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April 30—May 3

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Gary Bebow
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Join Us in Washington, April 30 – May 3
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To all of us involved in healthcare, President Bush’s proposed 2007 budget, specifically its $36 billion in Medicare cuts over five years through 2011, is a trumpet call for action. It is time for all of us involved with Arkansas healthcare to make our united voices heard on this issue, and to let our Congressional delegation know in no uncertain terms how devastating these cuts, if enacted, will be to the patients and hospitals of Arkansas.

To see what devastation the cuts will cause right here at home in Arkansas, consider these figures (based on information regarding the proposed Medicare cuts provided by the Centers for Medicare & Medicaid Services):

- The proposed reduction in the market basket update for inpatient and outpatient care of 0.45% in FY 2007, of 0.4% in FY 2008, and of 0.4% in FY 2009 will amount to $8.1 billion nationally. And here at home in Arkansas? Our best estimate is that the inpatient loss will be $59.3 million, and the outpatient loss $14 million.

- The proposed freeze in the payment update for inpatient rehabilitation facilities for 2007 and an update of market basket minus 0.4% in 2008 and 2009 will result in a loss of $1.6 billion nationally. Here at home in Arkansas, it will mean a loss of $18.3 million to rehab units and $17.7 million to freestanding facilities.

- The proposed four-year phase out of reimbursement for Medicare bad debt will mean a loss of $6.2 billion nationally. $43.8 million will be cut from Arkansas PPS hospitals, and an additional $3.9 million from our critical access hospitals.

Other proposed cuts in the Bush budget, both to Medicare and Medicaid, will also have a severely negative affect on healthcare, both nationally and right here at home in Arkansas.

We all know that cutting healthcare funds is NOT the way to a healthier America, nor to a healthier Arkansas. If these cuts go through, it will be a setback for our citizens, who deserve protected healthcare access.

2006 is definitely a year when hospitals need to speak up. Action is needed by each of us. We cannot wait for “the other guy” to do all of the talking!

It is important that each of our members let our congressional delegation know how these cuts will affect them at the grassroots level, in their own hospitals and in their own communities. When we speak to our elected officials in very specific ways about how their constituents will be affected by the proposed budget cuts, it truly makes an impact and can avert disaster for the nation’s healthcare system!

I urge each of you to consider joining us April 30-May 3 at the annual meeting of the American Hospital Association in Washington, D.C. We will visit with Senators Lincoln and Pryor, Representatives Berry, Boozman, Ross and Snyder and their staff members to let them know how the proposed Medicare and Medicaid cuts will affect Arkansans and Arkansas hospitals.

If you cannot go to Washington with us, please consider sitting down with these officials when they are at home in your district. Take members of your governing board, auxiliaries, even those who have been patients in your hospitals. Let them tell the story of what these cuts will mean to the hospitals of Arkansas. Their presence will make the proposed impacts a reality.

The most important thing is to speak up, to act, and not to wait for someone else to carry the message. We must act together, we must speak with a united voice, we must realize that this is a marathon race and not a sprint, and we must take action, now – TOGETHER!

Phil E. Matthews
President and CEO
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have partnered with healthcare providers throughout
Arkansas to make administering employee benefits simple.

With our online enrollment and HR management systems,
ALL your benefit information is just a key stroke away.
Robert L. Kerr, MD, has succeeded Steve Erixon as president and CEO of Baxter Regional Medical Center (BRMC) in Mountain Home as of March 13 while the hospital board of directors conducts a search for the position. Kerr, a retired physician and longtime member of the Mountain Home medical community, was most recently medical director for Arkansas Blue Cross Blue Shield.

Board chairman Clark Fletcher said, “Steve [Erixon], his team, the medical staff and our board of directors have created a hospital with the highest-quality patient care. BRMC is known throughout our state and nation as a state-of-the-art hospital with outstanding doctors, nurses and support staff. We look forward to continuing to provide our region with the best in healthcare.”

Surgical Hospital of Jonesboro was approved for membership by the AHA board of directors at its January 13 meeting. Nate Miller is CEO of the facility. Miller was previously administrator of HealthSouth Rehab Hospital in Jonesboro prior to joining the Surgical Hospital in February 2004. He has a master’s degree in physical therapy from the University of Central Arkansas and was named to Arkansas Business’ “Forty under Forty” for 2005.

Jay Bunyard, chairman of the board of directors of DeQueen Regional Medical Center, has announced the sale of the hospital to JCE Healthcare, Inc. of DeQuincy, Louisiana. Amy Vines is administrator of the facility. Hospital expansion and upgrade plans for 2006 include the opening of a 10-bed rehabilitation unit, as well as replacing obsolete equipment with the latest technology, including 4-D ultrasound.

Kurt Meyer, CEO of Rebsamen Medical Center, Inc. of Jacksonville, has been named chairman of the AHA Worker’s Compensation Self Insured Trust. Meyer succeeds Ron Rooney, president of Arkansas Methodist Hospital in Paragould, who has served as chairman for the past 13 years. Mark Deal, president and CEO of Delta Memorial Hospital in Dumas, was elected vice chairman.

Lee Simpson has joined The Bridgeway Hospital in North Little Rock as CEO/Managing Director, succeeding Joel Klein. Simpson is the former Vice President/Behavioral Health of St. Bernards Behavioral Health in Jonesboro. Prior to that, he worked in administration in hospitals and healthcare organizations in Memphis, Oklahoma City, San Antonio and Austin.

Arkansas Health Summit Will Help Educate Leaders on Health Issues Facing Our State

The Arkansas Hospital Association will co-host an Arkansas Health Summit with the Arkansas Medical Society, the University of Arkansas for Medical Sciences, the Arkansas Center for Health Improvement and the Arkansas Division of Health. The event was scheduled to take place in mid-April, but postponed to a later date due to the special legislative session called by Governor Huckabee. The Summit’s objective is to gather state legislators and educate them on health issues expected before the 2007 legislative session.

Arkansas Governor Mike Huckabee will speak regarding the health of those living in Arkansas and his Healthy Arkansas Initiatives, and Dr. Joe Thompson, Arkansas’ Surgeon General, will discuss the health status of the state and specific areas where improvements can be made. Attorney General Mike Beebe also has agreed to appear on the program.

Other speakers will cover topics such as Medicaid funding and reforms, evidence-based medicine, health promotion and disease prevention, flu pandemic, and tobacco settlement funds.

For more information about the Summit, please contact Arkansas Hospital Association Executive Vice President Bo Ryall at 501-224-7878.
Gary Bebow Brings a Commitment to Accessibility to the White River Medical Center

As you enter the main entrance of the White River Medical Center in Batesville, to the right of the information desk is a large window with a clear view into someone’s office. Looking inside, you see Gary Bebow, administrator and CEO of the White River Health System, standing as he works at his computer. He turns with a smile and a wave.

During his 15 years in Batesville, the White River Health System has grown from a community hospital to serving as a regional health network. Part of the reason may be Bebow’s intense commitment to being accessible to the community. “The window in my office lets people see me working for them, lets them know they can come in and visit. I can’t tell you how many times a day members of the medical staff, members of the community, and hospital employees stop and wave. They have learned that I’m available, and that has formed an all-important foundation for clear communication.

“Hospital administration is a 24/7 career,” he says. “People ask questions when you’re at the grocery store, in line at the movies, everywhere. Being accessible to people is what it’s all about.”

Bebow’s commitment to accessibility spreads throughout the several-county region served by the health system. “When I first came to White River Medical Center, we were essentially serving Batesville and the immediate surrounding area. Now, we have a broader service area and see ourselves as a truly regional health system. That is probably the most important change that has occurred in my 15 years here. We have shifted our focus from community to regional.”

That shift in focus has come, largely, because the community, hospital board, administrators, medical staff, and employees work together for the greater good. “We have continued to reach out to our region with more healthcare access points and services as each year passes,” he says. “Much of this growth is due to community influence. An important message for administrators everywhere is that we can’t lose touch with our communities. We must grow and make changes that the community sees as both relevant and needed.”

To make certain he has the ear of the region and understands its needs, Bebow has an unusually large health system board of 24 members. In addition, 24 people serve on a White River Medical Center advisory board, more than 30 on the women’s health advisory council, 11 on the Stone County Medical Center advisory board, 17 on the health system foundation board and more than 120 in the hospital volunteer organization. “Members of our administrative team are active throughout the area,” he says. “I guess you could say our hospital is very sensitive to our region, and does all it can to maintain an open, active, ongoing relationship with the public we serve.”

As head of the White River Health System, Bebow oversees both the 199-bed White River Medical Center in Batesville and the 25-bed Stone County Medical Center, a critical access hospital in Mountain View. In addition, he guides operation of the system’s three nursing homes in Mountain View, Horseshoe Bend and...
Marshall, the two residential care centers in Mountain View and Horseshoe Bend, eight rural health clinics/primary care physician establishments, outpatient care facilities in Mountain View, Cherokee Village and Batesville, and the system’s home health services, durable medical equipment supply and hospice care operations.

He has served as leader of the White River Health System for the past 15 years, coming to Batesville in 1991 from his former position as Chief Operating Officer for a hospital in Venice, Florida.

“I grew up in Alma, Michigan, a farming community of about 12,000,” Bebow says. “When I was growing up, I knew that farming was not going to be my career of choice, and I always had strength in mathematics and analytical skills. Accounting was a good choice for me.”

He graduated from Michigan State University with an undergraduate degree in accounting, then accepted his first job with the accounting firm of Ernst and Ernst, where he obtained his certified public accountant license and for three and one-half years worked on hospital accounting and audits.

“I admired my uncle, who had been the CFO of a hospital, then started his own CPA firm in Lansing, Michigan,” Bebow says. “I had long been interested in his work with hospitals, and that led to my working with hospitals in my years as an accountant. In those years, I began to develop a desire to have a more expanded view of the hospital setting.” In 1975, one of the hospitals for which he performed audits asked him to join its

Gary and Verona Brown-Bebow, MD

Gary Bebow, Les Frensley (WRHS Board President), Doyle Rogers, Josephine Raye Rogers and Dick Bernard (WRHS Foundation Board President), at ground breaking of the Josephine Raye Rogers Center for Women and Imaging.
staff, and his true career path began.
That hospital was W.A. Foote Hospital in Jackson, Michigan. At the
time, Foote, a major inner city public hospital, had just merged with a hospi-
tal owned by the Sisters of Mercy health system. “I was asked to come on board to help with financial transi-
tions related to the merger,” he says.
“The two cultures were, understand-
ably, very different. I learned a lot about compromise in those first years as a hospital financial officer.”
It was during his time at Foote that he began to take a keen interest in hospital management, specifically
strategic planning. He began taking courses at the University of Michigan toward a degree in hospital adminis-
tration, graduating in 1981 with a master’s in Health Services Administration.
“I knew that I would definitely be seeking an administrative position in the warmer South,” Bebow smiles.
“I was really getting tired of Michigan’s cold winter weather!”
Bebow joined the Venice (Florida) Hospital soon thereafter. He spent his first five years as Vice
President, Finance (CFO) of the hos-
pital, and his last five years there as its Chief Operating Officer. “I was lucky to move from hospital finance to operations,” he says. “It was a
great opportunity to become more
well-rounded as an administrator.
“There was a lot to learn in Venice,” he says. “We went from a summertime population of 35,000 to a winter popula-
tion of 70,000. That teaches you a lot about how to balance resources, employees, operations.”
His tenure there was from 1981-1990.
He credits his back-
ground in hospital finance as a reason the interviewing team for the White River Health System found him an attractive can-
didate. “A main issue then was the financial side of the operation,” he says. “I have now lived in Arkansas for 15 years, and I love it here. Every day, I am committed to provid-
ing accessible healthcare for patients in this part of the state. We look at it as providing the best care and services possible for the least cost possible.”
He says that too often, hospitals begin thinking of themselves primari-
ly as big businesses, rather than pri-
marily as service providers. “I think that today, the shift in healthcare is definitely back to the service side,” he says. “That is one of the major cycle changes I have seen in my years in healthcare. Today, we focus where we should, on customer service. Improved patient outcomes, more attention to safety and building strong community relationships are all a part of that emphasis on excel-
 lent customer service.”
2005 marked the opening of one of the health system’s greatest responses to regional needs – the new Josephine Raye Rogers Center for Women and Imaging. “The community believed in the mission, and trusted us to carry it out,” Bebow says. Though funding came from many sources including personal gifts and grants, the commu-
nity at large raised more than $5 mil-
lion toward construction of the new facility. It is a state-of-the-art unit

“We would all like limitless numbers of nurses, medical staff and technologies in order to provide the highest possible level of quality, but in today’s reality, that is not financially feasible.”
offering the latest in OB/GYN services, both outpatient and inpatient, as well as imaging services, community education and a research library accessible to the public.

Today, Bebow and his team are hard at work on another major improvement project — renovating the Stone County Medical Center in Mountain View. The community has already raised $250,000 for the project, underlining its belief in the hospital’s importance to the region. The project includes expansion to include additional med/surg beds and surgical suites, an enhanced emergency room and general updating of the entire facility. It is scheduled for completion later this year. “The renovation and expansion is something everyone in the community responds to, and can be proud of,” Bebow says.

