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With each of you, the Arkansas Hospital Association lived through the aftermath of Hurricane Katrina in Louisiana, Mississippi and Alabama with a mixture of heartache and hope. I say, “lived through,” because we weren’t simply “watching,” but were in full emergency action, working as a part of the nation’s emergency disaster response network on behalf of those leaving the storm-tattered Gulf states.

You can be proud of your Arkansas hospitals and the AHA, who together began coordinating the relocation of hospital patients, putting together medical teams to go to the storm-ravaged areas, in short, finding ways to bring loving words and a caring touch – their medical fingerprint – to the lives of countless storm survivors almost before Katrina’s savage winds abated.

Being a next-door neighbor to Louisiana, it just makes sense that our response there came quickest. You probably saw the many camera shots of helicopters and ambulances rescuing patients from hospitals in the New Orleans area. Several of those rescue units – both helicopters and ambulances – came from Arkansas hospitals.

But the fingerprint doesn’t stop there. Arkansas hospitals sent teams of nurses, physicians and medical supplies to both Louisiana and Mississippi. Their hard work saved the lives of many, and continues to save lives as area hospitals reach out to storm survivors finding respite and new beginnings in our state.

As we look back on those first difficult days and look forward to many months of rebuilding and relocating, it just makes good sense that each American did what we could to help, and that we continue to do so. Arkansas’ hospitals and the AHA are no exception.

And there are other AHA fingerprints of “caring in action” every day in Arkansas. One of the most visible fingerprints the AHA will leave this year is literally being seen on every hospital campus across the state.

The new state “No Smoking” law, prohibiting smoking on hospital grounds and in hospital buildings all over Arkansas, was an initiative pressed for by the AHA, another action that only makes good sense.

How can our hospitals, which stand for healthy living and the restoration of health itself, allow one of the most-documented health robbers – unhealthy tobacco smoke – on their premises? The short answer is, they can’t.

You’ve probably noticed large newspaper advertisements, heard radio commercials, and seen in-hospital posters reminding Arkansans of the change. These public service announcements are another fingerprint of the AHA – letting the public know about the new law and reminding people that smoking is being removed from hospitals statewide.

A less visible fingerprint is behind-the-scenes work being done to prepare for a worldwide flu pandemic. The AHA is working with the Arkansas Department of Health and Human Services to take already existing disaster readiness plans (like those used during Katrina), adapt them, and be as ready as possible for the waves of patients that would crowd our hospitals should a flu epidemic hit. All of this advance preparation just makes good sense.

Every year in the fall, the AHA presents its annual meeting, an opportunity to learn from cutting-edge experts in the hospital field. Presenting the best of the nation’s hospital experts in one place at one time just makes sense for our hospital staffs. This year, we hope you’ll join us October 19-21 as together we explore best practices that can help daily as we work in the hospital field.

This year’s annual meeting marks a very special anniversary for your AHA. We are nearing the end of our 75th year serving Arkansas hospitals, their staff members, employees and the millions of patients they have cared for over those many years.

It’s good to mark this special anniversary, because it reminds us of just how much work the AHA accomplishes in helping our hospitals do good in the midst of life’s storms and the many causes the AHA undertakes that just make good sense.

Phil E. Matthews
President and CEO
Arkansas Hospital Association
Imagine...

...a health care system where patients get the right care at the right time, every time. Where providers have the tools and resources to deliver that care. And patients and their families understand their role in maintaining their own health.

Imagination is the first stop on the road to change — the kind of change that goes beyond data collection and medical review. It’s more than quality improvement. It begins in the heart of each health care facility — the culture of the care environment and the dedication of each staff member, from clinical to clerical.

The Arkansas Foundation for Medical Care is working with health care providers across the state to make the most of the talent, commitment and compassion our state has to offer. Please share the vision of what health care in Arkansas can be. Together, we’ll get there.

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Education CALENDAR

October 14, Little Rock
Arkansas SocialWorkers
in Health Care Fall Conference

October 19-21, Little Rock
AHA Annual Meeting and Trade Show

October 26-28, Little Rock
Healthcare Financial Management Association (HFMA) Winter Workshop

October 27, North Little Rock
Arkansas Association for Medical Staff Services (AAMSS) Fall Conference

November 2-3, Little Rock
Case Management: An Essential Component for Healthcare Excellence

November 4, Little Rock
Arkansas Healthcare Human Resources Association (AHHRA) Fall Conference

November 9, Little Rock
Hospital Conditions of Participation Workshop

December 2, Little Rock
A Day With the Lawyers

December 6, 7, 8
(various locations)
CPT Coding Updates

December 7, Little Rock
Compliance Forum

January 10, Bismarck
CPT Coding Updates

Program information available at www.arkhospitals.org
Terry L. Amstutz has been named administrator of Magnolia City Hospital, succeeding Kirk Reamey who accepted the position of CEO of Ozark Health Medical Center in Clinton. Prior to moving to Magnolia, Amstutz was CEO of Morrison Community Hospital District in Morrison, Illinois and was CEO of Community Medical Center of Izard County in Calico Rock from 1990-2001.

Jim Richardson has been named president and chief executive officer of Saline Memorial Hospital in Benton. He has served as the interim CEO since February, and joins SMH with over 20 years of experience in hospital administration. He is a former CEO of Medical Park Hospital in Hope, as well as hospitals in Texas and Louisiana.

David Wheeler has been named administrator of Eureka Springs Hospital. With a professional background in surgical nursing and staff administration, he will be working toward a master’s degree in healthcare administration through St. Francis University in Joliet, Illinois. He is a former administrator of Bossier Specialty Hospital in Bossier City, Louisiana.

Cindy McClain, CEO, Select Specialty Hospital – Fort Smith, was named to Arkansas Business’ annual “40 Under Forty” list which recognizes intriguing business and political leaders under the age of 40. In March 2004, the Danville native was named CEO of the 32-bed long-term acute-care facility. McClain previously was director of patient services and medical records at Baptist Health Medical Center and Baptist Health Rehabilitation Institute in Little Rock.

Linda Worman has been named chief operating officer/administrator of Willow Creek Women’s Hospital in Johnson. Most recently, she was chief nursing officer/vice president of patient care services at Newton Memorial Hospital in Newton, New Jersey. She has also served in numerous healthcare leadership roles including officer in charge of evaluation records and other departments in the U.S. Army Nurse Corps in St. Louis, and chief nursing officer/vice president of nursing at the Jersey Shore Hospital in Jersey Shore, Pennsylvania.

Chris Whybrev has been named senior vice president and chief operating officer of North Arkansas Regional Medical Center in Harrison. Whybrev was most recently assistant CEO at Community Health System’s Western Regional Medical Center (WRMC) in Bullhead City, Arizona. Prior to joining WRMC in 2002, he served as a post-graduate Administrative Fellow from 2001-2003 at St. Vincent’s Hospital in Birmingham, Alabama.

Jerry Stevenson, president and CEO of St. Edward Mercy Health Network in Fort Smith, has named William P. Senneff chief operating officer for the network. Senneff was a former executive vice president and administrator of Sparks Health System in Fort Smith, before being named interim president and CEO of the facility in July 2003. His previous healthcare experience includes administrative positions in hospitals in Missouri, California, Indiana and Washington.

Susan Barrett, president and CEO of Mercy Health System of Northwest Arkansas, has named George Flynn executive vice president/chief operating officer. His responsibilities include supervising the operations of St. Mary’s Hospital in Rogers and Mercy Medical Clinics, as well as leading in-service line planning, operational infrastructure development and market development.

Ray Montgomery, president and CEO of White County Medical Center (WCMC) in Searcy, recently announced plans to buy its cross-town neighbor, Central Arkansas Hospital (CAH), which is owned and operated by Triad Hospitals, Inc. of Plano, TX. WCMC plans to house its rehabilitation and psychiatric centers in the current CAH facility.

Wayne T. Smith, president and CEO of Community Health Systems, Inc., recently announced the purchase of Newport Hospital. Hospital operations will be folded into Harris Hospital, a 132-bed facility also located in Newport. The Newport Hospital facility will be used for outpatient services.
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**Elder Care**
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**Medicaid**
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**State Children’s Health Insurance Program (SCHIP)**
Arkansas - 1-888-474-8275

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Arkansas Hospitals: Responding to KATRINA

The question: Are Arkansas hospitals able to respond immediately and effectively in the event of a local or national disaster? The answer (in light of our hospitals’ response to Gulf coast needs following Hurricane Katrina) is a resounding YES!

With three years of disaster planning under our belts funded by the state’s HRSA grants, including drills focusing on varying disaster scenarios, we discovered what we had not planned for was a massive population relocation from another state. Yet Arkansas’ hospitals proved themselves up to all challenges.

In this photo essay, follow the quick action of several Arkansas hospitals as they raced to the aid of Katrina’s victims in the Gulf States.

Arkansas Children’s Hospital (Little Rock) Director of Transport, Connie Eastlee (far right), discusses the plan for the trip to New Orleans with her flight team before they load up and fly to Louisiana to aid in hurricane relief efforts.

North Arkansas Regional Medical Center (Harrison) planned to leave almost immediately after Katrina hit. Here, the three ambulances they sent are seen leaving at 4 a.m. September 3, in order to reach the scene as soon as possible. NARMC also sent five boats, 12 crew members and a 31-foot trailer fully stocked with replenishable supplies.

From the time that approximately 8,000 evacuees entered the state through Fort Chaffee Saturday evening, September 3, Arkansas hospitals were immediately ready to receive patients, both at Fort Chaffee and at their respective facilities.

While we have not seen a large number of inpatient admissions statewide, there have been many people treated in Arkansas ERs for dehydration, chronic illness, minor infections and refills of medication. Patients with cancer are being followed, and efforts made to locate their medical records so that their chemotherapy and radiation treatments may resume.

Baxter Regional Medical Center (Mountain Home) sent ambulances loaded with personnel and supplies to Louisiana. Medical personnel helped staff a field hospital set up at Covington. Here, Bill Friel helps load an ambulance with supplies for the first of many trips to the region.

North Arkansas Regional Medical Center EMS Team Members join forces with Louisiana Corps of Engineers in an airboat to rescue Hurricane Katrina victims.
With thousands of evacuees housed in shelters, homes, hotels and camps across the state, we expect our hospitals, particularly the rural hospitals, to see increasing numbers of patients in the coming days, weeks and months.

Illnesses and diseases most likely to present are psychiatric conditions, infections from wounds exposed to toxic water, and aggravated asthma.

The AHA continues to track evacuees seen as inpatients or outpatients in our hospitals and is forwarding that information to the Division of Health and the American Hospital Association. The two-fold purpose for this data collection is to monitor the condition of the patients and to provide a national database to track displaced persons from Louisiana and Mississippi hospitals.
In areas ravaged by Hurricane Katrina, the hospital “H” also came to mean “hope” … and “heroes.”

Thousands of hospital workers held the line, endured the storm and survived the deluge — to care for their patients.

The stories are just beginning to be told:

At one New Orleans hospital, staff went days without food and water while evacuating patients — carrying some on stretchers, some on their backs — through floodwaters and up eight flights of stairs to waiting helicopters.

In Mississippi, a surgeon performed emergency surgery by flashlight, with floodwater rising over his feet and medical equipment failing.

At another hospital, food and supplies ran out, and many of the staff knew that they had lost their own homes. But they continued to accept new patients — treating evacuees and rescue workers alike.

The men and women of America’s Hospitals … heroes every day.

America’s Hospitals.
First in hope. First in care. Always there.
Before The MHA Group was a family of healthcare staffing firms it was a single entity known as Merritt, Hawkins & Associates. That was over 17 years and over 25,000 physician search assignments ago.

Times change, and Merritt, Hawkins & Associates has changed with them. From a firm of just six people operating out of a small office in Southern California, Merritt, Hawkins & Associates evolved into The MHA Group, which includes the following six affiliated companies:

- **Merritt, Hawkins & Associates**
  - permanent physician search and consulting

- **Staff Care, Inc.**
  - temporary (locum tenens) physician staffing

- **Med Travelers**
  - temporary allied healthcare professional staffing

- **RN Demand**
  - temporary nurse staffing

- **AmeriMed**
  - medical staff planning and consulting

The MHA Group now employs some 700 people nationwide and is headquartered in Irving, Texas, with regional offices in Atlanta, Georgia; Salt Lake City, Utah; and Irvine, California. From specializing in permanent physician searches it now offers a complete clinical staffing service, including all aspects of permanent and temporary physician and allied healthcare professional staffing. Through AmeriMed, it also offers a pure consulting capacity for those healthcare providers seeking expertise in medical staff development, physician needs assessment, physician relations and related areas.

Along the way, The MHA Group has earned a reputation for expertise and a strong customer orientation. It is these qualities which have led to multiple state hospital endorsements and preferred vendor selections. Indeed, The MHA Group is the preferred staffing vendor of 20 state hospital associations, including the Arkansas Hospital Association.

