

HANYS

2008 FEDERAL ISSUES BOOK

PRIORITIES FOR THE
HEALTH CARE COMMUNITY

HANYS



Healthcare Association
of New York State



Healthcare Association
of New York State

**HANYS' 2008 FEDERAL
ADVOCACY AGENDA**
April 2008

In Washington, D.C., the Healthcare Association of New York State (HANYS) advocates on behalf of its members in the regulatory and legislative arenas on issues including:

- protecting and improving the Medicare and Medicaid programs for patients and providers;
- building a stronger health care workforce;
- supporting hospitals and health systems in their efforts to provide the highest quality care to all;
- fostering the widespread adoption of health information technology; and
- expanding health care coverage for all.

HANYS represents more than 550 not-for-profit and public hospitals, health systems (hospital and hospital-based skilled nursing facilities, home health agencies, and hospices) as well as freestanding nursing homes and other health care organizations.

HANYS benefits in advancing the interests of New York hospitals and health systems through a strong, longstanding relationship with the New York State Congressional Delegation, whose members are leaders in Congress in protecting hospitals and health systems.

Delegation members hold key health care positions in Congress. U.S. Representative Charles Rangel (D-Harlem) chairs the House Ways and Means Committee, overseeing Part A of the Medicare program. Representatives Joseph Crowley (D-Queens/Bronx), Michael McNulty (D-Green Island), and Thomas Reynolds (R-Clarence) are members of that panel. Representatives Eliot Engel (D-Bronx), Vito Fossella (R-Staten Island), Edolphus Towns (D-Brooklyn), and Anthony Weiner (D-Brooklyn) are members of the House Energy and Commerce Committee, overseeing Medicaid and Medicare Parts B and D. U.S. Senator Charles Schumer (D-NY) is a member of the Senate Finance Committee, overseeing both the Medicare and Medicaid programs. Senator Hillary Rodham Clinton (D-NY) is a member of the Senate Committee on Health, Education, Labor, and Pensions, overseeing public health and aging issues.

HANYS conducts its advocacy in partnership with New York's allied hospital and health care associations and key state hospital associations. HANYS' work in Washington benefits from its close relationship with national groups such as the American Hospital Association (AHA), the National Association of Public Hospitals (NAPH), and the Association of American Medical Colleges (AAMC).

HANYS' 2008 Federal Priorities

HANYS strives to enable New York hospitals and health systems to provide the highest quality care for all patients and their communities by pressing for full funding of, and rational regulations for, the Medicare and Medicaid programs; health care workforce programs for nurses, allied health professionals, and physicians; and medical research initiatives. With

approximately three million elderly and disabled Medicare beneficiaries and four million low-income adults and children covered by Medicaid in New York State. Medicare and Medicaid issues are the core of HANYS' federal advocacy agenda.

The Federal Budget for FFY 2009

The Weak Financial Condition of New York Hospitals and Health Systems

HANYS' analysis has found that the average operating margin of New York hospitals was 0.9% in 2006, which follows an eight-year trend of annual losses totaling \$2.4 billion. The losses result from inadequate reimbursement from Medicare, Medicaid, and private insurance that fail to cover the cost of providing care. In 2006, nearly half of New York hospitals recorded margins below 1%. Health economists consider a 4% margin the minimum necessary to ensure hospitals have sufficient funds to improve patient care and to reinvest in modernization. Nationwide, only one other state's hospitals suffered lower margins on average than the average margin of New York's hospitals.

Federal Medicare and Medicaid funding must be protected to prevent a further decline in the fiscal health of New York hospitals and health systems.

The President's Proposed Budget Cuts

The budget process for each approaching federal fiscal year (FFY), which begins October 1, is launched in early February with the release of the President's budget requests for mandatory and discretionary spending. This year, President Bush's budget was largely rejected upon receipt on Capitol Hill.

At the request of HANYS and New York's allied health care associations, the New York State Congressional Delegation unanimously went on record against the President's proposed cuts of \$180 billion to Medicare and \$18 billion to Medicaid. Those cuts would have reduced Medicare reimbursement to New York hospitals and health systems by \$10 billion over the next five years. The Delegation understood that cuts of this magnitude would drastically reduce the resources hospitals and other providers would have to deliver the care their communities deserve, and would constrain the State of New York from providing health coverage and access to care to many New Yorkers.

In addition to Medicare and Medicaid cuts, the President proposed reducing funding for appropriated health-related programs including physician, nursing, and allied health professional workforce programs; medical research initiatives under the National Institutes of Health; and some rural health programs. HANYS is pressing Congress to increase funding beyond last year's levels for all of these programs in the appropriations process for FFY 2009.

The Congressional Budget Process

The U.S. Senate and House of Representatives passed budget resolutions that rejected the President's proposals to cut Medicare and Medicaid. These blueprints for spending do not call for specific reductions in spending for either program. Further, the resolutions would allow some increases in funding to health care workforce programs under the Public Health Service Act, medical research under the National Institutes of Health, and rural health programs.

In April, congressional leaders will work in a conference committee to reconcile some differences that exist between the two budget resolutions in hopes of agreeing to one overarching budget blueprint for FFY 2009.

Hospitals and Health Systems Remain Vulnerable to Medicare Cuts

Despite Congress' rejection of the President's proposed Medicare cuts, hospitals and health systems could still be vulnerable to reductions.

Both the House and Senate budget resolutions allow that should Congress address the pending Medicare physician fee schedule cut; the cost of that fix is subject to pay-as-you-go rules. That is, the cost of providing relief from that reduction must be paid for by offsets to other spending. HANYS understands that proposals being considered to provide temporary relief from the 10.6% cut currently slated for July 1, 2008 could cost up to \$15 billion over five years.