Though there is little down time in his career, Bebow says he enjoys spending time with his family, especially his wife, Verona Brown-Bebow, MD, his step-children, Clare, 15, and Tice, 18, and his grown children, Ella and her husband, Wes (who live in Memphis), and son Andy, his wife, Erika and their two-and-a-half-year-old son Graham (who live in North Carolina). He also enjoys playing golf.

He sees limited financial resources, federal cutbacks and the growth of the numbers of uninsured as real challenges for healthcare’s future. “We would all like limitless numbers of nurses, medical staff and technologies in order to provide the highest possible level of quality,” he says, “but in today’s reality, that is not financially feasible.” He adds that he believes challenges can be met and answers found if people are creative and work together.

That is one place the Arkansas Hospital Association really helps, he says. “The AHA represents hospitals’ views in enacting change, and is the catalyst for hospitals in the state to share ideas and provide consensus.”

As the future unfolds, he will remain accessible, will continue to build relationships with the many groups in his region, and will seek answers to the tough questions. “How many people can actually say they are working in the best job for them?” he asks. “I could not be in a better place or have a better career. I love this work.”

Jim Wann (Owner, Wann Office Supply and Treasurer, WRHS Foundation), Tony Rushing, Gerald Meacham (WRHS board member) and Gary Bebow (CEO/Administrator, WRHS) – team at the 11th Annual White River Health System Foundation Golf Classic benefiting the Josephine Raye Rogers Center for Women and Imaging.
AHA Testifies About Medicaid Losses

In September 2005, Arkansas Hospital Association (AHA) executive vice president Bo Ryall told members of the Arkansas Legislative Council’s Hospital and Medicaid Study Subcommittee that a law passed earlier that year was a good first step, but it wouldn’t generate enough new state revenues to allow a much needed Medicaid payment increase for hospitals. Act 2222 of 2005 provided for limited new Medicaid revenues that could go toward increasing the program’s long-standing hospital inpatient per diem cap, but only if insurance premium taxes paid to the state came in above forecasted levels.

Ryall based his comments on the findings of a study showing that hospitals lost about $33 million in 2002 taking care of Medicaid patients. He said that the losses were growing and would get worse with every passing year. The subcommittee reviewed the findings of that study and asked Ryall to address the issue again, once the AHA completed a planned update of its study to show more recent numbers.

On February 23, the subcommittee again turned its eyes and ears to Ryall and Susan Miller, a consultant with BKD Healthcare Group, as they reviewed the findings of the newly completed update. The lawmakers learned that the combined hospital losses had shot up to $64 million by 2004. While the new study included more hospitals — inpatient data was taken from 63 hospitals and outpatient data from 58, versus 46 facilities for the earlier study — a direct comparison of losses for the hospitals that participated in both studies shows their losses increased 36%, from $33 million to $45 million, over the two-year period.

According to Miller, who directed the study and authored the report, inpatient losses for 2006 could be as much as $26 million more than reported, since the data do not reflect amounts related to care for inpatients who exhaust their 24-day per year benefit limit. She also said that inpatient losses for 2006 could be double those recorded in 2004, considering changes in the state’s Medicaid upper payment limit program mandated by the federal Centers for Medicare & Medicaid Services that were effective July 1, 2005.

Ryall’s testimony was intended to provide further evidence that Medicaid must increase its hospital per diem cap, which has remained unchanged at $675 per day since 1996. The AHA has been working closely with Medicaid officials, legislators and the governor’s office to find additional state dollars to make that increase possible. The AHA will distribute copies of the report to all member hospitals for use in advocating for the increase with their local legislators.

### Highlights of the new findings are shown below:

<table>
<thead>
<tr>
<th>Total Costs, Reporting Period Ending in 2004</th>
<th>($277,026,112)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>$205,367,546</td>
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<tr>
<td>Outpatient</td>
<td>$71,658,566</td>
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<tr>
<td>Add: Medicaid Payments</td>
<td>$171,598,016</td>
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<tr>
<td>Inpatient</td>
<td>$139,875,405</td>
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<tr>
<td>Outpatient</td>
<td>$31,722,611</td>
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<tr>
<td>Losses Due to Inadequate Payments</td>
<td>($105,428,096)</td>
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<td>Inpatient</td>
<td>$65,492,141</td>
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<tr>
<td>Outpatient</td>
<td>$39,935,955</td>
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<tr>
<td>Less: Medicaid UPL Payments *</td>
<td>$41,362,807</td>
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<tr>
<td>Net Losses for Hospitals</td>
<td>($64,065,289)</td>
</tr>
<tr>
<td>Percentage Inpatient Costs Paid w/o UPL</td>
<td>68.1%</td>
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<tr>
<td>Percentage Inpatient Costs Paid w/UPL</td>
<td>88.3%</td>
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<tr>
<td>Percentage Outpatient Costs Paid</td>
<td>44.3%</td>
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<tr>
<td>Percentage Overall Costs Paid w/o UPL</td>
<td>61.9%</td>
</tr>
<tr>
<td>Percentage Overall Costs Paid w/UPL</td>
<td>76.9%</td>
</tr>
</tbody>
</table>

*UPL payments offset inpatient losses, bringing that total to $24,129,334
DHS Publishes Final Rule for HIPAA Administrative Simplification Standards

The Department of Health and Human Services published a February 16 final rule detailing the enforcement process for the Health Insurance Portability and Accountability Act’s (HIPAA) administrative simplification standards.

The rule extends the existing regulations for investigating noncompliance with the privacy standard to all of the administrative simplification standards, and elaborates on the rules for imposing civil monetary penalties on entities that violate the administrative simplification provisions.

The American Hospital Association is reviewing the rule and will issue a set of highlights to members soon.

In a related move, the Centers for Medicare & Medicaid Services recently posted answers to two new frequently asked questions regarding HIPAA’s administrative simplification standards.

The first question (ID# 6595) relates primarily to the use of the proposed transaction standard for claims attachments, and whether healthcare providers can use the proposed standard ahead of a final rule. The answer is yes.

The second question (ID# 6594) addresses which business structures are considered “organizations” under the final rule for National Provider Identifiers.

Go to http://a257.g.akamaitech.net/7/257/2422/01jan20061800/edocket.access.gpo.gov/2006/pdf/06-1376.pdf to see the new rule. The FAQs are located at http://questions.cms.hhs.gov/.
Approximately $2 Million in FEMA Reimbursement for Arkansas Hospitals

According to FEMA contractors, Arkansas hospitals will receive approximately $2 million in reimbursement for the treatment of uninsured evacuees from Hurricanes Katrina and Rita.

The reimbursement money was relatively easy to apply for but hospitals had a very limited time to apply for the funds. At press time, 98% of the claims had been processed.

At two February meetings in Little Rock, Jeff Cox, FEMA project officer, and several FEMA public assistance coordinators, answered questions about FEMA reimbursement posed by representatives of nearly 40 Arkansas hospitals. At both meetings, Cox explained he had been brought in specifically to work with hospitals to help them receive reimbursements due to them for the care and treatment of uninsured hurricane evacuees.

A recent study in the Annals of Emergency Medicine said about one ambulance in the U.S. is diverted every minute because hospital emergency departments could not receive additional ambulance patients, according to a new study by researchers at the Centers for Disease Control and Prevention. (2003 is the latest date for which data is available.)

Patients arrived by ambulance for 16.2 million ED visits in 2003, with about 31 ambulances arriving at a U.S. ED every minute, the study of National Hospital Ambulatory Medical Care Survey data found.

An estimated 501,000 ambulances were diverted during the year, and an estimated 45% of U.S. emergency departments reported diverting ambulances at some point during the year.

“This study again illustrates the incredible pressures facing hospitals in trying to meet the growing demand for emergency care,” said Caroline Steinberg, vice president of health trends analysis for the American Hospital Association.


ER Crowding is a Factor in Ambulance Diversions, Study Shows

A recent study in the Annals of Emergency Medicine said about one ambulance in the U.S. is diverted every minute from its intended emergency department because it was overcrowded and could not care safely for another sick or injured patient.

Using research from the 2003 National Hospital Ambulatory Medical Care Survey, the Centers for Disease Control and Prevention found that hospital emergency departments diverted ambulances when they were overcrowded, citing a lack of appropriate inpatient beds (51%), a high number of emergency department visits (50%), and complexity of emergency department cases (18%).

Also, about 16.2 million patients arrived by ambulance at emergency departments in 2003, representing 14% of the total emergency department visits made that year, according to the CDC. Of those visits, seniors accounted for 40%, the largest group transported by ambulances to emergency departments.

“Considering the biggest users of ambulance services are people over age 65, and the number of seniors is expected to substantially increase over the next decade, ambulance diversion could disproportionately affect this age group,” Catharine Burt, the study’s lead author, said in a news release.

A separate study by UCLA researchers, published with the CDC’s findings online in the Annals of Emergency Medicine, found that ambulance diversions at Los Angeles County hospitals more than tripled between 1998 and 2004.
In January, the American College of Emergency Physicians released its report showing Arkansas’ emergency care system graded as the worst among all states. Coincidentally, the report came at a time when the Arkansas Trauma Care Advisory Council is actively ramping up renewed efforts to address needs for a statewide trauma care network.

With those two actions serving as a catalyst, the Arkansas Hospital Association (AHA) convened a February 16 meeting of representatives from a half dozen hospitals across the state and staff members of the state Department of Health and Human Services’ Section of Emergency Medical Services and Trauma Systems (EMSTS) within the Division of Health, who are responsible for emergency services issues. The discussion centered on the lack of any designated trauma centers in the state and the steps that must be taken in order to establish an effective trauma care network for Arkansas.

The Arkansas Board of Health adopted a set of Rules and Regulations for Trauma Systems in 2002, but no hospitals have volunteered to meet those standards yet, for several good reasons. These include the added costs (for which there is no extra reimbursement) and the difficulty in getting cooperation of needed specialists who must be available in the facilities or on call to care for trauma-related cases.

Other issues involve the type of trauma registry that the EMSTS is using, the cumbersome requirements for case data that must be reported to the registry, liability concerns that hinder voluntary participation by many specialty physicians, and squabbles among insurers about which group is the primary payer on many trauma cases.

Participants agreed that legislation will be required to clear many of these hurdles. In the meantime, the EMSTS office will continue to investigate how a statewide system can best be attained. The most immediate task will be to collect information that can be used to support a request during a future legislative session for laws that will better enable and help to finance a true trauma care network for Arkansas.

The AHA workgroup will continue to meet as necessary to review new information as it becomes available.

The Agency for Healthcare Research and Quality reported January 16 that U.S. spending to treat trauma-related disorders nearly doubled between 1996 and 2003 to surpass heart disease as the leading medical expenditure by condition.

The number of Americans with medical expenditures for heart conditions increased nearly 17% to surpass cancer as the second leading medical expenditure by condition.

Go to http://meps.ahrq.gov/CompendiumTables/TC_TOC.htm to view the data for the report.
As a leader in your healthcare facility, how are you progressing? Have you selected the right people to be on your team? Are your leaders and managers properly trained?

Supervising may be a bit unnerving for some, especially those who have been moved into management positions without assistance in developing skills and competencies necessary for the job. Those individuals want to succeed in their new positions, and you want them to succeed. But they cannot learn to be excellent supervisors just by receiving a new title.

Studies of employee turnover show that the direct relationship with the supervisor is the Number 1 reason staff leave their current position. If you can help your managers become effective communicators, good leaders, excellent organizers and positive influences, your employee turnover rate should diminish and your hospital’s efficiency should increase. You enable your managers to achieve success when you sign them up for this certificate series.

The series will offer the following one-day workshops:

<table>
<thead>
<tr>
<th>Date</th>
<th>Workshop Title</th>
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<td>April 19</td>
<td>Leaping from Staff to Management: You’re a Manager…Now What?</td>
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<td>April 20</td>
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Series and workshop information is available on the AHA Web site at www.arkhospitals.org/calendar. For more information on this exciting new program, please contact Beth Ingram at 501-224-7878.
Arkansas Hospital Investment Program Now Available Through AHA Services, Inc.

Short-term and ultra short-term investment services are now available to AHA members through the Arkansas Hospital Association (AHA) subsidiary, AHA Services, Inc. (AHASI). AHASI has endorsed Bancorp South Investment Services, Inc. (BISI), a wholly owned subsidiary of Bancorp South Bank, as investment adviser to AHA member hospitals.

A letter announcing this endorsement was recently sent to all Arkansas hospital CEOs and CFOs. BISI began marketing the new program, called the Arkansas Hospital Investment Pool (AHIP) early in January 2006.

BISI provides ultra short-term and short-term fixed income investment services to participating hospitals that have excess reserves or operating capital needing to be put to work in the short term. The investment products BISI offers are designed to preserve capital, enhance returns and maintain liquidity.

BISI has a long and successful track record of providing fixed income investment instruments to hospital association members in Mississippi and Louisiana. In addition, they are in the process of finalizing an agreement with the Alabama Hospital Association service corporation to provide similar investment services to their member hospitals.

Questions about the program may be directed to Don Adams at the AHA by calling 501-224-7878 or e-mailing donadams@arkhospitals.org.

AAHT: Helping Hospital Trustees Better Understand and Become More Effective in Their Role

How can you educate your hospital’s governing board to be better-informed trustees of your organization? How can you provide networking opportunities for them with access to other trustees around the state? How can you offer information with a broad perspective on healthcare policy and issues, along with new insights and information on a trustee’s specific role within the hospital?

