Inpatient PPS Final Rule Talking Points

- The Inpatient PPS Final Rule goes on display today (July 29, 1999)and will be published tomorrow.

1)Update Factors

- The update factor for PPS hospitals is 1.1 percent. (MB increase (2.9) minus 1.8 percentage points) - Note: Market basket increase was up from 2.7 percent in the proposed rule.

- The PPS capital index is forecast to increase to 0.6, up from the proposed estimated 0.5.

- The latest estimate of the market basket for excluded hospitals and units for FY 2000 is 2.9 percent (up from 2.6 percent in the proposed rule). Accordingly, the update of the target hospitals for cost reporting periods beginning in FY 2000 is between 0.4 and 2.9 percent, or 0 percent, depending on the hospital's or unit's costs in relation to its limit.

2)Teaching physician, resident, and nurse anesthetists phase-out from wage index

- We are implementing a 5-year phase-out of all teaching physician Part A wage costs as well as all resident and Part A certified nurse anesthetists costs from the wage index. This is consistent with the recommendations made by an industry workgroup convened last fall by the American Hospital Association.

3)Capital Special Exceptions

- We received 6 comments to the FY 2000 proposed rule on potential changes to the special exceptions process. Three were in favor of changing the process and two were opposed to making any changes. In addition, MedPAC opposed expanding the process until we have a better estimate of the impact of any expansion.

- Two national hospital associations (Catholic Hospital Association and the Federation) were opposed to changing the policy. They believe that the special exceptions process was intended to be limited in scope. Because capital PPS is budget neutral, the commenters do not believe that the majority of hospitals should have their payments further reduced to expand the special exceptions process to a few hospitals. One of the commenters noted that Congress considered a similar proposal to expand the special exceptions process as part of the BBA deliberations, and ultimately did not include the proposal. The commenter believes this failure to act was an indication of Congressional intent, and that HCFA has no authority to disregard it and adopt these changes by regulation.

- Based on our evaluation of the comments received on the special exceptions process, we have decided that the more appropriate forum for addressing the capital special exception is the legislative process rather than the regulatory process.

- HCFA believes that making the changes suggested, would expand the special exceptions process beyond its original narrow focus.

Background

- In the PPS 1999 final rule, we solicited comment about the qualifying criteria for the capital special exceptions process. We received 4 timely comments. HCFA also met with 2 groups that expressed an interest in our changing the special exceptions process during the FY 2000 rulemaking process. One of these groups is represented by Representative Rangel.

- In the FY 2000 proposed rule, we described the various proposals made by these groups in order to solicit additional comments. The groups' proposal included (1) lowering the qualifying DSH percentage from 20.2 percent to 15 percent; (2) changing the required project completion date; and revising the qualifying criteria for a special exception so that only capital payment margins are considered, instead of capital payment margins and operating margins as is now the case; (3) changing the minimum payment level for most hospitals from 70 to 85 percent.

4)Centocor

- As you know, the Final Rule includes a provision on non-MedPAR data for platelet inhibitor drugs submitted by Centocor. We concluded that, at this time, the data are not reliable because we have not had sufficient opportunity to validate the data, and therefore it is not feasible to use the data for FY 2000. As we state in the final rule, without appropriate non-MedPAR data, the earliest we could make a determination using FY 199 MedPAR data would be in the FY 2001 proposed rule.

  We will be sending Mr. Thomas a letter tomorrow which outlines this in greater detail.

Congress of the United States
Washington, DC 20515

Deborah—
Did we ever do anything w/ this? Can you plz give me status? I'll need at least an interim reply -- perhaps enclosing a HCFA back note. CJ

June 16, 1999

Mr. Chris Jennings
Special Assistant to the President for Health Policy
The White House
Old Executive Office Building
1600 Pennsylvania Ave., NW
Washington, DC 20500

Dear Mr. Jennings:

Recently, the Health Care Financing Administration (HCFA) issued proposed regulations regarding the Medicare capital special exceptions process. We want to take this opportunity to once again urge you to revise the Medicare special exceptions process as part of the final FY 2000 hospital regulation. The Medicare capital special exceptions process was established pursuant to report language that we helped to insert in the Omnibus Budget Reconciliation Act (OBRA) of 1993 Conference Report. However, modifications to the special exceptions process are still needed. Institutions such as New York Presbyterian Hospital, which has facilities in our Congressional districts, did not receive adequate relief when the regulation was originally issued in 1994. After all this time, we can see no further reason to delay providing the type of relief that we had intended to achieve through the 1993 Conference Report language.

The OBRA Conference Report language called on HCFA to address the needs of hospitals that, through lengthy approval processes and other problems beyond their control, were not eligible for the "grandfather" provisions of the prospective payment transition. This language was included because hospitals that had to undertake major replacement or renovation projects during the transition to capital prospective payment are significantly financially disadvantaged compared to hospitals whose projects were completed before the transition and those that will build after the transition. It was our intention that such hospitals be put in a position of relative parity with grandfathered hospitals and later builders. It was also our intention that this treatment be available to any hospital in this situation. Unfortunately, the 1994 regulations did not achieve parity and conditioned payments on other measures of need, such as Medicare margins or DSH levels, despite the intent of the OBRA language.

Over the past five years, we and other members of Congress and the affected hospitals have worked with you and HCFA to find ways to make the existing regulations

more fair for hospitals whose projects have been caught in the transition. HCFA's recent proposed regulation for fiscal year 2000 hospital payments describes some of the suggestions for improvement that have been made and asks for comment, but does not actually propose new regulatory language. The proposed rule does, however, provide the opportunity to resolve this issue in the final regulation that will be issued later this summer. To achieve an equitable transition process, i.e., one that meets the intent of the 1993 Conference Report, the final regulation needs to address five major issues:

- The payment floor should be raised to 85 percent from the current 70 percent so that it will be comparable to the treatment of grandfathered hospitals.

- The offset against payments for Medicare inpatient surpluses should be eliminated, or, alternatively, all Medicare operating costs, both outpatient and inpatient, should be counted in determining whether a surplus exists.

- The DSH requirement should be eliminated. As an alternative, the requirement should at least be lowered to 15 percent, the threshold for eligibility for other DSH payments. In addition, the current eligibility threshold should be replaced with a sliding payment scale, similar to the concept used in calculating DSH add-ons to prospective payments.

- The placed in service date should be extended for hospitals that have experienced regulatory or other delays in completing their projects if they received CON approval by a date certain.

- There should be a reasonable cap on payments that minimizes the effect of any changes on payments to other hospitals. An annual cap equal to one percent of all capital payments would accomplish this. A rollover provision should be provided to ensure that the effect of the cap does not deny eligible hospitals the intended relief.

As you know, this is a matter of great importance to us. We hope you will take the steps necessary to ensure that the final FY 2000 regulations include revisions to the special exceptions regulations that meet the concerns we have outlined.

Sincerely,

Carolyn B. Maloney

CAROLYN B. MALONEY
Member of Congress

Nita Lowey

NITA LOWEY
Member of Congress

Part of hospital inpatient PPS rule — published 7/30
people will not be happy —
something that's not for
the reg process
push back from other hospitals
Ways & Means wouldn't do it —
reg process

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Center for Medicaid and State Operations
Family and Children's Health Programs Group
7500 Security Boulevard
Baltimore, MD 21244-1850

Ellen Anderson
Director, Office of Managed Care
New York State Department of Health
Empire State Plaza
Corning Tower, Room 2001
Albany, NY 12237

Dear Ms. Anderson:

Following our conditional approval to implement the New York Partnership Waiver in Phase 1 of New York City, there were several press stories that could have inadvertently left the impression that the waiver was being implemented for the entire state.

