

New York State Total (N=221)

BBA Fiscal Impact Summary (\$ in Millions)

	1996	1997	1998	1999	2000	2001	2002 (BBA Fully Phased In)	Cumulative Loss or Gain	
\$ Change from: Rate Year Pre-BBA Revenue by Category to Rate Year Post-BBA Revenue by Category									1996 to 2002
FPS Enacted Changes:									
PPS update	--	(38,858)	(187,402)	(314,048)	(418,579)	(495,374)	(575,154)	(2,029,415)	392,209
Outliers	--	(10,562)	(44,180)	(46,312)	(48,652)	(50,862)	(53,174)	(253,742)	91,777
IME	--	(18,742)	(85,131)	(137,774)	(194,118)	(236,436)	(239,983)	(912,184)	(219,936)
DSH	--	(1,305)	(6,303)	(11,391)	(16,614)	(22,052)	(26,333)	(83,998)	(12,971)
Transfers	--	0,000	(4,756)	(18,929)	(18,906)	(19,035)	(19,331)	(80,958)	(16,620)
PPS capital	--	(27,026)	(108,210)	(109,851)	(110,371)	(111,663)	(111,348)	(578,470)	(30,045)
PPS-exempt	--	(2,653)	(54,219)	(56,599)	(61,629)	(68,193)	(75,487)	(318,780)	34,775
Outpatient	--	(15,907)	(64,939)	(66,530)	(120,518)	(177,268)	(181,877)	(627,039)	(29,129)
Bad debt	--	(2,616)	(11,978)	(17,245)	(18,993)	(19,278)	(19,567)	(89,677)	(17,180)
Direct GME	--	0,000	0,000	0,000	0,000	0,000	0,000	0,000	76,415
Organ acquisition et al.	--	0,000	0,000	0,000	0,000	0,000	0,000	0,000	7,444
Total	--	(117,668)	(567,119)	(778,680)	(1,008,381)	(1,200,162)	(1,302,252)	(4,974,262)	93,283
Outpatient PPS:									
Proposed Rule impact	--	--	--	--	(52,258)	(107,233)	(110,021)	(269,512)	--
IME/DSH adj. impact	--	--	--	--	2,442	5,011	5,142	12,595	--
Managed Care Public Goods:									
Missing IME, direct GME, and DSH payments	--	--	(359,739)	(351,190)	(343,716)	(340,704)	(346,217)	(1,741,566)	--
GME carve-out	--	--	51,021	98,883	143,875	189,049	241,089	723,917	--
Residual missing payments	--	--	(308,718)	(252,307)	(199,841)	(151,655)	(105,129)	(1,017,650)	--
% Change from: Rate Year Pre-BBA Revenue by Category to Rate Year Post-BBA Revenue by Category									1996 to 2002
PPS update	--	-0.7%	-3.1%	-5.0%	-6.5%	-7.5%	-8.5%	-4.6%	6.8%
Outliers	--	-2.3%	-9.4%	-9.3%	-9.3%	-9.2%	-9.2%	-7.2%	21.1%
IME	--	-2.2%	-10.6%	-17.1%	-23.8%	-28.6%	-28.6%	-15.9%	-26.8%
DSH	--	-0.2%	-1.3%	-2.2%	-3.2%	-4.2%	-5.0%	-2.3%	-2.5%
Transfers	--	0.0%	-5.6%	-22.3%	-22.3%	-22.3%	-22.3%	-13.6%	-19.8%
PPS capital	--	-4.9%	-18.6%	-18.3%	-18.0%	-17.8%	-17.3%	-13.8%	-5.3%
PPS-exempt	--	-0.4%	-7.6%	-7.7%	-8.2%	-8.9%	-9.6%	-6.2%	5.1%
Outpatient	--	-1.6%	-6.6%	-6.6%	-11.6%	-16.6%	-16.6%	-8.8%	-3.1%
Bad debt	--	-6.3%	-28.8%	-41.3%	-45.0%	-45.0%	-45.0%	-30.4%	-41.8%
Direct GME	--	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	16.2%
Organ acquisition et al.	--	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	16.2%
Total	--	-1.4%	-6.4%	-8.5%	-10.7%	-12.5%	-13.2%	-7.8%	1.1%
Revenue Loss or Gain as % of Rate Year Pre-BBA Total Medicare Revenue									2002 Profile
PPS update	--	-0.4%	-2.1%	-3.4%	-4.5%	-5.1%	-5.8%	-3.2%	44.2%
Outliers	--	-0.1%	-0.5%	-0.5%	-0.5%	-0.5%	-0.5%	-0.4%	4.1%
IME	--	-0.2%	-1.0%	-1.5%	-2.1%	-2.5%	-2.4%	-1.4%	18.4%
DSH	--	0.0%	-0.1%	-0.1%	-0.2%	-0.2%	-0.3%	-0.1%	2.0%
Transfers	--	0.0%	-0.1%	-0.2%	-0.2%	-0.2%	-0.2%	-0.1%	1.5%
PPS capital	--	-0.3%	-1.2%	-1.2%	-1.2%	-1.2%	-1.1%	-0.9%	8.6%
PPS-exempt	--	0.0%	-0.6%	-0.6%	-0.7%	-0.7%	-0.8%	-0.5%	5.8%
Outpatient	--	-0.2%	-0.7%	-0.7%	-1.3%	-1.8%	-1.8%	-1.0%	14.0%
Bad debt	--	0.0%	-0.1%	-0.2%	-0.2%	-0.2%	-0.2%	-0.1%	1.5%
Direct GME	--	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Organ acquisition et al.	--	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	--	-1.4%	-6.4%	-8.5%	-10.7%	-12.5%	-13.2%	-7.8%	100.0%
Margin Analysis:									% Point Chg.
Inpatient operating PPS	20.1%	18.9%	15.8%	13.0%	10.6%	8.9%	7.8%	--	-12.3%
Inpatient capital PPS	12.9%	4.7%	-8.6%	-7.6%	-8.0%	-7.7%	-6.9%	--	-19.8%
Inpatient PPS-exempt	-0.1%	-0.5%	-8.4%	-8.6%	-9.2%	-10.0%	-10.8%	--	-10.7%
Outpatient	-15.4%	-17.5%	-24.1%	-24.3%	-31.5%	-39.5%	-39.4%	--	-24.0%
Direct GME	-24.4%	-24.4%	-24.4%	-24.4%	-24.4%	-24.4%	-24.4%	--	0.0%
Organ acquisition et al.	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	--	0.0%
Total Medicare	11.5%	9.9%	5.6%	3.5%	1.0%	-0.9%	-1.7%	--	-13.2%
Hospital patient care	-10.0%	-10.8%	-12.7%	-13.6%	-14.7%	-15.5%	-15.8%	--	-5.8%
Hospital operating	1.1%	0.5%	-1.1%	-1.8%	-2.6%	-3.3%	-3.5%	--	-4.7%
Hospital bottom line	1.7%	1.0%	-0.5%	-1.2%	-2.1%	-2.7%	-3.0%	--	-4.6%

THE WHITE HOUSE

WASHINGTON

November 4, 1999

MEMORANDUM TO THE PRESIDENT

FROM: Chris Jennings

SUBJECT: H.R. 3075, the Medicare Balanced Budget Refinement Act of 1999

CC: John Podesta, Steve Ricchetti, Maria Echaveste, Jack Lew, Gene Sperling, Bruce Reed, Larry Stein, Joel Johnson, and Mary Beth Cahill

Today, the House passed its version of the Medicare provider give-backs legislation by a vote of 388 to 25. It costs \$11.8 billion over 5 years. It provides relief for hospitals, nursing homes, home health providers, physicians, therapy providers, and rural health providers. With very few exceptions (such as an unnecessary and ill-advised payment increase for managed care and inadequate and controversial policies regarding teaching hospitals), most of the provisions included are workable with relatively small adjustments.

The primary challenges continue to be the lack of offsets for these new costs, the fact that no resources are being transferred to the Medicare trust fund to avoid a negative impact on the financial health of the Medicare program, and the front-loaded nature of the give-backs. On the last point, like the Senate, about half of the \$11.8 billion expenditures in the House bill are spent in the first two years, with most of this in 2001.

Since the Congress has forward-funded so much of its 2000 budget, probably cannot live under the unrealistic appropriations caps, and is considering tax policies that reduce revenue significantly, the availability of on-budget surplus dollars for 2001 is – or is almost – nonexistent. As a consequence, the dollars dedicated to 2001 spending (\$4.3 billion in the House and \$5.6 billion in the Senate) may need to be pushed into 2002 and beyond so that your FY 2001 budget has resources available for high-priority initiatives. Even though the 5-year total expenditures would likely be the same, this approach would still likely alienate many providers who are expecting administrative and legislative payment increases out of Washington this year and next year.

We are assessing whether the Congress feels strongly about the 2001 spending issue and if the Republican leadership will impose their own fiscal restraints for the early years of its budget. So far, the Congress appears largely unwilling to impose any fiscal restraints (or pay-for requirements) on itself on this issue.

Attached is an OMB letter we sent to the Congress today. As you will note, it does not reference the 2001 issue because we do not want to be the only ones raising it. We will keep you apprised of developments.



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

THE DIRECTOR

November 5, 1999

The Honorable Richard A. Gephardt
Democratic Leader
United States House of Representatives
Washington, D.C. 20515

Dear Mr. Leader:

This letter responds to your request on our views of the Balanced Budget Act adjustment bills that are currently being considered in Congress. As you know, the President is committed to moderating policies in the Balanced Budget Act of 1997 that are flawed or have unintended consequences for Medicare beneficiaries and providers. The Administration has taken numerous administrative actions to this end and believes that the Congress should not conclude its first session until necessary legislative changes are made.

Most of the Administration's specific policy suggestions and concerns with the House and Senate bills have been discussed at the staff level, and we will continue that collaboration. I want to take this opportunity to restate our commitment to broader Medicare reform and concern about the potential effect of the adjustment bills on the budget and Medicare trust fund.

The problems caused by the 1997 Balanced Budget Act that we have mutually identified are serious and require immediate action. However, even greater challenges are presented by the demographic and health changes of the 21st century. The doubling of the Medicare population in the next 30 years and advances in medicine will strain Medicare's ability to provide basic health services to seniors and people with disabilities. This is why the President developed a plan to strengthen and modernize Medicare, including adding a long-overdue, voluntary prescription drug benefit. This plan remains one of the Administration's top priorities and we hope to work with you to ensure its passage in 2000.

In the absence of broader reforms, the Administration continues to believe that legislation to correct problems with the Balanced Budget Act policies should be paid for and not undermine the solvency of the Medicare trust fund. The President's Medicare reform plan included a set of proposals to modernize traditional Medicare and reduce costs which would help in this regard. Other offsets, which could include appropriate tax offsets, could also be used. Regardless of the approach, I strongly encourage you to protect the progress we have made in extending the life of the Medicare trust fund and not reverse the gains which we have worked so hard together to achieve.

There are several provisions of the bills that we have identified in staff discussions that could be modified or eliminated. I want to reiterate our concern about a further slow-down of the implementation of the managed care risk adjustment system. The BBA required that payments to managed care plans be risk adjusted. To ease the transition to this system, we proposed a 5-year, gradual phase-in of the risk adjustment system. This phase-in forgoes approximately \$4.5 billion in payment reductions that would have occurred if risk adjustment were fully implemented immediately. The Medicare Payment Advisory Commission and other experts support our planned phase-in. These experts also believe that Medicare continues to overpay managed care plan. In light of this, we think that increased payments to managed care plans through this mandated slow-down of risk adjustment are unwarranted at this time.

The Administration would also support the inclusion of language to clarify the intent of Congress for determining aggregate payments to hospitals under OPD PPS. A technical drafting error in the BBA language authorizing the PPS system has produced some confusion over the aggregate payment formula for this system. The enactment of clarifying language on the subject would be most useful in eliminating the confusion caused by this drafting error.

BBA was an historic and major, bipartisan achievement. Because of its magnitude, it is not surprising that there are a number of modifications that we mutually agree are necessary to address its unintended and negative consequences. The Administration looks forward to working with you on these modifications to ensure that Medicare continues to provide high-quality, accessible health care.

Sincerely,

A handwritten signature in black ink, appearing to read 'Jacob J. Lew', written in a cursive style.

Jacob J. Lew
Director



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

October 18, 1999

THE DIRECTOR

Honorable William M. Thomas
Chairman, Subcommittee on Health
Committee on Ways and Means
United States House of Representatives
Washington, D. C.

Dear Mr. Chairman:

I am writing to respond to your request regarding how the Administration would score the attached language clarifying Congressional intent on the outpatient prospective payment system (PPS) enacted in the Balanced Budget Act (BBA).

As you know, the outpatient PPS was intended to rationalize outpatient payment policy. The intent of that legislation was to correct a flaw in outpatient payments, and included multi-year savings of \$7.2 billion from lower rates of cost growth under the new system. The law was not intended to impose an additional reduction in aggregate payments to hospital outpatient departments. No such reduction was contemplated when the BBA was negotiated, and we continue to believe that such a reduction would be unwise. The Medicare program needs to continue to encourage outpatient care, not discourage it by failing to pay its full costs.

Unfortunately, however, a technical drafting change has produced some confusion over the outpatient payment formula. The enactment of clarifying language on the subject would be most useful in eliminating the confusion caused by the technical drafting of the current law. The attached draft language would clarify the law and assist in carrying out the intent of Congress.

The Administration would not score the draft language, which would not modify the statutory provision, since it would only clarify the intent of Congress. Under the Budget Enforcement Act, legislative action is scored only when it changes current law. Findings or clarifications by Congress do not change the law and do not result in scoring. We are not aware of any cases since enactment of the Budget Enforcement Act in 1990 where findings or clarifications by Congress were scored. Therefore, the attached language, if enacted, would not be scored by the Office of Management and Budget.

Sincerely,

A handwritten signature in black ink, appearing to read "Jacob J. Lew".

Jacob J. Lew
Director

SEC. __. INTENTION REGARDING BASE AMOUNTS IN APPLYING THE HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM.—With respect to determining the amount of copayments described in paragraph (3)(A)(ii) of subsection 1833(t) of the Social Security Act, as added by section 4523(a) of Balanced Budget Act of 1997, Congress finds that such amount should be determined without regard to such subsection and clarifies that the Secretary of Health and Human Services has the authority to determine such amount without regard to such subsection, and that the base amounts to be calculated under paragraph (3)(A) not reflect any reductions in aggregate payments to hospitals for covered OPD services.



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

THE DIRECTOR

November 5, 1999

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Democratic Leader
United States House of Representatives
Washington, D.C. 20515

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Most of the Administration's specific policy suggestions and concerns with the House and Senate bills have been discussed at the staff level, and we will continue that collaboration. I want to take this opportunity to restate our commitment to broader Medicare reform and concern about the potential effect of the adjustment bills on the budget and Medicare trust fund.

The problems caused by the 1997 Balanced Budget Act that we have mutually identified are serious and require immediate action. However, even greater challenges are presented by the demographic and health changes of the 21st century. The doubling of the Medicare population in the next 30 years and advances in medicine will strain Medicare's ability to provide basic health services to seniors and people with disabilities. This is why the President developed a plan to strengthen and modernize Medicare, including adding a long-overdue, voluntary prescription drug benefit. This plan remains one of the Administration's top priorities and we hope to work with you to ensure its passage in 2000.

In the absence of broader reforms, the Administration continues to believe that legislation to correct problems with the Balanced Budget Act policies should be paid for and not undermine the solvency of the Medicare trust fund. The President's Medicare reform plan included a set of proposals to modernize traditional Medicare and reduce costs which would help in this regard. Other offsets, which could include appropriate tax offsets, could also be used. Regardless of the approach, I strongly encourage you to protect the progress we have made in extending the life of the Medicare trust fund and not reverse the gains which we have worked so hard together to achieve.

There are several provisions of the bills that we have identified in staff discussions that could be modified or eliminated. I want to reiterate our concern about a further slow-down of the implementation of the managed care risk adjustment system. The BBA required that payments to managed care plans be risk adjusted. To ease the transition to this system, we proposed a 5-year, gradual phase-in of the risk adjustment system. This phase-in forgoes approximately \$4.5 billion in payment reductions that would have occurred if risk adjustment were fully implemented immediately. The Medicare Payment Advisory Commission and other experts support our planned phase-in. These experts also believe that Medicare continues to overpay managed care plan. In light of this, we think that increased payments to managed care plans through this mandated slow-down of risk adjustment are unwarranted at this time.

