The Arkansas Foundation for Medical Care (AFMC) recently honored 28 healthcare facilities, including 20 Arkansas hospitals, with Quality Improvement Awards for their commitment to excellence in healthcare. Some hospitals received awards in more than one category. The awards were presented during AFMC’s 11th Quality Conference, held April 30 at the Embassy Suites Hotel in Little Rock. Hospitals receiving AFMC’s Hospital Quality Achievement Award for progress in one or more of the organization’s hospital quality improvement project areas related to heart attack, heart failure, inpatient pneumonia or surgical infection prevention include:

**Platinum Winners:**
- Sparks Regional Medical Center – Fort Smith
- White County Medical Center – Searcy
- St. Vincent Health System – Little Rock
- Baptist Memorial Hospital – Osceola
- Crawford Memorial Hospital – Van Buren

**Gold Winners:**
- Lawrence Memorial Hospital – Walnut Ridge
- Ozark Health Medical Center – Clinton
- Conway Regional Health System – Conway
- Arkansas Methodist Medical Center – Paragould
- Baptist Health Medical Center – Heber Springs
- St. Edward Mercy Medical Center – Fort Smith
- Baptist Health Medical Center – Little Rock

In addition, 18 hospitals received the Hospital Quality Measurement Award which was presented to hospitals that collect and submit data on AFMC’s inpatient quality improvement projects. They are:

**Platinum Winners:**
- White County Medical Center – Searcy
- Lawrence Memorial Hospital – Walnut Ridge
- Ozark Health Medical Center – Clinton
- Conway Regional Health System – Conway
- Community Medical Center of Izard County – Calico Rock
- St. Vincent Health System – Little Rock
- St. Anthony’s Healthcare Center – Morrilton
- Howard Memorial Hospital – Nashville
- St. Edward Mercy Medical Center – Ft. Smith
- Drew Memorial Hospital – Monticello
- Jefferson Regional Medical Ctr. – Pine Bluff
- CrossRidge Community Hospital – Wynne

**Gold Winners:**
- Sparks Regional Medical Center – Fort Smith
- Baxter Regional Medical Ctr. – Mountain Home
- Arkansas Methodist Medical Center – Paragould
- Baptist Health Medical Center – Heber Springs
- Baptist Memorial Hospital – Osceola
- Baptist Health Medical Center – Little Rock

Eleven hospitals were among the recipients of AFMC’s Innovator Awards, a special recognition for healthcare providers that share innovative and successful strategies and act as mentors. They are Sparks Regional Medical Center, White County Medical Center, Ozark Health Medical Center, St. Vincent Health System, Baptist Memorial Hospital-Osceola, St. Edward Mercy Medical Center, Crawford Memorial Hospital, Arkansas Methodist Medical Center Home Health, White County Medical Center Home Health, and St. Bernards Medical Center Home Health.

The Home Health Quality Achievement Award is given to home health agencies whose patients improve in areas such as “pain interfering with activities” and “improvement in status of surgical wounds.” White County Medical Center Home Health in Searcy won this award. For more information, visit [http://www.afmc.org/quality](http://www.afmc.org/quality).
Most areas in Arkansas will get a boost for their Medicare area wage index (AWI) values for FY 2005, but a majority of hospitals in the state won’t get the benefit of a higher AWI. According to the proposed rule for Medicare’s inpatient prospective payment system that was published last month, eight of the nine Medicare geographic areas covering Arkansas will see higher wage index values beginning October 1. The increases affect only those hospitals located in metropolitan statistical areas (MSAs). The AWI for rural Arkansas, where almost 65% of the state’s hospitals are located, will fall by about 3.25%.

The chart below shows the proposed AWI values for Arkansas as published in the May 26 Federal Register.

