



March 3, 2008

Skyline news

Reporting on New York's Health Care News

Governors Oppose Bush Medicaid Cuts

Last week, the nation's governors came out in strong opposition to the \$18.2 billion in cuts President George W. Bush proposed in his 2009 budget as well as Medicaid regulations that would reduce funding to states by billions more over the next five years. In a strongly worded letter on February 25, the bipartisan leaders of the National Governors Association—Governors Tim Pawlenty (R-MN), Edward G. Rendell (D-PA), James H. Douglas (R-VT), and Jon Corzine (D-

NJ)—called upon the bipartisan leadership of Congress to stop Medicaid regulations promulgated by the Centers for Medicare & Medicaid Services (CMS) over the last year.

“While states are committed to upholding their responsibility to Medicaid, we have significant concerns that the actions taken by CMS will effectively end the Federal government's participation in many crucial components of the Medicaid program and inappropriately shift those costs to states,” the

Governors said. “Congressional action is needed to prevent the rules from becoming final and to provide for a more appropriate and thoughtful review by Congress of these important policy changes.”

Further, testifying before the Senate Finance Committee on Feb. 26, Governor Janet Napolitano (D-AZ) called for the passage of another economic stimulus package, this time with assistance to states, including an increase

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GAO: Medicare Advantage May Mean Higher Costs for Some Beneficiaries

On February 27, the U.S. Government Accountability Office (GAO) presented a report to the U.S. House Ways and Means Subcommittee on Health challenging the conventional wisdom that all Medicare beneficiaries enrolled in Medicare managed care plans have lower out-of-pocket costs than Medicare beneficiaries who have remained in the fee-for-service Medicare program. Specifically, the GAO reported that 16% of Medicare Advantage (MA) enrollees have higher cost-sharing responsibilities for inpatient hospital services than their fee-for-service counterparts, while 19% have higher cost-sharing for home health services and 9% have higher cost-sharing for nursing home services. According to the GAO, cost-sharing varied substantially among plans. More than half a million beneficiaries were in plans that had no

cost-sharing for inpatient services at all.

“In contrast,” James Cosgrove, Acting GAO Director for Health Care, told the Subcommittee, “a similar number of beneficiaries were in MA plans that required cost-sharing that could result in \$2,000 or more for a 10-day hospital stay and \$3,000 or more for three average-length hospital stays.”

In 2007, fee-for-service Medicare beneficiaries paid a \$992 deductible for the first hospital stay, no deductible for subsequent stays, and a 20% copay for physician services, meaning inpatient costs for some MA enrollees were much higher than for their fee-for-service counterparts. Other GAO findings included that a relatively small portion of MA plans provide additional benefits with the “rebates” they receive from the Medicare pro-

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GNYHA Member Testifies on Federal Paperwork Burdens

On February 26, Linda Brady, M.D., President and CEO of the Kingsbrook Jewish Medical Center and Vice Chair of GNYHA's Board of Governors, testified on behalf of the American Hospital Association at a hearing of the Small Business Committee of the U.S. House of Representatives in Washington, D.C. The hearing—“Improving the Paperwork Reduction Act for Small Businesses”—was chaired by Congresswoman Nydia Velázquez (D-NY) and was called to determine ways to remove excessive paperwork burdens for small businesses as a result of Federal rules and regulations.

Dr. Brady pointed out the devastating impact of the President's budget and proposed Medicare and Medicaid cuts on hospitals

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Upcoming GNYHA Member Briefings

Critical Care Leadership Network Educational Program: End-of-Life and Palliative Care in the ICU

Date: Wednesday, March 12, 2008

Time: 9:00 a.m.–4:00 p.m.

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

This program, hosted by GNYHA and the United Hospital Fund, will aim to improve the quality of clinician and patient/family communication at the end of life, focusing on the transition to palliative care, the withdrawal of life-extending treatment, and “do not resuscitate” directives. It will also cover the conceptual, ethical, and operational issues of providing end-of-life care in the ICU. There is a nominal registration fee of \$25. *Critical care physicians from all GNYHA member hospitals are urged to attend.* For registration and more information, contact Eden Rollins (erollins@gnyha.org) at GNYHA or visit www.gnyha.org/endoflifecare.