**Client driven changes**

James Merritt, president of The MHA Group, notes that the firm’s evolution is the result of client driven changes.

“Once we had established our credentials as a resource driven source of permanent physician staffing expertise, our clients requested that we expand into other areas,” Merritt observes. “Every company we have added has been the result of pent-up demand among our clients. We now offer what we believe is the most comprehensive and effective healthcare staffing service in the industry.”

The firm has passed some impressive milestones and has had its share of the spotlight along the way. Still experiencing dynamic growth, The MHA Group was named to Inc. magazine’s list of the 500 fastest growing privately held companies several years ago. Through its sponsorship of the national Country Doctor of the Year Award, Staff Care, The MHA Group’s locum tenens firm, has been featured in such publications as USA Today, Parade, and The New York Times. In addition, The MHA Group conducts a series of staffing related surveys covering such topics as physician compensation, the locum tenens market, and physician appointment wait times. Original data compiled by The MHA Group has been referenced in hundreds of publications, from The Wall Street Journal to Modern Healthcare. In addition, executives with The MHA Group are nationally recognized for their presentations on numerous staffing topics, from the physician shortage to the impact of staffing on patient safety.

The MHA Group’s proven reputation and stature in the industry, however, retains its commitment to providing clients with premier healthcare staffing services backed by professionalism and unrivaled resources.

“Our goal is not to look back but to keep looking forward,” notes Mr. Merritt. “Our reputation was built one client at a time and we still approach our business that way.”

Those seeking more information about The MHA Group’s services and track record in Arkansas may call Harold Livingston at 469-524-1400 or 1-800-876-0500 or email: hlivinston@mhagroup.com. Further information is available through the firm’s Web site which can be accessed at www.mhagroup.com.
I have been a member of several state hospital associations and the best that I have seen is the Arkansas Hospital Association. Their guidance on complicated and conflicting regulatory issues has been a tremendous help. I am aware of issues before they become public and can prepare for them ahead of time. AHA has dealt with a variety of third party payors in a professional manner and has routinely obtained favorable results. The outstanding staff members have been strong advocates for all classifications of hospitals as well as the citizens of Arkansas. I cannot think of any group that has done more for healthcare than our Arkansas Hospital Association.

Herbert K. “Kirk” Reamey, CEO
Ozark Health Medical Center, Clinton

What do hospices and hospitals have in common? Well, enough to make membership in the Arkansas Hospital Association of critical importance to us at Arkansas Hospice. The staff and many of the services of AHA are valuable to us. Some of these services include participation in the group Workers Compensation Plan, executive and clinical staff salary surveys, and helpful workshops in various areas from medical records to patient service. Just as important to us is the continuous monitoring of state and federal legislative issues by AHA staff. Finally, it is inspiring to have the opportunity to address issues of common concern with healthcare executives in our monthly AHA Metropolitan District executives meeting. For all these reasons, and more, we at Arkansas Hospice appreciate the Arkansas Hospital Association and are glad to be included as members. Happy 75th Birthday AHA!

Michael Aureli, President
Arkansas Hospice, Little Rock

We at Baxter Regional Medical Center appreciate the valuable services the Arkansas Hospital Association offers its members. Not only does the AHA provide information about issues pertaining to hospitals, it offers analysis, predictions and explanations about how these issues will impact hospitals. The AHA’s full calendar of classes, workshops and Webinars provide opportunities for continuing education. But, overall, probably the most important aspect of the AHA is that it gives member organizations a unified voice to provide input on decisions made by government and business organizations about issues that affect hospitals.

Steve Erixon, CEO
Baxter Regional Medical Center, Mountain Home

Congratulations and thanks to the staff, the board of directors, and leaders “current and past” of the Arkansas Hospital Association for their 75 years of sustained support. Our Association is an integral part of the healthcare fabric within Arkansas. The AHA’s vital resources for professional disciplines have greatly assisted Drew Memorial Hospital and all hospitals across the state to improve and enhance image, quality, community confidence, and facility capabilities. The Association’s services and programs, research, and interpretations have been consis-
tently communicated providing critical information in the operation and management of our hospital. The educational programs, the development of a collective body to address healthcare issues to legislators and regulatory organizations, and the annual meeting providing a collaborative environment with fellow health leaders are all the products of our Association. As healthcare challenges become more diverse and dynamic in today's aging, consumer-driven society, we have a proven resource and support asset in the Arkansas Hospital Association.

Richard L. Goddard, CHE, CEO
Drew Memorial Hospital, Monticello

The Arkansas Hospital Association is a valuable asset for the hospitals in our state. The staff is a great resource and always willing to help with questions or research. The AHA is an effective advocate dealing with a broad range of issues. With all of the changes that are occurring in today’s healthcare environment, the importance of a strong hospital association is critical. Thank you for your great support.

Mike McCoy, CEO
Saint Mary’s Regional Medical Center, Russellville

As a transplant to Arkansas nearly two years ago, I have had the good fortune to work closely with the Arkansas Hospital Association staff right from the beginning. The well-informed professional staff was there to answer my questions about Arkansas regulations and to guide me to the appropriate resources in the state about several important issues. They are always just an email or telephone call away, ready to assist or advise about any situation. The AHA publications present current information about critical topics and staff members are ready to assist the hospitals when action is needed. My staff particularly appreciates the educational programs that relate to their departments, such as health information, finance, human resources, and others. The opportunity to network with peers, share information and work on key issues together builds an effective, professional healthcare community.

At Southwest Regional Medical Center, we are also a fan of AHA Services, Inc., as we regularly evaluate the quality of our contract services. We have utilized several companies endorsed by AHA, and have been very pleased.

Nancy Fodi, CEO
Southwest Regional Medical Center, Little Rock

As a smaller healthcare facility, Levi Hospital does not have all the capabilities to manage some of the daily needs of the organization. That is where AHA Services, Inc. comes in. AHA Services provides Levi with expertise in a number of areas such as health insurance, workers’ comp insurance, various supplemental health insurance plans, physician recruitment and locum tenens services. The services of AHA Services have allowed me to focus my attention on other matters, knowing that what they provide is of a high quality nature. I have appreciated the partnership Levi has had with AHA Services.

Patrick G. McCabe, Jr., President and CEO
Levi Hospital, Hot Springs
OSHA Planning Unannounced Inspections

The Occupational Safety and Health Administration (OSHA) said in an August 9 release that it has a plan targeting roughly 4,400 worksites for unannounced comprehensive inspections over the coming year. The plan is based on injury and illness statistics collected from 80,000 employers last year. The program will initially focus on worksites that reported 12 or more injuries or illnesses resulting in days away from work, restricted work activity or job transfer for every 100 full-time workers; or nine or more cases involving days away from work per 100 full-time employees, the agency said.

OSHA also will randomly inspect about 400 workplaces in industries with incident rates above the national average that reported low injury and illness rates, to review compliance with OSHA requirements. It said the plan will include nursing homes and personal care facilities, with inspections focused primarily on ergonomic hazards relating to resident handling; exposure to blood and other potentially infectious materials; exposure to tuberculosis; and slips, trips and falls. Visit http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=NEWS_RELEASE and click on OSHA regulations to read the announcement.

Hospital Harasser Goes To Jail

The man who threatened hospitals around the country over the spring and summer months, saying he planned to bring False Claims Act lawsuits against them for alleged violations of the Privacy Act and the Medicare Conditions of Participation, was sentenced July 28 to three years in prison by a Maryland District Court.

American Hospital Association member hospitals received notice via a June 29 AHA News Now mailing about a group called TMA International Trusts. That organization was threatening to bring False Claims Act lawsuits against hospitals across the country for alleged violations of the Privacy Act, based on allegedly “flawed” Medicaid applications.

TMA represented itself as a potential “qui tam relator,” or whistleblower. The American Hospital Association discovered that TMA, through its vice-chairman Bill Lovern, was contacting hospitals and threatening them with False Claims Act lawsuits, but offering to “settle” the matter if the hospital made payments to TMA. Lovern contacted the Arkansas Hospital Association (AHA) concerning TMA’s assertions.

TMA’s Web site, http://www.tmaittma.com, includes press releases indicating that hospitals were only the latest target in a series of legal attacks that were threatened. Allegations were that state Medicaid agencies had flawed Medicaid applications, and TMA tried to link hospitals to the Medicaid agencies.

Bill Lovern had been previously convicted on two counts of telephone misuse. He will serve two years, with one year’s sentence suspended. He also will serve three years of supervised probation and, if he violates his probation, he can serve up to an additional three years in prison.

Lovern is now incarcerated. In a letter to the prosecutor, with whom the American Hospital Association (AHA) worked to provide information to the court about Lovern’s behavior since his conviction, the AHA said that “the best way to get Mr. Lovern to cease his threatening and harassing behavior is to incarcerate him” for the previous conviction.

The letter said Lovern’s harassment of hospitals, state hospital associations, and some healthcare systems with letters, e-mail messages and phone calls demanding large sums of money in exchange for not bringing fraud and racketeering lawsuits was costing the organizations time and money that could have been “much better spent on things such as patient care.”

The prosecutor in the case thanked the AHA for its help in getting the judge to appreciate the need to sentence Lovern to time in prison.
AHA is Sponsoring New Medicaid Study to Gauge Effect on Arkansas Hospitals

The Arkansas Hospital Association (AHA) has engaged the Little Rock office of BKD, LLP to conduct a follow-up study on the continuing losses accruing to Arkansas hospitals due to inadequate Medicaid payments.

BKD conducted an initial study two years ago, which found that the state’s hospitals lost $33 million on Medicaid in 2002.

The new study will follow the same format with one exception. For its first study, BKD asked that individual hospitals provide them the needed information. Many hospitals did not comply with that request. So, for the upcoming study, BKD will seek information from hospital Medicare Cost Reports through Freedom of Information requests to the Medicare fiscal intermediary (FI). Hospitals should expect to hear from the FI soon that those requests have been made.

The AHA intends to use the information to again seek additional state funding for Medicaid hospital payments during the legislative session that will begin in January 2007. While the Arkansas legislature earmarked some funds for that purpose during the 2005 legislative session, it will be almost a year before the final amount is known, since it is tied to surpluses collected for fiscal years 2006 and 2007 in the state insurance trust fund. A majority of those trust funds are not collected until late in the fiscal year.

The association has begun to lay the groundwork for the additional Medicaid dollars. AHA representatives recently discussed the issue with leaders from the new Arkansas Department of Health and Human Services and the Medicaid program, and, in a separate meeting, discussed hospitals’ Medicaid needs with Arkansas Governor Mike Huckabee.

Poster and Print Ad Campaign Reminds that Hospital Campuses Are to be Smoke-Free

About a year ago, the Arkansas Hospital Association (AHA) board of directors began discussing what would become the AHA’s key initiative of the 2005 Arkansas legislative session.

The board believed that the state’s hospitals have common goals that are aimed not only at diagnosing and treating illness and injury, but also that are focused on promoting and improving community health. They agreed to demonstrate that commitment to their communities by supporting legislation to address a huge public health menace – smoking.

Those initial discussions culminated in Act 134 of 2005, which prohibits smoking of tobacco products in hospitals and on their grounds statewide. The law, which the AHA actively sought and supported as a matter of good public health policy, takes effect October 1.

To assist its member hospitals in preparing for their transition to smoke-free campuses, the AHA has developed a public service campaign to remind hospital employees, staff, patients and visitors about the new law.

Beginning in August, the print ad began to appear in newspapers statewide, bolstered by radio spots carrying the same message.

In addition, the AHA is providing each hospital with a digital poster file based on the print ad. Hospitals will be able to insert their own logo onto the poster, which can be reproduced and displayed throughout the hospital.

The print and radio ads will also be available to any member hospital wanting to place them in local media outlets.
Look what’s being removed from your hospital campus.

Beginning October 1, every hospital campus in Arkansas will be completely smoke free. This new law, Act 134 of 2005, will help make our entire state a much healthier place.
AFMC Seeking Improved Education, Communications on ER Usage

Members of the Arkansas Hospital Association (AHA) executive team met June 2 with representatives of the Arkansas Foundation for Medical Care (AFMC) to discuss AFMC’s efforts to better educate and communicate with providers and Medicaid patients about emergency room (ER) usage.

The session served as a progress report on steps AFMC has taken during the past six months to reduce the number of denials of Medicaid ER claims. AFMC is the state’s medical review contractor for acute care hospital services. The meeting was a follow-up to one held in December 2004, during which several hospitals complained about AFMC’s interpretation of the state’s “prudent layperson” law relating to approval of hospital emergency room claims.

Dr. Mike Moody, AFMC’s medical director, and Peggy Starling, the provider relations manager for the organization’s Medicaid Managed Care Services division, told the AHA that AFMC is committed to improving its education and communication efforts and believes those efforts already are yielding positive results.

