JULY 25, 2005

Skyline news

REPORTING ON NEW YORK'S HEALTH CARE NEWS

GNYHA Meets with HUD Secretary and FHA Commissioner

On July 12, 2005, GNYHA met with U.S. Housing and Urban Development (HUD) Secretary Alphonso Jackson and Federal Housing Administration (FHA) Commissioner/Assistant HUD Secretary Brian Montgomery to discuss the importance of the FHA's health care facility insurance programs to GNYHA members. The programs, which provide mortgage insurance to hospitals and nursing homes as a form of credit enhancement, reduce the cost of capital for their participating facilities and enable many facilities to access capital that might have no other means available. In New York State and New Jersey in particular, the programs serve the critically important role of permitting many GNYHA members to undertake essential capital projects in order to upgrade their facilities, provide state-of-the-art care, and serve the health care needs of their communities. In turn, GNYHA members often serve as the cornerstones of their own communities, thereby supporting HUD's

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NEW FEATURE! In this issue of *Skyline News,* we introduce "Health Care News In-Depth," a special supplemental insert that will run from time to time on topics of particular interest to GNYHA members, exploring in greater detail the issues that have an impact on health care delivery in the metropolitan New York area and surrounding states. If you would like to see a particular topic featured in "Health Care News In-Depth," please send an e-mail with your request to the editor at tufel@gnyha.org. Topics will be selected and published at the editor's discretion. ■

Commission on Healthcare Facilities in the 21st Century Holds First Public Meeting; Governor Appoints Regional Commissioners

The Commission on Healthcare Facilities in the 21st Century, chaired by Stephen Berger, held its first public meeting on July 13, 2005, in New York City. The 18 statewide Commission members introduced themselves, passed bylaws modeled after those of the State Hospital Review and Planning Council, heard remarks by NYS Department of Health (DOH) staff and Mr. Berger, received data books with information compiled by DOH in accordance with the Commission's enabling statute, and discussed the schedule of future meetings and other administrative matters.

Mr. Berger and Dennis Whalen, Executive Deputy Commissioner of DOH, stressed several times that the Commission "is not in the list business," refuting some characterizations of the body as a hospital and nursing home closure commission, and stressed that its broader mission is to recommend changes to New York's health care system that would improve access, increase and preserve quality, and realign resources in support of sustained vitality in the system. The Commission's vice chairman is Robert Hinckley, former Deputy Secretary to Governor Pataki. The Commission, which may go into executive session when discussing individual institutions, will

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Governor Proposes Plan to Combat Medicaid Fraud and Waste

On July 19, 2005, Governor George E. Pataki announced a five-point plan to combat Medicaid fraud, waste, and abuse in New York State. Although GNYHA's members have greatly enhanced their efforts to identify and eliminate erroneous billing over the last decade, the Governor's proposal is nevertheless expected to have a significant impact on the entire health care industry in New York. The Governor's plan was announced in the wake of a series of *New York Times* articles on fraud and abuse in the Medicaid program. Attorney General Eliot Spitzer has since indicated his support for the Gover-

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GNYHA Meets with HUD Secretary and FHA Commissioner *continued from page 1*

community development mission.

GNYHA was pleased to hear the Secretary and the FHA Commissioner express strong support for the programs and looks forward to a productive working relationship in the future.

Ensuring the Strength of the Portfolio: Although the programs often provide insurance for facilities that have limited access to capital, they have strict underwriting procedures, which, for hospitals, are carried out by the U.S. Department of Health and Human Services (HHS) under contract with HUD. The programs also undertake aggressive portfolio monitoring both directly and in coordination with HHS and local authorities, such as the Dormitory Authority of the State of New York, to ensure the financial strength of the FHA's portfolio. In addition, the hospital program has made great strides toward diversifying its portfolio, also for the purpose of becoming stronger. In the past, the FHA's hospital program had been concentrated heavily in New York State, which represented nearly 87% of the FHA hospital portfolio. However, in recent years, the program has underwritten insurance for a large number of hospitals across the country, including a number of critical-access hospitals as well as large academic medical centers, thus reducing the concentration in New York State to only 63%. At the same time, the program has remained committed to serving the capital needs of New York State's health care system by providing insurance for new construction, renovations, and refinancings.

