Arkansas hospitals received an August 4 Quality Advisory from the American Hospital Association (AHA) concerning the Joint Commission on Accreditation of Healthcare Organization’s (JCAHO) 2006 Accreditation Survey Contract and Business Associate Agreement Addendum. The advisory provided the latest information about negotiations between the AHA and the JCAHO regarding modifications to the original contracts that the JCAHO first distributed last May. It also gave instructions on how hospitals, including those that already have signed and returned their 2006 Accreditation Contract, can amend the JCAHO agreements. The deadline for executing and signing an amended agreement with the JCAHO is October 1, 2005.

There continues to be a general concern about complying with JCAHO standards that conflict with existing federal and state laws. The JCAHO has incorporated language as part of its modifications that will adequately address the matter for hospitals in some states. However, allied association legal counsel in other states, including Arkansas, are concerned about preserving individual state privileges and protections afforded to information and materials that are part of a hospital’s peer review process, if and when the information and materials are shared with JCAHO for accreditation purposes.

The AHA continues to assist these state hospital associations in working with JCAHO to create an effective and acceptable solution to address the unique needs of their hospitals related to protection of the peer review privilege. Arkansas Hospital Association legal counsel, Elisa White, who is involved in the negotiations, recommends that Arkansas hospitals wait for further information about resolution of the peer review issue before signing and returning their revised contract.

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, to be published August 12, 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 (DRG) 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.

Other key provisions of the final rule include:

- A full market basket update of 3.7% (3.3% for hospitals that do not report their data on 10 quality measures). To determine if a hospital qualifies for the full update in FY 2006, CMS will require hospitals’ continuous submission of quarterly data on its 10 quality measures; submission of data for patients discharged through fourth quarter of 2004 by no later than May 15, 2005; and validation of hospitals’ third quarter 2004 data submission. If a hospital’s third quarter data are not validated, then CMS will review third and fourth quarter data for validation.

- A reduction in the outlier loss threshold from $11,211 to $5,132.

- An increase in the rural adjustment from 19.14% to 21.3%.

- A plan for CMS to review by December 2005 its standards and process for determining whether limited-service applicants for a hospital provider number meet the Medicare definition of a hospital.

- A reduction of the labor share of the standardized amount from 71.1% to 69.7%.

CMS estimates that the aggregate impact of this proposed rule is a 3.4% increase in total Medicare payments, larger than projected by the proposed rule. However, some inpatient rehabilitation facilities (IRFs) would receive higher payments and others would receive lower payments than they did in FY 2005. The rule is expected to be published in the August 12, 2005 Federal Register. The policies and payment rates become effective October 1, 2005. The rule is available at [http://www.cms.hhs.gov/providers/hipps/cms-1500f.pdf](http://www.cms.hhs.gov/providers/hipps/cms-1500f.pdf).

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**Bill WouldResolve EMTALA/IMD Conflict**

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.
Inpatient Rehab Facility Final Rule

The Centers for Medicare & Medicaid Services (CMS) issued an August 1 final rule for the inpatient rehabilitation facility (IRF) prospective payment system in fiscal year 2006. The rule, which will appear in the August 15 Federal Register, is very similar to the proposed rule issued in May. It provides a full market basket update of 3.6%, reduces the outlier threshold to $5,132 from $11,211 and increases the adjustment for rural providers to 21.3% from 19.14%.

The rule also includes a new adjustment for IRFs designated as teaching facilities, a one-year phase-in of new labor market definitions used to adjust for geographic wage differences and a 1.9% across-the-board reduction to all IRF payment categories, known as case mix groups. CMS estimates the rule will result in a 3.4% increase in Medicare payments for IRFs. See the rule at http://www.cms.hhs.gov/providers/irfpps/.

NHIN Cost Estimates Top $200 Billion

Six months ago, Dr. David Brailer, who had just been named as the Bush Administration’s National Coordinator for Health Information Technology, outlined his agenda which included a goal of President Bush’s vision of having interoperable electronic health records for most Americans by 2015. At the time, Brailer did not mention how much the envisioned system might cost or who would pay for it.

Last week, an expert panel which includes Brailer, said that achieving a workable National Health Information Network (NHIN) in five years would require an estimated $156 billion in capital investment and $48 billion in annual operating costs. The report was published in the August 2 issue of the Annals of Internal Medicine. The estimate includes an estimated $50.7 billion in capital and $12.8 billion in operating costs for hospitals.

The NHIN would allow electronic viewing of inpatient and outpatient test results, inpatient and outpatient electronic health records and computerized physician order entry, electronic claims submission and eligibility verification, secure electronic patient communication and pharmacy electronic prescribing. The report concluded that achieving such a network in “a reasonable time frame” will require federal investment to facilitate standards and access to capital and to align financial incentives through changes in reimbursement policies.

HIPAA-Compliant Claims Required October 1

Beginning October 1, the Centers for Medicare & Medicaid Services (CMS) will no longer process electronic Medicare claims for payment unless they comply with the Health Insurance Portability and Accountability Act (HIPAA). Non-compliant claims will be returned to the filer for re-submission as compliant claims. The action affects claims for services provided under fee-for-service Medicare, ending a portion of CMS’ contingency plan for HIPAA-compliant claims in effect since October 16, 2003. Under the plan, Medicare continued accepting non-compliant electronic claims after the deadline. The contingency continues temporarily for other electronic healthcare transactions.

