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Skyline news

REPORTING ON NEW YORK'S HEALTH CARE NEWS

President Pushes Health Care Transparency with Executive Order

On August 22, 2006, President Bush issued an Executive Order that he contends will promote quality and the efficient delivery of health care provided by Federally administered programs, including Medicare, Medicaid, Department of Defense and Veterans Affairs health programs, and the Federal Employees Health Benefits Program. The announcement came while the President was in Minnesota touting his health transparency initiative, a cornerstone of his 2006 health care agenda aimed at facilitating the widespread availability and adoption of health savings accounts (HSAs).

Effective January 1, 2007, the Executive Order directs Federal agencies and, in turn, providers (including hospitals), health plans, and health insurance issuers contracting with the government, to utilize health information technology systems and products, where available, that meet recognized interoperability standards.

Additionally, the order requires Federal agencies to implement programs that measure the quality of services provided. Stakeholders as identified by the U.S. Department of Health & Human Services Secretary would develop these quality measures in "collaboration with similar initiatives in the private and non-Federal public sectors." Agencies would also be required to make available the prices that they and their health insurance plans pay to contracted providers. Lastly, each agency will be required to develop and iden-

tify approaches that facilitate high-quality and efficient health care (this includes offering HSAs). While intended for Federal health

program enrollees, much of the information required under the Executive Order is expected to be publicly available on the Web. ■

MedPAC Updates Analysis of Specialty Hospitals

This month, the Medicare Payment Advisory Commission (MedPAC) released an update of its 2005 report on physician-owned specialty hospitals ("specialty hospitals"). The number of specialty hospitals doubled from 2002 to 2004, prompting Congress to request the updated study. MedPAC used 2002 as the basis for the 2005 study, while 2004 served as the basis for the update. Key findings include:

- Specialty hospitals have below-average shares of Medicaid patients, even when controlling for service mix, a finding that has been confirmed by the Government Accountability Office.
- Despite lower lengths of stay, the cost of inpatient services in specialty heart hospitals is not less than that in community hospitals, while the cost of inpatient services in specialty orthopedic hospitals is statistically significantly greater than that in community hospitals.
- Specialty heart hospitals are associated with statistically significantly higher rates of cardiac surgery in an area and, therefore, with higher rates of Medicare spending.

• Specialty hospitals take market share from competitor community hospitals, which have responded by cutting staff and increasing profitable business lines such as imaging, rehabilitation, pain management, cardiology, and neurosurgery.

In the report, MedPAC expresses concern

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Study Confirms Strong Job Market for New Physicians

The New York Center for Health Workforce Studies (CHWS) recently released its biannual report, which found that the job market for new graduates of New York physician residency programs remains strong. In the report, *Residency Training Outcomes by Specialty in 2005 for New York*, more than three-quarters of respondents said that the region offered "many" or "some" jobs in their spe-

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GNYHA's Summer Enrichment Program Promotes Diversity in Health Care Management

This summer, GNYHA was proud to continue sponsorship of the Summer Enrichment Program (SEP), which seeks to promote diversity in health care management through internships for undergraduate and graduate students pursuing degrees in the field. Participating students are assigned to members of the senior management staff at GNYHA member facilities to gain firsthand experience with the operations and management issues facing health care organizations. In 1997, GNYHA formed a collaborative relationship with the Institute for Diversity in Health Management (IFD), the National Association of Health Services Executives (NAHSE), and the Association of Hispanic Healthcare Executives (AHHE) to coordinate the Summer Enrichment Program in the New York metropolitan area. The Summer Enrichment Program in New York is the most successful program of its kind in the nation. Approximately 200 students have taken part in this program, with 27 students participating in member facilities this summer.

In addition to their internship placements, various programming events took place for the student participants. Through the program, the students also attended the IFD National Leadership and Education Conference on Diversity on June 28–29, 2006, in Chicago. During the conference, the interns were able to network with health care leaders from across the country. A two-

day educational series for the participating students on July 19–20 exposed them to various types of health care management careers, and health care leaders working in a variety of sectors spoke about their own careers and their current roles and responsibilities, as well as the paths they each took to get to where they are today. Finally, on August 15, GNYHA hosted a graduation for the participating students and invited their sponsors and preceptors to attend. Each student made a presentation based on work done as part of the internship, and certificates were distributed.