Strengthening New York State's Health Care System: In order to address potential concerns about the financial circumstances facing New York State's health care system, GNYHA reviewed the role and charge of the State's Commission on Health Care Facilities in the 21st Century, whose mission is to ensure that New York State's health care system provides quality care and is responsive to community health care needs. (See related story on front page.) Thus, the activities of the Commission present opportunities for improving and strengthening the health care system, in turn potentially strengthening the FHA programs' portfolios. In addition, GNYHA reviewed some of the funding streams that are and will potentially become available to assist in strengthening the system, including the HEAL NY Capital Grant Program, which will provide $1 billion over four years for system restructuring and health care information technology; the Health Care Stabilization program, which will provide funding to stabilize "critical" health care providers; and the pending Federal-State Health Reform Partnership Waiver, which would amend the State's current 1115 waiver governing its participation in the Medicaid program. Should the waiver be granted, it is hoped that additional funding will be available for strengthening and restructuring the health care system in the State. ■

CCLC Urges Changes to SNF PPS Rule

In a letter sent to the Centers for Medicare & Medicaid Services (CMS) Administrator Mark McClellan on July 12, 2005, the Continuing Care Leadership Coalition (CCLC) urged that the agency's proposed rule on the fiscal year (FY) 2006 skilled nursing facility (SNF) prospective payment system (PPS) be modified substantially to eliminate millions in potential losses for New York SNFs. CCLC is GNYHA's long term care affiliate.

Referencing a CCLC analysis that projected losses to SNFs in New York State of more than $26 million if the rule as proposed were put into effect on October 1, 2005, CCLC called for two key modifications to the rule. First, CCLC recommended that CMS reconsider its decision to fully base the wage adjustments to facilities' rates on the new metropolitan statistical area (MSA) definitions, which for New York City–area SNFs would cause payment reductions of close to $12 million annually. CCLC stressed that, at minimum, it is essential that CMS provide a phased transition to the use of the new MSA definitions for SNFs, as was provided for hospitals in the final acute care inpatient PPS rule for FY 2005. Second, CCLC challenged the adequacy of the new 53 resource utilization group (RUG) case mix system revision proposed in the rule, and urged CMS instead to maintain the current system along with the current add-ons (which generate more than $1 billion in added funding for SNFs nationwide) and a full inflation adjustment for FY 2006.

GNYHA and CCLC will continue to keep members apprised of developments as this payment rule moves forward. ■

Commission on Healthcare Facilities *continued from page 1*

meet publicly twice more in 2005.

Data Books: The data books that were distributed to the commissioners include information on hospital and nursing home capacity, utilization, and profitability; capital debt; other health care providers; Medicaid and uninsured populations; and related matters. The data are available on the DOH Web site at **www.health.state.ny.us/facilities/rightsizing**. GNYHA is analyzing the data and will work with the Commission to ensure that it has the most timely and accurate information at its disposal. For example, because of constraints in available administrative data, information about hospital utilization was derived from the Statewide Planning and Research Cooperative System (SPARCS), a data set that is often used for clinical analysis but has also been found to be incomplete with regard to utilization.

Regional Commissioners: Separately, Governor Pataki announced his 12 appointees to serve as regional commissioners, one of whom—for the NYC region—is Jeffrey Sachs, who served as a member of the Governor's Acute Care Working Group chaired by Mr. Berger. The enabling statute calls for 36 regional commissioners in all, six in each of the six Commission regions, who will vote on matters affecting those regions. The remaining 24 regional commissioners will be appointed equally by Senate Majority Leader Joseph Bruno and Assembly Speaker Sheldon Silver. ■

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nor's proposal and has additionally called for the passage of two pending bills to facilitate health care fraud prosecution, one that would create a State false claims act, much like the Federal law, and another that would establish new specific health care fraud crimes. In turn, Senate Majority Speaker Joseph Bruno has advocated for yet another legislative proposal that would create a Medicaid Inspector General and has called for Statewide hearings in the fall.