HANYS strongly supports full and fair reimbursement to physicians, yet is concerned that cuts to hospital and health system reimbursement may be part of what funds the physician fix. HANYS is working in partnership with the Medical Society of the State of New York (MSSNY) to press for relief from the cut in a way that would not reduce payments to hospitals and health systems.

The House Budget Committee's resolution provides a "reconciliation instruction" to the Ways and Means Committee, requiring the panel to reduce spending within its jurisdiction by \$750 million over the next six years. The Ways and Means Committee has jurisdiction over the Medicare program and could use that reconciliation instruction to reduce Medicare spending. HANYS is working with the entire Delegation, including the Committee Chairman Charles Rangel, to protect hospitals and health systems.

HANYS is working with New York's allied associations, key state hospital associations, AHA, AAMC, and NAPH to protect hospitals and health systems in the FFY 2009 budget process.

Recommendations

- HANYS strongly opposes proposals to reduce Medicare and Medicaid program spending for health care services to hospitals and health systems.
- HANYS supports MSSNY in pursuing legislation to eliminate the scheduled Medicare physician fee schedule reduction without reducing payments to other providers.
- HANYS urges Congress to support increases for critical workforce programs for physicians, nurses, and allied health professions under the Public Health Service Act; National Institutes of Health medical research; and rural health programs.

Medicare Issues

As the budget process proceeds, legislation to address the pending Medicare physician fee schedule cut is being drafted on Capitol Hill. That bill may prove to be a vehicle for making other Medicare changes. In addition to possible legislation, some changes to Medicare provider reimbursement, such as revamping the hospital wage index system, will likely be made this year

by the Centers for Medicare and Medicaid Services (CMS), the agency that oversees the Medicare program.

Medicare Reimbursement Fails to Keep Pace with Cost Increases

Medicare reimbursement often does not cover the cost hospitals and health systems incur when providing care to Medicare patients. In 2006, about half of all New York hospitals experienced negative Medicare margins, losing money caring for Medicare patients. According to an AHA analysis using generally accepted accounting practices, hospitals nationwide received payment of only 91 cents for every dollar spent caring for Medicare patients in 2006.

Medicare “Trigger”—General Revenue Limits

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) established a policy whereby, when the Medicare trustees predict for two consecutive years that the level of general revenue going toward total Medicare expenditures over the next seven years will equal or be greater than 45% of total expenditures, Congress must consider proposals on how to slow Medicare spending. Congress is not required to act on any such proposal. There is no policy basis for choosing 45%.

The Medicare trustees this year tripped the trigger and the President sent to Capitol Hill his package of proposals to reduce program spending. These proposals, in addition to the \$180 billion worth of Medicare cuts the President proposed in his FFY 2009 budget, would increase cost sharing for higher income beneficiaries, establish medical malpractice reform, and require health information technology use. The House majority leadership, required by law to introduce the proposals as legislation, has clearly indicated opposition to the proposals and will not support their progression through the legislative process.

The President has proposed in his FFY 2009 budget that an automatic trigger be established to reduce Medicare spending should the Medicare trustees pull the 45% trigger. Specifically, the President has proposed automatic provider payment reduction of 0.4% when general revenues fund 45% of program expenses. The “sequester” would increase by 0.4% each year until the program funding drawn from general revenue fell below 45%. There is strong opposition to this proposal among health care leaders in Congress. HANYS strongly opposes this proposal.

Recommendation

- The arbitrary establishment of the general revenue trigger fails to recognize increases in the costs associated with providing care. Congress should eliminate the 45% trigger, rejecting the President’s proposal to build upon it.

Annual Medicare Inflationary Increases for Hospitals and Continuing Care Providers

The marketbasket, or inflationary update, for Medicare providers is determined annually by the Secretary of Health and Human Services and subject to modification by Congress. The update is the rate of price increases for goods and services a provider purchases such as wages, medical devices, pharmaceuticals, malpractice insurance, and energy. Updates are projected typically to be between 3% and 4% annually. As costs of providing care go up each year, a full marketbasket update is critical to lessen the gap between the cost of providing care and Medicare

reimbursement, ensure beneficiary access to services, and allow hospitals to reinvest in and update their facilities.

Under current law, the inpatient hospital, outpatient hospital, skilled nursing facility (SNF), home health agency (HHA), hospice, and inpatient psychiatric facility (IPF) Medicare Prospective Payment Systems (PPSs) are all subject to a full marketbasket update as determined by the Secretary for FFY 2009 and thereafter. Current law calls for the elimination of the update for inpatient rehabilitation facility (IRF) payments from April 1, 2008 through FFY 2009.

In his FFY 2009 budget, the President requests Congress eliminate the marketbasket update for all hospitals, SNFs, HHAs, and hospices for three years and impose additional reductions thereafter. If implemented, those proposals would equal a total cut of \$3.3 billion over five years for New York hospitals and health systems.

Recommendations

- HANYS strongly opposes any proposals to reduce or eliminate update factors to hospitals and health systems. HANYS urges Congress to reject the President's call for marketbasket cuts in any Medicare legislation that is passed this year.

Medicare Advantage Plan Overpayments

In its March 2008 report to Congress, the Medicare Payment Advisory Committee (MedPAC) indicated that Medicare is overpaying private Medicare Advantage (MA) plans by \$10 billion per year. Currently, 20% of Medicare beneficiaries are enrolled in one type of MA plan or another. MA managed care plans are paid about 13% more than what it costs to provide care to a beneficiary in traditional fee-for-service Medicare, while private fee-for-service MA plans are overpaid by 17%.