GNYHA thanks the following facilities that participated as sponsors in the program this summer: Beth Israel Medical Center, Continuum Health Partners, East New York Diagnostic and Treatment Center,

Interfaith Medical Center, Jamaica Hospital Medical Center, Kings County Hospital Center, Long Island College Hospital, Lutheran Health Care, Mercy Medical Center, Montefiore Medical Center, New York City Health and Hospitals Corporation Central Office, North Shore–Long Island Jewish Health System, NYU Medical Center, Our Lady of Mercy Medical Center, St. Barnabas Hospital, St. John's Riverside Hospital, St. Luke's–Roosevelt Hospital Center, SUNY Downstate Medical Center, The Mount Sinai Hospital, and The New York Eye and Ear Infirmary.

GNYHA also thanks IFD, NAHSE, and AHHE for collaborating on this initiative. This type of quality internship helps position students for postgraduate fellowships and/or employment, and GNYHA looks forward to expanding the program in the future. For more information about the Summer Enrichment Program, contact Amy Kaufman at GNYHA. ■

Medicare Delays Payments by Nine Days

As mandated by the Deficit Reduction Act (DRA), which was signed into law earlier this year, providers will receive delayed reimbursement from the Medicare program at the end of this Federal fiscal year (FY). Specifically, any claims that would have been paid during the last nine days of FY 2006 (i.e., September 22–30, 2006) will be held until the beginning of FY 2007. According to a

notice to providers, claims held during this period will be paid on October 2, 2006, without interest. The delay applies only to claims subject to payment and, as such, will not apply to full denials, no-pay claims, and other non-claim payments. The delay is an accounting mechanism included in the DRA, which moves \$5.2 billion in Medicare expenditures from FY 2006 to FY 2007. ■

San Francisco Enacts Universal Coverage Plan

On August 7, 2006, Mayor Gavin Newsom signed into law landmark legislation that will make affordable health coverage available to San Francisco's 82,000 uninsured adult residents. The law makes San Francisco the first city in the nation to provide its residents with universal access to health care, although earlier this year, both New York City and Suffolk County, New York enacted health insurance legislation requiring large retailers to contribute a

threshold amount to worker's health care.

The Health Care Access Plan, approved unanimously by town supervisors, will make subsidized coverage available to uninsured individuals who earn up to \$50,000, or roughly 500% of the Federal Poverty Level, and do not qualify for California's Medicaid program. Individuals will pay monthly premiums ranging from \$3 to \$200, depending on income, for coverage of primary and preventive services, prescription drugs, and spe-

cialty care provided through local health care providers. Mayor Newsom projects the law will cost \$200 million annually, which will be offset by an assessment on businesses that do not provide health benefits, a reallocation of money the City currently spends on indigent care, and monthly enrollee premiums and copayments. Businesses that oppose the legislation are expected to mount a legal challenge to the bill on the grounds that the law violates the Federal Employee Retirement Income Security Act (ERISA), which preempts state and local laws relating to employer-sponsored health plans. ■

Record Number of Americans Lack Health Insurance

The number of Americans without health coverage increased by 1.3 million to 46.6 million, or 15.9% of the population, according to a new U.S. Census Bureau annual report. The report, *Income, Poverty, and Health Insurance Coverage in the United States: 2005*, which was released on August 29, 2006, noted that the number of Americans without health coverage reached a record high since the Bureau began collecting these statistics in 1987. Economists attribute the increase to continued erosion of employer-based coverage—employment-based health insurance declined from 59.8% of the population in 2004 to 59.5% in 2005—and the fact that health insurance premiums continue to outpace wages and the overall rate of inflation.

The ranks of enrollees in government-sponsored health insurance programs such as Medicaid, Medicare, and Child Health Plus, remained steady with 27.3% covered by public insurance in 2005. The percentage and number of children under 18 years old without coverage increased between 2004 and 2005, from 10.8% to 11.2% and from 7.9 million to 8.3 million, respectively, though children continued to have a lower rate of uninsurance than adults.