Appointment of Inspector General: The Governor's plan will, most notably, create a Medicaid Inspector General (MIG) who will be responsible for coordinating antifraud resources throughout the State's administrative agencies and who is expected to collaborate with the Attorney General's Medicaid Fraud Control Unit (MFCU) and other relevant Federal and State government offices. The MIG, whose office the Governor proposes to institute through an Executive Order, will be granted expansive subpoena power and investigative authority to meet its objectives. The Governor expects the MIG to work closely with the State Office for Technology to enhance the technological aspects of Medicaid fraud prevention, including the ability to gather, organize, and analyze Medicaid claims and billing data to detect and prevent provider and recipient fraud, waste, and abuse. Along with the formation of the MIG, the Governor has appointed a former Federal prosecutor, Paul Schechtman, to assess the State's current Medicaid fraud initiatives and recommend structural changes by December 1, 2005.

The Governor also proposes a partnership with the State University of New York (SUNY) medical schools and teaching hospitals through which medical professionals affiliated with SUNY will help the New York State Department of Health assess the medical appropriateness of services rendered. In addition, the Governor is requesting that the Federal government permit New York State to join the "Medi-Medi" program, a Federal/State project that matches Medicare and Medicaid claims data to identify and prevent fraud and abuse.

GNYHA Member Compliance Initiatives: GNYHA members have undertaken significant efforts over the last 10 years to develop formal internal compliance programs and plans to ensure compliance with the law and to identify and correct possible instances of incorrect billing. Those efforts were initially undertaken in response to a series of audits that were pursued in the mid-1990s by U.S. Attorney Offices across the country. In connection with those audits, the U.S. Attorney Offices advised providers to implement internal compliance plans to identify and avoid problem areas and to minimize the assessment of penalties. Subsequently, the Office of the Inspector General for the U.S. Department of Health and Human Services issued Compliance Program Guidance for developing hospital and nursing home compliance plans, which GNYHA members took seriously and proceeded to implement. Some of the elements of these plans include providing training and education on potential problem areas, instituting monitoring procedures, appointing a compliance officer, and developing a mechanism for employees to report potential problems. To assist those efforts, GNYHA has provided members with several intensive, two-day seminars on how to create effective compliance plans; held monthly compliance workgroup meetings during the time frame in which members were initially developing and implementing their plans so that they could discuss implementation issues; and, through to the present, continues to provide members with a steady stream of information about new legal and regulatory requirements and potential problem areas. GNYHA's next compliance workgroup meeting, scheduled for August 2, 2005, will focus on the ongoing evaluation and assessment of existing compliance programs and will review the development of effective partnerships with outside auditors and attorneys to maximize compliance. GNYHA believes that these and similar efforts underscore its members' commitment to compliance. ■

Legislation Introduced on Medicare's 75% Rule

The Preserving Patient Access to Inpatient Rehabilitation Hospitals Act of 2005 (S.1405) was introduced recently in Congress. The legislation would maintain the threshold for compliance with Medicare's so-called 75% rule at 50% for two years. It is important to note that, if passed, the bill would also create a 17-member National Advisory Council on Medical Rehabilitation to advise Congress and the Secretary of the U.S. Department of Health and Human Services on the appropriate clinical criteria for admission to an inpatient rehabilitation facility. In addition, the Advisory Council would study the efficacy of inpatient rehabilitation services relative to other post-acute care settings through a comparison of cost and quality data.

