Arkansas hospitals have dramatically improved their national ranking in the care of Medicare patients, according to a recent analysis of new data by the Arkansas Foundation for Medical Care (AFMC). In its study, the AFMC found that Arkansas hospitals worked their way from 49th in the country in 2000-2001 to 35th at the end of 2004 based on 20 quality measures focusing on management of pneumonia, heart attacks, heart failure and surgical infection prevention for patients covered under the Medicare program. The ranking is based on data from 50 states plus the District of Columbia and Puerto Rico.

AFMC works with hospitals across the state to increase the number of patients who receive important aspects of care. The new analysis revealed that Arkansas has shown considerable improvement on most of the 20 measures which are tracked.

The state’s performance improved the most in the area of community-acquired pneumonia. For instance, ideally all patients with pneumonia should be assessed to see if they are due for a flu shot. In late 2000, only 5% of hospitalized Medicare patients were assessed for flu immunization status and immunized appropriately. By 2004, the rate had risen to more than 45% — higher than the national average of 43.4%. The percentage of pneumonia patients who received an antibiotic within four hours of arrival increased from 62.7% to 76.6% — compared to the national rate of 70.5%.

However, Arkansas hospitals did not fare as well on most of the indicators related to heart attack (acute myocardial infarction, or AMI). The percentage of patients receiving aspirin on arrival — long considered standard, life-saving care — rose from 75.3% to 81.2%. The national average is 88.4%.

“Arkansas hospitals have made impressive progress, and I am confident we will see more in the future,” said Dr. William E. Golden, AFMC’s vice president for clinical quality improvement. “They have embraced quality improvement as fundamental to modern medical care and, as a group, have jumped over the performance of peers in other states. AFMC will continue to work with Arkansas hospitals and other health providers to implement systems changes that make care safer and consistent with current clinical science.”

By a 52-47 vote on November 3, the Senate passed its budget reconciliation bill for fiscal year 2006 that would trim an estimated $36 billion from federal budget deficits which are forecast at $1.6 trillion over five years. The cuts total $6 billion for fiscal year 2006 which began October 1, 2005. The bill includes the following provisions affecting the Medicare and Medicaid programs:

- Two-year extension of the 50% threshold for inpatient rehabilitation hospitals to qualify as such for Medicare payments.
- One-year extension of the outpatient “hold harmless” provision for Sole Community Hospitals and rural hospitals with fewer than 100 beds; and rebasing and extension of the Medicare Dependent Hospital program until 2011.
• A permanent ban on physician self-referral to new limited-service hospitals.
• Increasing by at least 90,000 the number of visas available for foreign nurses and other healthcare professionals in short supply in the U.S.
• No direct hospital cuts in Medicare.
• Medicaid reductions that do not adversely impact hospitals or beneficiaries.

The House, whose budget committee approved a $54 billion deficit-reduction bill of its own November 3, is scheduled to vote on those budget measures this week. The committee bill includes a provision that would cut hospital emergency department care by at least $60 million over the next five years.

Arkansas Senators Blanche Lincoln and Mark Pryor informed the Arkansas Hospital Association November 2 of their intentions to vote against the budget bill. Both indicated that they continue to support hospital provisions found in the bill and are co-sponsoring stand-alone bills which address many of the bill’s items that hospitals have fought to attain. However, both senators said they opposed other provisions in the budget package which contains about $35 billion in new spending to go along with the cuts. Democrats generally opposed the bill because it increases the deficit when coupled with a $70 billion tax cut bill.

Once the House approves its bill, the budget reconciliation process will begin to blend the two bills into one. It is important that hospitals stay focused and vocal about the need to keep the Senate’s provisions as part of that final budget.

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CMS Patient Feedback Survey

The Centers for Medicare & Medicaid Services last week released for public comment its final Hospital HCAHPS survey instrument, the first national survey to collect uniform patient feedback on hospital care. The American Hospital Association (AHA)-backed survey will be implemented in 2006 as part of the Hospital Quality Alliance (HQA), the public-private collaborative whose members include the AHA and other key national stakeholders. CMS published the survey in the November 7 Federal Register and will accept comments through December 7.

Participation by hospitals will be voluntary, and results ultimately will be publicly reported on the Department of Health and Human Services’ Hospital Compare Web site. More information on the HCAHPS survey and on HQA is available at the CMS Web site, [http://www.cms.hhs.gov](http://www.cms.hhs.gov).

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AHA Advisory Covers JCAHO Plans

In a November 3 quality advisory, the American Hospital Association (AHA) zeroed in on three serious concerns about the Joint Commission on Accreditation of Healthcare Organization’s (JCAHO) plans to become a “purveyor of performance data analysis for a variety of purposes.” The AHA is particularly concerned about the JCAHO’s plans to seek patient level data from hospitals and use it in a way unrelated to accreditation. The AHA believes that the JCAHO plan raises Health Insurance Portability and Accountability Act (HIPAA) compliance issues.

Additionally, the AHA said that the new data-mining move is a duplication of the Hospital Quality Alliance effort and a conflict of interest. In the advisory, the AHA promised the field it would seek guidance from HHS on the privacy issues and would keep up pressure on the Joint Commission to end its sale of data analyses to third parties. In addition, the AHA has asked the Office for Civil Rights (OCR) to get involved and respond quickly with guidance.
that it requested to help hospitals deal with the HIPAA compliance issues. OCR is the agency within the Department of Health and Human Services specifically responsible for HIPAA enforcement. In its request, the AHA described hospitals’ concerns about providing patient level data as the JCAHO would require. “We stressed to OCR officials that patient privacy should not be treated as an afterthought,” said Don Nielsen, M.D., AHA’s senior vice president for quality leadership.