In New York, the percentage of people without health insurance actually declined by 1.2 percentage points, to 13.5% from 14.7% in 2004. This decrease, the second year in a row, can probably be attributed, in part, to the rapid increase in the number of adults enrolled in the State's Family Health Plus (FHP) program. More than 500,000 New Yorkers are enrolled in FHP less than four years after the State began accepting applications for this program. Among states, Texas had the highest percentage of uninsured (24.6%), while Minnesota had the lowest (8.7%).

For the full report *Income, Poverty, and Health Insurance Coverage in the United States: 2005*, go to: www.census.gov/prod/2006pubs/p60-231.pdf. ■

New York State to Participate in STRIVE Project

The Centers for Medicare and Medicaid Services (CMS), in coordination with the Iowa Foundation for Medical Care (IFMC), has asked 15 states, including New York, to voluntarily participate in the *Staff Time and Resource Intensity Verification* (STRIVE) project. Earlier this summer, the New York State Department of Health (DOH) agreed to participate in and coordinate the study project.

The purpose of the study is to recalibrate the nursing home Resource Utilization Group (RUG-III) case-mix weights, which are used to calculate Medicare reimbursement amounts, to reflect "current care protocols and resource needs." The study, last performed in 1997, will measure the number of minutes that various staff members spend caring for nursing home residents. In light of New York's expected transition from the Patient Review Instrument (PRI) to the Minimum Data Set (MDS) for Medicaid assessments, and the related use of a RUG-III-based case mix system to determine Medicaid payment amounts, the STRIVE study will have a significant impact on future payment levels for New York nursing facilities.

IFMC has asked a random sample of approximately 20 nursing homes around the state to participate, focusing on those facilities with HIV/AIDS patients, ventilation units, high Medicaid enrollment, and other special services, including Alzheimer's and dementia care, services for mentally ill patients, wound care, and traumatic brain injury. IFMC is also asking hospital-based nursing homes to participate in the study. IFMC is encouraging facilities not participating in STRIVE to provide volunteers to assist with data collection.

The STRIVE study is scheduled to begin in New York within the next few weeks and last until late winter 2007. The Continuing Care Leadership Coalition (CCLC), GNYHA's long term care affiliate, has been working with IFMC and DOH to help design, implement, and analyze the study. CCLC will also be hosting a two-day training session on September 18 and 19, 2006, for those volunteers wishing to participate in the study. For more information on STRIVE, or to discuss this opportunity, contact Laura Castelli at (518) 261-8180 or castelli@cclcn.org. ■

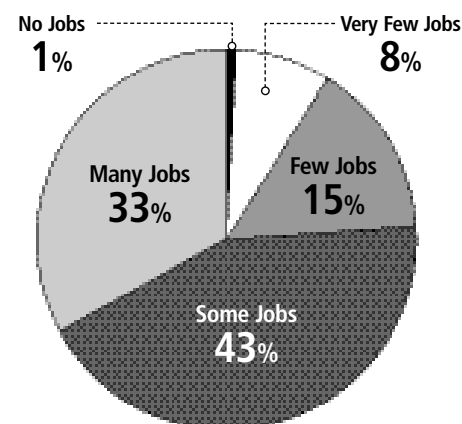
Strong Job Market for New Physicians

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cialty (see chart).

According to the report, in 2005, more than 94% of graduating physician resident

Perceptions of the Regional Job Market (of 2005 exit survey respondents who have searched for a job)



respondents who had actively searched for a practice position received at least one job offer at the time of survey completion. As in previous years, demand for primary care physicians remains less than for non-primary care physicians, though the gap seems to be closing. Physicians graduating from programs in dermatology, cardiology, anesthesiology, and emergency medicine reported the least difficulty finding a satisfactory practice position, while physicians graduating from programs in physical medicine and rehabilitation, geriatrics, and family practice reported the most difficulty.

CHWS is a research center based at the School of Public Health at University of Albany that tracks and reports on trends in a variety of health professions. The physician resident graduate report is generated from a survey distributed to physicians graduating from residency programs throughout New York. ■

Nine Additional Hospitals Join CLABs Initiative

On August 3, 2006, GNYHA and the United Hospital Fund (UHF) held a kick-off meeting for the nine additional hospitals joining the Central Line-Associated Bloodstream Infections (CLABs) Collaborative, bringing the total number of participants to 47. The Collaborative formed in spring 2005, and by the end of the first year, three-fourths of the original 38 participating hospitals had reduced hospital-acquired CLAB infections in intensive care units by 70% on average, with some hospital teams eliminating infections completely.

