The 2013 Legislative Session (and How it Could Affect Hospitals)

Lessons Shared by States: Hospitals Impacted by Recent Storms
get well connected

Arkansas Blue Cross and Blue Shield. A knowledgeable
connector of people, physicians and health-care places. Today,
health care isn’t just about illness or insurance. It’s about people
— caring about them, informing them, advising them, pointing
them in the right direction and helping them get there.

One way we keep physicians and patients connected is through
a Personal Health Record (PHR), available for each Arkansas
Blue Cross, Health Advantage and BlueAdvantage Administrators
of Arkansas member. A PHR is a confidential, Web-based,
electronic record that combines information provided by the
patient and information available from their claims data.

A PHR can help physicians by providing valuable information
in both every day and emergency situations.

To request access, contact PHR Customer Support at
501-378-3253 or personalhealthrecord@arkbluecross.com,
or contact your Network Development Representative.

Personal Health Records are good for our members, your patients and
Arkansas Hospitals

is published by
Arkansas Hospital Association
419 Natural Resources Drive • Little Rock, AR 72205
501-224-7878 / FAX 501-224-0519
www.arkhospitals.org

Beth H. Ingram, Editor
Nancy Robertson Cook, Managing Editor

BOARD OF DIRECTORS
Larry Morse, Clarksville / Chairman
Doug Weeks, Little Rock / Chairman-Elect
David Cicero, Camden / Treasurer
James Magee, Piggott / Past-Chairman
Scott Street, Rogers / At-Large
Peggy Abbott, Camden
Chris Barber, Jonesboro
David Berry, Little Rock
Kirsty Estrem, Berryville
John Heard, McGhee
Sharon Huffmire, Midway
Walter Johnson, Pine Bluff
Ed Lacy, Heber Springs
Jim Lambert, Conway
Ray Montgomery, Searcy
Ron Peterson, Mountain Home
Melody Trimble, Fort Smith
Barbara Williams, Conway

EXECUTIVE TEAM
Robert “Bo” Ryall / President and CEO
W. Paul Cunningham / Executive Vice President
Beth H. Ingram / Senior Vice President
Tina Creel / Vice President, AHA Services, Inc.
Don Adams / Vice President, Rural and Mental Health Services
Elisa M. White / Vice President and General Counsel
Jodiane Tritt / Vice President, Government Relations
Pam Brown / Vice President, Quality and Patient Safety

DISTRIBUTION
Arkansas Hospitals is distributed quarterly to hospital executives, managers, and trustees throughout the United States; to physicians, state legislators, the congressional delegation, and other friends of the hospitals of Arkansas.

FEATURED SECTION
The 2013 Legislative Session (and how it could affect hospitals)

2013 Legislative Session
8  The New Assembly
10  Hospital Voices Must be Heard
11  Medicaid Expansion – Board Position Statement
12  Medicaid Expansion Makes Economic Sense
13  Fundamentals of the Legislative Process

A Look Back – Annual Meeting, 2012
14  Cicero Named Weintraub Award Recipient
14  2012 Distinguished Service, Chairman’s Awards
15  Bowen Named Melville Administrator of the Year
16  AHAA Presents Administrator of the Year Awards
16  Regent’s Awards Presented at Breakfast
17  Trade Show Exhibitors and Sponsors

NewsSTAT
20  New AHA Board Members
21  Trauma System Update
27  Medicaid Proposal Expands Current Initiative
27  Payment Improvement Initiative to Speed Up
28  Prepared to Care: 24/7 Standby Role

Features
30  2013 Goals and Strategies
32  ACTION II SUSP: Surgical Safety Program
34  ‘Million Hearts’ Targets Cardiovascular Disease
36  nTelagent: Increase Collections, Improve Processes

Health Information Technology
37  OIG Criticizes HHS Oversight of Payments

Quality/Patient Safety
37  Next Round of Regional Forums Jan. 29, 30, 31
38  Care Transitions/Readmissions Drilldown Group
38  Hospital Engagement Network Enters Second Year
39  Vacci-what-omer?
40  Flu Cases Widespread, Rising in Arkansas

Emergency Preparedness
41  Hospitals Impacted by Superstorm Sandy
42  Hurricane Sandy Relief Fund
42  NY’s Public Health Emergency Carries Reminders

Medicare/Medicaid
43  AHA Wants RAC Inaccuracies Examined
43  Improvements Made to PECOS System
44  CMS Issues OPPS, Physician Fee Final Rules
45  CMS Issues ICD-10 Reference Tool
45  Home Health PPS Final Rule for 2013
46  Rule Covers Medicaid Primary Care Payments
46  CMS Eases Supervision for Outpatient Services

Departments
4  From the President
5  Education Calendar
6  Arkansas Newsmakers and Newcomers
Arkansas’ Most Important Decision

The most important issue for the Arkansas Hospital Association (AHA) during this year’s legislative session is the expansion of Medicaid eligibility to people earning up to 138% of the federal poverty level. This will open medical insurance to a quarter of a million Arkansans – those who currently do not qualify for Medicaid and remain uninsured.

Please see these people for who they are: don’t get trapped by loudly-proclaimed stereotypes. They are the disabled among us, many of them aged and infirm. They are families with both parents working to support their children. They are young people struggling to make ends meet, praying they don’t get sick because their employers offer no benefits. Whatever the reason, roughly 250,000 of our fellow Arkansans are uninsured, and when hospitalized, are often unable to pay their bills. This results in rising rates of uncompensated care for our Arkansas hospitals, a tremendous hardship of ever-growing intensity.

More people covered means less uncompensated care for our hospitals. Less uncompensated care means that our hospitals, particularly our rural hospitals, can remain economically viable. Without Medicaid Expansion, it is a fact that some of our hospitals will struggle to survive. When a hospital leaves a community, a huge economic driver dries up and often entire communities suffer the emotional, economic and financial consequences.

I won’t dance around the subject. Expanding Medicaid is a fiscally sound decision for our state, besides being the absolutely right thing to do for our patients.

The AHA’s conservative estimates assume that about $200 million of anticipated uncompensated care in 2014 would be covered by the Medicaid Expansion program. What a help that would be!

What about the cost to Arkansans? For the first three years of the program, the federal government will pick up 100% of the cost of the Medicaid Expansion in Arkansas. Thereafter, the federal share slowly decreases and the state share slowly increases, to a capped charge of 10% to the state, with the federal government continuing to fund 90%.

Let’s not fool ourselves. 10% of the coverage of Medicaid Expansion is a lot less than the “hidden tax” Arkansans now pay – money to cover the uninsured and the costs they incur. In fact, several studies show that Medicaid Expansion will save states money and strengthen the safety net.

Arkansas Governor Mike Beebe, the Department of Human Services’ Division of Medical Services (Medicaid), the AHA and many stakeholders are fully in favor of Medicaid Expansion. Our work is to explain the intricacies of the Expansion to our legislators, many newly elected and perhaps still not fully acquainted with the financial difficulties Arkansas hospitals face every day.

And now you see why this is the AHA’s most important focus for this legislative session. We are going to need your help. Please talk with your legislators about the importance of Medicaid Expansion. Help them understand that it could be a lifesaver for many Arkansas hospitals, and that it is certainly the right move for our fellow Arkansans. Please consider joining voter-VOICE via our website, www.arkhospitals.org. We’ll help you keep up with all legislative issues affecting Arkansas’ hospitals, and will help give insight into the discussions surrounding Medicaid Expansion.

Arkansas citizens and their hospitals are depending upon all of us to spread the word. Please get involved!