The answer? Join the Arkansas Association of Hospital Trustees (AAHT), an affiliate of the Arkansas Hospital Association (AHA). The AAHT was formed in 1993 to help hospital trustees become more informed and effective board members through education and communication. Now, in its 12th year, the Association membership has grown to more than 560 trustees, representing 47 Arkansas hospitals. Dr. Steve Smart of El Dorado serves as the AAHT’s current president.

“Interaction with directors from other hospitals throughout the state has been invaluable for me, and this benefit is available for your directors as well,” Smart says. “The AAHT offers the opportunity to be as involved and informed as a director could possibly desire. If there is no interest in new commitments of time, there are the options of simply utilizing the literature provided by AHA to stay abreast of trends and director responsibilities or to attend excellent continuing education programs sponsored by the AAHT for trustees. In addition, my personal exposure to the AHA is heightened by my representing the AAHT on the AHA Board of Directors.”

Membership in the organization is only $250 per hospital, and that entitles every one of your board members to all AAHT benefits. A brochure detailing those benefits and a membership application were recently mailed to all hospitals.

There truly is strength in numbers and there is value in linking to those with common needs, concerns, and goals. Please consider joining the Arkansas Association of Hospital Trustees and strengthening the voice of Arkansas hospitals. Contact Beth Ingram at 501-224-7878 for information about AAHT.
Arkansas Children’s Hospital Brings Home an EMMY Award

Arkansas Children’s Hospital (ACH) and Litzwire Sound & Vision were recently awarded a prestigious Emmy Award for their all-terrain vehicle (ATV) safety television spots entitled “ATVs are Not Toys.” The award was presented at the Mid-America Regional Emmy Awards ceremony held late last fall at the Hyatt Regency in St. Louis, Missouri.

The Mid-America Chapter of the National Academy of Television Arts & Sciences includes markets in Illinois, Missouri, Iowa, Kansas, Kentucky, Louisiana and Arkansas. In each award category, three finalists are selected as having the honor of being “Emmy Nominated” and one nominee wins the Emmy Award.

“The Emmy Award is certainly well known and highly prestigious,” said Scott Allen, director of Community Outreach at Arkansas Children’s Hospital. “It is a great honor for Arkansas Children’s Hospital and Litzwire Sound & Vision to be recognized for our work on these public service announcements promoting ATV safety. We believe these video spots will help raise awareness of ATV-related dangers, illustrate consequences of poor choices and cause families to give careful consideration before allowing anyone on an ATV.”

Arkansas has seen a continued rise in injuries to children resulting from ATV crashes. In 2004, ACH admitted 65 patients with ATV-related injuries. More than half of those injured were under age 12, most were riding adult-sized ATVs and very few were wearing helmets. National statistics indicate that children constitute only 14 percent of ATV drivers, but account for nearly 40 percent of ATV-related injuries.

The ATV safety spots are shown on cable systems originating in central, northeast and northwest Arkansas to help raise awareness of the need for ATV safety.

To view the Emmy-winning public service announcements go to www.archildrens.org and click on the link under ACH Spotlight on the right-hand side of the home page.

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Information Technology Forum Scheduled for April 26

Are you preparing for the wave of information technology that is sweeping healthcare today? Surely you wouldn’t spend hundreds of thousands or even millions of dollars on new equipment, new technology or new services without investing in appropriate education of your information technology department, would you?

In order to provide answers for hospitals to meet that challenge, the Arkansas Hospital Association in cooperation with the Arkansas Chapter, Health Information and Management Systems Society (HIMSS) will present an Information Technology Forum on Wednesday, April 26 at the Holiday Inn Select in Little Rock.

Forum presentations include: Developing practical information security policies; IT best practices for using technology to improve patient care, including the development of a new “eICU,” a self-developed PACS (Picture Archival and Communication System) and what telemedicine can mean to your hospital; the emerging RHIO (Regional Health Information Organization) movement; a discussion of the National Health Information Network; how to achieve CPHIMS designation; and an update from the Arkansas Chapter, HIMSS.

Program and registration information are available by clicking on www.arkhospitals.org/calendarworkshops.htm, or by contacting Beth Ingram at 501-224-7878 or bingram@arkhospitals.org. •

CMS Projects $4 Trillion Health Bill

According to numbers published by the Centers for Medicare & Medicaid Services (CMS), it took 30 years for the nation’s healthcare spending to top $1 trillion following the 1965 law that set up the Medicare program. The milestone occurred in 1995. CMS recently released its newest national healthcare expenditure projections which cover the next ten years. Those estimates show that the U.S. health bill will climb to $4 trillion by 2015. If that happens, the total will have increased 300% in just 20 years.

According to CMS, annual healthcare spending growth will continue to slow through 2007 and average 7.2% through 2015. That would be slower than in recent years, but still 2.1% faster than the annual growth in Gross Domestic Product (GDP). Hospital spending growth for 2005 is projected at 7.9%, which reflects a projected slowdown in inflation and in Medicaid spending growth. Nevertheless, it marks the second consecutive year that growth in the sector is expected to outpace growth in total personal healthcare expenditures.

If CMS' projections are correct, by 2015, public payer spending, including federal and state dollars, will account for 47.5% of the country’s total healthcare spending, and will consume 20% of GDP.

The study also forecast the following significant projections:

- Medicare spending will spike by 25% in 2006 due to the new prescription drug benefit, then average 7.5% growth between 2008 and 2015.
- Medicaid spending should average 8.6% growth annually from 2008 through 2015 when spending reaches $670 billion. Medicaid is a joint federal-state program for poor Americans.
- Private health insurance premiums slowed for a third consecutive year and grew by 6.8% in 2005. However, an upturn in the underwriting cycle in 2007 means that premiums will grow by a forecast 8.3% in 2009.
- Out-of-pocket spending is predicted to decline by 1% in 2006 after remaining stable at 5.6% growth in 2005. Consumers are expected to spend $421 billion out of pocket on healthcare by 2015, up from $248.8 billion in 2005.

For more details, visit http://www.cms.hhs.gov/NationalHealthExpendData/03_NationalHealthAccountsProjected.asp. •
An ad hoc committee composed of Arkansas hospital representatives met February 3 with Arkansas Blue Cross officials to discuss the insurer’s recent policy change requiring prior approval (PA) for certain “high-tech” outpatient imaging services.

Effective February 1, Blue Cross started requiring the PA for Computed Tomography, Magnetic Resonance Imaging, Positron Emission Tomography and Nuclear Cardiology procedures in an effort to better manage the utilization of those services.

During the meeting, Blue Cross representatives Mike Brown, Dr. Clement Fox and Dr. Pete Marvin reviewed the reasons why the insurer has implemented the policy, saying that it is an attempt not only to curtail over-utilization, but also to provide a mechanism for identifying physicians who are ordering the procedures and those delivering them. Currently, Blue Cross doesn’t have an information system capable of identifying physicians who may be over- or under-utilizing imaging services.

The three also responded to issues and concerns raised by the committee members. Primary among those concerns are physicians’ complaints related to the added workload and time-consuming process for obtaining the PAs. Dr. Fox shared data from the first week of operation (the call line for the PA went “live” on January 23) showing that the average response time to the calls ranged from four minutes and 20 seconds to seven minutes and 15 seconds (including answer time). However, since the process may often involve callbacks, there is no data to indicate how long it takes to get the final PA approved. Blue Cross will be working with its contractor, National Imaging Associates (NIA), to reduce those times where possible.

Hospitals are also concerned that physician reluctance to fully accept the process and obtain PAs for patients they refer will put hospitals at risk of losing reimbursements for those procedures, especially when the referring physician has no payment at stake for providing the imaging service or reading it. Blue Cross will deny payment for the technical and professional component related to the affected services absent a prior authorization, and hospitals can’t balance-bill patients for the unpaid amounts.

Dr. Fox noted that there is an incentive for referring physicians to abide by the new policy. Any physician who has signed a Blue Cross contract has an obligation to comply with the terms and conditions that govern the organization’s utilization management program. The PA policy is part of that program. Failure to comply may result in the physician being excluded from Blue Cross’ provider network.

During the first week of operations, NIA handled 312 calls requesting PAs. Of those, 238 were approved and 40 were disapproved for administrative (i.e. eligibility) reasons and four

The American Association of Colleges of Nursing (AACN) reported in December 2005 that enrollment in entry-level baccalaureate nursing programs increased 13% for the 2005-2006 nursing school classes, but nursing colleges and universities were forced to turn away 32,617 qualified applicants due to capacity constraints.

“Despite the successful efforts of schools nationwide to expand student capacity, our nation’s nursing schools are falling far short of meeting the current and projected demand for RNs,” said AACN president Jean Bartels.

The federal government projects a shortfall of 800,000 registered nurses by the year 2020. Pamela Thompson, CEO of the American Organization of Nurse Executives (AONE), said, “This data from AACN is troubling for all of us. We desperately need to increase the number of students graduating from baccalaureate programs, but the constraints on schools to accomplish this seem to be increasing. The shortage of faculty and limits to capacity could cripple our ability to graduate enough nurses to meet our future needs. We must continue to search for multiple solutions to this growing problem.”

AONE is an American Hospital Association subsidiary.
requests were withdrawn by the requesting physicians.

PAs for another 30 requests were given with an “alternative clinical recommendation,” an educational qualification. In short, those requests would not meet the guidelines for a PA if submitted for the same reasons as of May 1, 2006.

The discussions also covered these items:
- Although the policy went into effect February 1, Blue Cross will not deny payment for the failure to obtain a PA for procedures previously allowed under its coverage policy until May 1, 2006.
- Blue Cross is currently using NIA guidelines to cover reviews of procedures for which there are no Blue Cross guidelines. See the NIA guidelines at http://healthadvantage-hmo.com/providers/AuthInf.asp or at http://www.radmd.com.
- A set of “Frequently Asked Questions” about the prior authorization policy on outpatient diagnostic imaging procedures is available via Blue Cross’ secure AHIN Web site that providers can access through http://www.healthadvantage-hmo.com.
- While hospitals can’t obtain a PA for a physician, they may initiate the process by contacting NIA and providing initial demographic information on the patient.
- For now, physicians must contact NIA via telephone to request a PA. But, those physicians registered with the radmd.com Web site may retrieve a PA number via that address by logging on with their assigned user ID and password.
- Blue Cross is working with NIA to make the full PA process, from the initial request through actually obtaining the PA number, available online. Hopefully, that can be accomplished by May 1, 2006.
- Blue Cross is requiring the PA approval in cases where it is the secondary payer, but does not require it for Medi-PAK policies.

According to Blue Cross, the NIA review process is conducted at three levels. A non-clinician answers all calls and may grant a PA number for procedures that unquestionably meet the guidelines. If there are questions, the request is forwarded to a clinical nurse or a radiological technologist. If the matter remains unresolved, a physician handles the request. Denials are given only at the physician level.

Nurses May Conduct Some Medical Screening Exams, but Must Follow All Rules

During the Arkansas Hospital Association’s (AHA) “Day with the Lawyers” seminar on January 25, there was discussion as to whether registered nurses are able to conduct “medical screening examinations” (MSEs) as defined under the federal Emergency Medical Treatment and Active Labor Act (EMTALA).

AHA Legal Counsel Elisa White has learned that there is confusion about this issue traceable to Arkansas State Board of Nursing (ASBN) interpretations. White believes the confusion is related to the differences in factual scenarios presented to the ASBN and not to any inconsistency in the board’s policies.

The Rules and Regulations for Hospitals and Related Institutions in Arkansas addresses this EMTALA issue under Section 36(F)(1), which states, “Each patient presenting to the Emergency Department shall have a medical screening examination by a qualified medical personnel (QMP).”

According to the Arkansas Department of Health and Human Services, qualified medical personnel, including RNs, who have been formally designated by the hospital’s medical staff and governing authority may provide those medical screening exams. However, the Rules and Regulations further states, “The examination shall be completely documented. If a physician is not present, the qualified medical personnel shall contact the physician requested by the patient or the physician on call to discuss the assessment findings and determine the patient’s condition [emphasis added].”

In response to a request from the AHA, the ASBN has clarified that a registered nurse may perform a medical screening examination (MSE), as long as that examination is consistent with the RN’s scope of practice. The hospital must evaluate whether and to what extent an RN should be performing MSEs, and the specific requirements for the performance of MSEs by various personnel (RNs, APNs, etc.) should be set out in the hospital’s bylaws and rules and regulations.

Hospitals will want to ensure that appropriate personnel perform MSEs depending upon the overall complexity of the patient’s healthcare problem and that, if there is no physician present, the RN or other QMP must consult with a physician, who will determine if an emergency medical condition exists. In general, it is recommended that hospitals allowing RNs to perform screening exams provide clear protocols governing these evaluations and provide the nurses with prompt access to physician support as needed for patient care.

Hospitals that continue to have questions about this matter should feel free to contact the AHA at 501-224-7878 for additional information.
Help for Hospitals:  

Use SWOT to Attack Top 10 Changes in OPPS Final Rule

Based upon the big changes in the 2006 OPPS (Outpatient Prospective Payment System) final rule and the CPT code updates, I recommend hospitals follow a “SWOT” plan of attack in this top 10 list. Use it to implement, manage, and respond to APC revenue impact, code changes, and new billing requirements in your facility.