Among its initial steps, the AFMC has developed and is distributing a series of printed materials to hospitals designed to better inform Medicaid patients about proper usage of emergency rooms and to get them to contact Medicaid’s complaint line (1-888-987-1200) with problems rather than relying on the hospital to solve them.

The information explains reasons and conditions for which patients should see their primary care physician and gives examples of when it’s appropriate to go to a hospital ER. It tells the patients that hospitals which do not treat a condition after a medical screening exam shows there is not an emergency are doing exactly what Medicaid requires in those instances.

Starling said that she has met over the past few months with CEOs and ER personnel at several hospitals to provide the information, answer questions and take a more detailed look into the underlying reasons leading to ER claim denials. She emphasized the importance that hospitals fully document all ER claims, since approval may depend on the amount and detail of information supplied on the claim.

She said the meetings have been well received and have proven to reduce both the number of claim denials at those facilities and the ensuing complaints. According to the AFMC, the number of Medicaid ER claims submitted rose from about 140,000 in 2003 to 149,000 in 2004. The denial rate on ER claims has leveled off to about 20% of the sample set of claims pulled for the post-payment review (around 40% of paid claims), after peaking at around 26% in the period following October 2003, when Medicaid switched from reviewing 100% of all ER claims. When all ER claims were subject to a pre-payment review, the denial rate was about 19%.

Also, hospitals are billing Medicaid more often for medical assessment level care rather than for non-emergency outpatient care provided in their ERs, which is another AFMC goal. In 2003, about 6.1% of all claims were for medical assessment services. In 2005, that is up to 11.4%.

Starling said her goal is to hold similar meetings in every Arkansas hospital. In the meantime, hospitals continuing to have concerns about ER claim denials, as well as those wanting to set up meetings with their ER personnel, should contact Starling at (501) 375-1200, ext. 629.

Visa Allotments Help Nursing Shortage

The fiscal year 2005 Defense Department supplemental appropriations bill passed by Congress May 11 reassigned to the Philippines, India, and China 50,000 visas unfilled by other countries in the past four years. The American Hospital Association-backed provision will allow U.S. hospitals to resume recruitment of nurses from those countries, which had exceeded their visa quotas and are a primary source of registered nurses for U.S. hospitals struggling with a critical shortage of nurses.

Up to 50,000 additional visas for registered nurses and physical therapists are expected to ease a lengthy wait for nurses from the three countries. The State Department sharply restricted visa approvals for nurses from China, India and the Philippines in January to prevent the countries from exceeding an annual quota.

The onetime visa bonus will allow the department to recycle about one-third of the roughly 140,000 visas that went unused in 2001 through 2004. Typically, the U.S. caps the number of visas awarded each year and does not allow unused visas to be carried over to the next year.
Phil Matthews, new president and CEO of the Arkansas Hospital Association, says that after 35 years with the AHA, he’s still glad to come to work each day. “I have been with the AHA almost continuously since 1969,” he says. “I did have one short 10-month time away from the fold, but I was glad to come back and have been delighted to be here every day I have walked through that door!”

Matthews says he is particularly appreciative of the AHA’s truly dedicated staff, both on the executive and support levels, and of the honorable service given by each of the AHA’s board members. “Over the years, our board members and association members have joined us in trying to make a positive difference in the quality of healthcare for the people of our state,” he says. “I believe we have made a real difference to the people of Arkansas.”

Matthews steps in as CEO after the retirement of former AHA president and CEO Jim Teeter. “I think people are seeing it as an easy transition,” he says. “After all, my job is to keep a smoothly running organization running in the same mode — smoothly!”

The hospitals of the AHA have a lot to deal with in today’s tough financial atmosphere. “In this day and time, the hospital field is very competitive,” Matthews says. “It may, at times, seem hard to pull together for the common good, but it must be done. After all, there are really more similarities than dissimilarities in what hospitals deal with today. We are all dealing with issues of reimbursement, staffing, transparency, electronic health records, etc. It is imperative that our members join together, leave competitiveness at the door, and work together on the big issues we face in healthcare today.”

“My chief request of our members would be that they continue to work with us on issues critical to the healthcare field,” he says. “Sometimes we are working at the national level, sometimes at the state and local levels. Wherever the problems take us, it’s urgent that the members participate. After all, everyone has a vested interest in the outcome!”

Getting out to meet with new administrators on their home turf is one of Matthews’ main goals for the next several months. “I need to know what issues are most pressing for them,” he says. “At the same time, I need for them to know just how important their participation and involvement are as we work together on healthcare issues.”
Some of those issues at hand are truly giant-sized! Matthews lists dealing with the challenges of the uninsured, quality and quality reporting, transparency in billing, electronic health records, reimbursement, implementation of the new Medicare drug program and infection reporting as some of the main issues the AHA and its members will together face in the coming twelve months.

“Let’s take those from the top,” he says. “New reports tell us that we have almost 48 million uninsured in the U.S. Every day, our hospitals face overflowing Emergency Departments as the uninsured use EDs as their ‘physician of choice.’ It’s a real dilemma, and no one in Washington, DC seems to be putting it on the front burner for more than a few days at a time. This is an issue that must be dealt with at the national level. The sheer numbers of uninsured patients certainly put enormous pressure on hospital ERs, causing hospital CEOs to have trouble balancing the needs of the uninsured (whose care is un-reimbursed) with those of keeping their physical plants running and their equipment up-to-date. Our hospitals want to provide a medical safety net for all – and they do – but financially, they cannot continue to do so forever under today’s reimbursement structure.”

As to quality and quality reporting, Matthews says the AHA will continue to work with the Centers for Medicare & Medicaid Services (CMS), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Arkansas Foundation for Medical Care (AFMC) and Arkansas Blue Cross Blue Shield on their quality improvement and reporting programs. “Though there is more cohesion in what these different groups look for now than in the past, it’s important that we all strive for standardized quality data,” he says. “It’s important that all Arkansans-based quality initiative programs utilize existing data sources, where possible, and that they focus on meaningful quality measures. By using standardized data, we believe it will limit additional hospital data collection and submission efforts and costs related to compliance.”

Electronic health records may sound futuristic, but they need to be in place right now, Matthews says. “The only roadblocks seem to be a reluctance of physicians and hospitals to change over to a truly electronic way of record-keeping, and the great cost involved with making the transition. Both are valid. This is one of the main issues the AHA and its members will address in the coming months.”

Transparent billing is also vital for today’s hospitals. “We have an interim study committee in the Arkansas legislature beginning to look at this,” Matthews says, “and the AHA will continue to work on behalf of the state’s hospitals by helping legislators understand the issue and its implications for both hospitals and patients in our state.”

Phil Matthews and his wife, Brenda, are longtime residents of the Little Rock area. Brenda is a former teacher, retired from work at the State Department of Education. Their son, Craig, works with Alltel. Craig and his wife, Sara, a teacher, are the proud parents of seven-year-old Hunter Matthews. “It’s one of our greatest pleasures to have our family living close by,” Matthews says. And one of his favorite pastimes? Playing golf with his son and grandson!
Reimbursement issues are always at the foundation of most highly charged issues in healthcare, because if hospitals aren’t reimbursed for the care they provide, it becomes impossible for their doors to remain open.

“When you look at the minutes of AHA meetings of 40 years ago, reimbursement was a real issue then, too,” Matthews says. “We know the new drug program for senior citizens will end up costing more than those in Washington ever dreamed. With the rising federal deficits, the costs of ongoing wars in Iraq and Afghanistan, the costs of rebuilding after Hurricane Katrina, and rising costs of doing business each day, it’s getting hard for those in Washington to fund much-needed healthcare reform. In fact, to find money for other programs, Medicaid was cut by $10 billion over five years. At the AHA, we’re dedicated to supplying our legislature with hard facts on continuing losses accruing to Arkansas hospitals due to inadequate Medicaid payments. We’re also working to develop strategies to increase state Medicaid funding of hospital services.”

“We also continue to look at medical error rates and the possibility of infection rate reporting,” Matthews says. “It’s our goal to work with other healthcare-related groups, including the Department of Health and Human Services and AFMC, in developing a state-specific approach to reduce medical and medication errors in Arkansas hospitals.”

Matthews says you’ll see many of these mainline issues as topics of the AHA’s educational seminars and programming in the coming year.

“We urge each of our member hospitals, their administrative staff members and employees to join us in working for the betterment of the healthcare field.”
Russian Medical Delegation Visits AHA, Shares U.S. Workforce Issue Concerns

If the most important rule for delivering quality healthcare is to have well-trained, compassionate caregivers who provide the day-to-day, hands-on services to patients, then ensuring the future availability of that workforce ought to be Rule No. 2.

Not overlooking either rule is a dilemma puzzling healthcare leaders worldwide. A delegation of Russian physicians visiting in Arkansas recently agreed that workforce issues present common problems in their country and halfway around the globe in the U.S.

Little Rock was one of two stops during the group’s trip to America to learn more about U.S. hospitals and its healthcare system. While in the States, they split time between Little Rock and Washington, D.C.

The Russians, including four physicians and a facilitator, along with an interpreter from the University of Arkansas for Medical Sciences, met with members of the Arkansas Hospital Association executive team July 13. They asked questions about topics ranging from the organization, composition, governance and role of the AHA and hospital associations in general, to hospital ownership; state and federal rules and regulations; hospital capital expansion decisions; and relationships among healthcare providers, payer organizations and regulators.

They nodded in agreement that one of the most perplexing issues about the manpower situation is the encroaching retirement of many educators who teach upcoming healthcare professionals. In America, as those instructors retire, there are too few new qualified teachers to fill the void. Apparently the same is true in Russia. According to Dr. Vladimir Medvedev, the problem extends even into Russian medical schools where many physicians who instruct student physicians are nearing retirement age.

The topic that captured the most interest was the coordination and cooperation among the state’s hospitals and various government agencies in their emergency readiness planning efforts. The Russian physicians seemed impressed by the regional emergency readiness planning underway in the state, but showed a common understanding and connection with the state’s hospitals when they learned about the growing frustration over future funding of these efforts.
Reaching Far Beyond Facility Walls:
Baptist Health’s Mission of Community

Fall 2005  Arkansas Hospitals

Submitted by Mark Lowman, Vice President–Strategic Development, Baptist Health

Editor’s Note: In this time of financial uncertainty, it is vital that every hospital let its community(ies) know – loudly and clearly – just how many services it provides for the region. Every hospital must communicate its own message, sharing it and talking about it within the community. All not-for-profit hospitals must complete Form 990 each year. When you come to the part about “what your hospital does for your community,” do not be afraid to boldly say exactly what services are provided, how much charity care is given, and the important role your hospital plays socially, economically and medically in your region. To do so helps defend your hospital’s tax exempt, not-for-profit status, imperative for “keeping the doors open” in this uncertain time.

This article is a good example of sharing the message with the community. We include it here as a model for your use.

As you compile similar information – telling your hospital’s story – be sure to ask to meet with your local newspaper and give the editors the information, in written form, if possible. Call your local radio reporter and ask if they would like to do a short program on the hospital’s role in the community. Television often offers special interest programming that could feature your hospital and its importance to life. These possibilities will not come to you; you must ask for them and provide the information in a descriptive, useable format.

Baptist Health’s mission is to provide quality patient-centered services and health education, and to respond to the changing healthcare needs of the state’s residents with Christian compassion and personal concern.

Simply put, Baptist Health exists to serve the community.

The mission of taking care of the community encompasses the wide range of services employees provide our patients in hospitals, therapy centers, and clinics throughout the state. But that mission also includes serving the community outside our facilities’ walls.

In fact, Baptist Health’s community service is so extensive, many people would be surprised at the lengths to which Baptist Health goes to take care of the community above and beyond the expected services—and at no cost to the organizations and individuals being served.

For 85 years, Baptist Health has taken this approach and has been able to make an impact not just on the quality of healthcare in the state, but also on the quality of life. This long-term emphasis on community service starts with the board of trustees and senior management and goes all the way to the employees who volunteer their time on their own for a cause important to them.

Last year alone, Baptist Health and its employees touched more than 400,000 lives outside the hospital walls by donating services, time, talent, money, and support to almost 200 organizations and worthwhile causes.

One of the many ways Baptist Health is involved in the community, for instance, is by offering free healthcare services to an underserved population through the community clinic co-sponsored by Entergy at Stewpot, an outreach program for the homeless at First Presbyterian Church in downtown Little Rock.

“The Soup Kitchen was started over thirty years ago, and we were feeding (people),” said the Rev. Howard Gordon, the minister of First Presbyterian Church, “and as we fed, we realized that we would love to have a clinic. Baptist Health has become a very active and vital partner in trying to meet these needs.”

Every Friday at Stewpot, Baptist Health offers free healthcare services such as blood pressure and blood sugar screening, health monitoring, individualized health teaching, first aid, treatment for lice, and medical referrals for those who need further treatment. For many who take advantage of these services, there is nowhere else to go for healthcare.