Bo Ryall
President and CEO
Arkansas Hospital Association
<table>
<thead>
<tr>
<th>Date</th>
<th>Location</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 18</td>
<td>Little Rock</td>
<td>CPT, HCPCS Level II and OPPS Workshop</td>
</tr>
<tr>
<td>January 18</td>
<td>Little Rock</td>
<td>Arkansas Association for Hospital Engineering Workshop</td>
</tr>
<tr>
<td>January 29</td>
<td>Jonesboro, AR</td>
<td>ARbestHealth Regional Quality Forum</td>
</tr>
<tr>
<td>January 30</td>
<td>Little Rock</td>
<td>ARbestHealth Regional Quality Forum</td>
</tr>
<tr>
<td>January 31</td>
<td>Fort Smith, AR</td>
<td>ARbestHealth Regional Quality Forum</td>
</tr>
<tr>
<td>March TBD</td>
<td>Little Rock</td>
<td>Arkansas Healthcare Human Resources Association Spring Workshop</td>
</tr>
<tr>
<td>March 1</td>
<td>Little Rock</td>
<td>Arkansas Organization for Nurse Executives (ArONE) Spring Conference 2013</td>
</tr>
<tr>
<td>March 8</td>
<td>Little Rock</td>
<td>Arkansas Society for Directors of Volunteer Services Spring Conference</td>
</tr>
<tr>
<td>March 10-14</td>
<td>Chicago</td>
<td>American College of Healthcare Executives Congress on Healthcare Leadership</td>
</tr>
<tr>
<td>March 27</td>
<td>Little Rock</td>
<td>Crisis Communications Workshop</td>
</tr>
<tr>
<td>March 28</td>
<td>Little Rock</td>
<td>Hospital Preparedness Workshop</td>
</tr>
<tr>
<td>April 4-5</td>
<td>Little Rock</td>
<td>AFMC Quality Conference</td>
</tr>
<tr>
<td>April 28-MAY 1</td>
<td>Washington DC</td>
<td>American Hospital Association Annual Membership Meeting</td>
</tr>
<tr>
<td>May 8-10</td>
<td>Little Rock</td>
<td>Society for Arkansas Healthcare Purchasing and Materials Management Annual Meeting</td>
</tr>
<tr>
<td>May 15</td>
<td>Little Rock</td>
<td>Medicare 101 Workshop</td>
</tr>
</tbody>
</table>

Program information available at www.arkhospitals.org/events. Webinar and audio conference information available at www.arkhospitals.org/events.

---

**Group Buying Power Lowers Your Costs**

- Cost Containment
- Healthcare Education
- Financial and Reimbursement Services
- Information/Quality Management
- Insurance
- Workforce Solutions

*Find out more at:* www.ahaservicesinc.com

---

419 Natural Resources Drive • Little Rock, AR 72205 • ofc: 501.224.7878 • fax: 501.224.0519

AHA Services, Inc. is a wholly owned subsidiary of the Arkansas Hospital Association.
The Arkansas Health Executives Forum at its October 4 annual breakfast meeting elected 2012-2014 officers of the association. They are: Brian Barnett, FACHE, administrator—internal medicine, UAMS, Little Rock, president; Michael Givens, FACHE, administrator/COO, St. Bernards Medical Center, Jonesboro, vice-president; Scott Street, president and CEO, Mercy Health System of Northwest Arkansas, Rogers, secretary-treasurer; and Chris Barber, FACHE, president and CEO, St. Bernards Healthcare, Jonesboro, past-president and Regent. Directors are Sujay Kola, clinical effectiveness specialist, St. Vincent Health System, Little Rock; Beth Ingram, senior vice president, Arkansas Hospital Association, Little Rock; Tim Bowen, CEO, Mena Medical Center; and Kristi Estrem, FACHE, CEO, Mercy Hospital Berryville. Josh Conlee, president of the UAMSACHE Student Network, will represent that group on the AHEF board.

Richard A. “Dick” Pierson retired December 31, 2012 as vice chancellor for clinical programs at the University of Arkansas for Medical Sciences in Little Rock, after 31 years at UAMS. An active participant in Arkansas Hospital Association activities, Pierson served as Metropolitan Hospital District delegate on the AHA Board of Directors for two terms, chaired the Council on Government Relations, and in 2010 received the AHA’s highest honor, the A. Allen Weintraub Memorial Award.

Pierson also served on three committees of the American Hospital Association – the Governing Council of the Section for Metropolitan Hospitals, the Ad Hoc Committee on Public Access to Data Related Quality and the Committee on Health Related Professions.

Roxane A. Townsend, MD, has been named CEO of UAMS Medical Center and vice chancellor for clinical programs at the University of Arkansas for Medical Sciences in Little Rock effective February 1, 2013 succeeding Richard A. Pierson. Townsend previously served as assistant vice president for health systems at Louisiana State University in Baton Rouge, Louisiana. Melissa Fontaine, FACHE, UAMS Medical Center COO and associate vice chancellor for clinical programs, will serve as interim CEO until Townsend’s arrival.

James David Cicero retired as CEO of Ouachita County Medical Center in Camden December 31, 2012. Cicero served on the AHA Board of Directors for the past 11 years as Treasurer and Southwest Hospital District delegate, and represented the Arkansas Hospital Association on the Arkansas Health Services Permit Commission. In October, Cicero received the AHA’s highest honor, the A. Allen Weintraub Memorial Award.

Peggy Abbott, vice president of Ouachita County Medical Center in Camden, has been named CEO of the hospital succeeding David Cicero. Abbott has been with OCMC since 1987 and previously served as assistant vice president of administrative services and executive assistant. She is a member of the AHA’s Council on Government Relations and in late November was named Southwest Hospital District delegate to the AHA Board of Directors succeeding Tim Johnsen of Hot Springs. Her term expires October 2014.

Mark Hartman, FHFMA, senior vice president for finance and treasurer for the Arkansas Heart Hospital in Little Rock, was named CFO of the Year, Large Private Company Category, November 14 at the 2012 Arkansas Business CFO of the Year Awards luncheon held in Little Rock. Hartman is past president of the Arkansas chapter of the Healthcare Financial Management Association and board member of the American Heart Association, Central Arkansas Chapter.

Baptist Health in Little Rock was honored as Outstanding Corporation for the Association of Fundraising Professionals’ National Philanthropy Day Awards presented November 14 in Little Rock.

Darren Caldwell has been named CEO of Delta Memorial Hospital in Dumas effective November 1, 2012, succeeding Cris Bolin who recently resigned. Caldwell also will continue his duties as CEO of DeWitt Hospital.

Matt Driskell, MBA, FHFMA, has been named chief financial officer at Mena Regional Health System. He holds a bachelor’s degree in accounting, a master’s in business administration and is a Fellow of the Healthcare Financial Management Association. Driskell was most recently director of managed care, government reimbursement and business planning for the Georgia Health Sciences Health System in Augusta, Georgia.

David Hill has been named CEO of Booneville Community Hospital, succeeding Jerry Mitcham, who was acting as interim administrator. Hill most recently was CEO of two Integris facilities in Oklahoma; he has also served as CEO of Randolph County Medical Center
Lynn Smith, immediate past-president of the Arkansas Hospital Auxiliary Association, has been appointed to a three-year term on the American Hospital Association (AHA) Committee on Volunteers. As a member of the committee, she will help identify and recommend public policy issues, identify institutional practices requiring AHA consideration and action, advise AHA on programs and services directed to volunteers and auxiliaries, and provide AHA with community perspective on issues related to the field. Mrs. Smith is a volunteer with the Medical Center of South Arkansas in El Dorado.