I wanted to take this opportunity to clarify that the Health Care Financing Administration's (HCFA's) conditional approval to implement mandatory Medicaid managed care in New York City is only for the area designated as Phase 1 (Staten Island, lower Manhattan, and parts of Brooklyn.) We permitted New York to implement the waiver as early as July 1, 1999 contingent on compliance with the relevant conditions of approval.

HCFA has not provided conditional or final approval to move forward with implementation of the waiver in any areas of New York City beyond those designated in Phase 1 for the City. In accordance with Attachment E, item II.4 of the waiver terms and conditions, mandatory enrollment can begin no sooner than four months after the initiation of enrollment under the prior phase. In addition, HCFA must certify the operational readiness of the designated boroughs in each phase before granting approval for implementation. As you know, previous studies have shown that the provider network outside of Phase 1 in New York City lacks adequate capacity. HCFA will require additional documentation that this, and other, waiver provisions have been fulfilled before any extension of the waiver beyond Phase 1 in New York City can take place.

If you have any questions on this matter, please call Estelle Chisholm at (410) 786-3286. You may also call Lori Maatta, HCFA Central Office, at 410-786-7711 or Michael Melendez, HCFA NY Regional Office, at (212) 264-9121.

Sincerely,

David S. Cade
Director

DRAFT

FACT SHEET 7/27

July 1999

NEW YORK'S MANAGED CARE MEDICAID PLAN

Overview: ***On July XX, 1999, the Health Care Financing Administration(HCFA) sent a letter informing the State of New York that it could begin enrolling Medicaid beneficiaries in mandatory managed care in Staten Island, lower Manhattan and parts of Brooklyn. This approval is part of a New York State Medicaid Section 1115 waiver that was first approved in July 1997 and has been implemented in various upstate counties since then. HCFA's recent letter to New York confirms that the State has met the conditions of approval required prior to enrolling Medicaid beneficiaries in managed care. HCFA will permit the phase-in to expand to the other areas only after the State has demonstrated that all the terms and conditions have been fulfilled for those additional areas.***

The Social Security Act permits the Secretary of Health and Human Services discretion in waiving certain aspects of the Act in order to conduct experimental demonstration projects. These demonstrations are frequently aimed at redesigning a State's health system to better serve greater numbers of Medicaid beneficiaries while reducing costs through the use of various mechanisms, such as managed care. The Partnership Plan is one such demonstrations. The State has effectively dealt with many difficult issues in implementing the Partnership Plan in twelve upstate counties and in preparing to implement Phase 1 in New York City.

The Partnership Plan. On March 20, 1995, New York State submitted a section 1115 waiver application that would permit Federal financial participation in a demonstration called the Partnership Plan. The State proposed to move over two million currently eligible individuals and approximately 370,000 "Safety Net" (Home Relief) recipients into a managed care environment. When the Partnership Plan is completely implemented, about 85 percent of New York State's Medicaid eligible population will be in managed care.

Today's action will allow the State to begin enrolling Medicaid beneficiaries into managed care in Staten Island, lower Manhattan, and parts of Brooklyn. The State is required to submit ongoing monitoring and oversight items to HCFA within ninety days of commencement of mandatory enrollment.

Roll-out Plan for New York 1115 Wavier

Necessary Paper

Letter to State
Qs and As
Talk Points

Day of Roll-out

- Schedule Richardson/Whalen conference call

At Scheduled Time:

- Sally Richardson calls:
  Dennis Whalen, Executive Deputy Commissioner (518) 473-0458,

Upon Completion of Richardson/Whalen phone call:

- In coordination with OS/IGA, HCFA/IGA will fax letter and Qs and As to NYS Regional Office/RA and RD

- David Cade calls:
  Ellen Anderson (Director) or Phyllis Silver (Deputy Director),
  Office of Managed Care, NYS Department of Health
  (518) 474-5737

- L. Bishop calls:
  Donna Farlow, Medicaid Deputy Director
  (518) 474-3018, NYS Department of Health

- Mail and Fax Letter to Whalen and Farlow (HCFA/IGA)
  (518) 473-7071

- In coordination with OS/IGA, HCFA/IGA will call and fax letter to:
  Governor Pataki's Washington Office

- OL will call and fax letter to:
  Senate Finance Minority Staff (Moynihan),
  House Ways and Means Minority Staff (Rangel), and
  the Entire NYS delegation

- Allision Green will communicate with appropriate state legislative contacts and Judy Berek will contact advocate groups. These calls will be the same as for the conditional approval announcment.

- HCFA Press to Brief Ray Hernandez (NYT Reporter)

- With Qs and As: HCFA Press Office will field calls from press

The New York State Proposal. The New York State Partnership Plan proposal incorporates four broad initiatives:
(1). The transition of the State's acute care program from fee-for-service to managed care.
(2). Converting approximately 370,000 residents covered by the State's "Safety Net" program to Medicaid beneficiaries covered by a Federal entitlement program.
(3). The development of Special Needs Plans (SNPs) to serve: people who are HIV-positive or who have AIDS; adults who are seriously and persistently mentally ill; and children with serious emotional disturbances.
(4) The creation of a $1.2 billion fund to assist hospitals in moving to managed care. These funds help cover both retraining staff and establishing or expanding neighborhood-based clinics and health centers. This transition initiative will be funded by redirecting a portion of the State's Medicaid allotment for hospitals that treat a significant percentage of indigent or uninsured patients.

Delivery system. Counties in New York State will obtain contracts with managed care organizations. In order for a county to be permitted to implement the Partnership Plan, it must offer its Medicaid population a choice of at least two managed care organizations. Partially capitated plans will be utilized to ensure access to care in areas of the State that do not have sufficient managed care capacity. Managed care organizations will be encouraged to establish network arrangements with traditional providers, such as Federally Qualified Health Centers, school-based health centers, and Ryan White CARE Act providers.

Conditions. Before enrollment began in Phase 1 of New York City, the State fulfilled the conditions of approval. The following three principal conditions identified in HCFA's May 26, 1999 letter to the State have been met:

- The New York State Department of Health provided a detailed interim quality monitoring plan for early evaluation of the quality of care provided to Medicaid beneficiaries.
- The New York State Department of Health provided a detailed Statewide Quality Assurance Monitoring Plan, which included a subset specifically for New York City. [Both monitoring plans pay particular attention to vulnerable, at-risk populations such as people with diabetes, AIDS, asthma or hemophilia.]
- New York State submitted the final Partnership Plan Operational Protocol –the rules that govern the functions of the waiver. This protocol included the State's fair hearing policy for people who believe that they have not received the care or service that they needed.

Phase-In Process. Due to the complexity of the project, the State suggested that there be five separate phase-in areas of the waiver in New York City. The first two implementation phases are: Phase 1– Staten Island, lower Manhattan, parts of Brooklyn; and Phase 2 -- Northeast Queens and the North Bronx. HCFA has today only approved implementation of Phase 1, although Phase 2 could be ready for approval as early as November. There are currently no specific time frames beyond Phase 2.

Benefits. Medicaid managed care enrollees will be entitled to the same benefits that are available under Medicaid fee-for-service. Medicaid beneficiaries will receive a comprehensive benefits package through their managed care organization but certain services (e.g., long-term care services and prescription medicines) will continue to be provided on a fee-for-service basis.

Eligibility and enrollment. Most Medicaid-eligible New York residents eventually will be required to enroll in managed care. Enrollment will be phased in county by county or, in the case of New York City, zip code by zip code.