Medicare overpayments to MA plans threaten the future solvency of the Medicare program and generally do not improve the delivery of health care for beneficiaries, according to MedPAC. MedPAC has urged Congress to require CMS set MA plan payment benchmarks at 100% of the traditional fee-for-service level and that pay for performance should apply to plans.

In a prepared statement delivered before the House Ways and Means Health Subcommittee on March 11, MedPAC Chair Glenn Hackbarth stated, "By increasing payments to levels significantly above traditional Medicare, we have changed the signal we are sending to the market: Instead of efficiency-enhancing innovation, we are getting plans (for example, private [fee-for-service] plans) that are not well designed to managed care or improve quality and have higher cost."

Recommendation

- HANYS urges that overpayments to MA plans be eliminated.

Payment Adjustment for Training Physicians: Indirect Medical Education (IME)

New York State's 11 academic medical centers, 56 major teaching hospitals, and 42 minor teaching hospitals train 17% of our nation's physicians. About half of the physicians trained in New York stay in New York. The Medicare program assists in paying the cost of training new physicians. In part, this is done by the addition of a teaching adjustment to certain Medicare payment systems to help compensate for higher indirect costs that facilities encounter when training medical residents. For the Inpatient PPS, the current law adjustment for each episode of care is 5.5% for FFY 2009 and beyond.

The President's budget request to Congress for FFY 2009 proposed the IME be cut by 60%, reducing it from the current 5.5% to 2.2%. That cut, if implemented, would have reduced funding to New York teaching hospitals by \$2.9 billion over the next five years. Any IME reduction undermines teaching hospitals' ability to train physicians and compromises the safety net function that major teaching hospitals serve. Therefore, the "ripple effect" of IME cuts is felt throughout the health care delivery system.

The Bush budget proposes the elimination of direct IME payments to teaching hospitals that care for MA patients. Currently, the Medicare program pays IME directly to teaching hospitals, at the directive of Congress, when caring for MA patients. Congress legislated the change in 1998 to ensure fair reimbursement to teaching hospitals, as MA plans had not been passing through IME payments to hospitals. Medicare continues to pay MA plans an IME amount nonetheless.

Recommendations

- HANYS recommends teaching hospitals' capacity to train physicians and fulfill their safety net function be protected by maintaining the current 5.5% IME adjustment. HANYS urges Congress to reject the President's call for IME cuts in any Medicare legislation that is passed this year.
- HANYS opposes and urges Congress to reject the President's proposal to eliminate Medicare IME funding to teaching hospitals for the treatment of Medicare Advantage patients.
- Over the last few years, CMS has implemented a teaching adjustment for IPFs and IRFs. CMS should also apply a teaching adjustment to the outpatient department and SNF payment systems to capture the higher indirect teaching costs associated with the care provided in facilities of this type that train physicians. Further, an adjustment similar to the children's hospital payments should be included in payments to cancer hospitals.

Payment Adjustment for Labor Costs: Area Wage Index

Providing care is labor-intensive, so it is no surprise that the cost of labor is the largest operating cost for hospitals. Labor costs account for between 60% and 70% of hospital operating expenses, on average. The Medicare hospital area wage index is a geographic adjustment designed to modify Medicare payments for differences in wages across labor markets for all Medicare providers subject to a PPS, including hospitals, SNFs, and HHAs. CMS assigns hospitals and other providers to a labor market, either a statewide rural area or urban areas called Core-based Statistical Areas (CBSAs).

The wage index is one of the most significant determinants of a provider's overall Medicare reimbursement levels. Small fluctuations in a hospital's wage index can result in large reimbursement changes.

The current system is flawed. The hospital wage data it is built upon lags four years behind the actual market rates for nurses and other employees. Administrative mechanisms available to hospitals to "reclassify" from one labor market to another for wage index purposes are limited. Additionally, because PPSs are budget-neutral systems nationwide, when one area benefits, another loses. For these reasons and others, the current wage index system leads to enduring inequities in reimbursement between hospitals, even between hospitals in the same state.

In acknowledgement of the flawed nature of the current Medicare wage index system, Congress has required MedPAC and CMS to develop proposals to improve the system. MedPAC submitted its report on the subject to Congress in 2007, recommending complete replacement of the current wage index methodology. The proposal would use primarily Bureau of Labor Statistics general economy wage information instead of hospital reported wages for the calculation. BLS data are less specific than hospital data, but are more current. MedPAC also proposes development of wage indexes at the county level instead of by CBSAs. According to MedPAC, this would eliminate the need for hospital reclassifications. MedPAC's goal is to propose a simplified system that will exhibit less volatility from year to year within and across labor markets, and allow for the use of more current wage data.

CMS will release its proposals for wage index reform in April as part of the proposed rule for the Inpatient PPS for FFY 2009. CMS has the administrative latitude to make many changes to the wage index system. However, to accept MedPAC's proposal to use BLS data would require a change in the law.

Recommendation

- HANYS supports changes in the wage index system that would allow for the use of up-to-date wage data and less variation from one labor area to another. However, we have concerns over the use of BLS general economic data instead of actual hospital wage data for the calculation and with any proposal that would entirely eliminate hospital wage index reclassifications. Further, HANYS supports the principle that any new significant changes in the wage index system should be done such that hospitals are held harmless from decreases in their wage index as a result of moving to a new system.

Medicare Disproportionate Share Hospital (DSH) Payments

The Medicare program provides a payment adjustment to acute care hospitals and inpatient rehabilitation facilities that care for a disproportionate share of low income patients. DSH payments support the safety net function that many urban, suburban, and rural hospitals serve in their communities.

The President proposed to cut hospital DSH payments by 30% over the next two years, lessening DSH support for New York hospitals by \$1.6 billion over five years.

