Area wage index values for hospitals located in four of the eight Medicare geographic areas designated for Arkansas improved between publication of the Centers for Medicare & Medicaid Services’ Proposed Rule for Prospective Payment System (PPS) Inpatient Hospital Services in May and those found in the Final Rule, which was published in the August 1 Federal Register. Hospitals in the other four areas of the state lost ground. The table below shows the Arkansas AWI values for FY 2003 compared to values for 2004 as originally proposed and the final published values.

<table>
<thead>
<tr>
<th>Geographic Area</th>
<th>FY 2003 AWI Actual</th>
<th>FY 2004 AWI Proposed</th>
<th>FY 2004 AWI Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arkansas Rural</td>
<td>0.7666</td>
<td>0.7746</td>
<td>0.7703</td>
</tr>
<tr>
<td>Fayetteville-Springdale MSA</td>
<td>0.8100</td>
<td>0.8038</td>
<td>0.8362</td>
</tr>
<tr>
<td>Fort Smith MSA</td>
<td>0.7895</td>
<td>0.7740</td>
<td>0.8390</td>
</tr>
<tr>
<td>Jonesboro MSA</td>
<td>0.7843</td>
<td>0.7755</td>
<td>0.7777</td>
</tr>
<tr>
<td>Little Rock-NLR MSA</td>
<td>0.9097</td>
<td>0.8905</td>
<td>0.8887</td>
</tr>
<tr>
<td>Memphis MSA</td>
<td>0.8920</td>
<td>0.9325</td>
<td>0.8973</td>
</tr>
<tr>
<td>Pine Bluff MSA</td>
<td>0.7962</td>
<td>0.7753</td>
<td>0.7855</td>
</tr>
<tr>
<td>Texarkana MSA</td>
<td>0.8126</td>
<td>0.8198</td>
<td>0.8117</td>
</tr>
</tbody>
</table>

The FY 2004 wage index values are based on data collected from Medicare cost reports submitted by hospitals for cost-reporting periods beginning in FY 2000.

In June 2003, the Office of Management and Budget and the U.S. Census Bureau announced the creation of new Metropolitan Statistical Areas, including one for Hot Springs, Arkansas. However, the earliest any of those areas will be assigned an AWI value would be FY 2005. According to CMS, the new areas must be evaluated for possible effects on the overall hospital wage index.

The Final Rule also updates the Medicare PPS base rate amounts for FY 2004. Unless Congress acts to include provisions to equalize the base rate found in H.R. 1, the House version of the Medicare prescription drug bill, the amounts for hospitals across the country will differ, depending on where they are located (see table below).

Hospitals in large urban areas – MSAs having at least 1 million people – will have a $4,424.84 standardized rate, about 1.6% more than other hospitals, which get a base PPS payment of $4,354.79. Currently all hospitals are being paid the same base rate, $4,250.79, a result of the FY 2003 budget bill, which mandated that all hospitals receive the rate for large urban areas until October 1, 2003.

<table>
<thead>
<tr>
<th>Component</th>
<th>Large Urban Base Rate</th>
<th>Other Area Base Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labor-Related</td>
<td>$3,146.06</td>
<td>$3,096.25</td>
</tr>
<tr>
<td>Non-Labor Related</td>
<td>$1,278.78</td>
<td>$1,258.54</td>
</tr>
<tr>
<td>Total</td>
<td>$4,424.84</td>
<td>$4,354.79</td>
</tr>
</tbody>
</table>

The capital standard federal payment rate for FY 2004 is $415.47.
The August 1, 2003 Medicare Inpatient Prospective Payment System (PPS) Final Rule (see preceding article) contains an error in its calculation of the FY 2004 hospital wage index. When corrected, all U.S. hospitals should see marginally higher wage index values. The cause of the error is traced to three New York hospitals that reported salaries for a full year, but are shown in Medicare’s public use file as having fiscal year end dates of January 31, 2000 rather than the correct date of December 31, 2000.