Hospital concerns and precise requests made to OCR are detailed in a legal memo drafted by outside counsel and available on AHA’s Web site, http://www.aha.org, under “What’s New.”

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**CMS Physician Reporting Initiative**

The Centers for Medicare & Medicaid Services (CMS) announced on October 31 a voluntary quality reporting initiative for physicians which could be a first step to a Medicare pay-for-performance program for doctors. The initiative starts in January with 36 quality measures developed by the American Medical Association, the National Quality Forum and other groups. More measures will be phased in during 2006.

The agency said the data will be for its use and physicians’ and will not be made available to the public. Hospitals already receive additional Medicare payments for reporting data to the CMS, and the agency has begun a pay-for-performance demonstration project involving large medical groups. The CMS announcement did not address additional reimbursement for physicians who report the data under the latest initiative. CMS said the initiative is part of its ongoing effort with Congress to make sure Medicare is paying doctors adequately without increasing overall program costs.

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**Medicare FY 2006 OPPS Final Rule**

The Centers for Medicare & Medicaid Services has released its 2006 Outpatient Prospective Payment System (OPPS) final rule, applying a full 3.7% market basket update, which, together with other changes in the rule mandated by the Medicare Modernization Act (MMA), will result in average payment increases of about 2% to urban hospitals and 3.9% to rural hospitals. As required by the MMA, the rule ends “hold harmless” payments for small rural hospitals and rural sole community hospitals (SCHs), however it provides an adjustment to rural SCHs that will increase payments by 7.1% in 2006.

The rule continues the decline in coinsurance rates Medicare beneficiaries will pay for many hospital outpatient services. Prior to the implementation of the OPPS in August 2000, the beneficiary often paid more than 50% of the total payment to the hospital for a service. Coinsurance rates for OPPS services are being reduced gradually until the beneficiary’s share for any outpatient service will be 20% of the hospital’s total payment. Under the final rule, the coinsurance rate for 31 additional medical and surgical Ambulatory Payment Classifications (APCs) will decline to the 20% minimum, a 21% increase in the number of APCs at the 20% coinsurance level over calendar year (CY) 2005.

It also reduces the maximum coinsurance rate for any service to 40% of the total payment to the hospital for the APCs in 2006, down from 45% this year. Overall, average beneficiary co-payments for all outpatient services are expected to fall from 33% of total payments in CY 2005 to 29% in CY 2006. This represents a decline in beneficiary liability of more than $400 million from the CY 2005 OPPS to the CY 2006 OPPS. The final rule sets the outlier threshold at $1,250 for 2006. Outlier payments are intended to partially compensate hospitals for certain high cost services. To be eligible for an outlier payment, the estimated costs for a service must be greater than 1.75 times the payment amount for the APC and greater than the
The changes to the payment rates and increased volume of services contribute to an overall increase in projected payments to over 4,200 hospitals for Medicare outpatient services of $27.6 billion in 2006 compared to projected payments of $26.2 billion in 2005, an increase of 5.2%.


The federal government should develop a nationwide patient authentication standard that protects individuals’ information and lead an effort to offer financial incentives to providers in order to foster the electronic exchange of health information and to create a system of instantly accessible health records for all Americans, according to two key recommendations released October 25 by the Commission on Systemic Interoperability (CSI).

In all, the Commission, which formulated its recommendations around the tenets of adoption, interoperability and connectivity, pinpoints a total of 14 steps for creating a connected system of instantly accessible health records for every American. Such a system would lead to dramatic improvements in patient safety, quality of care, convenience, satisfaction and health while helping to rein in soaring healthcare costs.

In their report, Ending the Document Game: Connecting and Transforming Your Healthcare through Information Technology (http://endingthedocumentgame.gov/PDFs/Recommendations.pdf), the 11 commissioners focused on giving people the information they need to make wiser decisions about their healthcare and helping consumers understand how electronic records and other technology are critical to achieving that goal. The CSI also calls on government to “act with urgency to revise or eliminate regulations” that impede implementation of interoperable electronic health records, most notably the Physician Self-Referral (Stark) law and the Federal Anti-Kickback Law.

The AHA Calendar

November 2005

8  Audio Conference – Physician Relations: Basics to Improved Quality & Strategic Success – Successful Engagement of Busy Clinicians for Patient Centered Care
9  “CMS Revised Hospital Conditions of Participation: What Every Hospital Needs to Know” Workshop, Holiday Inn Select, Little Rock
10 AHAA (Auxiliary) Board Meeting, AHA Headquarters, Little Rock
10  Audio Conference – Establishing an Effective Hospital Staffing and Productivity Culture 2005 – Toolbox for Labor Cost
10-11 SAHPMM (Purchasing/Material Management) Fall Education Seminar, UAMS Campus, College of Public Health, Education Building III, Little Rock
11  AHA Board of Directors Meeting, AHA Headquarters, Little Rock
14  Audio Conference – Understanding and Assessing the AOA/HFAP Accreditation Process: Making the Switch from JCAHO to HFAP, Customer/Hospital Perspective
15  Audio Conference – Physician Relations: Basics to Improved Quality & Strategic Success – Masquerade or Masterpiece: The Quality Challenge
17  Audio Conference – Establishing an Effective Hospital Staffing and Productivity Culture 2005 – Staffing and Scheduling Tips and Tricks