The Administration would also support the inclusion of language to clarify the intent of Congress for determining aggregate payments to hospitals under OPD PPS. A technical drafting error in the BBA language authorizing the PPS system has produced some confusion over the aggregate payment formula for this system. The enactment of clarifying language on the subject would be most useful in eliminating the confusion caused by this drafting error.

BBA was an historic and major, bipartisan achievement. Because of its magnitude, it is not surprising that there are a number of modifications that we mutually agree are necessary to address its unintended and negative consequences. The Administration looks forward to working with you on these modifications to ensure that Medicare continues to provide high-quality, accessible health care.

Sincerely,



Jacob J. Lew

Director

TOP LIST OF CONCERNS

1. **Managed care risk adjustment:** Delay should be eliminated. Fall-back: possible ok with another year in transition, but need to have 2001 progression (not just 90/10 in 2001).
2. **Teaching hospitals:** Should include Senate's more generous IME provision (fallback: '00-02 at 6.5 percent). Drop the House's controversial redistribution proposal for graduate medical education (cost: \$0.4 billion over 5 years).
3. **Hospital outpatient department:** Both bills should include clarification of intent; both House and Senate should use directed scoring.
4. **Children's health:** Should include the Senate extension of the \$500 million outreach fund (expires in the next few months)
5. **Obstructs modernization proposal and demonstration:** Delays allowing the Secretary to use "inherent reasonableness" authority that allows gives her flexibility to set rates more appropriately (support Senate: delay until a GAO report is done). Delays competitive pricing demonstration, requires reporting on including FFS. This demo provides important information on competitive managed care proposals (compromise: no delay but make demo like our competition proposal).
6. **Therapy caps:** Support Senate moratorium rather than House 3rd cap, which we think is inadequate. (compromise: raise existing caps, but drop outlier policy).
7. **Home health:** Drop link of cut to implementation of PPS. Drop PIP extension – will cause worse overpayment problems that we have now. Prefer Senate phase-in to House delay.
8. **Skilled nursing facilities:** Prefer House approach of using across-the-board market basket increase to adding to rehab RUGs.
9. **Hospital outpatient department:** Outlier policy possible but unnecessary; transition policies not needed if 5.7 percent fixed.
10. **Pap smears:** Support immediate increase but want Secretary to have the authority to update in the future.

MISCELLANEOUS

1. **Home health:** OK with OASIS payment if no double billing
2. **Rural:** Have technical fix to 96-hour stay for critical access hospitals
3. **Managed care:** Oppose charging trust fund for education campaign
4. **Rehab PPS:** Prefer House, which gives Secretary transfer authority
5. **Immunosuppressants:** Support expanding drug coverage; want to give Secretary authority to limit coverage period to keep spending within amount allowed.
6. **FQHC:** Oppose Senate provision; reviewing alternatives
7. **CHIP data:** Support the Senate policies (none in the House)

New York ~~Post~~ Herald Tribune

**PRESENTATION TO THE ANNUAL CONFERENCE OF
THE HEALTHCARE ASSOCIATION OF NEW YORK STATE BY
FIRST LADY HILLARY RODHAM CLINTON**

HANYS CONTACT:

Steven Kroll, Vice-President, Governmental Affairs

Office With Voice Mail (518) 431-7727

Home [redacted P6/b(6)]

At Conference (beginning Wednesday at noon) (518) 644-9400

[ask for HANYS conference center staff]

Cellular Phone With Voice Mail [redacted P6/b(6)]

Pager [redacted P6/b(6)]

PROPOSED SCHEDULE:

Mrs. Clinton will be greeted by Daniel Sisto, the President of the Healthcare Association New York State (HANYS).

HANYS is the statewide trade association for New York's not-for-profit hospitals, health systems, and affiliated continuing care providers. (95% of New York's hospitals are not-for-profit)

We will be expecting the First Lady to arrive at approximately 11:20 –11:30 a.m.

Upon arrival, we would like Mrs. Clinton to have a brief introductory meeting of approximately ten minutes with Mr. Sisto.

Mr. Sisto will then escort Mrs. Clinton to a reception room where she will be greeted by the HANYS leadership for approximately fifteen minutes. I have attached a HANYS Board list for your information (Attachment A). Many of these individuals will be on-hand to greet Mrs. Clinton.

Mr. Sisto and the HANYS leadership will escort Mrs. Clinton to the main auditorium where she will address an audience of hospital and health system executives and trustees.

We would be pleased if Mrs. Clinton would accept questions from the audience. Please advise us if this will be possible. Please also advise us if Mrs. Clinton would like us to arrange for press availability after her remarks and prior to departing Bolton Landing.

October 7, 1999 4:00 P.M.

ISSUES OF CONCERN FOR NEW YORK'S HOSPITALS AND HEALTH SYSTEMS

We would be grateful if the First Lady would be willing to address any or all of these issues in her remarks.

- **HANYS has long shared the First Lady's goal of expanding access to health insurance to all Americans. HANYS believes the availability of tobacco settlement funds presents a unique opportunity to make incremental progress towards this goal for both children and families.**
- **HANYS members believe Congress and the Administration should work together to enact legislation and promulgate regulations that restore Medicare funding and repair the Balanced Budget Act (BBA) this fall. (More information on BBA repairs follows in background section of this document.)**
- **HANYS believes many of the federal managed care reform proposals currently under consideration represent an important step in ensuring that insurers and managed care companies are more accountable to consumers. Many of the proposed reforms have already been enacted into law in New York and should be extended to all Americans.**
- **HANYS also believes that discussions of federal managed care legislation should be broadened to address health care providers' growing payment problems with HMOs and insurers. For example, HANYS supports the establishment of a federal prompt payment standard for all payers, as New York State's hospitals are experiencing tremendous growth in accounts receivable and retroactive denials of payment by managed care plans and insurers.**
- **HANYS has a similar managed care agenda at the state level. HANYS "Health Insurance Payer Integrity Agenda," which is attached (Attachment B) will be a key focus of the HANYS membership this fall when the State Legislature considers HCRA successor legislation.**

BACKGROUND INFORMATION ON HANYS MEMBERSHIP AND HANYS ADVOCACY AGENDA

Diversity of New York State's Hospitals

New York State has a diverse hospital community. New York has:

- **some of world's largest academic medical centers,**
- **some of the smallest hospitals that dot the heartland of America, and**
- **many suburban, community and small urban hospitals that are essential health care resources to the fastest growing communities in New York State.**

The persons who govern and administer these hospitals are fiercely proud of their individual institutions. The different types of hospitals have unique needs and the New York hospital community works hard to balance the needs of each type of hospital in our collective public advocacy agenda.

The entire audience would be personally touched by the First Lady's remarks if she would balance her address to equally recognize each of these three types of hospitals.

BACKGROUND INFORMATION ON HANYS MEMBERSHIP AND HANYS ADVOCACY AGENDA

HANYS' Position on Balanced Budget Act Repairs

- **HANYS members believe Congress and the Administration should work together to enact legislation and promulgate regulations that restore Medicare funding and repair the Balanced Budget Act (BBA) this fall.**
- **The Administration has also proposed billions of dollars in additional provider payment cuts during 1999. The additional proposed cuts, in the form of BBA extenders, are inappropriate given the BBA has already saved billions more than originally estimated.**
- **Having a balanced budget is important. But, the Medicare cuts in the balanced budget law went too far.**
- **Lawmakers have the opportunity to make restorations to Medicare and reverse the mounting consequences of the BBA before our communities are too severely impacted.**
- **The almost \$5 billion in BBA cuts on New York State providers has already forced hospitals to make difficult choices that may run counter to our mission of community service.**
- **The BBA repair funds proposed thus far by Congress and the Administration are inadequate to address the unintended consequences of the BBA in all priority areas. It will be impossible to make meaningful restorations to all types of hospitals, nursing homes, and home care providers without a greater commitment of funds.**
- **Adequate funding must be made available so BBA relief legislation and regulation can address the needs of teaching hospitals and non-teaching hospitals alike – whether urban, suburban, or rural.**
- **Medicare's proposed outpatient PPS will disproportionately reduce hospital outpatient revenue in New York State (Additional Information in Attachment C).**

- **HANYS supports the legislative efforts in the Congressional Health Committees to increase outpatient PPS funding. HANYS has developed a legislative proposal that would restore funding to the outpatient PPS. The proposal has been introduced in the House of Representatives as H.R.2979.**
- **Regulatory repairs to the Outpatient PPS are also necessary. HANYS is urging the Administration to rescind the across-the-board 5.7% reduction in payment rates in the proposed rule. A large majority of House and Senate members of both parties oppose this reduction, which was not required by the BBA. This reduction will reduce outpatient payments in New York by about \$45 million per year. The Administration should also include a teaching and Disproportionate Share Hospital (DSH) adjustment in the outpatient PPS.**
- **A list of HANYS-supported legislation to repair the BBA is attached (Attachment D).**

Impact of Current BBA Restoration Proposals on New York

The Administration has suggested a much smaller pool of funds for repairing the BBA than either Republicans or Democrats in Congress. The Administration's proposed BBA repair fund is inadequate to address the unintended consequences of the BBA in all priority areas. It will be impossible to make meaningful restorations to GME, hospital outpatient, nursing homes, and home care without a greater commitment of funds.

The BBA will reduce Medicare hospital spending in New York by approximately \$4.75 billion over five years.

The Administration's proposed BBA extenders would reduce total Medicare spending in New York by approximately \$3.2 billion over the next ten years, the majority of which would likely come from hospital payments.

White House - Proposes to return \$7.5 billion over ten years to providers and health plans

New York's Potential Share = \$300 million over five years for all providers and health plans (not just hospitals)

Rep. Bill Thomas and House Republicans - Propose to return approximately \$10 billion over five years to providers and health plans

New York's Potential Share = \$800 million over five years for all providers and health plans (not just hospitals)

Sen. William Roth - Propose to return approximately \$7.5 billion over five years to providers and health plans

New York's Potential Share = \$600 million over five years for all providers and health plans (not just hospitals)

Sen. Tom Daschle and Senate Democrats

Proposes to return \$20 billion over five to ten years to providers and health plans

New York's Potential Share = \$800 million to \$1.6 billion over five years for all providers and health plans (not just hospitals)

Major Emerging Issue – Medicare DSH Formula

The Health Care Financing Administration (HCFA) has recently begun revisiting the Medicare Disproportionate Share Hospital (DSH) payment formula in a manner that could result in the loss of hundreds of millions of dollars in Medicare Disproportionate Share (DSH) payments to New York State's safety net hospitals.

In order for hospitals to qualify for Medicare DSH payments, they must demonstrate that they treat a high number of poor and uninsured patients. The proxy for calculating the number of poor and uninsured patients for each hospital is based on a formula that includes the number of Medicaid days. Recently, HCFA has incorrectly decided that there have been significant DSH overpayments to hospitals as a result of the inclusion of a state-created Medicaid category called Home Relief (HR) in this calculation of Medicaid days.

HCFA and the Medicare Fiscal Intermediary had previously told HANYS that New York's Medicare DSH calculations were in compliance with federal requirements. However, very recently, HCFA has revised its position on this issue and told hospitals that state "Medicaid" days must be excluded, even though hospitals do not have the ability to distinguish these patients from their "federal" Medicaid patients. The recalculation could potentially cost New York State's approximately 125 DSH hospitals an estimated \$160 million per year. HCFA has indicated this new policy could be both retrospective and prospective, and result in the recoupment of funds going back several years. In addition, approximately 19 hospitals would lose DSH eligibility if these days were excluded.

These recoupments and future reductions would be in addition to BBA cuts already in effect and would deepen the plight of already financially troubled safety net providers. Our State's Medicare DSH hospitals are located in every corner of New York State, in every Congressional district, with one exception. These safety-net providers use these essential DSH payments to maintain access to health care for every patient that comes through their doors, regardless of the patients' ability to pay or insurance status. Many of these providers have received letters from the fiscal intermediary indicating that closed Medicare cost reports, dating back to 1993 or 1994, would be reopened for the purpose of recalculating their Medicare DSH allotments.

BACKGROUND INFORMATION ON NEW YORK STATE'S HOSPITALS & HEALTH SYSTEMS FOR FIRST LADY HILLARY RODHAM CLINTON

New York Hospitals: Serving Their Communities

New York State has approximately 250 urban, rural, and suburban hospitals that form the core of our health care system. These hospitals, which range in size from two to 1,171 beds, are a crucial source of many essential services for all New Yorkers.

New York State's urban, suburban, and rural hospitals provide an astounding array of high-quality health care services for their communities, as well as visitors to the Empire State, and persons from around the world who come to New York seeking cutting edge medical treatment. From our academic medical centers and teaching hospitals, which provide access to the most advanced technologies, to the community hospitals that offer local access to essential medical and emergency services, New York State's hospitals make a difference in thousands of lives each day. For example:

- New York State's fifteen organ transplant centers performed 1168 major organ transplants in 1997.
- Around-the-clock lifesaving information is just a phone call away at six regional poison control centers.
- Advanced trauma care is always available at forty-seven regional, area, and pediatric trauma centers. Nine burn centers are also always on stand-by.
- Hundreds of satellite outpatient clinics bring health care directly to New York State's most underserved urban and rural populations. Hospitals and hospital-sponsored primary care clinics and offices are the primary source of health care for the uninsured.

Service to communities is our bottom line. Hospitals are major sponsors of meals-on-wheels and other nutrition programs, support groups, teen outreach programs, school-based health clinics, immunization programs, and often provide transportation to and from health facilities for seniors and the disabled.

New York Hospitals: Special Missions

Sixty-five New York State hospitals in thirty-six counties are designated as rural, or serve predominantly rural communities. In seventeen of these counties, there is only one hospital. For geographically isolated New Yorkers, rural hospitals are the only guarantee of readily accessible emergency and lifesaving care. More than two dozen hospitals are over fifteen miles from the nearest alternative hospital, often over secondary roads. Rural hospitals are the safety net for their communities and treat predominantly elderly and low-income individuals and families. Many have developed specialized services that enable senior citizens to get excellent health care close to home. 74% of rural hospital inpatient days in New York are for Medicare and Medicaid patients.

More than 100 New York State hospitals have teaching programs. These institutions make our state one of the world's premier centers for medical excellence. The hospitals provide the finest training for more than 15,000 physicians and other health care professionals, provide access to care for the poor and uninsured, make available cutting edge medical technology, and serve as the foundation of a powerful biomedical research industry. New York State trains 16% of the nation's medical residents and educates 10% of the nation's medical students, drawing 10% of the nation's total National Institutes of Health grant funding.

Despite trying financial times, many New York "Disproportionate Share" hospitals continue developing services targeted at improving the health status of uninsured and Medicaid patients. These hospitals are the backbone of care for New York's most vulnerable populations

More than 100 New York State hospitals provide specialized services for persons living with AIDS and HIV. New York State continues to have the largest percentage and number of persons living with AIDS in the nation. Of the 266,000 AIDS cases reported to the Centers for Disease Control through June 1998, 47,000 of the individuals, or 17.6%, live in New York.

New York Hospitals Strengthening The State Economy

In 1997, New York State's hospitals employed the equivalent of approximately 410,000 full-time workers who earned almost \$18 billion in wages, salaries, and benefits that were re-circulated in the state economy.

New York State's hospitals spent \$28.9 billion on staffing, goods, and services for patient care in 1997.

New York State's prestigious academic medical centers and community teaching hospitals sponsor biomedical research and teaching programs that generate an annual \$2.5 billion infusion of out-of-state funding to New York's economy, offsetting any costs to New York State businesses or governments by an almost three-to-one margin.

New York Hospitals Efficient and Effective

New York State's hospitals had the nation's lowest number of full-time workers per patient caseload — 4.2 versus the national median of 5.3 in 1997.

These hospitals had a median occupancy rate of 62.4% in 1997, compared to the national median of 44.7%.

Ninety-six percent of New York State's hospitals are either not-for-profit (83%) or government-run (12%). Only 5% are for-profit. Recent studies have found that not-for-profit hospitals are more cost-efficient than for-profit facilities.

In the last four years, overall Medicaid spending has risen by only 5%. Medicaid spending for hospital services in New York State has actually dropped 26% over the same period.

New York Hospitals Financial Challenges

The financial viability of New York State's hospitals is being threatened by:

- severe reductions in Medicare and Medicaid funding,
- growing problems with HMOs and other health insurers who withhold, delay, and deny payment for health care services that have been appropriately provided, and
- the growing number of uninsured in New York State.

The number of uninsured in New York State has continued to rise -- from 2.9 million in 1994 to 3.2 million currently. New York's hospitals are the caregivers for these New Yorkers, and for millions more who are underinsured. Our hospitals provided \$1.4 billion in uncompensated care in 1997, and another \$1.54 billion in uncompensated care in 1998.