“We have doctors giving serious medicine to people who the world does not take seriously. We’ll have great lines out there in the snow, and the rain, and the wet. What that says to me is how much those people need to be taken care of,” Gordon said.

Baptist Health has also contributed to services at Stewpot in ways beyond healthcare, including distributing caps and gloves in the winter and water bottles in the summer, providing diapers to mothers, and helping people find shelter.

At the Watershed Human & Community Development Agency, also in downtown Little Rock, the mission is to help people move from dependen-
of our patients have incomes that are less than 200 percent of the poverty level. We serve around 10,000 patients each year and could not extend or sustain the level of services we provide to our patients without Baptist Health.”

Baptist Health’s support of rural clinics has included the expertise of health professionals, aid in physician recruitment, financial aid, and even furnishing a clinic with equipment and furniture.

“As we have expanded into additional underserved areas or provided new services, Baptist Health has always given us additional support. I shall never forget how, when we unexpectedly lost a lease in Huntsville, the Baptist Health van was dispatched to Madison County in northwest Arkansas so that we could continue to provide services while securing another location,” Campbell said.

Baptist Health is also affiliated with Mainline Health Systems, which has clinics in Portland, Wilmot, Eudora, Dermott, and Fountain Hill.

“Mainline Health Systems is the only facility that provides full perinatal care, including delivery, in Chicot County,” said Betty Gay Shuler, executive director of Mainline Health Systems. “Without our clinics, the low-income perinatal patients would have no recourse for treatment within 50 to 60 miles.”

Another emphasis of Baptist Health’s community service is care for children.

At P.A.R.K. (Positive Atmosphere Reaches Kids), an innovative after-school and summer program that offers intensive educational and life-skill experiences for at-risk youth in the eighth through 12th grades, Baptist Health has provided nutritious meals and snacks for these students free of charge since the program began. BH also offers a scholarship for graduates of the program to attend the Baptist Health Schools of Nursing and Allied Health.

“What we do is, we try to bring kids in who have very low GPAs, attack their deficiencies, raise their GPAs, and then send them off to college,” said Keith Jackson, founder of P.A.R.K.

“Baptist Health was one of the companies that came in from the beginning. They believed in what we were doing. They understood the nutritional value that they could add to that with their feeding program. And so we don’t have to spend a hundred and something thousand dollars a year to bring food in. We get to put that money on the bottom line to help these kids go to college,” Jackson said.

At several school districts in the state, Baptist Health has helped children in a wide variety of ways. This includes free athletic physicals, free immunizations and health screenings, and a variety of programs that help these students live healthier lives.

“All school districts need help from their community, and Baptist Health has played a vital role in many of the programs here within the Little Rock School District,” said Johnny Johnson, LRSD athletic director. “With all of the programs that Baptist Health offers here in Little Rock and statewide, they continue to make a huge difference in the lives of the children in the state.”

These examples mark just a few of the ways Baptist Health gives to communities all across Arkansas. The positive impact and volume of work and support Baptist Health consistently gives is simply part of our mission to serve.
Your hospital needs capital. After all, you must keep up with ever-improving technology, tend to facility and infrastructure maintenance and perhaps are planning an expansion to increase services.

According to Nathan Kaufman, senior vice president of healthcare strategy for ACS Healthcare Solutions, hospitals have two primary sources for that capital: self-generated profits (operating margin) and the debt market.

“The debt market uses operating margin as the primary criterion for determining the amount and price of the capital it will lend a hospital,” Kaufman says. “So a hospital’s operating margin is one of the primary determinants of future success.”

He says hospitals must consistently generate a 3 percent to 5 percent operating margin to succeed in the long-term. “That margin is also the major funding source for such ‘mission critical’ services as providing indigent care,” he says. And the truth is, if there is no margin, the hospital may not be able to stay afloat.

“To consistently achieve an optimal operating margin, a hospital must be certain that its expenses are at best-practice industry benchmarks – discovered by analyzing published data on similar-sized hospitals – and that its revenues are consistently increasing,” Kaufman says. “This ensures that, in the end, revenues exceed expenses.”

He cites current roadblocks to profit margins as:

- Hospital expenses increasing by at least 5 percent a year due to manpower shortages, the high cost of drugs and supplies, physicians’ demands to be paid for their medical staff duties (e.g. on-call coverage) and the escalating cost of the hospital infrastructure itself, and
- Government-mandated care (i.e. Medicare/Medicaid and charity care), which represents about two-thirds of most hospitals’ admissions and ED visits, is reimbursed at 70 percent of the cost of providing that care. If government reimbursement grows at all, it usually increases by 1 percent or 2 percent a year.

Thus, he says, to add an operating margin to the bottom line, hospitals must rely on reimbursement from only one-third of their patients – those with private insurance. “That’s why there is no task more critical or complex for a hospital than effective negotiations with insurance companies,” he says.

Kaufman offers the following as key rules for negotiating successfully:

1. Negotiate for rates based on what you need to achieve a reasonable operating margin. Many hospitals set their rates based on what competitors have negotiated and/or based on their rates from the year before. It is important to note that the medical-surgical occupancy rate in the nation is over 75 percent, which means that, in most markets, there is insufficient capacity for the insurance companies to shift patients away from a “non-participating” hospital. Also, just because the hospital accepted poor rates in the past doesn’t mean that it needs to repeat that mistake. When a hospital accepts poor rates, the community suffers because the hospital cannot afford new technology and other necessary components of its infrastructure.

2. The wording of a payer contract is as important as the rates themselves. Insurance companies boast that they are proposing a good deal for the hospital because they are offering ‘only’ a certain percentage increase in rates. But what payers give in rates, they take away in subsequent paragraphs. Payers use many “sleight of hand” negotiating strategies to reduce reimbursement, such as bundling the price for two services for which they had previously paid separately. Also, payers demand a separate, lower HMO fee schedule from the PPO fee schedule, even though there is absolutely no difference in benefit to the hospital between an HMO plan and the PPO plan. Then the insurance companies heavily market the HMO plan, which shifts patients to the lower fee schedule.

3. Rates should be set proportionate to volume. Your largest payer should pay at least 130 percent of Medicare payments. All other payers should pay more since their volume is less.

4. Every hospital must be prepared to walk away from a payer offering a poor contract. Most hospitals do not get significant concessions from an insurance company until the contract is terminated. This is a painful but necessary step for successful negotiations. Insurance companies will attempt to extend their contracts while they work the local politics to put pressure on the hospital to accept their terms. Hospitals are now hiring public relations firms with expertise in crisis communications to be ready to terminate a contract with a major payer if necessary.

“Hospital performance continues to be driven by the revenue generated through payer contracts, and hospitals need to fight for their fair share of the available money in healthcare,” Kaufman says. “Analyzing insurance company margin versus hospital margins, it would appear that hospitals need to do a better job of negotiating rates to obtain that revenue.”

Information for this article first appeared in Trustee magazine, July 2005.
The Uninsured: What Arkansans and the Numbers Say about Arkansas

It’s no secret that our nation is deeply concerned about the rising cost of healthcare, and with good reason. Figures from the last 30 years show the average annual cost for healthcare more than tripled between 1977 and 1987; then increased another 47% between 1987 and 1997; then increased another 11% between 1997 and 2000; and is continuing to spiral up and out of reach for millions of Americans.

Uninsured; Underinsured

The total number of uninsured Americans is currently estimated to be between 45 and 48.3 million, out of a July, 2005 total U.S. population of 295,734,134. That means that on any given day, more than 1/6 of our total population falls into the ranks of the uninsured!

In addition to the uninsured, there are millions more who are underinsured. These are the people who have minimal coverage and will suffer tragic financial crises if a major illness or accident comes their way.

Sadly, there are millions more who believe they have good coverage and access to high quality healthcare, but find their coverage lacking when they become involved with high-cost claims.

The ongoing tragedy of these statistics is that the numbers are predicted to continually rise – some say to 53 million within the next five years. As corporations, state agencies, schools, and smaller employers trim their expenses, add more part-time workers and cut benefits, employees must bear a greater percentage of the financial burden for their healthcare.

Most who are underinsured or uninsured fall between the ages of 18 and 65 and are working, many at low-wage jobs, some at more than one job, just to make ends meet. Too often, when faced with assuming the cost for their own healthcare, these low-wage workers opt to spend their hard-earned dollars for food, shelter and other expenses. Healthcare insurance goes by the wayside.

Over the past 20 years, per capita spending for healthcare continued to rise at a rate that far outpaced more meager rises in disposable personal income. Co-pays for pharmaceuticals, physician visits, and hospitalizations have spiraled, and are likely to continue to do so. This could force even more workers to drop health plans (due to lack of affordability) and “take their chances,” hoping against hope they will not need to access the healthcare system.

Already in today’s healthcare picture, we see many people “taking their chances,” forgoing preventive screening procedures to save money and neglecting healthcare until they become seriously ill.

How Healthy Are Arkansas Adults?

According to recent statistics, Arkansans have more health problems than the average United States citizen; the fact remains that health needs persist whether or not an individual is well-insured, adequately insured, underinsured or uninsured.

Statistics also show us that 24% of Arkansans aged 18-64 are uninsured, compared with 20% nationwide, and that most employed American adults receive some form of insurance from employer-provided plans; however, such coverage in Arkansas is lower than the national average (56% in Arkansas; 64% nationwide).

Differences in the rate of uninsured adults by race/ethnicity are also higher in Arkansas than the national average. In Arkansas, 22% of blacks are uninsured, compared to 21% nationwide; and in Arkansas 38% of Hispanics are uninsured, compared to 34% nationwide.

In the 2001 Arkansas Poll, 74% of respondents said they were willing to pay more taxes in exchange for healthcare reform. While Arkansas has been a leader in getting insurance coverage for children, a similar model needs to be instituted for adults in the state.

Background of the Arkansas Poll

The Arkansas Poll is conducted each year by the Diane D. Blair Center of Southern Politics and Society under the direction of Dr. Janine Perry, Associate Professor of Political Science at the University of Arkansas. The
most recent poll (Fall, 2004) included healthcare-related questions on insured and uninsured adults prepared by Kathleen Barta, EdD, RN and Marianne Neighbors, EdD, RN, faculty members of the University of Arkansas’ Eleanor Mann School of Nursing.

How Was the 2004 Arkansas Poll Conducted?

Between October 5 and October 20 (2004), the Survey Research Center at the University of Arkansas dialed 4,789 randomly selected Arkansas telephone numbers. These attempts yielded 758 completed surveys.

The remainder of the surveys were not completed for a variety of reasons, i.e. the resident’s absence, a refusal to participate, a busy or disconnected line, or the resident’s ineligibility.

Employing guidelines established by the American Association for Public Opinion Research, the poll’s cooperation rate was documented at 44%. This figure reflects completed surveys as a percentage of all eligible individuals contacted. The survey’s margin of error is +/- 3 percent.

To assess the representativeness of the sample drawn for the poll, the Arkansas Poll team opts to publish what most polling organizations do not: a comparison of survey respondents’ key demographic characteristics to those of the state as a whole. This information is reported in the table below.

**And the People Say…**

According to results of the 2004 Arkansas Poll, the national concern about health insurance is also on the minds of many Arkansans. Trends in the Arkansas Poll indicate health issues, including insurance coverage, are of growing importance to Arkansans.

Respondents in the 2003 Arkansas Poll indicated that “health and medical insurance” was the third most important problem facing people in Arkansas, ranking behind education and unemployment/lack of jobs. In the 2004 Arkansas Poll, “health insurance” was shown to be citizens’ number one concern.

Eighty-six percent of the respondents supported a plan to provide health insurance coverage for uninsured adults in Arkansas. Seventy-two percent would provide such coverage for all uninsured adults. Those respondents who would not cover all uninsured adults would cover employed and low income uninsured adults.

When asked what services should be covered for currently uninsured adults, the vast majority of respondents would include most services found in traditional insurance plans (see Table 3). Sixty-two percent of the respondents said they would support increased taxes to insure the uninsured.

When asked about current access to high quality, affordable healthcare, results were mixed. Seventy percent reported excellent or good access to high quality healthcare; 56% reported excellent or good access to affordable healthcare.

Thus, poll results indicate when designing a system to increase access to care, attention needs to be placed on both quality and affordability.

**Summary**

Covering the uninsured is supported by many in America, and by a majority of those polled in the Arkansas Poll. It is time for Arkansas to consider details of a plan to cover uninsured adults that is supportable by the public.

The Institute of Medicine’s 2004 report “Insuring America’s Health” offers five principles for assessing coverage proposals. These principles state that health coverage should be universal, continuous, affordable to individuals and families, affordable and sustainable for society, and enhance health and well-being. Such principles can be used to evaluate and compare different approaches when addressing the challenge of Arkansas’ uninsured.