The Centers for Medicare & Medicaid Services’ (CMS) information systems flagged the hospitals as having a 31-day reporting period. Under the process for establishing area wage index values, hospitals with a reporting period of less than 360 days have their data annualized. That resulted in salaries for the three NY hospitals, which were used in calculations of national total salaries, being approximately 12 times higher than they should have been.

Using the inflated salaries, CMS arrived at the national average hourly wage of $24.81 published in the August 1 Federal Register. Correcting the data for these hospitals drops the national average hourly wage to approximately $24.71. The lower national average hourly wage would result in wage index increases of approximately 0.4% for all urban and rural areas and slightly more in the MSAs containing the hospitals with erroneous data. The higher wage index is estimated to add between $230 million and $250 million to the FY 04 inpatient PPS hospital payments for the year.

CMS is aware of the error and plans to publish a technical correction notice in a future Federal Register. For now, it is unclear when this notice will become available, as additional issues continue to be brought to CMS’ attention. The American Hospital Association is working with CMS to make sure the issue gets resolved.

The Centers for Medicare & Medicaid Services (CMS) published in the August 12 Federal Register a proposed rule updating Medicare outpatient prospective payment system (OPPS) rates for calendar year 2004. The proposed rates are based on actual hospital costs derived from 2002 claims for outpatient services. The rule would allow a 3.8% increase for individual services provided to Medicare beneficiaries in hospital outpatient departments and aggregate payments to outpatient departments will rise 5.7%. Total payments to hospitals under OPPS are expected to be about $22.8 billion in 2004, up from an estimated $21.6 billion in 2003.

CMS doesn’t call for an across-the-board reduction in temporary additional payments (called pass-through payments) for new drugs and devices because it isn’t expected that the payments will exceed 2% of total OPPS payments. That’s the pass-through cap imposed by Medicare law for 2004.

In other provisions, the proposed rule would:

- Remove from the 2004 pass-through list eight drugs and biologicals and two device categories that met the criteria for transitional pass-through payments in 2002 and 2003.
- Package the costs of drugs and biologicals with median costs below $150, as well as the cost of implantable devices, into the payment rate for the primary procedure or treatment with which the products are usually furnished.
- Separate the ambulatory payment classifications (APCs) for drugs and biologicals with median costs at or above $150 and to set payment rates based on an analysis of
hospital cost data. That might result in a significant decrease in payment to the hospital, compared with 2003 levels.

- Continue to pay separately for blood, blood products, and hemophilia clotting factors and limit payment decreases for these items to approximately 10%.
- Restructure new technology APCs to enable Medicare to pay more accurately for services assigned to these APCs.
- Set the proposed threshold for outlier payments under the OPPS at 2.75 times the APC payment rate, but set a separate outlier threshold amount for community mental health centers that appear to have received disproportionately high outlier payments.

The proposed rule is found at [http://www.cms.hhs.gov](http://www.cms.hhs.gov). Comments will be accepted until October 6, and a final rule will be published later in the fall. The rule will be effective for services on or after January 1, 2004.

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Arkansas Hospitals Embrace Quality Project

The Arkansas Foundation for Medical Care (AFMC), Arkansas’ Quality Improvement Organization (QIO), reports that 68 eligible hospitals in the state (85%) have registered for the QualityNet Exchange, which is the path to the QIO Clinical Warehouse for data. Arkansas’ participation rate is better than half of the other states in the nation. Participation in the QualityNet Exchange program gives participating providers access to statistical comparison data for state, regional and national benchmarking.

In addition, Arkansas’ Critical Access Hospitals (CAH) have emerged as leaders with their efforts and participation in transmitting data to the National QIO Clinical Warehouse via the QualityNet Exchange. Eighty-two percent of the state’s CAHs have signed up for this quality improvement program. The state’s CAHs have been gathering project data in conjunction with the Arkansas Department of Health, Office of Rural Health and Primary Care and Health Data Solutions (HDS), a division of the AFMC, since October 2002. Presently HDS has transmitted data from the 4th quarter 2002 and the 1st quarter 2003 to the QualityNet Exchange website.

