All systems are “go” to begin paying hospitals under the Arkansas Medicaid program’s new inpatient hospital $850 per diem cap. That’s what state Medicaid officials told the Arkansas Hospital Association last Thursday. Governor Bebee signed the final papers last week, paving the way for the increase. Medicaid is notifying affected hospitals their updated interim rates and immediately will begin paying new claims associated with admissions as of July 1, 2006 based on those per diems.

According to the latest information handed down on May 10, Medicaid inpatient claims submitted by affected hospitals with dates of service on or after July 1, 2006 will be paid based on the individual hospital’s reasonable cost, up to the $850 per day limit, using newly determined interim per diem rates and year-end cost settlements. Those hospitals with a current interim per diem reimbursement rate of $675 have been reviewed and new interim rates were loaded as of May 11, 2007. Hospitals with a current interim per diem of less than $675 will have no rate change until the next tentative cost settlement is calculated and determined by Pinnacle Business Solutions, Arkansas’ Medicare fiscal intermediary.

Medicaid will settle retroactively on claims for admissions on or after July 1, 2006 which were previously paid under hospitals’ old rates via a mass adjustment. However, the program must have at least one week of claims history reflecting the updated rates before making those adjustments.

The Medicaid staff is also finalizing plans for distributing hospital incentive payments related to its Inpatient Quality Incentive Payment (IQIP), or pay-for-performance, program. The Arkansas Foundation for Medical Care has identified the hospitals which qualify for the add-on payments of up to $50 per day from among the facilities that chose to participate in the new IQIP program. The state Department of Health and Human Services plans an official announcement about the IQIP on May 22. The incentive payments also apply to claims with dates-of-service on or after July 1, 2006. Adjustments to compensate for balances owed on previously paid inpatient claims at the new interim rates, as well as the IQIP adjustments, will be processed by June 30, 2007.

The Arkansas Hospital Association last week distributed to all member hospital CEOs a summary of Medicare’s Proposed Hospital Inpatient Prospective Payment System Rule for Fiscal Year 2008. The document is also accessible at http://www.arkhospitals.org/hottopics.htm.

Arkansas hospitals stand to lose about $31 million in Medicare payments in FY 2008, despite the fact that most hospitals will receive a full market basket payment update of 3.4%. However, the market basket gains are more than offset by a combination of reductions related to the Medicare Area Wage Index and a 2.4% “behavioral offset” that the Centers for Medicare & Medicaid Services (CMS) included because of fears that adoption of the expanded set of diagnosis related groups (DRG) in the proposed rule would create a risk of increased payments as a result of hospital coding issues.
When the Arkansas Hospital Association met with representatives of the Centers for Medicare & Medicaid Services’ Dallas Regional Office last February, a question was asked regarding Medicare’s revised Condition of Participation (COP) for Patients’ Rights. One of the major changes in the COP is the hospital death reporting requirement. The Regional Office recently distributed additional information regarding specifics that must be included when a hospital issues a death report.

A form with those details has been finalized and is available for hospital compliance officers and others hospital personnel who may wish to review it. Find the form on the Arkansas Hospital Association Web site at [http://www.arkhospitals.org/hottopics.htm](http://www.arkhospitals.org/hottopics.htm). Direct specific questions to Dodjie B. Guioa at the Dallas Regional Office ([Dodie.Guioa@cms.hhs.gov](mailto:Dodie.Guioa@cms.hhs.gov)).

Contrary to comments by the American Hospital Association (AHA) and other groups about the negative effects of such a move, the Centers for Medicare & Medicaid Services’ (CMS) Final Rule governing Long Term Care Hospitals (LTCH) for Fiscal Year 2008 cuts payments to those facilities by $460 million over the next three years by expanding the 25% Rule to all LTCHs, including free-standing, satellite and grandfathered hospital-within-hospitals. Unlike the proposed rule, CMS will implement the expansion by using a three-year transition.

The rule, released May 2, increases the LTCH standard payment by 0.71% to $38,356.45. The update includes a market basket increase of 3.2% and a coding reduction of 2.49%. The high-cost outlier threshold is $22,954, a 54% increase over 2007. Overall, the net impact of the rule is negative 3.8%, a reduction of more than $153 million over 2007 Medicare LTCH payments.