Recommendations

- HANYS strongly opposes any proposals to reduce DSH payments for safety net hospitals and urges Congress to reject the President's call for DSH cuts in any Medicare legislation that is passed this year.
- HANYS recommends Congress remove the current limit on DSH payments to rural hospitals, equalizing the DSH formula for rural and urban hospitals.

Medicare Recovery Audit Contractor (RAC) Program

The Medicare Recovery Audit Contractor (RAC) program was authorized by the MMA and was administered by CMS. While the demonstration, conducted in New York, California, and Florida ceased in early 2008, the RAC program will continue because it was permanently authorized by The Tax Relief and Health Care Act of 2006. CMS is required to expand the program to all 50 states by 2010.

RACs are private companies under contract with CMS to review Medicare claims, recover overpayments, and correct underpayments made to hospitals and other providers. In the demonstration and in the pending national rollout of the RAC program, RACs keep a significant portion of whatever payment inaccuracy they identify. HANYS estimates the RAC contingency fee to be about 25% of payment errors recovered. CMS has not publically disclosed what the contingency fee level is.

While providers are not opposed to increased oversight to ensure accurate payment, the misguided financial incentives governing the RAC process and a notable lack of oversight by CMS have resulted in a demonstration project marred by aggressive and obscured RAC activities, promoting significant challenges for hospitals and other providers.

CMS has made a number of significant changes, improving how the RAC program will operate when it is expanded nationally. However, HANYS is concerned that CMS has not addressed a number of important issues that created challenges for the providers in the demonstration states, problems that will be replicated nationwide if corrections are not made prior to the national expansion.

HANYS' concerns include the inappropriate and generous contingency fees the government pays for a contractor's denial of claims, need for increasing CMS' oversight of the RAC, and the necessity of qualified RAC staff.

Further, HANYS is concerned the inadequate levels of oversight CMS provided over the RACs during the demonstration will be replicated in the national expansion. CMS should report regularly to Congress and the public on ongoing RAC activities, including denial and appeals data.

Recommendations

- HANYS urges Congress to change the authorization of the RAC program to remove the contingency fee incentive structure, replacing it with a set fee for the scope of all the work under the purview of the RACs and establishing clear performance standards for the RACs.

- HANYS urges CMS to bolster oversight of RACs in the national expansion, creating clear structural guidelines that govern all RACs to ensure that processes, procedures, and expectations are consistent and fair from one RAC to the next. This information should be made public.
- HANYS urges CMS to develop a “fast track” RAC correction process whereby patterns of RAC errors are quickly reversed by CMS.
- HANYS requests Congress require CMS and RACs to establish an electronic claims tracking mechanism prior to the national rollout, whereby hospitals and other providers can monitor the progress of claims going through the review process
- HANYS believes CMS should put more requirements in place to ensure qualified medical personnel are employed by RACs to review claims.
- HANYS recommends CMS limit medical necessity reviews. CMS should require that RAC staff reviewing claims for medical necessity be qualified in the area of expertise for the claims being reviewed.

Medicare Inpatient Pay-for-Performance/Value-Based Purchasing Program Proposals

The Deficit Reduction Act of 2006 required CMS to develop a plan that could be used to implement hospital inpatient pay for performance, or value-based purchasing (VBP) beginning FFY 2009. Instead of a specific proposal, CMS released a set of policy options in 2007. CMS would need a legislative directive from Congress to implement any VBP program for inpatient hospitals in the Medicare program.

CMS has taken the position that implementation of value-based purchasing could result in savings to the Medicare program by permanently cutting funds from the inpatient hospital payment system, a budget-neutral system. HANYS opposes any VBP program that would permanently remove funds from the inpatient PPS. MedPAC has advised Congress that savings should not be a goal of a VBP program.

The CMS policy options would carve out between 2% and 5% from the Medicare inpatient payment system and reallocate a portion of it to hospitals that qualify as good performers—this pool of money would amount to over \$5 billion per year at a 5% carve-out. Hospitals that are not considered good performers and/or have not shown improvement could see their Medicare inpatient payments reduced by as much as the full 5%. Because the proposed methodology would allow for a maximum VBP return of 100% of a hospital’s contribution to the pool, there would be excess funds after this distribution. CMS proposed alternatives for these funds including eliminating some of the VBP carve-out from the hospital payment system altogether.

Under such a VBP scenario, for those hospitals that do not meet the threshold to qualify for increased reimbursement, but rather experience a reduction in their Medicare rates, the likelihood of being able to reinvest in the information systems and staff training needed to achieve the necessary level of improvement is dimmed.

As congressional health committees examine the CMS policy options and consider others for establishing a VBP program under Medicare for hospitals, HANYS urges Congress to focus on the need to allow all hospitals to improve their performance as measured by widely accepted and

currently utilized measures. A program designed to improve hospital performance should not remove funds from the system; to do so would prevent some hospitals from ever being able to catch up.

Recommendation

- Any VBP proposal considered by Congress should reward the hospitals and health systems that improve their performance without preventing those that need to improve from being able to make the investments in technology and labor necessary to do so. Savings should not be achieved from any VBP quality improvement program.

Hospital-Acquired Conditions: Inpatient Payment Reductions

In the inpatient setting, complications associated with a patient's condition can result in higher reimbursement for the care the hospital provides to that patient. It can be the case that complications are developed while a patient is in the hospital. CMS has implemented a policy to reduce hospitals' reimbursement in certain circumstances when a complication is thought to have developed during the patient's hospital stay.

CMS has identified eight conditions it considers reasonably preventable through the application of evidence-based guidelines. The acquisition of certain infections are among the eight. Hospitals have been required to submit a present on admission (POA) indicator with each secondary condition as of January 1, 2008.

