Leah A. Osbahr, president of Lawrence Health Services in Walnut Ridge, has been named recipient of the Arkansas Health Executives Forum’s C. E. Melville Young Administrator of the Year Award. The award will be presented during the Arkansas Hospital Association’s annual Awards Dinner, Thursday, October 5, at the Peabody Little Rock.

Osbahr has been President of Lawrence Health Services for two years. Prior to taking the helm, she was Director of Medical Services at UAMS for six years, and respiratory care supervisor at Baptist Health Medical Center-Little Rock for seven years. During her tenure at Lawrence Health and Lawrence Memorial Hospital, she has led the hospital to JCAHO accreditation without recommendation; spearheaded construction on a new emergency department, outpatient and clinical wing; field-tested the first community health center to be in a hospital, and added additional rooms to the hospital wing.

Osbahr obtained her Master in Health Services Administration from the University of Arkansas at Little Rock and her Masters in Public Health from Tulane University, after earning her Baccalaureate of Science in Respiratory Care from the University of Central Arkansas.

The Arkansas Hospital Association (AHA) is preparing to distribute its annual Wage and Salary Survey. Again this year, the AHA is conducting the survey in conjunction with the Oklahoma Hospital Association, which will collect, compile and tabulate all data, and issue the report. The survey will be sent to each member hospital electronically and may be completed and submitted online. All hospitals are encouraged to take advantage of the electronic capabilities of the survey. Responding online will improve the efficiency for processing information and the timeframe for returning a meaningful report.

The survey materials will be emailed to the individual at each hospital who provided an email address on response sheets included with their hospitals’ completed 2005 Wage and Salary Survey. If the hospital did not participate last year, the materials will go to the hospital CEO.

Aeschylus’ Greek tragedy, Prometheus Bound, is about the rebel Titan Prometheus who stole fire from Zeus and gave it to the primitive mortals on the earth. For this, he was bound to a mountain and punished for centuries. Today, a new PROMETHEUS may be starting a fire of its own in a self-guided effort to ignite hospital payment reform. If it works, this titan workgroup will more likely be praised than punished.

The last attempt to structure a new payment system occurred more than 30 years ago, when researchers at Yale University began working on the use of Diagnosis Related Groups (DRG) as a case classification system. But, that was done with direct support of the former Health Care Financing Administration. PROMETHEUS, on the other hand, doesn’t seem to have official government-sponsored backing.

The new PROMETHEUS (Provider payment Reform for Outcomes, Margins, Evidence, Transparency, Hassle reduction, Excellence) is a group of individuals led by Francois de Brantes, former program leader for healthcare initiatives at GE Corporate Healthcare. This team
of experts in healthcare economics, law, policy, plan operations, and performance measurement carefully designed the innovative payment concepts.

PROMETHEUS’ volunteer participants come from private groups including the American Hospital Association, Harvard School of Public Health, Leapfrog Group, and Blue Cross and Blue Shield Association, among others, but are not serving as representatives of their work organizations. Their goal is to establish a healthcare payment system based on Evidence-based Case Rates, or ECRs, that can be easily implemented and used by all payers.

Last week, PROMETHEUS finished the first phase of its project and issued a white paper report that it has been developing for the past 20 months. The report outlines basic concepts of an ECR payment system. The next phase involves launching pilot projects by the end of 2007 in four markets covered by multiple payers. To learn more, see http://www.prometheuspayment.org/assets/documents/pdf/PROMETHEUS%20WP%20Draft%20May2006%20(5).pdf.

Audiocast Correction

The September 6, 2006 issue of AHA’s The Notebook erroneously reported that a September 26 Centers for Medicare & Medicaid Services (CMS) audiocast concerning the National Provider Identifier (NPI) will begin at 2:30 p.m. Eastern Time. Instead, the 90-minute call will begin at 2:00 p.m. Eastern Time.

To participate in this NPI Roundtable, call 1-877-203-0044, pass code 4795739. CMS will address common questions related to Medicare’s guidance on Subparts. While CMS will only address questions from a Medicare perspective, the information may be helpful to all healthcare professionals.

AHA Testifies About Community Benefit

American Hospital Association (AHA) Chairman-elect Kevin Lofton testified before the Senate Finance Committee last week that the current community benefit standard allows not-for-profit hospitals the flexibility to tailor programs and services to community needs and does not need to be changed.