Exempted and excluded populations. Some Medicaid beneficiaries are exempted or excluded from the Partnership Plan. Exempted populations will have the option to enroll in managed care organizations but will not be required to enroll. Those exempted include: people with HIV/AIDS, people who are seriously and persistently mentally ill, people for whom a managed care provider is not geographically accessible, pregnant women already receiving prenatal care from a non-participating primary care provider, and Native Americans. Some of these populations (such as those living with HIV/AIDS or suffering from mental illness) could, within the next several years, be required to participate in manage care through Special Needs Plans. This could only occur after a series of milestones designed to protect these beneficiaries are fulfilled.

Because some patients need specialized care and/or live in institutions, they will be excluded from the option to enroll in managed care organizations. Some examples of excluded populations are: people who are dually eligible for Medicaid and Medicare, residents of nursing facilities, residents of State-operated psychiatric facilities, and Medicaid-eligible infants living with incarcerated mothers. Medicaid beneficiaries in these excluded groups represent approximately 15 percent of the State's Medicaid eligibles.

Community input. Since signing the Partnership Plan waiver in July of 1997, HCFA and New York State have been conducting many efforts to ensure a smooth transition to Medicaid managed care in New York State. Quarterly public meetings are conducted at which community groups and the general public can provide comments about managed care to HCFA, New York State and City officials.

Meetings are also held with health advocacy workgroups every 4-6 weeks to discuss access and quality of care issues. We have elicited advocates' opinions and concerns on the waiver and have received significant support and information through these activities. We will continue to solicit community advice about all aspects of the waiver. These forums have provided HCFA, New York State, and New York City staff with an opportunity to dialogue with the community about their concerns and suggestions. This partnership with the advocates has helped -- and will continue to help -- shape the policies and procedures of the Partnership Plan.

Current status. On July 15, 1997, HCFA approved the State's 1115 waiver application and issued Special Terms and Conditions for program implementation. The first five New York counties "went live" with Medicaid managed care on October 6, 1997. As of April 1999, twelve counties have begun to implement the waiver. These counties are: Albany, Broome, Columbia, Erie, Greene, Monroe, Niagara, Onondaga, Ontario, Rensselaer, Saratoga and Oswego. Schnectady County is scheduled to implement September 1, 1999.

On May 26, 1999, HCFA granted conditional approval to implement the Partnership Plan in Phase 1 of New York City. All required documentation was submitted by the State and approved by HCFA. The State will now begin notifying Medicaid beneficiaries to enroll in managed care plans.

DRAFT 7/27

GENERAL QUESTIONS

Q. HCFA sent New York State a letter on May 26, 1999 granting conditional approval to implement its Medicaid managed care waiver in New York City. What were the conditions of approval and have they been met?

A. Based on documentation received from the State, the conditions have been met. As a result, HCFA announced today that the State could move forward with mandatory enrollment of Medicaid beneficiaries into managed care within Phase 1 of New York City. Phase I includes lower Manhattan, parts of Brooklyn, and Staten Island.

The three principal conditions of approval listed below:

- The New York State Department of Health provided a detailed interim quality monitoring plan for early evaluation of the quality of care provided to Medicaid beneficiaries.
- The New York State Department of Health provided a detailed Statewide Quality Assurance Monitoring Plan, which included a subset plan for New York City. [Both monitoring plans pay particular attention to vulnerable, at-risk populations such as people with diabetes, AIDS, asthma or hemophilia.]
- New York State submitted the final Partnership Plan Operational Protocol --the rules that govern the functions of the waiver. This protocol included the State's fair hearing policy for people who believe that they have not received the care or service that they needed.

As I said, based on the State's documentation and their acceptance of the waiver Terms and Conditions, HCFA will allow the State to begin notifying Medicaid beneficiaries of the managed care plans available to them.

Q. Why is HCFA's recent letter putting so much emphasis on these conditions?

A. HCFA's first responsibility is to assure that high quality standards for health care are maintained in Medicaid and that the rights of Medicaid beneficiaries are protected. This letter is the latest step in a careful process developed by HCFA to achieve those goals. That process has established procedures to protect the needs and rights of New Yorkers enrolling in Medicaid managed care, as were agreed to under the waiver. HCFA expects New York State to implement these conditions and assure quality health care and full protection of the rights of Medicaid beneficiaries.

To that end, HCFA and the State agreed in the terms and conditions when the waiver was approved in 1997 that the specified conditions would be met.

Q. What exactly is the Partnership Plan?

A. The Partnership Plan is New York State's Medicaid Section 1115 waiver for a statewide health reform demonstration that was approved by HCFA on July 15, 1997. The waiver grants authority for the State to serve Medicaid beneficiaries through managed care plans. These demonstrations are frequently intended to restructure a State's health system and reduce costs through the use of various mechanisms, such as managed care, while providing high quality care to greater numbers of Medicaid beneficiaries.

Q. How many people will the Partnership Plan cover?

Once fully implemented statewide, the Partnership Plan will enroll approximately 2.1 million people, or about 85% of the New Yorkers who are currently eligible for Medicaid. The plan will also extend Medicaid eligibility to approximately 370,000 safety net beneficiaries. Additionally, the Partnership Plan waiver requires the State to provide three types of enhanced managed care organizations, known as Special Needs Plans, to serve individuals with HIV/AIDS, adults with serious mental illness, and children with serious emotional disturbances.

The Partnership Plan is being implemented statewide in a series of phases, with the last phase scheduled for implementation in August 2000. Implementation began on October 6, 1997, with five upstate counties: Albany, Rensselaer, Columbia, Greene, and Saratoga. To date seven additional upstate counties have been approved for implementation: Ontario (January 1, 1998), Monroe (March 1, 1998), Erie and Broome (May 4, 1998), Niagara (September 4, 1998), Onondaga (October 16, 1998), and Oswego (April 1, 1999). Schnectady is scheduled to begin September 1, 1999.

Phase 1 of New York City's implementation of the Partnership Plan will include Staten Island, lower Manhattan, and parts of Brooklyn. This will be followed by the phase-in of additional areas of the City as appropriate.

Q. What successes have been seen in the current counties that have implemented the Partnership Plan to date?

A. There are several indicators demonstrating that Medicaid beneficiaries have greater access to high quality care under the Partnership Plan.

- Access -- The access of Medicaid managed care enrollees to their primary care physicians and to specialists has significantly improved when compared to the previous fee for service system. Another indicator of success is that the number of Medicaid complaints per thousand enrollees decreased from 1.5 in the last quarter to 1.1 this quarter.
- Quality -- In several of the upstate counties, a number of plans are performing significantly

better than the statewide Medicaid average in the following areas: childhood immunizations; well child visits in the first 15 months of life; well child visits in the third, fourth, fifth and sixth year of life; and cervical cancer screenings. Another area showing early promise is improved management of asthma.

Close to 28,000 Medicaid beneficiaries enrolled in managed care between October and December of 1998, bringing total enrollment in the counties participating in the Partnership Plan to over 150,000 beneficiaries. This is nearly 60% of the Medicaid eligible population in the first eleven counties to implement the Partnership Plan.

Q. How many people does HCFA expect to be enrolled in Medicaid managed care in Phase 1 in New York City? How many when the City is completely enrolled?

Approximately 260,000 to 300,000 Medicaid beneficiaries will be enrolled in Phase 1. When the Partnership Plan is implemented throughout New York City, approximately one million City residents will be enrolled in Medicaid managed care.

Q. Why does HCFA believe that the waiver will be good for beneficiaries in New York City?

A. The Partnership Plan is bringing new doctors into the Medicaid health care delivery system. For example, in Phase 1 in lower Manhattan, there are 100 obstetricians/gynecologists participating in fee-for-service (traditional Medicaid) compared to 170 in managed care. The number of pediatricians participating in fee-for-service is 75, compared to 125 in managed care. The State reported 3,159 specialists in the Medicaid managed care networks as compared with 1,859 specialists in fee-for-service Medicaid. This represents a 70% increase in the number of specialists available to Medicaid recipients in Manhattan.