What is SWOT? It’s an acronym that stands for Strengths, Weaknesses, Opportunities and Threats. Your hospital should plot out strategies based upon the “hot spots” listed below. Outlining your “SWOT” list with the appropriate team members will assist in designing your facility’s execution plan. (Note: This list is not in order of importance; facilities should order it based on the services they provide.)

1. Medicare’s commitment to new technology APC revenue. Based upon the refinement of payment bands, updated surgical/implantation criteria, and movement of APC revenue from new technology to established APC groups, hospitals should monitor their new technology APCs carefully in the coming year. Compare your facility’s specific 2005 to 2006 APC payments to yield insightful revenue analysis.

2. Large amount of CPT/HCPCS code, status indicator, and APC changes. Based upon previous years, 2006 brings a number of new APC revenue opportunities; however, direct careful attention to the following areas – packaged status indicators (SI) changed to a payable APC, category III code(s), deleted CPT code(s), and deleted temporary HCPCS code(s) with conversion to permanent HCPCS code(s).

   It’s important to use Addendum B final 2006 APC payments and condition codes (CC) – CH, NI, NF. Work with the deleted CPT/HCPCS code(s) first; and replace with new code if applicable. This is extremely important with deleted HCPCS codes, as Medicare has replaced them with permanent codes. Be sure to expose HIM coders to Category III and HCPCS codes under OPPS along with 2006 CPT.

3. New outlier formula for both hospitals and community mental health services (CMHS). For hospitals, the formula changes so that outlier payments are triggered when the cost of furnishing a service or procedure by a hospital exceeds 1.75 times the APC payment amount, and exceeds the APC payment rate plus $1,250. The outlier payment will continue to be calculated as 50% of the amount by which the cost exceeds.

   For CMHS, the formula changes when cost of furnishing a service or procedure exceeds 3.40 times the APC payment rate and the outlier payment is calculated as 50% of the amount by which the cost exceeds 3.4 times the APC payment rate.

4. APC payment changes for vascular access procedures. With new CPT codes introduced in 2004, Medicare had enough data to create new APCs 621, 622 and 623 with APC national payments of $489.85, $1,264.39 and $1,615.56. This is a major increase from 2005 – in some cases up to 55%. Due to the varying service sites in which these procedures can be performed (interventional radiology, special procedures, treatment rooms, cardiology, and the operating room) and different application of CPT codes – HIM v. CDM – remember to re-validate the accuracy of your CPT code reporting to ensure APC revenue integrity.

5. Update your pharmacy CDM from the inside out. Medicare finalized outpatient drug payments using Average Sale Price (ASP) + 6%, which has integrated payment for both acquisition and overhead costs in aggregate. This means no extra C codes for 2006 (whew!), but it also means your pharmacy CDM needs immediate and continued attention. A slew of status indicator changes along with HCPCS updates will keep the APC reimbursement analyst busy. Medicare will continue to pay for transitional pass through drugs (status indicator [SI] G), separately payable drugs without pass through payments (SI K), vaccines (SI L, F), and orphan drugs (G).

   Use 2006 Addendum B and sort through the above status indicators in order to assist with your CDM update. Remember, pharmacy systems typically have “sub-basements” that must be mapped to your CDM tediously in order for the HCPCS to transfer to the UB-92 claim form.
Recheck your revenue codes and do not forget to validate each quarter a number of claims to ensure APC revenue integrity to include HCPCS code(s) and units.

6. Radiopharmaceuticals (RP) and nuclear medicine. Medicare adopted status indicator H along with more HCPCS codes to identify separately payable RP’s based on the hospital’s charge adjust to cost for CY 2006. CMS will continue to collect data and ask for your input in anticipation of the 2007 updates. Again, with the added APC revenue opportunities, it is imperative to re-validate your nuclear medicine CDM for updated RP HCPCS codes.

7. Wound care updates, including CPT and HCPCS. There are major changes within the CPT manual along with major HCPCS updates and changes for the products (Integra, Apligraf, Dermagraft, Trancyte, and Orcel) used during these procedures. There’s a whole new skin section in the 2006 CPT Manual under integumentary to implement. CMS will also separately pay for 97602 (nonselective wound care debridement). This requires immediate education for the HIM outpatient coders, CDM updates, and department involvement.

8. Stick it to me—injections and infusions. For the second year, major updates to drug administration require education in a variety of different departments, including ED, urgent care, ambulatory care, chemotherapy, and IV therapy units in which injections, infusions and chemotherapy are provided. Not only do we have to contend with the 2006 updates, facilities will have to mix both CPT (20 codes) and HCPCS (eight C codes) in order to get this right. Even Medicare says that this will be a difficult task for hospitals to implement!

To help educate staff, remember your 4 Ds:
- Distribution information, including 2006 CPT updates, November 2005 CPT Assistant, CPT 2006 overview, and transmittals from Medicare to the appropriate departments including coding, clinical, compliance and billing.
- Detail. Review the detail and instructions for both 2006 CPT and HCPCS with appropriate departments.
- Documentation. Although distributing and poring over the detail is critical, reviewing documentation requirements with specific clinical personnel is the key to the entire puzzle. Develop forms to help ease this burden using input from the specific departments. Good documentation will allow you to choose the right codes in a straightforward manner. Consider a revenue cycle specialist in the ED who combines clinical and financial knowledge to charge injections and infusions, since nurses may be overwhelmed with the changes.
- Dedication. This is not a one-shot implementation project; you must monitor and assess injections and infusions’ coding and billing via documentation and back-end claims submission. Provide ongoing feedback to specific departments to assist with compliance and APC revenue integrity results.

9. Observation services a chronic offender. Once again, CMS issued updated HCPCS codes for observation services. It’s important to note that while observation is simplified, this does not negate the continued need for appropriate physician orders that state why the patient is receiving observation and reliable charge capture to include units and additional services provided during observation. Hospitals need to continue to monitor documentation versus claims submission in this area.

10. Device-dependent APC payments. With device-dependent APC payments fluctuating from year to year, it is critical that hospitals take the time to review their generated APCs and perform a revenue comparison from 2005 to 2006. This is a great opportunity to look at your most frequently reported device-dependent APCs and perform a comprehensive coding review, data transference assurance, charge capture reliability, and FI APC payment reconciliation.

Review Table 16 in the final rule for the complete list of APCs and then run this against your own internal data. Pull a selective sample of claims to perform your internal audit, compile results, provide education and feedback where necessary, and repeat to show your improvement.
U.S. Healthcare Spending Holds Steady

U.S. spending on healthcare increased 7.9% in 2004 to $1.88 trillion, holding steady at about 16% of gross domestic product, according to a new report from the Centers for Medicare & Medicaid Services (CMS). Spending on hospital care grew 8.6%, largely due to the rising costs of providing care but was less than the increase in spending on physician services (9.0%) and home health care (13.3%).

Public spending for hospital care increased 7.9%, led by a 9.9% increase in Medicaid spending, while spending by private payers remained stable at roughly 9.5%. CMS attributed the Medicare increase largely to an enhanced federal matching rate and increased payments to providers that treat a disproportionate share of low-income, uninsured patients.

The data is reported in the January/February issue of Health Affairs.

U.S. healthcare spending rose 7.4% last year

U.S. healthcare spending grew 7.4% in 2005 to surpass $2 trillion and is expected to grow 7.3% in 2006, the CMS said in an annual report. That’s down from a recent peak of 9.1% growth in 2002. The increase in spending on hospital services, 7.9%, outpaced overall healthcare spending growth for the second year in a row. The CMS said Medicare spending will exceed $790 billion in 2015, up from $309 billion in 2004. Medicaid spending, meanwhile, will hit $670 billion in 2015, up from $293 billion in 2004.

Additional $36 Billion Medicare Reduction Proposed in President’s 2007 Budget

Practically on the heels of congressional action to approve a federal budget bill for fiscal year 2006 that will take about $11 billion from the Medicare and Medicaid programs between now and 2010, President Bush in early February released his budget recommendations for FY 2007 that would take another $36 billion in cuts from the Medicare program over five years projected out through 2011. This time, the reductions would have a more direct hit on hospitals through the following means:

- A reduction in the market basket update for inpatient and outpatient care of 0.45% in FY 2007; of 0.4% in FY 2008, and of 0.4% in FY 2009. ($8.1 billion)
- A freeze in the payment update for inpatient rehabilitation facilities for 2007 and an update of market basket minus 0.4% in 2008 and 2009. ($1.6 billion)
- A freeze in the payment update for skilled nursing facilities for 2007 and an update of market basket minus 0.4% in 2008 and 2009. ($5.1 billion)
- A freeze in the payment update for home health care for 2007, and an update of market basket minus 0.4% in 2008 and 2009. ($3.5 billion)
- A four-year phase-out of reimbursement for Medicare bad debt. ($6.2 billion)
- An adjustment of payment for hip and knee replacements in post-acute settings. ($2.4 billion)
- The administration also proposed an overall Medicare spending cap, which, if exceeded, would require automatic across-the-board cuts to all provider payment. This could be significant.

The administration also proposes to wring out another $5.9 billion in other cuts to Medicaid through a draw down of public providers’ payments with the use of intergovernmental transfers, instituting further restrictions on Medicaid upper payment limits and reducing the allowable Medicaid provider tax that some states rely on to generate Medicaid matching funds.

In addition to the Medicare and Medicaid cuts, the president’s proposed budget for fiscal year 2007 contains about $133 million in proposed cuts to rural health programs administered by the Department of Health and Human Services’ Health Resources and Services Administration. Among those proposed cuts, funding for rural flexibility grants would be eliminated, down from $64 million in funding this year; and rural health outreach funding would decline to $10 million from $39 million this year.

“Hospitals already are stretching scarce resources to respond to the daily challenges of providing care to all who come through our doors,” said American Hospital Association President Dick Davidson. “...We share the Administration’s goal to improve health in America and expand access and coverage for the uninsured, and will continue to work toward health coverage for all. But the budget put forward by President Bush is a step backward in protecting access to care for all Americans.”
JCAHO “Surge Hospital” Guide Now Available

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) recently issued a guide describing how community, state and federal healthcare planners can establish temporary facilities called “surge hospitals” to supplement existing hospitals in an emergency.

The guide examines the various types of surge hospitals, and how to plan for, establish and operate them and how surge hospitals were established during the recent hurricanes in the Gulf Coast.

“Hurricanes Katrina and Rita have shown us that having plans to ‘surge in place,’ meaning expanding a functional facility to treat a large number of patients after a mass casualty incident, is not always sufficient in disasters because the healthcare organization itself may be too damaged to operate,” the JCAHO notes.


New Video Shows Clinicians How to Treat Children Exposed to Chemicals Used in Bioterrorism Attacks

Now available is the Department of Health and Human Services’ Agency for Healthcare Research and Quality (AHRQ) video The Decontamination of Children: Preparedness and Response for Hospital Emergency Departments. This is a 27-minute video that trains emergency responders and hospital emergency department staff on how to decontaminate children who have been exposed to hazardous chemicals during a bioterrorism attack or other disaster.

Produced for AHRQ’s Bioterrorism Preparedness Research Program by Michael Shannon, M.D., M.P.H., Chief of the Division of Emergency Medicine at Children’s Hospital, Boston, the video outlines key differences between decontaminating children and adults; provides an overview for constructing portable and permanent decontamination showers and designating hot and cold zones; and provides steps to establishing and maintaining pediatric decontamination capacity in a hospital emergency department.

This video provides a step-by-step demonstration of the decontamination process in real time and trains clinicians about the nuances of treating infants and children, who require special attention during decontamination procedures. For example, children may be frightened not only by the emergency situation itself, but also may be afraid to undergo decontamination without their parents; children also take longer to go through the decontamination process than adults.

“The Decontamination of Children” video provides a valuable and straightforward overview for first responders and hospital emergency personnel on decontaminating infants, children, and parents who have been exposed to dangerous chemical agents,” said AHRQ Director Carolyn M. Clancy, M.D. “I hope this will be a valuable tool for those taking care of children, who will be one of our most vulnerable populations during a bioterrorism attack or other emergency.”

A short clip from “The Decontamination of Children” can be found online at http://www.ahrq.gov/research/decontam.htm. A free, single copy of the video – available in DVD or VHS format – may be ordered by calling 1-800-358-9295 or by sending an e-mail to ahrqpubs@ahrq.gov.

AHRQ has funded more than 50 emergency preparedness-related studies, workshops, and conferences to help hospitals and healthcare systems prepare for medical emergencies. More information about these projects can be found online at http://www.ahrq.gov/browse/bioter.htm.
The Department of Health and Human Services (HHS) on January 12 announced that $100 million in funding is being made available to U.S. states, territories and regions as part of the administration’s plan to prepare the nation for a potential flu pandemic. The funding is part of $350 million included in the recent emergency appropriation for combating pandemic influenza passed by Congress in December.

These initial grants will be awarded to all 50 states, seven territories, the Commonwealth of Puerto Rico and the District of Columbia. Each state will receive a minimum of $500,000, with additional allocation of funds by population. In addition to the state grants, funds are being awarded to New York City, Chicago and Los Angeles County. The remaining $250 million from the appropriation will be awarded later this year in accord with guidance that will require progress and performance.