Under the federal Balanced Budget Act (BBA) of 1997, Medicare reimbursement to New York hospitals will be reduced by approximately 4.75 billion between 1998 to 2002. Already, hospitals are feeling the severe effects of the first two years of the BBA, as is evidenced by their weak financial performance in 1998 and 1999.

Meanwhile, private health insurers are increasingly denying claims for payment or flouting the state's Prompt Payment Law (as evidenced by the \$244,300 in fines levied against 18 of the state's health plans in 1999).

New York State hospitals had the second lowest "profit margin" in the United States in 1997. The median margin for New York hospitals was a razor-thin 0.82% compared to 3.83% for all U.S. hospitals. Those slim margins are being eroded by further funding cuts.

According to financial information filed by 194 of the state's 240 hospitals, the small aggregate surplus of 1997 has been wiped out by a loss on operations of more than \$140 million in 1998, a swing of more than \$250 million in one year. These statewide losses have translated into layoffs, postponed or terminated programs, unpaid vendors, a hospital bankruptcy, and several hospitals on the edge of insolvency.

SOURCES:

Hospital Statistics 1999, American Hospital Association

HIV/AIDS Surveillance, December 1998, Centers for Disease Control

The Source Book: The Comparative Performance of U.S. Hospitals, Deloitte & Touche and Health Care Investment Analysts, Inc., 1999

NYS Department of Health, *Health Facilities Directory*, July, 1999

ES202 Report, NYS Department of Labor, 1998

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Attachment B**Health Insurance Payer Integrity Agenda**

Health care providers throughout New York State are experiencing significant problems with managed care and other insurers routinely withholding, delaying, and denying payment for health care services that have been appropriately provided. Retroactive denial of payment for pre-authorized services, delayed payment for services already provided, and the financial collapse and weakness of many managed care companies have led to a tremendous increase in accounts receivable for all health care providers. Despite New York State laws regulating utilization review agents, mandating prompt payment of health care claims, and establishing an external appeal process, health care providers have continued to see unpaid or late bills increase significantly this year, as managed care and other insurers refuse to comply with existing laws. Existing penalties provide no incentive for payers to change behavior and comply with the law. To resolve these critical and growing problems, HANYS is pressing for active and effective enforcement of existing laws, as well as enactment of HANYS' Payer Integrity Legislative Agenda.

Attachment B**Health Insurance Payer Integrity Agenda**

Health care providers throughout New York State are experiencing significant problems with managed care and other insurers routinely withholding, delaying, and denying payment for health care services that have been appropriately provided. Retroactive denial of payment for pre-authorized services, delayed payment for services already provided, and the financial collapse and weakness of many managed care companies have led to a tremendous increase in accounts receivable for all health care providers. Despite New York State laws regulating utilization review agents, mandating prompt payment of health care claims, and establishing an external appeal process, health care providers have continued to see unpaid or late bills increase significantly this year, as managed care and other insurers refuse to comply with existing laws. Existing penalties provide no incentive for payers to change behavior and comply with the law. To resolve these critical and growing problems, HANYS is pressing for active and effective enforcement of existing laws, as well as enactment of HANYS' Payer Integrity Legislative Agenda.

HEALTH INSURANCE PAYER INTEGRITY

HANYS' LEGISLATIVE AGENDA

HEALTH INSURANCE GUARANTEE FUND

Create a guarantee fund to ensure that health care providers are reimbursed for services in the event of the default of a health insurance plan. The guarantee fund would be funded by an assessment on all health insurers, imposed in the event of a default. The proposal would be modeled after guarantee funds for life insurance and property/casualty insurance that already exist in state law.

PROMPT PAYMENT LEGISLATION

- Define "clean claims" as a Uniform Billing Form (UB-92) with all fields correctly filled.
- Establish a trigger mechanism for automatic enforcement of penalties.
- Reduce the timeframes for prompt payment and provide a reduced timeframe for claims submitted through electronic transmission.
- Increase penalties for failure to comply.

YEAR 2000 PAYMENT LEGISLATION

- Require the state's Medicaid system, HMOs, and other health insurers to demonstrate the Year 2000 operational compliance of their payment systems or to establish a prospective interim payment system.
- Provide health care providers with liability protection if they exercise reasonable due diligence in preparing for Year 2000 problems.
- Alter the Medicaid payment methodology to ensure that Year 2000 capital compliance costs are fully reimbursed, rather than discounted 44%.

PRIOR AUTHORIZATION AND UTILIZATION REVIEW (UR)

- Define "prior authorization of a health care service" to ensure that such prior authorization guarantees payment to the health care provider when the service is provided.
- Require the Department of Health to standardize UR criteria.
- Mandate the disclosure of UR criteria used by UR agents.
- Require advance notice of changes in the UR criteria.
- Amend the third-party appeal statute to allow providers to initiate an appeal of concurrent denials.

(over)



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DISPUTE RESOLUTION

Establish a system for disputes over payments and payment practices between health care providers and health insurance payers to be resolved by an independent entity.

PROSPECTIVE INTERIM PAYMENT

Require health insurers to establish a prospective interim payment (PIP) system when the insurer fails to comply with prompt payment and utilization review statutes or excessively and inappropriately denies payment through the UR process.

EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT PAYMENTS

Require health insurers to pay for all emergency room services that hospitals are mandated by federal law to provide to patients.

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THE BALANCED BUDGET ACT (BBA) AND MEDICARE OUTPATIENT PPS September 1999

BACKGROUND

- In 2000, as mandated by the BBA, Medicare will change the way in which it pays for outpatient services – from the current system of reimbursing hospitals based on their reasonable costs – to a prospective payment system (PPS).
- Outpatient services are typically delivered in hospital-based clinics, ambulatory care and surgery centers, and emergency rooms.
- Medical advances allow hospitals to increasingly provide care in outpatient settings. Procedures that only a few years ago would require a multiple night hospital stay, now can be done in the outpatient setting. This trend is an appropriate response to our changing health care system and will result in more and more patients receiving care in less invasive and often less expensive hospital outpatient departments.

PROBLEMS WITH THE HCFA-PROPOSED MEDICARE OUTPATIENT PPS:

- Rather than maintaining total funding for outpatient PPS at current levels (as intended by Congress), HCFA has proposed that hospital payments be reduced by 5.7% to reflect reductions in beneficiary co-payments. Congress had intended to offset these beneficiary changes with Medicare funding, not provider payment cuts. The proposed implementation of this 5.7% cut is not spread equally across the nation. New York will be one of the largest losers with total outpatient payments reduced 12.1%.
- The outpatient PPS will result in hospitals receiving only 76 cents for each dollar spent for outpatient services provided. In New York, hospitals will lose even more – 30 cents on the dollar. These losses will continue to escalate, as the BBA will reduce by 1% the annual outpatient marketbasket “inflation” update for the years 2000 to 2002.
- Certain hospitals will have disproportionately large reductions – as much as 40% of their current Medicare outpatient revenue. Small rural, major city and suburban teaching, city and suburban safety-net, and specialty hospitals, like cancer hospitals, are among those that will see the largest reductions in Medicare outpatient revenue.
- Many of the hospitals that lose the most under the PPS treat a larger than average number of low-income and uninsured individuals. Many of these same hospitals also have a significantly higher percentage of clinic and emergency department visits than other hospitals.

- The BBA requires HCFA to develop methods to control unnecessary outpatient volume. HCFA has proposed constraining future Medicare hospital outpatient spending through estimated spending targets called volume and expenditure caps. These caps do not take into account actual use of outpatient services. If triggered, these arbitrary targets will reduce payments to every hospital, including those who have been efficient in providing care. These arbitrary caps may result in the limiting of services and technologies and treat all providers as guilty by association.

SOLUTIONS

The following regulatory and legislative actions can restore funding to the outpatient PPS and assure fairness to New York's disproportionately city, suburban, and rural hospitals.

HANYS has asked HCFA to take the following regulatory actions:

- **Eliminate the proposed 5.7% reduction in outpatient hospital payments.** Congress never intended to make this reduction in outpatient funding and HCFA has the authority to rescind this reduction. More than 75 U.S. Senators and 250 House Members have written to HCFA requesting that this proposed reduction be rescinded.
- **Eliminate the proposed volume and expenditure caps.** The caps should be eliminated and replaced with an appropriate utilization control policy that specifically targets the abuse of services.
- **Include a teaching and disproportionate share adjustment (DSH).** When developing other hospital payment systems, HCFA has consistently included teaching and DSH adjustments to assure that providers are adequately reimbursed for the increased intensity of care provided in teaching hospitals and for providing care to large numbers of indigent patients. HCFA should include a teaching and DSH adjustment in the outpatient PPS.

Congress should take the following legislative actions:

- **Implement H.R. 2241 by Rep. Mark Foley (R-Florida).** When the outpatient PPS is implemented, many large urban, and small rural hospitals throughout the U.S. will lose 20-40% of their Medicare outpatient revenue in one year. To prevent these precipitous drops in Medicare revenues from harming hospitals and the Medicare beneficiaries who rely on them, this AHA-backed legislation should be enacted to limit each hospital's outpatient payment losses for three years.
- **Increase payments for emergency departments (ED) and clinic visits.** One of the ways to help many of the essential city, suburban, and rural safety-net hospitals with the largest losses is to increase payments for emergency department and clinic visits. EDs provide life saving care that is not available to Medicare beneficiaries in any other setting. These services are provided without consideration of ability to pay and it is essential that Medicare adequately reimburse hospitals for its share of emergency services. Clinics provide many preventative and inexpensive services that monitor and manage the health status of Medicare beneficiaries, resulting in lower utilization of more expensive health care services. Hospitals that have the highest share of clinic visits also treat the highest percentage of poor patients. Clinic rates should be increased to assure that access to clinic services is preserved. HANYS has drafted legislation to increase payments for ED and clinic visits.
- **Restore the full marketbasket update for 2000 to 2002.** One way to restore funding to the outpatient PPS is to rescind the annual 1% reduction in the outpatient PPS "inflation" update factor. Without the restoration of the full marketbasket update, payments will in effect be reduced an additional 3%, eroding any other improvements which may be implemented. HANYS has drafted legislation to restore the full marketbasket update.

Attachment

C

Proposal to Increase Outpatient PPS Payments for Emergency Department and Clinic Services

Proposal: Provide increased payments for emergency department (ED) and clinic APCs by establishing a permanent fixed ED add-on factor and a permanent fixed clinic add-on factor. The add-on factors will be developed such that, in the first year of the outpatient PPS, total payments for ED visits will equal total ED visit costs and total payments for clinic visits will equal total clinic visit costs less 5.8%.

Rationale: It is inappropriate that hospitals suffer losses of 24% or more in providing emergency and clinic services to Medicare beneficiaries, as will happen if the outpatient PPS is implemented as currently proposed. Emergency departments provide life saving care that is not available to Medicare beneficiaries in any other setting. These services are provided without consideration of ability to pay and it is essential that Medicare adequately reimburse hospitals for its share of emergency services. In addition, clinics provide many preventative and inexpensive services that monitor and manage the health status of Medicare beneficiaries, resulting in lower utilization of more expensive health care services.

Impact: HANYS estimates that required ED add-on factor is 32% and the clinic add-on factor is 24%. These add-on factors would result in increased outpatient PPS payments of 3.9% (\$1.9 billion over the period July 2000 to December 2004). The hospitals that would benefit the most from this proposal are those that tend to focus of providing for the basic health care needs of their communities. For example, the characteristics of the 100 urban and 100 rural hospitals that are helped the most are as follows:

- ✓ These hospitals provide core outpatient services in their communities:
 - For the top 100 urban hospitals, 68% of their outpatient services are ED and clinic visits;
 - For the top 100 rural hospitals, 52% are ED and clinic visits.

(Nationally, ED and clinic visits account for about 25% of all outpatient visits.)
- ✓ These hospitals tend to be smaller:
 - Of the top 100 urban hospitals, 71 have less than 200 beds;
 - Of the top 100 rural hospitals, 88 have less than 50 beds and the other 12 are between 50 and 99 beds.
- ✓ The top 100 rural hospitals tend to serve wide geographic areas and many are already recognized as unique by Medicare:
 - 63 are the only hospitals in their county and 41 are 20 or more miles from the next closest hospital;
 - 57 are either sole community or Medicare dependent hospitals.

These 100 urban hospitals and 100 rural hospitals would gain 15 to 16% above the outpatient PPS payment levels as currently proposed.



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Attachment

D

❖❖ **1999 New York Co-Sponsors** ❖❖
of Legislation to
Repair the Balanced Budget Act (BBA)

[Text, summaries, co-sponsor lists, and other information on these bills can be found on the
Library of Congress legislative information site at <http://thomas.loc.gov>.]

LEGISLATION THAT AFFECTS HOSPITALS

**RESTORE FUNDS TO HOSPITAL
MARKETBASKET, REPEAL FEE-FOR-
SERVICE DISPROPORTIONATE SHARE
CUT, AND FREEZE INDIRECT MEDICAL
EDUCATION (IME) REDUCTION AT
OCTOBER 1, 1998 LEVEL (6.5%)**

**Medicare Hospital Emergency
Assistance Legislation (HEAL)
(H.R.2266)**

*Introduced by Reps. Nita Lowey (D-Harrison) &
Jack Quinn (R-Hamburg)*

Rep. Maurice Hinchey (D-Saugerties)
Rep. Peter King (R-Seaford)
Rep. John LaFalce (D-Tonawanda)
Rep. Michael McNulty (D-Green Island)
Rep. Jerrold Nadler (D-Manhattan)
Rep. Louise Slaughter (D-Fairport)
Rep. Anthony Weiner (D-Brooklyn)

**INCREASE CLINIC AND ER RATES,
RESTORE FUNDS TO OUTPATIENT
MARKETBASKET, AND THREE-YEAR
STOP-LOSS TRANSITION TO OUTPATIENT
PROSPECTIVE PAYMENT SYSTEM**

**Medicare Hospital Outpatient Payment
Equity Act (H.R.2979)**

Introduced by Rep. Rick Lazio (R-Brightwaters)

**THREE-YEAR STOP-LOSS TRANSITION TO
OUTPATIENT PROSPECTIVE PAYMENT
SYSTEM**

**The Hospital Outpatient Preservation
Act of 1999 (S.1263/H.R.2241)**

*Introduced by Sen. James Jeffords (R-VT) &
Rep. Mark Foley (R-FL)*

Rep. Maurice Hinchey (D-Saugerties)
Rep. Carolyn McCarthy (D-Mineola)
Rep. Michael McNulty (D-Green Island)
Rep. Gregory Meeks (D-Far Rockaway)
Rep. Thomas Reynolds (R-Springville)

**GRANTS FOR SMALL, NON-PROFIT,
DISTRESSED COMMUNITY HOSPITAL**

**The Community Hospital Preservation
Act (H.R.2236)**

Introduced by Rep. John LaFalce (D-Tonawanda)

Rep. Maurice Hinchey (D-Saugerties)
Rep. Michael McNulty (D-Green Island)
Rep. Gregory Meeks (D-Far Rockaway)

**REPEAL OF MEDICARE TRANSFER
PROVISION**

**Medicare Common Sense Hospital
Payment Act of 1999 (S.37/H.R.405)**

Introduced by Sen. Charles Grassley (R-IA) & Rep. Jim Nussle (R-IA)

Rep. Gary Ackerman (D-Queens)
Rep. Sherwood Boehlert (R-New Hartford)
Rep. Eliot Engel (D-Bronx)
Rep. Michael Forbes (D-Quogue)
Rep. Ben Gilman (R-Middletown)
Rep. Maurice Hinchey (D-Saugerties)
Rep. Sue Kelly (R-Katonah)
Rep. Peter King (R-Seaford)
Rep. John LaFalce (D-Tonawanda)
Rep. Rick Lazio (R-Brightwaters)
Rep. Nita Lowey (D-Harrison)
Rep. Carolyn Maloney (D-Manhattan)
Rep. Carolyn McCarthy (D-Mineola)
Rep. John McHugh (R-Pierrepont Manor)
Rep. Michael McNulty (D-Green Island)
Rep. Jerrold Nadler (D-Manhattan)
Rep. Major Owens (D-Brooklyn)
Rep. Jack Quinn (R-Hamburg)
Rep. Jose Serrano (D-Bronx)
Rep. John Sweeney (R-Troy)
Rep. Nydia Velazquez (D-Brooklyn)
Rep. James Walsh (R-Syracuse)

