not expand the program to inpatient drugs. And, despite strong opposition from the provider community, the law also creates an Independent Payment Advisory Board (IPAB) that would make binding recommendations on Medicare payment policy (though hospitals are excluded from its recommendations through 2019). ■

Budget *continued*

however, Senate leaders have expressed interest both in restoring funding and the industry transfer proposal.

The Assembly and Senate responded favorably to concerns expressed by the nursing home community about the Paterson Administration’s Medicaid regional pricing reimbursement proposal, with the Assembly eliminating the proposal altogether and the Senate postponing implementation from April 1, 2010, to July 1, 2011. (The emergency budget legislation signed by Governor Paterson last week postpones regional pricing until a final State budget is enacted.) Both the Assembly and Senate would accept the Governor’s proposed nursing home bed hold reimbursement changes and cap on rate appeals. For home care, both chambers would reject the Governor’s proposal to cap personal care hours at 12 hours per day.

The Governor, in a March 30 statement, expressed disappointment in the proposals. “Unfortunately, the spending plans that the Senate and Assembly have put forward did

not include enough cuts to move us toward the goal of a fiscally responsible and sustainable State budget. In fact, in light of the State’s worsening revenue situation, additional reductions beyond even those included in my original budget proposal may ultimately be necessary,” Paterson said.

GNYHA Activities GNYHA continues to meet with legislators and Paterson Administration officials to protect our members from the harmful cuts and tax increases in the Executive Budget. While grateful for some of the restorations contained in the Assembly and Senate budget resolutions, much more work needs to be done. More restorations could be achieved—and public health improved—if the Legislature agreed to include some of the important revenue proposals put forward by Governor Paterson, including a tax on sugary beverages and an increase in the State’s tobacco tax. Both houses of the Legislature rejected the sugary beverage tax, and while the Assembly accepted the tobacco tax increase, the Senate did not. GNYHA urges all members to continue to communicate their budget concerns with their local State legislators. ■

GNYHA MEMBER BRIEFING

Strategies for Early Resolution of Medical Malpractice Claims: Active Case Conferencing

Date: Monday, April 26, 2010

Time: 9:00 a.m.–12:30 p.m.

Registration begins at 8:30 a.m.

Location: GNYHA Conference Center

This first in a series of conferences will examine active case conferencing for early resolution of malpractice claims. Under this system, judges specially trained in medicine and mediation skills conduct case conferences and use every appearance as an opportunity to explore settlement. The NYC Health and Hospitals Corporation (HHC) uses active case conferencing. This conference is supported by the NYS Health Foundation. To register, please contact Linda Tam, ltam@gnyha.org. ■