Two bills involving Medicaid disproportionate share hospital (DSH) funds that are critical for Arkansas hospitals were recently introduced in Congress. They are The Access to Hospitals Act of 2003 (S. 652/H.R. 328) and The Medicaid Safety Net Hospital Improvement Act of 2003 (S. 204/H.R. 1342). DSH funds provide supplemental financing necessary to help hospitals offset the costs of caring for low-income and indigent patients. Funding for the DSH program is extremely important for Arkansas, where the percentage of uninsured patients that are hospitalized grew from 3.8% of all inpatients in 1997 to 6.8% in 2001.

S. 652 and H.R. 328 would restore DSH program funding that was cut last year due to the expiration of provisions of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000. The BIPA froze, for FY 2001 and 2002, funding cuts to Medicaid DSH state allotments that were part of the Balanced Budget Act of 1997. The Medicaid Safety Net Hospital Improvement Act of 2003 (S. 204 and H.R. 1342) is another attempt to increase the minimum federal Medicaid DSH allotment for states with the smallest Medicaid DSH programs, including Arkansas.

The American Hospital Association (AHA) and nine other national healthcare organizations have written members of Congress seeking support for the bills. The letter notes that approving the bills would be a step toward addressing the issue of coverage and access for the uninsured and it points out that the fiscal crisis states are currently experiencing, combined with the fiscal challenges hospitals are facing, make Medicaid DSH funding more important than ever. Arkansas senators Blanche Lincoln and Mark Pryor are co-sponsors of S. 204, but have not signed S. 652. None of the state’s four congressmen have signed to co-sponsor either House bill yet. The AHA letter is posted at [http://www.aha.org](http://www.aha.org).

The American Hospital Association (AHA) has joined with the Federation of American Hospitals (FAH) and the Association of American Medical Colleges (AAMC) to launch a national voluntary quality initiative. Originally deemed Project Public Trust, the effort is now formally called The Quality Initiative: A Public Resource on Hospital Performance. The project, which has support of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the National Quality Forum (NQF), the Centers for Medicare & Medicaid Services (CMS), the Agency for Healthcare Research and Quality (AHRQ), AARP, and the AFL-CIO, has been under development since late 2002 and is now being rolled out for members.

The initial phase of the initiative is directed at getting hospitals to voluntarily report the results of their performance on 10 quality measures related to three medical conditions – acute myocardial infarction, heart failure, and pneumonia. The 10 measures are common to JCAHO’s ORYX program and CMS’ 7th scope of work. They also have been endorsed by the NQF as national standards of hospital quality measurement. The AHA distributed a May 1 advisory to all its member hospitals detailing the first phase of this initiative. The advisory
included a pledge of participation form and all instructions, explanatory documents, and enrollment forms necessary for hospitals to join the project as participants.

Subsequent phases of the project will add measures on selected new conditions, aspects of care, and patients’ perspectives of their care. These measures will be added in a process that enables input from a broad array of interested parties, including consumers, purchasers, and healthcare providers. The measures will be added as soon as an agreement has been reached on what aspects of hospital care should be measured next and the NQF has attained consensus on valid and reliable measures that can be used to assess those aspects of care.

The AHA, the AAMC, and the FAH strongly urge all their member hospitals to participate in this quality initiative in response to pressure from many fronts for more and better publicly available information about the quality of hospital care. By working together, hospitals and the organizations named above are pledging to coordinate these efforts for all parties involved — hospitals, consumers, and purchasers. Support from the hospital community also will minimize the potential of confusing the public in the future with incomplete, poorly analyzed, and conflicting or misleading information.

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The Little Rock healthcare market was in the spotlight once again on April 25 as part of the ongoing Federal Trade Commission (FTC) and Department of Justice (DOJ) joint hearings on competition law and policy in the healthcare field. For that session, a panel of hospital and health insurance leaders was convened April 25 to examine the competitive effects of health insurance “monopsony” situations. As defined by one of the panelists, monopsony is the ability of a firm to profitably set market-wide reimbursement rates below competitive levels for a sustained period of time. Mergers between health insurers raise concerns that monopsony power could be exercised against providers, forcing them to accept unreasonably low rates and unattractive contract terms.

Stephen Mansfield, president and CEO of St. Vincent Health System in Little Rock, told the FTC and DOJ officials that a significant rise in health insurance premiums for employers and individuals across Little Rock was partially attributable to the Blue Cross plan’s failure to include additional cost-efficient providers. Dennis Hall, president of Baptist Health Care System in Birmingham, AL, testified that his hospital can’t generate adequate capital without improved revenue from payers. Yet, he said that switching to another insurance plan is not an option because there are no viable alternatives to his region’s Blue Cross Blue Shield plan.

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Senators Sam Brownback (R-KS) and Ben Nelson (D-NE) have introduced the Rural Community Hospital Assistance Act. The bill enhances the Critical Access Hospital program, which provides special Medicare reimbursement for certain rural hospitals with 15 or fewer inpatient beds; helps rural hospitals with 50 or fewer inpatient beds by allowing them to use cost-based reimbursement instead of PPS; ensures that these hospitals will receive 100% compensation for treating Medicare patients who fail to supply their co-pay portion of the costs; and provides additional funding for technology and infrastructure needs.

The bill is a companion measure to H.R. 937, introduced by Reps. Jerry Moran (R-KS) and Jim Turner (D-TX) in February. The legislation is part of a larger agenda to improve healthcare in rural America that includes measures to help ensure that rural hospitals can recruit and retain the highly qualified staff they need by establishing a more equitable Medicare area wage index and continuing better Medicare base payments for rural and other urban hospitals.
During the Federal Relations Forum program of the American Hospital Association’s Annual Membership Meeting on April 28, hospital representatives from across the country heard from administration officials and lawmakers about the prospects for Medicare and Medicaid changes that will be addressed by the 108th Congress.