States and municipalities are to use these funds to accelerate and intensify current planning efforts for pandemic influenza and to exercise their plans. The focus is on practical, community-based procedures that could prevent or delay the spread of pandemic influenza and help to reduce the burden of illness communities would contend with during an outbreak.

In December, HHS Secretary Michael Leavitt met with senior officials from all 50 states and launched a series of preparedness summits to be held in every state over the next several months. The goal of the summits is to enhance state and local preparedness. In addition to this new funding and the state summits, HHS has sought to foster planning by developing checklists for individuals and families, businesses and state and local health departments to aid their pandemic preparedness efforts.
In a November 14 letter to State Survey Agency directors, the Centers for Medicare & Medicaid Services (CMS) provided guidance for the implementation of new regulations regarding the location and relocation of Critical Access Hospitals (CAH).

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), enacted in December 2003, contained a number of modifications to the CAH statutory requirements. Included was a new provision that eliminated the use of state-issued necessary provider designations, which allow participation of CAHs that do not meet the requirement to be located 35 miles from a hospital or another CAH or, in the case of mountainous terrain or in areas with only secondary roads available, a 15-mile drive.

The MMA stipulates that the necessary provider designations would no longer be issued on or after January 1, 2006. The MMA allows grandfathering for CAHs that were already certified via a necessary provider designation prior to January 1, 2006, but the Act raised questions about the grandfathering of those medically necessary providers that build replacement facilities in new locations.

The interpretive guidelines address the criteria used by a CMS Regional Office to determine if a CAH that relocates continues to be essentially the same provider serving the same community so that the same provider agreement would continue to apply to the CAH or medically necessary provider at the new location. The guidelines are available at http://www.cms.hhs.gov/medicaid/survey-cert/letters.asp.
Overview

The intent of the CAHPS®, Hospital Survey (also known as Hospital CAHPS or HCAHPS) initiative is to provide a standardized survey instrument and data collection methodology for measuring patients’ perspectives on hospital care.

While many hospitals collect information on patient satisfaction, there is no national standard for collecting or publicly reporting this information that would enable valid comparisons to be made across all hospitals. In order to make “apples to apples” comparisons to support consumer choice, it is necessary to introduce a standard measurement approach.

HCAHPS can be viewed as a core set of questions that can be combined with a customized set of hospital-specific items. HCAHPS is meant to complement the data hospitals currently collect to support improvements in internal customer services and quality related activities.

Three broad goals have shaped the HCAHPS survey. First, the survey is designed to produce comparable data on the patient’s perspective on care that allows objective and meaningful comparisons between hospitals on domains that are important to consumers. Second, public reporting of the survey results is designed to create incentives for hospitals to improve their quality of care. Third, public reporting will serve to enhance public accountability in healthcare by increasing the transparency of the quality of hospital care provided in return for the public investment.

With these goals in mind, the HCAHPS project has taken substantial steps to assure that the survey will be credible, useful, and practical. This methodology and the information it generates will be made available to the public.

HCAHPS Development

The Centers for Medicare & Medicaid Services (CMS) has partnered with the Agency for Healthcare Research and Quality (AHRQ), another agency in the Department of Health and Human Services, to develop HCAHPS. AHRQ has carried out a rigorous, scientific process to develop and test the HCAHPS instrument. This process has entailed multiple steps, including a public call for measures; review of existing literature; cognitive interviews; consumer focus groups; stakeholder input; public response to several Federal Register notices; a three-state pilot test; consumer testing; and small-scale field tests.

The HCAHPS survey is composed of 27 items: 18 substantive items that encompass critical aspects of the hospital experience (communication with doctors, communication with nurses, responsiveness of hospital staff, cleanliness and quietness of the hospital, pain control, communication about medicines, and discharge information); four items to screen patients to appropriate items; three items to adjust for the mix of patients across hospitals; and two items to support congressionally-mandated reports.

In May 2005, the 27-item HCAHPS survey was formally endorsed by the National Quality Forum (NQF), a voluntary consensus standard-setting organization established to standardize healthcare quality measurement and reporting. The NQF endorsement represents the consensus of many healthcare providers, consumer groups, professional associations, purchasers, federal agencies, and research and quality organizations.

Acting upon an NQF recommendation, CMS commissioned an independent research firm, Abt Associates, Inc., to conduct an analysis of the benefits and costs of HCAHPS. The Abt report, which includes detailed cost estimates for hospitals, can be found at http://www.cms.hhs.gov/hospitalqualityinitiatives/30_hospitalHCAHPS.asp.

On November 7, 2005, CMS published the final public call for comments on the HCAHPS survey, with a 30-day public comment period.

Mode Experiment

Following OMB approval of the survey, CMS will initiate a large-scale study to investigate whether the four approved modes of survey administration (mail, telephone, mail with telephone follow-up, and active IVR), as well as the mix of patients a hospital serves, systematically affect survey results. A representative sample of hospitals will be invited to participate in this experiment.

Training for HCAHPS

Training for administering the Hospital CAHPS survey was held in February 2006. All survey vendors that intend to administer the survey, as well as hospitals that plan to conduct the survey for themselves, were required to attend.

Dry Run

A short “dry run” of the survey will be implemented following training. This dry run will give hospitals and survey vendors the opportunity to gain first-hand experience collecting and transmitting HCAHPS data — without the public reporting of results. Using the official survey instrument and the approved modes of implementation and data collection protocols, hospitals and survey vendors will collect HCAHPS data for one or two months and report it to CMS. All hospitals that intend to participate in HCAHPS must take part in
the dry run for one or both months. The data collected during the dry-run phase will not be publicly reported.

**National Implementation**

Collection of HCAHPS data intended for the public reporting of results will commence shortly after the conclusion of the dry run. Hospitals will voluntarily implement HCAHPS under the auspices of the Hospital Quality Alliance, a private/public partnership that includes the major hospital associations, government, consumer groups, measurement and accrediting bodies, and other stakeholders who share a common interest in improving hospital quality.

This first full national implementation of HCAHPS is planned for late 2006, with the first public reporting of HCAHPS results slated for late 2007. HCAHPS results will be posted on the Hospital Compare Web site, found at [www.hospitalcompare.hhs.gov](http://www.hospitalcompare.hhs.gov), or through a link on [www.medicare.gov](http://www.medicare.gov).

**Quick Facts about HCAHPS**

- HCAHPS will result in the first truly national, standardized, publicly reported benchmark of hospital patients’ perspectives of their care.
- Participation in HCAHPS is voluntary; there are no financial incentives or disincentives tied to the survey.
- All short-term, acute care, non-specialty hospitals are invited to participate.
- Hospitals may use an approved survey vendor, or collect their own HCAHPS data.
- Hospitals may either integrate the HCAHPS items within their own patient satisfaction survey, or implement HCAHPS as a separate survey.
- The survey can be conducted by mail, telephone, mail with telephone follow-up, or active IVR; CMS will adjust the results prior to public reporting for mode of administration and patient-mix effects.
- Hospitals will survey a random sample of their live discharges who were 18 and older at admission, had an overnight stay, and had a non-psychiatric diagnosis.
- Hospitals should survey patients on a monthly basis and submit data to CMS on a monthly or quarterly basis.
- Hospitals are asked to provide 300 completed surveys per year; for smaller hospitals, as few as 100 completed surveys are needed for public reporting.
- Hospitals will own their raw HCAHPS data and are free to analyze it as they wish.
- Hospitals may preview their HCAHPS results prior to public reporting.

**For More Information**

To learn more about HCAHPS, please visit the following Web sites:

- For information about training: [www.hcahpsonline.org](http://www.hcahpsonline.org)

**To Provide Comments or Ask Questions:**

- To communicate with CMS staff about implementation issues: [Hospitalcahps@cms.hhs.gov](mailto:Hospitalcahps@cms.hhs.gov)
- To communicate with AHRQ staff on survey development issues: [Hospital-CAHPS@ahrq.gov](mailto:Hospital-CAHPS@ahrq.gov)
- For technical assistance, contact the Arizona QIO: [hcahps@azqio.sdps.org](mailto:hcahps@azqio.sdps.org) or 1-888-884-4007

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**Supreme Court Upholds Assisted-Suicide Law**

The Supreme Court, in mid-January, upheld Oregon’s unique physician-assisted suicide law. With this ruling, the Court held that the Bush administration improperly tried to use a drug law to prosecute Oregon doctors who prescribe overdoses to help terminally ill patients end their lives.

In a 6-3 vote, the justices held that federal authority to regulate doctors does not override the 1997 Oregon law.

The ruling is seen as a reprimand to former Attorney General John Ashcroft, who claimed in 2001 that doctor-assisted suicide is not a “legitimate medical purpose” and warned that Oregon physicians would be punished for helping people end their lives under the state law.

In the majority opinion written by Justice Anthony Kennedy, he said the “authority claimed by the attorney general is both beyond his expertise and incongruous with the statutory purposes and design,” adding that “Congress did not have this far-reaching intent to alter the federal-state balance.” Kennedy wrote for himself, now-retired Justice Sandra Day O’Connor and Justices John Paul Stevens, David Souter, Ruth Bader Ginsburg and Stephen Breyer.

Writing for himself, Chief Justice John Roberts and Justice Clarence Thomas, Justice Antonin Scalia said federal officials have the power to regulate the doling out of medicine. “If the term ‘legitimate medical purpose’ has any meaning, it surely excludes the prescription of drugs to produce death,” he wrote.

The Oregon law was written to cover only extremely sick individuals with incurable diseases, and whom at least two doctors agree have six months or less to live and are of sound mind.
Study Estimates Costs, Benefits of Increasing Hospital Nurse Staffing

A study in the January/February issue of *Health Affairs* estimates the national cost of increasing hospital nurse staffing and the resulting improvements in patient outcomes. It concludes that increasing the proportion of nursing hours that are provided by registered nurses, without increasing total nursing hours, would avoid nearly 60,000 potential adverse outcomes for patients and reduce hospital expenses by an estimated 0.1%.

Kathy Sanford, president of the American Organization of Nurse Executives, told AHA *News Now* she has no argument with the research. However, she said the nation’s growing shortage of nurses is central to the discussion, noting there aren’t enough nurses graduating from nursing school to replace those retiring and meet future demand.

“Nurse training is expensive,” Sanford said, which is why AONE is working with the AHA and others to lobby for increased funding for nurse faculty and education. AONE is a subsidiary of AHA. For more information and to view the study, go to [http://content.healthaffairs.org/cgi/content/abstract/25/1/204](http://content.healthaffairs.org/cgi/content/abstract/25/1/204).

Studies Estimate Potential Impact of Reducing Public Health Coverage

Only 9% of low-income adults with public health insurance would have access to an alternative source of insurance in the absence of public coverage, a new study from the Kaiser Commission on Medicaid and the Uninsured estimates. The analysis of a national survey of families by researchers at the Urban Institute found the vast majority of enrollees affected by cutbacks in eligibility for public programs would likely be left uninsured. (More information on this study is available at [www.kff.org/medicaid/7449.cfm](http://www.kff.org/medicaid/7449.cfm).

Another new study, in the January/February issue of *Health Affairs*, suggests that savings achieved by reducing eligibility and enrollment in public health insurance programs largely shifts those costs to safety-net providers and other state or local programs that care for the uninsured. More on this study is available at [http://content.healthaffairs.org/cgi/content/full/25/1/237?ijkey=Bzunw9Sr22Wlo&keytype=ref&siteid=healthaff](http://content.healthaffairs.org/cgi/content/full/25/1/237).

Survey Examines Impact of Meth Abuse on County EDs

The National Association of Counties has released a survey exploring the impact of methamphetamine abuse on hospital emergency departments. The vast majority of the 200 hospitals surveyed (in 39 states) were county-owned or operated. Nearly three-quarters reported increases in methamphetamine-related ED visits in the past five years, and nearly half said visits related to methamphetamine exceeded those for any other illicit drug.

A majority of respondents said methamphetamine-related visits were driving up their hospital’s costs and that such patients were often uninsured.

A full copy of the NACo survey “The Meth Epidemic in America: The Effect of Meth Abuse of Hospital Emergency Rooms” can be found at [http://www.naco.org/Template.cfm?Section=Special_Surveys&Template=/ContentManagement/ContentDisplay.cfm&ContentID=18837](http://www.naco.org/Template.cfm?Section=Special_Surveys&Template=/ContentManagement/ContentDisplay.cfm&ContentID=18837). The report also includes an accompanying survey titled “The Challenges of Treating Meth Abuse.”
When it comes to quality of care, you want the best for your facility. That means well trained, proven physicians and allied health professionals who have both the clinical skills and the interpersonal skills to provide the highest level of care.

The MHA Group can help you meet this standard.

We are the industry leader in healthcare staffing and consulting, specializing in the placement of both permanent and temporary physicians and allied healthcare professionals. With over 17 years of experience and over 700 staffing professionals we offer the expertise and resources to be successful in today’s highly competitive staffing market.

The MHA Group is the Endorsed Staffing Provider of AHA Services

For complete information about our services and track record in Arkansas please contact us at:

Your Presence is Requested in Washington, DC
American Hospital Association Annual Meeting, April 30 – May 3

“The Women and Men of America’s Hospitals: First in Hope, First in Care, Always There” is the theme for the American Hospital Association’s annual membership meeting April 30-May 3 in Washington, DC. During the event, Arkansas hospital CEOs, administrators, and trustees will visit with Arkansas’ congressional delegation on Wednesday, May 3, and join the State Chamber of Commerce in honoring the delegation with a dinner Monday, May 1.

