



JULY 10, 2006

Skyline news

REPORTING ON NEW YORK'S HEALTH CARE NEWS

NYS Approves Malpractice Rate Increases

GNYHA has learned that New York State Insurance Superintendent Howard Mills has approved medical malpractice insurance premium rate increases for physicians of 9% as of July 1, 2006. The approved rate increase for physicians enrolled in the State's Medical Malpractice Insurance Plan, or MMIP—the State program that provides insurance for physicians and other health care providers (including several hundred nursing homes) who are unable to obtain medical malpractice insurance in the commercial marketplace—is 12%, as of July 1, 2006. The rate

increase for professional practices, which is officially viewed as an “optional” layer of protection (though many physician groups feel compelled to purchase such coverage), is 6%. Thus, for physicians purchasing individual coverage as well as coverage for their group practice, the annual increase will be 15%, which is a very high increase, particularly for specialists with already high premium costs. For instance, according to the American College of Obstetricians and Gynecologists, the newest rate increase means that an OB-GYN on Long Island will be paying at least \$181,000 for his or her

medical liability insurance. GNYHA continues to work with the Medical Society of the State of New York, American College of
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GNYHA Completes First Phase of Pay-for-Performance Training Pilot

GNYHA has completed the first phase of a new pilot program that is designed to assist members in optimizing their performance scores in the area of pay-for-performance (P4P) and on quality report cards in general. The program facilitates the development of hospital-based quality improvement coaches to help ensure that the care that is provided within hospitals is consistent with the various P4P initiatives, is properly documented, and will therefore be properly recognized by the Centers for Medicare & Medicaid Services (CMS) and other payers for reimbursement and qual-

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NYS Legislature Approves Physician Managed Care Bill

In the waning days of the 2006 legislative session in Albany, the NYS Senate and Assembly approved legislation designed to help physicians in their dealings with health insurance companies and health maintenance organizations. The bill (S. 8417 / A. 11996), sponsored by Senator Nick Spano (R–Yonkers) and Assemblyman Adam Bradley (D–White Plains), is an amended version of a variety of bills that have been supported by the provider community and represented a compromise between the physician community and the insurance industry.

The bill focuses on three areas: physi-

cian coding, recovery of overpayments from physicians, and physician credentialing by health plans.

Physician Coding: Specifically, the bill states that health plans shall accept and initiate the processing of all health care claims submitted by a physician pursuant to and consistent with the current version of the American Medical Association's current procedural terminology codes, reporting guidelines, and conventions as well as the Centers for Medicare & Medicaid Services' health care common procedure coding system. Insurers would still not be required to pay, however, if they found that a claim wasn't complete, the service provided was not a covered benefit, the service was not medically necessary, the service was investigational or experimental, or that the insured didn't obtain a referral, a pre-certification, “or satisfy any other condi-

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Attendees at the P4P training session at GNYHA.

NYC Releases Coastal Storm Plan; GNYHA Coordinating Coastal Storm Exercise

In conjunction with the NYC Office of Emergency Management (OEM), Mayor Michael Bloomberg recently released NYC's updated Coastal Storm Plan. The revised plan specifically addresses the evacuation of health care facilities and outlines the newly developed "Private/Volunteer Ambulance and Ambulette Coordination Center" (PVAACC). The PVAACC, staffed by ambulance and ambulette providers, will coordinate transportation resources among health care facilities evacuating patients and residents. The revised NYC Coastal Storm Plan is posted at www.gnyha.org/eprc/general/evac, in the members' area of the "Evacuation and Sheltering Issues" section of GNYHA's Emergency Preparedness Resource Center Web site.

Exercises: In order to test various components of NYC's plan, OEM is conducting a multi-part coastal storm exercise. The first part of the exercise, an executive-level tabletop held on June 8, tested decision-making among representatives from various NYC agencies and organizations, including GNYHA, the NYC Health and Hospitals Corporation (HHC), the NYS Department of Health, and the NYC Department of Health and Mental Hygiene. GNYHA and HHC have been working closely with OEM to coordinate the second part of the exercise, to be held on July 11, which will test the health care facility evacuation component of the Coastal Storm Plan. Participating facilities will activate their internal evacuation plans and test how those plans interface with NYC agencies in coordinating resources and sharing information. OEM will activate its emergency operations center to assess interagency coordination and the PVAACC in order to test the coordination of transportation resources. In addition, in August, OEM will conduct an exercise component that tests evacuation and sheltering of NYC residents. ■

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Obstetricians and Gynecologists, 1199 SEIU United Healthcare Workers East, medical malpractice insurers, and others to find solutions to the stalemate in Albany on medical liability reform.