During a September 13 hearing on charity care and community benefit, Lofton, president and CEO of Catholic Health Initiatives in Denver, noted that the AHA Board of Trustees in May unanimously adopted a resolution calling for standardized public reporting of community benefit based on a model developed by the Catholic Hospital Association of the U.S. (CHA) in cooperation with VHA, Inc.

Sen. Charles Grassley (R-IA), who chairs the committee, scheduled the hearing to better understand what benefits not-for-profit hospitals provide to the public in exchange for their tax exempt status. He has directed his staff to develop proposals on ways to make sure that the hospitals deliver adequate care to the poor and benefit for their communities. Last year Grassley surveyed 10 U.S. hospital systems about their community benefits. Responses showed that they provided more than half a billion dollars in uncompensated care to patients in 2004.

The AHA resolution on community benefit differs from the CHA/VHA model by including bad debt and the unpaid costs of government-sponsored healthcare as a community benefit. Lofton admitted to “intellectually honest differences” within the field regarding reporting Medicare underpayment or bad debt. But, he said those differences should not and are not preventing not-for-profit hospitals from reporting the value of their community benefit.

The Arkansas Hospital Association is currently conducting a community benefit survey for the state’s hospitals. All member hospitals are strongly encouraged to participate.
The Federal Emergency Management Agency (FEMA) has released the National Incident Management System’s (NIMS) implementation activities for hospital and healthcare systems. The 17 activities are based on similar requirements that were put into place for state and local agencies.

The National Bioterrorism Hospital Preparedness Program, administered by the Health Resources and Services Administration (HRSA), has clearly identified several activities among these 17 with which hospitals receiving funding under the program in FY 2006 must comply. Hospitals receiving HRSA preparedness funding will be required to gradually come into compliance with all the NIMS implementation elements over time. Other hospitals also are encouraged to implement them.

The FEMA announcement and a summary and detailed description of the activities can be found online at http://www.fema.gov/emergency/nims/index.shtm.

**CMS Begins IPPS Studies**

In its 2007 Medicare inpatient prospective payment system (IPPS) final rule, the Centers for Medicare & Medicaid Services (CMS) indicated that it would complete two studies to serve as a foundation for the 2008 IPPS rule. The agency has now signed contracts with groups that will conduct the studies. Under the first contract, RTI International will study methods of improving estimates of the cost of Medicare inpatient hospital discharges used in constructing the DRG relative weights, a key determinant of the amount Medicare pays for an inpatient hospital stay.

The second contractor, RAND Corporation, will evaluate alternative severity-adjusted DRG classifications systems. The systems to be evaluated are all variants of the Yale severity of illness system developed under contract with CMS in 1989. RAND Corporation will analyze at least two years of MedPAR for the 2008 proposed rule, due out in May 2007. Another two years of data may be analyzed for at least some of the systems by the time a final report is completed.

**ASC Data File**

Ambulatory Surgical Centers (ASC) can access a data file for use in modeling the methodology for calculating ASC facility payment amounts under the revised payment system proposed for implementation in CY 2008. The Centers for Medicare & Medicaid Services (CMS) recently posted a file which contains the proposed pricing and historical utilization data that formed the basis for the proposed ASC conversion factor calculation and the alternative ASC conversion factor calculation described in the August 23, 2006 Federal Register. The file is available online by clicking on the hyperlink titled “Supporting Data Files for CMS-1506-P” at http://www.cms.hhs.gov/ascpayment/06_cms1506P.asp in the “Downloads” section.

**Physician-Hospital Collaboration Project**

Is there a link between hospitals’ ability to provide financial incentives for physicians and improved quality of care? For example, would making incentive payments available to surgeons for achieving lower infection rates and fewer readmissions with complications result in improved patient outcomes and lower overall hospital and Medicare costs?

To find out, the Centers for Medicare & Medicaid Services (CMS) is soliciting applicants for a new demonstration program known as the Physician-Hospital Collaboration Demonstration (PHCD). Under the program, a hospital would be paid its usual inpatient rate for the patient’s care and physicians would get a portion of any savings resulting from quality improvement and efficiency initiatives on their part. The incentive payments would only be allowed for documented, significant improvements in quality of care and savings in the overall costs of care.

The project will focus on the entire scope of care for a surgical episode or other episode of illness involving hospital inpatients. It will encompass physician groups and up to 72 hospitals.
in a limited number of geographic areas across the country, and will test whether making
incentives available to physicians for quality and efficiency improvement can increase quality
while reducing hospitals’ and Medicare costs.