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**Table 2 Comparison of 2004 AR Poll with State Demographics**

<table>
<thead>
<tr>
<th></th>
<th>2004 AR Poll Sample</th>
<th>State of Arkansas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Age Category</td>
<td>45-54 years of age</td>
<td>35-44 years of age</td>
</tr>
<tr>
<td>Average # persons</td>
<td>2.5</td>
<td>2.5</td>
</tr>
<tr>
<td>Average # persons</td>
<td>2.5</td>
<td>2.5</td>
</tr>
<tr>
<td>Male</td>
<td>43%</td>
<td>49%</td>
</tr>
<tr>
<td>Marital Status</td>
<td>61% married</td>
<td>58% married</td>
</tr>
<tr>
<td>Gender</td>
<td>43% male</td>
<td>49% male</td>
</tr>
<tr>
<td>Educational Attainment:</td>
<td>high school graduates</td>
<td>87.5%</td>
</tr>
<tr>
<td></td>
<td>college graduates</td>
<td>76%</td>
</tr>
<tr>
<td></td>
<td>31%</td>
<td>17%</td>
</tr>
<tr>
<td>Median household</td>
<td>$25,001-$35,000</td>
<td>$32,182</td>
</tr>
<tr>
<td>Income</td>
<td>83.0%</td>
<td>80.0%</td>
</tr>
<tr>
<td>Race/Ethnicity:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>83.0%</td>
<td>80.0%</td>
</tr>
<tr>
<td>Black or African</td>
<td>9.1%</td>
<td>15.7%</td>
</tr>
<tr>
<td>American</td>
<td>Multi-Ethnic</td>
<td>1.6%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>2.1%</td>
<td>3.2%</td>
</tr>
<tr>
<td>Native American</td>
<td>1.7%</td>
<td>0.7%</td>
</tr>
<tr>
<td>Asian</td>
<td>0.5%</td>
<td>0.8%</td>
</tr>
</tbody>
</table>

Source: All data from the Arkansas Poll or the U.S. Bureau of the Census, Census 2000.

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**Table 3 Support for Services to be Covered in Plan (Percent Yes)**

<table>
<thead>
<tr>
<th>Service</th>
<th>% Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening and Prevention?</td>
<td>92</td>
</tr>
<tr>
<td>Vision and Dental Care?</td>
<td>79</td>
</tr>
<tr>
<td>Hospital and Emergency Care?</td>
<td>97</td>
</tr>
<tr>
<td>Substance Abuse Treatment?</td>
<td>57</td>
</tr>
<tr>
<td>Mental Health Care?</td>
<td>90</td>
</tr>
<tr>
<td>Prescription Medication Coverage?</td>
<td>95</td>
</tr>
<tr>
<td>Chronic Disease Care?</td>
<td>95</td>
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Source: All data from the Arkansas Poll or the U.S. Bureau of the Census, Census 2000.
Medical Debt and Difficulties in Paying Medical Bills On the Rise

More than one-third of working-age Americans reported problems paying medical bills in 2003, particularly those who were uninsured or underinsured, according to estimates from a Commonwealth Fund survey released recently. Other groups showing difficulty in meeting medical bills include women, African Americans and those with health problems.

Adults with medical bill or debt problems were significantly more likely to leave a prescription unfilled, forgo a needed doctor’s visit, or skip recommended tests or follow-up visits than other adults, the report adds. “While policymakers should be concerned about the uninsured, who are at greatest risk, the study shows that the plight of the ‘underinsured’ must also be addressed,” the authors conclude. “Health plans that expose patients to high medical costs – whether through the absence of key benefits, high cost-sharing, or the denial of claims – contribute significantly to families’ bill and debt problems.”

To see the results of the 2003 Commonwealth Fund Biennial Health Insurance Survey, go to: http://www.cmwf.org/publications/publications_show.htm?doc_id=290074.

AHRQ Releases New Data on Uninsured

More than one in three Hispanics under age 65 was uninsured in 2004, according to survey data released by the Agency for Healthcare Research and Quality. That compares with about one in five African Americans and one in seven whites, the Medical Expenditure Panel Survey (MEPS) indicates.

Overall, 19% of all working-aged adults were uninsured as were 12% of children. “These results confirm the urgency of identifying effective policies to expand access to care for all Americans, particularly Hispanics,” said AHRQ Director Carolyn Clancy, M.D. “The MEPS is a unique resource for evaluating the impact of proposed solutions for different populations.”


ER Visits Up 26% Since 1993, As 12.3% of ERs Closed

Emergency department visits rose to an all-time high in 2003, 113.9 million annually, up 26% from the number recorded in 1993, the Centers for Disease Control and Prevention says in a new report.

The number of emergency departments in the U.S. decreased by 12.3% over the same time period.

Adults, especially seniors, drove the trend, with emergency rooms reporting a 26% increase in patients 65 years and older. Approximately 14% of ER visits resulted in a hospital admission in 2003. On average, patients spent 3.2 hours in the emergency department and waited 46.5 minutes to see a doctor.

Read the CDC report at http://www.cdc.gov/nchs/data/adb/ad358.pdf.

Hospital Charity Care Understated by Nation’s Hospitals

A new report by PricewaterhouseCoopers says that America’s hospitals are absorbing higher levels of charity care and bad debt and may be providing far more free care than the $25 billion they report annually.

The report says that the charity care numbers may be underestimated because of the “burdensome and expensive process that hospitals must go through to classify a patient as charity care.”

It shows that 92% of the hospitals surveyed said at least part of their bad debt could be classified as charity care. The report also notes that uncompensated care, of which charity care is a component, increased by 20% from 1999 to 2003, to $24.9 billion.
Covering the Uninsured Could Save Billions

Healthcare economist and Emory University professor Kenneth Thorpe believes that it may be necessary for the government to spend money to save money on healthcare costs.

On May 23, Thorpe projected that four models proposed last year by the National Coalition of Health Care to expand healthcare coverage to all Americans would save more money than they would cost to implement. The coalition is comprised of almost 100 organizations employing or representing about 150 million Americans.

In a 2004 report, the group proposed four models for achieving universal health coverage: requiring employer-based coverage while providing subsidies for low-income Americans, expanding existing public health insurance programs, creating new public programs for the uninsured, and publicly financing universal coverage.

Thorpe projects each model would reduce healthcare spending by at least $320 billion over 10 years when combined with quality and safety improvement, administrative simplification and cost-containment measures recommended in the 2004 report.

In 2004, nearly 48 million Americans had no healthcare coverage, and the number is expected to grow to 54 million within a decade.

Lack Of Coverage by the Uninsured Costs All Employers

Premiums for employer-provided health insurance on average will cost an extra $922 for family coverage and $341 for individual coverage in 2005 to cover the unpaid healthcare expenses for the uninsured, according to a study released June 8 by Families USA.

That’s one of every $12 spent for employer-provided health insurance, or 8.5% more than it would be if everyone in the U.S. had health insurance, according to the analysis by Emory University professor and healthcare economist Kenneth Thorpe.

The study estimates that nearly 48 million Americans will be uninsured for the entire year in 2005, and that the cost of uncompensated care provided to the uninsured will exceed $43 billion nationally. By 2010, the study projects nearly 53 million Americans will be uninsured for the entire year, and that the average extra cost to annual premiums will rise to $1,502 for family coverage and $532 for individuals.

See http://www.familiesusa.org/site/PageServer?pagename=Paying_a_Premium_splash to read the study.
Arkansas AWP Law is Now In Effect; Implementation Clarified

After a 10-year hiatus and a long, strange ride through the state and federal court systems, the Arkansas Patient Protection Act of 1995, the state’s Any Willing Provider (AWP) law, is taking its place among enforceable state acts.

On June 29, the 8th Circuit Court of Appeals in St. Louis ruled against Arkansas Blue Cross Blue Shield, Inc, which had petitioned to keep the state’s ban on enforcing the 1995 law in place. Blue Cross’ appeal came following a February 2004 decision by Little Rock Federal District Judge Jim Moody to lift an injunction on the law that he, himself, originally put in place in 1997.

The Court of Appeals action was made even more ironic since the 8th Circuit originally upheld that ruling. The catalyst for the change was a unanimous 2003 U.S. Supreme Court decision that upheld a similar AWP law in Kentucky. The court found that law not to violate the Employee Retirement Income Security Act (ERISA), which restricts states in issuing rules on employee benefits. The previous injunction on the Arkansas law was based on ERISA preemption arguments.

The effect of the ruling, which does not apply to self-insured plans, is that insurers doing business in Arkansas must now allow all providers meeting the payer’s entry requirements into their networks.

The Court’s decision means that Act 490 of 2005 will not go into effect. That law, also AWP legislation, was passed as a safeguard and was ready for implementation if the Circuit Court of Appeals had ruled in favor of Blue Cross’ attempt to keep the injunction over the 1995 law in place.

Acts 491 and 960 of 2005, which cover enforcement of the previous AWP laws, became effective as of August 12, 2005.

The Arkansas Insurance Department has issued a directive (2-2005) regarding the state’s Any Willing Provider (AWP) laws, including acts passed in 1995 and 2005.

The directive clarifies application of the 1995 law as amended by the 2005 laws. It describes the types of group health plans subject to the laws and defines which healthcare providers are entitled AWP rights.

In addition, the directive advises that every health plan and accident and health insurer give providers, upon request, a written application form and description of the application process for requesting network access, instructs that the insurers provide a written description of terms that providers must meet to qualify for admission to their networks and sets restrictions governing healthcare provider discrimination.

“Any willing provider” means that health insurance companies must pay the same benefits to any provider willing to accept the same terms as the existing contracted in-network providers.

Application for Section 1011 Funding Now Available Online

The online form for hospitals to apply for Section 1011 of the Medicare Modernization Act funding is now available at the Web site of the Centers for Medicare & Medicaid Services’ (CMS) contractor for that program, TrailBlazer Health Enterprises. Section 1011 authorized funding to reimburse hospitals for some of the uncompensated costs of providing emergency care to undocumented immigrants. Hospitals must submit both a paper application and an online form to be eligible for the funding.

Hospitals that have submitted a paper application and received a letter of acknowledgement need only fill out the electronic version to complete the application process. All other hospitals should fill out the online application and then will be prompted to print out and send in a paper form. Go to https://www.trailblazerhealth.com/Section1011/Default.aspx to find the form. In mid-September, questions and final responses from an August 31 teleconference about Section 1011 will also be available on the site. In addition, Trailblazer’s new call center for providers with questions about the enrollment process is now operational. The number, which is available from 9 a.m. to 4:30 p.m. CST (Central Standard Time), is (866) 860-1011.
The Centers for Medicare & Medicaid Services (CMS) on August 1 placed on display a final rule on the inpatient rehabilitation facility prospective payment system (IRF PPS) for fiscal year (FY) 2006. The rule was similar to the proposed rule issued May 25, with few changes in response to comments.

Key provisions of the final rule include:
- A full market basket update of 3.6 percent.
- A reduction in the outlier loss threshold from $11,211 to $5,132.
- An increase in the rural adjustment from 19.14 percent to 21.3 percent.
- A new adjustment for IRFs designated as teaching facilities.
- A one-year phase-in of new labor market definitions based on core-based statistical areas, including a hold-harmless provision for rural IRFs reclassified as urban.
- A 1.9 percent across-the-board reduction to all IRF payment categories, known as case mix groups (CMGs).
- A substantial revision to the system for classifying patients into CMGs and a re-weighting of the CMGs.
- Creation of a weighted motor-score index that replaces the current index.

CMS estimates that the aggregate impact of this proposed rule is a 3.4 percent increase in Medicare payments, larger than projected by the proposed rule. However, some IRFs would receive higher payments and others would receive lower payments than they did in FY 2005.

A copy of the final rule is available at www.cms.hhs.gov/providers/irfpps/. Further AHA analysis of this rule is underway.

PPS Rule Aids Relocations of Critical Access Hospitals, But Expands Post-Acute Transfer DRGs from 30 to 182

The draft fiscal year 2006 rule for Medicare’s inpatient prospective payment system (IPPS), which Centers for Medicare & Medicaid Services (CMS) proposed last May, included very restrictive guidelines for the relocation and replacement of critical access hospital (CAH) facilities.

The proposed rule would have made it almost impossible for CAHs that had previously been designated as “necessary providers” to build new facilities, unless those projects were underway by December 8, 2003.

In its IPPS Final Rule, CMS is allowing those necessary provider CAHs to relocate, as long as the facility in its new location meets all three of the “75%” criteria that previously applied. That is, 75% of the patients must come from the same service area as before the relocation; 75% of the services must be the same as at the prior facility; and 75% of the staff must be the same as at the prior facility.

CMS did not adopt provisions in the proposed rule that would have set a date by which a CAH must notify CMS of its intent to relocate or would have required that construction plans were underway by a certain date.

The final rule also expands Medicare’s post-acute care transfer policy from 30 to 182 diagnosis-related groups (DRGs) at a cost of $780 million per year, despite strong opposition from Congress, the American Hospital Association, state hospital associations and individual hospitals across the country.

