Arkansas 3rd District Congressman John Boozman, the lone Republican in Arkansas’ Washington delegation, is one of 75 GOP House members who signed a letter circulated by Rep. Peter King (R-NY), Cliff Stearns (R-FL), Dave Reichert (R-WA) and Rob Simmons (R-CT) to Health and Human Services Secretary Michael Leavitt opposing the Bush Administration’s proposals to cut Medicaid through the regulatory process.

The White House budget plan for fiscal year 2007 reduces Medicaid expenditures by $13.6 billion over five years. Of that total, $12.2 billion could be implemented without input from Congress, regardless of whether Congress passes a budget resolution with no Medicaid cuts. The administration could take action to impose the cuts by implementing major policy changes through rules and regulations. Those who signed the letter expressed their belief that such changes require input from Congress, as well as states, healthcare providers and patient groups, in order to avoid serious, unintended consequences.

Reductions contained in the president’s 2007 budget include limiting payments to public providers to cost, reducing the allowable provider tax rate for generating Medicaid matching dollars from 6% to 3% and further curbing other Medicaid financing mechanisms. The letter said, “While we agree that we must work to control entitlement spending, these proposals do not get at the root causes of entitlement growth and would seriously disrupt financing of Medicaid programs around the country.” It goes on to voice concern that such dramatic policy initiatives would jeopardize hospitals’ abilities to serve “Medicaid and uninsured populations and perform other critical services in their communities.”

The American Hospital Association (AHA) is working in partnership with the Federation of American Hospitals and the Association of American Medical Colleges to provide each U.S. hospital with a comprehensive impact analysis of the FY 2007 hospital inpatient prospective payment system proposed rule. The analysis will give each individual hospital specific results of how the proposed changes will affect their facilities.

In comparison, other groups and companies are conducting much narrower analyses for certain departments of the hospital, such as cath labs, that will focus on how limited Diagnosis-Related Groups (DRGs) are affected. The proposed rule, released in April, is extremely complex, with the Centers for Medicare & Medicaid Services (CMS) proposing the most significant changes to the DRGs since the inpatient system’s inception in 1983. The rule substantially changes payment for certain services and potentially redistributes billions of dollars among hospitals.

AHA’s analysis will detail the impact of both CMS’ proposed changes to the calculations of DRG relative weights and the creation of a new set of severity-adjusted DRGs. Once finalized, the AHA will distribute the analysis to each state hospital association, which will in turn distribute it to individual hospitals.
Section 1011 Funds Going Unclaimed

Section 1011 of the Medicare Modernization Act of 2003 established a program for federal reimbursement of emergency health services furnished to undocumented aliens. The provision set aside $250 million each year for Fiscal Years (FY) 2005-2008 for those purposes. Each state receives a specific allotment of funds under the program. Arkansas’ allotment has been about $645,000 per year for fiscal years 2005 and 2006.

Payments are made from the state allotments directly to enrolled hospitals, physicians, and ambulance providers for some or all of the costs of providing emergency healthcare and related hospital inpatient services, outpatient services, and ambulance services provided to eligible individuals. The first quarterly payment to providers under the Section 1011 program was issued February 27. Of the $122.5 million available, the more than 9,000 healthcare providers enrolled in the program claimed and received only $25.5 million.

TrailBlazer Health Enterprises, LLC, is the national contractor for the Section 1011 program and is the only contractor for processing all requests for Section 1011 provider payments. Hospitals wanting to request 1011 payments must do so by enrolling with TrailBlazer and then submitting payment requests to TrailBlazer. All Section 1011 payment requests must be submitted electronically. The next quarterly payment will be made on May 29.

For more information, see [https://www.trailblazerhealth.com/section1011/](https://www.trailblazerhealth.com/section1011/).

IRF PPS Rule Proposed

The Centers for Medicare & Medicaid Services (CMS) on May 8 issued the proposed fiscal year 2007 rule for the Inpatient Rehabilitation Facility (IRF) Prospective Payment System. The rule can be found on the CMS Web site, and will be published May 15 in the Federal Register. Comments on the proposed rule are due July 7.