HANYS and AHA support the overarching goal of this policy to reduce incidence of serious preventable events. However, HANYS and AHA are concerned that a number of the conditions selected by CMS are not always preventable. Determining whether a complication or condition was present upon admission to the hospital can be challenging, if not impossible.

Recommendation

- HANYS and AHA urge CMS to work with the Centers for Disease Control and Prevention (CDC) before implementing the payment reductions in FFY 2009 to identify research and specific prevention guidelines for the hospital-acquired conditions that will assist hospitals in following the appropriate steps to prevent these conditions from occurring after admission.

Quality Reporting: Hospitals

Hospitals report a growing number of inpatient quality of care and patient satisfaction measures to CMS. The reporting of outpatient measures began April 1, 2008. Successful reporting of these quality measures ensures that hospitals receive a full marketbasket update for their inpatient and outpatient Medicare reimbursement. Failure to successfully report these measures results in a 2% reduction in an institution's Medicare payments.

HANYS supports hospitals reporting these measures, but has concerns about the process CMS uses to "validate," or determine whether a hospital has successfully reported the data. HANYS and AHA are working with CMS to ensure that the validation process CMS uses is consistent, statistically valid, and transparent.

Also, HANYS and AHA are urging the U.S. Department of Health and Human Services (HHS) to ensure that all of its agencies follow the same rules with regard to quality data submission. Currently, there are significant differences in the way CMS and CDC require hospitals to submit quality measures.

Developing Quality Measures

Developing quality measures is a complex process that must take into consideration the latest evidence-based medicine and the most effective way to capture processes and outcomes. HANYS and AHA fully support the efforts of the Hospital Quality Alliance (HQA), a public-private partnership of key stakeholders that work in concert to develop a standardized national quality reporting program. CMS, which is part of HQA, uses and applies HQA measures.

Recommendations

- HANYS urges CMS to improve the reporting measure validation process to make it more transparent and consistent.
- HANYS is pressing CMS to increase the sample size of patient charts it uses in the validation process beyond the current five records per quarter, to ensure a more statistically significant sample.
- HANYS urges HHS to ensure all of its agencies, such as CMS and CDC, use the same reporting requirements and validation processes.
- HANYS urges that only HQA-approved measures be used in the Medicare program.

Outpatient Department Payment Equity

An increasing number of services are provided to patients on an outpatient basis, including outpatient surgeries, check-ups and treatment in hospital-based clinics, and visits to hospital emergency rooms. The Outpatient PPS is under-funded. By CMS' own estimations, the system pays only 87 cents for every dollar of hospital outpatient care provided to Medicare beneficiaries. Payments for emergency room visits and clinic services have been particularly affected by the under-funding. This is especially important in communities where patients tend to receive much of their primary care through emergency room or clinic services. Safety net hospitals are the major source of clinic care in many communities.

Recommendation

- HANYS recommends new monies be applied to the Outpatient PPS to ensure hospitals are reimbursed for the cost of providing care.

Quality Reporting: Continuing Care Providers

Skilled nursing facilities and home health agencies also report quality measures. HHAs that successfully report quality data receive a full marketbasket update. If an HHA fails to successfully report quality measures, its Medicare marketbasket update is reduced by 2%. Currently, there is no link for SNFs between the measures they report and the marketbasket update applied to their Medicare payments.

HANYS encourages CMS to improve the current measures to ensure that accurate information about SNF and HHA care is communicated to patients and others. For example, current HHA measures are not refined enough to differentiate the health outcomes between long-term patients with chronic conditions and short-term, less complicated patients.

Recommendation

- CMS should develop richer continuing care reporting measures that more accurately reveal the complexities of patients' conditions and care needs.

Home Health Agencies' PPS Behavioral Offset

Beginning January 1, 2008, CMS implemented the first significant refinements to the Home Health PPS since the payment system went into effect in October 2000. The factors included in the calculation of the resources used to treat patients were expanded to incorporate additional clinical conditions and comorbidities, adjustments for the amount of therapy services used, and increased payment for successive home health episodes.

CMS determined that a "behavioral offset" was necessary to adjust the base payment rate downward over four years to prevent expenditure increases resulting from coding practice changes based on financial incentives and not factors related to patient characteristics. The CMS-determined behavioral offset is excessive, cutting HHA reimbursement by 11% over the next four years.

While coding changes do account for part of the increase, CMS must more adequately account for how patients being treated by HHAs are more complex. Patient assessment data demonstrate that significant change in patient characteristics has resulted in an increased use of resources. Factors contributing to this change include earlier discharges from general acute hospitals, Inpatient PPS changes that provided incentives to treat higher-acuity patients, and other post-acute regulations such as the inpatient rehabilitation "75% rule," which divert more medically complex patients to the home health setting.

The coding cut will be particularly severe for hospital-based home health providers that often treat medically complex, post-acute patients not admitted by community-based home health agencies.

Recommendation

- HANYS urges CMS to reassess the excessively high behavioral offset cut it is applying to HHA payments. CMS should examine how HHA patients continue to be more complex and require more intensive services.

Skilled Nursing Facility Coverage: Three-Day Qualifying Inpatient Hospital Stay

The requirement of a three-day qualifying inpatient hospital stay as a prerequisite for Medicare coverage for nursing home care should be re-examined. Absent a three-day qualifying stay, Medicare patients do not qualify for Medicare coverage for any SNF care. This requirement complicates a patient's ability to access appropriate care. Even patients who do experience a hospital stay prior to admission in an SNF may stay less than three days in the hospital due to

improved standards and efficiencies of care and the use of observation bed time. This requirement also too soon shifts the burden to states and the Medicaid program.