**IME REDUCTION AT OCTOBER 1, 1998
LEVEL (6.5%)**

**Graduate Medical Education Payment
Restoration Act (S.1023/H.R.1785)**

Introduced by Sen. Daniel Patrick Moynihan & Rep. Charles Rangel (D-Harlem)

Sen. Chuck Schumer
Rep. Joseph Crowley (D-Elmhurst)
Rep. Maurice Hinchey (D-Saugerties)
Rep. Carolyn Maloney (D-Manhattan)
Rep. Carolyn McCarthy (D-Mineola)
Rep. Michael McNulty (D-Green Island)
Rep. Jerrold Nadler (D-Manhattan)

**DIRECT PAYMENT OF MEDICARE
DISPROPORTIONATE SHARE TO
HOSPITALS FOR MEDICARE+CHOICE
PATIENTS**

**Medicare+Choice Carve-Out
(H.R.1103/S.1024)**

Introduced by Rep. Charles Rangel (D-Harlem) & Sen. Daniel Patrick Moynihan

Sen. Chuck Schumer
Rep. Gary Ackerman (D-Queens)
Rep. Eliot Engel (D-Bronx)
Rep. Maurice Hinchey (D-Saugerties)
Rep. Peter King (R-Seaford)
Rep. John LaFalce (D-Tonawanda)
Rep. Nita Lowey (D-Harrison)
Rep. Carolyn Maloney (D-Manhattan)
Rep. Carolyn McCarthy (D-Mineola)
Rep. Michael McNulty (D-Green Island)
Rep. Gregory Meeks (D-Far Rockaway)
Rep. Jerrold Nadler (D-Manhattan)
Rep. Major Owens (D-Brooklyn)
Rep. Jack Quinn (R-Hamburg)
Rep. Jose Serrano (D-Bronx)
Rep. Louise Slaughter (D-Fairport)
Rep. Ed Towns (D-Brooklyn)
Rep. Nydia Velazquez (D-Brooklyn)
Rep. James Walsh (R-Syracuse)

**DIRECT PAYMENT FOR HOSPITAL-BASED
NURSING AND ALLIED HEALTH
EDUCATION TO HOSPITALS FOR
MEDICARE+CHOICE PATIENTS**

D

**Medicare Nursing and Paramedical
Education Act of 1999 (House) and the
Nursing and Allied Health Payment
Improvement Act of 1999 (Senate)
(S.1025/H.R.1483)**

*Introduced by Sen. Daniel Patrick Moynihan,
Reps. Phil Crane (R-IL) & Ken Bentsen (D-TX)*

Sen. Chuck Schumer
Rep. Michael McNulty (D-Green Island)
Rep. Charles Rangel (D-Harlem)

LEGISLATION THAT AFFECTS HOME CARE

D

**ELIMINATION OF 15% HOME CARE
REDUCTION, ESTABLISHMENT OF 3-YEAR
INTEREST-FREE REPAYMENT PERIOD
FOR OVERPAYMENTS**

Medicare Home Health Improvement Act (H.R.2618)

*Introduced by Reps. Gary Ackerman (D-Queens)
& Sherwood Boehlert (R-New Hartford)*

Rep. Joseph Crowley (D-Elmhurst)
Rep. Michael Forbes (D-Quogue)
Rep. Maurice Hinchey (D-Saugerties)
Rep. Sue Kelly (R-Katonah)
Rep. Peter King (R-Seaford)
Rep. Carolyn Maloney (D-Manhattan)
Rep. Carolyn McCarthy (D-Mineola)
Rep. John McHugh (R-Pierrepont)
Rep. Michael McNulty (D-Green Island)
Rep. Jerrold Nadler (D-Manhattan)
Rep. Jose Serrano (D-Bronx)
Rep. Louise Slaughter (D-Fairport)
Rep. Edolphus Towns (D-Brooklyn)
Rep. James Walsh (R-Syracuse)
Rep. Anthony Weiner (D-Brooklyn)

**ELIMINATION OF 15% HOME CARE
REDUCTION, ESTABLISHMENT OF 5-YEAR
INTEREST-FREE REPAYMENT PERIOD
FOR OVERPAYMENTS, ELIMINATION OF
INCREMENTAL BILLING REQUIREMENT,
AND REPORT TO CONGRESS ON OASIS**

Medicare Home Health Payment Improvement Act of 1999 (H.R.2492)

*Introduced by Reps. Eliot Engel (D-Bronx) & Rick
Lazio (R-Brightwaters)*

**ELIMINATION OF 15% HOME CARE
REDUCTION, INCREASE IN PER VISIT
LIMITS, INCREASE IN PAYMENTS TO
AGENCIES UNDER THE NATIONAL
AVERAGE, ESTABLISHMENT OF 3-YEAR
INTEREST-FREE REPAYMENT PERIOD FOR
OVERPAYMENTS, ESTABLISHMENT OF
OUTLIER PAYMENTS, ELIMINATION OF
INCREMENTAL BILLING REQUIREMENT,
AND SURETY BOND CHANGES**

Home Health Equity Act of 1999 (S.1310)

*Introduced by Sens. Susan Collins (R-ME) &
Christopher Bond (R-MO)*

*Several other bills that would provide
BBA relief to home care agencies have
been introduced.*

*Details on H.R.1917, H.R.2240, H.R.2361,
H.R.2546, H.R.2628, S.1358, and S.1414
can be found on the Library of Congress
internet site (<http://thomas.loc.gov>) or
obtained from HANYS.*

D

LEGISLATION THAT AFFECTS SKILLED NURSING FACILITIES

PAYMENT ADD-ONS FOR COMPLICATED RUGS THAT HAVE HIGH CONCENTRATION OF UTILIZERS OF NON-THERAPY ANCILLARIES

(S.1500) Introduced by Sens. Orrin Hatch (R-UT) and Pete Domenici (R-NM)

OTHER ISSUES

PERMIT MEDICARE PAYMENT FOR ALS INTERCEPT SERVICES FURNISHED IN AREAS OTHER THAN RURAL AREAS

Medicare Paramedic Intercept Service Equity Act of 1999 (H.R.2711)

Introduced by Rep. Sue Kelly (R-Katonah)

Rep. Benjamin Gilman (R-Middletown)
Rep. Thomas Reynolds (R-Springville)
Rep. John Sweeney (R-Troy)

ESTABLISH EXEMPTIONS OR REPEAL THE \$1,500 CAP ON OUTPATIENT REHABILITATION SERVICES

Medicare Rehabilitation Benefit Improvement Act (S.472/H.R.1837)

Introduced by Sens. Charles Grassley (R-IA), Harry Reid (D-NV), Kent Conrad (D-ND), & Reps. Richard Burr (R-NC) & Benjamin Cardin (D-MD)

Sen. Charles Schumer
Rep. Maurice Hinchey (D-Saugerties)
Rep. Jerrold Nadler (D-Manhattan)
Rep. James Walsh (R-Syracuse)

Reinstatement of the Medicare Rehabilitation Benefit Act of 1999 (H.R.1385) Introduced by Rep. Jo Ann Emerson (R-MO)

Rep. Sherwood Boehlert (R-New Hartford)
Rep. Vito Fossella (R-Staten Island)
Rep. Maurice Hinchey (D-Saugerties)
Rep. John LaFalce (D-Tonawanda)

FULL FUNDING OF MEDICARE MANAGED CARE PAYMENT INCREASES

Medicare Health Plan Fair Payment Act of 1999 (S.307/H.R.406) Introduced by Sens. Ron Wyden (D-OR) & Gordon Smith (R-OR), Reps. Jim Nussle (R-IA) & Darlene Hooley (D-OR)

Rep. John McHugh (R-Pierrepont Manor)

**IMPACT OF THE PRESIDENT'S MEDICARE REFORM PROPOSAL ON
HOSPITAL SYSTEMS**

**1. NO NEW TRADITIONAL FEE FOR SERVICE SAVINGS UNTIL AFTER
THE BALANCED BUDGET ACT EXPIRES IN 2003**

2. INCREASES PAYMENT FOR 2000 THROUGH 2002

**A. TAKES ADMINISTRATIVE ACTION TO RELIEVE SOME BURDENS OF
BALANCED BUDGET ACT 1997**

- Delay of hospital transfer policy
- Delay of volume control mechanism
- Slow transition to the prospective payment system for outpatient services

B. PROPOSED LEGISLATIVE ENHANCEMENTS

- Direct payments to disproportionate share hospitals beginning in 2001
- Included \$7.5 billion quality assurance fund

**3. MODERATES BALANCED BUDGET ACT 1997 SAVINGS PROVISIONS
AFTER 2003 FOR HEALTH SYSTEMS**

- No new cuts for hospital outpatient departments
- No new cuts for disproportionate share hospitals
- No new cuts for nursing homes
- No new cuts for home health providers

**4. FULL GEOGRAPHIC ADJUSTMENT FOR MANAGED CARE
PAYMENTS**

PARTICIPANTS FOR MEETING ON NEW YORK HOSPITALS

The First Lady

Senator Schumer

Senator Moynihan

Josh Isay

Senator Schumer's COS

David Podoff

Finance Committee staff

Charles Konigsberg

Finance Committee staff

Jonathan R. Scheiner

Congressman Rangel's office

Dennis Rivera

President, 1199 National Health and Human Service Employees Union, SEIU

Ken Sunshine

1199 National Health and Human Service Employees Union, SEIU

Ken Raske

President, Greater NY Hospital Association

Dr. Spencer Foreman

President, Montefiore Medical Center

Rima Cohen

Greater NY Hospital Association

Karen Heller

Greater NY Hospital Association

Jennifer Cunningham

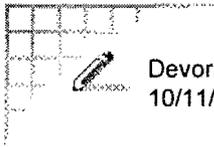
SEIU NY State Council

here's the nurses
information —

also, you are

off the hook re: your

345
3



Devorah R. Adler
10/11/99 02:29:29 PM

Record Type: Record

To: Paul D. Glastris/WHO/EOP@EOP
cc:
Subject: asthma and pediatricians / pbor

Here is our asthma stat re: school attendance

Over the past 15 years, the number of children afflicted with asthma has doubled to total about 6 million. The most rapid increase in prevalence over this time period has occurred in children under the age of 5, with rates increasing over 160 percent. Asthma is one of the leading causes of school absenteeism, resulting in over 10 million missed school days each year.

Here's why the pediatricians are pleased with PBOR:

It allows pediatricians (who are technically specialists) to be designated as primary care providers for children and when discussing review of medical decisions, it requires decisions involving the care of children to be reviewed by pediatricians.

The pediatricians also like the strong medical necessity language and the ability to write drugs off the formulary.

Please call with questions.

Devorah

[Handwritten notes in cursive script, mostly illegible due to blurriness and fading. Some words like "asthma" and "school" are faintly visible.]

THE NEW YORK STATE NURSES ASSOCIATION
October 14, 1999 Annual Business Meeting

Presiding Officer, President: Dr. Barbara Joyce, PhD, RN
President-Elect: Dr. Phyllis Collins, EdD, RN (Two-year term as President begins 10/17/99)
Executive Director: Martha L. Orr, MN, RN

WHY WE EXIST

- To advocate for nurses and patients
- Preserve nursing as an autonomous profession
- Advance standards of quality nursing care
- Promote access to quality health care as a right not a privilege

WHO WE ARE

- The professional association for registered nurses in New York State and a constituent of the American Nurses Association.
- The oldest (since 1901) and largest state nurses association (SNA) in the US with more than 33,000 members and the leading advocate for the state's 240,000 registered nurses[901
- The number one labor union for RNs in New York with 150 public and private sector health care facilities across the state

WHAT WE DO

Collective bargaining

- Address nurses employment and workplace conditions
- Advance RN participation in decision-making processes
- Obtain fair salaries, benefits and professional working conditions for nurses

Practice

- Focus on the delivery of quality nursing care
- Address the organization and delivery of nursing services
- Promote high standards of clinical practice
- Protect the public by assuring that only licensed nurses deliver nursing care

Legislation

- Seek whistleblower legislation to protect RNs from retaliation when nurses uphold the public trust and report unsafe patient care
- Expand coverage for millions of New Yorkers who are uninsured or underinsured
- Support patients' rights to informed decision making, including information on nurse staffing
- Promote workplace safety laws, including reduction of occupational hazards and violence

Education

- Promote high standards for basic and advanced nursing education
- Identify and address the cycles of nursing shortages

12-1998 TUE 04:57 PM NYSNA PGA

FAX NO. 5187829533

P. 03/04

Important Current Issues:

Inadequate RN staffing is reaching a crisis point

In an attempt to cut costs, facilities are expecting RNs to care for more and sicker patients. This has led to excessive mandatory overtime, and to "floating," which means moving nurses to units where they are not familiar with the equipment or medications. Employers are also attempting to de-skill the nurse workforce, substituting minimally trained and unlicensed personnel for RNs. These practices are a threat to patient safety.

We have used the slogans: "Ask for a Real Nurse, Ask for an RN" and "Every Patient Deserves a Registered Nurse."

Nurses need whistleblower protection

Nurses who speak up to promote quality health care need protection from employer retaliation. Without that protection, employers maintain an atmosphere of intimidation, which often prevents nurses from speaking frankly even to inspectors. We have used the slogans: "Whistleblowers Save Lives," and "Nurses Shouldn't Have to Choose Between Their Patients and Their Jobs."

RNs want a larger voice in the organization and delivery of health care

Nurses are the most numerous providers in the health care system and they have the most frequent, direct contact with patients. This gives them valuable insights, which should help shape health care policy. To accomplish this, nursing needs:

Medicaid and Medicare reimbursement directly to nurse providers

Sufficient financing to employers to recruit and retain RNs

Support for nursing education at the bachelor's and graduate levels to address the cyclical shortage of RNs.

CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
WASHINGTON, D.C. 20515

Extension of Remarks
Representative Pete Stark
Introductory Statement for the Health Care Worker Needlestick Prevention Act
May 20, 1999

Mr. Speaker, I am pleased to join with my colleagues Marge Roukema (R-NJ), George Miller (D-CA), and Rob Andrews (D-NJ) to introduce the Health Care Worker Needlestick Prevention Act, a bill to prevent dangerous, costly and preventable needlestick injuries to our nation's health care workers.

For far too long, we have stood by and watched as health care workers suffer needlestick and sharps injuries in our nation's hospitals our health care system. According to a 1997 report by the Occupational Safety & Health Administration (OSHA), approximately 800,000 hospital-based workers are injured annually from accidental needlesticks. Many of those injuries infections from bloodborne diseases, the worst of which include HIV/AIDS, and Hepatitis B & C.

OSHA estimates that approximately 16,000 needlesticks are contaminated by the HIV/AIDS. As of December 1998, the Center for Disease Control (CDC) had documented 54 cases of HIV seroconversions from needlesticks and more than 110 "possible" cases among U.S. healthcare workers. In addition, according to the International Health Care Worker Safety Center at the University of Virginia, there are an estimated 18 to 35 new occupational HIV infections of health care workers occurring from accidental needlesticks each year.

These injuries are largely preventable through use of newer technologies that use engineering devices to minimize accidental needlesticks. Hundreds of hospitals across the country have already converted to the use of these devices, but there are still thousands that haven't done so. Our legislation would make such safety devices the norm rather than the exception.

The Health Care Worker Needlestick Prevention Act is modeled after a California state law. Last year, California became the first state in the nation to require needlestick protections. The legislation was signed into law by then-Governor Pete Wilson and was endorsed by a wide coalition including the California Health Care Association (the state hospital trade association), Kaiser Permanente, health care workers, and labor unions alike.

The California Occupational Safety and Health Administration (Cal-OSHA) has estimated that each needlestick injury costs between \$2,234 and \$3,832 for treatment, testing, and prophylactic drugs. Cal-OSHA has also estimated that the California safe needles and sharps law, passed last year and effective this August, will save affected businesses and facilities over \$100 million per year in excess of the cost of the new devices. Similar bills are now pending in state legislatures across the country.

10/12/88 18.00 2020011040

While states are stepping to the plate to address this pressing concern, this is a national crisis and it deserves a national solution. The Health Care Worker Needlestick Prevention Act would amend OSHA's bloodborne pathogens standard to require the use of safe needle technology as the means for preventing needlestick injuries. It is a real-life solution that recognizes that these technologies are still not available or appropriate for use in every situation. To that end, it includes an exception process if the device would interfere with patient or worker safety, interfere with the success of a medical procedure, or if no such device is available in the marketplace. It would also require stricter reporting of needlestick injuries and creates a new clearinghouse on safer needle technology within NIOSH (National Institute for Occupational Safety and Health) to collect the data and to assist employers with training curriculum and other advice on available technologies.