<table>
<thead>
<tr>
<th>Geographic Area</th>
<th>FY 2004 AWI Actual</th>
<th>FY 2005 AWI Proposed</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arkansas Rural</td>
<td>0.7703</td>
<td>0.7453</td>
<td>(3.2%)</td>
</tr>
<tr>
<td>Fayetteville-Springdale MSA</td>
<td>0.8362</td>
<td>0.9387</td>
<td>12.3%</td>
</tr>
<tr>
<td>Fort Smith MSA</td>
<td>0.8390</td>
<td>1.0180</td>
<td>21.3%</td>
</tr>
<tr>
<td>Hot Springs MSA</td>
<td>0.7703</td>
<td>1.0997</td>
<td>42.8%</td>
</tr>
<tr>
<td>Jonesboro MSA</td>
<td>0.7777</td>
<td>0.7991</td>
<td>2.8%</td>
</tr>
<tr>
<td>Little Rock-NLR MSA</td>
<td>0.8887</td>
<td>1.0206</td>
<td>14.0%</td>
</tr>
<tr>
<td>Memphis MSA</td>
<td>0.8973</td>
<td>1.0561</td>
<td>17.7%</td>
</tr>
<tr>
<td>Pine Bluff MSA</td>
<td>0.7855</td>
<td>1.0009</td>
<td>27.4%</td>
</tr>
<tr>
<td>Texarkana MSA</td>
<td>0.8117</td>
<td>0.8432</td>
<td>3.9%</td>
</tr>
</tbody>
</table>

The proposed rule indicates a single national hospital base PPS rate as required by the Medicare Modernization Act of 2003 rather than one base rate for hospitals in large urban areas of the country and another for all other hospitals. The national base rate of $4,561.32 is adjusted up by 3.3% from FY 2004, reflecting a full inflation-based increase for the year for hospitals that comply with the act’s quality reporting requirements. Other hospitals receive a base rate of $4,543.67. That 2.75% jump is based on a full market basket increase minus 0.55%.

Composition of the base rate also changes for hospitals in areas with AWI values of 1.0 or less. The labor-related part of their Medicare rate is lowered, allowing them to keep a bigger percent of their base payment.

<table>
<thead>
<tr>
<th>Component</th>
<th>Full Update (3.3%)</th>
<th>Reduced Update (2.75%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labor-Related</td>
<td>$3,243.10</td>
<td>$3,230.55</td>
</tr>
<tr>
<td>Non-Labor Related</td>
<td>$1,318.22</td>
<td>$1,313.12</td>
</tr>
<tr>
<td>Total</td>
<td>$4,561.32</td>
<td>$4,543.67</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Component</th>
<th>Full Update (3.3%)</th>
<th>Reduced Update (2.75%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labor-Related</td>
<td>$2,828.02</td>
<td>$2,817.08</td>
</tr>
<tr>
<td>Non-Labor Related</td>
<td>$1,733.3</td>
<td>$1,726.59</td>
</tr>
<tr>
<td>Total</td>
<td>$4,561.32</td>
<td>$4,543.67</td>
</tr>
</tbody>
</table>

The capital standard federal payment rate for FY 2005 is proposed to be $416.59.
Medicare payments for home health services will increase by 2.5% in fiscal year 2005 under new limits proposed in the June 2 issue of the Federal Register. The proposed home health rule increases total Medicare home health payments by $270 million in 2005 and the national 60-day episode payment rate is to climb from $2,213.37 to $2,268.70. In addition, the Centers for Medicare & Medicaid Services (CMS) is required under the Medicare Modernization Act of 2003 to raise payments for services in a rural area by 5% for episodes and visits ending on or after April 1, 2004. That change adds another $20 million to Medicare home health payments through December 31, 2004.

The rule is available online at http://www.cms.hhs.gov/providers/hha. Comments are due August 2.

The Office of Inspector General (OIG) for the Department of Health and Human Services published in the June 8 Federal Register a draft supplement to its Compliance Program Guidance (CPG) for hospitals. According to the OIG, the guidance will supplement, rather than replace, its 1998 CPG, which addressed the fundamentals of establishing an effective hospital compliance program. It said the new guidance takes into account recent changes to hospital payment systems and regulations, evolving practices, current enforcement priorities, and lessons learned in the area of corporate compliance.

Areas addressed include submission of accurate claims and information; the referral statutes; payments to reduce or limit services; the Emergency Medical Treatment and Active Labor Act (EMTALA); substandard care; relationships with federal healthcare program beneficiaries; HIPAA privacy and security rules; and billing Medicare and Medicaid substantially in excess of usual charges.

The OIG emphasizes that neither the supplemental guidance nor the original 1998 guidance is intended as a model program, but that the two documents collectively offer a set of guidelines that hospitals should consider when developing and implementing a new compliance program or evaluating an existing one. Comments on the draft guidance will be accepted through July 23.

See http://a257.g.akamaitech.net/7/257/2422/06jun20041800/edocket.access.gpo.gov/2004/pdf/04-12829.pdf to read the draft supplement.