Moreover, the New York State Department of Health has reported that in Phase 1 in lower Manhattan, there are high ratios of providers:

- 62,000 Medicaid eligibles
- 447 primary care providers in the managed care networks (not including obstetricians and gynecologists)
- 139 Medicaid eligibles per primary care provider

- 29,000 Medicaid children under the age of 20
- 125 pediatricians (without taking into consideration family practice providers)
- 232 Medicaid children per provider

Q. Will Medicaid beneficiaries have a choice of health care plans in the City?

A. The Partnership Plan must guarantee choice of Medicaid managed care plans under the waiver. Although there have been some high profile health plan withdrawals recently (e.g., Oxford, Empire Blue Cross/Blue Shield), Medicaid beneficiaries will enjoy a wide choice of Medicaid managed care plans. The HCFA Regional Office has worked extensively to ensure access to providers and choice of Medicaid managed care plans. There will be a total of 14 plans participating in New York City, four of which are City-wide. Here are the number of plans participating, by borough:

- Manhattan 6
- Brooklyn 9
- Staten Island 9
- Queens 6
- Bronx 9

Any Medicaid beneficiary can select any plan in their borough, and see any provider in the network regardless of location.

Q. What does approval mean for New York City hospitals preparing for this transition to managed care?

A. Under the terms and conditions, as soon as New York City implements the 1115 waiver, hospitals will be able to draw more funds from the Community Health Care Conversion Demonstration Project Fund. This program provides special help for safety net hospitals that have traditionally cared for Medicaid beneficiaries, supports work force restructuring and other changes necessary for a smooth transition to managed care. Hospitals have already received 15 percent of the funds to begin the transition. They were eligible to receive another 15 percent upon Federal and State agreement of a start date. They will receive the remainder as Medicaid beneficiaries enroll into managed care. These funds will help secure a future in the managed care world for the safety net providers who have the most experience caring for Medicaid beneficiaries.

Q. How do health care advocates, community groups and the general public feel about the waiver?

A. Since signing the Partnership Plan waiver in July of 1997, HCFA and New York State have been conducting many efforts to ensure a smooth transition to Medicaid managed care in New York State. Quarterly public meetings are conducted at which community groups and the general public can provide comments about managed care to HCFA, New York State and City officials. Meetings are also held with health advocacy workgroups every 4-6 weeks to discuss access and quality of care issues. We have elicited advocates' opinions and concerns on the

waiver and have received significant support and information through these activities. We will continue to solicit community advice about all aspects of the waiver. These forums have provided HCFA, New York State, and New York City staff with an opportunity to dialogue with the community about their concerns and suggestions. This partnership with the advocates has helped -- and will continue to help -- shape the policies and procedures of the Partnership Plan.

Q. Under the waiver, the State was supposed to implement managed care in New York City by early to mid-1998. It is now a year later. Why the delay?

A. Implementing the Partnership Plan in the upstate counties took longer than New York State and HCFA anticipated. In addition, the State and the City were not prepared for HCFA to conduct onsite readiness reviews until October of 1998. Since the Partnership Plan was approved, HCFA has provided technical assistance to the State. In fact, a year ago HCFA offered to meet with the State to conduct the readiness review. That review generated the conditions identified in HCFA's recent conditional approval letter to New York State.

Q. New York City hasn't done a very good job of helping people get Medicaid. Isn't this just another way for the City to save money at the expense of a vulnerable group of people?

A. HCFA and the US Department of Agriculture have been working with New York City and State officials to ensure that eligible people are enrolled in the Medicaid and food stamp programs. Based on our ongoing work with the State, HCFA believes that the City and State are now moving in the right direction. However, there is more work to be done and we will continue to work with appropriate officials in New York on this issue to ensure that the law is followed.

But this is a different issue. By moving people into managed care, the Partnership Plan will enable more Medicaid beneficiaries to access quality health care services. In fact, the waiver is expected to enroll nearly 400,000 individuals who were previously covered by a State-only program. HCFA's recent agreement with New York on fair hearings ensures that Medicaid managed care enrollees have access to every possible method for maintaining access to treatment and monitoring quality of health care.

Q. What protections will there be in the Partnership Plan for people with AIDS and other special needs?

A. Protecting the needs of special populations has been a special focus of HCFA's negotiation of the fair hearings process with New York. The Partnership Plan waiver requires the State to provide three types of enhanced managed care organizations, known as Special Needs Plans (SNPs), for individuals who are HIV positive or who have AIDS, adults with serious mental illness, and children with serious emotional problems. These populations can enroll in Special

Needs Plans on a voluntary basis until at least April 2001, at the earliest. The State is prohibited from requiring people with special needs to enroll into the SNPs needs plans until the plans have been operating on a voluntary basis for at least one year and HCFA has certified that the SNPs have fulfilled all the requirements under the Partnership Plan Terms and Conditions.

In addition to the exemption policy, there are requirements for monitoring the quality of care delivered to special populations. For example, the State is required to submit a plan detailing how it will collect quality of care data for people with special needs who enroll in Medicaid managed care organizations. The State is further required to ensure that the External Quality Review Organization, which will annually monitor quality in managed care organizations, specifically monitor activities for people with special needs.

Q. Are there any other groups exempted or excluded from participating in Medicaid managed care?

A. Yes. Other groups considered to be exempted are:

- persons for whom a participating managed care organization is not geographically accessible,
- pregnant women already receiving prenatal care from a primary care provider not participating in a Medicaid managed care network,
- Native Americans.

They will have the option of enrolling in managed care organizations, but will not be required to join.

In addition, certain Medicaid populations are excluded because they require specialized care and/or live in institutions. People in these groups will not be given the option to enroll in Medicaid managed care. Some examples of excluded populations are persons who are dually eligible for Medicaid and Medicare, residents of nursing facilities, residents of state-operated psychiatric facilities, and Medicaid-eligible infants living with incarcerated mothers.

Q. How can HCFA ensure that the terms and conditions of the waiver will be enforced?

A. HCFA's Regional Office in New York City as well as the Central Office in Baltimore will closely monitor the demonstration to assure that the State adheres to all of the requirements of the waiver and that patient's rights are safeguarded.

If New York State were to be found out of compliance with any aspect of the section 1115 waiver, the Secretary of Health and Human Services has the discretion to require that the State implement a corrective action plan. As part of this process, the Secretary could stop the enrollment of Medicaid beneficiaries into managed care. The Federal government could penalize

the State by withholding funds until the Partnership Plan is brought in line with requirements of the waiver. We do not anticipate problems with New York's waiver.

Q. Isn't managed care inherently bad for people with expensive or long-term illnesses? What is HCFA going to do to make sure people with serious problems get the care they need?

A. In fact, managed care can provide preventive services and a coordinated system of care that many people may never have enjoyed before. And, in addition to the oversight and enforcement that will be done by New York State, HCFA will carefully monitor the progress of this large and complex demonstration project. Before going forward, HCFA will review the managed care organizations that will participate, assure that proper marketing materials and enrollment procedures are in place, and make sure that the special health care needs of individuals can be met.

If HCFA believed that New York State or the City were not ready to manage this transition, we would not allow it to go forward. HCFA received an unprecedented number of inquiries and regular input from advocacy organizations and other interested parties during the discussions about the Partnership Plan. These groups are continuing their involvement. Between HCFA, New York State, and New York City staff, many people will be monitoring the progress of this waiver. We will immediately respond to any concern.

PATIENT RIGHTS AND FAIR HEARING QUESTIONS

Q. Why should vulnerable Medicaid beneficiaries be stuck in a system that denies care and makes them go through an appeals process?