The legislation was introduced in the Senate by Senators Ben Nelson (D-NE), Rick Santorum (R-PA), and John Corzine (D-NJ), and in the House by Congress members Nita Lowey (D-NY), Frank LoBiondo (R-NJ), and John Tanner (D-TN). GNYHA is extremely grateful to all the legislation's sponsors for their continued support on this important matter. ■

AROUND TOWN

Michael D. Israel has been appointed Interim President and Chief Executive Officer of Westchester Medical Center (WMC). The appointment coincides with the decision by WMC's Board of Directors to extend the institution's management contract with Pitts Management Associates for an additional six months. Mr. Israel comes to WMC from North Shore-Long Island Jewish Health System, where he served as Chief Operating Officer. He has also served as Vice President of Duke University Health System and Chief Executive Officer of Duke University Hospital. Mr. Israel is expected to be onsite at WMC at the beginning of August. ■

Key Senators and Largest Hospital Groups Express Support for New Initiative Promoting Greater GPO Transparency

A bipartisan group of United States senators and the nation's largest hospital associations expressed support this month for an industry-led initiative, called the Healthcare Group Purchasing Industry Initiative, which encourages health care group purchasing organizations (GPOs) to abide by the highest ethical standards and business practices. Nine of the nation's largest GPOs, including GNYHA Ventures, Inc. and representing an estimated 80% of the country's GPO volume, have signed on to the initiative, which commits them to extraordinary levels of transparency and disclosure. The result of several years of internal industry review and consultations with the United States Senate, the initiative has been well received by key senators and by health care associations whose members benefit from working with GPOs.

Support from Senator Schumer and Others: Recognizing GPOs' important service to hospitals and patients, Senators Charles Schumer (D-NY), member of both the Senate Finance and Judiciary committees; Jon Kyl (R-AZ), member of both the Senate Finance and Judiciary committees; Edward M. Kennedy (D-MA), member of the Senate Judiciary Committee; Sam Brownback (R-KS), member of the Senate Judiciary Committee; and John Cornyn (R-TX), member of the Senate Judiciary Committee have all offered support for the initiative.

Senator Schumer noted the role GPOs play in controlling health spending. "With health care costs soaring through the roof," he said, "GPOs perform an extremely valuable service for our hospitals and consumers. I am hopeful that with the steps the industry has taken, the Senate will not have to intervene."

The Mission: As part of the initiative's mission, participating GPOs will voluntarily answer questions that address ethics, codes of conduct, and policies and procedures of their business practices. All answers from individual GPOs will be accessible on the group's Web site, **www.healthcaregpoii.com**, at a future date (not yet announced). At the end of the year, the initiative's coordinator will compile all the responses in an Annual Summary.

In response to the heated interest in the industry's practices, the group decided to accelerate the implementation of its monitoring practices, moving up the date on which it will release the questionnaire responses from spring 2006 to October 1, 2005. At present, questionnaires have already been sent to the participating GPOs.

In addition to the questionnaire, an inaugural Best Practices Forum is planned for January 2006, at which GPOs will come together to share best practices with the goal of enabling the entire industry to innovate and provide better quality services. The forum will take place at least once a year.

Hospital and Health Association Supporters: The major hospital and health associations that expressed support include the American Hospital Association, Association of American Medical Colleges, Catholic Health Association of the United States, Federation of American Hospitals, National Association of Children's Hospitals, National Association of Public Hospitals and Health Systems, and the National Rural Health Association. ■

FDNY Decision Reflects GNYHA's Efforts to Help Hospitals Reduce Infection Rates

Health care facilities within the New York City Fire Department's (FDNY's) jurisdiction are now permitted to install alcohol-based hand rub (ABHR) dispensers in corridors outside of patient rooms and other areas as long as specific FDNY conditions are met. GNYHA is pleased with FDNY's change in position since installation of ABHR dispensers will assist members with their infection control efforts. FDNY had previously taken the position that the use and installation of ABHR dispensers should conform to the requirements of the National Fire Protection Association (NFPA) Life Safety Code (LSC) 2000 edition, which prohibited the placement of ABHR dispensers in egress corridors. However, in April 2004, the NFPA Standards Council approved a tentative interim amendment (TIA), which permits placement of ABHR dispensers in egress corridors if certain criteria are met.