Earlier this year, the Centers for Medicare & Medicaid Services (CMS) began investigating Medicaid upper payment limit (UPL) programs and the use of intergovernmental transfers (IGTs) to draw down federal Medicaid dollars in several states, including Arkansas. The move was part of a Bush Administration attempt to curb or eliminate the two types of mechanisms for securing supplemental Medicaid funding. The White House also had hoped to get changes in the IGT policy included as part of the FY 2005 Federal Budget Proposal, but that failed.

On April 28, CMS administrator Mark McClellan sent a letter to Sen. Charles Grassley (R-IA) implying that CMS will be denying federal match for payments financed with IGTs, which are legal under current law and regulations. That letter spurred a response from National Association of Public Hospitals and Health Systems (NAPH) president Larry Gage, who questioned the agency’s ability to implement the new policy. Gage argued that the policy, which restricts a state’s use of IGTs and certified public expenditures to finance
Medicaid services, can’t be valid without undertaking the public rulemaking processes required by law.

Gage told McClellan that CMS’ new policy fails to recognize that funds held by a public entity are public funds, regardless of whether they were earned by reimbursement received for services provided or through subsidies granted from taxpayer funds. He added, “State government budgets are barely managing to keep abreast of the ever-growing costs of providing Medicaid coverage, and many simply will be unable to foot the bill to replace the non-federal share of additional support payments such as DSH for safety net providers to the extent that CMS is disallowing IGTs.”

One of the most challenging parts of effective hospital management is ensuring compliance with the reams of rules and regulations that govern the healthcare field. That’s especially true when those rules involve the Emergency Medical Treatment and Active Labor Act (EMTALA). Congress recognized that challenge and attempted to offer some much needed assistance through the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).

To meet the act’s requirements, the federal Centers for Medicare & Medicaid Services (CMS) has announced that it will establish a Technical Advisory Group (TAG) to review hospital regulations and responsibilities under EMTALA. The TAG will assist CMS in the development of rules that will help protect patient rights while minimizing burdens on hospitals and physicians. The group will consist of 19 members, two of whom must be agency officials. The remaining members will be appointed by the Secretary of Health and Human Services from nominations submitted by interested parties.

The advisory group is also required to have at least two patient representatives, two CMS regional office staff members who have been involved with EMTALA complaint investigations, seven practicing physicians in the fields of emergency medicine, and one representative from a state survey agency involved in EMTALA investigations.

The Federal Communications Commission (FCC) on June 8 issued an extension of up to 30 days on the freeze on licensing of high-powered private land mobile radio service users in the 460-470 MHz band. The FCC indicated it would extend the freeze in a meeting last week with the American Hospital Association (AHA) and its American Society for Healthcare Engineering (ASHE). The groups have been working with the FCC to protect hospitals — many of which use wireless medical telemetry equipment that operates in this bandwidth — as they make the transition to the frequencies set aside for wireless medical telemetry in 2000.

Many hospitals have been unable to move into the dedicated spectrum due to financial constraints and a lack of equipment on the market. AHA and ASHE officials have argued that allowing higher-powered users to operate in the 460-470 MHz band now could result in interference with those radio signals, creating a potential threat to patients’ safety. Their efforts resulted in a six-month freeze beginning last October and a 60-day freeze, which was issued in April. The AHA will continue to push for a longer extension into 2005 so that hospitals have additional time to transition into the dedicated Wireless Medical Telemetry Service spectrum.
Healthcare Spending Rate Dips

Healthcare spending growth slowed for the second consecutive year in 2003, according to a study released June 9 by the Center for Studying Health System Change. Total healthcare spending per privately insured person rose 7.4% in 2003, slowing from 9.5% in 2002 and 10% in 2001. Spending on hospital inpatient services rose 6.5%, slowing from 8.4% in 2002, while spending on hospital outpatient care rose 11%, slowing from 12.9% in 2002. The authors said the decline in spending for hospital services reflected a slowing in hospital utilization growth from higher than usual growth in 2001 and 2002. Go to http://www.hschange.org/CONTENT/680 to read the study.

Awards To Honor Healthcare Professionals

Cherokee Uniforms, designer and manufacturer of healthcare apparel, is accepting nominations for its 2004 Cherokee Inspired Comfort Award through June 30, 2004. Individuals are encouraged to nominate nurses and other non-physician healthcare professionals in four categories who, through exceptional service, sacrifice and innovation, have profoundly impacted the lives of others.