A. HCFA has worked hard with New York State to protect beneficiaries' access and quality of care. For example, as Phase 1 is implemented, Medicaid beneficiaries will have access to a greater number of providers than they did under fee for service. In the event that a beneficiary does not receive the care that they feel they deserve, the waiver has protections regarding notice and appeal rights. These protections are an important part of the President's Patient Bill of Rights. Disclosure of information, choice of providers, access to emergency care, the right to a second opinion on treatment decisions, and the right to a complaints and appeals process are all components of that Bill of Rights. The Administration is committed to ensuring those rights for Medicaid beneficiaries.

Q. What are the requirements of the fair hearing process?

A. The fair hearings process guarantees Medicaid beneficiaries the right to be heard when they believe they have been denied access to proper medical care, or when they believe their benefits have been improperly reduced. Medicaid beneficiaries must be given written notice explaining the reason for any decision to deny, reduce, suspend or terminate services. The right to a hearing also applies when beneficiaries' claims for Medicaid benefits are not acted on promptly. Beneficiaries also retain the right to review evidence and the right to a fair hearing before an impartial decision maker. These rights are crucial for all health care consumers and the Federal government could not allow the Partnership Plan to go forward until the fair hearings policy with New York was firmly established.

Q. Are fair hearing requirements the same in every 1115 waiver demonstration project?

A. No. HCFA works with every State receiving a Medicaid waiver to develop fair hearing requirements based on the State's unique situation and the nature of their demonstration program. In New York, the fair hearing requirements were finalized after many discussions with New York State and City officials and after seeking input from concerned patient advocacy groups, health care providers, consumers, and the general public.

Q. What does this requirement mean for Medicaid beneficiaries enrolled in the Partnership Plan?

A. Medicaid beneficiaries will have the right to request a State fair hearing for denials of service. The State may require that they first exhaust the internal managed care plan grievance process. In addition, beneficiaries may also choose to use the following safeguards prior to requesting an external fair hearing:

- Beneficiaries may complain to the New York State Department of Health at any time.
- Beneficiaries may change primary care physicians without cause twice a year.
- Beneficiaries may receive a second opinion from another physician for the diagnosis of a condition, treatment or proposed surgical procedure.

Q. Will this policy have a significant impact on New York's fair hearing process?

A. We expect that New York will have a strong fair hearing process. New York State has demonstrated that it provided various safeguards in an attempt to resolve issues prior to reaching a fair hearing. Therefore, we believe that New York State will not encounter a significant increase in the number of fair hearings. In the special terms and condition of the waiver the State agreed to implement the fair hearings process and we expect them to follow through on that commitment.

Q. What are the Special Term and Conditions governing fair hearings in New York?

A. The Special Terms and Conditions of the Partnership Plan outline the complaint and appeal procedures for the Partnership Program. This section states, "All beneficiaries must be informed of their right to file complaints, [whether oral or written], appeals, and their right to fair hearings. The State must assure that all managed care plans have approved internal complaint and appeal procedures in place." New York State agreed to these terms and conditions on July 15, 1997.

Q. Why is establishing the fair hearing appeals process so difficult, and how long has HCFA been negotiating this with New York?

A. The Partnership Plan waiver was agreed to by New York State on July 15, 1997. That waiver, as negotiated between HCFA and New York, contained a section establishing the fair hearing rights of Medicaid beneficiaries enrolled in managed care. At the time the waiver was signed, there was clear agreement about the requirement for a fair hearing process. It is true that New York State raised the fair hearing process as an issue earlier this summer. However, they withdrew their objections and are now complying with HCFA's requirements.

HCFA believes the fair hearing policy is essential to ensure beneficiary rights and to provide a course of action when beneficiaries believe that their benefits have been erroneously reduced or denied. In addition, the Partnership Plan requires that New York State hold training sessions for health care providers, managed care plans and administrative law judges to ensure that they are clear about Medicaid beneficiaries' rights to promptly appeal decisions that reduce or deny medical care.

Q. Exactly what patient rights are being mandated by HCFA in New York?

A. HCFA is merely requiring New York to follow the agreement reached with the approval of the Partnership Plan in July of 1997. Under that agreement, New York State agreed to allow beneficiaries fair hearings when a Medicaid managed care enrollee's services are denied, terminated, or reduced. Prior to requesting a fair hearing, the State may first require a beneficiary to exhaust the managed care plan's internal grievance and appeal processes.

New York State agreed that individuals are further protected by other rights, including the right to complain to the New York State Department of Health at any time, to change primary care doctors twice a year for any reason, and to seek a second opinion of their doctor's diagnosis or recommendation for surgery.

Q. What will happen if the State doesn't comply with the terms of the fair hearings set out in HCFA's recent letter?

A. In the event New York was unable to comply with the fair hearing conditions set forth in our letter, HCFA would not have permitted the New York City Partnership Plan to begin enrollment in New York City. If the State was found to be out of compliance with this or any other component of the Section 1115 waiver while the Partnership Plan is in operation, the Secretary of Health and Human Services has the discretion to require that New York State implement a corrective action plan. As part of this process, the Secretary could stop enrollment into Medicaid managed care plans. In addition, the Federal government could penalize the State by withholding funds until the demonstration was brought in line with requirements of the waiver.

New York has a long history of being able to work with HCFA and resolve complicated issues. We are certain that this issue will be worked out as well. HCFA does not anticipate problems with New York's complying with the Partnership Plan waiver agreement as signed in July of 1997.

Q. Did HCFA just make up this fair hearing requirement, as alleged by New York State?

A. No. This requirement has been known for a significant period of time. At the time the waiver was signed in July of 1997, there was clear agreement about the requirement for a fair hearing process.

Q. Can beneficiaries complain to the New York State Department of Health?

A. Beneficiaries can complain to the New York State (NYS) Department of Health at any time. They do not have to wait for the completion of the Medicaid managed care internal grievance and appeal process to file a complaint with the New York State Department of Health. The complaint can be heard by both the managed care plan and the NYS Department of Health on parallel tracks. A decision on the part of either the plan or the NYS Department of Health to deny the service will trigger notification of an adverse action. The managed care plan or State must at this point notify the beneficiary of their right to apply for a Fair Hearing. Information outlining this process will be part of the Member Handbook provided to all Medicaid beneficiaries participating in the Partnership Plan.

Q. What are the implications of New York's Fair Hearings policy on the Department's position on Grijalva?

A. In 1997, New York State and HCFA agreed on a set of Terms and Conditions for approval of the 1115 waiver. These Terms and Conditions include a Fair Hearings policy that New York is required to follow, and we have ensured that New York will abide by those requirements. The policy is based on what was agreed to with New York, and the policy is relevant only to that State. Moreover, when HCFA's final regulation on Medicaid managed care is published, New York will be required to follow the Fair Hearings policy established in that rule.

Thurs. 7/29 2 pm

Greater New York Hospital Association
555 West 57th Street / New York, N.Y. 10019 / (212) 246-7100 / FAX (212) 262-6350
Kenneth E. Raske, President

July
Twenty-eight
1999

TO: Chris Jennings

FROM: Rima Cohen

RE: Conference Call on July 29

Thank you for meeting with us on July 1 and agreeing to participate in the follow-up conference call scheduled for **Thursday, July 29 from 2:00 to 3:00 p.m.**

Attached please find 1) a list of administrative changes we believe the Clinton Administration should consider to alleviate the effect the Balanced Budget Act's Medicare reductions have had on New York's academic health centers, and 2) a letter from Senator Charles Schumer to President Clinton regarding this issue.