Given the importance of the use of ABHRs for infection reduction purposes, GNYHA has been involved in ongoing communications with FDNY about the importance of the use and installation of ABHR dispensers in light of the U.S. Centers for Disease Control and Prevention (CDC) guidelines for hand hygiene in health care settings that were published in October 2002. The guidelines strongly recommend the use of ABHR in health care settings. In addition, GNYHA and its members place a significant priority on infection reduction initiatives.

In July 2005, FDNY informed GNYHA that it no longer objected to the installation and use of ABHR dispensers in health care facilities. However, in addition to requirements defined in the NFPA-approved TIA, FDNY is requiring additional conditions. Of note, FDNY limits ABHR dispenser capacity to 1 liter, whereas the NFPA permits capacity up to 1.2 liters. FDNY also requires ABHR dispensers to be of the manual type, which dispense only when operated manually.

GNYHA members can contact Alison Burke at GNYHA for complete NFPA and FDNY conditions regarding the installation and use of ABHR dispensers or with any questions about this issue. ■

Health Care news In-Depth

A SPECIAL SUPPLEMENT TO SKYLINE NEWS

JULY 25, 2005

Clinical Health Information Technology

GNYHA IS ACTIVELY addressing the rapidly developing area of health information technology (IT) and clinical data exchange on behalf of its members at the regional, State, and Federal levels. Through the New York Clinical Information Exchange (NYCLIX) initiative, GNYHA, its members, and other health care entities are developing a regional clinical data exchange project. GNYHA is also working to inform State and Federal efforts involving health IT and to ensure that members understand the impact these developments will have on their organizations.

GNYHA Members Initiate Clinical Data Exchange Project

GNYHA's members and several other health care entities have initiated a clinical data exchange project called the New York Clinical Information Exchange (NYCLIX). Its goal is to improve the quality and efficiency of patient care by enabling the exchange of patient data, via a virtual network, for the purposes of treatment. By providing patient data from other health care providers at the point of treatment, NYCLIX seeks to speed time to a patient's accurate diagnosis and treatment and to reduce both errors in care and redundant diagnostic testing.

To focus planning efforts for its first phase, NYCLIX will target the emergency department (ED) as an initial site for deployment. Data from two NYC boroughs indicate that between 21% and 30% of ED visits are from patients either seen at another ED in the past year or who receive primary care at another hospital.

Through a clinical data exchange, NYCLIX will seek to mitigate the large gaps that can occur in the continuity of care when a patient presents at an emergency department and is unable, for various reasons, to relate information about prior diagnoses, procedures, or medication history. Planning for subsequent phases of NYCLIX anticipates expansion of the data exchange into other sites of patient care.

The formal planning phase for this project has started and is informed by input from the NYCLIX Workgroup (see chart below for list of participants). Over the next 18 months, NYCLIX will solicit input from participant entities and seek to establish business and technical requirements; develop a technical