We stand here today with broad-based support similar to that which made the California law possible. Our legislation is endorsed by numerous organizations including: the Service Employees International Union; the American Nurses Association; the American Federation of State, County and Municipal Employees; Kaiser Permanente; The Consumer Federation of America; Becton Dickinson, a major medical device manufacturer; and the Emergency Nurses Association, the American Public Health Association, and AIDS Action.

It is time to take the appropriate step of protecting our health care workers. They simply should not be forced to risk their lives while trying to save ours.

Mr. Speaker, I want to especially thank Congresswoman Roukema for her leadership on this issue and urge my colleagues on both sides of the aisle to join us in support this crucial effort.

Attached is a more detailed summary of the bill.

Apr-21-98 11:23am

From-U,S,REP,JOHN OLVER

2022281224

T-383 P-02/09 F-082

JOHN W OLVER

DATE RECORDED

APPROPRIATIONS

TRANSPORTATION

MILITARY CONSTRUCTION

SHIP AT LARGE

Congress of the United States House of Representatives Washington, DC 20515-2101

1027 HARRISON BUILDING OFFICE BUILDING WASHINGTON, DC 20515-7101 (202) 225-5335 (202) 225-1234 Fax

DISTRICT OFFICE 57 DUFFIELD STREET SUITE 310 FITCHBURG, MA 01501 (413) 532-3010 (413) 532-2545 Fax

CONG. FEDERAL BUILDING 38 CONNOR STREET FITCHBURG, MA 01501 (413) 442-0500 (413) 442-2792 Fax

462 MAIN STREET FITCHBURG, MA 01501 (978) 342-6722 (978) 342-8155 Fax

IMPROVE HEALTH CARE FOR AMERICA'S UNDERSERVED COSPONSOR THE MEDICAID NURSING INCENTIVE ACT

April 12, 1999

Dear Colleague:

Each year, millions of Americans go without the health care services they need simply because physicians are not available to treat them. This problem plagues urban and rural areas alike. From the streets of Los Angeles, California to the hills of North Adams, Massachusetts, Americans are unable to find physicians who are willing to establish practices in their communities.

Medicaid beneficiaries are particularly vulnerable to problems with accessing health care, since an increasing number of health professionals have chosen not to care for them or have been unwilling to locate in the inner-city or rural communities in which many beneficiaries live. Fortunately, there is an exception to this trend: nurse practitioners and clinical nurse specialists frequently accept patients whom others will not treat and serve in areas where others refuse to work. This exception was highlighted in The 1994 Physician Payment Review Commission's Report to Congress which indicated that nurse practitioners play a disproportionately greater role in caring for underserved populations than do physicians.

Congress has already recognized the valuable services of nurse practitioners and clinical nurse specialists. For more than a decade, CHAMPUS has provided direct payment to nurse practitioners. In 1990, Congress mandated direct payment for nurse practitioner services under the Federal Employee Health Benefits Plan (FEHBP). In 1997, under the Balanced Budget Act, Congress provided direct Medicare reimbursement for nurse practitioners and clinical nurse specialists in all geographic areas. The bill I am introducing will establish the same payment policy under Medicaid.

I urge you to join me in making cost-effective high quality health care available and accessible to all Americans. Please contact Kelly Bovio of my staff, at 5-5335, to cosponsor the Medicaid Nursing Incentive Act.

Sincerely,

John W. Olver Member of Congress

economic slowdown, a reduction in anticipated revenues, or an unexpected increase in mandatory spending could cause publicly held debt to exceed the new limits and create a debt crisis.

DEMOCRATIC LOCK BOX

The Democratic Lock Box creates a supermajority point of order against a budget resolution or any legislation that does not save at least 40 percent of the on-budget surplus for Medicare over the next 15 years and adds a new supermajority point of order against a budget resolution that violates the off-budget treatment of Social Security. (The budget act already contains supermajority points of order against a budget resolution or any legislation that reduces the Social Security surplus.)

The Democratic Lock Box has several advantages over the Republican approach.

(1) *It protects Social Security.* The language reserves all Social Security surpluses for Social Security, and does not allow these surpluses to be used for anything that does not increase the Solvency of the Social Security program.

(2) *It protects Medicare.* The Democratic bill reserves 40 percent of the on-budget surplus for Medicare; allows sufficient funding to extend the life of the Medicare III Trust Fund through at least 2027.

(3) *It relies on responsible enforcement mechanisms.* The Democratic approach does not establish binding limits on publicly held debt and does not create a risk of default. Enforcement is through current budget procedures and across-the-board cuts. The Lock Box also restores the current pay-as-you-go point of order, which makes certain that no on-budget surplus can be used. Without a change in law, the Republican tax cuts will result in a pay-as-you-go sequester, which will come largely from Medicare.

(4) *It reduces more debt.* The Democratic Lock Box reduces more debt than the Republican proposal, which will lower future interest costs and free up government resources to meet its existing Social Security and Medicare obligations.

COMPARISON OF DEMOCRATIC AND REPUBLICAN LOCK BOX PROPOSALS

Democratic	Republican
Reserves 77 percent of unified surplus for Social Security and Medicare.	Claims to reserve 62 percent of unified surplus for Social Security but includes "trap door" loopholes.
Prevents Social Security surpluses from being used for other purposes.	Allows Social Security surplus to be used for anything labeled "Social Security reform" including tax cuts.
Reserves 40 percent of on-budget surplus for Medicare; allows sequestration through 2027.	Reserves nothing for Medicare.
Enforcement through existing budget rules and across-the-board cuts; procedures that ensured the first budget surplus since 1969.	Enforcement through debt crisis, paring United States credit worthiness at risk and jeopardizing Social Security benefits.
Requires 60 votes to violate off-budget treatment of Social Security or to touch Medicare reserve.	Requires 60 votes to violate off-budget treatment of Social Security; reserves nothing for Medicare.
Reduces debt held by the public to \$1.6 trillion in 2009, \$300 billion below the Republicans.	Reduces debt held by the public to \$1.9 trillion in 2009.

SOCIAL SECURITY AND MEDICARE LOCK BOX ACT

The "Social Security and Medicare Lock Box Act" creates new budget points of order and budget enforcement mechanisms that would preclude any portion of the Social Security surplus or any portion of the surplus reserved for Medicare from being used for new spending or tax cuts. Over the next 15 years, the lockbox would save 77 percent of the total unified surplus. The Medicare reserve would save 15 percent of the unified surplus and 40 percent of the on-budget surplus over the next 15 years.

SECTION 1: SHORT TITLE

Titles the bill the "Social Security and Medicare Lock Box Act."

SECTION 2: DEFINITIONS

Amends section 3 of the Congressional Budget Act of 1974 by adding a definition of the term "Medicare surplus reserve." The Medicare surplus reserve refers to surplus amounts reserved to strengthen and extend the Medicare program.

SECTION 3: PROTECTION OF SOCIAL SECURITY TRUST FUNDS

Section 3 reaffirms Congress's support for the off-budget treatment of Social Security (section 13301 of the Omnibus Budget Reconciliation Act of 1990).

SECTION 4: SOCIAL SECURITY OFF-BUDGET POINT OF ORDER

Section 4 creates a supermajority point of order in the House and Senate against a budget resolution that violates the off-budget treatment of Social Security (section 13301 of the Omnibus Budget Reconciliation Act of 1990).

SECTION 5: MEDICARE SURPLUS RESERVE POINT OF ORDER

Section 5 creates a supermajority point of order in the House and Senate against a concurrent resolution on the budget (or amendment, motion, or conference report on the resolution) that would decrease the surplus in any of the fiscal years covered by the budget resolution below the level of the Medicare surplus reserve.

SECTION 6: ENFORCEMENT OF MEDICARE SURPLUS RESERVE

Section 6 creates a supermajority point of order in the House and Senate against any bill, joint resolution, amendment, motion, or conference report that would decrease the Medicare surplus reserve in any of the years covered by the budget resolution.

SECTION 7: SUPERMAJORITY POINTS OF ORDER

Section 7 makes all new points of order created in this amendment waivable only by a three-fifths supermajority vote.

SECTION 8: MEDICARE SURPLUS RESERVE

Section 8 lists the amounts reserved for Medicare in each year from 2000-2014. These amounts total \$65 billion over 2000-2004; \$76 billion over the period 2000-2009, and \$707 billion for the period 2000-2014. This section also creates a procedure that requires these amounts to be adjusted annually in the budget resolution to make certain that they are sufficient to extend the solvency of the Hospital Insurance Trust Fund through 2027. The Medicare surplus reserve, however, cannot exceed the total on-budget surplus in any year so as not to deplete the Social Security surplus.

SECTION 9: PAY-AS-YOU-GO AND DISCRETIONARY CAP EXTENSION

Section 9 extends current budgetary discipline embodied in the discretionary spending caps, the paygo rule in the Senate, and the paygo sequestration provisions of the Budget Enforcement Act until Congress enacts legislation certifying that it has ensured the long-term fiscal solvency of Social Security and the solvency of Medicare through fiscal year 2027.

SECTION 10: ADJUSTMENT OF BUDGET LEVELS AND REFERRAL

Section 10 directs the Chairmen of the Budget Committees to revise the budget resolution to make it consistent with this Act and repeals the provision of the budget resolution that weakened the paygo rule in the Senate by allowing the on-budget surplus to be used for tax cuts.

By Mr. DASCHLE (for himself, Mrs. BOXER, and Mr. DORGAN):

S. 863. A bill to amend title XIX of the Social Security Act to provide for Medicaid coverage of all certified nurse practitioners and clinical nurse specialists to the Committee on Finance.

MEDICAID NURSING INCENTIVE ACT

Mr. DASCHLE. Mr. President, today I am introducing the Medicaid Nursing Incentive Act, a bill to provide direct Medicaid reimbursement for nurse practitioners and clinical nurse specialists.

This legislation eliminates a counterproductive Medicaid payment policy. Under current law, State Medicaid programs may exclude certified nurse practitioners and clinical nurse specialists from Medicaid reimbursement, even though these practitioners are fully trained to provide many of the same services as those provided by primary care physicians. This policy is both discriminatory and shortsighted; it severs a critical access link for Medicaid beneficiaries.

The ultimate goal of this proposal is to enhance the availability of cost-effective primary care to our nation's most vulnerable citizens.

Studies have documented the fact that millions of Americans each year go without the health care services they need, because physicians simply are not available to care for them. This problem plagues rural and urban areas alike, in parts of the country as diverse as south central Los Angeles and Lemmon, South Dakota.

Medicaid beneficiaries are particularly vulnerable, since in recent years an increasing number of health professionals have chosen not to care for them or have been unwilling to locate in the inner-city and rural communities where many beneficiaries live. Fortunately, there is an exception to the trend: nurse practitioners and clinical nurse specialists frequently accept patients whom others will not treat and serve in areas where others refuse to work.

Studies have shown that nurse practitioners and clinical nurse specialists provide quality, cost-effective care. Their advanced clinical training enables them to assume responsibility for up to 80 percent of the primary care services usually performed by physicians, often at a lower cost and with a high level of patient satisfaction.

Congress has already recognized the expanding contributions of nurse practitioners and clinical nurse specialists. For more than a decade, CHAMPUS has provided direct payment to nurse practitioners. In 1990, Congress mandated direct payment for nurse practitioner services under the Federal Employee Health Benefits Plan. The Medicare program, which already covered nurse practitioners and clinical nurse specialist services in rural areas, was modified under the Balanced Budget Act of 1997 to provide coverage for these services in all geographic areas. The bill I am introducing today establishes the same payment policy under Medicaid.

April 22, 1999

CONGRESSIONAL RECORD—SENATE

S4115

Mr. President, the ramifications of this issue extend beyond the Medicaid program and its beneficiaries. There is a broader lesson here that applies to our effort to make cost-effective, high-quality health care services available and accessible to all Americans.

One of the cornerstones of this kind of care is the expansion of primary and preventive care, delivered to individuals in convenient, familiar places where they live, work, and go to school. More than 2 million of our nation's nurses currently provide care in these sites—in home health agencies, nursing homes, ambulatory care clinics, and schools. In places like South Dakota, nurses are often the only health care professionals available in the small towns and rural counties across the state.

These nurses and other nonphysician health professionals play an important role in the delivery of care. And this role will only increase as we move from a system that focuses on the costly treatment of illness to one that emphasizes primary preventive care and health promotion.

But, first, we must reevaluate outdated attitudes and break down barriers that prevent nurses from using the full range of their training and skills in caring for patients. In 1994, the Pew Health Professions Commission concluded that nurse practitioners are not being fully utilized to deliver primary care services. The commission recommended eliminating fiscal discrimination by paying nurse practitioners directly for the services they provide. This step will help nurse practitioners and clinical nurse specialists expand access to the primary care that so many communities currently lack.

As I have worked on access and reimbursement issues related to nurse practitioners and clinical nurse specialists, I have encountered two related issues I would also like to highlight.

Later this month, I plan to introduce legislation to increase the reimbursement rate for nurse practitioners and clinical nurse specialists who practice in rural and underserved areas. Currently, physicians who serve in a health professional shortage area receive a 10 percent boost in their Medicare payment as an incentive to provide services in the regions that need them the most. As we know, nurses are already providing critical primary and preventive care in these areas and deserve the bonus payments that physicians are already receiving.

I would also encourage my colleagues to closely monitor the impact of Medicaid managed care on access to care provided by nurse practitioners and clinical nurse specialists. In some areas of the country, implementation of managed care has prevented patients from continuing to receive health care services from nurse practitioners and clinical nurse specialists because they are not listed as primary care providers or preferred providers. Advanced practice nurses provide cost-effective,

local, quality care, and I am concerned about early reports that access to these professionals is being limited by new health delivery arrangements. We should certainly keep an eye on this issue as Medicaid managed care systems develop.

Mr. President, I hope my colleagues will carefully consider the issues I have raised and support the measure I am introducing today, recognizing the critical role nurse practitioners and other nonphysician health professionals play in our health care delivery system, as well as the increasingly significant contribution they can make in the future. I ask unanimous consent that the full text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 853

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Medicaid Nursing Incentive Act of 1999".

SEC. 2. MEDICAID COVERAGE OF ALL CERTIFIED NURSE PRACTITIONER AND CLINICAL NURSE SPECIALIST SERVICES.

(a) IN GENERAL.—Section 1905(a)(21) of the Social Security Act (42 U.S.C. 1396d(a)(21)) is amended to read as follows:

"(21) services furnished by a certified nurse practitioner (as defined by the Secretary) or clinical nurse specialist (as defined in subsection (v)) which the certified nurse practitioner or clinical nurse specialist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not the certified nurse practitioner or clinical nurse specialist is under the supervision of, or associated with, a physician or other health care provider;"

(b) CLINICAL NURSE SPECIALIST DEFINED.—Section 1905 of such Act (42 U.S.C. 1396d) is amended by adding at the end the following:

"(v) The term 'clinical nurse specialist' means an individual who—

"(1) is a registered nurse and is licensed to practice nursing in the State in which the clinical nurse specialist services are performed; and

"(2) holds a master's degree in a defined area of clinical nursing from an accredited educational institution."

(c) EFFECTIVE DATE.—The amendments made by this section shall become effective with respect to payments for calendar quarters beginning on or after January 1, 2000.

By Mr. BINGAMAN (for himself and Mr. CHAFEE):

S. 854. A bill to designate April 22 as Earth Day; to the Committee on the Judiciary.

EARTH DAY ACT

Mr. BINGAMAN. Mr. President, this bill that I have sent to the desk is being introduced on behalf of myself and Senator CHAFEE. It is entitled "The Earth Day Act." Its purpose is to designate April 22 as Earth Day.

Today, of course, is April 22. Let me provide a little history for my colleagues or anyone listening.

The first Earth Day was 29 years ago, in 1970, and I think we are all aware that Earth Day was first conceived by

our former colleague, Senator Gaylord Nelson, who is universally considered the founder of Earth Day.

He has written a short summary of what brought Earth Day about, how it came about. In it he points out that in a speech that he gave in Seattle in September of 1969, he announced that there would be a national environmental teach-in in the spring of 1970. And the wire services picked up that story. And the next thing he knew, there was a movement afoot to actually have that happen.

That first Earth Day involved some 20 million Americans. Since then, the concept and the idea of Earth Day has focused the attention of the country, focused the attention of the world, in fact, on the importance of our environment and the importance of preserving and maintaining our environment. We have a great debt of gratitude we owe to former Senator Nelson for his leadership on this.

We also owe a great debt of gratitude to the person that did the nuts and bolts work of organizing that first Earth Day, and that, of course is Denis Hayes. He is now president of the Seattle-based Bullitt Foundation, but he has been recognized recently by Time magazine as one of their heroes of the planet. I think his instrumental role, his essential role in bringing about that first Earth Day, making such a success of it, has been recognized by all.