The annual meeting format has much to offer. Participants have the opportunity to attain American College of Healthcare Executives Category I credit through a workshop on the Baldrige Award. Hospital trustees will have several educational opportunities to discuss issues such as boardroom disorder, trends in healthcare and their implications for effective governance, and making the most of the board-CEO partnership.

Several executive briefings will be held on topics such as making the case for information technology, improving care through management diversity and surviving Hurricanes Katrina and Rita. Other session leaders will discuss quality improvement strategies for disparities in care, connecting with communities and changing the debate on the value of healthcare.

Attendees also will hear presentations from Newt Gingrich, former Speaker of the House, and a federal relations forum with leaders from Congress and the Administration.

Meeting and registration information has been mailed to American Hospital Association members or you may register online at www.aha.org. Please fax a copy of your meeting registration form to Beth Ingram at the Arkansas Hospital Association (501-224-0519) to receive special mailings detailing Arkansas events. You may also email attendance plans to bingram@arkhospitals.org.

What are the American Hospital Association’s Strategic Goals, 2006-2008?

The American Hospital Association’s Strategic Plan for 2006-2008 is our roadmap to a better future for hospital leaders and the people and communities they serve. It is designed to fix a course for the association to be the strongest advocate for the needs of hospitals and health systems and an important source of ideas that can help members create the kind of community-based healthcare that assures every American the right care, at the right time, in the right place.

The plan provides an overview of the AHA’s strategic direction and finances, highlights the specific goals that will guide the association along the way, and illustrates how the strategies address the planning assumptions that AHA developed last year. For our members, it can give them a useful window on the national issues that affect their futures as well. The plan can be found at www.aha.org. Click on the “Members Only Access” section and then select “2006 - 2008 AHA Strategic Plan.” Do you have questions or feedback? Contact Gene O’Dell, AHA’s vice president of strategic planning, at godell@aha.org.

A Member-Driver Organization

When we say the American Hospital Association is a member-driven organization, what do we mean? We are articulating one of the basic tenets of this association: the hospital leaders we represent are the compasses that determine the direction of this organization.

Our job is to help you do your job … to make your organizations the best they can be for the patients and communities you serve. As the AHA sets a course for its future, its Strategic Plan must reflect the challenges and priorities facing the women and men at the front lines of care, such as:

■ Building a stronger foundation for healthcare. Millions of children and adults go without proper healthcare because their families cannot afford health insurance premiums. Chronically ill Americans are often left alone to manage their complicated, sometimes debilitating illnesses. The AHA stands for a unified healthcare policy that expands coverage, creates fairer payment systems, and provides better management of care.

■ Enhancing community trust and accountability. Every hospital leader should be prepared to talk to his or her community about the work their organization has done on quality and patient safety. To this end, the AHA will continue our key role in the Hospital Quality Alliance, which is helping the public get useful information about hospital quality. We also are helping to lead the Surgical Care Improvement Project (SCIP), a collaborative quality effort aimed at improving surgical care in the nation’s hospitals. America’s hospitals are committed to providing the highest quality of care possible to their patients and communities. Your participation in initiatives like the Hospital Quality Alliance and SCIP offer a powerful reminder to your community of what makes your hospital the special place it is.

■ Strengthening the hospital-community bond. Hospitals have a powerful story to tell about what they mean to the people and communities they serve. At a time when hospitals face signifi-
cant challenges, it's never been more important for you to make sure your community understands the many ways in which your commitment to mission makes life better for those you serve. Renew your hospital’s partnership with your community, and help create in it a sense of ownership in the hospital … the community hospital. Our task is to remind people that hospitals are places where people take care of people with dignity and compassion, inside and outside the four walls, from bedside to billing office.

- Demonstrating your hospital’s contribution to a healthier, stronger America. Healthcare spending is a worthy investment in people’s lives. Every dollar invested in healthcare services produces a return of between $2.40 and $3.00 – a return that comes in the form of fewer deaths, increased longevity, and improved outcomes in several important areas of care. And hospitals not only play a critical role in the health of Americans, they also contribute more than $1.3 trillion to the nation’s economy. They remain a stable source of employment even during times of economic stress, and support other businesses when they purchase the goods and services needed to provide care. Help the public understand that the health benefits we receive as a nation far outweigh the dollars spent, and that spending on healthcare is an investment in the economy, people and a healthier society.

The AHA’s Strategic Plan provides an overview of the AHA’s three-year strategic direction, highlighting specific goals that will guide us along the way, and it illustrates how the goals address the planning assumptions that we developed earlier this year.

Behind every goal and every commitment of resources is a direct connection to the vital work hospitals and health systems must accomplish for the people who rely on them. And as you take a look at the 2006-2008 Strategic Plan (available online at the address above) and the accompanying Strategy Map (below on this page), keep in mind the vision that you and your colleagues across America created when this organization was formed: the vision of a society of healthy communities, where all individuals reach their highest potential for health.

— Dick Davidson
President, American Hospital Association

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2006-2008 AHA STRATEGY MAP

VISION:
A society of healthy communities, where all individuals reach their highest potential for health.

MISSION:
To advance the health of individuals and communities; the AHA leads, represents and serves hospitals, health systems and other related organizations that are accountable to the community and committed to health improvement.

VALUES:
People…Integrity…Leadership…Diversity…Collaboration

GOALS

1. ENABLING HOSPITALS TO BETTER SERVE THEIR PATIENTS AND COMMUNITIES (shorter term)
To implement advocacy strategies and related member services that target:

STRATEGIES:
1A) Protecting the Health Care Safety Net
1B) Expanding Coverage
1C) Enhancing Performance Improvement
1D) Improving Community Health
1E) Increasing Public Accountability
1F) Improving Governance and Building Coalitions

2. DEVELOPING A HEALTH CARE DELIVERY SYSTEM FOR THE 21ST CENTURY (longer term)
To pursue new strategies and advocate for models promoting individuals receiving the right care, at the right time, in the right place.

STRATEGIES:
2A) Preserving the Health Care Safety Net
2B) Securing Coverage for All
2C) Improving Quality and Patient Safety
2D) Advancing Community Health
2E) Ensuring Public Trust and Confidence
2F) Broadening the Base

3. OPTIMIZING OPERATIONAL EFFECTIVENESS
To create and maintain a member- and user-focused organization that promotes excellence, collaboration, innovation, growth and development.

STRATEGIES:
3A) AHA People and Organizational Strategies
3B) AHA Information Technology
3C) AHA Financial Strength
3D) AHA Membership Recruitment and Retention
3E) AHA Governance Process
Arkansas PAC Contributions Recognized

During 2005, the Arkansas Hospital Association Political Action Committee (AHAPAC) received $27,895.35 in contributions, primarily from hospital executives and employees throughout the state. These donations, which are shared between the Arkansas Hospital Association and the American Hospital Association, make possible the financial support those organizations are able to provide to political candidates seeking state or federal elective offices.

Contributions of any amount from all contributors to the AHAPAC are seriously needed and deeply appreciated. However, special acknowledgement is given individuals who contribute at certain threshold levels. Those individuals qualify for recognition as members of the American Hospital Association’s Capitol Club or its Chairman’s Circle.

Capitol Club membership is awarded for individuals who contributed $250 or more to AHAPAC during the year, while the Chairman’s Circle membership is earned with a $500 donation. We thank the individuals from Arkansas who qualified for membership in each of these clubs.

Arkansans who contributed at least $500, becoming members of the AHAPAC’s 2005 Chairman’s Circle are:

Don Adams, Arkansas Hospital Association
Robert Bash, Bradley County Medical Center
Roger Busfield, Arkansas Hospital Association, Retired
David Cicero, Ouachita County Medical Center
Paul Cunningham, Arkansas Hospital Association
Dean Davenport, BKD, LLP
Stephen Erixon, Baxter Regional Medical Center
Dan Gathright, Baptist Health Medical Center-Arkadelphia
Russell D. Harrington, Jr., Baptist Health

Members with minimum contributions of $250 who qualify for membership in the 2005 Capitol Club are:

Robert P. Atkinson, Jefferson Regional Medical Center
Chris Barber, St. Bernards Medical Center
Gary Bebow, White River Health System
JoAnn Butler, Arkansas Hospital Association
Tina Crel, AHA Services, Inc.
Harrison Dean, Baptist Health Medical Center-NLR
David Dennis, St. John’s Hospital-Berryville
Nancy Fodi, Southwest Regional Medical Center
Joel Klein, The BridgeWay
Ray Kordsmeier, Conway
Edward Lacy, Baptist Health Medical Center-Heber Springs

Mental Health Parity Act Extension

The House and Senate in early January approved a one-year extension of the Mental Health Parity Act of 1996, which has been extended each year since its original expiration in 2002.

While this congressional action maintains the protections afforded by the bill as passed in 1996, it falls short of broader parity legislation called for by the American Hospital Association (AHA) and some 250 other health organizations.

In an October 2005 letter prompted by Hurricane Katrina, these groups warned Senate and House leadership that loopholes in the 1996 statute, which requires group health plans to fund mental health benefits at the same level as medical and surgical benefits, allow for higher co-payments, deductibles and co-insurance payments for mental health services.

The groups said a mere extension of the law “is no remedy and would further perpetuate the discrimination faced by those with mental health needs.” The AHA has long advocated parity for hospital days, outpatient visits, co-pays, deductibles and maximum out-of-pocket costs for in-network services.
Arkansas Medicaid Recovering Excess Payments

Representatives of the Arkansas Medicaid program report once again that they are close to beginning the process to recover overpayments related to emergency room claims dating back to September 1, 2003 when Medicaid changed the way it reviews and pays those claims.

Prior to that date, the Arkansas Foundation for Medical Care (AFMC), the medical review contractor, reviewed 100% of Medicaid emergency room (ER) claims, approving or denying them for payment. Since then, the ER claims are paid as submitted to EDS, Medicaid’s intermediary, and AFMC does post-payment reviews on a sample set of claims from each hospital.

Although AFMC has been reviewing ER claims under the new process for more than two years, and denying some, Medicaid has not attempted to recover any payments related to those denied claims. Plans were in place to send out recovery letters early in 2005, but they were halted when Medicaid had to develop regulations pursuant to the Medicare Fairness Act of 2005, which impacts denied claims.

Medicaid’s most recent tally shows that the total amount to be recovered is about $1.4 million for claims denied during the span of more than two years. The hospital-specific range runs from about $300 to more than $170,000, depending on the volume of claims submitted by the hospital.

Medicaid started the recovery process March 1. The amounts to be repaid do not include payments that hospitals received for lab and x-ray charges billed in conjunction with the denied ER visit.

Medicare Proposes Inpatient Psychiatric Facility Rate Increase

Inpatient psychiatric facilities would receive an average 4.2% increase in their Medicare payment rates for discharges occurring on or after July 1, 2006 under a January 13 proposed rule by the Centers for Medicare & Medicaid Services (CMS).

Under the proposed rule, the nation’s freestanding governmental psychiatric hospitals receive the largest share of the aggregate increase.

The payment increase would affect approximately 1,800 inpatient psychiatric facilities (IPFs), including freestanding psychiatric hospitals as well as certified psychiatric units in general acute care hospitals and critical access hospitals that are paid under Medicare’s Inpatient Psychiatric Facility Prospective Payment System (IPF PPS), which was mandated by the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act (BBRA) of 1999 and made effective January 1, 2005.

The IPF PPS bases payments on a single federal per diem rate that includes both inpatient operating and capital-related costs, including routine and ancillary services. The proposed per diem rate for Rate Year (RY) 2007 is $594.66, up from $575.95 in RY 2006. The base rate is adjusted to account for patient and individual facility characteristics.

Plus, the IPF PPS provides a higher payment for each electroconvulsive therapy (ECT) treatment furnished during the IPF stay. Medicare also continues to pay separately for certain costs, including the costs of physician and non-physician practitioner services, bad debt and direct graduate medical education costs.

During a three-year period for transitioning from cost-based reimbursement to the PPS, inpatient psychiatric facilities will be paid a blend of costs and the federal payment rate. For cost reporting periods beginning in calendar year 2006, IPF payment rates will be based 50% on the cost-based methodology and 50% on the federal PPS rate.

A final rule will be published this spring. The new payment rates and policies will become effective for discharges occurring on or after July 1, 2006.

For detailed information, see http://www.cms.hhs.gov/InpatientPsychFacilPPS/01_overview.asp.
OIG Reports FY 2005 Medicaid Savings; Shows Funds Put to “Better Use”

For the six-month reporting period of fiscal year (FY) 2005 that ended September 30, 2005, the Office of Inspector General (OIG) focused on accounting for Medicaid funds and payment for Medicaid prescription drugs. Because the federal share of Medicaid spending is expected to exceed $192 billion in FY 2006, the OIG is anticipating that its work in this area will increase in importance.

The OIG examined state financing mechanisms used to maximize Medicaid payments, documented how the Medicaid program pays too much for prescription drugs compared with prices available in the marketplace and testified before the Senate Finance Committee on its Medicaid work.