Shelly Weilenman has been named administrator/chief nursing executive of Summit Medical Center in Van Buren. Weilenman was most recently chief nursing officer at Coastal Carolina Hospital in South Carolina.

Melody Trimble, FACHE, CEO of Sparks Health System in Fort Smith and Summit Medical Center in Van Buren, has been named group vice president of the Southern and Western Division of Health Management Associates, parent company of both facilities. She currently serves as Arkansas Valley District representative on the Arkansas Hospital Association board of directors. Effective January 1, 2013, Trimble began her new position and plans to relocate to Naples, Florida soon.

James T. “Jim” Sato, FACHE, retired as CEO of Helena Regional Medical Center effective October 15. Kevin Decker, assistant CEO at Medical Center of South Arkansas in El Dorado, will serve as interim CEO at Helena while a search for a permanent CEO is underway. Both facilities are owned and operated by Community Health Systems of Brentwood, Tennessee.

Tim Bowen, CEO of Mena Regional Medical Center, was named the 2012 recipient of the C. E. Melville Young Administrator of the Year Award during the Arkansas Hospital Association’s annual meeting. Bowen, a native of Mena, was named CEO last year after working at the hospital for several years.

Lynn Smith, immediate past-president of the Arkansas Hospital Auxiliary Association, has been appointed to a three-year term on the American Hospital Association (AHA) Committee on Volunteers. As a member of the committee, she will help identify and recommend public policy issues, identify institutional practices requiring AHA consideration and action, advise AHA on programs and services directed to volunteers and auxiliaries, and provide AHA with community perspective on issues related to the field. Mrs. Smith is a volunteer with the Medical Center of South Arkansas in El Dorado.

Shelly Weilenman has been named administrator/chief nursing executive of Summit Medical Center in Van Buren. Weilenman was most recently chief nursing officer at Coastal Carolina Hospital in South Carolina.

Melody Trimble, FACHE, CEO of Sparks Health System in Fort Smith and Summit Medical Center in Van Buren, has been named group vice president of the Southern and Western Division of Health Management Associates, parent company of both facilities. She currently serves as Arkansas Valley District representative on the Arkansas Hospital Association board of directors. Effective January 1, 2013, Trimble began her new position and plans to relocate to Naples, Florida soon.

James T. “Jim” Sato, FACHE, retired as CEO of Helena Regional Medical Center effective October 15. Kevin Decker, assistant CEO at Medical Center of South Arkansas in El Dorado, will serve as interim CEO at Helena while a search for a permanent CEO is underway. Both facilities are owned and operated by Community Health Systems of Brentwood, Tennessee.

Tim Bowen, CEO of Mena Regional Medical Center, was named the 2012 recipient of the C. E. Melville Young Administrator of the Year Award during the Arkansas Hospital Association’s annual meeting. Bowen, a native of Mena, was named CEO last year after working at the hospital for several years.
Every two years, Arkansas voters elect new members to the Arkansas House of Representatives and the State Senate to serve their constituents, ensuring that our legislative branch fulfills its responsibilities to enact law, set state spending priorities and provide the checks and balances for the judicial and executive branches of state government. Each of these elections creates a new assembly, largely due to the fact that the individual members – the legislators – make unique each legislative body. The 2012 election was even more unusual than the normal two-year cycle in that all 135 seats were “open” due to the census requiring legislative redistricting.

However, this incoming legislature – the 89th General Assembly – will be even more unique than any General Assembly since Reconstruction. After the swearing-in ceremonies on January 14, 2013, there will be 21 Republicans and 14 Democrats serving in the Arkansas Senate as well as 51 Republicans, 48 Democrats, and one Green Party member serving in the Arkansas House of Representatives. The Senate President pro tempore will be Michael Lamoureux, an attorney from Russellville, and the Speaker of the House will be Davy Carter, an attorney and banker from Cabot. Both of these men are Republicans.

While party affiliation plays a role in the internal politics of each chamber, the party affiliation of an individual lawmaker is not an issue in regard to the work that legislators do for hospitals.

The 2013 legislative session will offer many opportunities to affect hospitals, to be sure. Both national and state politicso have a watchful eye on our legislature this year. Not only is it the first time since Reconstruction that Arkansas has a Republican majority in the House and in the Senate, but also, Arkansas is tackling some huge policy matters in ways that are a bit different and a bit more intriguing than in other states; and maybe on a different time-table.

Like many other states, Arkansas is struggling with how to create a Health Benefits Exchange, how to appropriately and efficiently connect disparate health information technology platforms to allow for the exchange of health information throughout the state, how to modify the healthcare delivery system to save money in the state’s Medicaid program and still provide great care to our citizens, how to ensure adequate education for our school children, how to lower costs of our corrections system, how to improve our highways and transportation systems, how to provide opportunities for economic development, and many other “how-tos.”

It is no secret that hospitals play a role in all of these endeavors. Hospitals are widely known for providing acute care to patients and families and hospitals are an amazing economic engine for communities. Decisions made in each of these areas will affect how well hospitals are able to serve their patients, families, and communities, and there is a ton of work to be done.

Topping the priority list for hospitals this session will be Medicaid Expansion. While the Patient Protection and Affordable Care Act (PPACA) required that each state expand Medicaid eligibility for patients with extremely limited means, the Supreme Court ruled that states have the option to move forward with the expansion and gave them the ability to determine their own Medicaid eligibility criteria. As a result, Arkansas is struggling with the question of expanding Medicaid to an additional 250,000 Arkansans.

Currently, non-disabled parents in a family of four must earn less than $3,000 per year (17% of the federal poverty level) to qualify for Medicaid coverage. Expanding Medicaid to the statutory requirement of the PPACA (138% of the federal poverty level) would modify that income limit and allow all members of a family of four that earns $31,800 to be Medicaid eligible.

The Arkansas Department of Human Services estimates that covering more Arkansans through Medicaid Expansion will save the state $372 million in state general revenue funds over the first eight years of the program. Most of this projected savings is due to a cost shift of waiver and other programs that currently require the state to put up about 30% of the funds required to run the program. Under the proposed Medicaid expansion, those programs would be fully covered by federal funds.
It is easy to get wrapped up in the minutia of various bills or proposals, but at the heart of what hospitals need is the basic tools to be able to continue to serve our patients, our families, and our communities. As lawmakers make decisions, they must hear from their local hospitals. They want your input and your perspective. They, too, want to do what is best for our hospitals.

dollars for a period of time, while the state’s share would increase to a maximum of 10% by 2021. Specifically for hospitals, Medicaid Expansion offers a payment mechanism for services that our hospitals provide now to uninsured or underinsured patients who are not able to pay for the care that they receive or who have no affordable insurance product available to them. In 2010, unreimbursed care for patients in our hospitals topped $338 million. If nothing is done and things progress as they have over the last few years, by 2014, hospitals’ unpaid costs of care for their uninsured patients will likely surpass $430 million, and more in each following year. Those losses pose an imminent danger to the state’s hospitals, which are anchors for local healthcare systems and networks and are top employers in our communities. While expanding Medicaid will not completely resolve all uncompensated care, Medicaid Expansion could mean that $200 million of what is now uncompensated care could be covered by the program.

In addition to the direct benefit to hospitals, providing coverage to those who are now uninsured should have a direct economic benefit to employers. Coverage should offer better access to the healthcare system and increase productivity, affording workers the chance to avoid prolonged illnesses which otherwise keep them off the job.

The task of expanding Medicaid will not be easy. Because the legislature is responsible for appropriating all funds – including federal funds for this program – Medicaid Expansion rests in the hands of our lawmakers. In order to be able to spend the dollars that Medicaid Expansion can make available to Arkansans, 75% of the legislature must approve the appropriation.