He is now, of course, trying to get in place the organization to make Earth Day 2000, which will occur exactly a year from today, an even greater celebration than we have known before.

Mr. President, I firmly believe that it is appropriate that we officially designate April 22 as Earth Day and that we permanently designate it as Earth Day. It has come to be known as Earth Day—April 22—for all of us. There are celebrations and teach-ins, and recognitions going on throughout our country today. As we hear the news about Kosovo, which is bad, and the news about Littleton, Colorado, and the terrible tragedy there, which is bad, and many of the other news stories that bombard us, it is good to know that there is one news story that we can all celebrate and rally around, and that is that today, again, we will be able to celebrate Earth Day.

Mr. President, it is my sincere hope that Senator CHAFEE and I can work in the next year to gain additional cosponsors and to obtain enactment of this, so that by the time Earth Day 2000 arrives, we will be able to have this in law, have it signed by the President. I am sure it will be supported by all of our colleagues. I think we all recognize the importance of this to many of the people we represent. I hope very much that the bill can be enacted.

By Mr. BIDEN:

S. 855. A bill to amend the Internal Revenue Code of 1986 to provide the same tax treatment for danger pay allowance as for combat pay; to the Committee on Finance.

NEEDLESTICK TALKING POINTS

- California is the first state to pass legislation that will require the use of safer needlestick devices and needless systems in public and private health care facilities. Hospitals and health care employers in California are expected to save over \$100 million per year after implementing the California Occupational Safety and Health.
- Health care workers (HCWs) suffer between 600,000 and one million injuries from conventional needles and sharps annually. These exposures can lead to hepatitis B, hepatitis C and Human Immunodeficiency Virus (HIV)—the virus that causes AIDS.
- At least 1,000 HCWs are estimated to contract serious infections annually from needlestick and sharps injuries.
- Registered nurses working at the bedside sustain an overwhelming majority of these exposures.
- Needlestick injuries are preventable. Over 80% of needlestick injuries could be prevented with the use of safer needle devices.
- Less than 15% of U.S. hospitals use safer needle devices and systems.
- In 1992, the Food and Drug Administration issued an alert to all health care facilities to utilize needleless IV systems wherever possible. This alert is merely a recommendation, not a mandate. Therefore, health care facilities are under no legal obligation to comply.
- The first safe needle designs were patented in the 1970s, and the FDA has approved over 250 devices for marketing as safety devices.
- More than 20 other infections can be transmitted through needlesticks, including: tuberculosis, syphilis, malaria and herpes.

California Staffing Law

- The state of California is the first state to pass legislation addressing nurse-staffing levels. California Assembly bill 394 signed into law by Governor Gray Davis on Oct. 10, 1999 requires all patient care units in hospitals to meet fixed minimum nurse-to-patient ratios.
- This legislation also requires adequate orientation for nurses who float to other hospital units.

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FOR IMMEDIATE RELEASE
October 13, 1999

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Registered Nurses: Experts on the Front Lines
Keeping the "Care" in Health Care

NEWS RELEASE

CALIFORNIA'S NEW NURSE STAFFING MANDATE HIGHLIGHTS CRISIS IN NURSE STAFFING NATIONALLY

Washington, D.C. – California became the first state to require all patient care units in hospitals to meet fixed minimum nurse-to-patient ratios when Governor Gray Davis signed legislation (AB 394) October 10. "This is a signal that nurses' and health care consumers' concerns over nurse staffing have reached critical mass," says Beverly L. Malone, PhD, RN, FAAN, President of the American Nurses Association (ANA). ANA/California (ANA/C), a constituent member of the ANA federation of state nurses associations, supported the measure.

Caregivers' and consumers' concerns have risen dramatically as many institutions have decreased the numbers of registered nurses (RNs) caring for an increasingly acutely ill patient population, cutting corners by substituting unlicensed assistive personnel for RNs. "Too often, managed care has meant managed cost," says Malone. "If the health care industry continues to dig in its heels and fight for false economies on the backs of patients and RNs, we can expect to see more and more bills on the floors of state legislatures calling for mandated minimum nurse-to-patient ratios."

Malone points out that a number of studies have proven the link between adequate nurse staffing and positive patient outcomes. "Presently, the system works to keep patients out of the hospital as long as possible, and to discharge them as soon as possible. Patients are sicker, and care is more complex. Cutting the numbers of RNs, substituting unlicensed aides for registered nurses, and preventing RNs from speaking out about patient care concerns are exactly the wrong moves," says Malone.

MORE...



NURSE STAFFING MANDATE/2...

In its 1999 *Principles of Nurse Staffing*, the ANA calls for staffing decisions to be made on the basis of three sets of principles: those related to patient care, staff-related issues, and institution/organization concerns. Among the *Principles* are that appropriate staffing levels for a patient care unit should reflect analysis of individual and aggregate patient needs. The document further states, "The specific needs of various patient populations should determine the appropriate clinical competencies required of the nurse practicing in that area."

"What the *Principles* boil down to," says Malone, "is what should be the obvious — staffing decisions should be based on real patient conditions and real provider competencies, not on a cookie-cutter approach that treats both patients and their nurses as widgets on an assembly line."

Citing concerns related to mandated nurse-to-patient ratios, Malone noted, "While we're glad that passage of the California nurse staffing mandate has once again focused public attention on RN understaffing, we're also concerned that mandated minimum ratios not also become staffing ceilings."

"It gets more complicated than that," says Malone. "If an institution simply states that it has met a mandate because it has 'X' number of RNs per patient in a unit, that fails to completely address other significant concerns. Some of these nurses may be 'floaters,' who may be newly graduated nurses who need to become acquainted with the protocols of the unit to which they're assigned." AB 394 does require orientation of nurses "floating" to a unit and of temporary nursing personnel.

"Other nurses, compelled to work mandatory overtime, may be concerned about the quality of care they can deliver after working several days' worth of 12-hour shifts in a row," says Malone. "Understaffing takes a toll not only on patients, but on the health of nurses, who risk injuries ranging from infection by bloodborne pathogens due to needlestick and sharps injuries, to back injuries."

"There is an emerging nursing shortage," says Malone, "and chronic understaffing is not helping to alleviate it. Nurses may elect to leave the acute care setting, and young people are not entering nursing in the numbers needed to meet the growing demand. We must remember that nurses enter their profession in the first place to provide safe, quality, compassionate care. Understaffing impedes their ability to do this. Hospitals also need to care for those who care. No nurse should have to face preventable risks of injury and death in the course of patient care. Also, with a shortage exacerbating patient care issues, it only highlights the importance of matching the appropriate providers to meet the needs of increasingly ill patients." Malone notes that ANA/C is one of the founding members of the California Nursing Workforce Initiative, a committee that is looking at this critical component of adequate and appropriate staffing.

"The idea that 'a nurse is a nurse is a nurse' — that one can just count nurse bodies and patient bodies and state the ratio between them — just doesn't hold," says Malone, "any more than the notion that patients are interchangeable in their specific needs. Clinical knowledge, knowledge of the unit, and getting enough down-time between shifts also influence the quality of care."

MORE...

NURSE STAFFING MANDATE/3...

"Finally," says Malone, "nurses need to be protected from retaliation from their employers when they advocate for their patients -- more so than ever in a health care environment rendered unnecessarily risky both to patients and their caregivers by chronic RN understaffing." Such whistleblower protections are included in the "Bipartisan Consensus Managed Care Improvement Act" (HR 2723) passed by the U.S. House of Representatives October 7.

The "Patient Safety Act" (HR 1288), introduced March 25, also includes whistleblower protections for nurses, as does the companion Senate bill (S 966) introduced May 5. Both HR 1288 and S 966 would require health care institutions to make public specific information on staffing levels, staffing mix, and patient outcomes. At a minimum, they would have to make public the number of registered nurses providing direct care; numbers of unlicensed personnel utilized to provide direct patient care; average number of patients per registered nurse providing direct patient care; patient mortality rate; incidence of adverse patient care incidents; and methods used for determining and adjusting staffing levels and patient care needs.

"John and Jane Doe can find out more about the quality of a car or a toaster they're thinking about purchasing than about the quality of hospital care they, their parents, or their children might expect to receive," says Malone. "Some things just don't make sense no matter how you look at them, and this inability to find out about the quality of our health care is one of them."

AB 394 went through several major changes before it reached its final form, most notably that the original numeric ratios were removed from the legislation, leaving in place a requirement that the California Department of Health Services promulgate regulations by January 1, 2001. In signing the bill, Davis and Kuehl reached an agreement to delay the implementation schedule one year, to January 1, 2002. This compromise was struck to ensure the Governor's signature -- hospitals stated a concern about the time constraints imposed to set the ratios.

-- AB 394 bill text (and amendments) are available at: www.leginfo.ca.gov.

-- The Governor's statement to the legislature on the bill is at:
www.ca.gov/s/governor/ab394sign.html.

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American Nurses Association is the only full-service professional organization representing the nation's 2.6 million Registered Nurses through its 53 constituent associations. ANA advances the nursing profession by fostering high standards of nursing practice, promoting the economic and general welfare of nurses in the workplace, projecting a positive and realistic view of nursing, and by lobbying the Congress and regulatory agencies on health care issues affecting nurses and the public.

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MEMORANDUM OF SUPPORT

A2623

**By Assemblyman Gottfried
Passed Assembly**

S3234

**By Senator DeFrancisco
Senate Health Committee**

AN ACT to amend the public health law and the education law, in relation to disclosure of nursing quality indicators, and prohibiting certain use of the title "nurse"

The New York State Nurses Association, whose members include 32,000 registered professional nurses and whose lobbying efforts represent the needs of the more than 220,000 registered nurses in the state and the patients they serve, supports the above-referenced bill. This legislation is part of NYSNA's priority legislative agenda during this period of health care restructuring and transition.

The bill is designed to accomplish three related goals: disclose to consumers information related to hospital and nursing home staffing, disclose rates of nursing quality indicators and prohibit use of the title "nurse" by anyone not licensed under Article 139 of the Education Law (the Nurse Practice Act.)

Disclosure of staffing ratios is needed to afford consumers additional data needed to make informed decisions related to choice of hospitals and nursing homes. In many instances, health insurers do not provide choice of hospitals in a community. Knowledge of staffing ratios will assist consumers in "moving the market" based on many factors, including sensitivity to nursing staffing patterns. Information is currently maintained that details the ratio of registered professional nurses, licensed practical nurses, and unlicensed assistive personnel within the direct care staffing mix. Additionally the disclosure compares this data to the level of patient acuity (a determinant of the intensity of nursing care required.)

Disclosure of nursing quality indicators is needed to more accurately analyze the quality of care delivered in the state's hospitals. For too long, quality determinations have been based solely on a medical model of success, one that uses such measurements as mortality rates and length of stay following surgical interventions. Disclosure of nursing quality indicators, including but not limited to rates of infection occurring in the facility, incidents of patient falls and bedsores, and medication errors provides additional information about the quality of care delivered. Disclosure of nursing quality indicators will enhance knowledge of quality by providing additional information, reflecting a nursing model of quality care. Additionally, nursing quality indicators have a direct relationship to the quality of direct care staffing and can be used by consumers to complement the information derived from staffing ratios.

(more)

NYSNA

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Prohibition on the use of the title "nurse" is needed to assist patients in understanding who is delivering their care. Current law prohibits use of the titles "Registered Professional Nurse" and "Licensed Practical Nurse" except by persons licensed under the Nurse Practice Act. There is no such limit on the title "nurse." Unlicensed staff members have been given titles such as Nurse Technician and been given name badges that only identify the individual as part of the Nursing Department. This pattern is prevalent in all health care settings, from the person that advertises their services as "baby nurse" to assist parents with newborn care to the medical office receptionist who is called "doctor's nurse." These practices have led to the mistaken assumption by patients that unlicensed persons are actually licensed providers of nursing care.

This legislation is needed to restore the public's confidence in health care services. Recent national public opinion surveys have indicated an increasing concern for quality health care. The American Hospital Association commissioned a poll on Public Perceptions of Health Care and Hospitals. Among the ten fundamental opinions reported by the surveyors was a finding that "the key indicator that people referred to as a measure of the quality of their hospital care was the nurse. They hold a strong belief that skilled nurses are being systematically replaced by poorly trained and poorly paid aides." In a survey commissioned by the American Nurses Association, of the seven cost-cutting practices explored, the two top concerns of the public related to changes in nursing staffs. Americans fear that reducing the number of registered nurses will negatively affect the quality of patient care. They also worry that the use of unlicensed health care workers to replace RNs will diminish quality. The *American Journal of Nursing* surveyed registered nurses with results that warn RNs are feeling the pressures of nursing staff cutbacks in hospitals and increased use of unlicensed assistive personnel. Almost 90% of the nurses polled expressed serious concerns that those same cost-saving practices are diminishing the safety and quality of patient care.

The legislation is sought by both the nursing community and consumer groups. Similar legislation has been introduced by Congressman Hinchey at the request of the American Nurses Association. NYSNA believes that New York State must enact this bill to provide protections and information to New Yorkers using state mechanisms to provide incentives for compliance. We strongly urge passage of these important efforts.

2/18/99, 2/23/99, 3/99

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BILL NUMBER: A2623

PURPOSE OR GENERAL IDEA OF BILL: To provide the

public with information regarding nursing staffing levels, and to legally forbid those who are not registered (RNs) or licensed practical nurses (LPNs) from portraying themselves to the public as "nurses."

SUMMARY OF SPECIFIC PROVISIONS: Requires hospitals to disclose nursing quality indicators:

- * The numbers of RNs and LPNs providing direct care and the ratio of patients per RNs (full-time equivalent) providing direct care.
- * The number of unlicensed personnel utilized to provide direct patient care.
- * The incidence of adverse patient care incidents including, medication errors, and patient injuries.
- * The methods the hospital uses for determining and adjusting staffing levels.
- * Data regarding complaints filed with state or federal regulatory agencies or accrediting agencies, and regarding investigations as a result of those complaints.

Amends section 6903 of the Education Law to forbid anyone who is not an RN or LPN (or otherwise authorized by the Education Law to practice nursing) from using the title "nurse" or any other title or abbreviation that would represent to the public that the person is authorized to practice nursing.

JUSTIFICATION: As a result of pressure to cut costs,

many hospitals are decreasing the numbers of registered and licensed practical nurses on staff and replacing them with unlicensed personnel. In addition to compromising patient care, this situation also confuses patients, who cannot be sure if the "nurse" attending to them is an RN or LPN, or an unlicensed attendant. This bill will help combat these problems by requiring hospitals to disclose information on the numbers of RNs, LPNs and unlicensed staff utilized to provide direct patient care.

The Education Law currently prohibits unlicensed people from using the term "registered nurse" or "licensed practical nurse." But there is no bar to an unlicensed person using the title "nurse." This bill would limit use of the title "nurse" to persons legally authorized to practice nursing under the Nurse Practice Act.

PRIOR LEGISLATIVE HISTORY:

1997 and 1998: A.3607.passed Assembly

FISCAL IMPLICATIONS: None

EFFECTIVE DATE: 180 days after becoming law.

MEMORANDUM IN SUPPORT

A3089
By Assemblywoman Nolan
Assembly Codes Committee

S1453
by Senator Spano
Senate Labor Committee
ON AGENDA, 3/9/99

AN ACT to amend the labor law and the public health law, in relation to prohibiting retaliatory personnel actions by certain employers against employees who provide certain information to a governmental agency or department

The New York State Nurses Association, representing 32,000 registered professional nurses, strongly supports the above-referenced legislation. Enactment of A3089/S1453 is urgently needed to ensure the public that there is no gag on the health care workers upon whom they depend. Professional practice demands that registered nurses and other health care professionals advocate for the needs of their patients. Standards defining unprofessional conduct specifically refer to failure to file reports required by law. In fact, health professionals are individually licensed by the state, rather than institutionally licensed, to ensure that the professional upholds the ethics and standards of the profession, in spite of the pressures in health care settings placed upon them by their employers.

This bill, part of NYSNA's legislative agenda, was first introduced in the Assembly following a hearing sponsored jointly by the Labor, Health, Higher Education and Social Services Committees on the Understaffing of Professional Nurse Positions in Health Care. During that hearing, nurses from throughout the state testified on the staffing crises they face daily. Many acknowledged that they testified in spite of their belief that their employers could and might retaliate against them for speaking up. In fact, one nurse who registered to testify failed to appear after an article in her local newspaper identified her as a spokesperson on the staffing crisis in her area. The nurse sent her apologies to the legislators, stating that she had already begun to feel abused by management due to her planned participation in the hearing.