A preliminary review of the proposed rule includes a mandatory 3.4% market basket update, as required by law; a payment cut of 2.9% to adjust for coding; and a slight increase in the outlier threshold to $5,609. The -2.9% coding adjustment, in addition to pressures such as the 75% Rule and CMS’ local coverage determinations, would further worsen patients’ access to rehabilitation care and increase volatility for providers. CMS estimates the rule would increase Medicare payments to IRFs by $40 million over 2006 levels.

The American Hospital Association is reviewing the rule, will provide a detailed analysis for members soon and will submit comments to CMS. Comments are due to CMS by July 7.


AWI Public Use File

The Centers for Medicare & Medicaid Services (CMS) has posted on its Web site, [http://www.cms.gov](http://www.cms.gov), the May 2006 Wage Data Public Use File (PUF) for the FY 2007 wage index. Hospitals have until June 12 to submit correction requests to CMS and their fiscal intermediaries (FIs) to correct errors due to CMS or FI mishandling of the final wage index data. There is no accompanying occupational mix PUF, because hospitals are working to submit new occupational mix data for FY 2007 that is due June 1. For more on the occupational mix survey, see the agency’s April 21 memorandum which will be posted shortly at [http://www.aha.org/aha/key_issues/medicare/content/42106_occmix.doc](http://www.aha.org/aha/key_issues/medicare/content/42106_occmix.doc).
Occupational Mix Adjustment Details

Based on a recent ruling by the U.S. Court of Appeals for the Second Circuit, the Centers for Medicare & Medicaid Services (CMS) was required to change the descriptions of the data and methodology that will be used to calculate the occupational mix adjustment for use in calculating the fiscal year 2007 Medicare hospital rates. According to the proposed rule, hospitals will not have to meet the requirement that they accept or deny their geographic reclassification for FY 2007 reclassifications within 45 days of the publication of the final inpatient rule, as they will not have the information on which to base that decision. Instead, CMS will choose what they think is the hospital’s best option for the final rule.

When the occupational mix public use file comes out after the final rule, hospitals would have 30 days to notify CMS if they wanted to rescind what was in the final rule. For FY 2008, hospitals will still need to meet the September 1 deadline for filing a geographic reclassification application, but will be able to subsequently submit supplemental data based on the final wage data for FY 2007. CMS also is seeking comments on how to handle hospitals with missing data. Comments on the proposed rule are due June 12. The agency plans to post an occupational mix calculator to its Web site soon. For more information, see http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/cms1488p2.pdf.

Hospitals, Businesses Share Healthcare Interests

American businesses and hospitals share common interests in shaping the nation’s healthcare system for the future. That was the message U.S. Chamber of Commerce president and CEO Tom Donohue sent to attendees at the American Hospital Association’s Annual Membership Meeting during his comments May 2. Donohue urged hospital and business leaders to work together to expand coverage to the uninsured and reduce the cost of healthcare. Donohue said that the steady decrease in Medicare and Medicaid reimbursement and the increase in demand for healthcare services is hurtling the American healthcare system toward “the tipping point.”

Donohue also urged hospital and business leaders to introduce wellness programs to prevent employee illness, saying the Chamber has experienced a 12% reduction in worker utilization of healthcare services since it provided wellness counseling. He also stressed the importance of allowing small businesses to collectively purchase health insurance at competitive rates, and said immediate medical liability reform is needed because the current liability environment, “sucks the vitality out of the healthcare system.” To view a Webcast of Donohue’s talk, go to http://www.aha.org/aha/advocacy-grassroots/advocacy/advocacy/2006/06webcasts.html.

HCAHPS Survey Drawing Near

After an extensive and inclusive process of development, testing and public review, the HCAHPS Hospital Survey is now on its way to national implementation. The U.S. Office of Management and Budget officially approved the use of the Hospital Survey in January 2006, allowing the Centers for Medicare & Medicaid Services (CMS) to proceed with the next steps. In March, CMS sponsored mandatory training sessions (both in person and via the Web) for survey vendors and hospitals planning to self-administer the Hospital Survey. Hospitals using vendors were not required to attend training. Additional Web-based training sessions were held last month for hospitals and vendors that were unable to participate in the initial session.

