Members of the Arkansas Hospital Association’s (AHA) executive team traveled to Washington March 9-10 to visit with aides for each of the state’s senators and congressmen about hospitals’ concerns over potential Medicaid cuts and other matters on the association’s advocacy agenda. AHA president Jim Teeter and senior vice president Paul Cunningham made the trip primarily to lay groundwork for hospitals’ advocacy issues now, as Congress begins its budget-making process, rather than waiting until hospital CEOs and trustees from across Arkansas gather in Washington as part of the American Hospital Association Annual Meeting, which will be held May 1-4.

As important as it was to review the issues, the meetings presented an occasion to meet for the first time and begin building a relationship with several key health aides who are relative newcomers to their congressman’s staff. Those include legislative assistants Sarah Harvey (Rep. Marion Berry), Joy McGlaun (Rep. Vic Snyder), Kathee Facchiano (Rep. John Boozman), and Kate Callanan (Rep. Mike Ross). The AHA representatives also met with Anna Taylor, legislative correspondent with Sen. Blanche Lincoln’s office, and with Tate Heuer and Marisa Pryor, who handle health issues for Sen. Mark Pryor.

Arkansas hospital CEOs and trustees who attend the upcoming Annual Meeting will have an opportunity to meet with their congressmen and to have lunch with Senators Lincoln and Pryor. Plus, each of the aides named above and many others will be the AHA’s guests for a dinner in their honor as a part of the Arkansas activities.

During the meetings last week, the AHA covered issues including opposition to Medicaid cuts that are being discussed in conjunction with the budget talks, and to any new Medicare cuts that could be considered. There was a general consensus that cuts could harm Arkansas’ Medicaid program and that hospitals in the state have come to rely on the use of intergovernmental transfers as a way to help pay for care provided to Medicaid patients.

In addition, discussions touched on the move nationally for an extension of the moratorium on development of limited service hospitals; concerns about how the rule limiting payment to long term care hospitals could eventually harm community acute care facilities; and the AHA’s support of potential legislation that could enhance Medicaid disproportionate share hospital funds available for Arkansas.

Congress took its initial steps toward forming a budget for fiscal year 2006 last week when the House and Senate both approved their individual budget resolutions. On March 9, the House Budget Committee adopted a budget resolution that directs the House Energy and Commerce Committee to reduce spending for programs under its jurisdiction — including the Medicaid program — by $20 billion. A day later, the Senate Budget Committee approved a budget resolution that calls on the Senate Finance Committee to find Medicaid spending reductions totaling $14 billion over five years.

The Senate committee also accepted an amendment expressing the “sense of the Senate” that reconciliation should not impose Medicaid reductions that would undermine the program’s
viability or shift a disproportionate share of the financial support for the program to state or local governments. While the amendment clearly expresses the wishes of the committee, it does not carry the force of law. The resolutions set targets for spending and tax cuts which congressional committees must adhere to as they craft legislation for the coming fiscal year.

By March 11, the House Budget Committee had begun marking up a budget outline that would require $18 billion in cuts over five years from programs under the House Ways & Means Committee’s jurisdiction, with a $4 billion cut in the first year. While not specifically mentioning Medicare, it is highly likely that a large portion of the cuts may have to come from the Medicare program.

In releasing the White House budget plan for FY 2006 last month, the Bush administration voiced its intent to reduce Medicaid spending by as much as $60 billion over the next 10 years. However, any move by Congress to reduce Medicare spending for the year beginning October 1, 2005 would be a departure from President Bush’s proposed spending plan which protects Medicare from cuts.

March 16
IRF Call Rescheduled

The February 22, 2005 issue of *The Notebook* reported that the Centers for Medicare & Medicaid Services (CMS) was hosting two conference calls for providers regarding the Medicare Inpatient Rehabilitation Facility (IRF) 75% Rule. The first call took place on February 23. CMS has now issued notice that the second call will be postponed from March 16, 2005 until Wednesday March 23, 2005. Participants can begin calling in at 1:00 CST on that day. The phone number is 1-800-811-0667 and the call’s pass code is 4225450. The presentation will begin promptly at 1:30 CST. It is not necessary to register in order to participate. All other information in the February 22 article is correct.

MedPAC Discusses CAH Program

During its March 11 meeting, the Medicare Payment Advisory Commission (MedPAC) discussed the growth and costs of Medicare’s critical access hospital (CAH) program, in preparation for a report due to Congress in June on the impact of recent changes to that program. Critical access hospitals are small, isolated hospitals that receive Medicare payments based on their actual costs to provide care. They are exempt from Medicare’s inpatient prospective payment system.

Congress first introduced the CAH program in 1997 to bolster care in rural areas. Since then, the CAHs have benefited from higher Medicare payments and from their expansion of better-paying services and reduction of less profitable ones, according MedPAC’s analysis. More hospitals became eligible for critical-access status under the Medicare Modernization Act of 2003, which raised the bed maximum to 25 from 15.

According to data presented to the commission, there now are 1,075 critical access hospitals, including 23 CAHs in Arkansas. Data also show that between 1998 and 2003, the program helped improve payer margins by 83% for small, rural facilities that moved to CAH status, while the margins for potentially eligible hospitals that did not make the conversion dropped more than 100% over the same period.