Other legislative items on the priority list are also Medicaid-related and include measures that would improve oversight for the Arkansas Payment Improvement Initiative, the payment system transformation that the major insurance carriers and Medicaid are jointly undertaking.

This new payment system creates a payment system based on episodes of care and a mechanism by which specific providers identified by the payor – known as Principal Accountable Providers – are subject to gain- or risk-sharing based on meeting the target price and quality measures of the episode. While private insurance companies are able to modify contracts with individual providers under their contract terms, the Medicaid program must receive a review from the legislature prior to changing the payment terms made to providers. Because Medicaid and the commercial payors are planning to dramatically increase the number of episodes, providers need a much larger role in helping to determine the appropriate target price of the episodes as well as which quality measures are appropriate for the episode.

Also of significant importance to hospitals is the need for certain legal liability protections for healthcare providers. In 2003, the Arkansas Legislature enacted Act 649 of 2003 known as the “Civil Justice Reform Act of 2003.” This legislation offered many protections for healthcare providers including provisions such as requiring medical malpractice actions to be filed in the county where the alleged injury occurred, establishing that a party pays damages according to its percentage of fault for an injury, requiring that expert testimony be given by a provider of the same specialty as the defendant, and more. Since 2003, the Arkansas Supreme Court has chipped away at some of the previously approved protections afforded in the 2003 act. In order to re-establish those protections or to include additional judicial protections for the medical community, Arkansas’ Constitution must be modified.

In addition to the items listed above, as bills continue to be filed and topics expanded, more issues for hospitals will arise. It is more important than ever to be involved in the legislative process. It is easy to get wrapped up in the minutia of various bills or proposals, but at the heart of what hospitals need are the basic tools to be able to continue to serve our patients, our families, and our communities. As lawmakers make decisions, they must hear from their local hospitals. They want your input and your perspective. They, too, want to do what is best for our hospitals.
THE 2013 LEGISLATIVE SESSION

by Jodiane Tritt, Vice President, Government Relations, Arkansas Hospital Association

Hospital Voices Must Be Heard in This Legislative Session!

As the Arkansas Legislature convenes on January 14, 2013, and issues loom for hospitals and the healthcare system, it is more important than ever for hospital voices to be heard. Fifty-six members of Arkansas’s 135-member legislature will be serving their first terms in their respective chambers. Even for very seasoned legislators, healthcare issues are complicated and not easily resolved. Those complexities are magnified when mixed with other issues related to education, transportation, corrections, the environment, technology, et cetera. Arming legislators with the best available information is the key to their success and the key to the viability of our hospitals.

The Arkansas Legislature is comprised of a 100-member House of Representatives and a 35-member Senate. Unlike the federal legislative process, which can be lengthy and drawn out, Arkansas enacts laws quickly. Once a legislator has a bill drafted by the Bureau of Legislative Research and introduced in the first chamber, that bill has a good chance of being enacted within a very short amount of time. For example, if a bill is introduced on a Friday, it will be assigned to a committee that day. By the following Tuesday, that same bill will be voted on in committee and will head to the chamber floor for a vote on Wednesday.

Assuming that the bill passes the chamber on Wednesday, it will be received by the other chamber and assigned to a committee that day, which means that by the next Friday, that bill can be voted on by the committee and submitted for a vote on the chamber floor on Monday. That same Monday, that bill will be sitting on the Governor’s desk awaiting his signature to become an act.

The House of Representatives and the Senate have a similar committee structure, but do not mimic one another completely. Committees on Education; Judiciary; Public Health, Welfare, and Labor; Revenue and Tax; Aging, Children and Youth/Legislative and Military Affairs; Agriculture, Forestry, and Economic Development; City, County, and Local Affairs; Insurance and Commerce; and State Agencies and Governmental Affairs are the most similarly structured, although the Senate committees have only eight members and the House of Representatives committees have 20.

The House has a separate committee for Public Transportation, while the Senate has one for Transportation, Technology, and Legislative Affairs. In addition to the individual chamber committees, there are joint committees that require members from both the Senate and the House of Representatives. Those committees are Budget, Performance Review, Retirement and Social Security, Energy, Children and Youth, Communications and Technology, and Legislative Council.

Most legislation that pertains to hospitals and healthcare is heard in the Public Health, Welfare, and Labor Committee; however, many issues are heard in other committees, too. It is important to know on which committees your individual legislators serve. It is also important to know the roles of your legislators in each committee, because the House of Representatives and the Senate select chairpersons of committees differently. In the Senate, the chairs are largely selected by seniority while in the House of Representatives, the chairs are appointed by the Speaker of the House.

Because of the speed and the complexity of healthcare issues, legislators need to hear from their local hospitals on matters affecting their organizations. When speaking with legislators, be sure to be specific, brief, direct, timely, and constructive. If you have expert knowledge, share it! A legislator cannot possibly be an expert on every issue. Be sure to contact your legislators when there is still time to take action. A letter written, a phone call made, an email or text sent after a bill has been voted on is ineffective. Perhaps the biggest key to success in working with legislators is to be prepared. If you have a solid understanding of the subject to be discussed and know the arguments for – and against – your position, the better able you will be to inform your legislators.

As always, the legislative session offers hospitals opportunities to be a part of making policies that help hospitals continue to serve our patients, families, and communities and to continue to be major employers throughout the state. Taking an active role in the legislative process is imperative and greatly increases the viability and success of our hospitals.

Jodiane Tritt is Vice President, Government Relations, at the Arkansas Hospital Association. You may reach her at jtritt@arkhospitals.org.
Fundamentals of the Legislative Process

It may have been awhile since we took Civics classes in high school, so as we enter the 2013 Legislative Session, it’s instructive to recall how legislation is enacted in Arkansas. As you know, the General Assembly is held in odd-numbered years, with a Fiscal Session now being held in even-numbered years. This chart maps the progression of legislation through the state legislature.

Medicaid Expansion – An AHA Board Position Statement

AHA Board of Directors Position Statement on Medicaid Expansion
(adopted unanimously on August 10, 2012, at the monthly meeting of the AHA Board of Directors)

To assure better access to health and healthcare for all Arkansans, the Arkansas Hospital Association Board of Directors fully supports the expansion of Medicaid eligibility in Arkansas to 138% of the Federal Poverty Level. This expansion of the Medicaid program would encourage newly insured Arkansans to seek medical care at the earliest stages of illness, rather than waiting to seek care at the most expensive point of care – the hospital emergency department.

Because this expansion of Medicaid eligibility would provide insurance coverage for a large percentage of Arkansas’s uninsured, who historically pay only about 20% of costs; it will help ease the burden of uncompensated care for hospitals. This burden climbs dramatically each year.

For these reasons, the Arkansas Hospital Association Board of Directors urges our state’s leaders to support the expansion of Medicaid. This is a matter of improving the physical health of our citizens and the financial stability of our vulnerable hospitals, many rural, which provide essential services to the people of Arkansas.
The haggling over Medicaid expansion in Arkansas, the political back and forth, will likely go on well into the 2013 legislative session. The differing camps each offer up valid arguments for debate, and while the General Assembly is just getting underway, there are simply too many issues to address for a resolution to come anytime soon.

Will the Legislature eventually approve expansion as prescribed under the Patient Protection and Affordable Care Act (ACA)? Is the State adequately protected if the Feds can’t keep up their end of the bargain ad infinitum? Will the Governor seek a global waiver from the Secretary of HHS to allow the full flexibility for concessions which might improve the chances for approval; and, would the Secretary actually grant such a request? Her nod could lead to a lower income threshold for eligibility, as well as co-pays and drug testing for Medicaid patients and other less publicized requirements.