Immediate Crisis Averted: In other news, GNYHA believes that a potential crisis facing the MMIP has been averted. As reported previously in *Skyline News*, the MMIP has a deficit of \$430 million for policy years 2000–05. GNYHA learned in May that the MMIP would not have sufficient funds from premiums and associated interest earnings to cover any more claims for the years 2000 and 2001 without a decision from the State Insurance Department (SID) on a mecha-

nism to obtain funding to pay for those claims. GNYHA has learned that SID now believes that it is the responsibility of the State's property and casualty guaranty fund to cover the shortfalls that have developed as a result of a number of insurers exiting the marketplace since 2000 and 2001, who, therefore, cannot be assessed to make up for the past year's shortfalls attributable to their "books of business." This situation obviates the need to assess the remaining carriers, who, if assessed, would have sharply increased premiums for hospitals, physicians, and nursing homes. GNYHA is very pleased with SID's decision on this matter. ■

NYS Legislature Approves Physician Managed Care Bill *continued from page 1*

tion precedent to receiving covered benefits from the physician," among other exceptions.

Overpayments: The bill states that, other than for duplicate claims, a plan must notify a physician in writing 30 days in advance before engaging in overpayment recovery efforts and shall not initiate overpayment efforts more than 24 months after the physician received the original payment. Exceptions to the time limitation apply if the insurer has a "reasonable belief of fraud or other intentional misconduct," including "abusive billing" by the physician, or if the overpayment effort was required by, or initiated at the request of, a self-insured plan,

or required by a State or Federal program.

Credentialing: On health plan credentialing of physicians, the bill says that a health plan shall complete review of a physician's application to participate in the in-network portion of the plan's network within 90 days of receiving the completed application, though more time can be taken because of the failure of a "third party" to provide necessary documentation or because "non-routine or unusual circumstances require additional time for review." Once the Senate delivers the bill to the Governor, the Governor will have 10 days (excluding Sundays) to sign or veto the bill. ■

Upcoming GNYHA Member Briefing

Legionella Bacteria in Health Care Facilities

Date: Wednesday, July 12, 2006

Time: 9:00 a.m.–11:30 a.m.

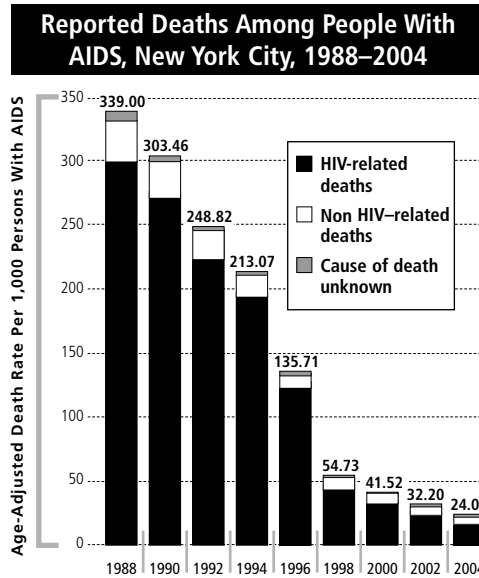
Location: GNYHA Conference Center, 555 West 57th Street, 15th Floor

This briefing will update members on prevention, surveillance, and identification of legionella bacteria in health care settings. Representatives from the New York State Department of Health and the New Jersey Department of Health and Senior Services will review guidance on environmental and engineering infection control strategies for preventing environment-associated infections in

health care facilities and identifying health care-associated infections using epidemiologic principles. In addition, representatives from Kroff Chemical Company, Inc. will discuss technologies available to control growth and amplification of legionella bacteria in potable water systems in health care settings. The review of technologies will include discussions of efficacy, cost, and long-term corrosive effects of some interventions on plumbing systems. For more information, contact Alison Burke, and to register, contact Laurie Sangirardi at sangirardi@gnyha.org, at GNYHA. ■