In addition to the training sessions, vendors as well as any hospitals that plan to self-administer the Hospital Survey will be required to participate in a “dry run” of the survey later this spring. Survey respondents for this dry run will include patients discharged in April, May and June; hospitals and vendors must participate in at least one of those three
months. Because the dry run is intended to give hospitals and vendors practice in administering the survey and collecting data, results will not be made public. Full implementation with public reporting will begin in October 2006 and last through June 2007. All subsequent periods of survey administration will cover 12-month blocks, with hospitals updating their data reports on a quarterly basis. For more information about national implementation of the HCAHPS Hospital Survey, please visit http://www.hcahpsonline.org or contact CMS at Hospitalcahps@cms.hhs.gov.

Study: Health Improvements Outweigh Costs

The value of improvements in the health of Americans from 1980 to 2000 significantly outweighed the additional healthcare expenditures, according to a new study by researchers at United BioSource Corp., RTI International and Duke University. “We calculate that over the last 20 years, the return on investment is positive for overall national healthcare spending, Medicare spending on heart attack, stroke, breast cancer and diabetes and all major healthcare innovations which we could both identify and which were associated with these four diseases,” said lead researcher Bryan Luce. Each additional dollar spent on overall healthcare services was calculated to produce health gains valued from $1.55-$1.94.

The authors conclude that cost should not be considered in isolation without estimating the value of the investment in healthcare. The study appears in the March issue of the journal *Value in Health*.

AHA Board Highlights

During its regular monthly meeting on May 12, the Arkansas Hospital Association board of directors:

- Heard a presentation by Mike Brown, executive vice president/External Operations, and Steve Abell, vice president/Enterprise Networks for Arkansas Blue Cross and Blue Shield regarding the current status of and future plans for Blue Cross’ quality and cost public reporting initiatives;

- Discussed those Blue Cross initiatives and passed a motion that the AHA should form a quality and transparency committee to advise Blue Cross and any other payer organization seeking AHA input on the development and display of publicly available cost and quality reports;

- Learned that Arkansas 3rd District Congressman John Boozman is among 75 Republican House members to sign a “Dear Colleague” letter to HHS Secretary Michael Leavitt opposing White House efforts to cut Medicaid funding through the regulatory process;

- Learned about the American Hospital Association’s newly adopted policy on hospital pricing transparency and agreed that the new Arkansas Hospital Association’s committee on pricing and quality transparency should report to the board in August with recommendations regarding steps that the state association ought to pursue in addressing the issue of price transparency;

- Discovered that the Arkansas Disability Rights Center is the state’s designated agency to serve as the Protection and Advocacy (P&A) System for approximately 500,000 individuals with disabilities in Arkansas. The agency is vested with authority to protect human, civil and legal rights of all Arkansans with disabilities consistent with federal law, including authority to investigate healthcare facilities and other organizations for the suspicion of neglect and abuse of disabled persons;
• Learned that members of the AHA executive team met May 8 with Medicaid officials to develop additional information which CMS has requested to further support the proposed state Medicaid plan amendment which would provide for an increase in the per diem cap on inpatient hospital rates. CMS’ request for more information was informal, so the 90-day clock on its timetable for action did not stop;

• Heard that officials with the Arkansas Medicaid program have reaffirmed their intent to submit a plan amendment to allow an increase in hospital outpatient rates. However, new outpatient rates won’t take effect at the same time as the new cap on inpatient rates. Medicaid has not yet begun the plan amendment process for the outpatient increase and won’t do so until the program has a new finance director in place;

• Learned that the state Board of Health has adopted a resolution for the director and the staff to develop proposed legislation for the 2007 legislative session to establish a trauma system for the state;

• Heard that the state Board of Health has developed a proposed set of rules and regulations to implement the recently enacted Clean Indoor Air Act of 2005;

• Reviewed a rule proposed by the Arkansas Insurance Commissioner, which expands the list of healthcare practitioners covered by the state’s Any Willing Provider law;

• Learned that two state committees that include hospital representatives recently met to discuss issues related to the formation of a state trauma care network; and

• Heard that the Arkansas Department of Health and Human Services has submitted a “Request for Information” to health insurance carriers to obtain input on design, implementation and operation of the new Arkansas Safety Net Benefit Program.