Answers to those questions and others may not be clear for months. The crux of the matter centers on the future cost of the program, if expansion happens. Even if the federal government makes good on its promise to cover a huge majority of the costs associated with adding 250,000 to the Arkansas Medicaid rolls over the coming years, there are concerns that the state will be on the hook down the road for more than it can afford. Hopefully, the latest set of projections from Arkansas Department of Human Services and Medicaid leaders which show expansion actually could net $629 million in state general revenue (SGR) savings between 2014 and 2021 can serve to ease that fear.

As you might imagine, those numbers garner more than a few quizzical looks which convey the thought, “We can cover that many more people and save that much money at the same time? It sounds too good to be true!” Many folks don’t believe things add up, including some who will cast key votes on the issue. However, as ESPN analyst Lee Corso might say, “Not so fast, my friend.”

A new report from the Kaiser Family Foundation agrees that states should see net budget gains, even as millions of low-income uninsured residents obtain health coverage. According to the report, “Combining Medicaid costs with a conservative estimate of state and local non-Medicaid savings on uncompensated care, the Medicaid expansion would save states a total of $10 billion over 2013-2022, compared to the ACA without the expansion. Net state savings are likely to be even greater because of other state fiscal gains that we could not estimate based on 50-state data.”

Still, might it not make more sense to take the safer road? Just leave things alone and concentrate solely on “bending the cost curve” for the current Medicaid popula-
tion without the added weight of new enrollees due to expansion?
Well, maybe. But, it might not be that simple. Things seldom are. Automatically assuming that a choice to forego Medicaid expansion resolves the issue of new recipients who otherwise would not enroll in the Medicaid program — and the increased costs — might be premature.
Arkansas’ hospitals already know that opting out of Medicaid expansion will cost them around $200 million per year in uncompensated care related to the uninsured patients who they care for.
Individuals and businesses will feel the pain, too, as at least a portion of their insurance premiums is sensitive to and affected by those uncompensated care costs. It’s that doggone hidden tax nobody will fully acknowledges.

The state won’t be immune, either, according to the Kaiser report, which argues that there is a cost of doing nothing. Medicaid enrollment and spending are projected to rise more than usual, even in states that elect not to expand coverage.
Arkansas, for example, could see its Medicaid rolls climb by an estimated 30,000-35,000 recipients beyond normal expectations, sans expansion. Call it the woodwork effect. Other ACA provisions, such as simplifying the enrollment process via new state health insurance exchanges, are poised to coax from “out of the woodwork” increased numbers of adults and children who already are eligible for the program, but not yet on the Medicaid rosters. Subtract the benefit of a much higher federal share of their costs under expansion — along with even a fraction of the aforementioned SGR savings over the coming years, which would not be realized — and the result is that SGR spending on Medicaid could jump substantially, regardless of approval.

Would Arkansas bear a cost for Medicaid expansion? Yes. But, it could be much less than expected, considering the extra amounts likely to be incurred even if nothing is done. In the end, it could literally be a small price to pay for the healthcare coverage which so many Arkansans need.

Study Shows Arkansas Would Benefit Significantly with Medicaid Expansion

An independent study conducted by the Rand Corporation, a nonprofit organization that helps improve policy and decision making through research and analysis, concludes that expanding the Arkansas Medicaid program as prescribed under the Patient Protection and Affordable Care Act of 2010 (ACA) not only would positively impact lives in the state, but would do much to improve our state’s economy, as well.
The study, commissioned by the Arkansas Center for Health Improvement (ACHI), finds that expansion could result in 2,300 fewer deaths each year, with the added benefit of infusing 6,200 new jobs by 2016.
It also projects economic impact to the state with approval of Medicaid Expansion. Economic projections as of 2016, taking into account expenditures the state would have to make for full implementation, ACA reductions in funding to hospitals for uncompensated care and the inflow of federal funding, the study projects a net increase on Arkansas’ gross domestic product of $550 million annually.
By 2016, if the ACA is fully implemented, the Rand study projects 400,000 Arkansans to be newly covered either through Medicaid or through the purchase of private coverage through the insurance exchange. If the state does not move forward with full implementation, the study estimates that 571,000 Arkansans will be uninsured. “This independent assessment of what full implementation of increased coverage options through the ACA offers Arkansans validates a call for action,” says ACHI Director and Arkansas’ Surgeon General, Dr. Joe Thompson. “Not only would we save lives, but we would also stabilize our healthcare system and benefit our economy. It also would help our state catch up to what other states already offer their citizens through the Medicaid program.”
The full study, including county-by-county impact projections for 2016 (with estimates for additional revenue and new enrollment) can be found on the ACHI website: www.achi.net.

Paul Cunningham is Executive Vice President of the Arkansas Hospital Association. You may reach him at pcunningham@arkhospitals.org.
David Cicero, president and CEO of Ouachita County Medical Center in Camden since 2001, is the recipient of the Arkansas Hospital Association’s (AHA) 2012 A. Allen Weintraub Memorial Award. He received the award during the Association’s Annual Awards Dinner held in conjunction with the 82nd Annual Meeting and Trade Show October 3-5 at the Peabody Hotel in Little Rock.

The AHA board selected Cicero as the recipient of the Association’s highest honor during its August 10 meeting in Little Rock.

Among his many accomplishments during his 34 years at the Camden facility, first as associate administrator, then CFO and executive vice president before being named president in January 2001, Cicero has overseen many changes and enhancements at the hospital. Among them are a complete reconstruction of the medical/surgical and obstetrical units and construction of a new ICU, renovation of the Women’s Services Unit and implementation of Electronic Health Records.

He also was an innovator of a DRG Grouper System for use on the AS-400 that was sold to several hospitals.

A dedicated community member, Cicero serves on the Camden Airport Commission, the Ouachita Valley Community Foundation board and the Camden Chamber of Commerce board.

Long active in the AHA, Cicero served as treasurer of the board for the past three years and as the representative of the Southwest District for the previous eight years. He also represented the AHA on the Arkansas Health Services Permit Commission.

In 2010, he was honored with the American Hospital Association’s Grassroots Champion Award.

The A. Allen Weintraub Memorial Award is named for the late administrator of St. Vincent Infirmary Medical Center in Little Rock. It is the highest honor presented to Arkansas hospital administrators.

2012 AHA Distinguished Service, Chairman’s Awards

The AHA board selected three deserving individuals to receive 2012 Distinguished Service Awards, which were presented during the Annual Awards Dinner in conjunction with the AHA’s 82nd Annual Meeting and Trade Show October 3-5 at the Peabody Hotel in Little Rock.

John P. Burge, MD of Lake Village, John Henderson, MD of Searcy, and Herbert K. “Kirk” Reamey, III of Clinton were honored for their distinguished service.

In addition to his 44 years as a general surgeon in practice in Lake Village, Dr. John Burge is an advocate for physicians and his community. He just completed 24 years serving in several capacities at the local hospital.

The AHA’s highest award for administrators, the A. Allen Weintraub Memorial Award, is presented to David Cicero (right), CEO, Ouachita County Medical Center, Camden.
eral leadership roles, including chair-
man, on the board of the Arkansas
Medical Society, and has served on the
boards of the Arkansas Foundation
for Medical Care (AFMC), the State
Board of Health and the Arkansas
Health Care Access Foundation. He
also serves on the boards of the Bank
of Lake Village and Chicot Memorial
Medical Center.