For more information contact AFMC at 1-877-375-5700.

*Editor’s Note: The QualityNet Initiative is a separate process from the Quality Initiative spearheaded by the American Hospital Association.*

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Robot-Assisted Surgery Is Meeting Topic

The Arkansas Health Executives Forum (AHEF) will host a very interesting lunch meeting Wednesday, October 1 to discuss robot-assisted surgery. Dr. Samuel Smith, who has been using the Da Vinci technology at Arkansas Children’s Hospital, will be the featured speaker. AHEF president Christy Hockaday has issued an invitation to the meeting to all Arkansas hospital executives interested in learning more about this topic.

The meeting will be held in the Brandon Conference Center North at Arkansas Children’s Hospital in Little Rock. Lunch will begin at 11:30 a.m. with the presentation to begin at 11:45 a.m. Those planning to attend should RSVP by September 5th to Lee Gentry, AHEF secretary-treasurer at lentry@lawrencehealth.net or at (870) 886-1265. There is no registration fee.
Joseph A. White, CHE, former vice president/administration at Middlesex Hospital in Middletown, Connecticut, will be the featured presenter at the October 23 American College of Healthcare Executives/Arkansas Health Executives Forum Breakfast. The annual breakfast meeting is part of the Arkansas Hospital Association’s 73rd annual meeting October 22-24 at the Hot Springs Convention Center.

White will discuss “The ER: Core Business of the Community Hospital” and methods adopted by his facility to meet the demand on hospital emergency departments, while not becoming a drain on other services. Since the 13 million patients per year who are admitted through the ER now represent over 40% of all inpatient admissions in the U.S., many community hospital ERs are now actually generating the majority of their institution’s overall business, making the ER itself the hospital’s primary core business.

Recipients of the ACHE Regent’s Awards will be announced at the breakfast, also. For ticket information, please call the AHA at 501-224-7878 or click on http://www.arkhospitals.org/calendar, and then click on October 22-24.

The AHA Calendar

September 2003

3 AHA Metropolitan Hospital District, AHA Headquarters, Little Rock
5 Introduction to Health Care Payment Systems Webinar
9 EMTALA – Part I Webinar
10 Compliance Forum, Holiday Inn Select, Little Rock
11 AHAA (Auxiliary) Board of Directors, AHA Headquarters, Little Rock
12 AHA Board of Directors, AHA Headquarters, Little Rock
15 HIPAA for Coding, Billing & Reimbursement – Part I Webinar
15 Cardiovascular Coding, Billing & Reimbursement – Part 1 Webinar
16 EMTALA – Part 2 Webinar
16 Focus on CPT: OPPS for the Respiratory & Cardiovascular Webinar
17 Cardiovascular Coding, Billing & Reimbursement Webinar
17 Combating Terrorism: A Global Response Webinar
18 HIPAA for Coding, Billing & Reimbursement – Part 2 Webinar
18 Healthcare Recruitment: Improving the Process, Holiday Inn Select, Little Rock
19 Money Matters: Finances for Nonfinancial People, Holiday Inn Select, Little Rock

Jason Spring has been named administrator of Hot Springs Surgical Hospital, succeeding Aubrey Allensworth. Spring was formerly administrator of St. Vincent Rehabilitation Hospital in Sherwood, and was recipient of the 2002 C. E. Melville Young Administrator of the Year Award.

David Callecod, CEO of Central Arkansas Hospital in Searcy, has resigned to accept a similar position at Marion General Hospital in Marion, Indiana. Marion is home to Indiana Wesleyan University, where Callecod has served on the President’s Advisory Committee of the Board of Trustees since 1999. Ben Frank will serve as Interim CEO after Callecod’s departure in October.

Dzaidi Daud has been promoted from outpatient administrator to administrator of Vista Health, formerly known as Harbor View Mercy Hospital, in Fort Smith. Texarkana Behavioral Associates d/b/a Vista Health Fort Smith assumed ownership of Harbor View Mercy Hospital in June.