Senate Majority Leader Bill Frist, M.D. (R-TN) told the audience that he hoped Congress would pass a bipartisan Medicare reform bill before the July 4 recess. He said seniors are demanding a prescription drug benefit and that the Senate and House are ready to address a Medicare delivery system that is “antiquated, fragmented, and overly bureaucratic,” if a partisan filibuster can be avoided. Frist also predicted that medical liability reform was unlikely to pass unless Democrats got behind it.

Health and Human Services (HHS) Secretary Tommy Thompson promised to continue to work with hospitals to cut red tape and improve the regulatory process. The Secretary cited the agency’s close partnership with the AHA in working for common-sense changes to the Health Insurance Portability and Accountability Act’s (HIPAA) medical privacy rule and in implementing a raft of other paperwork reduction measures recommended by his task force on regulatory relief. That task force included several hospital leaders. And, he announced that HHS has set up an $80 million fund to help states provide coverage to those whose serious illnesses hurt their ability to obtain insurance.

Senator Ted Kennedy (D-MA) repeated his message from last year that the quality of American healthcare relies on the strength of the country’s hospitals and called for the undoing of the harsh and excessive cuts of the past. Kennedy said the issue of adequate funding isn’t resources, it’s priorities.

Minority Whip Steny Hoyer of Maryland, the second-ranking Democrat in the House, citing mounting pressures on hospitals, condemned Medicare reductions recommended by the Medicare Payment Advisory Commission and criticized the House’s recent proposal to cut $93 million from Medicaid. He said that the administration’s proposed changes to Medicaid, including a $93 billion cut over ten years “inevitably will lead to a decrease in services.”

Finally, during a “Congressional Crossfire” session, Sen. Jeff Bingaman (D-NM) and Rep. Henry Waxman (D-CA) suggested that cutting tax revenues by up to $500 billion would divert spending from Medicare. The two agreed that such a measure could be a repeat of the 1997 Balanced Budget Act, with serious payment cuts for hospitals. Republican panelists Sen. Craig Thomas of Wyoming and Rep. Richard Burr of North Carolina disagreed, saying the president’s proposed 10-year, $400 billion Medicare budget could fund a prescription drug benefit for the neediest elderly and ensure adequate provider payments. The panelists also sparred over the president’s plan to revamp Medicaid, with Democrats saying it would send millions of Americans to the ranks of the uninsured. The plan lets states cut service for a third of current recipients and extend coverage to others, in exchange for more federal support.

Tommy Thompson, Secretary of the Department of Health and Human Services (HHS), released the initial quality data from home health agencies on May 1. The data covered home health services provided in eight states and is the first data to be released under an HHS initiative announced in February to help consumers compare home health agencies.

HHS plans to expand the project this fall to the nearly 7,000 Medicare-certified home health agencies nationwide. The eleven measures being reported to the public were selected from 41 Outcomes and Assessment Information Set (OASIS) outcome measures used by home health agencies since 1999. They include measures related to improvement in patient
mobility and mental health, daily living activities, and patient medical emergencies. Data was collected from home health agencies in Florida, Massachusetts, Missouri, New Mexico, Oregon, South Carolina, West Virginia, and Wisconsin. The data is available online at http://www.medicare.gov/HHCompare/Home.asp#NewSearch.

Nurse Reinvestment Act

Department of Health and Human Services’ Health Resources and Services Administration is accepting applications for three grant programs funded by the Nurse Reinvestment Act. The grants will support career advancement and training programs for nursing personnel; internship, and residency programs for nurse graduates and registered nurses; and programs to enhance collaboration and communication among nurses and other healthcare professionals, and promote nurse involvement in organizational and clinical decision-making. Each program will award roughly $3 million in grants in fiscal year 2003. Applications are due by June 6. For more, go to http://www.bhpr.hrsa.gov/grants/default.htm.

EDS, the Arkansas Medicaid fiscal intermediary, began informing hospitals in the state last week that AT&T telephone numbers used for transmitting claims are being disconnected on June 29, 2003 because AT&T is replacing their service. Hospitals that have transmitted claims by dialing (800) 328-2427 or (501) 492-0039 will need to change that number to (866) 627-0017 before June 29, 2003. There will be no capability to transmit claims after June 29, 2003 via the old telephone number. Hospitals transmitting claims through a vendor system must contact the vendor and notify them of the new telephone number. Contact the EDS Provider Assistance Center at (800) 457-4454 or (501) 376-2211 with any questions.

The AHA Calendar

| May 7 | AHA Metropolitan Hospital District, AHA Headquarters, Little Rock |
| 7-9  | SAHPMM (Purchasing/Materials Mgmt.) Annual Meeting and Trade Show, Clarion Resort on the Lake, Hot Springs |
| 8    | AHAA (Auxiliary) Board of Directors, AHA Headquarters, Little Rock |
| 8    | AHA Northeast Hospital District, Crittenden Memorial Hospital, West Memphis |
| 8    | Arkansas Health Executives Forum meeting, Saline Memorial Hospital, Benton |
| 9    | AHA Board of Directors, AHA Headquarters, Little Rock |
| 9    | ASWHC (Social Workers) Spring Conference, Arkansas Children’s Hospital, Little Rock |
| 9    | Discharge Planning Webinar |
| 9    | “So, You’re a Hospital Supervisor – Now What?,” Holiday Inn Select, Little Rock |

Barry Pipkin, chief executive officer of The BridgeWay in North Little Rock, has been promoted to vice president of the Behavioral Health Division of Universal Health Services. Pipkin will maintain responsibility for The BridgeWay as well as the company’s psychiatric hospitals in Kentucky, Louisiana, Georgia, and San Juan, Puerto Rico.