Other areas that the OIG focused on in the six-month period in FY 2005 included: (1) the publication of two audits of Medicaid claims for school-based services; (2) identifying vulnerabilities in the National Institutes for Health (NIH) review process; and (3) increasing administrative enforcement through the imposition of civil monetary penalties.

The OIG reported $35.4 billion in savings and recoveries during FY 2005, made up of $32.6 billion in implemented recommendations to put funds to better use, $1.2 billion in audit receivables and $1.6 billion in investigative receivables. The OIG doubled savings and recoveries since FY 2000.

The OIG identified that its biggest challenge in FY 2006 will be the implementation of the Part D program, which will be the largest expansion of the program since its creation.

HHPPS Utilizes Revised MSA Designations

Under new instructions from the Centers for Medicare & Medicaid Services (CMS), Medicare’s home health prospective payment system (HHPPS) annual update for calendar year 2006 is the first that uses the Office of Management and Budget’s revised area labor market Metropolitan Statistical Area (MSA) designations.

CMS Pub. 100-04, Transmittal No. 764, established a one-year transition period to implement the new area labor market designations. The transition index consists of a blend of 50% of the new area labor market designations’ wage index and 50% of the old area labor market designations’ wage index.

The fixed dollar loss ratio, used in the determination of outlier payments, has been re-estimated to 0.65, and the loss-sharing ratio of 0.80 remains unchanged. A new table reflecting the transitional 2006 wage index changes will be installed in the Home Health Pricer software.

AFMC Compliance Workbook Available

The Arkansas Foundation for Medical Care’s (AFMC) Hospital Payment Monitoring Program (HPMP) is making available the latest edition of the HPMP Compliance Workbook.

This workbook is an updated version of the PEPP Compliance Workbook, which AFMC distributed to all Inpatient Prospective Payment System (IPPS) hospitals under the Payment Error Prevention Program (PEPP) in 2000.

The workbook focuses on the role of compliance officers regarding payment error monitoring and prevention in acute care hospitals. It was designed to give practical guidance and provide helpful tools for hospitals that are seeking to develop, update, or strengthen their compliance efforts.

Information contained in the workbook can help hospitals identify and improve their compliance program structures and processes that contribute to payment errors, with emphasis on areas currently being monitored by the Centers for Medicare & Medicaid Services (CMS).


To request a hard copy of the workbook (only one per hospital, please), contact Tori Gammill, HPMP administrative assistant, at 479-649-8501, ext 248.
Medicare Long Term Care Hospital Proposed Rule Would Maintain Current Federal Payment

The Centers for Medicare & Medicaid Services (CMS) issued a January 19 proposed rule for Medicare’s long term care hospital prospective payment system (LTCH PPS) that keeps the federal payment for those facilities at $38,086.04 for the 2007 rate year.

CMS said that the proposal is based on an analysis of the LTCH case-mix index and margins before and after implementation of the LTCH PPS program and the latest available LTCH cost reports, which indicate that LTCH Medicare margins were 8.8% for FY 2003 and 11.7% for FY 2004.

The proposed federal rate is consistent with MedPAC’s recent update recommendation for the LTCH PPS. Long-term care hospitals, in general, are defined as hospitals that have an average Medicare inpatient length of stay greater than 25 days.

These hospitals typically provide extended medical and rehabilitative care for patients who are clinically complex and may suffer from multiple acute or chronic conditions. Services usually include comprehensive rehabilitation, respiratory therapy, head trauma treatment and pain management.

There are now approximately 375 long-term care hospitals in the U.S., a number which is up about 32% since the implementation of the LTCH PPS in FY 2003.

The final rule, which will be effective for discharges occurring on or after July 1, 2006 through June 30, 2007, will be published later this spring.

Go to http://www.cms.hhs.gov/LongTermCareHospitalPPS/ for more information.

Medicare Contractor Reorganization Underway

The Centers for Medicare & Medicaid Services (CMS) announced January 6 that it has awarded contracts for four specialty groups that will be responsible for handling the administration of Medicare claims from suppliers of durable medical equipment, prosthetics and orthotics.

The new contracts are the first of 23 that will be awarded by 2011 to fulfill requirements of the contracting reform provisions of the Medicare Modernization Act of 2003.

CMS selected the four new Durable Medical Equipment Medicare Administrative Contractors (DME MACs) through a competitive bidding process, replacing the current Durable Medical Equipment Regional Carriers (DMERCs).

Geographic jurisdictions are slightly realigned from those formerly serviced by the DMERCs in an attempt to improve service to beneficiaries and providers, support the delivery of coordinated and quality care, and provide greater administrative efficiency and effectiveness for the traditional fee-for-service Medicare program.

The new DME MAC for Arkansas is Palmetto Government Benefits Administrators located in South Carolina.

Under the current Medicare contractor system, fiscal intermediaries process claims for Part A providers such as hospitals, skilled nursing facilities and other institutional providers. Carriers process claims for physicians, laboratories and other suppliers under Medicare Part B.

When contracting reform is fully implemented, the current fiscal intermediary and carrier system will be replaced by MACs responsible for both Part A and Part B claims. The new structure will mean beneficiaries and providers will have a single point of contact with the Medicare program.

The DME MACs will immediately begin transition activities and will assume full responsibilities for the claims processing work currently performed by the DMERCs on July 1, 2006. Once operational, the DME MACs will serve as the point of contact for all Medicare suppliers, whereas beneficiaries will pose their claims-related questions to Beneficiary Contact Centers.

Go to http://www.cms.hhs.gov/MedicareContractingReform for more information.
Anyone who has visited the Centers for Medicare & Medicaid Services’ (CMS) Web site in the past would probably agree that finding specific information there is often like looking for the proverbial needle in a haystack.

It seems that all those howls of frustration finally made their point with the agency’s powers-that-be, because CMS recently launched its redesigned Web site, which is supposed to be more “user-friendly.”

CMS says that its new Web site, which went live December 15, features consistent organization and navigation, timely, relevant and accurate content, an improved Google search feature and much more.

The new Web site is organized in four levels: Top-Level Subject Area (such as Medicare), Category (i.e. hospitals), Section (i.e. PPS Rule) and Page Number. At any time during a visit, it’s possible to navigate back to the Top-Level Subject Area that displays all categories in that area.

The new Web site has one-stop-shopping areas called “Centers” that are targeted to specific professional needs. For example, Providers or Partners have the option to browse the Web site by their area of interest in specific “Provider and Partner Centers,” where help finding and obtaining the most up-to-date information can be found.

CMS also plans to continue evaluating the new Web site in order to provide the best organization and navigation – to help users continue to retrieve the information they are looking for in the most efficient way possible.

CMS urges people to check out the new Web site at http://www.cms.hhs.gov. Find out more by going to the banner entitled “Launch of the Agency’s Redesigned Website.” — Paul Cunningham
Arkansas Hospital Association

The Centers for Medicare & Medicaid Services (CMS) says that a demonstration project on pay-for-performance (P4P) has yielded statistical evidence showing the payment model improves the quality of healthcare for patients. The conclusion was based on the findings of the Hospital Quality Incentive demonstration in which improvements in care were tied to an award of monetary bonuses in CMS’ Medicare payments to hospitals.

The demonstration, in which more than 260 hospitals voluntarily participated, began in October 2003 and included 36 hospitals with fewer than 100 beds, as well as smaller hospitals. Five clinical areas were measured: (1) heart attack, (2) heart failure, (3) pneumonia, (4) coronary artery bypass graft, and (5) hip and knee replacement. Composite quality scores were calculated for each demonstration hospital by combining individual clinical area measures into an overall quality score for each clinical condition.

Medicare will distribute $8.85 million in bonuses to hospitals that demonstrated measurable improvements in care during the first year of the project, including $1,756,000 distributed to 49 hospitals for heart attack care; $1,818,000 to 52 hospitals for heart failure care; $1,139,000 to 52 hospitals for pneumonia care; $2,078,000 to 27 hospitals for heart bypass; and $2,061,000 to 43 hospitals for hip and knee replacement.

The largest bonus awarded, $326,000, will be to a medical center for heart bypass patient care. The second largest bonus was $249,000.

The demonstration began in October 2003 with more than 260 hospitals agreeing to participate. It is scheduled to end in September of this year. —
Arkansas Retains High Medicaid FMAP at 73.37%

The Department of Health and Human Services has published the Federal Medical Assistance Percentages (FMAP) for U.S. states and territories in fiscal year 2007, which begins October 1, 2006. Published annually, the percentages are used to determine the federal matching shares for the Medicaid and State Children’s Health Insurance Program.

The state FMAP rates are derived from a legislatively set formula that compares the average income for a state to that average income of the U.S. Under the formula, Arkansas’ FMAP for fiscal year 2007 will be 73.37%, which is the highest rate of any state except Mississippi.

It means that the federal government will continue to fund about $3 for each $1 in state matching funds that are allocated and paid for Medicaid programs.

The rates can be viewed at http://a257.g.akamaitech.net/7/257/24422/01jan20051800/edocket.access.gpo.gov/2005/pdf/05-23392.pdf.

2006 Telehealth Payment Amount Explained

Section 1834(m) of the Social Security Act established the amount Medicare paid as the telehealth originating site facility fee for services provided from October 1, 2001, through December 31, 2002.

The amount was set at $20. For such services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee was increased as of the first day of the year by the percentage increase in the Medicare Economic Index (MEI).

The 2006 MEI increase is 2.8%. Thus, for calendar year 2006, the payment amount for HCPCS code Q3014 (telehealth originating site facility fee) is 80% of the lesser of the actual charge or $22.47, which is 102.8% of the 2005 fee. The beneficiary is responsible for any unmet deductible amount or co-insurance.

Find more information about the telehealth originating site facility fee payment amount by going to http://new.cms.hhs.gov/transmittals/downloads/R41BP.pdf on the CMS Web site.
Arkansas hospitals that haven’t yet done so should submit their application for a National Provider Identifier (NPI). The NPI will replace healthcare provider identifiers in use today in standard healthcare transactions.

All Health Insurance Portability and Accountability Act (HIPAA) covered entities, except small health plans, must begin using the NPI on May 23, 2007; small health plans have until May 23, 2008.

Medicare systems began accepting claims including an existing legacy Medicare number or an NPI as long as it was accompanied by an existing legacy Medicare number on January 3, 2006, and will accept the claims containing both numbers through October 1, 2006.

Beginning October 2, 2006, and through May 22, 2007, the Centers for Medicare & Medicaid Services’ (CMS) systems will accept an existing legacy Medicare number and/or an NPI. This will allow for 6-7 months of provider testing before Medicare claims including an NPI only are accepted as of May 23, 2007.

After that date, Medicare claims that don’t have an NPI will not be paid. More explicit instructions on time frames and implementation of the NPI for Medicare billing will be issued later this year.

While the NPI is automatically entered for Medicare purposes upon completion of the application process, healthcare providers are responsible for informing other payers of their NPI, when it is assigned. Other health plans with whom providers do business will give instructions as to when healthcare providers may begin using the NPI in standard transactions.

An instructional Web tool, called the NPI Viewlet, is available for viewing at http://www.cms.hhs.gov/medlearn/npiviewlet.asp and under “HIPAA Latest News” at http://www.cms.hhs.gov/hipaa/hipaa2 on the CMS Web site. This tool provides an overview of the NPI, a walk-through of the application, and live links to the National Plan and Provider Enumeration System’s (NPPES) Web site where the learner can apply for an NPI. It is designed for all healthcare providers.

To apply for an NPI, visit: https://nppes.cms.hhs.gov on the CMS Web site. To request a paper application, call 1-800-465-3203.

In addition, the Centers for Medicare & Medicaid Services has issued a new “fact sheet” explaining the NPI. The fact sheet may be viewed by going to http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPIFactSheet_010906.pdf.

Reminder: It’s Time to Apply for Your Hospital’s National Provider Identifier

Guidance For NPI Use Now Offered by CMS

The Centers for Medicare & Medicaid Services has posted guidance to help Medicare enrolled healthcare providers determine how they should handle “subparts” and whether these will need a separate National Provider Identifier for use in standard electronic transactions under the Health Insurance Portability and Accountability Act (HIPAA). The Act requires the reporting of a standard unique identifier on electronic claims and other standard electronic transactions by May 23, 2007.


Ambulance Inflation Factor for 2006 is Announced

Medicare’s Ambulance Inflation Factor (AIF) for calendar year (CY) 2006, has been released to contractors. Prior to January 1, 2006, during the transition period, the AIF was applied to both the fee schedule portion of the blended payment amount (both national and regional) and to the reasonable cost or charge portion of the blended payment amount separately, respectively, for each ambulance provider and supplier.

As of January 1, 2006, the total payment amount for air ambulance providers and suppliers will be based on 100% of the national ambulance fee schedule, while the total payment amount for ground ambulance providers and suppliers will be based on either 100% of the national ambulance fee schedule or 60% of the national ambulance fee schedule and 40% of the regional ambulance fee schedule. Additionally, the AIF for CY 2006 has been set at 2.5%.
Dr. Dennis O’Leary, president of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), sent a December 13, 2005 letter to accredited hospitals advising that they will be provided access to their hospital-specific data before the reports are released to the BlueCross BlueShield Association (BCBSA).