Organizations eligible to participate in the project include physician groups; integrated delivery
systems (IDSs); or organizations representing a coalition of physician groups or integrated
delivery systems. Hospitals may be included in a healthcare group, if affiliated with the group
under an arrangement structured so that it may participate in the project.

For more, see [http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?filterType=

**NPI Application Removed From Web**

Beginning on September 20, 2006, the PDF version of the National Provider Identifier (NPI)
Application/Update Form (CMS-10114) will no longer be available for download on the CMS
forms Web site, and there will not be a link to that form from the National Plan and Provider
Enumeration System (NPPES) page ([https://nppes.cms.hhs.gov/NPPES/Welcome.do](https://nppes.cms.hhs.gov/NPPES/Welcome.do)). Healthcare
providers may still apply for NPIs in one of three ways:

- Use the Web-based NPI application process. Log onto the NPPES,
  [https://nppes.cms.hhs.gov/NPPES/Welcome.do](https://nppes.cms.hhs.gov/NPPES/Welcome.do); or
- Agree to have an Electronic File Interchange organization (EFIO) submit application
data on their behalf (i.e., through a bulk enumeration process); or,
- Obtain a copy of the paper NPI Application/Update Form (CMS-10114) and mail the
  completed, signed application to the NPI Enumerator located in Fargo, ND, where staff
  at the NPI Enumerator will enter the application data into NPPES. The form will be
  available only upon request through the NPI Enumerator. Healthcare providers who
  wish to obtain a copy of this form must contact the NPI Enumerator in any of these
  ways:

  Phone: 1-800-465-3203 or TTY 1-800-692-2326  
  E-mail: customerservice@npienumerator.com  
  Mail: NPI Enumerator  
  P.O. Box 6059  
  Fargo, ND 58108-6059

**Medicare Part B Premium Increase**

The basic Medicare Part B premium will rise next year to $93.50 a month, an increase of $5,
according to a White House announcement. However, more affluent beneficiaries will pay a
new surcharge, from $12.50 to $68.60 a month, depending on their incomes. The surcharge
applies to 1.5 million people with annual incomes exceeding $80,000 for individuals or
$160,000 for married couples filing joint tax returns.

The standard premium for 2007 is lower than Medicare first predicted. In May and again in July,
the Centers for Medicare & Medicaid Services (CMS) estimated that the monthly premium,
currently $88.50, would climb to about $98 in 2007. Citing reasons for the lower premium, Dr.
Mark McClellan, former CMS administrator, said Medicare spending for doctors' services, while
still growing at a brisk pace, increased less than expected in the last year.

That slowdown could have been aided by the fact that physicians received the same Medicare
rates in 2006 as they were paid in 2005. It was still more than CMS planned to pay. Medicare
physician rates were supposed to be cut 4.4% in 2006, but the Deficit Reduction Act of 2005
cleared the way for a reversal and extended Medicare’s 2005 payment rates through for another year. Without a similar intervention, the rates are scheduled for a 5.1% reduction in 2007.

The premium is set each year to cover about 25% of projected spending under Part B. If the planned 2007 cuts don’t take effect and Medicare rates are frozen through 2007, the monthly premium will go up another $1.50 per month.

*(Benton)* **Saline Memorial Hospital** held a groundbreaking ceremony on September 1 to kick off construction of an emergency department expansion project. Once completed, the 15,567 square-foot facility will more than double the size of the hospital’s current ED area. The expansion will increase total exam rooms from six to eleven and will house new equipment and technology, including digital x-ray and computer networks that allow physicians to view past patient records as well as review up-to-date pharmaceutical data.

*(Hot Springs)* **St. Joseph’s Mercy Health Center** has announced plans to build a new diagnostic clinic on 20 acres just outside the gate of Hot Springs Village, where many medical tests will be available to patients who currently must drive to Hot Springs or Little Rock for the exams. Details about the size and design of the new clinic have not been finalized.

*(Searcy)* **White County Medical Center** has acquired a new state-of-the-art Volume CT imaging system. The new equipment enhances physicians’ abilities to capture patient information that they need to diagnose disease and life-threatening illnesses. The speed of the machine allows it to show images of a beating heart in five heartbeats, an organ in one second and perform a whole body scan in ten seconds. It can create 64 high-resolution anatomical images as thin as a credit card. The images then combine to form a three-dimensional view of the patient’s anatomy.