Community Benefit Reporting

Date: Tuesday, March 18, 2008

Time: 9:00 a.m.–12:00 noon

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

Keith Hearle, President of Verite Consulting and a national expert on community benefit, will explain the basics of quantifying and reporting community benefit activities. He will also cover the new Schedule H attached to the revised IRS Form 990, which hospitals must use to document, quantify, and report community benefit. Presentations will be given by GNYHA members who are implementing community benefit reporting processes. For more information, contact Lloyd C. Bishop (bishop@gnyha.org); to register, contact Evelyn Guthwin (guthwin@gnyha.org), at GNYHA.

World Energy Solutions, Inc.

Dates: Tuesday, March 25, 2008

Time: 2:00 p.m.–3:00 p.m.

Location: Web-based Demonstration

Last week, GNYHA Services, Inc. announced a new group purchasing agreement with World Energy Solutions, Inc., a provider of on-line auction services for electricity, natural gas, and green credits. World Energy uses a “reverse auction” process in which the winning supplier is the lowest bidder. Services are no-cost and risk-free to GNYHA members because the winning supplier pays World Energy’s fees and there is no obligation to accept the bid—although clients typically save 5–30% on energy costs. During the demonstration, World Energy will discuss how the auction process works and the comprehensive services it provides in arranging for and conducting the auction. For more information or to register, contact Barbara Green (212-259-0720; green@gnyha.org) or Justin Muschong (212-258-5304; jmuschong@gnyha.org) at GNYHA. ■

GNYHA Supports Authority of Public Health Council and DOH to Consider Impact of Ambulatory Surgery Centers on Hospital Care

GNYHA has filed with the NYS Supreme Court, Albany County, a motion for leave to appear as an *amicus curiae* in support of the authority of the Public Health Council (PHC) and the NYS Department of Health (DOH) to consider the impact of proposed freestanding, non-hospital-sponsored ambulatory surgery centers (ASCs) on surrounding hospitals and their services when the PHC and DOH review applications for certificates of need (CON). GNYHA’s motion is in response to litigation initiated by the South Shore Surgery Center (whose application to establish a freestanding ASC in Islip, New York, has not yet been approved) challenging the PHC voting process and the authority of the PHC and DOH to consider the impact of proposed ASCs on surrounding hospitals and their services.

GNYHA takes the position that the PHC has not only the authority but the responsibility to take into account the impact that new freestanding ASCs might have on surrounding hospitals and the essential health care services the hospitals provide to their communities. In support of this position, GNYHA outlines the relevant provisions of NYS’s Public Health Law, DOH regulations and guidelines

governing the establishment of ASCs in particular, and the purposes and goals of health planning as undertaken by the State of New York. GNYHA’s filing of an *amicus curiae* brief was undertaken with DOH’s consent.

GNYHA has long called for a moratorium on the establishment of new freestanding, non-hospital-sponsored ASCs because of their negative impact on hospitals and hospitals’ ability to provide services to their communities. ASCs tend to concentrate on low-risk, high-profitability cases, leaving hospitals with higher-risk, lower-profitability cases and the responsibility to provide the full array of services their communities require, many of which result in significant losses for hospitals. The report of the Commission on Health Care Facilities in the 21st Century underscores that freestanding ASCs deprive hospitals of much-needed revenue and correspondingly undermine their ability to serve their communities.