CMS implemented the 25% Rule in 2005 to require that only 25% of admissions to the LTCH can be patients who were previously admitted to the co-located or “host” acute care hospital. For LTCH patients exceeding this 25% threshold, CMS reimburses the LTCH at the lower payment rate for general acute hospitals. It has already caused the closure of one Arkansas LTCH.

While the AHA has supported efforts to more specifically define LTCH patients, the association believes the 25% Rule misses the mark by focusing on the patients’ source of referral rather than their clinical characteristics. Last year, CMS commissioned the Research Triangle Institute (RTI) to identify feasible patient and facility criteria that would help to distinguish LTCHs from other acute care facilities. In commenting on the proposed rule, AHA suggested that rather than moving forward with it at this time, CMS ought to work with the RTI and LTCH providers to develop appropriate facility and patient-centered criteria to determine the types of patients that should be treated in LTCHs.

Skilled nursing facilities (SNF) are due to receive a full market basket update of 3.3% under the Centers for Medicare and Medicaid Services’ (CMS) proposed rule updating the SNF Prospective Payment System (PPS) for Fiscal Year (FY) 2008. The update is rebased on 2004 costs, rather than using the 1997 costs that were used in past years. However, the rebased and revised market basket for FFY 2008 will be 0.2% lower than the market basket under the current methodology. The proposed rule was published in the May 4 Federal Register and comments will be accepted until June 29. To view a display copy of the proposed rule, go to [http://www.cms.hhs.gov/SNFPPS/LSNFF/list.asp#TopOfPage](http://www.cms.hhs.gov/SNFPPS/LSNFF/list.asp#TopOfPage), click on “Show only items whose Year is 2008” and refer to CMS-1545-P.
The newest incarnation of Medicare’s rule covering the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) looks a lot like last year’s model. Since the Centers for Medicare & Medicaid Services (CMS) isn’t making any policy changes for Rate Year (RY) 2008, the rule actually has been issued as a notice to update the RY 2007 rates, therefore, there is no comment period.

In the notice, CMS expresses its intent to raise the inpatient psych facility per diem rate to $614.99 beginning July 1, 2007; to increase the outlier fixed dollar loss threshold to $6,488; and increase the payment for electroconvulsive therapy (ECT) treatment to $264.77. Medicare will continue to use the current Diagnosis Related Group, Rural, Teaching, Variable Per Diem, Age, and Comorbidity Conditions adjustment factors as in RY 2007.

Because the three-year transition period from a reasonable cost-based reimbursement to full prospective payment for IPFs expires in 2008, facilities will be paid 100% of the federal IPF PPS rate starting with cost report periods beginning on or after January 1, 2008. CMS has made no changes to the 70% Stop-Loss provision for RY 2008. The proposed rule appears in the May 4 Federal Register. A display version of the rule is available at http://www.cms.hhs.gov/InpatientPsychFacilPPS/02_regulations.asp#TopOfPage.

The House voted 221-205 on May 10 to pass another emergency supplemental spending bill (H.R. 2206) for the war in Iraq and Afghanistan. The bill retains language included in a previous supplemental spending bill for the war which would place a one-year moratorium on a proposed Centers for Medicare & Medicaid Services (CMS) rule that would cut $4 billion from the Medicaid program, and also would prevent CMS from developing regulations that eliminate payments for graduate medical education under Medicaid. The President vetoed that bill.

The Senate likely will pass its own version of the supplemental legislation, and the two bodies will need to agree on a final bill to send back to President Bush, who has threatened another veto, in part because it includes funds for healthcare and other programs unrelated to the war efforts.

The House Education and Labor Subcommittee on Health, Employment, Labor and Pensions on May 10 heard opposing views from business and labor on legislation (H.R. 1644) that would remove “assigning” and “directing” other staff as two necessary functions that would qualify a charge nurse to be a supervisor under the National Labor Relations Act (NLRA).

Testifying against the bill on behalf of the U.S. Chamber of Commerce, HR Policy Association and Society for Human Resource Management, labor attorney Roger King noted predictions are unfounded that millions of employees would suddenly be reclassified to supervisory status as a result of National Labor Relations Board (NLRB) rulings. Instead, evidence from discussions with various types of employers throughout the country and a review of NLRB case filings shows virtually no employer initiated actions to reclassify employees from non-supervisory to supervisory status under the NLRA.