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NYS COMMUNITY HEALTH INFORMATION EXCHANGE PROJECTS

PROJECT NAME AND REGION	PARTICIPANTS TO DATE	ACTUAL OR PLANNED FUNCTIONALITY
New York Clinical Information Exchange (NYCLIX), New York City	NYU, NYP, Montefiore, Maimonides, MSKCC, NYC HHC, Mount Sinai, Health Quest, Lenox Hill, Continuum, St. Vincent CMC, VNSNY, Kingsbrook Jewish, Catholic Health of LI, MSSNY, NYC Dep't. of Health, IPRO, United Hospital Fund, GHI, Lutheran, Metro Jewish, Winthrop	Create a data exchange to deploy a Continuity of Care Record (CCR)–type data elements to emergency department clinicians.
Health Connection Card Program, Queens	NYC Health and Hospitals Corporation, New York Hospital Queens, Jamaica and Flushing hospitals	Provide patients with a portable, accessible personal health record on a smart card.
Upper Manhattan Health Initiative, Northern Manhattan	NYC Health and Hospitals Corporation, NewYork-Presbyterian, St. Luke's-Roosevelt, Mount Sinai, and North General hospitals; Mount Sinai Medical School; Columbia University; Congressman Charles Rangel's office	Establish a data exchange among health care organizations of upper Manhattan to implement disease management and improve community health outcomes.
Brooklyn Data Exchange Initiative, Brooklyn	Maimonides, Kingsbrook Jewish, Lutheran, VNSNY, Metropolitan Jewish	Create a clinical data exchange among Brooklyn health care providers.
Taconic Health Information Network and Community, Hudson Valley region	Taconic IPA, MedAllies, HealthVision, All Scripts, NextGen, Kingston Hospital, Benedictine Hospital, St. Francis Hospital, Vassar Brothers Medical Center, Laboratory Corporation of America	Create a community health care portal that integrates existing electronic messaging and data exchange capability with a full electronic medical record for physicians.
North County Health Data Exchange, Adirondack region	Adirondack Medicine Inc., Glens Falls Hospital, HIXNY	Create a portal to exchange clinical data with results reporting, e-prescribing, patient education, and secure patient/physician communications functionality.
Capital District Regional Task Force, Capital region	Northeast Health, Saratoga, and St. Peter's hospitals; Capital Care, Community Care, Prime Care, and Capital District Family Medicine physician groups; CDPHP and HIXNY	Create a community patient index and enable provider access to patient health information at the point of care.
Rochester Health Information Organization, Monroe County region	Strong Health, Via Health, Unity Health, Finger Lakes HSA, Excellus, Preferred Care, RIPA, GRIPA, Eastman Kodak, Xerox, University of Rochester, Monroe County Government, Association for Senior Citizens	Develop secure e-mail for health care providers; establish clinical information exchange of lab results, images, medication history, and reports.
WNY Health Care Information Coordinating Council, Western New York	Public Health Alliance, University of Buffalo, WNY HealtheNet, Buffalo Academy of Medicine, UNYPHIED	Complete feasibility study to expand from billing transactions to clinical data exchange. Develop data repository, e-prescribing, regional credentialing, and disease management functionality.
UNYPHIED, Western New York	Physicians, hospitals, payors, vendors, associations, rural healthcare networks in Western New York	Collaborate on development of a personal health record, regional credentialing, e-prescribing, and a diagnostic data network.

Clinical Data Exchange Project

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prototype; address legal issues including privacy, security, and liability; and select governance and business sustainability models.

Several subcommittees have been formed and are addressing legal issues, technical models, governance, business sustainability, clinician input, and evaluation. A Steering Committee, chaired by Mark Lipton, M.D., Director of Clinical Informatics at NYU Medical Center and co-chaired by Gilad Kuperman, M.D., Director of Quality Informatics at NewYork-Presbyterian Hospital, is leading the process and ensures that planning activities stay on track. Susan Stuard, Associate Vice President at GNYHA, is serving as project director.

Additional accomplishments to date include development and submission of a grant proposal to the National Library of Medicine to fund its planning phase, and inclusion in the Computer Sciences Corporation and Markle Foundation application to the U.S. Department of Health and Human Services to be a demonstration project for a national health information infrastructure.

Organizations interested in learning more or becoming involved in NYCLIX should contact Susan Stuard at stuard@gnyha.org. ■

DOH Developing Health IT Agenda

GNYHA recently organized a briefing for the NYS Department of Health (DOH) executive staff on community data exchange projects in the State, at which the New York Clinical Information Exchange (NYCLIX) and several regional projects sought to educate DOH about their community efforts and inform the State's agenda for health information technology (IT).