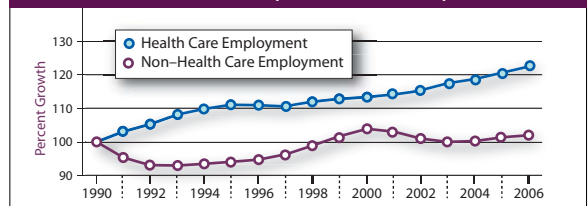
If you have questions about GNYHA’s brief or the litigation, contact Susan C. Waltman or Rebecca Urbach at GNYHA. For more information about GNYHA’s activities with respect to ASCs and the CON process, contact Doris Varlese at GNYHA. ■

Report Documents Critical Role of Health Care Employment in New York Economy

A recently released report from the Center for Health Workforce Studies documents the critical role that the health care sector plays for New York’s employment and the overall New York economy. *The Health Care Workforce in New York, 2006: Trends in the Supply and Demand for Health Workers* indicates that employment in the health sector accounted for 11.4% of total employment in New York in 2006. Nationally, 8.7% of employment is in the health sector, making the representation of health sector jobs in New York more than 30% higher than it is nationally. According to the report, between 1990 and 2006, employment in New York’s health care sector—which has seen a steady and continuous annual increase in employment since 1997—grew by more than 22%, while employment in all other sectors grew by just over 2%.

The full report is available at chws.albany.edu. ■

Employment Growth in the Health Care and Non-Health Care Sectors, New York State, 1990–2006



Source: Center for Health Workforce Studies, *The Health Care Workforce in New York, 2006: Trends in the Supply and Demand for Health Workers* (Albany: School of Public Health, University at Albany, 2007).

Bush Administration Finalizes Rule on Provider Taxes

On Feb. 21, the Centers for Medicare & Medicaid Services (CMS) issued a final regulation, effective Apr. 22, 2008, that changes the Federal rules governing the health care–related taxes states may impose in order to receive Federal matching payments under the Medicaid program. State government officials across the country fear that the new rules will result in losses of hundreds of millions of dollars in Federal Medicaid funding. CMS estimates that the rule will save the Federal government \$430 million in Medicaid spending over the next five years, though many state budget analysts believe the actual impact on state budgets will be much higher. Thus, it may be deemed necessary, once the rule is fully analyzed, to ask Congress to stop this rule along with the other Medicaid rules Congress has already placed, or is considering placing, under moratorium.

Federal Reimbursement Limits: Since the early 1990s, the Federal government has tried to limit states' ability to reimburse health care providers for state taxes the providers pay. This effort began after the Federal government alleged that some states were taxing providers, using the resulting revenue to draw down Federal Medicaid matching dollars, and then reimbursing providers directly for the

cost of the tax. The Federal government contended that such arrangements allowed states to avoid putting up a true state share of Medicaid spending, thus inappropriately shifting the costs of the Medicaid program to the Federal government.

In response, Congress (through law) and CMS (through regulation) established rules and principles to determine permissible provider taxes. In general, the Federal government defines "permissible classes" of providers that may be taxed (such as hospitals and skilled nursing facilities) and then requires that taxes be broad-based and uniform (for example, providers within a class are generally taxed at the same rate) and that individual providers are not "held harmless"—that is, reimbursed for the cost of the tax, through Medicaid or other state payments. The requirements that taxes be broad-based and uniform may be waived—a tax can exclude certain providers within a class, for instance—but only if the tax meets a complicated test to determine that it is generally redistributive and that the amount a provider pays is not directly correlated to Medicaid or other state payments the provider receives.

Final Rule: The final rule tightens the provider tax rules in potentially significant ways. First,

responding to a provision in the Tax Relief and Health Care Act of 2006 (P.L. 109-432), the rule reduces the maximum permissible tax on net patient service revenues from 6% to 5.5% for the period Jan. 1, 2008, through Sept. 30, 2011—a reduction that was the result of a compromise, after major advocacy by GNYHA, the American Hospital Association, and others. That year, President Bush proposed reducing the maximum tax to 3%, which would have greatly reduced Federal Medicaid funding to states across the country.