Recommendation

- HANYS urges CMS to revise the three-day qualifying hospital stay prerequisite for Medicare reimbursement for SNF care by including both a patient's inpatient stay and hospital observation time.

Hospice Reimbursement Structure Refinement

The current hospice reimbursement structure is based on services and costs of care when the benefit was created in 1982. Significant technological, pharmaceutical, and medical delivery advances have changed the services received under the benefit.

A re-evaluation of the hospice payment system could assess whether changes to the benefit structure and payment rates would improve the accuracy of the payment rate. Accurate payment is important to ensure that the program is paying rates that cover providers' costs for all types of patients.

To assess the accuracy of the current payment system, CMS will need to collect data on a variety of aspects involved in providing hospice care that it does not currently collect. For example, CMS will need to pull together details on services provided, personnel providing the care, and frequency and duration of patient visits. Only then can a comprehensive evaluation of patient costs and service use by hospice patients be possible.

Recommendation

- HANYS believes a study should be done to collect the data necessary to restructure the Medicare hospice benefit to reflect modern standards of practice and care.

Physician Resident Training in Non-Hospital Settings

A hospital may receive Indirect Medical Education and Direct Medical Education (DME) payments for residents' training in non-hospital settings, typically a physician's office or freestanding clinic, if the residents spend their time in patient care and the hospital incurs all of the costs of the program. Current CMS policy requires that there be a written agreement stating that the hospital will incur all, or substantially all, of the costs for the training program at the non-hospital site. In cases where the supervising physicians are volunteers, CMS currently has extremely restrictive policies regarding teaching payments to providers for residents in non-hospital settings. These policies often result in CMS disallowing payments.

Recommendation

- HANYS supports legislation that would specify that in instances where supervising physicians freely agree to forego compensation as faculty at a non-hospital site and the teaching hospital pays the residents' stipends, benefits and other training costs, if any, as agreed to by the parties, the hospital has incurred "all or substantially all" of the costs of the program and should be entitled to count the residents for DME and IME reimbursement purposes.

Medicaid and SCHIP Issues

In federal fiscal year 2006-2007, New York's Medicaid program provided health insurance for about 4.2 million elderly and disabled, and low-income people, including children and their parents, pregnant women, and people with disabilities. Medicaid funding also provides a significant degree of support to public safety net hospitals to help cover the cost of services for nearly three million uninsured New Yorkers.

Bush Administration Efforts to Reduce the Federal Medicaid Baseline

Over the course of the last two years the Bush Administration released several regulations that would, if implemented, reduce the federal government's exposure on Medicaid by as much as \$50 billion over the next five years, according to a March 2008 report by the House Oversight and Investigation Committee.

Three of these regulations would directly harm hospitals and the patients they serve. HANYS estimates these proposals could result in reductions of as much as \$4.8 billion to New York hospitals and health systems over the next five years:

- **Public Hospital Regulation:** This final regulation, currently under a legislated moratorium until May 25, 2008, would limit states' ability to draw down federal funds for public safety net hospitals by limiting Medicaid reimbursement. The New York City Health and Hospitals Corporation—New York City's public hospital system—would suffer the loss of hundreds of millions of dollars per year under this regulation. The payment system that has been in place for public hospitals allows them to provide such essential services as trauma and burn centers for their communities.
- **Graduate Medical Education Regulation:** This proposed regulation is under a legislated moratorium until May 25, 2008. It would eliminate federal funding for Medicaid Graduate Medical Education (GME). Medicaid GME helps fund the cost of training physicians in teaching hospitals, which includes public hospitals. These interns and residents provide hands-on medical services to Medicaid-eligible patients and others. HANYS estimates that New York would lose \$600 million per year in federal funds if this regulation were implemented. New York State is the premiere provider of medical education in the country.
- **Outpatient Department Regulation:** This proposed regulation, not currently under a moratorium, would limit currently covered Medicaid services. Many services, particularly for the pediatric population, would no longer be covered in the outpatient setting, were this rule to go into effect. In addition, this regulation would eliminate GME Medicaid reimbursement for outpatient services.

Blocking the Medicaid Regulations

A temporary, legislated moratorium preventing the Bush Administration from implementing these harmful Medicaid public hospital and GME regulations expires on May 25, 2008. At HANYS' urging, the entire New York House Delegation, along with more than 200 other

Representatives, have cosponsored legislation introduced in the House by Representative Eliot Engel (D-Bronx) that would extend the moratorium for one year.

Bolstering Representative Engel's long-standing efforts, House Energy and Commerce Committee Chairman John Dingell (D-MI) and Representative Tim Murphy (R-PA) introduced legislation (H.R. 5613) to block all damaging Medicaid regulations, in addition to the hospital regulations. The bill would block until April 2009 the hospital regulations and regulations that would cut federal Medicaid funding to rehabilitation services, school-based transportation and outreach services, provider taxes, and targeted case management. Similar legislation is expected to be introduced in the U.S. Senate by Senator Jay Rockefeller (D-WV) shortly.

Congressional majority leaders may break apart the bill, adding its provisions piece by piece to the next moving legislative vehicle likely to pass Congress and be signed into law by President Bush. All eyes are on the first possible legislative vehicle, the Iraq and Afghanistan War Supplemental Funding bill, which will likely be considered by the House in April. The current moratorium on the public and teaching hospital regulations expired May 25, 2008.

Recommendations

- HANYS strongly urges Congress to block all of the Medicaid regulations, including those that would cut funding to public and teaching hospitals.
- HANYS urges the New York State Congressional Delegation to cosponsor H.R. 5613, working to pass into law all of its provisions to ensure the federal government commitment to Medicaid is maintained.