CMS originally proposed expanding the policy to 231 DRGs, which would have cost hospitals almost $900 million in fiscal year 2006 alone.
Advisories About Medicare Rules

The American Hospital Association (AHA) issued Regulatory Advisories in late August to member hospitals concerning the Center for Medicare & Medicaid Services (CMS) final rules for Medicare’s prospective payment systems (PPS) covering inpatient hospital services and Skilled Nursing Facilities for fiscal year 2006, and for the proposed Medicare outpatient PPS rule for calendar year 2006. The inpatient PPS advisory asks specifically that hospital chief financial officers examine the payment changes to the rule and the negative impact of the expanded transfer provision on fiscal year 2006 Medicare revenues. The advisory also should be shared with billing and medical records departments and clinical leadership to ensure they are aware of all policy changes impacting diagnosis related groups (DRG) coding, as well as items eligible to receive new technology add-on payments in FY 2006.

The advisory for the proposed outpatient PPS rule suggests that hospitals model the impact of the proposed ambulatory payment classification (APC) changes on 2006 Medicare revenues. Go to http://www.aha.org/aha/members_only/member/050824_apcrates01_06.html to view a spreadsheet comparing the changes in APC payment rates and weights from 2001–2006 that is available for AHA members.

Comments on the proposed outpatient PPS rule must be submitted to CMS before the September 16 deadline. Feel free to use the AHA’s comment letter as a guide; it is available at http://www.aha.org. The outpatient PPS continues to be underfunded, paying hospitals about 87 cents for every dollar spent providing outpatient care to Medicare beneficiaries.

EMTALA Born-Alive Infant Requirements

In August 2002, President George W. Bush signed into law the Born-Alive Infants Protection Act. The law gives every infant “born alive” at any stage of development full legal rights under federal law.

According to the law, an infant is “born alive” if he or she is “expelled or extracted from his or her mother... at any stage of development,” and afterward, “breathes or has a beating heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, regardless of whether the expulsion or extraction occurs as a result of natural or induced labor, Caesarean section or induced abortion.”

Arkansas hospitals should be aware that, according to an April 22, 2005 Memorandum issued to State Survey Agency Directors, the Centers for Medicare & Medicaid Services (CMS) is interpreting the Act to mean that protections under the federal Emergency Medical Treatment and Active Labor Act (EMTALA) will apply to any infant “born alive” anywhere on the hospital’s campus.

This means that a medical screening examination will be required, and if the infant is suffering from an emergency medical condition, an obligation arises to admit the infant or to comply with either the stabilization requirement or the transfer requirement under EMTALA.

Arkansas Hospital Association (AHA) legal counsel, Elisa White, reported to the AHA board that several out-of-state hospitals have been surveyed based upon complaints that they failed to provide an EMTALA screening to a “born-alive infant.” All hospitals should be sure to document their compliance with EMTALA with regard to any infant meeting the definition of “born alive.”

Proposed 2006 Home Health Agency Payments Show Increases

The Centers for Medicare & Medicaid Services (CMS) announced on July 7 a proposed 2.5% increase in Medicare payments to home health agencies for the 2006 calendar year. The proposed update is equal to the market basket percentage – a measure of inflation – minus 0.8 percentage points, the update set by Congress in the Medicare Modernization Act of 2003.

CMS also is proposing adopting revised market area definitions that are used to adjust payments for geographic differences in wage levels and other costs. With the use of these new definitions, CMS estimates that rural home health agencies will see a 3.5% increase in payments, and urban home health agencies will see a 2.3% increase.

Proposed OPSS Rule Changes

The Centers for Medicare & Medicaid Services (CMS) on July 18 issued its proposed Hospital Outpatient Prospective Payment System rule for calendar year 2006, which includes a 3.2% payment update for hospital outpatient services. The proposed increase, together with other policy changes required by the Medicare Modernization Act (MMA) and a change in outlier payments, will result in a 1.9% increase in total payments for hospital outpatient services.

Among the MMA changes is the elimination of the “hold harmless” payments for small rural hospitals having fewer than 100 beds and for Sole Community Hospitals (SCH) in rural areas. However, CMS also proposes to increase payments for rural SCHs by 6.6%.

The rule also includes significant payment and policy changes for drugs and outlier payments, and proposes to apply a payment discount when multiple imaging procedures are performed in the same session.

The proposed rule, which the American Hospital Association is reviewing, was placed on display for publication in the July 25 Federal Register and is available on the CMS Web site at www.cms.hhs.gov/providers/opps/. A final rule is expected by November 1.

Bill Would Resolve EMTALA/IMD Conflict at Non-Public Psychiatric Hospitals

Sen. Olympia Snowe (R-ME) has introduced legislation that would allow non-public psychiatric hospitals to receive reimbursement for care provided under the Emergency Medical Treatment and Active Labor Act (EMTALA) to Medicaid beneficiaries aged 21-64.

The Medicaid Emergency Psychiatric Care Act would resolve the existing conflict between EMTALA and the Institution for Mental Diseases (IMD) exclusion that currently prohibits non-public psychiatric hospitals from receiving Medicaid reimbursement for emergency psychiatric treatment delivered to Medicaid patients aged 21-64.

The bill is supported by the American Hospital Association. Rick Pollack, American Hospital Association executive vice president, wrote in a letter to Snowe, “This will relieve overcrowding in emergency departments and provide the appropriate care these patients deserve in a more timely manner.”

The National Association of Psychiatric Health Systems and other associations also have endorsed the legislation.

The IMD exclusion has been part of the Medicaid program for 40 years. It bars federal contributions toward the cost of medically necessary services provided Medicaid beneficiaries ages 21-64 in certain institutions that fall within the definition of an “institution for mental disease,” and does so for no apparent reason.

Opponents of the exclusion say it is premised on the outdated assumption that the federal government should not share responsibility for providing treatment to individuals with mental health disorders.

CBO Report Shows that 25% of Medicare Beneficiaries Account for 85% of Medicare Spending

New figures from the Congressional Budget Office (CBO) confirm that a small number of Medicare beneficiaries account for most of that program’s spending.

In addition, the CBO says that the best predictor of high spending is the number of chronic illnesses a beneficiary must treat.

A new CBO report shows that 25% of beneficiaries accounted for 85% of Medicare spending in 2001 and for 68% of cumulative spending during the five calendar years 1997 through 2001.

Beneficiaries whose costs were high over several years tended to have one or more of seven chronic illnesses: asthma, chronic obstructive pulmonary disease, chronic renal failure, congestive heart failure, coronary artery disease, diabetes, and/or senility.
CMS is Moving Ahead with Implementation of 75% Rule

The Centers for Medicare & Medicaid Services (CMS) is moving ahead with implementation of the 75% Rule that is the basis for classifying hospitals as inpatient rehabilitation facilities (IRFs) for purposes of Medicare payment. The announcement, published as a notice in the June 24 Federal Register, came after the Government Accountability Office (GAO) issued its report in April on IRF classifications.

In a June 21 press release, CMS noted that the GAO had not recommended delaying the final rule’s implementation any further.

Congress had required the Secretary of the Department of Health and Human Services (HHS) to delay implementation of the 75% final rule, issued in May 2004, until the completion of GAO’s review.

The rule provides for a four-year transition period, during which the required percentage of patients with a qualifying condition (the “compliance threshold”) increases gradually from 50% to 75%. Under the transition, at least 50% of the total inpatient population of an IRF must have at least one of the 13 medical conditions listed in the May 7, 2004 final rule for cost reporting periods beginning on or after July 1, 2004 and before July 1, 2005.

Other compliance percentages apply for the remainder of the transition period until the compliance percentage reaches 75% for cost reporting periods beginning on or after July 1, 2007.

In addition, during the transition period, patients with a secondary condition that meets one of the qualifying conditions may also count toward the applicable percentage if certain conditions are met.


Final FY 2006 SNF Rule in Effect October 1

The Centers for Medicare & Medicaid Services’ (CMS) final rule for the skilled nursing facility (SNF) prospective payment system (PPS) for fiscal year 2006 makes only minor changes to the provisions included in the May 19 proposed rule.

Among its provisions, the rule implements the mandated update of 3% that takes effect October 1, 2005 and is estimated to increase SNF payments by $530 million during the 12-month period, an increase from the proposed rule’s estimate of $510 million.

It also includes SNF payment refinements, such as:

• Elimination of Payment Add-ons

The current SNF PPS payment add-ons – 20% for medically complex payment categories (known as RUGs, or resource utilization groups) and 6.7% for rehabilitation RUGs – will expire. Their termination is being postponed by three months to January 1 to reduce the estimated annual impact of negative $1.4 billion to a nine-month reduction of $1.02 billion.

• Nine New RUGs

As proposed by CMS, the final rule will add nine RUGs to the payment system beginning January 1, 2006. These new RUGs are intended for medically complex rehabilitation patients.

• Proposed Case Mix Adjustment for Nursing

The final payment add-on to the nursing component of each payment category will be 8.51%, an increase from the proposed 8.4%. CMS said the add-on is to account for the system’s inability to accurately predict patients’ resource utilization. The adjustment takes effect January 1, 2006 and has a nine-month fiscal impact of $510 million. As it did for general acute hospitals, CMS will implement the new labor market definitions based on core-based statistical areas through a one-year transition.

A copy of the final rule is available at http://www.cms.hhs.gov/providers/snffps.

New NUBC Form Released

The National Uniform Billing Committee (NUBC) has released the new UB-04 form and data set specifications that healthcare providers must use to process healthcare claims beginning in 2007, when the current UB-92 form and data set will be discontinued.

Providers will be able to transition to the new form between March 1 and May 22, 2007, when both the new and current forms/data sets will be accepted, but must begin using the new form and data set by May 23, 2007.

Health plans, clearinghouses and other information support vendors must be ready to handle and accept the new form and data set by March 1, 2007. The NUBC, which maintains the standard billing data set for healthcare providers, revised the form and data set to better align with the Health Insurance Portability and Accountability Act’s transaction standard and other national standards.

For information on obtaining full color proofs of the form for testing purposes, or a beta release of the corresponding data specifications manual, contact Todd Omundson, associate director of the American Hospital Association’s health data management group, at tomundson@aha.org.
Ozone Action Days Warn Citizens Of Unhealthy Air Quality

With autumn’s official arrival September 21, Arkansans want to be outdoors enjoying the Natural State. However, in Arkansas autumn does not guarantee cool weather. So even in the fall on days when temperatures are more like summer, Arkansans should be aware of the dangers to their health.

Ozone, the main ingredient of smog, presents a serious air quality problem because even at low levels, ozone can cause a number of respiratory effects. Ozone is a gas that occurs both in the earth’s upper atmosphere and at ground level and can be good or bad, depending on where it is found.

Good ozone occurs naturally in the earth’s upper atmosphere — 10 to 30 miles above the earth’s surface — where it shields us from the sun’s harmful ultraviolet rays. Bad ozone is located in the earth’s lower atmosphere, near ground level, where it is formed when pollutants emitted by cars, trucks, industrial smoke stacks, construction and farm equipment, lawn mowers and outboard motors react chemically in the presence of sunlight. Pollutants can also come from gas stations, oil-based paints and cleaning solvents.

Ozone pollution conditions are of greatest concern during the hotter months when the weather conditions needed to form ground-level ozone — lots of sun and hot temperatures — normally occur. When high ozone concentrations are forecast and the air quality will be unhealthy, the Arkansas Department of Environmental Quality declares an Ozone Action Day.

According to Dr. Frank Wilson, state epidemiologist with the Arkansas Department of Health and Human Services, several groups of people are particularly sensitive to ozone — especially when they are active outdoors — because physical activity causes people to breathe faster and more deeply. Active children are the group at highest risk from ozone exposure because they often spend a large part of their time playing outdoors. Children are also more likely to have asthma, which may be aggravated by ozone exposure.

“Children like to play outside, and on steamy afternoons this could spell danger,” Wilson said. “Their lungs are still developing, and they breathe more rapidly and inhale more air pollution for their size than do adults. On days when ozone levels are high, these factors put children at increased risk for respiratory problems.”

Active adults of all ages who exercise or work vigorously outdoors have a higher level of exposure to ozone than people who are less active. People with asthma or other respiratory diseases that make the lungs more vulnerable to the effects of ozone will generally experience serious health effects earlier and at lower ozone levels than less sensitive individuals.

Wilson said an adult breathes about 20,000 times each day, and when adults exercise heavily, they may increase their intake of air by as much as 10 times their level at rest.

“When ozone levels are high, exercising outdoors greatly increases the chances that we will suffer the symptoms of ozone exposure,” he said.

In general, as concentrations of ground-level ozone increase, more and more people experience health effects, the effects become more serious, and more people are admitted to the hospital for respiratory problems. When ozone levels are very high, everyone should be concerned about ozone exposure.