We will make the necessary arrangements for the conference call and **we will call your office at 2:00 on Thursday.**

In the event that you are disconnected during the call, please dial 1-800-869-6615 and request to be connected to the Raske conference call.

Participating in the call will be Kenneth E. Raske, President of Greater New York Hospital Association; Dennis Rivera, President of 1199 National Health and Human Service Employees Union, SEIU; and their respective staffs.

If you have any questions, please contact Patti Giambalvo at Greater New York Hospital Association, at 212-506-5402.

We look forward to speaking with you.

SUGGESTED MEDICARE ADMINISTRATIVE CHANGES

THAT WOULD HELP NEW YORK'S HEALTH CARE PROVIDERS

Adjust the Reimbursement Rate Cap on Inpatient Psychiatric and Rehabilitation Services for Geographic Cost Differences: The Balanced Budget Act of 1997 (BBA) required the Secretary of Health and Human Services to estimate the 75th percentile cost (or "target amount") for inpatient psychiatric services and inpatient rehabilitation services. (The broad Medicare category "rehabilitation" includes such disparate services as the intensive services provided by burn units and the much less intensive services provided by units that provide physical therapy after treatment of broken bones.) In implementing this provision, HCFA imposed a cap at the 75th percentile amount, and refused to adjust the cap for legitimate differences in costs among geographic areas. Thus, the exact same dollar amount cap applies to burn units in New York City that applies to rehabilitation units that offer less intensive services, like hip fracture rehabilitation, in rural Iowa, where costs are lower. This means that the greatest losses suffered from the cap are suffered by urban hospitals that provide intensive services, rather than inefficient providers in each geographic area. Typically, HCFA adjusts caps or average payments for differences in wage costs, using the HCFA wage index. HCFA could, of its own accord, adjust the 75th percentile estimate for wages, thus relieving inner city teaching hospitals that offer costly, intensive services to the Medicare population from bearing the full brunt of the cap.

Adjust the Proposed Outpatient Prospective Payment Rates to Reflect the Higher Costs Incurred by Teaching and Disproportionate Share Hospitals: The BBA required HCFA to develop a prospective payment system (PPS) for outpatient services, as opposed to the modified cost reimbursement system that is currently in effect for outpatient services. Under a PPS, like the PPS for inpatient services, hospitals are paid rates derived from national averages, as opposed to rates based on their own costs. Despite the fact that HCFA's own analysis shows that teaching hospitals and disproportionate share hospitals (DSH) have higher costs than other hospitals, HCFA has not proposed adjusting the outpatient PPS rates for teaching hospitals or DSH hospitals. Thus, HCFA's analysis shows that the hospitals hurt most by the change to an outpatient PPS include major teaching hospitals and high DSH hospitals. HCFA should propose permanent teaching and DSH adjustments for outpatient PPS rates.

Provide Stop-Loss Payments to Protect Hospitals from Severe Losses Due to the Outpatient PPS: HCFA's fiscal impact analysis of its proposed outpatient PPS shows that half of the hospitals in New York City for which HCFA had data would lose 20% or more of their current level of Medicare payments for outpatient services. Such losses would have a devastating impact on hospitals in New York. Thus, HCFA should provide stop-loss payments to ensure that hospitals do not lose an excessive amount of their outpatient reimbursements due to the PPS. Alternatively, HCFA should institute an "outlier" payment system to provide adequate reimbursements to hospitals whose

legitimate outpatient costs far exceed national averages. A similar system currently applies to the inpatient PPS.

Provide a Part B Add-On for Nursing Homes in the RUGs-III Demonstration Project: The BBA included a provision to provide an appropriate method for transitioning nursing homes participating in HCFA's "Nursing Home Case Mix and Quality Demonstration" (RUGs-III) from the demonstration reimbursement system to the new PPS for skilled nursing facilities required by the BBA. Over 600 nursing homes participated in the demonstration in six states (KS, ME, MS, NY, SD, TX). The premise of the amendment was to provide an appropriate transition from the system nursing homes were actually under at the time the BBA was enacted to the new system. Unfortunately, HCFA has proposed excluding from the facility-specific rate for RUGs-III facilities an add-on for the estimated costs of Part B services that they provide, notwithstanding the fact that such an add-on is being provided to all other facilities. The purpose of the BBA provision for RUGs-III facilities was not to penalize them for participating in the demonstration, but to provide a proper transition. Thus, HCFA should use its discretion and provide a Part B add-on for RUGs-III Demonstration facilities.

CHARLES E. SCHUMER
NEW YORK

United States Senate

WASHINGTON, DC 20510

July 20, 1999

The President
The White House
Washington, DC 20500

Dear President Clinton:

I write to share my concerns about the devastating cuts the Balanced Budget Act of 1997 (BBA) is imposing on New York health care facilities and to ask for your help. New York facilities face a staggering $545 million in reduced reimbursements over five years if the proposed outpatient prospective payment system (PPS) is fully instituted. While the BBA did address some problems with Medicare, many New York facilities will be forced to provide lower quality care if the full BBA cuts are implemented.

For example, the Medicare cuts threaten Rochester's Strong Memorial Hospital's ability to fund the Poison Control and Information Center. The center, which receives 30,000 calls each year, prevents numerous unnecessary emergency room visits and has saved thousands of lives. Because of BBA cuts, Long Island College Hospital in Brooklyn, which serves a diverse, low-income community, may be unable to meet its operating costs in the near future. I am convinced that, with your leadership, the Health Care Financing Administration (HCFA) can ameliorate some of the most damaging Medicare cuts facing New York's health care facilities.

In the ten years before the BBA was enacted, New York health care facilities engaged in a momentous effort to cut waste and fat. In 1997, the BBA required all U.S. health care facilities to cut out waste and unnecessary treatments in order to strengthen Medicare, but I have visited numerous hospitals across the State and I know there is no more fat to cut. If faced with additional cuts, the facilities will have to cut muscle and bone, that is, vital programs and staff. New York now needs the Administration's help in making administrative changes in four key areas.

Most importantly, I believe HCFA's proposal to adjust the amount Medicare beneficiaries pay for hospital outpatient services is, as 78 Senators recently wrote Administrator DeParle, "a misrepresentation of Congressional intent and threatens the integrity of a broadly supported compromise." HCFA's proposal, which would reduce hospital payments by 5.7 percent, alone will cost New York's hospitals about $200 million over five years. I request HCFA address this administratively by implementing the adjustment as intended by Congress. Additionally, to help ensure good health care in New York, HCFA administratively should:

- Eliminate the volume and expenditure caps. Developed to cut out fraud and waste, they should not limit payments to efficient hospitals focusing on the special needs of their communities.

- Adjust the caps for inpatient psychiatric and rehabilitation reimbursements to reflect the high wage costs that hospitals face in expensive areas such as New York. This would save New York hospitals about $65 million over five years.

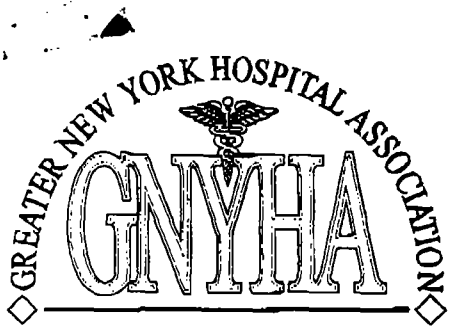
- Ease the transition to the nursing facility PPS for states participating in the "Nursing Home Case Mix and Quality Demonstration," by providing additional compensation to these facilities. This would provide New York skilled nursing facilities as much as $40 million in relief through 2002.