Solucient Recognizes Arkansas Hospitals

Two Arkansas hospitals received recognition in the July 25 issue of Modern Healthcare related to Solucient’s annual roster of its 100 Top Hospitals for 2004. Chambers Memorial Hospital (Danville) was listed among Solucient’s 20 top performing hospitals in the 25-99 bed category. St. Vincent Infirmary Medical Center (Little Rock) was listed in the company’s 100 performance improvement leaders for large community hospitals having 250 beds or more. Solucient rates its top 100 hospitals based on how well they compare with other Solucient facilities on measures of clinical and financial performance. The program
was designed for use by hospital boards and executives, rather than consumers, to identify and compare hospital wide benchmark performance as a part of their improvement process.

Final FY 2006 SNF Rule

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 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/snfpps](http://www.cms.hhs.gov/providers/snfpps).

Hospital Drug Discounts Expanded

Rep. Jo Ann Emerson (R-MO) introduced legislation in July that would expand the 340B drug discount program for certain safety net hospitals to include inpatient drugs and critical access hospitals. Emerson’s Safety Net Inpatient Drug Affordability Act (H.R. 3547) is backed by the American Hospital Association. The 340B drug discount program allows eligible safety net providers to buy drugs for patient use at a significant discount, on average about 50% less than average wholesale prices. However, it’s currently limited to outpatient drugs and excludes critical access hospitals. Currently, 23 of Arkansas’ 84 acute care hospitals are Critical Access Hospitals.

CERT Bar Coded Cover Sheets

All medical record request letters from Medicare’s Comprehensive Error Rate Testing (CERT) Documentation Contractor to healthcare providers include a bar coded cover sheet. Arkansas hospitals receiving those requests from the CERT contractor should remember to use the bar coded cover sheet as the first page of the faxed records that they send to respond to the requests. Because the bar code on the sheet provides identifying information about the records to the CERT contractor, hospitals should also make sure the bar code cover sheet is
clean and distinct. The CERT contractor scanners cannot read cover sheets if their print quality, especially the print quality of the bar code, is poor.


Healthcare Trends, Trials and Tribulations

Noted healthcare consultant Jamie Orlikoff will keynote the Arkansas Hospital Association’s (AHA) October 19-21 75th Annual Meeting at The Peabody Little Rock. A popular speaker with Arkansas executives and trustees, Jamie will discuss the importance of healthcare leaders understanding the technological, clinical, regulatory and consumer-driven changes looming on the horizon. In his address, he will identify key emerging healthcare trends and analyze how they will affect hospitals and other healthcare organizations in the years to come.

Programming information is available by calling the AHA at (501) 224-7878 or by clicking on http://www.arkhospitals.org/register.htm after August 10.

All About Arkansas

(Benton) Saline Memorial Hospital (SMH) held a birthday party last month, celebrating its 50th anniversary of serving the people of Benton and the surrounding areas. The hospital was opened in 1955 as a 28-bed facility. It now boasts 167 beds and a campus that includes almost 241,000 square feet of inpatient and outpatient treatment areas, a separate home health/hospice unit, an ambulance service and two medical office buildings. In February, SMH opened the 35,000 square-foot Saline Surgery Center, and the hospital operates a satellite clinic in Bryant.

(Hot Springs) National Park Medical Center recently set up a new ClubMom program that is meant to provide monthly information and guidance for soon-to-be parents. ClubMom is a membership program that serves as a resource for the expectant parents by making available a monthly newsletter complete with helpful hints about many aspects of the pregnancy through the first few weeks of an infant’s life. In addition, the information gives extensive information about the hospital’s medical and nursing staffs and about facilities available at the Hot Springs hospital.

(Jonesboro) St. Bernards Medical Center is making the latest diagnostic technology available through its new St. Bernards Imaging Center. The new outpatient facility houses some of the most sophisticated diagnostic imaging equipment in use anywhere in the country, including a 64-slice computed tomography (CT) scanner which can scan the entire body in less than 10 seconds. The all-digital Imaging Center, located several blocks east of the main St. Bernards campus, is a single-level 29,000-square-foot structure which was designed to accommodate outpatient diagnostic procedures in a setting which is very customer friendly.

The AHA Calendar

August 2005
9 Internal Auditing Techniques to Secure APC Revenue Integrity for Chargemaster Workshop, Holiday Inn Presidential Conference Center, Little Rock
10 Arkansas Continuing Service Readiness (CSR) Workshop, Embassy Suites, Little Rock (CSR Hospitals Only)
12 AHA Board of Directors Meeting, AHA Headquarters, Little Rock
Final Thoughts

You’ve heard it before. There’s an ancient Chinese curse that goes, *May he live in interesting times.* It’s frequently referenced in presentations and usually draws a chuckle from audiences. Apparently, Robert F. Kennedy first used it at the end of a speech in 1966, concluding, “Like it or not, we live in interesting times.”

*We* certainly live in interesting times. However, for my money — and in my lifetime — no other year has been quite as interesting, eventful and maybe even significant as was 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 The 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 begin in 1968 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 school teacher 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.

(*This is the fifth in a series of articles leading up to the AHA’s Diamond Anniversary 75th Annual Meeting in October 2005.*)