The American Hospital Association’s (AHA) Annual Membership Meeting in Washington, D.C. is a little more than a month away. The meeting offers the nation’s hospital executives, managers and trustees the opportunity to get firsthand knowledge about the many issues confronting the healthcare field. It also will serve to officially kick off the AHA’s Advocacy Agenda for 2006. This year, the AHA has a four-part agenda.

The primary goal is to protect care for patients and communities by opposing the cuts to Medicare and Medicaid funding proposed in the President’s FY 2007 budget plan. In addition, the AHA will continue its work toward a permanent fix to the “75% Rule,” which requires that, to be reimbursed as an inpatient facility under Medicare, 75% of a rehabilitation facility’s patients must be treated for a set of 13 specific conditions, seek a permanent ban on physician self-referral to new limited-service providers and address a number of challenges in caring for people in rural areas. Some of those efforts will be aimed at:

- Advocacy for the Rural Community Hospital Assistance Act, which creates a new payment system that makes hospitals with between 25 and 51 beds eligible for cost-based reimbursement for Medicare inpatient and outpatient services and expands cost-based reimbursement for Critical Access Hospital (CAH) skilled nursing facilities, home health services and ambulance services;
- Pushing for the Rural Health Equity Act, which ensures that Medicare Advantage plans pay CAHs at least 101% of costs for inpatient and outpatient services, regardless of whether the CAH has a contract with the patient’s Medicare Advantage plan;
- Supporting the Safety Net Inpatient Drug Affordability Act — legislation that expands the 340b program to include inpatient services and to allow critical access hospitals to participate; and
- Ensuring that important rural healthcare programs receive adequate funding in the regular congressional appropriations cycle, through which federally funded programs receive their annual funding amounts. Among the programs for which we advocate annually: Rural Health Outreach Grants, Rural Health Research, Rural Hospital FLEX Grants and State Offices of Rural Health.

For complete details on those and other items, go to [http://www.aha.org](http://www.aha.org) and click on 2006 AHA Advocacy Agenda.

---

Reminder:

**Governance Leadership Conference April 7**

Innovations in community benefit and health improvement, the changing role of trustees in the world of public reporting and building sustainable physician relations — all three topics will be addressed at the annual Arkansas Association of Hospital Trustees’ Governance Leadership Conference April 7 in Little Rock.

Hospital trustees, CEOs and management teams will hear from community initiatives expert Tyler Norris; John Combes, president of the Center for Healthcare Governance; and healthcare consultant Tom Atchison as they discuss these important issues and the impact they have on hospitals and governance leaders. All Arkansas Hospital Association (AHA)
member hospitals are encouraged to send a team to the conference at the special registration fee of $125 each, when you send three or more from the same facility!

The AHA has a limited number of “scholarships” to offer hospitals wanting to send trustees but do not have the budget to support their attendance. The scholarships are made available by corporate sponsors AHA Services, Inc. and QHR.

The program brochure is available by clicking on [http://www.arkhospitals.org/calendar.htm](http://www.arkhospitals.org/calendar.htm), or by calling Beth Ingram or Donna Boroughs at (501) 224-7878.

In a comment letter about the Centers for Medicare & Medicaid Services’ (CMS) proposal to cut Medicare payments to long-term care hospitals (LTCH) by 14.7% in rate year 2007, the American Hospital Association (AHA) expressed concerns that the cuts would "severely and inappropriately threaten patient access to LTCH care.” The association is particularly concerned with CMS’ proposal to omit the 3.6% market basket update and change the short-stay outlier policy by paying cases at the significantly lower inpatient prospective payment system rate. The AHA said the policy change would "violate the integrity of the LTCH prospective payment system."

A recent Lewin Group study found that the combined proposals would lower Medicare payments to LTCHs to 5% below the cost of providing care. The AHA recommends that CMS instead develop more specific LTCH admissions criteria and expand Quality Improvement Organization review to ensure that appropriate patients are admitted. The final rule is slated for release next month.