Federal Medical Assistance Percentage Increase for State Fiscal Relief

Medicaid is jointly funded by states and the federal government, but the federal government does not contribute its fair share to New York's Medicaid program. The Federal Medical Assistance Percentage (FMAP), or the amount the federal government pays toward New York's Medicaid costs for most services, is 50%. This is the lowest share for any state, a level shared by nine states. The federal government pays as much as 77% of other states' costs.

Particularly at a time of economic downturn, states experience funding gaps. As New York State works to balance its budget amid decreasing revenues and a slumping economy, Congress should provide temporary assistance to states in the form of an FMAP increase. For every one percent increase in the federal share, the state would generate approximately \$450 million in new federal funds.

Congressmen Peter King (R-Seafood) and Thomas Reynolds (R-Clarence), along with House Energy and Commerce Committee Chairman John Dingell and Health Subcommittee Chairman Frank Pallone (D-New Jersey), have introduced legislation in the U.S. House to provide a five quarter, 2.9% increase, in all states' FMAP. HANYS strongly supports this legislation.

Recommendations

- HANYS advocates for increasing the FMAP to New York State. The increase could be done through an across-the-board augmentation to bring the state to a higher federal match, as in the Dingell-King bill, which proposes a temporary increase.

- Alternatively, FMAP for children in the Medicaid program could be increased. Currently, the state receives a federal match of 65% for children covered by the State Children's Health Insurance Program (SCHIP). The federal government should demonstrate its commitment to all children by providing that same level of match to children covered by the state's existing Medicaid program. Doing so would increase federal funding to New York State by more than \$650 million a year.

340B Drug Discount Program Expansion

Section 340B of the Public Health Service Act created the 340B drug discount program, enabling public hospitals, non-profit DSH hospitals, community health centers, and other federal grantee providers to purchase outpatient drugs paid for by Medicaid at a reduced price. These eligible providers typically serve the nation's most indigent and vulnerable patient populations. Access to these reduced prices helps ensure these safety net providers continue to effectively serve the Medicaid population and their communities. Drug manufacturers are required to provide these discounts to participate in the Medicaid program.

While the 340B drug discount program provides significant savings to both government and providers, the program currently covers outpatient drugs only and is available to a limited number of safety net providers.

Recommendation

- HANYS urges Congress to extend the 340B drug pricing program to inpatient drugs purchased by safety net providers and expand the program to include Critical Access Hospitals, Sole Community Hospitals, Rural Referral Centers, Medicare Dependent Hospitals, and children's hospitals.

State Children's Health Insurance Program

SCHIP was created by the Balanced Budget Act of 1997 and funded for an initial period of ten years. Last year, Congress passed two bipartisan reauthorization bills that would have increased program funding by \$35 billion over the next five years. The President vetoed both bills. In December 2007, Congress passed and the President signed a temporary funding bill to extend SCHIP through March 2009. The bill included some additional funding to help states to maintain enrollment levels.

On August 17, 2007, the Bush Administration released a new policy directive that limits states from expanding coverage using federal dollars to children in families over 250% of the federal poverty level (FPL) unless certain, very difficult conditions are met.

Currently New York State's SCHIP program (Child Health Plus B) covers children in families with incomes up to 250% of FPL. New York State is pursuing a policy to cover children in families with incomes up to 400% of FPL, regardless of the August 17 directive.

In his FFY 2009 budget, the President proposed SCHIP be reauthorized, increasing SCHIP allotments by almost \$20 billion over the next five years, significantly less than the two bills passed by Congress last year. The President's budget also includes language that would follow the August 17 directive, but lower to 200% the eligibility cap.

Recommendations

- HANYS supports SCHIP reauthorization and expansion as was called for by Congress.
- HANYS urges Congress to block via legislation the Administration's August 17 directive to states limiting federal support for SCHIP coverage of children in families with income above 250% FPL.

Quality Improvement

Hospital Quality Improvement Initiatives

New York hospitals continue to demonstrate their leadership and commitment to quality improvement and reporting of quality data. Through participation in a vast array of public and private quality improvement initiatives, hospitals across the state have implemented many evidence-based practices that are leading to quality improvements and increased patient safety. HANYS' Quality Institute is aggressively pursuing efforts to identify and assist members with implementation of new evidence-based practices to improve the quality of care.

HANYS and its member hospitals are national leaders in the Institute for Healthcare Improvement (IHI) 5 Million Lives Campaign. As IHI's designated statewide coordinator, HANYS works with statewide partners such as DOH and IPRO to disseminate education, tools, and successful practices to help hospitals implement ongoing improvements. HANYS continues to work to support the alignment of the IHI initiatives with the CMS and The Joint Commission measures, including providing its members with linkages, examples, techniques, and impact data.

HANYS has also advanced an innovative educational series, *Teamwork and Technique: Achieving Critical Care Excellence* initiative, which is designed to help hospitals improve patient safety and reduce complications in critical care units. Through the integration of the aviation industry's crew management principles with evidence-based clinical practices drawn from the IHI quality initiatives, this initiative assists hospitals in meeting CMS' quality reporting requirements, The Joint Commission standards, and other top initiatives including the IHI 5 Million Lives Campaign.

Moreover, New York's health care providers continue to make the prevention and treatment of infections a high hospital priority and have implemented various initiatives to prevent and reduce infections. Hospitals have also actively engaged in regional collaboratives to prevent Methicillin-resistant *Staphylococcus aureus* (MRSA) and central line infections, and have participated in the HANYS-led initiatives to prevent ventilator-associated pneumonia and, through the *Teamwork and Technique* initiative, reduce infections in critical care units.

Recommendation

- HANYS' Quality Institute will continue to lead New York hospitals and health systems in implementation of new evidence-based practices to improve the quality of care for all patients.