The AHA Calendar

May 2006
16 Hospital Margin Improvement: Process to Improve Bottom Line Performance – Revenue Improvement – Part III (A Four-Part Audio Conference)
17 Immigration and Foreign Healthcare Professionals – Hiring Health Care Employees Residing in the United States – Part II (A Two-Part Audio Conference)
22 ASWHC (Social Workers) Spring Conference, Arkansas Heart Hospital Annex, Little Rock
22 Hospital Margin Improvement: Process to Improve Bottom Line Performance – Supply and Service Cost Management – Part IV (A Four-Part Audio Conference)
24 Building a Culture of Commitment (Mid-Management Certificate Series) Holiday Inn Select, Little Rock
25 Health Care Quality: How to Use ORYX Data to Make Meaningful Changes – Session II (A Two-Part Audio Conference)

Newsnotes About Arkansas Folks

Vista Health Fayetteville and Vista Health Fort Smith, both psychiatric institutions, were approved for membership by the AHA Board of Directors at the May 12 meeting. Kyle Naples is chief executive officer of both facilities.
One of the earliest movies I remember seeing was back in 1958 or ‘59 at the old Heights Theater in Little Rock. *The Mouse That Roared* was a campy farce about the tiny island-nation of Grand Fenwick that comes out of nowhere and, with the best of intents, stuns the world by invading the U.S with a 20-man army. I couldn’t help but think about that movie last week when learning more about a small group, which, as part of its worthy cause, has some unusually wide-ranging regulatory authority over healthcare organizations.

This newly noticed regulator has actually been around for a while, but has somehow managed to escape detection. That’s not so hard to believe, when you consider that healthcare is subject to more rules than practically any other field. More than 30 agencies oversee some aspect of the healthcare delivery process — and that’s just at the federal level. It takes a sheaf of paper three times larger than IRS code and its related tax policies — more than 130,000 pages — to adequately spell out Medicare rules alone. Various state agencies add more pages and compliance expectations.

With all that second-guessing already going on, the discovery of a new set of watchful eyes is always frustrating, especially when it comes out of the blue. Just ask members of the AHA board who were practically stunned last Friday after hearing about a “new” watchdog on the block; one that has actually been flying around under the radar for about 30 years.

The Disability Rights Center, Inc. (DRC) has been in operation since the late 1970s. It is a federally authorized and funded nonprofit organization that is also designated by the Governor to serve as the state’s Protection and Advocacy (P&A) System charged with protecting the rights of all Arkansans with disabilities consistent with federal law. The DRC deals with nursing homes much more than hospitals, but over the years has popped in for the occasional hospital visit, too. Most recently, DRC reps arrived unannounced at a Little Rock hospital back in March to investigate a complaint registered by a disabled patient. Since then, the AHA has learned considerably more about the DRC, such as its legal authority not only to investigate complaints related to suspicions of patient abuse and neglect, but also to randomly come into organizations for monitoring purposes. The shocking part is that when they arrive, the DRC investigators/monitors are allowed unfettered access to an organization’s facilities, records and patients. Fortunately, there’s not much preparatory work, since the visits are generally unannounced. Although it is not required, DRC reps ought to give a courtesy check-in with the hospital executive staff.

According to director Nan Ellen East and senior staff attorney Jan Baker, the DRC may use “any appropriate technique and pursue administrative, legal or other appropriate remedies to protect and advocate on behalf of individuals with disabilities to address abuse, neglect or other violations of law.” While it does not provide written reports about the reviews and doesn’t assess penalties, the DRC can notify agencies such as CMS or OIG if violations are discovered. It also may sue on behalf of an individual or on its own behalf, although the Arkansas DRC has never filed a suit against a hospital.

Hospital execs who don’t know about the DRC (that could be a sizable group) might tend to balk at giving the DRC all it seeks, particularly when it comes to unlimited access to the hospital and its records. There are, after all, HIPAA concerns, right? Apparently not. There’s a bypass that keeps HIPAA from impeding the function of the DRC, since disclosure of the information is required by law.

In brief, if folks from this small disability rights group come knocking on the door looking for broader access than practically any other oversight agency to investigate complaints or to monitor compliance, don’t be too quick to dismiss their claims of legitimacy and authority, and don’t ignore the ferocious roar. It is for real.

Later this week, the Arkansas Hospital Association will distribute additional information on the DRC to member hospitals. In the meantime, check out [http://www.arkdisabilityrights.org](http://www.arkdisabilityrights.org). That way, you may not feel like complete strangers if the DRC decides to come a’callin'.

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**Final Thoughts**

By Paul Cunningham