In a related action, Rep. Michael Ferguson (R-NJ) is calling on his House colleagues to sign a letter urging Health and Human Services (HHS) Secretary Michael Leavitt to delay the proposed regulation that would go into effect July 1. Arkansas hospital officials should contact your representative to sign the letter, and urge the delay of a policy that could seriously impact LTCHs and their patients.

Currently, there are seven LTCHs in Arkansas serving patients with chronic or catastrophic illness or injuries, who require hospital stays of 25 days or longer. All are autonomous hospitals located within the walls of a “host” hospital.

Most LTCH patients are medically stable but fragile and in need of extended medical and nursing care. The LTCHs work with local community hospitals to provide a more appropriate setting for the care of patients who need the longer rehabilitation times to recover from the effects of spinal cord injuries, brain trauma, stroke, heart attack and other debilitating conditions, and who may be too ill for discharge to a nursing facility, an acute care rehabilitation hospital or their homes.

The American Hospital Association supports Ferguson’s attempt to get CMS to delay action on the proposal until a study to be conducted by The Research Triangle Institute is complete. That study will help develop more specific LTCH admissions criteria to target medically complex, long-stay patients.

Health Resources and Services Administration (HRSA) has published a proposed rule that would require states to report to the National Practitioner Data Bank adverse licensure actions taken against any healthcare practitioner or entity licensed or authorized by the state to provide healthcare services. It also would require states to report any negative actions or findings that a state licensing authority, peer review organization or private accreditation entity has concluded against a healthcare practitioner or entity.

The proposed changes, which the American Hospital Association continues to assess, would implement a longstanding section of the Social Security Act that calls for this additional
information to be reported to the data bank. However, it does not affect the current responsibility of hospitals to report adverse actions affecting the clinical privileges of a physician or dentist. HRSA will accept comments on the proposed rule through May 22. Additional information about the National Practitioner Data Bank is available at http://www.npdb-hipdb.com. To view the proposed rule, see http://a257.g.akamaitech.net/7/257/2422/01jan20061800/edocket.access.gpo.gov/2006/pdf/06-2686.pdf.

Calls Update Rural Hospital Act

The American Hospital Association (AHA) has scheduled two calls to update members on the status of the Rural Community Hospital Assistance Act (S. 933 and H.R. 2350). The Act would extend 101% cost-based reimbursement to Critical Access Hospital post-acute care services. It also would provide an option for rural hospitals with 50 inpatient beds or less to receive enhanced cost-based reimbursement for inpatient, outpatient and select post-acute care services. In the Senate, S. 933 was introduced by Senator Brownback (R) and Senator Ben Nelson (D) and in the House H.R. 2350 was introduced by Rep. Jerry Moran (R) and Rep. Hinojosa (D).

Steve Ahnen, AHA senior vice president, will lead the calls and Lisa Kidder, senior associate director, AHA Federal Relations will present. To participate, dial 1-888-318-6431. The pass code is RCHAA. The calls will last one hour and will review the same material.

You may choose from either one of two dates for the call. The first call is scheduled for Wednesday, April 12, at 12:00 Noon Central Standard Time (CST). The second is Thursday, April 13, at 12:00 Noon CST. Choose from the date that best fits your schedule.

In order to assure there are sufficient lines for all interested listeners, the AHA is asking interested hospitals to RSVP to Hilda Fisher at hfisher@aha.org or via fax (312) 422-4590 using the form for the calls that the AHA distributed March 23.