“High levels of ozone can cause shortness of breath, coughing, wheezing, headaches, nausea and eye and throat irritation,” Wilson said. “People who suffer from lung diseases like emphysema, pneumonia, asthma and colds can have more trouble breathing when the air is polluted.”

by Ann Wright, Healthy Arkansas, Arkansas Department of Health and Human Services

People should plan outdoor activities when ozone levels are lower, usually in the morning or evening.

Children like to play outside, and on steamy afternoons this could spell danger.
Ozone continues to cause lung damage even when the symptoms have disappeared. The best way to protect your health is to find out when ozone levels are elevated in your area and take simple precautions to minimize exposure even when you don’t feel obvious symptoms.

“People’s chances of being affected by ozone increase the longer they are active outdoors,” he said. “If you’re involved in something that requires heavy exertion, try to reduce the time you spend on this activity or do something else that requires more moderate exertion, such as going for a walk rather than a jog. In addition, people can plan outdoor activities when ozone levels are lower, usually in the morning or evening.”

Following are a few things to “do” and “not do” on Ozone Action Days:

**Do**
- Limit driving. Share a ride, carpool, or ride the bus.
- Combine errands.
- Keep your car well tuned, avoid jackrabbit starts and excessive idling.
- Stay indoors as much as possible.
- Refuel your vehicle during evening hours and don’t fill the tank completely.

**Don’t**
- Do lawn and gardening chores that use gasoline-powered equipment.
- Use oil-based paints and solvents.
- Use products that release fumes. If it smells strong, it may be wrong. (This includes paint strippers and varnish – even things like fingernail polish remover.)
- Exercise outdoors.

“The best thing we can do is to prevent ozone smog from forming in the first place,” Wilson said. “Everyone can do a small part in keeping our air clear. Even the smallest actions taken by individuals can add up to a big difference.”

Ann Wright works in External Communications, Division of Health of the Arkansas Department of Health and Human Services.

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**Growing Physician Shortage May Loom on Horizon**

At the AHA annual meeting October 19-21 of this year, you’ll have the opportunity to hear a presentation on looming physician shortages called, “Will the Last Physician in America Please Turn Off the Lights?” The presentation is based on a new book cautioning that America is running short of physicians, a trend that will impede access to medical services, increase costs and frustrate efforts to reform the healthcare system.

Titled, “Will the Last Physician in America Please Turn Off the Lights? A Look at America’s Looming Doctor Shortage,” the book is intended as a wake-up call for politicians, physicians, patients and the healthcare industry, say co-authors James Merritt and Joseph Hawkins, healthcare recruiting executives with Dallas-based The MHA Group.

Merritt and Hawkins have observed physician supply and demand trends for more than 20 years and distill their observations in the narrative, explaining why we are running out of physicians and what the physician shortage means to healthcare delivery.

“We have to recognize the fact that unless changes are made, physicians are going to be an endangered species in America,” notes Hawkins. “The first step to addressing this problem is to acknowledge that it is a problem.”

The authors explain why healthcare experts have long believed that America has too many physicians, and how this has inhibited the supply of doctors at precisely the wrong time. They outline reasons for the physician shortage and examine the differing practice styles of younger and older physicians and the effect that the growing number of women in medicine is having on physician supply.

They also look at the crisis in emergency medicine and the vanishing breed of old school “country doctors,” concluding with sugges-

Kurt Mosley, Vice President of Business Development for The MHA Group, will discuss “Will the Last Physician in America Please Turn Off the Lights?” at this year’s Arkansas Hospital Association Annual Meeting October 19-21. The MHA group is part of AHA Services, Inc.’s service consortium.
New JCAHO Patient Safety Goals for 2006

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has announced that effective January 1, 2006, revisions made to Information Management standard IM.6.20 require hospitals to collect information on the language and communication needs of patients.

Specifically, the standard requires that each medical record contain, as applicable, the patient’s language and communication needs, in addition to the patient’s name, gender, address, date of birth, and authorized representative, if any. This new requirement underwent field review, and input was provided by members of the Hospital Professional and Technical Advisory Committee.

According to the JCAHO, research shows that differences in language and culture can have major impacts on the quality and safety of care, and that disparities in health services and outcomes are associated with race, ethnicity and language.

See http://www.jcaho.org/About+Us/News+Letters/JCAHOnline/jo_05_05.htm#lip for more information.

New JCAHO Requirement Puts Patient’s Native Language in Chart

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CMS Issues “Roadmap” to Quality, Presents it to Congress

The Centers for Medicare & Medicaid Services (CMS) on July 25 presented congressional committees with jurisdiction over Medicare and Medicaid with a “roadmap” for improving the nation’s healthcare quality.

The agency’s plan features five strategies to achieve improvements in the quality of the nation’s healthcare services:
• Work through partnerships – within CMS, with federal and state agencies, and especially with non-governmental partners – to achieve specific quality goals.
• Develop and provide quality measures and information as a basis for supporting more effective quality improvement efforts.
• Pay in a way that reinforces a commitment to quality and helps providers and patients take steps to improve health and avoid unnecessary costs.
• Assist practitioners and providers in making care more effective, particularly through the use of effective electronic health systems.
• Bring effective new treatments to patients more rapidly and help develop better evidence so that doctors and patients can use medical technologies more effectively.

CMS said the ultimate goal of its roadmap is “to ensure the right care for every person every time and to do this by making care safe, efficient, patient-centered, timely and equitable.”

New Law Designed to Enhance Patient Safety

On July 29, President George W. Bush signed into law the Patient Safety and Quality Improvement Act, designed to enhance patient safety by encouraging voluntary reporting of medical errors.

The new law, backed by the American Hospital Association, creates a national database of medical errors, designates individual reports as confidential and shields participating providers from liability. Those protections should make it easier for healthcare providers to share the information for educational purposes.

The new act also creates patient safety organizations to promote information sharing.

AHA Launches Surgical Care Improvement Project

The American Hospital Association (AHA) July 28 launched a national partnership with leading public and private healthcare organizations to reduce surgical complications by 25% by the year 2010.

Unveiled at the recent Health Forum and AHA Leadership Summit in San Diego, the Surgical Care Improvement Project will provide hospitals and caregivers with strategies proven to reduce four common surgical complications: surgical wound infections, dangerous blood clots, perioperative heart attack and ventilator-associated pneumonia.

In addition to physician and healthcare organizations, partners in the initiative include the federal Agency for Healthcare Research and Quality (AHRQ), the Centers for Medicare & Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC).

To learn more, go to http://www.aha.org/aha/key_issues/patient_safety/resources/scipindex.html.

The Blue Cross Blue Shield Quality Reporting Initiative

Arkansas Blue Cross Blue Shield (ABCBS) informed the Arkansas Hospital Association (AHA) in late May of its intent to participate in a national Blue Cross Blue Shield Association (BCBSA) initiative to publicly report hospital quality data.

Mike Brown, Arkansas Blue Cross senior vice president, met with the AHA executive team May 25 to discuss ABCBS’ plans to be a part of the project to assemble publicly available data on selected measures.

The BCBSA initiative relies primarily on existing data already submitted and reported for the Centers for Medicare & Medicaid Services’ Hospital Compare Web site and the Quality Check Web site of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

The ABCBS reports will reflect how individual hospitals compare with overall plan rates, the statewide rate and the national rate in their compliance with 15 measures relating to three conditions: acute myocardial infarction, heart failure and pneumonia.

In addition, the BCBSA quality initiative, which involves 14 plans covering 29 states, includes similar comparisons on three Agency for Healthcare Research and Quality (AHRQ) patient safety indicators: postoperative septicemia, failure to rescue and decubitus ulcer.

The patient safety measures are based on Medicare participation (MedPAR) data for the state’s hospitals. ABCBS is finalizing its plans for including information about Arkansas hospitals in this national reporting project, although no specific timeframe has been set.

Arkansas Blue Cross is in the process of generating and reviewing the initial reports for each hospital in its network and will give the hospitals an opportunity to review the information to ensure it is correct before making it public. ABCBS representatives were to contact CEOs of each Arkansas hospital having a Blue Cross contract, either in person or by phone, to discuss the initiative and their individual hospital data.
In October of this year, the Arkansas Hospital Association (AHA) will celebrate its 75th anniversary. For three-quarters of a century, the people and organizations that make up this association have banded together for the common purposes of improving their communities’ healthcare quality and raising the level of health services for and health status of all Arkansans.

From its meager beginnings in 1929 as a loosely knit group, the AHA has come to be recognized as one of the state’s most effective, successful and trusted advocacy organizations.

We thought it would be interesting at the end of this, our 75th year, to take a glance back at some of the history of the AHA, and some of the main issues the state’s hospitals have faced over the years.

Our early twentieth century storage, archiving, and retrieval system made that more challenging than it sounds. The files, when finally located, revealed little about the history of the association for much of its first 25 years. We can, however, take a look at what was happening in our nation as the fledgling AHA took shape. And once we reach the 1950s (and archival records are more complete), we can take an in-depth look at the issues hospitals have faced and with which they have struggled over the past five decades.

**1929 – The Beginning**

It was 1929, one of America’s most memorable years. The Roaring Twenties were about to come to a screeching halt, although few knew how much life was about to change.

Folks were preparing for a new decade, but they had no clue about the upheavals in store. Sifting through the year’s events three-quarters of a century later, we can point to a few good things that occurred in 1929. For most Americans, however, it was not, as Frank Sinatra would sing, a very good year.

Our 31st President, Herbert Hoover, probably wished he had skipped 1929 altogether. Hoover took the oath of office on a gloomy, rainy day in late March – a foreshadowing of things to come. His 1928 campaign was filled with the promise of prosperity. He was going to put “a chicken in every pot and a car in every garage.” By the end of the year, he realized he’d need more chickens and cheap cars.

1929 didn’t officially become a very bad year until October. Hoover’s plans were blind-sided by the public’s insatiable desire to invest every dollar they had – and some they didn’t – in a stock market that kept going up, up and away. They forgot it is universally recognized that whatever goes up must come down. It did. The market peaked in September of ’29, then crashed during the dark days of Black Thursday, Black Monday and Black Tuesday, losing 91% of its value by October 29th and spiraling the country into The Great Depression.

So, what about those good memories of 1929? Well, it was a year of “firsts.” Hollywood presented its first Academy Awards, Babe Ruth became the first baseball player to hit 500 home runs, and the first regularly scheduled television broadcasts were transmitted. Oh, and on Wall Street, the first automatic electric stock quotation board was installed. Talk about bad timing.

In the world of science and medicine, penicillin was first used to fight an infection and the electroencephalo-
gram (EEG) for recording brain waves was introduced. Down in Texas, administrators at Baylor Hospital in Dallas were responsible for setting up the first U.S. group hospital insurance plan. The Baylor Plan would later evolve into Blue Cross and Blue Shield of Texas.

Here in Arkansas, a small group of hospital leaders got together in 1929 and formed the Arkansas Hospital Association (AHA). It was the first time Arkansas hospitals would work together, trying to improve the state’s healthcare quality and health status.

**Fast Forward to the 1950s**

As I said before, the earliest comprehensive AHA records date back to the 1950s. In 1955, the AHA was a very informal organization with minimal dues, a part-time, unpaid executive secretary (who was actually a Blue Cross employee), and few resources. The prime source of funds was the sale of advertising for its magazine, *Hospitality*. In a typical month, the association’s receipts and expenses totaled around $2,000, give or take a few nickels and dimes.

Still, the AHA board met practically every month at one of several downtown Little Rock hotels, such as the Albert Pike, the Marion and the Sam Peck. Their discussions covered issues ranging from hospitals’ relationship with the Health Department and Blue Cross Blue Shield to nursing issues (a shortage of practical nurses had everyone’s attention), minimum wage laws and – what’s this? – *hospital liability costs*!

By 1956, the AHA was strongly considering affiliating with the American Hospital Association out of Chicago (if it could only get past the need to pay those pesky dues), had begun to formalize a relationship with the Joint Commission on Improvement of Patient Care and was getting involved with sticky political matters, including one to set up an independent commission to oversee the Arkansas State Hospital for Nervous Diseases. There was also considerable unrest about a federal bill called the “Military Dependents Medi-Care Program.”

The growing influence of politics amounted to about $17 per day.

As early as 1956, the AHA board saw something else that would be necessary, if the AHA was to be a viable player in the state’s political arena. For almost two years the board’s primary order of business was to find a way to hire and support a full-time executive secretary to lead the association.

It wasn’t an easy sell. To do so meant that the AHA’s 120 members (including the Alamo Hospital, Des Arc General Hospital, Kirksy Maternity Hospital, Wallis Hospital, Elizabeth Hospital and other long-forgotten names) would have to agree to a 450% dues increase.

Fortunately, the board and its subcommittee charged with coming up with a plan were visionaries, and very persistent. Those men, including Richard Scruggs, John Gilbreath, Bob Berryman, Bill Hedden, Andrew Talley, Noble Smith, Nelson Evans, Rev. J.W. Kordsmeier, Tom Graham, Fax Robertson, Marvin Altman, Carlos Smith and A. Allen Weintraub, realized what was at stake for the future. They convinced the membership and on December 1, 1958, Graham Nixon, a former state senator, became the AHA’s first full-time executive secretary.