Ongoing Continuing Care Provider Quality Improvement Initiatives

Health care providers across the continuum remain committed to implementing aggressive quality improvement initiatives. HANYS supports the national nursing home campaign known as Advancing Excellence in America's Nursing Homes. This campaign is driven by a coalition of long-term care providers, caregivers, medical and quality improvement experts, government agencies, consumers, and others, whose goals are to improve the quality of care and quality of life for people in America's nursing homes.

HANYS partnered with other state associations to form the Empire Quality Partnership, which is actively participating in the national Advancing Excellence in America's Nursing Homes campaign, in addition to being the state convener for quality improvement education and information.

In 2008, both Advancing Excellence and the Empire Quality Partnership will concentrate on using Internet technology for providing more information to nursing homes to support their facility-specific quality initiatives.

Recommendation

- As a founding member of Advancing Excellence in America's Nursing Homes, CMS should develop policy goals that expand its support of this nationally coordinated program of nursing home quality improvement through education, information, tools, and resources.

Workforce

Throughout New York State, in rural, suburban, and urban communities, a shortage of physicians, nurses, and allied health professionals threatens patients' access to needed health services. HANYS encourages the federal government to fund and support programs to attract, train, and retain health care professionals in hospitals and health systems.

Physician Shortages

Physician shortages are projected to increase in the coming years. In February 2005, AAMC recommended a 15% increase in U.S. medical school enrollment. Subsequent analysis of key factors that affect physician supply and demand by AAMC's Center for Workforce Studies found that a 30% increase was warranted to meet the future need for physicians.

Already insufficiently funded by the federal government, successful workforce grant programs necessary to ameliorate the nationwide health care workforce shortage would be undermined further by cuts in the President's budget. The Bush budget proposes cuts to the Public Health Service Act (PHSA) workforce programs under Title VII (health professions education) and funding to the National Health Service Corps (NHSC), which helps New York's under-served communities attract physicians and other health professionals, including dentists and nurses.

The House and Senate budget resolutions reject the President's proposals for reductions to these programs, providing some additional funding over last year's levels. HANYS believes that funding for these programs, particularly the NHSC, should be dramatically increased.

Recommendations

- Federal funding to NHSC and workforce grant programs under Title VII of PHSa must be increased to ensure an adequate supply of physicians, particularly in under-served areas.
- To meet the future demand for physicians, increasing enrollment in the nation's medical schools would require the removal of the cap on the number of residency positions funded by Medicare.

Nursing and Allied Health Professions Shortages

Now several years into a nursing and allied health professions shortage, the federal government should continue its commitment to easing the shortage through fully funding successful programs, such as those originally passed under the Nurse Reinvestment Act and now part of the PHSa. However, the President's budget proposes a 29% reduction in funding to train nurses under Title VIII of PHSa, including the elimination of the \$61 million Advanced Education Nursing Program, which provides grants to help fund graduate education in nursing and train nursing faculty. The budget also proposes to eliminate every program under Title VII of the PHSa, which helps develop a skilled and diverse clinical workforce.

To help address the nursing workforce shortage, a number of hospitals throughout New York State are, or have been considering, the recruitment of qualified, foreign nurses from countries such as the Philippines, India, China, and Korea. The employment based-3 (EB-3) visa has been the primary visa applied for by skilled foreign workers, including nurses. The law limits the number of EB-3 visas available to each country each year. HANYS is working with AHA to "recapture" unused EB-3 visa slots from prior years. Doing so would free up needed visas. The processing of ongoing visa requests is taking up to four years to complete.

Recommendations

- Federal funding to the workforce grant programs under Title VIII of PHSa must be increased to ensure an adequate supply of nurses and allied health professionals
- HANYS supports the recapture of prior years' unused EB-3 visa slots to allow qualified, foreign-trained nurses to provide care in the United States.

Health Information Technology

HANYS considers the widespread adoption of health information technology (IT) a public good. The successful implementation of IT systems in hospitals and continuing care settings has proven to dramatically reduce medical errors, improve the quality of care, and increase efficiency. IT can enable public health officials to move quickly to identify and respond to threats from naturally occurring diseases, the effects of natural disasters, and potential bioterrorist attacks.

The driving force behind hospitals' investment in IT is not savings, but the goal of improving the quality of patient care. IT has the potential to reduce overall health care system costs, but evidence is lacking to support the notion that any measurable amount of savings will accrue to

providers. IT will reduce duplicate testing and help prevent errors that can lead to added costs. However, savings models suggest that payers and purchasers of health insurance, including large employers, will garner the preponderance of savings.

The barriers to achieving widespread IT adoption are vast. While some hospitals and health systems have sophisticated and comprehensive IT systems, these “early adopters” are a minority. The investment needed to achieve widespread IT adoption is staggering. A recent analysis of the nationwide cost of outfitting providers with comprehensive IT systems over a ten-year period was between \$276 billion and \$320 billion. (Source: “The Value of Health Care Information Exchange and Interoperability,” *Health Affairs*, January 2005.)

HANYS believes that the benefits to be gained by widespread health IT adoption clearly warrant a significant investment on the part of both public and private stakeholders—from public and private payers and health care providers. To date, the federal government has provided only a token amount of funding to promote the widespread adoption of health IT.

Recommendations

- The federal government should take the lead in providing access to capital to providers to enable widespread IT adoption through: (1) an add-on to Medicare reimbursement—with special adjustments for low-volume Medicare providers; (2) the development of a low-interest, revolving loan fund; and (3) the establishment of a grant program for high-need providers.
- The federal government should provide greater leadership in the development of a path to true interoperability standards for health IT.

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