Second, and more significant, state government officials are concerned that the rule will result in more restrictive interpretations of what types of taxes are permissible and much tighter rules about what types of payments to providers, including non-Medicaid payments, may trigger an allegation that a state is holding a provider "harmless" from the cost of a tax and, in turn, trigger reductions in Federal Medicaid revenue. State officials also fear that the Federal government has replaced statistical tests, under which they could easily tell if a tax was permissible, in favor of more subjective judgments, making it difficult for states to enact taxes on providers with any certainty.

GNYHA is working closely with the Spitzer Administration to determine the potential impact of the new final rule on NYS, and will work closely with the Governor and the New York delegation on solutions. ■

Bush Medicaid Cuts *continued from page 1*

in the Federal Medicaid matching rate.

"Medicaid needs your immediate attention," Governor Napolitano said. "States expected an enrollment increase during our economic downturn. What states did not expect—and should not occur—was the intentional move by the Administration to remove billions of dollars of Federal Medicaid dollars from our existing health care system" through regulations. "Taken together, these regulations reduce Federal investment in Medicaid by close to \$15 billion over the next five years and enact substantive policy changes that, in many cases, Congress has considered and expressly rejected. . . . In Arizona, we stand to lose nearly \$30 million this year in investments in graduate medical education—a program that has been essential to attracting and training new health care professionals and extending access to low-income individuals."

Congress has placed a moratorium through May 25 on the implementation of two regulations to eliminate Medicaid funding for graduate medical education and to drastically reduce funding for public providers. Other regulations, however, have been proposed since the moratoria were enacted last year, including damaging regulations on Medicaid outpatient services and on permissible taxes states may levy on health care providers. GNYHA will continue to work with the New York delegation to bar implementation of those regulations, in part through gaining support for H.R. 3533, the Public and Teaching Hospital Preservation Act, sponsored by Congressman Eliot Engel (D-NY), which would extend the moratoria into 2009. GNYHA is also strongly supporting H.R. 5268, sponsored by Congressmen Frank Pallone (D-NJ) and Peter King (R-NY) to provide for a temporary Federal Medicaid matching rate increase for states. ■

Critical Care Leadership Network:



Second Annual 24-Hour ICU Survey

On March 25, GNYHA and the United Hospital Fund will be undertaking the **Second Annual 24-Hour ICU Survey**. Last year, 143 ICUs across 69 hospitals participated. This year, we need even more ICUs to join this critical data collection effort. To prepare for the survey, please let your colleagues and GNYHA know that you will be participating. For more information and to register your interest in participating, go to www.gnyha.org/ICUsurvey or contact Zeynep Sumer at GNYHA. ■

Medicare Advantage

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gram. (Rebates are provided to encourage plans to lower costs, and are equal to 75% of the difference between a plan's premium bid and a benchmark amount established by the Medicare program.) Instead, 69% of rebates are used by plans to reduce beneficiary cost-sharing amounts, 20% are used to reduce premiums for beneficiaries, and only 11% are used to provide additional benefits over and above what Medicare fee-for-service offers. The GAO also reported that plans in the aggregate spend 87% of their premium revenue on medical expenses, with 9% allocated to administration and marketing expense and 4% for profits.

The Subcommittee is likely to consider changes to the way MA plan premiums are calculated in legislation later this year. ■

GNYHA Member Testifies

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nationally, including his proposed regulations eliminating Medicaid graduate medical education payments for teaching hospitals. She pointed out the considerable new paperwork and administrative burdens placed on providers following the shift from Medicare fee-for-service to Medicare managed care, and she outlined the duplicative nature of Federal audit practices. Specifically, the Centers for Medicare & Medicaid Services conducts six types of activities to protect against improper payments, waste, and fraud and abuse: cost-report auditing, medical reviews, benefit integrity, Medicare secondary payer reviews, provider education, and matching Medicare and Medicaid claims. Dr. Brady pointed out that quality improvement organizations, fiscal intermediaries, Medicare administrative contractors, carriers, program integrity officers, and recovery audit contractors (RACs), among others, are all tasked with carrying out these activities to one degree or another. While each contractor has an individual Statement of Work, their tasks often overlap, meaning nurses and coders must pull patient charts time and again and go through a repetitive process. The RAC process has been particularly challenging, as the RACs have had little experience with the Medicare program and,

SPECIAL UPDATE: FOCUS ON QUALITY

When GNYHA and the United Hospital Fund (UHF) began a series of cooperative initiatives to enhance the quality of care in hospitals, they hoped to design an effective model to improve patient outcomes. Now, less than three years later, four collaboratives have been launched, the Critical Care Leadership Network has been created, frontline staff have become quality coaches, and a standardized model to support these initiatives has been identified.