However, in its report, MedPAC staff expressed concern about growth in costs of the program and discussed potential changes aimed at curbing those costs. Of particular interest is whether CAHs should continue to be paid 101% of costs or be moved to a fixed payment for providing emergency services and regular Medicare rates for all other services.
MedPAC Wants Moratorium Extended

The Medicare Payment Advisory Commission (MedPAC) recommended March 9 an 18-month extension to the current moratorium on self-referral to new physician-owned limited-service hospitals until January 1, 2007. The recommendation was part of a report to Congress issued in connection with Senate Finance and House Ways & Means committee hearings on the issue. MedPAC also recommended payment refinements to the Medicare inpatient prospective payment system and granting gainsharing abilities between physicians and hospitals. The current moratorium on new physician-owned specialty hospitals, which expires July 1, 2005, was part of the Medicare Modernization Act of 2003.

Go to http://www.medpac.gov/publications/congressional_reports/Mar05_SpecHospitals.pdf to read the full report.

MedPAC: Link Payment, Quality

In its March 1 Annual Report to Congress, the Medicare Payment Advisory Commission (MedPAC) recommended that the Centers for Medicare & Medicaid Services should pay more for higher quality performance from hospitals, home health agencies and physicians. According to the report, MedPAC believes that by instituting these recommendations, decision makers will consider more explicitly which technology brings valuable improvement to the length and quality of the patient’s life, thereby making Medicare payments more accurate and improving the value of care provided.

MedPAC also recommended: (1) for the hospital inpatient and outpatient prospective payment systems and the outpatient dialysis payment system, updates must be equal to the market basket index minus 0.4%; (2) for the physician fee schedule, the update must be equal to the market basket less an allowance of 0.8% for productivity; and (3) for the home health facility, MedPAC recommended that Congress eliminate the update to payment rates for home health care services for 2005.

AHA Board Highlights

During its March 11, 2005 meeting, the Arkansas Hospital Association (AHA) Board of Directors:

- Heard a report that AHA president Jim Teeter and senior vice president Paul Cunningham traveled to Washington on March 9-10 to meet and visit with the chief health aides for the state’s congressional delegation about the association’s advocacy agenda for the 109th Congress.
- Received an update on legislative items and bills being considered by the Arkansas General Assembly that could impact hospitals in the state. More than 3,000 bills have been filed during the session, including more than 550 bills that were filed March 7, the final filing date.
- Heard specifically about SB 982, the proposed Medicaid Fairness Act, which is meant to ensure fair treatment of healthcare providers that treat Medicaid recipients. The bill would require the Department of Human Services to promulgate rules to outline the basis upon which they deny claims. It would also require that they deny claims in writing and cite which specific rule has been violated.
- Learned that state Medicaid officials are working to implement two AHA board recommendations related to ER claim denials and to the billing and payment of observation bed services.
- Heard a report on the launch of Hospital Compare, a consumer-friendly display of hospital quality data, which should be available April 1. The Hospital Compare Web site will allow consumers to view hospital-specific quality data for 17 quality
measures related to heart attack, heart failure and pneumonia care, which participating acute care hospitals submitted through the national Hospital Quality Alliance.

- Learned that the National Quality Forum (NQF) steering committee responsible for reviewing the latest draft of the patient perceptions of care survey known as HCAHPS has issued its recommendations for public comment. The panel recommended a total of 27 survey questions, including five patient demographic questions and 22 questions on seven key aspects of hospital care concerning things from nursing care to care from doctors, the hospital environment, experiences in the hospital, when the patient left the hospital, and an overall rating of the hospital.

- Learned that the AHA is supporting efforts by some of its long term care hospital (LTCH) members to secure changes that would affect the August 2004 federal rule for the Medicare LTCH prospective payment system.

- Heard that, even though its original authorization has expired, the Arkansas Legislative Nursing Commission will continue to meet outside the legislative arena for the foreseeable future to work toward the establishment of a state Nursing Center as a 501(c)3 not-for-profit corporation.

- Heard a presentation by Boyd Ward, executive director of the Arkansas Regional Organ Recovery Agency (ARORA), who discussed ARORA’s organ procurement process, registry, and the “Organ Donation Breakthrough Collaborative.” Mr. Ward said that working under “best practices” guidelines since 2003, ARORA has increased its number of organ donors by 59% and tissue donors by 241%. In 2004, the organization saw a record 62 organ donors.

- Learned about the House Budget Committee’s blueprint for a FY 2006 federal budget that requires $18 billion in cuts over five years from programs under Ways & Means Committee’s jurisdiction, which could lead to discussions about Medicare funding cuts; and causes the House Energy & Commerce Committee to cut $20 billion from programs within its jurisdiction, including Medicaid. The Senate Budget Committee’s blueprint calls on the Senate Finance Committee to find Medicaid spending reductions totaling $14 billion over five years.

- Learned that the AHA Regional Policy Board 7 will meet in April in Little Rock. The primary issues to be discussed will be limited-service providers and strategies for getting physicians and hospitals to work closer together.

---

**The AHA Calendar**

**March 2005**

17-18 ASHMPR (Marketing/Public Relations) Spring Conference, The Arlington, Hot Springs

**April 2005**

1 Outpatient Prospective Payment System (OPPS) Update: Coping with the Problem Areas, Holiday Inn Presidential, Little Rock

6 AHA Metropolitan Hospital District, AHA Headquarters, Little Rock

7 AHA Northeast Hospital District, Great River Medical Center, Blytheville

7 AAMSS (Medical Staff Services) Spring Conference, Holiday Inn Select, Little Rock

8 AHA Board of Directors Meeting, AHA Headquarters, Little Rock

8 AONE (Nurse Executives) Spring Conference, Embassy Suites, Little Rock

20 AAHT (Trustees) Conference, Holiday Inn Presidential Center, Little Rock

27-29 HFMA (Financial Management), Clarion Resort, Hot Springs

29 AHHRA (Human Resources) Spring Conference, Embassy Suites, Little Rock