Registered nurses fight battles for patients every day. Sometimes they are unable to change management practices by working within the system. Sometimes they are compelled to notify state regulators of failures to meet state standards of safe practice. Such issues include inappropriate use of unlicensed personnel, failure to follow occupational safety standards and inappropriate staffing decisions that require overtime at the point of exhaustion or floating to another assignment without sufficient preparation.

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The bill appropriately amends both the labor law and the public health law to ensure that no health employer can legally restrict any health care provider from advocating for their patients. The public health law amendment is modeled after the statute banning managed care gag orders. The New York State Nurses Association believes that patients in hospitals and other health care settings deserve no less protection than the enrollees in a managed care plan.

NYSNA endorses the passage of A3089/S1453 which ensures that health care providers in this state will not be gagged when they should be advocating for their patients.

2/4/99, 2/19/99, 2/23/99, 3/5/99

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BILL NUMBER: S1453

PURPOSE: To provide that an employer can not discharge, penalize, or in any other manner discriminate against an employee for commenting to the public subsequent to filing a complaint, making report or commenting to the appropriate governmental agency or department regarding the policies or practices of a health care facility which may negatively impact upon the quality of or access to patient care.

SUMMARY OF PROVISIONS: Section 1 amends section 215 of the Labor Law

to provide that no employer or his agent or the officer or agent of any corporation, shall discharge, penalize, or in any other manner discriminate against any employee because such employee has made a complaint or report to his or her employer, or to the commissioner or his or her authorized representative, or to the appropriate governmental agency or department, that the employer has violated any provision of this chapter, or because such employee has caused to be instituted a proceeding under or related to this chapter, or because such employee has testified or is about to testify in a investigation or proceeding under this chapter.

If after investigation the commissioner finds that an employer has violated any provision of subsection 1 or subsection 1(a), the commissioner may, by an order which shall describe particularly the nature of the violation, assess the employer a civil penalty of not less than two hundred nor more than two thousand dollars. Notwithstanding the provisions of section two hundred thirteen of this chapter, the penalties set forth in this section shall be the exclusive remedies available for violations of this section.

Section 2 amends Section 215 of the Labor Law by adding a new subdivision 1-a to provide no facility licensed pursuant to article twenty-eight or thirty-six of the public health law, shall by contract, policy or procedure prohibit or restrict any health care provider from filing a complaint, making a report or commenting to the appropriate governmental agency or department regarding the policies or practices of such facility which may negatively impact upon the quality of or access to patient care. In addition, no facility licensed pursuant to article twenty-eight or thirty-six of the public health law, shall by contract, policy or procedure prohibit or restrict any health care provider from commenting to the public subsequent to filing a complaint, making a report or commenting to the appropriate governmental agency or department regarding the policies or practices of such facility which may negatively impact upon the quality of or access to patient care.

Section 3 adds a new section, 280i-e, to the Public Health Law to provide that no facility licensed pursuant to article twenty-eight or thirty-six, of this chapter, shall by contract, policy or procedure prohibit or restrict any health care provider from filing a complaint, making a report or commenting to the appropriate governmental agency or department regarding the policies or practices of such facility which may negatively impact upon the quality of or access to patient care. In addition, no facility licensed pursuant to article twenty-eight or thirty-six of this chapter, shall by contract, policy or procedure prohibit or restrict any health care provider from commenting to the public subsequent to filing a complaint, making a

report or commenting to the appropriate governmental agency or department regarding the policies or practices of such facility which may negatively impact upon the quality of or access to patient care.

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EXISTING LAW: No protection exists for those individuals providing information concerning violations of the law occurring in health care facilities which are divulged to the public

JUSTIFICATION: The public should be protected by disclosures of dangerous health care practices. This bill would encourage open discussion of these revelations without the reporting individual being penalized by losing their jobs. At hearings and roundtables, individuals have repeatedly noted that they feared for their jobs and that the public suffered for the lack of disclosure.

LEGISLATIVE HISTORY: S. 1394-A of 1998

FISCAL IMPLICATIONS: None.

LOCAL FISCAL IMPLICATIONS: None.

EFFECTIVE DATE: This act shall take effect immediately.

Family Health Plus/Comparison of Proposals

Feature	New York State Health Care Campaign's Version	New York State Assembly's Version	Senator Bruno NO PROPOSAL	Governor Pataki NO PROPOSAL
Eligibility	Covers all adults in families that earn up to 250% of the poverty level (\$41,750 for a family of 4), like Child Health Plus.	Covers adults with minor children with household incomes up to 200% of poverty (\$33,400 for a family of four) – but only covers other adults with household incomes up to 120% of poverty (\$9,888 for a single person household).	?	?
Resource Test and Documentation	None, as there are none for Child Health Plus or expanded Medicaid eligibility for pregnant women.	Ineligible if cash assets (including retirement or children's college savings) equal to more than half of the household's income.	?	?
Benefits	Comprehensive, including vision and dental.	Comprehensive, except excludes vision and dental coverage.	?	?
Premiums	<p>No cost for adults with household incomes below 160% of poverty (\$26,720 for a family of four).</p> <p>Those with household incomes between 160% and 222% of poverty (\$26,720-\$37,074 for a family of four) pay \$9 per person, per month.</p> <p>Those with household incomes between 222% and 250% (\$37,074-\$41,750) pay \$15 per person, per month.</p> <p>No copayments.</p>	<p>No cost for adults with household incomes below 160% of poverty (\$26,720 for a family of four).</p> <p>Those with household incomes between 160% and 200% of poverty (\$26,720-\$33,400 for a family of four) pay \$9 per person, per month.</p> <p>No copayments.</p>	?	?

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Family Health Plus/Comparison of Proposals

Direct Pay Reform	Direct pay pool to make premiums affordable.	\$120 million subsidy pool to reduce direct pay premiums by 10%.	?	?
Application Process	A single, streamlined application process to determine eligibility for any of the state's insurance programs.	Department of Health must develop a single application for Medicaid managed care, Child Health Plus and Family Health Plus that is "easy to understand and complete"	?	?
Financing	50% federal Medicaid matching funds for all eligible adults and 90% of the state share of the tobacco settlement, plus general funds as needed.	50% federal Medicaid matching funds for all eligible adults and 90% of the state share of the tobacco settlement.	?	?
Other Key Provisions		Subsidizes COBRA coverage for workers who lose their jobs. Increases expanded Medicaid eligibility for pregnant women to 250% of the poverty level.	?	?

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Family Health Plus

What is Family Health Plus?

Family Health Plus is a proposal to make affordable health coverage available to lower and moderate income working New York adults who earn too much to qualify for Medicaid, but have no access to affordable coverage through their employer.

It is modeled after the successful Child Health Plus program, which offers comprehensive, affordable health insurance to children and teenagers.

Like Child Health Plus, families who earn up to 250 percent of the poverty level would be eligible (\$34,000 for a family of three), with premiums based on income and family size.

While adults would be required to make reasonable contributions to their health care, total out of pocket expenses for Family Health Plus, including premiums, would be modest and affordable to encourage broad participation in the program.

Family Health Plus would make coverage available to all lower-income working New Yorkers, including legal immigrants, giving working families the health security they expect and deserve.

Family Health Plus would also help adults who can afford to purchase private health insurance if it is reasonably priced, by establishing a pool that would lower premiums in the individual insurance market significantly.

Why Does New York Need Family Health Plus?

Despite a robust economy and record-low unemployment, over 3.1 million New Yorkers – nearly one in five residents under age 65 – do not have health insurance. The number of uninsured in New York is higher and growing faster than in the rest of the nation.

Thanks to recent expansions of Child Health Plus and Medicaid, the vast majority of New York's uninsured children will soon be eligible for coverage.

However, most parents of these children, along with many single, working adults and couples with no children at home, have no access to affordable health insurance. In most cases, parents in three-person families have to earn less than \$10,300 a year to qualify for Medicaid – and single, childless adults less than \$4,300 a year.

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**How Will
Family Health
Plus be
Financed?**

Funding is available for Family Health Plus. A provision of the federal welfare "reform" law allows states to expand health coverage to working families, and the federal government will pay for half of the cost for many enrollees. Likewise, New York State will receive \$1 billion annually for the next 25 years as a result of the settlement with tobacco companies over smoking-related health costs states have incurred over the years.

Allocating these revenues to Family Health Plus would make a significant down-payment on establishing affordable health coverage for all New Yorkers.

**What About
Coordination
with Other
Programs and
Outreach?**

Family Health Plus would be coordinated with existing health insurance programs like Child Health Plus and Medicaid. Families would go through a simple, streamlined application process to determine eligibility for all of the state's insurance programs, so that it is easy to enroll and easy to move from one program to another as eligibility changes because of changes in age, income or family size.

As is the case for children and teenagers applying for Child Health Plus, and pregnant women applying for expanded Medicaid coverage, there would be no resource test or accompanying documentation requirements for parents and other adults applying for Medicaid or Family Health Plus. Those with modest savings for retirement or a child's education should not be forced to spend those resources in order to qualify for needed health coverage.

The Family Health Plus proposal includes a series of initiatives designed to educate families and individuals about the insurance options available to them and to eliminate difficulties in applying for health coverage. These initiatives, which mirror those currently being implemented for Child Health Plus and Medicaid-eligible children, include community-based public education, outreach and enrollment assistance, and a streamlined enrollment and recertification process.

Conclusion?

There are more than 3 million reasons why New York needs Family Health Plus.

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RNs At Work: Here Are the Facts

Registered nurses in New York State are struggling to provide quality care to their patients in the face of insufficient staffing resources, increased patient acuity, and facility management that is often unresponsive to their concerns about patient care.

Those are some of the findings of the "RNs at Work" survey conducted by NYSNA and analyzed by nurse attorney and health policy consultant David Karpow. The survey was designed to get a picture of what RNs face in the course of their working day by taking a "snapshot" of staffing levels, patient census, and other workplace conditions on one weekday (March 24) and one weekend day (March 27). Over 900 RNs responded to the survey.

"From both the statistics and the comments nurses wrote at the end of the survey form, it is clear that nurses are working extremely hard in difficult situations to care for sicker and sicker patients," said Karen Ballard, director of NYSNA's Practice and Governmental Affairs Program. "Even with their best efforts, many nurses report that they are not able to meet their own standards. For example, 46% of the nurses responding said they could not provide the level of nursing care that their patients needed."

Too Many Very Sick Patients

The survey revealed that average patient loads were high. Hospital medical-surgical nurses reported an average patient load of 9.4; critical care nurses an average patient load of 3.14. Twenty-two percent of hospital nurses were responsible for 10 or more patients on their shift.

"We are in a (critical care unit) which relies only on census, not on acuity," one nurse wrote. "It is not uncommon for an RN to have 11 patients. We come in early, get no breaks (and) leave late. I don't bathe patients any more. There is no time!"

"As a new grad, I don't think I should be responsible for 12-14 patients a night with only three RNs on the floor, when there should be four. I feel scared about my license because I don't have enough experience in case of an emergency."

Not surprisingly, 31% of hospital nurses and 48% of all nurses reported

that the census on their unit has increased in the past two years. A full 79% of hospital nurses and 76% of nurses overall report that acuity has gone up during that same time.

"The continuing rise in patient acuity, which we have seen since the 1990s, underscores the need to take acuity into account when staffing units," said Carolyn McCullough, director of NYSNA's collective bargaining program. "Failing to do so puts patients at risk. That's why we are increasing our efforts to win labor agreements that contain strict staffing guidelines based on census and patient acuity levels."

How Good Is The Care?

When asked their opinion of the care they were able to give, over 25% reported that they were not able to complete all of the patient care tasks required by their patients. Over a third said that they were not able to

provide comfort and support to patients and their families. Over 40% were unable to provide needed education and teaching to patients and their families. Even more disturbing, 45% said that they did not have time to provide a thorough assessment of their patients—a critical finding. "Patient assessment is absolutely essential to determining patient safety and planning for patient care needs," Ballard said. "Any patient who is not being properly assessed is being denied appropriate nursing care and put at risk for an untoward event."

Medication Administration Comes First

The area of patient care about which nurses gave the most positive response was in administering medication. Eighty nine percent said they were able to ensure that all medications were given safely. "This response sup-

ports what we learned during the last nursing shortage, which is that administering medication is a nurse's top priority," Ballard said. "When staffing is inadequate, other tasks like dressings, treatments, and patient education may be slighted, but that drop in quality of care will not necessarily be reflected in an increased number of adverse medication events."

Asked to rate the level of care that staffing allowed them to deliver on the day of the survey, 44% felt that they were able to provide high-quality care. But a larger number — 48% — rated the care as "minimally safe," and 4% felt that the care was not even up to that basic level.

"I have never gone off duty feeling satisfied that I have done my best for my patients. I go home feeling happy to leave the stressful environment but...unfulfilled as a nurse."

Lots of Overtime

Given the pressure on staffing, it's not surprising that nurses are working a lot of overtime. On the two days studied, 30% worked one or more hours of overtime, almost all of it voluntary. However, 29% of them also worked one or more hours of unpaid time. Thirty-four percent reported that they had to stay beyond the end of their shifts to complete patient care tasks, and half of them had to stay to complete documentation. Twenty-five percent of nurses did not take a meal break during their shift.

"The day I returned to work after an illness, I was mandated to work 16 hours, and as a result my illness has relapsed and I am out of work again."

"Everyday off I have, staffing calls me to work. We're also asked to do doubles frequently, I am a new nurse and already wondering how I can maintain this pace."

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Photo: Joe M. Lopez/Visual

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Is Anyone Listening?

A striking result of the survey was RNs' strong opinions that their concerns are not understood and addressed. Over three-quarters said that their facility's chief executive officer and/or board do not understand the problems that nurses face in providing patient care. A strong majority — 64% — said that their concerns about patient care are not taken seriously.

"We are asked to assume more and more responsibilities with less support and virtually no management presence at all. If we try to verbalize legitimate concerns about safety or patient needs we are labeled troublemakers and retaliation is taken."

"Administration sets up unrealistic goals for floor nurses. I think they are very out of touch and too far removed to see how hard it is to accomplish everything. I doubt they could get out on a floor and do it themselves."

"The only thing management seems to care about is paperwork."

Forty percent said that they are asked to perform tasks for which they do not feel completely competent, and 45% said that they have been asked to float to other units without proper orientation.

Almost three-quarters of the nurses who responded said that they believe that facility and agency administrators do not appreciate the extent to which work demands impact upon the RN's family and other obligations.

Good News About Collegiality

Notably, a majority believes that their nurse manager does her best to respond to their problems. Also notable, and encouraging, is the fact that fully 85% said that their RN colleagues will assist them when they need help.

"We are able to provide good care only because the nurses on my unit form a cohesive team."

"The conditions in my med/surg unit are frustrating and stressful, but the nurses I work with are truly caring professionals who go the extra mile every day."

Choosing a Facility...and a Career

When asked if they would recommend that relatives or friends receive treatment in their facility, 26% said that they would not; 45% said they would; and 25% were unsure.

When asked what choice they would make if deciding on a career today, 28% said they would choose nursing; 21% would choose another career in health care; while 31% would look outside of health care entirely. About two-thirds of nurses plan to be working in nursing in another five years. Nineteen percent say that they plan to be working in another field, and 15% do not plan to be working.

Hire More Nurses

New York's RNs have strong opinions about what can be done to improve the difficulties they face in trying to provide good patient care. Eighty-eight percent said that their facility or agency needs to hire more RNs. Sixty-six percent said that the facility or agency needs to hire more unlicensed personnel to assist RNs. However, only 37% thought that more LPNs are needed.

Most NYSNA members will not be surprised at the results of this survey. It confirms anecdotal reports from the field and underscores the need for significant changes in the way healthcare is delivered. In the survey's comments section, one nurse after another reiterated the same observation:

"Healthcare today is simply business. Money is first. Patient is last."

This distortion of priorities deeply troubles nurses and adds to the stress level that many respondents described.

"I was so exhausted at the end of my shift, I did not have the energy to give floor report. I came home with chest pain and a headache."

Now What?

This survey is the first step in what will be an ongoing effort by NYSNA to amass information on the RN workforce. The Association has hired as consultants two nurse researchers, Christine T. Kavner of New York University and Carol S. Brewer of the University at Buffalo (SUNY), who are analyzing available information on the New York state nursing workforce and employment trends. NYSNA will use this information during labor negotiations, to support legislative initiatives, and in its contacts with the NYS Departments of Health and Education.

Note: NYSNA thanks all those members who took time from their busy schedules to complete the staffing survey. You have done a service to your patients and your colleagues.