The Federal Department of Health and Human Services, Agency for Healthcare Research and Quality (AHRQ), has released a DVD titled “Cross Training Respiratory Extenders for Medical Emergencies (Project XTREME)” to train non-respiratory care healthcare professionals, such as physicians, physician assistants and nurses, in providing basic respiratory care and ventilator management to adult patients in any mass casualty event.

A related report also funded by AHRQ, “Project XTREME: Model for Health Professionals’ Cross-Training for Mass Casualty Respiratory Needs,” provides further information on the training model as well as the research and methodologies used in developing it. Among the possible emergencies when such auxiliary clinical help may be necessary are influenza pandemics, bioterrorist attacks involving anthrax or other agents, or outbreaks of severe acute respiratory illnesses.

The DVD includes six training modules with interactive quizzes to test viewers’ knowledge about infection control, respiratory care terms and definitions, manual ventilation (using hand-held bags), mechanical ventilation (using the two types of ventilators included in the Federal government’s Strategic National Stockpile of medicines and medical supplies for emergencies), airway maintenance and airway suctioning. A free, single copy of the DVD and a CD-ROM with the report may be ordered by calling 1-800-358-9295 or by sending an e-mail to ahrqpubs@ahrq.hhs.gov. AHRQ has funded more than 60 emergency preparedness-related studies, workshops and conferences to help hospitals and healthcare systems prepare for public health emergencies. More information about these projects can be found online at http://www.ahrq.gov/prep/.

The Centers for Medicare & Medicaid Services (CMS) has announced plans to post on its Web site the contact information for all Medicare Advantage (MA) Organizations offering Private Fee-for-Service (PFFS) plans. Posting the information would allow Medicare providers to easily access the plans’ terms and conditions of payment, which establish the rules that providers must follow if they choose to furnish services to plan members. The terms and conditions also specify the amounts the plan will pay providers for covered services and the amounts providers are permitted to collect from members. CMS is taking this step in response to provider inquiries and concerns that additional assistance is needed for providers to understand the PFFS program, and specifically how they will be paid.

PFFS plans are required to make their terms and conditions of payment reasonably available to U.S. providers, but it is the provider’s responsibility to obtain the information. CMS hopes its efforts will make that task easier for healthcare providers. The contact information will be posted soon at http://www.cms.hhs.gov/PrivateFeeforServicePlans.

The U.S. Department of Agriculture is making available $62.9 million in distance learning and telemedicine loans, $50 million in loan and grant combinations and $15 million in grants through its Distance Learning and Telemedicine (DLT) Program. The funds are targeted at meeting educational and healthcare needs of rural America through the use of advanced telecommunications technologies. Their specific purpose is to help finance equipment for expanding educational resources in isolated rural areas, including distance learning improvements for both rural Critical Access Hospitals and other key community healthcare facilities.

Applications for the $15 million in distance learning and telemedicine grants must be received by June 8, 2007 and will compete nationally for funding. Applications for loans and

Beginning in June, the Hospital Quality Alliance (HQA) will start displaying hospital-specific mortality data on its Hospital Compare Web site. On May 3, the American Hospital Association (AHA) posted a Quality Advisory concerning the new reports, which will show mortality data for patients who died within 30 days of being admitted to the hospital for heart attack and heart failure. The HQA chose mortality data on these conditions because information already is being reported on the steps hospitals take to treat patients who suffer from two conditions.

These “outcome” measures will be displayed and labeled differently from the current clinical process measures. They will first be “risk adjusted” to account for differences in patients’ conditions that make them more likely to die. Then, the public reports will show hospitals in one of three categories — “as expected,” “better than expected” or “worse than expected” — providing clear, understandable language on what the information reflects.

Because this is an addition to the quality reporting regimen, it is likely to generate interest from people and organizations, including the media within Arkansas communities. Hospitals should be prepared to respond to the inquiries about what the information is and what it means for patient care. The AHA advisory includes suggestions about steps to take in preparing to respond to those questions. To review the Quality Advisory, go to [http://www.aha.org](http://www.aha.org).