I look forward to continue to work with you and your staff to improve Medicare and strengthen the nation's health care system. Your recently proposed Medicare proposal is a good start and I plan to work in the Congress to see that it is enacted. I do ask, however, that you work with me to ensure that New York health care systems are able to provide the excellent level of care for which they are known around the world.

Sincerely,

Charles Schumer

Charles E. Schumer
United States Senator



FACSIMILE TRANSMISSION

555 West 57th Street / New York, N.Y. 10019 / (212) 246-7100 / FAX (212) 262-6350
Kenneth E. Raske, President

Date: Wednesday, July 28, 1999

Time: 3:28 pm

TO: **Teresa Jones**
202-456-5557

FROM: **Rima Cohen**
Vice President, Insurance Options Development

Phone: 212-506-5527
E-Mail: cohen@gnyha.org

We are transmitting **6** pages including this cover sheet. If you have not received all of the pages, PLEASE CALL OUR OFFICE AS SOON AS POSSIBLE.

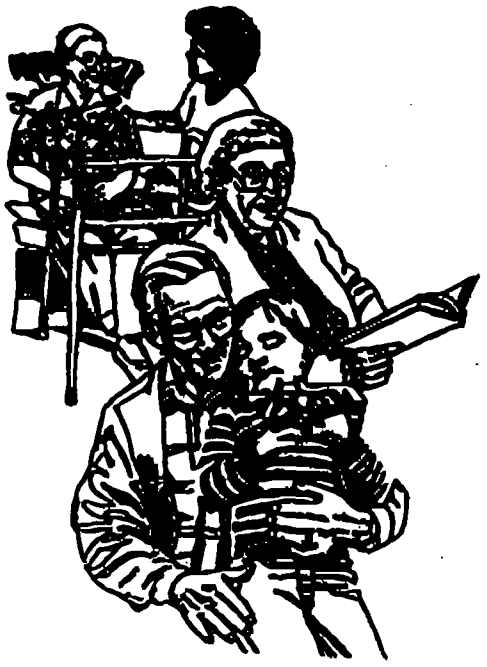
MESSAGE:

Following are details about and materials in preparation for tomorrow's conference call at 2:00.

Main Number (212) 246-7100
Fax Number (212) 262-6350

Hard Copy ☐ will ☑ will not be sent by mail.

HEALTH CARE FINANCING ADMINISTRATION



ADDRESSEE: Deborah Adler

PHONE: _____

FROM: Maria Marshall

OFFICE OF THE ADMINISTRATOR
200 INDEPENDENCE AVE., S.W.
ROOM 314G
WASHINGTON, DC 20201

PHONE: 202-690-6726
FAX : 202-690-6262

TOTAL PAGES:	ADDRESSEE'S FAX MACHINE NUMBER:	DATE:
Cover + 8		7/27

REMARKS: Sorry this is late.

Ref: HCFA-1053-F
RIN: 0938-AJ50

TO : The Secretary
Through: DS _____
COS _____
ES _____

FROM : Deputy Administrator
Health Care Financing Administration

SUBJECT: Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2000 Rates--ACTION (REGULATIONS)

ACTION REQUESTED IMMEDIATELY

BACKGROUND

Medicare pays for hospital inpatient services under prospective payment systems (PPSs) in which payments are made at predetermined rates for the operating and capital-related costs associated with each hospital discharge. Payment rates for PPS hospitals and the payment limits for hospitals excluded from PPS are updated each year to take into account changes in the cost of goods and services used by hospitals, as well as other factors. We are required by law to publish a proposed rule on PPS policy changes and payment rates in the Federal Register by April 1 and a final rule by August 1.

Under current law, the update factors for the operating standardized amounts for PPS hospitals and the hospital-specific rate for sole community hospitals (SCHs) and Medicare-dependent small rural hospitals (MDHs) is the PPS operating market basket percentage increase minus 1.8 percentage points. The update factor for excluded hospitals and units is equal to the increase in the excluded hospital operating market basket less a percentage between 0 and 2.5 percentage points, or 0 percentage points, depending on the hospital's or unit's costs in relation to its limit.

On May 7, 1999, we published the proposed rule in the **Federal Register**. We received 82 pieces of correspondence on the proposed rule. The changes that we have made in response to those comments are discussed below.

PROVISIONS OF THE FINAL REGULATIONS

The major provisions of the final FY 2000 hospital inpatient PPS rule are as follows:

OPERATING PROVISIONS

• FY 2000 update for PPS hospitals. We set forth factors for determining the FY 2000 prospective payment rates for hospital operating costs, calculated on the basis of the formulae specified in the statute. On the basis of the latest forecast of the FY 2000 market basket increase of 2.9 percent (up from the estimate of 2.7 percent in the proposed rule) for hospitals subject to PPS, the resulting update factor for the standardized amounts is 1.1 percent. The update factor for the hospital-specific rate applicable to SCHs and MDHs is also 1.1 percent.

• Hospital wage index. We are updating the FY 2000 wage index based on hospitals' wage data as reported for their cost reporting periods that began in FY 1996. The overall impact is a 0.1 percent increase in hospital payments (prior to applying the budget neutrality factor). Payment to rural hospitals would increase by 0.4 percent. Rural Puerto Rico would experience the greatest positive impact, 1.8 percent.

We are implementing the first year of a 5-year phase-out of all teaching physician Part A wage costs as well as all resident and Part A certified registered nurse anesthetists (CRNA) costs from the wage index. This is consistent with our general policy to exclude from the wage index calculations those costs that are paid for separately from the PPS. We are basing the FY 2000 wage index on a blend of 80 percent of a wage index calculated without removing CRNA, teaching physician, and residents' costs, and 20 percent of a wage index calculated after removing these costs. This method is consistent with the recommendations made by and the overall agreement reached with an industry workgroup convened last fall by the American Hospital Association.

• DRG Reclassifications and Recalibration of Relative Weights. To avoid compromising our ability to process and pay hospital claims during the period leading up to and immediately following January 1, 2000, we are not implementing any revisions to the ICD-9-CM codes. We are reclassifying some existing codes into different DRGs relating to burns, newborns, mental diseases, and disorders on the basis of inquiries and correspondence received. We also address DRG issues included in the public comments on pancreas transplants, immunotherapy, and heart assist devices.

We are using the same basic methodology for the FY 2000 recalibration of DRG relative weights as we used for FY 1999. We have recalibrated the DRG weights based on data from bills received by HCFA through March 1999 for approximately 11.3 million Medicare discharges from PPS and short-term acute care hospitals.

In this final rule, we address public comments we have received on the use of non-Medicare Provider Analysis and Review (MedPAR) data to reassign and recalibrate DRGs (an issue addressed in the Conference Report language that accompanied the Balanced Budget Act of 1997 (BBA), and discussed in detail in the proposed rule). One specific aspect related to non-MedPAR data for platelet inhibitor drugs submitted by a manufacturer. We concluded that, at this time, the data are not reliable because we have not had sufficient opportunity to validate the data, and, thus, it is not feasible to use the data for FY 2000. We state in the final rule that, without appropriate non-MedPAR data, the earliest we could make a determination using FY 1999 MedPAR data would be in the FY 2001 PPS proposed rule. As we did in the proposed rule, we state the guidelines under which any non-MedPAR data should be made available to us for reclassifying and recalibrating DRGs and specify timeframes for submission of data to be considered during a fiscal year.

- Sole Community Hospitals. Regarding the definition of urban areas for purposes of classifying a hospital as a sole community hospital (SCH), in the final rule we continue to define "urban" for SCH status purposes as meaning the Office of Management and Budget's definition of Metropolitan Statistical Area (MSA).

- Rural Referral Centers. We are updating national and regional case-mix values for FY 2000, using the methodology set forth in the Medicare regulations.