Under a highly controversial pilot project, the JCAHO is creating and issuing reports to the BCBSA based on hospital performance measurement data submitted to the accrediting organization. The scheduled December release of the next group of reports has been delayed to allow hospitals to review their data, which were made available on the hospital’s password-protected JCAHO extranet site no later than mid-January.

The files posted on the hospital’s extranet site will not include the patient safety indicator data or plan-specific rates that are included in the BCBSA reports. They will include hospital-specific data compared to state and national averages for the time period covering the second quarter of 2004 through the first quarter of 2005. Most of these data are already publicly available on the Joint Commission’s Quality Check Web site; however, that Web site currently does not portray quarterly measure rates.

The data being posted to the selected hospital secure JCAHO extranet sites, and to be included in the BCBSA reports, are based on data that the affected hospitals have previously transmitted to the Joint Commission through their measurement system vendors.

As part of its 2007 National Patient Safety Goals, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has proposed new goals for JCAHO-accredited hospitals covering safety of medications, identification of safety risks inherent in the organization’s patient population, disruptive behavior among the organization’s staff, orientation for temporary workers, improved recognition and response to changes in patient conditions and harm associated with healthcare worker fatigue.

The JCAHO is concerned with the complexity of dosing and monitoring requirements, patient compliance and drug or dietary interactions that can result in adverse drug events. Implementation expectations address the use of standardized practices in monitoring.

The 2007 proposed goals would also require that the organization identify safety risks inherent in its patient population through risk assessments and continuous reassessments. In particular, the JCAHO lists identifying patients at risk for falls, which is a requirement from past years, as well as identifying patients at risk for suicide and preventing decubitus ulcers.

In response to a study that concluded that 88% of respondents have encountered some form of disruptive behavior among staff members, the new goals would require accredited hospitals to develop guidelines for acceptable behavior as well as identify, report and manage disruptive behavior.

Finally, the 2007 proposed goals would require the organization to identify conditions and practices that contribute to healthcare worker fatigue and take action to minimize those risks. Implementation would involve better management of work hours and instituting schedules that reflect known effects of sleep physiology.
Possible Quality Measurement Oversight Board

The Institute of Medicine (IOM) has recommended that Congress establish an independent board within the Department of Health and Human Services to coordinate a national system for healthcare performance measurement and reporting that builds on the work of key public and private organizations, including the Hospital Quality Alliance.

The IOM suggested that Congress authorize $100 to $200 million in annual funding for the board, develop measurement and reporting tools and issue an annual report to Congress reviewing its activities and progress.

The IOM panel also recommended Congress fund research to address current gaps in quality measurement and reporting, test reporting formats and evaluate the cost and care consequences of quality measurement and reporting, among other issues.

New Infection Control Guidelines on Antibiotic Resistant Bacteria Expected Soon

New hospital infection control guidelines designed to slow the spread of antibiotic-resistant bacteria are expected from the Centers for Disease Control and Prevention within the next few months, according to a report from Bloomberg News. The new rules are expected to intensify sterilization requirements for healthcare workers, increase testing of patients who may harbor dangerous germs and may call for hospitals to create special quarantine wards.

CDC researchers say they are especially concerned about antibiotic resistant bacterial infections that arise in hospitals and spread to homes and crowded workplaces.

To learn more, visit the CDC Web site at http://www.cdc.gov.

Latest Hospital Quality Data Posted

The Hospital Quality Alliance (HQA) updated its Hospital Compare Web site December 15 with the latest data from participating hospitals. The site enables patients and families to compare the performance of the nation’s acute care hospitals on 20 quality measures for care provided to adult patients in 2004 and 2005 for heart attack, heart failure, pneumonia and the prevention of surgical infections.

About three-quarters of the roughly 4,000 reporting hospitals provided information on the 18 measures for heart attack, heart failure and pneumonia. In addition, many hospitals provided data on two measures for surgical infection prevention added to the site in September.

This year, HQA participants plan to begin collecting and sharing data from a new national survey on patients’ perceptions of hospital care, known as HCAHPS, pending final approval by the federal Office of Management and Budget.

HQA partners include the American Hospital Association and other hospital groups, Centers for Medicare & Medicaid Services, AFL-CIO, AARP and others.
Surgical Care Improvement Project: Is Your Hospital On Board?

More than 42 million operations are performed each year in U.S. hospitals to protect, enhance and save lives. But too often, post-operative complications can prolong a patient’s suffering, disrupt their families and add to the cost of care for everyone. The Surgical Care Improvement Project (SCIP) is a new patient safety initiative intended to reduce those dangerous and costly complications and to improve surgical care for hospital patients.

The SCIP involves the entire care team – doctors, nurses, anesthesiologists and quality improvement staff – in preventing four of the most common surgical complications: surgical site infections, blood clots, heart attacks and ventilator-associated pneumonia. The goal is to reduce these complications by 25% within five years. Hospitals across the country are committing to participate in the SCIP because they see real benefits to their patients – better care and less chance of developing serious complications that can affect a patient’s health.

Improving quality of care continues to be a top priority for hospitals, and participating in SCIP is an excellent way to continue and extend quality improvements. While the project is currently being launched as a quality improvement program, in 2007 the Hospital Quality Alliance will ask all hospitals to consider collecting data for public reporting. More information will be available next year. Arkansas hospitals that have not joined the project can sign up and start making a difference in surgical care for their patients now.

For more information, go to the American Hospital Association’s (AHA) Web site – http://www.aha.org – and click on the SCIP icon. Print out AHA’s SCIP Quality Advisory and commit to being part of SCIP by completing and sending back the sign-up sheet.

The advisory also includes tips and strategies to prepare for participating in SCIP. If you have additional questions, please call AHA Member Relations at 1-800-424-4301. •

NIH Expands Network Modeling Infectious Disease Outbreaks

Four new teams have joined an international research network developing computer-based simulations of pandemic flu and other infectious disease outbreaks, the National Institutes of Health reports.

One team including Brigham & Women’s Hospital in Boston will develop ways to identify new clusters of emerging infectious diseases and track antimicrobial resistance in hospitals and emergency settings, NIH said.

It also will optimize strategies for using patient care data from large health systems in infectious disease models.

The four research teams will receive about $7.8 million over the next five years, and collaborate with four existing network teams established in 2004. •
JCAHO Won’t Sell Performance Data

The Board of Commissioners of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) voted at its November 18-19 meeting not to sell performance measurement data analyses to private third-party payers.

In a statement on the matter, the JCAHO said that accreditation contract language consistent with this intent will be drafted and made available to any accredited organization that wishes to incorporate it into its JCAHO contract.

At the same time, the commissioners affirmed the Joint Commission’s need to secure access to patient-level performance data to support its ongoing accreditation-related measurement activities. In so doing, the Board agreed that there is need for resolving a series of outstanding issues involving this effort that have been raised by the American Hospital Association (AHA), especially those involving compliance with the Health Insurance Portability and Accountability Act. The JCAHO said it would work in collaboration with the AHA to resolve these issues.

It appears clear that the commitment in the Joint Commission’s November 21 statement “not to sell performance measurement data analyses to private third party payors” applies to any new plans for data-sharing going forward.

However, in order to avoid any misunderstandings, Arkansas Hospital Association legal counsel Elisa White further clarified that the Joint Commission does have a contractual obligation to fulfill its responsibilities to the current Blue Cross Blue Shield Association pilot project. As specified by this contract, the third set of data reports have been issued, and the final set of reports was to be issued during the first week of March 2006.

The Joint Commission’s involvement in the pilot project will then be concluded.

JCAHO Survey Price Hike Announced

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) will increase its fees for full on-site accreditation and certification surveys by 5% as part of a 2006 operating plan and budget recently approved by its Board of Commissioners.

The average estimated on-site survey fee increase for hospitals would be $465, or $155 for critical access hospitals. There will be no increase in the annual base rate fees or for any of the other types of on-site surveys.

At its recent meeting, the board also reappointed Fred Brown as its chair for an additional one-year term. Founding president and CEO of BJC Healthcare in St. Louis and a former chair of the American Hospital Association (AHA) Board of Trustees, Brown was appointed to the JCAHO Board by the AHA.

JCAHO Unannounced Survey Exceptions

As of January 1, 2006, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) began conducting all regular accreditation surveys on an unannounced basis, with a few exceptions.

During the field engagement process, the JCAHO determined that it is not appropriate or feasible to conduct unannounced surveys in certain “small” healthcare organizations.

Therefore, between 2006 and 2008, the unannounced surveys will occur in the year that the organization is due for survey. Subsequent surveys will occur within 18-39 months of the organization’s first unannounced survey, based on pre-established criteria generated from Priority Focus Process data and other factors.

Accredited organizations can identify up to 10 days each year in which an unannounced survey should be avoided (i.e., black-out dates).

Go to http://www.jcaho.org/accredited-organizations/svnp/qa_unannounced.htm to see the Unannounced Survey Q&A.
JCAHO Alert Encourages Medication Reconciliation, but Causes Confusion

On January 25, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) issued a Sentinel Event Alert encouraging healthcare organizations to reconcile a patient’s medications as the patient transitions from one care setting or practitioner to another to help avoid medication errors such as omissions, duplications, dosing errors, or drug interactions.

Medication reconciliation is also the subject of a preexisting JCAHO National Patient Safety Goal, but unlike the requirements of the Goal, which are mandatory, implementation of the tactics in the new Alert is not required.

In order to comply with the current National Patient Safety Goal related to medication reconciliation (Goal 8), JCAHO requires hospitals to: (1) obtain and document a complete list of the patient’s medications upon admission; and (2) to communicate a complete list of the patient’s medications, including new medications that are being ordered and old medications that are being resumed, to the next provider whenever the patient is “referred or transferred to another setting, service, practitioner, or level of care within or outside the organization.” The broad requirements of Goal 8 provide hospitals with considerable flexibility in designing medication reconciliation processes.

The Alert is more detailed than Goal 8 and recommends that hospitals consider three specific operational tactics related to medication reconciliation. The tactics, which are not mandatory, are summarized below with a description of how they differ from mandatory JCAHO requirements.

Tactic 1: Placing the reconciled medication list in a highly visible location in the chart and including other specific information on the list (dosage, drug schedules, immunizations, allergies and drug intolerances).

JCAHO already requires hospitals to create a reconciled medication list and defines medication broadly to include vaccines. JCAHO does not require hospitals to have a separate form for the list, to place the list in a specific location in the chart, or to include allergies and drug intolerances on the list.

Tactic 2: Creating a process for reconciling medications at all “interfaces of care” (admission, transfer, discharge), determining “reasonable” time frames for the reconciliation process and involving patients, doctors, nurses, and pharmacists in the process.

JCAHO already requires hospitals to have processes for reconciling medications upon admission, discharge, and transfer, and specifies that patients should be involved in the creation of the medication list on admission. JCAHO does not require that the medication reconciliation process identify timeframes for reconciliation or specify what type of hospital personnel should be involved in the process.

Tactic 3: Providing the patient with a complete list of all medications upon discharge and encouraging the patient to carry the list and share it with all of the patient’s healthcare providers.

JCAHO requires hospitals to provide the next healthcare provider with a reconciled list of medications but does not require that hospitals provide patients with a reconciled list of medications and encourage the patient to carry the list and share it with others.

Again, the Alert recommends that the reconciliations be done at every transition of care in which new medications are ordered or existing orders are rewritten. Transitions in care include changes in setting, service, practitioner or level of care.

As outlined above, this process comprises five steps: 1) develop a list of current medications; 2) develop a list of medications to be prescribed; 3) compare the medications on the two lists; 4) make clinical decisions based on the comparison; and 5) communicate the new list to appropriate caregivers and to the patient.

ELECTRONIC HEALTH RECORDS

Report Pushes EHR Funding; Seeks Dedicated Annual Amount

A new report by the Center for Health Transformation outlines recommendations for spurring the adoption of electronic health records based on the successful practices of health data exchanges known as regional health information organizations (RHIOs).

The report calls on Congress to pass “comprehensive” health information technology (IT) legislation this year that includes grants or loans to create and develop RHIOs and removes regulatory barriers to health IT progress.

The Center advocates dedicating 1% of federal discretionary spending, or roughly $7 billion a year, to health IT, which it calls vital to reducing medical errors and increasing disaster preparedness. Former House Speaker Newt Gingrich, who founded the Center, said, “There are communities around the country that are already realizing the power of health information networks. Their strategies, expertise and technology are connecting caregivers in ways that are saving lives and saving money. We now need to put these tools in the hands of providers and people nationwide.”

AHRQ Releases Learning Resources to Help Providers Adopt Health IT

The Health and Human Services’ Agency for Healthcare Research and Quality (AHRQ) has launched a new suite of learning resources to help healthcare providers adopt health information technologies.

Part of the agency’s National Resource Center for Health Information Technology, the tools include descriptions of AHRQ-funded research projects and emerging lessons from the field, a knowledge library with links to more than 5,000 health IT information resources, and an evaluation toolkit to help those implementing health IT projects.

The agency’s $166 million health IT initiative funds more than 100 projects in various healthcare settings, including hospitals.

“This shared learning tool brings the lessons of experience together in one place, so we can help providers avoid problems and achieve greater benefits when they make their move to health IT,” said AHRQ Director Carolyn Clancy, M.D.

To access the materials, go to http://www.healthit.ahrq.gov.

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