A Notable Clinical and Public Health Achievement: AIDS-Related Deaths in NYC See Substantial Decline

The death rate among people with AIDS in New York City has dropped dramatically since 1988, when there were nearly 300 HIV-related deaths per 1,000 people with AIDS, compared with just 17 HIV-related deaths per 1,000 people with AIDS in 2004, according to the New York City Department of Health and Mental Hygiene (DOHMH). DOHMH also reports that, “as of March 31, 2005, 95,707 New Yorkers had been diagnosed and were known to be living with HIV/AIDS,” including 34,246 living with HIV only and 61,461 living with AIDS. DOHMH notes, however, that the actual number of people with HIV/AIDS in New York City is higher, given that an estimated 25% of people living with HIV have never been tested and do not know they are infected. ■



Note: Rates are age-adjusted to the 2000 NYC Census population.

Source: New York City Department of Health and Mental Hygiene, HIV Epidemiology Program, 2006.

JCAHO Revises Standards for Emergency Management Exercises and Disaster Privileges for Volunteers

Effective July 1, 2006, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) implemented revised standards pertaining to emergency management exercises and disaster privileges for volunteers who offer their services to institutions during a disaster. The revisions to the emergency management exercises standard (EC.4.20) include additional evaluation requirements, as well as a change in the timing of the exercises. While exercises must still be conducted twice a year, they are no longer required to be conducted at least four months apart and no longer than eight months apart. The revised standard regarding granting disaster privileges for volunteers who are licensed independent practitioners (MS.4.110) includes the following: **1)**

requires that licensed independent practitioners present two forms of identification (instead of one under the old standard) in order to be granted disaster privileges in a hospital, and **2)** imposes a 72-hour time frame on the license verification process. Also effective July 1, 2006, JCAHO has implemented a new standard (H.R.1.25) concerning the assignment of disaster responsibilities to practitioners who are not licensed independent practitioners (for example, nurses). The standard establishes a process for assigning disaster responsibilities to those volunteer practitioners that is almost identical to the process for granting disaster privileges to licensed independent practitioners. ■

Fair Share for Health Care Act Fails to Pass the Legislature

The NYS Legislature ended the 2006 session without voting on the Fair Share for Health Care Act, legislation sponsored by Assemblyman Richard Gottfried (D–Manhattan) and Senator Nicholas Spano (R–Westchester) that would require businesses with 100 or more employees (excluding agriculture and manufacturing) to pay a \$3 per hour assessment on each of their workers to support the public costs of providing health care for their employees. Employers could offset the assessment by the average amount they spend for employee health benefits. The legislation was originally proposed by the New York Working Families Party and was supported by GNYHA, 1199 SEIU United Healthcare Workers East, and many other consumer and labor groups.

The Assembly Health Committee had proposed a series of amendments to the bill designed to address concerns raised by the business community and some legislators. Those amendments would have lowered the assessment to \$1.90 per hour, raised to 250 or more workers the firm size to which the mandate would apply, and exempted additional industries from the assessment. Nonetheless, the legislation failed to gain sufficient traction to pass the Legislature, particularly in the Senate, where Majority Leader Joseph Bruno announced that he and the majority of his Senate colleagues could not support the bill. Significantly, gubernatorial candidate Eliot Spitzer, who has been endorsed by the Working Families Party, came out in opposition to the bill. Ultimately, neither the Assembly nor the Senate brought the legislation to a vote.

While the bill’s proponents expressed their disappointment, the Working Families Party noted that the debate over Fair Share had laid the groundwork for consideration of more comprehensive legislation going forward. GNYHA, in particular, is eager to advance a proposal it sponsored with 1199 SEIU—Cover New York—that provides a blueprint for achieving universal coverage in NYS. ■

JCAHO Announces 2007 National Patient Safety Goals

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) recently announced the fifth iteration of its National Patient Safety Goals (NPSGs) and related requirements for hospitals and all other accredited organizations for 2007. The NPSGs are specific to the various types of health care programs accredited and certified by JCAHO. According to JCAHO, the purpose of the NPSGs is to promote specific improvements in patient safety by highlighting problematic areas in health care and using evidenced-based solutions to address those problems.