The model that has been developed is one that relies upon strong collaboration across participating hospitals, which work together to implement an identified "bundle" of activities to improve their delivery of care and to share best practices for accomplishing that goal. The model also includes commitment from senior hospital leadership, dedication of multidisciplinary teams, regular educational sessions, technical support, clinical "experts on call," the involvement of frontline staff, and data collection and analysis. Over the last three years, GNYHA and UHF have rolled out four separate collaboratives focusing on reducing the rate of both central line-associated bloodstream and *Clostridium difficile* infections, improving perinatal safety, and implementing rapid response systems in hospitals.

In addition, GNYHA and UHF created the Critical Care Leadership Network to coordinate a unified approach for delivering care in the New York metropolitan area by sharing and standardizing the implementation of evidence-based practices to improve patient outcomes in the ICU.

Look for a special insert on the GNYHA/UHF quality initiatives in a future issue of *Skyline News*. In the meantime, if you have questions about GNYHA's quality and patient safety activities, contact Terri Straub, Zeynep Sumer, or Gina Shin at GNYHA. ■



CMS Says National Health Care Spending Will Outpace Economic Growth and Inflation

National Coalition's Upcoming Summit to Address Health System Costs and Reform

The Centers for Medicare & Medicaid Services (CMS) has issued a report on the expected growth in health care spending over the 10-year period 2007–17. The report, in the Feb. 26 issue of *Health Affairs*, estimates that costs will rise to \$4.3 trillion annually in 2017, at a 6.7% average annual rate of increase, outpacing the growth rate of both the economy and general inflation.

The report estimated 7.5% growth in the hospital sector in 2007, slowing to a 7.2% increase in 2008, and eventually falling to a 6.4% projected growth rate in 2017.

In response to these findings, the Partnership for Quality Care (PQC), whose founders include GNYHA and 1199 SEIU United Healthcare Workers East, issued a statement underscoring the need for a reformed health care system that ensures affordable, high-quality care for all Americans. An association of 1 million frontline health care workers and providers caring for 50 million patients annually, the PQC recommended that policymakers focus their efforts on investing in the efficient delivery of quality care. The PQC also

highlighted the challenge that the uninsured present to the goal of containing costs while improving quality, as well as the fiscal sustainability of the providers that care for them.

Upcoming Summit: The PQC is hosting a summit in Washington, D.C. on Mar. 19, at which leading health care providers will discuss successful initiatives in restraining costs and increasing the quality of care. The speakers will include Kenneth E. Raske, President, GNYHA; George Halvorson, CEO, Kaiser Permanente; Andrew Stern, President, Service Employees International Union; Dennis Rivera, Chair, SEIU Healthcare; Thomas Glynn, COO, Partners Healthcare; Lloyd Dean, CEO, Catholic Healthcare West and Chair of the Catholic Health Association; Stuart Guterman, Commonwealth Foundation; Kenneth Thorpe, Chair, Health Policy and Management, Rollins School of Public Health; Mohammad Ahktar, M.D., President, National Medical Association; and Mitra Behroozi, MedPAC Commissioner and Executive Director, 1199 SEIU National Benefit Fund. ■

thus, have required countless hours of hospital staff time to respond to RAC requests.

Dr. Brady also outlined a number of other Federal rules and requirements, including

quality reporting, that add burdens and costs for financially strapped health care providers. To view a full copy of Dr. Brady's testimony, go to www.house.gov/smbiz. ■