At the briefing, DOH described its newly formed State health IT task force, which includes representatives from DOH and the NYS Department of Insurance, Office of Mental Health, Office of Mental Retardation and Developmental Disabilities, Office for Technology, and others. This task force has several subcommittees including finance, legal issues, standards and interoperability, public awareness, e-prescribing, regional health information organizations (RHIOs), and public health. Dennis Whalen, DOH Executive Deputy Commissioner, stated that DOH is seeking to enable IT adoption by the health care community and may set minimum standards for interoperability and address State legal issues regarding health IT. DOH also plans to convene a health IT stakeholders group with players from all areas of health care. Building on the United Hospital Fund's (UHF's) NYS Health Information Technology Policy Summit, DOH has asked UHF to draft recommendations about how a stakeholders group could be convened and run.

William Schroth, consultant to DOH and chair of the health IT task force, described State funding streams for health IT. For the health IT funding under the HEAL NY Capital Grant Program, priority may be given to multi-stakeholder projects and to entities that cannot access alternate financing. A request for proposal (RFP) process will be used to solicit applications for health IT funding, and DOH expects it will take several months to develop the first RFP. In addition, the State Medicaid waiver, now being negotiated by DOH and the Centers for Medicare & Medicaid, may include funding for health IT in areas such as e-prescribing, RHIOs, and electronic health records. ■

HEAL NY CAPITAL GRANT PROGRAM	
Description:	Capital grant program to encourage improvements in and efficiency of the health care delivery system
Intent:	Fund information technology and health system restructuring
Funds:	$250 million per year for each of four years
Constraints:	May be used only for capital purposes, not operating costs
Timing:	DOH expects RFP will take several months to develop
Criteria:	Criteria for IT funding may emphasize multi-stakeholder projects and availability of alternate financing

Federal Health IT Agenda and Legislation

The Federal agenda for health information technology (IT) is moving forward quickly with recent policy announcements from the U.S. Department of Health and Human Services (HHS) and the introduction of several health IT bills in Congress. These developments will define clinical data exchange standards in the future, shape quality measure reporting and pay-for-performance initiatives from Medicare and Medicaid, and set forth funding mechanisms for community data exchange projects.

On June 6, HHS Secretary Michael Leavitt announced the formation of a standards-setting group for health IT—the American Health Information Community (AHIC). AHIC, to be chaired by Secretary Leavitt, will comprise 17 nominated industry representatives. AHIC has four primary charges: recommend privacy and security protections, oversee standards development and certification, recommend an Internet-based architecture, and define a succession strategy for AHIC to become a private-sector initiative within five years. To enable this work, HHS issued four requests for proposals, in 1) privacy and security of national health information infrastructure, 2) health IT standards development and certification, 3) electronic health records for physicians, and 4) development of a prototype for an Internet-based national health information network.

In addition, seven health IT bills have been introduced in Congress in 2005. The bills' overall themes include development of interoperability standards, creation of a safe harbor to foster diffusion of health IT, grant and loan programs for community health information-exchange projects, and implementation of quality measurement standards to be used for pay-for-performance. On July 20, the health IT bills sponsored by Senators Frist and Clinton, and by Senators Enzi and Kennedy, were combined into a new, jointly sponsored bill, the *Wired for Health Care Quality Act.* ■

LEGISLATION	STANDARDS	IT SAFE HARBOR	HIT FUNDING	QUALITY STANDARDS
National Health Information Incentive Act of 2005 *Gonzalez/McHugh (H.R. 747)*	•		•	
21st Century Health Information Act of 2005 *Murphy/Kennedy (H.R. 2234)*		•	•	
Information Technology for Health Care Quality Act *Dodd (S. 1223)*	•		•	•
Health Information Technology Act of 2005 *Stabenow/Snowe (S. 1227)*	•		•	•
Medicare Value Purchasing (MVP) Act of 2005 *Grassley/Baucus (S.1356)*		•		•
Wired for Health Care Quality Act *Frist/Clinton/Enzi/Kennedy (S.1418)*	•		•	•