Retiring in January 2012 as a cardi-
ologist in Searcy, Dr. John Henderson
began a new role as medical director
of quality and patient safety at White
County Medical Center (WCMC). Dr.
Henderson served an active
role in merging Central Arkansas
Hospital with WCMC in 2005 while
actively serving both hospitals. He
served on the board of AFMC as
a cardiology consultant and most
recently as chairman.

Kirk Reamey recently retired as
CEO of Ozark Health Medical Center
in Clinton, bringing to a close a more
than 40 year career in healthcare. He
had a long and distinguished career
in the U.S. Army, serving as admin-
istrator at many Army hospitals in
the United States and Korea. Retiring
from the Army in 1998, he accepted
the position as CEO of Magnolia
Hospital and then moved to Ozark
Health. Reamey served 10 years on the
AHA board of directors, most recent-
ly as At-Large Delegate, was presi-
dent of the former Arkansas Hospital
Administrators Forum, board member
of the AHA Worker’s Compensation
Self-Insured Trust and a member of
the American Hospital Association’s
Regional Policy Board 7.

Earl Goatcher of Clinton was
selected by Larry Morse to receive the
AHA Chairman’s Award. Goatcher
completed both his term as presi-
dent of the Arkansas Association
of Hospital Trustees and as trust-
ee delegate to the AHA board in
October, 2012. During his two-year
tenure, he was a true mentor for
hospital trustees in the state, bring-
ing to fruition the new partnership
with Best on Board, a governance
education, testing and certification
service. He has represented trustees
both in the state and nationally at
meetings of the American Hospital
Association, discussing important
healthcare issues and the value of
governance education.

Tim Bowen, CEO of Mena
Regional Medical Center, was
named the 2012 recipient of the C.
E. Melville Young Administrator of
the Year Award during the Arkansas
Hospital Association’s annual
meeting. Bowen, a native of Mena,
was named CEO of the 65-bed Mena
Regional Health System in 2011.

Bowen first came to work at the
hospital in 2006 as a nuclear medicine
technologist. Intrigued by the business
aspects of running a hospital, in
2008 he earned his MBA attending
night classes, and was promoted to
assistant administrator, overseeing
the hospital’s clinic operations and
new business developments.

He was selected as CEO three
years later. The hospital has about
270 employees and $65 million in
total patient revenue.

Involved in his community, Bowen
sits on the boards of the Arkansas
Health Executives Forum and the
Mena Chamber of Commerce and is
active with the American College of
Healthcare Executives.

A side note: He was born in the
hospital over which he is now CEO.
A LOOK BACK – ANNUAL MEETING, 2012

AHAA Presents Administrator of the Year Awards

Lynn Smith, immediate past president of the Arkansas Hospital Auxiliary Association, presented two awards during the opening session of the Arkansas Hospital Association’s annual meeting. Given in two categories, the awards were presented to Sheila K. Williams, CEO of HSC Medical Center in Malvern, “Administrator of the Year Award for Hospitals Under 100 Beds,” and to Melody Trimble, FACHE, CEO of Sparks Health System in Fort Smith, “Administrator of the Year Award for Hospitals Over 100 Beds.”

Regent’s Awards Presented at ACHE/AHEF Breakfast

Chris Barber, FACHE, CEO of St. Bernards Healthcare in Jonesboro and Arkansas’ ACHE Regent, presented two Regent’s Awards during the October 4 ACHE/AHEF Breakfast. John Recicar, director, Trauma Center, Arkansas Children’s Hospital in Little Rock, received the ACHE Early Healthcare Career Award, and Susan Greenwood, FACHE, vice president for Quality, Safety and Risk Management and Nurse Executive, St. Bernards Healthcare in Jonesboro, received the ACHE Senior Healthcare Career Award.
A LOOK BACK – ANNUAL MEETING, 2012

We would like to thank, once again, our wonderful Trade Show Exhibitors and Sponsors. Sponsors are highlighted in red print. These businesses and organizations bring the latest in technology and services to our healthcare audience. This year, the Trade Show once again sold out. We also thank each of our Annual Meeting attendees and their guests for visiting the Trade Show.

Trade Show Exhibitors and Sponsors

3M
AAMSCO Identification Products
Administrative Consultant Services, LLC
AFMC
AHA Services, Inc.
AHA Workers Compensation Self Insured Trust
Airetech Corporation
Airgas Medical Services, Inc.
Alberici Healthcare Constructors
American Data Network
American Red Cross
Arrcom Systems, Inc.
Arkansas Association for Healthcare Engineering, Inc.
Arkansas Association for Healthcare Trustees
Arkansas Blood Institute
Arkansas Blue Cross Blue Shield
Arkansas Chapter HFMA
Arkansas Dept. of Health, Office of Rural Health and Primary Care
Arkansas Health Care Access Foundation, Inc.
Arkansas Health Executives Forum
Arkansas Hospice
Arkansas Hunger Relief Alliance
ARORA
Bancorp South Insurance Services
BKD, LLP
Care View Communication
CareLearning
CDI Contractors, LLC
Cedar Bridge
Chem-Aqua, Inc.
Commerce Bank
Community Health Centers of Arkansas
Community Hospital Corporation
Construction Specialties
CoreSource
Correct Care
Coventry Health Care
CPSI
Crews & Associates, Inc.
Cromwell Architects Engineers, Inc.
Crothall Healthcare
CSS Health Technologies
Danner Medical Waste
DocuVoice
EmCare Inc.
Emergency Staffing Solutions
Engelkes & Felts, CPAs
EXIT Marketing
EZ Way, Inc.
Fleming Companies
Franklin Collection Service
Friday, Eldredge & Clark, LLP
Garrett Callahan Company
Gideons International Auxiliary
Guldmann Inc.
Hagan Newkirk
Harrison Energy Partners
HBE Corporation
HEALTHCareERS Network
Heartland
Heartland Medical Sales & Services
HHB Services
Hill-Rom
HORNE, LLP
HP Enterprise Services
Hubble Mitchell Business Interiors
Hughes, Welch & Milligan, LTD
Information Solutions
Inman-EMJ Construction
Innerface Architectural Signage
Innovative Power Solutions
Intego Software LLC
Iry Electric Distributors
John Storm Medical Equipment Co., Inc.
Johnson Controls, Inc.
Johnson Controls, Inc.
Johnstone Flooring
Legacy Rehabilitation
LHC Group
LifeShare Blood Centers
Lonseal
Mass Enthusiasm Inc.
McNeary, Inc.
MDM Healthcare
Medicus Firm
Merritt Hawkins
Midwest Healthcare, Inc.
Morgan Hunter Healthsearch
Nabholz Construction Services
National Research Corporation
NovaSys Health
Novitas Solutions, Inc.
nTelagent
Pacific Interpreters, Inc.
Pinnacle Business Solutions
Pinnacle Health Group
Pinnacle Pointe Hospital
Polk Stanley Wilcox Architects
Press Ganey
Prism Medical
Professional Data Services
Prognosis Health Information Systems
Radiology Associates, P.A.
Rehab Care
Rich & Cartmill, Inc.
Robins & Morton
Saint Louis University School of Public Health
Service Professionals, Inc.
Shannon Sales
Signet Health Corporation
Simplex Grinnell
Southwest Imaging
Southwest Solutions Group
Specialized Radiology Partners
STL Communications, Inc.
Success EHS
SunRx
Take Care Arkansas
The Estopinal Group
The Midland Group
The Right Solutions
UAMS Medical Center
UAMS-Center for Rural Health
UAMS-South Central Telehealth Resource Center
US Foodservice
USDA, Rural Development
VALIC Financial Advisors
Valley Services, Inc.
VHA Oklahoma/Arkansas
Voice Products
VSP - Vision Service Plan
Western Waterproofing Company
Wittenberg, Delony & Davidson Architects
Workplace Resources of Little Rock
A LOOK BACK – ANNUAL MEETING, 2012

A delegation from Ozark Health Medical Center, Clinton. From left, Darrell Moore, Director of Foundation, David Deaton, CEO, Earl Goatcher, immediate past chair of the Arkansas Association of Healthcare Trustees, and Herbert K. Reamey III, immediate past CEO, recently retired.

