The Arkansas Hospital Association’s ad hoc Medicaid Quality Indicator Committee, which was formed to assist state Medicaid officials in developing metrics and standards for a Medicaid pay-for-performance (P4P) program, held its second meeting on June 7. The Arkansas Department of Health and Human Services included plans for the P4P program in the State Medicaid Plan (SMP) amendment that it submitted in March to allow for an increase in the inpatient hospital per diem cap. The Centers for Medicare & Medicaid Services (CMS) later asked for additional information on the quality measures to be used and how hospitals would qualify for the incentive payments of up to $50 per day.

Before responding to the questions, Medicaid sought input from hospitals, which spurred a need for the committee. During its initial meeting May 24, the group decided that Medicaid’s P4P program should focus on a subset of the quality measures. Those measures were reported in the May 31, 2006 issue of The Notebook.

The committee also agreed at the time that clinical data on Medicaid patients will be obtained from the National Medicare Data Warehouse, where hospitals submit the all-payer data for the Hospital Quality Alliance, and that qualifying thresholds for the incentive payments should be based on 3rd and 4th quarter data for 2005. Data validation will be based on a review of 10 pertinent Medicaid charts from each submitting hospital, with the expectation of 80% accuracy in the abstraction and submission process. Reconsideration requests concerning the validation will be handled by AFMC.

The June 7 meeting focused on how to measure compliance and what thresholds will signal qualification for the initial incentive payments. The proposed SMP amendment specifies that a hospital must meet the clinical performance threshold for two-thirds of the metrics, which means five or more of the seven measures. The group reached agreement on the following compliance issues:

- Medicaid will allow hospitals to qualify in two ways: (a) by performing in the last two quarters of 2006 at or above the rate marking the state 75th percentile for the measure, based on the 3rd and 4th quarters of 2005; or (b) by demonstrating a year-to-year 25% reduction in failure rate for the measure to reflect absolute improvement in performance.

- Hospitals will be able to combine the two compliance methods to reach the requirement of complying with standards on two-thirds of the measures. In other words, they will be allowed to qualify on some measures under method (a) and on others under the method (b).

For the first year, hospitals will qualify for the incentives based on six months of clinical data (July-December 2006). In following years, the incentives will be based on compliance with the standards as determined with data for the calendar year (January-December). Clinical thresholds and selection of performance measures will be decided by October of the year prior to the start of the measurement.

Medicaid officials will include these details in the formal response to CMS, which then must approve the full SMP amendment for the increased per diem cap and the P4P component.
Clinical Lab Exemption Expiring

An expiring provision of the Medicare Modernization Act (MMA) of 2003 could cause many hospitals to pay extra for their clinical laboratory services. Independent laboratories have been exempted for several years from a federal policy that would require them to bill hospitals rather than Medicare. This exemption, originally granted in 2000, was most recently extended under Section 732 of the MMA, but it will end as of December 31, 2006, unless it is renewed.

After that date, pathologists will no longer be able to bill Medicare for the technical component (TC) of the lab services they provide for hospitals, and must bill the hospital instead. Without the exemption, these services would be subject to the Medicare prohibition against unbundling provisions, which require hospitals to provide directly, or under arrangement, all services furnished to hospital patients and bill Medicare for these services. So, if a specimen (such as blood, urine or tissue) is taken from a hospital patient, the TC of the diagnostic test must be billed by the hospital.

If the patient is an outpatient, then only the hospital could bill Medicare for these TC services. For inpatients, the TC would be included in the DRG rate, so the hospital receives no additional money for these services. The hospital then would have to pay the pathologist out of the Medicare payment it receives for either inpatient or outpatient care.

The burden would fall especially hard on rural hospitals that rely on clinical laboratories for surgical pathology services. They would either need to bring these services in-house, or revise their contracts with independent labs to pay directly for their TC services.

The American Hospital Association (AHA) met with the College of American Pathologists in late May and is scheduling meetings with lawmakers and their staffs to discuss getting the provision extended. The AHA would like to again pursue a permanent extension for these arrangements. If they can’t get it, then extending the exemption for a certain number of years would be the fallback.

Arkansas Gero-Psych Payment Glitch

Arkansas hospitals that offer Medicare gero-psych services will soon receive letters from Pinnacle Business Solutions (PBS), the state’s Medicare Fiscal Intermediary (FI), about the possibility of erroneous payments for those services over the past several months. The problem dates back to January 1, 2006, when Medicare changed to a prospective payment system for inpatient psychiatric services.

The Arkansas Hospital Association learned last week that some hospitals may have been overpaid for the services since that date. Others may have received less than they should have. PBS is in the process of contacting each facility to notify them of the problem. If recoveries are necessary, the FI will work with the hospitals to minimize the number and the amount it will need to compensate for the overpayments. Whether or not a hospital was overpaid will be determined as the FI reviews a hospital’s interim rates. The problem should affect only hospitals for which PBS is the Medicare FI.

Medicaid Eligibility Policy Change

Beginning July 1, people seeking Medicaid eligibility will be required to furnish proof of citizenship. The mandate was a part of the 2006 federal immigration policy changes included in a law signed by President Bush in February. The new Act adds teeth to existing federal legislation that says a person must be a citizen to receive Medicaid benefits, except when needing emergency care. Until now, most states have accepted a signed declaration as proof
of U.S. citizenship and 46 states operate their Medicaid programs under that practice. However, the White House has informed them that the attestation will no longer be allowed. The new law will impact Medicaid applicants and recipients. The State of Arkansas is working on a draft compliance policy. It is expected that the vast majority of people can be verified via an Arkansas birth certificate, which should be available through the Division of Health. If born in another state, the record ought to be on file with the Social Security Administration. However there will no doubt be some for whom it will be difficult or impossible to verify citizenship. Once verification is completed, it will not need to be done again until everyone is reevaluated.