The AHA Calendar

April 2006
5 AHEF (Arkansas Health Executives Forum), The Future of Healthcare Financing, Holiday Inn Select, Little Rock
5-7 HFMA (Financial Management), Arlington Hotel, Hot Springs
6 AAMSS (Medical Staff Services) Spring Conference, Holiday Inn Select, Little Rock
7 AAHT (Trustees) Governance Leadership Conference, Embassy Suites, Little Rock
13-14 AHA Board of Directors, Red Apple Inn, Heber Springs
19 Leaping from Staff to Management: You're a Manager…Now What? (Mid-Management Certificate Series) Holiday Inn Select, Little Rock
20 Leaping from Staff to Management: You're a Manager…The Next Steps, (Mid-Management Certificate Series) Holiday Inn Select, Little Rock

Newsnotes About Arkansas Folks

Jamie Carter, CEO of Crittenden Memorial Hospital in West Memphis, and Herbert K. “Kirk” Reamey, CEO of Ozark Health Medical Center in Clinton, have been named directors on the AHA Worker’s Compensation Self Insured Trust. Carter succeeds Jim Richardson of Benton and Reamey succeeds Robert R. Reddish of Lake Village. After fulfilling one-year terms expiring in the spring of 2007, both Carter and Reamey will be eligible to serve a three-year term.
The push for more public data about the nation's hospitals is the latest rage in healthcare circles. It's called transparency, and its aim is to reveal all aspects of hospital operations so that consumers will have access to more facts for use in making healthcare decisions. The transparency movement sprouted following the Institute of Medicine's release of its 1998 report, *To Err Is Human*, which concluded that as many as 98,000 people die in America's hospitals each year as a result of medical errors. It's grown like a weed since then.

That report created quite a stir among government and business leaders and consumer groups for hospitals not only to make patient safety and quality improvements, but also to document their progress. The pressure for accessible, reliable quality information eventually led to the formation of the Hospital Quality Alliance (HQA), a national initiative started by the American Hospital Association and other hospital groups to promote the idea that hospitals ought to report their quality information and make it generally available to the public.

The Centers for Medicare & Medicaid Services (CMS) partners in this transparency tango by collecting the quality data hospitals submit and distributing it on the Internet via the Hospital Compare Web site. Once there, anybody can access and review the results to see how individual hospitals compare on each of the clinical measures reported.

The next step toward total transparency appears to be aimed at hospital prices. Earlier this month, Allan Hubbard, director of President Bush's National Economic Council, warned that if hospitals don't voluntarily adopt consumer pricing transparency policies, it will be imposed on them by Congress and the Bush administration.

Hubbard pointed to four bills now before Congress that would establish provider pricing transparency programs. At least two of them would require hospitals and ambulatory surgical centers to report the average and median charges for the 25 most frequently performed inpatient and outpatient procedures and the 50 most commonly prescribed drugs. The Department of Health and Human Services (HHS) then would be required to post this pricing data on the Internet.

HHS Secretary Michael Leavitt is taking another approach. Rather than requiring hospitals to report their charges, he said that HHS soon will begin posting the amounts that Medicare actually pays hospitals for some of the most common procedures. His goal is to supplement consumers, who already have access to quality information, with an added bonus of knowing what Medicare pays individual hospitals. He's betting that the same dynamic, which hopefully will make quality go up, should also make prices go down.

Well, maybe or maybe not. The Secretary overlooks a few minor facts. Medicare payments have less to do with hospital prices than with a hospital's location, wage index value and case mix. In fact, the payments don't necessarily relate whatsoever to a hospital's costs and often don't even cover the cost of providing the care for Medicare patients.

As a result, hospitals with large numbers of Medicare and Medicaid patients use basic math to set prices high enough to recover the costs not paid for by these programs; and the pressure to pass along the cost of care to paying patients in the form of higher prices gets more intense with every uninsured and underinsured patient who comes to the hospital for care.

Giving consumers baseline knowledge of what a hospital charges or gets paid isn't a bad idea, but it won't explain that some hospitals offer more complex services, such as burn units or trauma care, and treat patients who use more resources, resulting in higher prices overall. Nor will it account for the differences among health plans' billing and payment procedures, which can result in misleading comparisons.

If transparency programs eventually find a way to make those price influences crystal clear, they'll still have to contend with idiosyncrasies of the human element. Finding a way to add transparency to individual physician judgment, which can and does lead to a wide variation of charges, has baffled analytical experts with tons of experience for years. We have to wonder if the government alone can mandate something that may require divine intervention.