DEMOGRAPHICS

Locations

rural	suburban	urban
17%	18%	46%
21%	23%	56%

Type of Facility

large teaching hospital	home health	school	rehab	diagnostic treatment center	HMO/managed care	community hospital	nursing home	state facility	ambulatory care	other
377	28	23	4	4	5	324	53	10	28	36
42%	3%	3%	0%	0%	1%	36%	6%	1%	3%	4%

"Last night I had two intubated patients, one of whom had just had open heart surgery. Unfortunately, lately we have been sedating and paralyzing our intubated patients much more than in the past, since we are unable to watch over the patients closely."

Clinical specialties

ambulatory	critical	gerontology	DR	psychiatric	public health	med/surg	parent-child	school	other
60	153	59	28	62	46	215	56	24	185
8%	17%	7%	3%	7%	5%	24%	6%	3%	21%

"What a time to do a survey! This was not a typical day. Usually understaffed — without clerical support and with much greater turnover."

Shift worked

Days/8	Even/8	Nights/8	Days/12	Nights/12
385	144	90	158	118
44%	16%	10%	17%	3%

"I work as a PICU nurse. When our census is low, we are frequently floated to the ER, burn unit, adult ICU, POCU, PACU...all of the above units are adult units. I know for a fact that no one in the PICU has been oriented to these units..."

Full/part-time

full-time	part-time	per-diem/hospital	per-diem/agency
749	120	34	3
83%	13%	4%	0%

Age Mean: 45 (sd=8.6)

22-24	25-34	35-44	45-54	55-64	65+
14	107	283	292	120	14
2%	12%	31%	32%	19%	2%

Years as RN Mean: 17.9 (sd=8.8)

0-4	5-9	10-19	20-29	30+
85	120	291	262	133
10%	13%	33%	29%	14%

"We labor with no linen, minimal or nonexistent pharmacy, non-delivery of tube feedings, or trays, poor transport backup and on and on. It is sometimes a miracle that we give as good care to the patients as we do. I love nursing and consider it the most important job that I could do. Yet, I could not recommend it as a profession."

"I basically love my job. On OB, we rarely have staffing problems. My frustrations are with the administration's lack of understanding, compassion, and gratitude for jobs well done."

Highest education level

Diploma	BSN	MSN	Doctorate-nursing	Associate	Baccalaureate-other	Masters-other	Doctorate-other
158	306	56	1	258	77	32	4
18%	34%	7%	0%	29%	9%	4%	0%

**BACKGROUND ON NEW YORK MEDICARE
BALANCED BUDGET ACT (BBA) BILLS**

There are four major issues in the Medicare Balanced Budget Act (BBA) adjustments act that have strong implications for New York.

The first, clearly, is the indirect medical education (IME) adjustment provision. Under the BBA, this adjustment was lowered from 7.0 to 5.0 percent between 1999 and 2002. The Senate bill would keep this adjustment at 6.5 percent (the 1999 level) through 2003 while the House would keep it at 6.0 percent (the 2000 level) for an additional year (2001). The Senate provision costs \$800 million over 5 years, versus the House provision's cost of \$300 million. We prefer the Senate but could potentially extend the 6.5 percent adjustment until 2002 rather than 2003.

The second issue is the House proposal to change the current direct graduate medical education (GME) payment to a national average payment amount. Although studies suggest that the current variation in GME payments is hard to explain, such a change would have profound geographical distribution effects, particularly on New York. As a note, the Administration supported this proposal in 1993 and, if asked publicly, we can say that this is not a BBA fix and should be further studied.

Third, the hospital outpatient department payment issue remains a major concern for New York hospitals. We are hoping that Congress will provide the technical fix (directed scoring of a legislative clarification of intent) that we need to administratively correct the 5.7 percent payment reduction that was erroneously put into law in 1997.

Finally, New York has two of the ten cancer hospitals nationwide. Under the BBA's hospital prospective payment system (PPS), cancer hospitals' payments would be reduced by over 30 percent. The Senate bill would include these hospitals in PPS but would ensure that their payments are no less than 100 percent of their 1996 payments. The House exempts them from the system for 2 years, which we have proposed to do administratively. The hospitals generally prefer the Senate for fear of what might happen to them after the exemption. The Administration staff believe that we should not permanently hold cancer hospitals harmless but the Moynihan staff think that this is preferable since at least we will get these hospitals into the new system. This is also a big issue for Massachusetts and Florida. Given this difference of opinion, it might be preferable if you remain silent.



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Kenneth E. Raske, President

The Need for BBA Relief for Major Teaching Hospitals and Inner-City Hospitals

I. Conclusion

The Balanced Budget Act of 1997 (BBA) was enacted while the hospital industry is in the midst of a daunting transition from a regulatory financing model to a market-based financing model. Problems attendant to this transition are particularly acute for major teaching hospitals and inner-city hospitals. While the overarching policy goals of the BBA are very worthy, the Medicare funding cuts were too deep too soon in the context of the industry's transition to a market model.

A BBA fiscal impact model developed by the GNYHA Center for Health Economics and Informatics (CHEI) found that the BBA cut baseline payments to major teaching hospitals more than to other hospitals. In fact, compared with 1996 payments, while the BBA slowed the rate of growth for other hospitals, major teaching hospitals will actually receive less Medicare reimbursement in 2002 than they did in 1996, *not adjusting for inflation*.

To reduce the overwhelming financial stress currently experienced by major teaching hospitals and to hospitals in inner cities, it is recommended that Congress and the Administration moderate some of the BBA provisions, including:

- Halt the IME cut, as proposed by Senator Moynihan and Congressman Rangel,
- Carve out DSH from Medicare+Choice premiums, and
- Accelerate the carve out of GME from Medicare+Choice premiums.

The risk of not moderating the effects of the BBA is that major teaching hospitals and hospitals in inner cities might not be able to maintain access to services that are vitally important to the community.

II. Overview of the Transition to a Market-Based System

The entire hospital industry is going through a major transition from a regulatory financing model to a market-based financing model. Of the three major payers of hospital-based services, private insurers, Medicaid, and Medicare, this transition is occurring fastest in the private sector, but increasingly for Medicaid through mandatory managed care, and for Medicare through the Medicare+Choice program. The market-based model is defined by hospitals competing for business on the basis of price, service availability, and service quality.

The two major challenges in the market model are:

- How to price services; and
- How to negotiate effectively when the buyer has a market advantage.

These challenges are particularly acute for inner-city hospitals and for major teaching hospitals, which have much higher-than-average costs per insured patient.

III. Hospitals in New York City Have Both Inner-City and Major Teaching Hospital Challenges

The challenge for inner-city hospitals is that they have higher-than-average costs due to having a high proportion of uninsured patients. The uninsured population in the United States is growing rapidly, especially in New York, where the proportion of uninsured non-elderly persons is almost 20%, compared with a national average of 18%. The proportion of uninsured non-elderly persons in New York City is an astounding 28%. Part of the cause of the accelerated growth of the uninsured population is the unintended consequences of welfare reform. New York's Medicaid budget is actually falling because of declining enrollment, despite provisions in the welfare reform law requiring continued Medicaid coverage for families and individuals leaving the income support program.

The challenge for major teaching hospitals is that they have higher-than-average costs due to direct teaching costs, as well as high other costs associated with the teaching mission, such as:

- High uncompensated care costs. Teaching hospitals receive two-thirds of all Medicare disproportionate share hospital (DSH) payments. These payments are at risk, however, because they are currently not paid on behalf of Medicare+Choice enrollees, and the payment formula will be changed to reallocate a substantial portion of DSH funding to rural hospitals.
- The high cost of tertiary/quaternary care, complex trauma care, high-risk patients, and the clinical testing of new technologies and treatment protocols.

A. The Indirect Medical Education (IME) Adjustment

The higher-than-average costs associated with teaching hospitals are not captured in the Medicare case-mix adjustment, so a proxy was developed in the form of the IME adjustment, which is based on the number of residents per patient, even though these costs are not a function of the resident count, but rather somewhat associated with it. The U.S. Health Care Financing Administration's (HCFA's) regression model explains a very small amount of the cost variation among hospitals, leaving a very high amount unaccounted for. Therefore, historically, Congress increased the IME adjustment above the empirical level, although 30% of this premium is being phased out under the BBA.

Another vehicle for compensating teaching hospitals for their higher costs is the stop-loss, or "outlier," provision. Five percent of total inpatient payments are set aside to pay for 80% of a hospital's loss above a stop-loss threshold. With the decline in the IME and DSH adjustments under the BBA, the need for outlier payments increased; however, the available funds are fixed. Therefore, the stop-loss threshold had to be raised by 30%, or from \$11,100 in fiscal year (FY) 1999 to \$14,575 in FY 2000. A important technical correction to the outlier formula under the BBA somewhat mitigated this problem by eliminating outlier underpayments to teaching and DSH hospitals.

B. The Medicare Inpatient Margin for Teaching and DSH Hospitals

Despite the higher-than-average cost of teaching and DSH hospitals, it appears that they have high Medicare inpatient margins under the Medicare Prospective Payment System (PPS). The reason for this is that the measure of Medicare cost per patient does not include allocated costs of uninsured patients and uncompensated care by HMOs and Medicaid. The fact that major teaching hospitals and public hospitals have the lowest total margins in the United States is evidence of the magnitude of uncompensated care provided by these hospitals.

IV. Market Challenges

Having reviewed the higher costs associated with major teaching hospitals in inner cities, the context then exists for reviewing challenges of the competitive marketplace, which, again, include pricing and negotiating with insufficient market power.

A. Pricing and Other Contract Provisions

There are three principal challenges for hospitals in determining correct pricing and other contract provisions in a competitive market:

1. **Marginal Per Diem Pricing.** Hospitals must be able to value each day of care not based upon the average cost for the entire stay, but based upon the marginal cost of each day. This is because HMOs engage in the practice of denying payment for days in which they deem there was insufficient activity. The problem is that, for the time being, they are denying payment based upon the average cost per day even though the denied days were clearly less costly. Developing marginal per diem pricing capability requires fully revamping hospital cost accounting methods, which is an extremely difficult task.
2. **Credit.** Hospitals must learn to establish payment terms by analyzing the claims processing capability and solvency of their insurance contract partners. This is because hospitals have found that, unlike government payers, many HMOs (most in New York) do not have electronic claims capability and, more importantly, are in very poor financial condition. There is as yet no vehicle to compensate hospitals for the outstanding claims they have with insolvent insurers.

3. Pricing Competitively. Even when services are appropriately valued and optimal payment terms established, major teaching hospitals must still price their services based on the level of competition for each service. That is, in order to maintain their volume of "bread-and-butter" services for which there is high competition, such as routine inpatient care and outpatient care, they must match the prices of their community hospital or free-standing competitors. This means, however, that the prices for tertiary services would have to be increased. This is a delicate balance, since the market might not bear higher prices for complex services.

B. Negotiating With Insufficient Market Power

If hospitals were able to determine optimal pricing and payment terms, they would not necessarily be able to command them in negotiations with managed care companies for two principal reasons:

1. System Capacity. In the metropolitan New York area, hospitals have average occupancy rates of 80%, the highest in the United States. But while a 20% vacancy rate is desirable from an operating perspective, it has proven to be too low for bargaining power.
2. System Consolidation. While hospitals could increase their bargaining power through industry consolidation, antitrust laws, however appropriate from other perspectives, are an impediment to more thorough systems integration. This paradox is more pronounced in large urban areas where there are many free-standing hospitals compared with some rural and suburban communities that are *de facto* one-hospital towns. Indeed, rural hospitals have historically had the highest total margins of any hospital group because of their ability to command high rates from private sector payers.

Again, problems associated with the transition to a competitive market have been most concentrated in the private sector. However, they have expanded to Medicare through the Medicare+Choice program, and to Medicaid through mandatory managed care enrollment. New York is simply the latest state to receive a HCFA waiver, and its new program will include severely mentally ill and HIV+ patients.

V. Summary

In summary, the transition to a successful market model requires universal health insurance coverage, and the development of sophisticated pricing, payment, and negotiating strategies, neither of which is currently in place. In this context, it is urgent that Congress and the Administration moderate the effects of the BBA on major teaching hospitals and inner-city hospitals. At risk is the ability of these hospitals to maintain critical services to patients and communities.

Prepared by the GNYHA Center for Health Economics and Informatics, Karen S. Heller, Executive Director, July 1999.



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SCHUMER ON MEDICARE PROPOSAL: GREAT PLAN WITH ONE BIG FLAW – HURTS NY HOSPITALS

On the day after President Clinton released his Medicare proposal, U.S. Senator Charles E. Schumer outlined how the cuts in the new plan, on top of the ones made under the 1997 Balanced Budget Act, would hurt New York's hospitals.

"Overall, I believe the president's plan is an excellent one. Any plan that can protect Social Security on into the second half of the 21st century, modernize Medicare, bring a prescription plan that recipients want and need and bring the budget deficit to zero should receive everyone's support.

Schumer also applauded Clinton's proposal to rectify the HMO "carveout." HMO's had been keeping some of the Medicare reimbursements that should have rightfully gone to teaching hospitals and to those which treat large numbers of poor patients. This provision, which has been championed by Senator Daniel Patrick Moynihan, will save New York's hospitals \$400 million over the next 5 years.

"There is, however, one major flaw: New York's hospitals are given the short shrift," said Schumer. The plan cuts funding to hospitals by \$39 billion over 10 years on top of the deep cuts in the 1997 Balanced Budget Act. New York is hit especially hard because we are one of the world's leading medical centers. Our share of the cuts will be about \$1.7 billion in the city and \$3.2 billion throughout the state."

In total, the cuts will be about \$2.8 billion for NYS hospitals and \$1.4 billion for NYC hospitals over 10 years (netting out the gain of the HMO "carveout").

Here are estimates of the effect that the President's proposal will have on some of New York State's hospitals.

- Strong Memorial in Rochester which suffered cuts of \$68.4 million from the BBA, will be cut an additional \$37.0 million under the new Medicare plan. To give you an idea of how thin profit margins are, in 1997 Strong Memorial had an operating profit of 4.0% – meaning that on their total medical operations (not including cafeteria, endowment investment, pharmacy, etc.) they made a 4.0% profit. In 1998, after just one year of BBA cuts their profit margin dropped to a slim 2.5%.

- Beth Israel in New York which suffered cuts of \$91.6 million from the BBA, will be cut an additional \$49.3 under the new Medicare plan. Beth Israel's profit margin was -0.25% in 1997 and was a flat 0.0% in 1998.
- Long Island Jewish which suffered cuts of \$87.5 million from the BBA, will be cut an additional \$47 million under the new Medicare plan. In 1997, Long Island Jewish had an operating profit of 1.3%. In 1998, one year after the BBA, it operated at a 0.3% loss.
- University Hospital Health Science Center in Syracuse which suffered cuts of \$35.2 million from the BBA, will be cut an additional \$19.0 million under the new Medicare plan. University Hospital had an operating profit of 3.8% in 1997 and 2.5% in 1998.
- Albany Medical Center which suffered cuts of \$52.2 million from the BBA, will be cut an additional \$28.0 million under the new Medicare plan. Albany Medical's operating profit dropped from 2.3% to 0.8% between 1997 and 1998.
- Buffalo General Hospital (the entire system) which suffered cuts of \$102.4 million from the BBA, will be cut an additional \$55.2 million under the new Medicare plan. Buffalo General's operating margin dropped from -0.1% in 1997 to -1.4 percent in 1998.
- Mt. Vernon Hospital which suffered cuts of \$13.3 million from the BBA, will be cut an additional \$7.3 million under the new Medicare plan. Mt. Vernon's operating margin was -6.2% in 1997 and -4.0% in 1998.
- Sisters of Charity Hospital in Staten Island which suffered cuts of \$37 million from the BBA, will be cut an additional \$20.2 million under the new Medicare plan. Sister of Charity's operating margin was -0.9% in 1997 and -2.0% in 1998. Staten Island University Hospital which suffered cuts of \$88.8 million from the BBA, will be cut an additional \$43.4 million under the new Medicare plan. Staten Island University's operating margin was 3.3% in 1997 and 1.7% in 1998.
- St. Joseph's Hospital in Yonkers which suffered cuts of \$13.7 million from the BBA, will be cut an additional \$7.4 million under the new Medicare plan. St. Joseph's operating margin was a thin 0.3% in 1997 and a thinner 0.1% in 1998.

"I have spoken with Secretary Shalala and OMB Director Lew and am going to the White House on Thursday to impress upon Administration officials that while this Medicare proposal is a strong one, these cuts to our hospitals risk the very fabric of our health care system," said Schumer.