Ben Sasse, Healthcare Reform breakfast speaker

Leadership Workshop speaker David Rubenstein

Keynote speaker Brian Boyle

Views from the Trade Show! Each year the AHA sponsors a Trade Show as part of its Annual Meeting. With more than 125 exhibitors and sponsors, the 2012 Trade Show was sold out! Our Annual Meeting attendees and their guests look forward to this remarkable event each year.
David Berry, FACHE, Senior Vice President, Arkansas Children’s Hospital, Little Rock (left) accepts award honoring the hospital’s 75 years of membership in the American Hospital Association (AHA) from Tucker Bonner, AHA’s Regional Representative (right).

Governor Mike Beebe presented the Opening Address at the AHA’s 82nd Annual Meeting October 3-5. His topic: the importance of supporting Medicaid Expansion.

Patient Safety and Quality Workshop speaker Steve M. Berkowitz MD

AHAA immediate past president Lynn Smith receives a plaque from AHA Chairman Larry Morse honoring her service on the AHAA Board of Directors.

AHA President and CEO Bo Ryall and AHA Board Chairman Larry Morse drawing the names of five AHAA recipients of $100 cash prizes. Always a highlight!

Barbara and Harold Mitchell (CEO at Bradley County Medical Center) and Judy Teeter of Little Rock
At its October 4 meeting, the Arkansas Hospital Association House of Delegates ratified elections of John Heard, Sharon Huffmire and Barbara Williams to the AHA 2012-2013 Board of Directors. In subsequent days, as retirements and position changes were announced, Peggy Abbott also was elected to the board. Here are the new members of the AHA Board of Directors:

- Peggy Abbott, incoming CEO of Ouachita County Medical Center in Camden, will represent the Southwest District succeeding Tim Johnsen, former CEO of Mercy Hospital Hot Springs. Abbott’s term expires in October 2014.
- John Heard, president of McGehee Hospital, will represent the Southeast District succeeding Darren Caldwell, CEO of DeWitt Hospital. Heard’s four-year term expires October 2016.
- Sharon Huffmire, president of the Arkansas Hospital Auxiliary Association, will serve through October 2013. She succeeds Lynn Smith of El Dorado.
- Barbara Williams, Ph.D., trustee for Conway Regional Health System and president of the Arkansas Association of Hospital Trustees, will serve through October 2014. She succeeds Earl Goatcher of Clinton.

At the AHA’s January board meeting, a new treasurer will be elected to succeed David Cicero, who retired in December.

---

Hughes, Welch & Milligan, LTD.
Certified Public Accountants

At Hughes, Welch & Milligan, CPAs, we have made a commitment to providing professional services to the Healthcare Industry. Our experienced professionals work closely with clients and their staff to ensure they are receiving the level of service you should expect out of your CPA firm.

Visit Us Online at www.hwmcpas.com

Batesville, Arkansas
Bill Couch, CPA, FHFMA
870-793-5231
bcouch@hwmcpas.com

Hughes, Welch & Milligan, CPAs is a full service accounting firm offering a wide range of services to the Healthcare Industry:

- Financial Statements and Employee Benefit Plan Audits
- Medicare and Medicaid Cost Report Preparation
- Reimbursement and Compliance Issues Consulting
- Critical Access Hospital Consulting
- Strategic Planning for Acquisitions, Sales, Mergers & Expansions
- Revenue Cycle Analysis
- Feasibility Studies
- IRS Form 990 Preparation
Getting Arkansans to the Right Care Quickly
A Trauma System Update
From the Arkansas Department of Health

The Problem:
Injury is the number one killer of Arkansans between the ages of one and 44. Arkansas’ injury fatality rate is 30% higher than the national average and 82% higher with respect to deaths from motor vehicle accidents. This problem is exacerbated by Arkansas’ rural road system, the twelfth largest in the nation. In addition, in a study conducted by the American College of Emergency Physicians in December 2008, Arkansas was cited as having the worst system of emergency care in the nation. Prior to the passage of the Trauma System Act by the Arkansas Legislature in 2009 (see below), Arkansas was one of three states without a trauma system and the only state without a designated trauma center.

Implementation:
The Arkansas Department of Health (ADH) is the agency responsible for implementation of the trauma system. There are numerous components of a successful system. The information below demonstrates the significant progress toward making a trauma system in Arkansas a reality.

Hospital Designation: The designation process is intensive for hospitals. A great deal of preparation is required. Seventy-five hospitals have submitted intent applications to become trauma centers (from Level I, the highest level of designation, to Level IV, the lowest level). To date, 58 hospitals have been designated at the following levels:
- Level I (provides comprehensive clinical care and is a community resource; i.e., has education, research, and outreach components): 5
- Level II (provides comprehensive clinical care; from a clinical standpoint, a Level II provides the same care as a Level I): 5
- Level III (provides treatment for mild and moderate single system injuries; most traumatic injuries can be treated at a Level III facility): 19
- Level IV (provides stabilization for severely injured patients; transfer to a higher level trauma center is usually required): 29

It is noted that certain out-of-state hospitals are included in the Arkansas trauma system due to the number of Arkansas trauma patients treated at these hospitals.

Funding for Hospitals:
- Level I trauma centers receive between $1 million and $1.5 million each year of designation
- Level II trauma centers receive between $500,000 and $750,000 each year of designation
- Level III trauma centers receive between $125,000 and $187,500 each year of designation
- Level IV trauma centers receive between $25,000 and $37,500 each year of designation

For FY 2013, hospitals at the various levels will receive the following amounts:
- Level I trauma centers: $1,410,000
- Level II trauma centers: $705,000
- Level III trauma centers: $176,250
- Level IV trauma centers: $35,250

The amount of money the hospitals receive for each year of designation is dependent on the amount of “carry forward” funding available in a given year. As the “carry forward” funds will diminish from FY 2012 to FY 2013, principally due to more hospitals being designated and being paid, less money over base funding is available to be distributed to participating hospitals. These funds are designed to support ongoing readiness costs for continued participation in the trauma system rather than payment for uncompensated care of trauma patients.

Funding for Emergency Medical Service (EMS) Providers: A total of 118 EMS providers across the state are participating in the trauma system. Like hospitals, participating EMS providers are eligible to receive trauma readiness funds. Each provider is funded based on the service area of the provider and the type of service (basic life support/advanced continued on page 22
life support) afforded. Additional funds are available to providers in rural areas of the state. A total of $3,107,031 will be distributed to EMS providers this year. Due to the reduction of “carry forward” funds, as noted above, overall funding for EMS providers for FY 2013 is down from the $3,500,300 available in FY 2012.

**Funding for EMS Training Sites:** Twenty-three training sites are eligible to participate in the trauma system. These sites provide training for new emergency medical technicians (EMTs) and paramedics. A total of $244,373 is available this year to increase our EMS workforce.

**Funding for EMS Associations:** The Arkansas Ambulance Association and the Arkansas Emergency Medical Technician Association are eligible to receive approximately $69,820 each to provide advanced trauma related training to currently licensed EMTs and paramedics.