- Graduate Medical Education (GME). We are clarifying and revising the policies governing GME to address questions and issues that have arisen since we published final rules in 1997 and 1998 to implement the caps on GME included in the BBA. These changes relate to: (1) the definition of an approved geriatric program and the definition of residents (to include allopathic and osteopathy residents); (2) the requirements for GME payment for resident training in nonhospital settings; (3) the methodology for adjusting hospital full-time equivalent (FTE) caps for new medical residency training programs; (4) the temporary adjustment to the FTE caps to reflect residents affected by hospital closures; and (5) the methodology for determining the weighted number of FTE residents. In addition,

we are implementing changes to address the situation of a hospital that, prior to the BBA, sponsored its newly approved medical residency training program temporarily at another hospital while a new hospital facility was under construction. We have made technical changes to address public comments received on the proposed rule.

CAPITAL PROVISIONS

• FY 2000 Update. We are specifying the factors for determining the capital Federal rate and the hospital-specific rate for determining FY 2000 prospective payments for inpatient capital-related costs. The PPS capital index is forecast to increase 0.6 percent, up from the estimated 0.5 percent in the proposed rule. Upon review, we have discovered that incorrect data were used in estimating the proposed adjustment of -0.7 percent adjustment for DRG reclassification and recalibration in the proposed capital update recommended for FY 2000. The revised adjustment for the effect of FY 1998 reclassification and recalibration for the capital update for FY 2000 is +0.1. The update factor for FY 2000 is +0.3 percent.

• Special Exceptions Process. In this final rule, we discuss the extensive public comments we received in response to our solicitation for suggestions for changing the process and eligibility criteria for hospitals for the special exceptions payments for certain eligible hospitals to receive additional payments for major construction or renovation projects that began soon after the start of the capital PPS. After careful consideration of all of the comments, we have concluded that the more appropriate forum for addressing changes to the special exceptions payment process and eligibility criteria is the legislative process in the Congress, as was the case when similar changes were considered in drafting the BBA, rather than the regulatory process.

HOSPITALS AND HOSPITAL UNITS EXCLUDED FROM PPS

• FY 2000 update. The latest estimate of the market basket for excluded hospitals and units for FY 2000 is 2.9 percent (up from 2.6 percent in the proposed rule). Accordingly, the update of the target amounts for hospitals for cost reporting periods beginning in FY 2000 is between 0.4 and 2.9 percent, or 0 percent, depending on the hospital's or unit's costs in relation to its limit.

In addition, we are revising the regulations to specify the appropriate target amount to be used for new excluded hospitals

and units, and for excluded hospitals or units that (1) are part of a multicampus hospital but alter their organizational structure so that they are no longer part of that multicampus hospital and (2) continue to provide inpatient services as separate excluded hospitals or units.

Report on Adjustments Payments to Excluded Hospitals and Units. As required by the BBA, we have included in the final rule the first annual report on the total amount of adjustment payments made to excluded hospitals and units that were adjudicated during FY 1998. Adjudications are made in response to adjustment requests filed by hospitals when their operating costs are in excess of their rate-of-increase ceiling due to changes in the types of patients served or inpatient care services that distort the comparability of a cost reporting period to the base year.

• Changes in bed size or status of excluded hospital units. To provide more flexibility to a hospital in the use of its beds and footage space, we are adopting, as final, the proposed revision which provides that, for purposes of exclusion from PPS, an excluded psychiatric or rehabilitation hospital unit may decrease the number of beds and square footage or close the entire excluded unit "at any time" during a cost reporting period under certain conditions. We are making one change to address public comments--we are allowing increases or decreases in square footage, and decreases in bed size, at any time if needed to comply with Federal, State, or local laws regarding the physical facility, or to address catastrophic events such as fires, floods, earthquakes, or tornadoes.

• Payment for Services Furnished in Satellite Hospital Locations. To avoid potential problems of duplication or inappropriate payment, in the proposed rule, we explicitly defined "satellite facilities" and proposed payment methodologies for these satellites that generally would not have permitted payment to satellites as an excluded hospital or unit if the satellite was located in a PPS hospital. In response to public comments, we have revised this policy in the final rule. We have decided to treat the satellite facility of an excluded hospital or unit, for purposes of payment, as a part of the excluded hospital or unit and to pay it on the same basis as the excluded hospital or unit if certain criteria are met. If the excluded hospital or unit has a satellite location that fails to meet the specified criteria, the entire hospital or unit would lose the exclusion from the PPS.

• Responsibility for care of patients in hospitals within hospitals. To prevent PPS overpayments and to ensure that

patients are not inappropriately transferred for financial reasons from a PPS hospital to a PPS-excluded hospital or unit before completion of a complete episode of acute care, we proposed to deny exclusion to a hospital-within-a-hospital for a cost reporting period if, during the most recent cost reporting period for which information was available, the excluded hospital-within-a-hospital transferred more than 5 percent of its inpatients to the PPS hospital in which it is located. As a result of numerous public commenters objecting to the 5 percent threshold, we have revised this policy. In the final rule, we specify that for a hospital-within-a-hospital, the number of Medicare discharges will not include discharges of a patient to another hospital in the same building or on the same campus if the patient is subsequently readmitted to the hospital-within-a-hospital and (2) the hospital-within-a-hospital had discharged (to the other hospital) and subsequently readmitted more than 5 percent of the total number of inpatients discharged from the hospital-within-a-hospital in that fiscal year.

• Critical Access Hospitals (CAHs). We have adopted as final our proposal to allow a response time of up to 60 minutes if the CAH is located in an area of a State that is defined as a frontier area (that is, having fewer than six residents per square mile) or meets other criteria for a remote location adopted by the State and approved by HCFA. This was an effort to recognize the special needs of rural areas in meeting beneficiaries' health need and at the same time not allowing practices that jeopardize patients health and safety.

BUDGET IMPLICATIONS

Based on the continuing decline in hospital operating costs and the related record high levels of hospital Medicare and total operating profit margins, we recommended an update for hospitals in both large urban and other areas of 0.0 percentage points (which is consistent with the President's FY 2000 Budget Proposal). However, as noted above, we are implementing the updates required by the law.

We estimate that the overall impact of this final rule will be to reduce payments to hospitals by approximately $125 million in FY 2000.

FEDERALISM

We have reviewed the provisions of this final rule under the threshold criteria of Executive Order 12612. We have determined that it does not significantly affect States' rights, roles, and responsibilities.

EXPECTATIONS

We expect that we will continue to receive comments on our decision to defer to the legislative process as the more appropriate forum for addressing changes in the capital exceptions payment process and eligibility criteria process and eligibility. Under current regulations, any changes to the exceptions payments must be budget neutral; hence capital payments to all hospitals would have to be reduced to accommodate the changes for a few hospitals.

We have received numerous correspondence from congressional leaders regarding the use of non-MedPAR data in the assignment of DRGs. There also has been congressional interest in the issue of allowing a hospital that was under construction at the time of enactment of the BBA and temporarily was training residents at another hospital to have its GME FTE adjustment cap determined under the BBA provisions applicable to new medical residency programs. We believe the provisions of this final rule are indications of our good faith efforts to address these issues.

We expect that the hospital industry will accept our revisions to the policies relating to payment to satellites of excluded hospital and units and transfers from hospital-with-hospitals to PPS hospitals and readmissions as responsive to their comments.

URGENCY

This final rule must to be published by July 30 to meet the August 1, 1999 statutory deadline as well as to allow sufficient time for the 60-day congressional review period for major rules before the October 1, 1999 implementation date.

RECOMMENDATION

I recommend that you sign the attached final rule for publication in the Federal Register.

DECISION

Approved _____ Disapproved _____ Date _____

Michael M. Hash

Attachment