This step would lead the association to a more noticeable, conspicuous and relevant level at a time when healthcare issues were ramping up to take center stage on national and state policy agendas. Within a year, on November 24, 1959, the AHA was formally incorporated and recognized among state leaders as the official representative for Arkansas’ hospitals.

Long before that milestone, the still-unofficial AHA began immediately weighing-in on bills affecting hospitals that were introduced during the 1959 legislative session. Working out of a small office provided by Arkansas Blue Cross Blue Shield, the AHA became the eyes, ears and voice of hospitals across Arkansas, serving as both advocate and watchdog, and speaking out on proposals for minimum wage increases, amending the Nurse Practice Act, expanding the authority of the state Welfare Department, charitable immunity and tax exemptions for non-profit hospitals.
Of course, there were the inevitable payment issues, too. Some things have changed incredibly little over the past 40 years. By the end of 1959, the AHA had endorsed a new hospital contract from Arkansas Medical and Hospital Service, Inc. (aka Blue Cross and Blue Shield). The contracts were a bit different back in that day. Blue Cross balked at paying hospitals 100% of their charges. Instead, the contracts specified that hospitals would receive a minimum of 97% of those billed amounts.

**On to the ‘60s**

Another payment disagreement proved more difficult to resolve. The Arkansas Welfare Department already reimbursed hospitals on a cost basis for poor patients under the state’s old age assistance (OAA) program, a 1950s version of Medicaid. In 1959, the state was offering 90% of a hospital’s costs, up to $20 per day. The AHA and its hospitals insisted that the rates be upped to full charges before compromising with a proposal for actual costs with no limits.

The state wouldn’t budge and, in 1961, dug their heels in deeper when guidelines for paying hospitals via a new federal healthcare program, medical assistance to the aged, mirrored the 90% cost limit.

In May 1961, the AHA drew a line in the sand with a resolution stating its members would no longer accept patients covered under either the federal or the state programs without an agreement for reimbursing hospitals their actual costs. They set a July 1, 1961 deadline. Only an 11th-hour request from Gov. Orval Faubus prevented the action. Negotiations eventually led to an agreement for paying hospitals their costs up to $25.50 per day for patients under the federal program. OAA payments remained unchanged.

A year later, continued complaints about the Welfare Department’s reimbursements, along with a new set of concerns about its denial of hospital admissions, eventually led to an agreement that the state pay the actual costs of care. It was a hard fought victory for the AHA. Still, some who were around then say that the state’s refusal to pay billed charges set the stage for hospital’s massive government program write-offs and the resulting high prices of today.

As 1962 rolled on, Arkansas hospitals found themselves thinking more about other matters. The AHA and the state Medical Society were both worried about a bill before Congress to provide “certain medical benefits through the Social Security System for elderly patients.” There was also a growing interest in a new-fangled notion about community health planning, including an assessment of the need for more hospitals.

And, a new concern moved to the top of hospital priority lists throughout the country. The ongoing Cold War led to rumors of a new “hot” war. The AHA and its hospitals, and those in every other state, began preparing themselves to respond to possible mass casualty disasters. It was a reasonable precautionary step. The threat to end America’s nine-year outbreak of peace lay just 90 miles from the southern tip of Florida — in Cuba.

In the autumn of 1962, Arkansas hospitals were thus preparing themselves to care for the mass casualties our state would see from the literal fallout of a global nuclear war. Every other hospital and healthcare issue had taken a back seat.

America held its collective breath for 13 days in October while President John F. Kennedy decided how the U.S. would respond to intelligence photos showing Soviet nuclear missile installations under construction on the island of Cuba, 90 miles off the Florida coast. The relatively short strike distance, Air Force bases in Jacksonville and Blytheville, and missile silos scattered across the hills of central Arkansas, north of Little Rock, made the state a potential target if the unthinkable happened.

Kennedy chose to face-off with the Soviets by way of a naval blockade against ships carrying the missile equipment to Cuba. The other side blinked, the world didn’t end and life resumed a normal pace for another year, when an unthinkable event did...
up more issues affecting healthcare and hospitals. One of those was the Fair Labor Standards Act of 1965. The law increased the federal minimum wage to $1.25/hour, made non-government hospitals subject to the law and added more than 15% to the state average cost per patient day.

A more far-reaching federal bill carried the name of Arkansas Congressman Wilbur Mills, who chaired the House Ways and Means Committee. The Mills Bill eventually would become law despite efforts by the American Medical Society against “the most deadly challenge ever faced by the medical profession.” The powerful Arkansan proved to be the key to the bill’s success. We’d know its result forevermore as Medicare.

The AHA realized that the devil would lie hidden deep in the details, and history told them that those details could translate to problems down the line. The board worked with the American Hospital Association to fight for Medicare reimbursements that would cover hospitals’ full costs. But, the die was cast. In May 1967, the AHA wrote Mills complaining that Medicare had already underpaid the state’s hospitals by at least $874,000 in its first six months. Things would never change.

Meanwhile, the AHA remained active in state legislative and regulatory arenas on matters ranging from routine to cutting edge. The on-again/off-again battle of wills with the state Department of Welfare over inadequate payments was on again. A 1966 AHA study confirmed that hospitals had lost $1.7 million caring for welfare patients the previous year.

Politics, policies and payment issues aside, the AHA never serves its members as well as when doing good for patients and families. There is no better example than a 1967 law involving a new concept for treating tuberculosis patients in Arkansas. For too many years, TB patients had been isolated for treatment at the state’s sanatorium in Booneville. The AHA was largely responsible for changing that practice by backing a bill allowing the patients to be treated in regional general hospitals much closer to their homes.

I suspect that if you knew a family who was reunited or brought closer together as a result, you understand why passing that law ought to be recognized as one of the AHA’s greatest achievements.

1968 – A Standout Year

For my money, no other year has been quite as interesting, eventful and maybe even significant as 1968. There were wars and rumors of wars. The morning papers and the evening news served as primers for the Tet offensive in Vietnam, the USS Pueblo’s capture in North Korean waters and the Soviet-led invasion of Czechoslovakia.

It was a year filled with political unrest, marked by assassinations (Robert F. Kennedy and Martin Luther King), demonstrations (Columbia University), revolts (students in Paris) and riots (the Democratic National Convention in Chicago).

Yet, 1968 ended on an upbeat note. In space, Apollo 8, the first manned mission to the moon, slipped into lunar orbit on December 24. That evening, astronauts Frank Borman, Jim Lovell and William Anders did a live Christmas Eve TV broadcast showing pictures of the earth and moon as seen from the spacecraft, and took turns reading from the Book of Genesis recounting the story of Creation.

Back on Planet Earth, hidden beneath the canopy of world events, 1968 was also an interesting time for healthcare. In Arkansas, hospitals were beginning to feel the effects of “government creep” on their operations. The flimsy foothold that Congress had gained in 1965 with the Medicare program had become first a narrow ledge, then a pathway leading the federal government toward its role as a dominant third party payer of healthcare services, and particularly of hospital services.

In December 1967, Arkansas Hospital Association (AHA) president Graham Nixon had appeared before the state Legislative Council, explaining how communities would eventually be forced to absorb the heavy financial burden Medicare was placing on their hospitals. Three months later, state legislators would flirt with the idea of a hospital rate setting commission to keep the “tremendous rise in hospital costs” in line with “the earning capacity of our citizens.”

As if Medicare wasn’t creating enough problems, the state of Arkansas would, in 1968, begin setting up its own policies for running a Medicaid program. Hospitals figured the chances of that being a good thing for them couldn’t be too high. They were right.

At the same time, the state was establishing its first comprehensive health-planning agency to develop a blueprint for hospital capital expansion projects. It was part of Congress’
initial attempt to control federal hospital payments. That agenda later led to state certificate-of-need laws (Arkansas’ law was passed in 1975) that would further affect Medicare and Medicaid reimbursements.

The AHA was directly connected with each of those interesting battles during the year, and more. The association successfully negotiated an agreement regarding state reimbursements for rehabilitation services and worked with the Arkansas Department of Health to completely revise the state’s rules governing hospitals. In response to a series of tornadoes in the state, the AHA helped to establish the first statewide emergency radio network to help reduce confusion among hospitals and other providers following such disasters.

One of the better decisions of the year involved the AHA’s new Careers Program. Armed with special funding that indicated the importance of the matter, the AHA embarked on an effort to ease the manpower woes of the state’s hospitals. To lead this endeavor, Nixon chose a 28-year-old former schoolteacher and book salesman as the AHA’s first education director. It was a good fit. Over the next 37 years, Jim Teeter and the rest of the AHA would experience many more interesting times together.

Dig Those ‘70s

Charles Dickens might have called it the best of times and the worst of times. Okay, so it wasn’t necessarily the best of times. “It” was the 1970s, for cryin’ out loud. Remember? Disco, mood rings, lava lamps and fashion faux pas. Kent State, Monday Night Football, the Pentagon Papers, Pong, Roe v. Wade, Watergate, Patty Hearst, Jimmy Hoffa, Attica, 8-track tapes and Nike running shoes. Those are just a few of the images on our mental ‘70s flashcards.

During the first half of the decade alone, George Wallace was shot and paralyzed, both President Richard Nixon and his veep, Spiro Agnew, resigned; U.S. helicopters flew off the roof of the American Embassy in Saigon, evacuating the last Americans there; oil prices soared to $11.56 per barrel; the Beatles broke up; and we learned a new, universally-recognized distress call, “Houston, we have a problem.”

In the narrow world of hospitals and healthcare, the stage was set for a new environmental jargon laced with three- and four-letter acronyms. There was the Department of Health, Education and Welfare (HEW), the Department of Social and Rehabilitative Services (SRS), and the state’s comprehensive health planning (CHP) office, whichfeds also called their designated planning agency (DPA).

In Arkansas, hospitals dealt with the Regional Medical Program (RMP), the Arkansas Health Systems Foundation (AHSF) and local Health Systems Agencies (HSAs). Medicare gave us the Professional Standards Review Organization (PSRO), Blue Cross introduced its Hospital Utilization Program (HUP) and we began to hear about a newfangled healthcare notion called the health maintenance organization (HMO).

Arkansas hospitals were very concerned about forced spending limits under capital expenditure review (CER), a program set up under Public Law 92-603, which was actually Section 1122 of the Social Security Act. The folks who were responsible for administering programs under the law could be found in 314(A) and 314(B) agencies. Code-breakers have been stumped by less confusing alpha-numeric shorthand.

By January 1970, the Arkansas Hospital Association (AHA) was increasing programs to meet member needs. The association’s staff had grown to four professionals, after luring current AHA president Phil Matthews out of banking and finance a few months earlier, and its cup of challenges continued to fill and run over.

The AHA cleared one of its first hurdles of the 1970s with a successful campaign to get individual hospital support to establish and help fund a Masters level nursing degree at the State College of Arkansas in Conway (that’s today’s University of Central Arkansas). It helped provide instructors for other Associate Degree nursing programs across Arkansas and waylaid an impending nurse shortage.

Between January 1, 1970 and June 30, 1975, the AHA tackled issues such as compliance with Hill-Burton free care policies, price controls during the short-lived Economic Stabilization Program, changes posed by the National Labor Relations Board, the energy crisis, establishing a statewide emergency medical program, implementing Blue Cross’ new health data network, improving hospital quality and, of course, adequate reimbursements.

Yet, the two most prominent items during the period were internal matters. In April 1973, at a special membership meeting, the AHA House of Delegates approved a major change in the association’s dues structure. It would cement the association’s long-term viability as a leader and advocate for all the state’s hospitals.

Then, on July 1, 1973, Graham T. Nixon, the AHA’s first and only executive director for almost 15 years, resigned due to health reasons. Three months later, the AHA board reached into the Michigan Hospital Association for its next leader. Roger Busfield, a native Texan with a desire to come back to the South, saddled up and took the reins of the AHA December 1, 1973.

This completes part one of a two-part series. We will finish our look at the AHA’s first 75 years in the Winter edition of Arkansas Hospitals.
The University of Arkansas for Medical Sciences’ College of Public Health was renamed August 10 in honor of the late Dr. Fay Boozman, who was director of the Arkansas Department of Health from 1998 until his death in a farming accident March 19 of this year.

Under Boozman’s leadership, the Arkansas Center for Health Improvement – a partnership between UAMS, the Health Department and Arkansas Blue Cross & Blue Shield – was initiated. He is also remembered for helping Arkansas’ share of monies from the 1998 tobacco industry settlement go directly to health-related causes.

In addition to this honor, Boozman will further be remembered by the Arkansas Hospital Association with presentation of a special Chairman’s Award at its annual Awards Dinner October 20. Dr. Boozman’s family is expected to accept the award in his memory.
You wouldn’t trust just anyone with these little details.

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