**The AHA Calendar**

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<td>21 Audio Conference: Clostridium Difficile (C.diff): Old Bug, New Challenges</td>
<td>4 AHA Board of Directors, Peabody Hotel, Little Rock</td>
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<td>4-6 Arkansas Hospital Association’s 76th Annual Meeting and Trade Show, Peabody Hotel and Statehouse Convention Center, Little Rock</td>
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<td>24 Environment of Care Workshop, Holiday Inn Select, Little Rock</td>
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<td></td>
<td>26 Dealing with Conflict (Mid-Management Certificate Series), Holiday Inn Select, Little Rock</td>
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<td></td>
<td>27 Dealing with Conflict (Mid-Management Certificate Series), Hampton Inn, Little Rock</td>
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**Newsnotes About Arkansas Folks**

Angela Richmond has been named president and CEO of Community Medical Center of Izard County (CMCIC) in Calico Rock. She succeeds co-administrators Meryl Grasse, MD, and Genna Nave, RN. Richmond is a former director of finance for Ozarks Medical Center in West Plains, Missouri and has over 25 years of business experience. Dr. Grasse will continue at CMCIC overseeing new construction and Nave will remain quality/infection control/discharge planning coordinator at the hospital.
In August, after a considerable amount of thought and deliberation, and on the advice of a committee that thoroughly studied the matter, the Arkansas Hospital Association (AHA) board of directors voted to voluntarily establish a Web site to display price and quality information for Arkansas hospitals. The board may have felt much like those 7th Cavalry troops who followed General George Armstrong Custer to the banks of the Little Big Horn River. It wasn’t an easy decision, but it probably was the only choice. They decided to be proactive and intervene on an issue that is steadily gaining in popularity among members of Congress and state legislatures.

Like it or not, the move gives the state’s hospitals a head start on the inevitable. Despite all evidence to the contrary, neither Congress nor the White House seem inclined to abandon the idea that making information about hospital charges publicly available is good for consumers. They believe it will help people make better informed choices about their healthcare. CMS has already begun publishing the prices it pays hospitals for some services, and legislation to augment that effort by requiring price reports have been promised, with a few bills already introduced in Washington and scales leaning in that direction in Little Rock.

The most recent federal bill went into the hopper last week. Rep. Michael Burgess’ (R-TX) Health Care Price Transparency Act of 2006 (HR 6053), would require states to disclose certain hospital charges and to make the information available to the public by October 1, 2007. A more harsh transparency proposal was recently rejected as part of the House health information technology bill. It called for the development of a method for hospitals to report “uniform price data” for inpatient services. Other legislation is waiting in the wings.

The Burgess bill incorporates many, if not most, of the components that the American Hospital Association (AHA) board previously agreed on before taking the leap to encourage the nation’s hospitals to get out in front of the issue. Recognizing the gathering storm, that board last April approved a policy statement which endorses the sharing of meaningful information with consumers about the price of their hospital care.

Arkansas is actually a late arrival to the sharefest. It will become the 39th state to make hospital prices public. Thirty-two states require the reporting; seven others, if you include Arkansas, do it voluntarily, which gives hospitals a bit more say in what to report and how to display it.

The Arkansas Web site will closely mirror the Louisiana Hospital Association’s Hospital Information site (http://www.lahealthinform.org). For now, it will reflect average prices that hospitals charge only for Medicare patients who are admitted with conditions under a limited set of DRGs. That could expand to cover all patients in the future. And, each hospital’s page will contain a table which will reflect the hospital’s ratings on all CMS HospitalCompare quality measures at a single glance, rather than having consumers link to the CMS site and view each measure separately.

The new transparency site also will address several caveats included in the AHA policy statement, such as including an explanation about why prices of similar care can vary not only from hospital to hospital, but from patient to patient within the same hospital, and it will contain information to educate consumers about the vast difference between charges and the actual payments that hospitals receive for services. The goal is to have the Web site go live by mid-November. Before that occurs, every hospital will have at least a 30-day window to review its data to be displayed and make changes, if necessary.

One thing that won’t be reported is what patients might expect to pay out-of-pocket for a hospitalization. It ought not to be up to hospitals alone to provide information to consumers and that’s something which insurers can best hand out.

The American Hospital Association policy statement recommended as much, saying that insurers should be a part of the equation by making available information about enrollees’ expected out-of-pocket costs in advance of medical visits. It’s not coincidental that Rep. Burgess’ bill concurs and takes the added step of requiring insurers to provide that information to consumers for certain services, whenever it’s requested.