Now in its second year, the Cherokee Inspired Comfort Award was developed to acknowledge the expertise, dedication and compassion that nurses and non-physician healthcare professionals demonstrate through their work. This award program raises public awareness of these vocations by putting the winners’ extraordinary accomplishments in the spotlight. Cherokee will announce the winners nationally in September 2004.

The 2004 winners will come from four categories: Registered Nurses (RNs), Licensed Practical Nurses/Licensed Vocational Nurses (LPNs/LVN), Student Nurses and other non-physician healthcare professionals. Candidates may be nominated in two categories but only may win in one. Submission forms and guidelines are available at Cherokee Uniforms’ website, http://www.cherokeeuniforms.com.

The AHA Calendar

June 2004

16 AHA Board of Directors, Chateau on the Lake, Branson, MO
16-18 Administrators Forum Summer Leadership Conference, Chateau on the Lake, Branson, MO
17 Patient and Family Relationships, Holiday Inn City Center, Fort Smith
22 Intermediate ICD-9 Coding Workshop, Embassy Suites, Little Rock
23 Intermediate CPT Coding Workshop, Embassy Suites, Little Rock
23 Staffing Services Program, Holiday Inn Select, Little Rock
24 Staffing Services Program, Holiday Inn Northwest, Springdale

Editor’s Note: The Arkansas Hospital Association (AHA) will hold its Summer Leadership Conference June 16-18 at Chateau on the Lake in Branson, MO. The Notebook will not be published June 22. The next issue of The Notebook will be June 29.
The newly proposed rule governing Medicare’s inpatient prospective payment system (PPS) for the 2005 fiscal year is one of those Good News/Bad News things for Arkansas hospitals. A quick glance at the rule as proposed in the May 26 Federal Register reveals that our hospitals should fare comparatively well next year. They get a full market basket update for their base payment, if they submit the required quality information. Area wage index (AWI) values for practically all of the state’s Medicare-designated geographic areas will go up, some substantially. And, the AWI values, which are meant to reflect regional differences in pay scales, will be greater than 1.0 in more than half the geographic areas, including a new Arkansas urban area. That’s a first.

The news is especially good for hospitals located in Hot Springs. In June 2003, the Office of Management and Budget and the U.S. Census Bureau announced the creation of 49 new MSAs nationwide, including one for Hot Springs, or, more precisely, Garland County. The MSA designation will help that county in numerous ways, including improved Medicare reimbursements for hospital services delivered there. The proposed rule recognizes the new MSA and assigns it a wage index value of 1.0997, the highest value for any area of the state. That compares with a 0.7703 AWI that the Hot Springs hospitals get as rural Arkansas facilities for fiscal 2004.

Now, the bad news: Despite the AWI increase for most Arkansas geographic areas, most hospitals, which are located in rural parts of the state, will get a lower wage index value. Removing the Hot Springs hospitals from the mix of facilities used to calculate the rural wage index is a major reason why that value is about to slide back to 0.7453, a drop of about 3.25%.

Arkansas’ rural wage index hasn’t been that low since FY 2001, when it was 0.7445. A wage index value of less than 1.0 adjusts the labor portion of a hospital’s Medicare PPS base payment downward, reducing reimbursements and making it more difficult for hospitals with the low AWI values to pay the wages and salaries necessary to compete in regional and national markets for qualified healthcare workers.

The proposed rule, which has an October 1 effective date, does incorporate some provisions of the Medicare Modernization Act of 2003 (MMA) that should help ease that pain a little. One is the continuation of a single base payment for all hospitals at a level previously reserved only for facilities on large urban areas like New York or Los Angeles. The single rate was in place for most of FY 2003 as a result of intense hospital lobbying, but would have reverted to two separate rates, if not for the MMA.

The $4,561.32 base rate is an increase of 3.3% over FY 2004, reflecting a full inflation increase for the year. That payment rate will apply to hospitals complying with the MMA’s quality reporting requirements. According to the Arkansas Foundation for Medical Care, the state’s Quality Improvement Organization, practically all Arkansas hospitals are poised on the verge of submitting their quality data and should get the full update. Hospitals that do not report their data receive a base rate of $4,543.67, about a half-percent less than the full market basket increase.

Plus, hospitals in areas having an AWI less than or equal to 1.0 get an added bonus of a lower labor-related component of their base rate. Lowering the labor-related payment makes the portion of the base rate that is subject to further reduction due to a low AWI a bit smaller and lets those hospitals keep more of the base payment. It sounds complicated, and it is. The end result is that it will help to restore some of the payments rural hospitals will lose due to their new wage index value.

**Final Thoughts**