The new NPSGs become effective January 1, 2007.

New in 2007: Changes for 2007 affect NPSG 8, which was clarified; NPSG 13, which was expanded; and NPSG 15, which is new.

NPSG 8 requires accredited organizations to “accurately and completely reconcile medications across the continuum of care.” JCAHO has clarified NPSG 8 so that it now requires organizations to provide a complete list of current medications to the patient upon discharge from the facility. In addition to hospitals, this requirement is applicable to

the Ambulatory Care, Assisted Living, Behavioral Health Care, Critical Access Hospitals, Disease-Specific Care, Home Care, Long Term Care, and Office-Based Surgery programs.

NPSG 13 requires accredited organizations to “encourage patients’ active involvement in their care as a patient safety strategy.” This goal has a new requirement that organizations define and communicate the means for patients and families to report concerns about safety.

NPSG 15 requires accredited organizations to identify “safety risks inherent in [their] patient populations.” A requirement under this goal specifies that behavioral health care organizations, as well as psychiatric hospitals and general acute care hospitals that are treating patients for emotional or behavioral disorders, identify patients (clients) at risk for suicide.

There is also one new NPSG requirement for Home Care Programs under Goal 15 that requires organizations to identify risks associated with long-term oxygen therapy such as home fires.

GNYPHA Briefing: At a recent GNYHA brief-

ing on the 2007 NPSGs, held on June 15, 2006, Rick Croteau, M.D., Executive Director for Strategic Initiatives at JCAHO, noted that, although organizations across the country continue to struggle with implementing a process to achieve 100% compliance with NPSG 8, regarding medication reconciliation, JCAHO believes that this goal is important because medication errors are among the most frequently occurring types of medical errors. According to Dr. Croteau, the medication reconciliation requirements under this NPSG attempt to address issues such as ineffective communication among caregivers, which is the most frequently cited category of root causes in serious adverse events reported to JCAHO, as well as the most vulnerable parts of the patient care process, which are the “links between the steps or handoffs.” A complete copy of Dr. Croteau’s presentation and his specific slides on medication reconciliation can be accessed in the Quality and Patient Safety section of GNYHA’s Web site at www.gnyha.org.

A complete listing of the 2007 NPSGs can be found at www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals. ■

GNYHA Completes First Phase of Pay-for-Performance Training Pilot *continued from page 1*

ity purposes.

GNYHA developed this program with support from a grant awarded to the GNYHA Foundation by the New York State Department of Health through the Health Workforce Retraining Initiative in response to hospital concerns related to hospital performance on quality measurement initiatives.

The first phase of the program consisted of a two-day training session for prospective quality improvement coaches, which was held on June 21–22, 2006, and repeated on June 27–28. More than 160 hospital personnel from many disciplines—including environmental services staff, food service staff, nursing assistants, registered nurses, transporters, and managers—participated. The P4P training utilized innovative strategies to promote

teamwork, coaching skills, and knowledge in the areas of quality and patient safety. Through the use of interactive case studies and role playing, participants developed strategies to improve communication, redesign workflow, and work with employees who resist change.

At the conclusion of this first phase of the program, participants were able to identify the P4P performance metrics including the new patient satisfaction survey, understand the importance of clear and concise documentation as it relates to the performance metrics, and better understand the role the multidisciplinary health care team plays in improving performance. It became evident from the outcomes of the case studies and exercises that teamwork and ongoing effective communication are essential to the success of

all P4P initiatives. In addition, participants recognized that quality is not the responsibility of only one department in a hospital. Rather, everyone within the health care team has a role in optimizing quality of care and patient satisfaction.

The second phase of the pilot will include on-site follow-up by GNYHA at the participating hospitals with workforce-management committees and senior leadership. Through this effort, hospitals will create an infrastructure to support the quality coaches and customize additional programs to meet the needs of the facility.

Upon completion of the pilot, GNYHA will contact other hospitals about participating in the program. For additional information, contact Terri Straub or Julie Mathew, both at GNYHA. ■