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15 Behavioral Interviewing (Mid-Management Certificate Series), Holiday Inn Select, Little Rock
16-18 SAHPMM (Purchasing/Materials Management) Annual Meeting and Trade Show, Clarion Resort, Hot Springs
17 Hospital Emergency Preparedness Forum, Embassy Suites, Little Rock
18 Chargemaster Workshop, Embassy Suites, Little Rock
22 Infant and Pediatric Abduction: Complying with Joint Commission and CMS Standards – Webinar #T2308
23 Nursing Law Update, Holiday Inn Select, Little Rock
24 Implementing Rapid Response Teams Audioconferences: From Teams to Systems – Creating a Reliable Rapid Response System
24 ASWHC (Social Workers) Spring Conference, St. Vincent Infirmary Medical Center, Little Rock
29 Governance Accountabilities and Opportunities in the Quest for Quality (Online Governance Education Program)
31 AFMC Quality Conference: Reaching Greater Heights in Health Care Quality, Statehouse Convention Center, Little Rock
Many thanks go to the lively group of Arkansans who attended the American Hospital Association’s (AHA) Annual Membership Meeting last week in Washington, D.C. In addition to the enjoyable camaraderie, those who trekked to DC this year made the most of their opportunity to do a little politicking about issues important to Arkansas hospitals with the state’s congressional delegation and their aides, and they heard firsthand from a parade of DC pols who gave their personal takes on many of the same subjects.

Sen. Orrin Hatch (R-UT), for example, is not at all happy with the Centers for Medicare & Medicaid Services (CMS). The six-term elder statesman from Utah thinks CMS’ proposed rule to severely curtail the use of intergovernmental transfers for drawing down Federal Medicaid dollars is wrong. Hatch also said that the Senate Finance Committee, of which he is a member, would examine CMS’ proposal to implement $22 billion in Medicare payment cuts in anticipation of coding changes the agency claims hospitals might make under a new severity-adjusted diagnosis-related group system. Unfortunately, he wasn’t optimistic that Congress would be able to agree this year on reforming the physician payment formula, and predicted another freeze at the current rates.

Labor Secretary Elaine Chao’s remarks focused on workforce needs, as expected, but she also zoomed in on the administration’s strong opposition to the Employee Free Choice Act (S. 1041), better known as the “card check” bill. That’s the legislation which would end employees’ long-standing right to a secret ballot union election by allowing unions to represent a work unit if a majority of its workers sign authorization cards in a so-called “card check” process. Chao received an enthusiastic response when she said, “The bill will be vetoed if it is sent to the president.”

A highlight of the meeting occurred when former Federal Reserve Board Chairman Alan Greenspan took center stage for a sit-down interview with PBS’ Susan Dentzer. Their conversation gravitated to Medicare’s long-term financial stability and Greenspan was very candid in predicting that wealthier Americans ultimately will need to pay larger co-payments to keep the Medicare program solvent. In his opinion, the Medicare program is teetering on the edge of a very serious problem.

He expects that the coming retirement of the baby boomers, extraordinary advances in medical technologies and increasing life expectancy will lead to extremely higher Medicare costs at the same time that significantly fewer workers will be paying into the Medicare Trust Fund. Greenspan said that the end result should come as no surprise; simple math tells the tale. He also believes that until Congress addresses the impending Medicare crisis, there should be no move to expand coverage to the uninsured.

Rep. Pete Stark (D-CA), who chairs the Ways and Means Health Subcommittee, will never be mistaken as hospital friendly, but he seems far less a fan of Medicare Advantage plans. He criticized CMS for overpaying the Part C plans by at least $60 billion in the last five years, and said that his subcommittee would more closely scrutinize them this year. Stark also said the government should propose a single health information technology plan and pay providers over several years for implementing it.

Finally, House Ways and Means Committee Chairman Charles Rangel (D-NY) said no issue pending before Congress is more demanding of a bipartisan solution than improving the nation’s healthcare. He said all stakeholders must come together to develop a universal plan for healthcare coverage. Coincidentally, before the final gavel, the AHA presented a five-part “national framework for change” to improve healthcare, which calls for a focus on wellness; encouraging more efficient and affordable care; promoting higher quality care; providing better information; and implementing coverage for all, paid for by all. The AHA Board of Trustees will review the latest version of the framework in July, and the association will continue seeking to build consensus for change guided by the framework’s principles.