All About Arkansas

(Blytheville) Great River Medical Center (GRMC) has broadened the service capabilities of its Nuclear Medicine Department with the addition of a new gamma camera. The new equipment will allow GRMC to perform cardiac stress tests, bone scans, pre-surgery gallbladder scans, and will yield better images from thyroid scans.

(Dumas) Delta Memorial Hospital (DMH) will hold an open house for its new hospital facility on Saturday, June 17. Patients will begin moving into the new Critical Access Hospital at its highly visible location on Highway 65 the following day. The new facility combines previously disjointed patient services into efficient modules, improving patient flow, privacy and satisfaction. Mark Deal, president and CEO of DMH, informed the AHA last week that a formal Grand Opening will take place on July 22 from 1:00 to 2:30 p.m.

(Jonesboro) NEA Medical Center is now operating a new emergency room. The hospital recently completed a 4,000 square-foot renovation project that added two treatment rooms and a larger waiting area. The additional space will allow physicians to see more patients seeking urgent care and the new treatment rooms are especially designed and prepared for cardiac response.

The AHA Calendar

June 2006
14 AHA Board of Directors, Chateau on the Lake, Branson, MO
14-16 Arkansas Hospital Administrators Forum Summer Leadership Conference, Chateau on the Lake, Branson, MO
20 Audio Conference: Basics of Appealing Denials for Inpatient Facilities
26-27 careLearning Users Meeting, Kansas City Airport Marriott, Kansas City, MO
30 Audio Conference: The 411 on 855s: The New Provider Enrollment Rules and the Revised CMS 855 Forms

Editor's Note: The Arkansas Hospital Association will hold its Summer Leadership Conference June 14-16 in Branson, MO. The Notebook will not be published June 20. The next issue of The Notebook will be June 27.
When the Centers for Medicare & Medicaid Services (CMS) released the proposed rule governing Medicare’s Inpatient Prospective Payment System for Fiscal Year (FY) 2007, it emphasized the fact that the rule represented the first significant revision of Medicare’s Inpatient Prospective Payment System (IPPS) since its implementation in 1983. Among the more typical annual tweaks, CMS wants to alter the way it calculates DRG weights in FY 2007 and then move to an entirely new patient classification system beginning in FY 2008. CMS noted that the proposed changes were meant to more accurately reflect hospitals’ costs and to prevent excessive payments for low-severity patients receiving certain types of care. It also stressed that the reforms could aide rural hospitals that often must offer a range of low-profitability services. After reading those intents, hospital officials in many rural states probably loosened their collars, gulped heavily and felt a little like Fredo Corleone, in *The Godfather, Part II*, after brother and Family Don, Michael, kissed him on the cheek. What lay beneath their quizzical looks was the collective thought, “Uh-oh, this can’t be good.”

Following release of the proposed rule, the American Hospital Association, the Federation of American Hospitals and the Association of American Medical Colleges got together and agreed to jointly sponsor an impact analysis so that all are on the same page concerning the proposed changes, which are budget-neutral and add no new money to the system. The study, recently completed by The Moran Co., shows that 30 states would suffer net losses next year as a result of the redistribution of Medicare payment dollars.

As you might expect, most of the “loser” states are located in the Southeast and Midwest parts of the country, although a couple of heavily populated states in the Northeast also stand to lose hefty amounts. And, yes, a large majority of them are rural states, including Arkansas, where hospital losses are estimated to be about $25 million. Those dollars are critical for supporting the healthcare infrastructure in a small rural state like Arkansas.

Although the Moran study certainly isn’t flawless — numbers are based on Medicare’s existing rather than new software that groups patient diagnoses into DRG classifications — it’s probably the most reliable information available for use in assessing what CMS’ plans are. For Arkansas, those numbers show most hospitals would actually do well under the proposed new DRG weights, but they stand to lose ten times as much once a new patient classification system is in place. While not every Arkansas hospital would wind up in the “loser” category after combining the two major changes, about 60% could suffer losses of more than 1% in total payments, and only a few might see gains of more than 1%.

The same scenario is played out in many other states. Too many. So the American Hospital Association last week submitted a 61-page set of comments detailing its concerns about the proposed rule and making several recommendations. Many state, local and regional hospital associations, including the Arkansas Hospital Association, followed suit with their own comment letters saying that after 23 years, it’s definitely time to incorporate meaningful improvements into the Medicare IPPS. However, to accomplish that goal, CMS should work in cooperation with hospital groups to include refinements which will provide an equal incentive to treat all types of patients and conditions.

Generally, the letters advocate a one-year delay in the proposed DRG changes, revising CMS’ proposed DRG-weighting methodology, better demonstrating why a new DRG classification system is needed and if so, then implementing it simultaneously with the new weighting system to provide better predictability and reduce the volatility created by these two, generally off-setting changes and adopting a three-year phase-in for any DRG-related changes.

Clearly, the middle-aged IPPS needs an injection of much-needed improvement. While the hospital community would like to trust that CMS could do the right thing to make it happen, most likely it’ll take commitment by both groups to work together to ensure a positive outcome. Without those checks and balances, too many hospitals could find themselves ending up like Fredo Corleone, sleeping with the fishes rather than living to fish another day.