Teams from the nine hospitals were briefed on strategies to implement the Collaborative, components of central line insertion and dressing kits, and how to use the JENY Web site (www.jeny.ipro.org/clabs), which is the Collaborative's vehicle for sharing information as well as for archiving learning sessions and related teleconferences. In addition, to

help New York State members of the Collaborative prepare for New York State's required public reporting of CLABs and certain surgical infections, which will begin January 1, 2007, GNYHA provided an overview of the New York State legislation and related reporting requirements. Speakers for the session included Roopa Kohli-Seth, M.D., Assistant Professor, Department of Surgery, Division of Surgical Critical Care, and Maxine Shepherd, R.N., Clinical Nurse Manager, Medical ICU, both at Mount Sinai Hospital and School of Medicine; and Brian Koll, M.D., Director of Infection Control at Beth Israel Medical Center. As the Collaborative



Brian Koll, M.D., Director of Infection Control at Beth Israel Medical Center in Manhattan, addressing the participants at the August 3 CLABs Collaborative meeting.

moves into its second year, GNYHA and UHF will strive to help hospitals meet reporting challenges and will introduce new strategies to sustain the success of both this initiative and future quality initiatives. ■

OIG and CMS Issue Final Rules Protecting Health IT Donation for E-Prescribing

The Department of Health and Human Services Office of the Inspector General (OIG) and the Centers for Medicare & Medicaid Services (CMS) recently issued final rules to create, respectively, a safe harbor and an exception to the physician-self referral, or "Stark," law in relation to certain electronic prescribing (e-prescribing) and electronic health record (EHR) arrangements. The rules take effect October 10, 2006.

The final rules permit the donation of certain health information technology (IT) to physicians under limited circumstances. Two specific scenarios are addressed: 1) electronic or "e-prescribing" arrangements, as required by the Medicare Prescription Drug, Improvement, and Modernization

Act of 2003; and 2) EHR arrangements.

Specifically, the OIG adds two new safe harbors to the existing regulations—one that protects certain arrangements involving e-prescribing items and services and another that protects certain arrangements involving EHR items and services. Likewise, CMS creates new, related exceptions to the revised regulations.

The provisions in each area specify the technology covered by the safe harbor or exception, the standards with which the donated technology must comply, the permissible donors and recipients, acceptable standards for selection of recipients, the value of allowed protected technology, and whether the provisions allowing the donation expire after a certain date. ■

CMS Launches Program to Fight Medicaid Fraud and Abuse

The Centers for Medicare & Medicaid Services (CMS) recently launched the Federal Medicaid Integrity Program (MIP), the first national strategy to combat fraud and abuse in the program's 41-year history. The MIP was created by the Deficit Reduction Act of 2005 (DRA), which mandates program elements including 1) the use of contractors to review Medicaid payments, conduct audits, identify overpayments, and educate providers; 2) hiring 100 full-time employees for the MIP; 3) state cooperation with the MIP; 4) enhanced funding for Medicaid fraud control activities; and 5) expansion of the Federal Medicare-Medicaid, or "Medi-Medi," data mining system.

The DRA further requires the creation of the Comprehensive Medicaid Integrity Plan, "a comprehensive plan for ensuring the integrity of the program established under this title by combating fraud, waste, and abuse." CMS has issued the initial Plan, which includes an overview of the MIP's statutory requirements, organizational philosophy, functions, and five-year implementation plan.

GNYHA will continue to monitor these developments and attempt to work with appropriate Federal and state agencies to represent its members' interests in this new project. ■

MedPAC Updates Analysis

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about the increase in service volume and Medicare spending associated with physician-owned specialty hospitals, but does not make specific policy recommendations nor does MedPAC address any Medicare payment policy issues, as it did in its 2005 report. The updated study of physician-owned specialty hospitals can be found at MedPAC's Web site,

www.medpac.gov. ■