**Arkansas Trauma Communication Center (ATCC):** The purpose of the ATCC is to ensure that traumatically injured patients are transported to the most appropriate hospital(s) to treat their specific injuries in the shortest time possible. Call center operators (trained paramedics and nurses) triage and advise on transport of major and moderate trauma patients to hospitals with the appropriate capability to provide optimum care.

Prior to the trauma system, EMS providers transported trauma patients to the nearest hospital regardless of that facility’s ability...
to care for the injury. In many cases the patient needed a higher level of care. Through receiving guidance from the ATCC, ambulances are now able to bypass those lower level facilities and quickly deliver patients to definitive care. If for some reason a trauma patient in a lower level facility is determined to need a higher level of care, the ATCC can also assist with the hospital-to-hospital transfer. In the past, the receiving hospital’s emergency department would often spend several hours to arrange the acceptance of the traumatically injured patient at a higher level facility. Now, with the resources of the ATCC and cooperation of the state’s hospitals and EMS providers, the average time of acceptance has been reduced to six minutes and seven seconds.

Three major changes in our medical delivery system were necessary for this to be possible:

1. Real time notice of hospital capability and capacity to care for trauma patients (room availability and medical specialty services) is monitored 24/7 through an Internet based “Trauma Dashboard” that was developed for the Arkansas Trauma System. The ATCC is able to instantly see what hospital has what services available immediately upon notification of an injured patient.

2. Statewide capable communications infrastructure (trauma radios) have been provided to more than 500 ambulances to enable our EMS providers to call the ATCC from the scene of an accident for assistance in selecting the most appropriate hospital for the injured patient. This has proven to be effective in allowing ambulances the ability to bypass the closest hospital by providing them with information needed to make the decision to transport to a hospital that can treat specific injuries. This now makes getting trauma patients to definitive care in the shortest possible time a reality in Arkansas.

3. Hospitals had to change long standing policies to allow medical staff in the emergency department the ability to accept patients rather than requiring an admitting specialist to be notified by pager and, after sometimes lengthy discussions, making the decision to either accept or reject the patient.

Since January 3, 2011, the hospital destination of 27,029 trauma patients has been coordinated through the ATCC (2,894 major, 8,116 moderate, and 16,019 minor). The ATCC has facilitated 9,295 hospital transfers (947 major, 2,552 moderate, and 5,796 minor) and 17,734 EMS calls from the scene of an accident (1,947 major, 5,564 moderate, and 10,223 minor). Increased volume and experience continues to indicate specific areas where further improvement opportunities exist. One specific example involves serious hand injuries, in particular amputations of fingers where reattachment may be possible. Several meetings with hand specialists have been held to specifically identify where the capability and capacity exist for these patients both in-state and out-of-state. In addition, the ATCC will begin a new practice of confirming that a hospital-to-hospital transfer is urgent in order to make the most effective use of our limited EMS resources.

Trauma Image Repository: The creation of the Trauma Image Repository (TIR) is yet another important development as a result of our trauma system. Final technical work is being done to allow hospitals across the state to be able to upload radiological images to a secure repository and forward those to the physician specialist who will provide care. This system will speed up treatment from the point of injury to definitive care and will decrease the amount of repeated radiological studies performed. This is especially important for our pediatric patients.

The following is a recent experience with TIR: “TIR saved a life! A young person struck by a car while on a bicycle had an epidural hematoma and was changing neurologically. TIR pushed the films from a Level III Trauma Center to a Level I Trauma Center. The images were
downloaded (within 1 minute) and the receiving trauma center was able to have an entire operating crew with neurosurgeons available when she arrived. She spent 13 minutes in the trauma room and went up to the OR where she had her epidural evacuated safely and she is doing very well. A life was saved tonight!” Todd Maxson, MD; September 28, 2012.

**Governor’s Trauma Advisory Council (TAC):** The TAC and its six subcommittees (Finance, Hospital Designation, Quality Improvement/ Trauma Regional Advisory Councils, Injury Prevention, EMS, and Rehabilitation) meet on a monthly basis and furnish valuable guidance to ADH on development of the trauma system. This statutorily mandated 26 member committee of experts is invaluable to the success of the system.

**Trauma Regional Advisory Councils (TRACs):** There are seven TRACs throughout Arkansas. All meet routinely to address local needs such as regional destination protocols for EMS providers and performance improvement indicators and plans. All participating hospitals, EMS providers and other local stakeholders are active on these councils.

**Performance/Quality Improvement:** In addition to the current initiative to contract with a Quality Improvement Organization (see upcoming FY 2013 initiatives below), efforts have already begun to engage in performance/quality improvement at both the TRAC and TAC levels. Should situations arise in which there is a question about the performance of various components of the trauma system (e.g., hospitals, EMS providers, ATCC, etc.), these are initially referred to the performance/quality improvement subcommittees of the TAC for resolution.

**Trauma Education:** A contract in the amount of $934,000 was recently signed with the Arkansas Trauma Education and Research Foundation. The Foundation will provide 13 trauma-related courses to a wide variety of physicians, nurses, and emergency medical services personnel. This was identified by the TAC as being a much needed service in our state and the availability of these courses is expected to dramatically improve trauma care. A significant change has been made in the way these courses have traditionally been delivered. Prior to this contract, most courses were offered only in Little Rock. Today, they are being conducted in various locations throughout the state, thereby making the training more accessible, particularly for those in rural areas.

**Trauma Registry:** The Trauma Registry is operational statewide and is in the early stages of recording and tracking individual cases of traumatic injury from their inception through all phases of treatment, including rehabilitation. Reports are being run to identify performance improvement issues and trends in trauma treatment statewide. As of October 1, 2012, 74 hospitals are participating in the statewide trauma registry and have submitted 29,832 records.

**Website Development:** ADH’s website at [www.healthy.arkansas.gov](http://www.healthy.arkansas.gov) hosts a wide range of documents concerning hospital designation and the grant process for hospitals, EMS providers, and EMS training sites. In addition, ADH completed a three-hour training video for hospitals seeking trauma center designation and two videos dealing with the ATCC. These are all located on the website under “Most Requested” on the right-hand side of the ADH home page.

**Injury Prevention:** A grant in the amount of $578,000 was provided to the Injury Prevention Center (IPC) at Arkansas Children’s Hospital. The IPC implements the Statewide Injury Prevention Plan designed to reduce the burden of injury mortality and morbidity.
The IPC works closely with ADH’s Hometown Health Improvement initiative and TRACs to engage local stakeholders. The Injury Prevention Subcommittee oversees the implementation of the Statewide Injury Prevention Plan designed to reduce the burden of injury mortality and morbidity. The committee reviews injury trend data over time to identify priorities for prevention activities and to monitor progress in injury prevention.

**Rehabilitation:** Beginning January 1, 2011, the Arkansas Spinal Cord Commission (ASCC) began a statewide needs assessment for rehabilitation. Rehabilitation is a critically important component of a successful trauma system. The “Trauma Rehabilitation Strategic Plan 2012-2015” presented to the TAC includes four major goals: to ensure Arkansans who sustain traumatic disabling injuries have access to high quality, comprehensive rehabilitation in our state, to create a systematic approach to capture acute, rehabilitation, and community data metrics to determine areas of improvement in trauma patient outcomes, to build the capacities of healthcare providers to deliver quality rehabilitative care, and to increase individuals’ options to integrate successfully into the community. The Memorandum of Agreement with the Spinal Cord Commission provides $500,000 to the ASCC for this purpose for fiscal year 2013.

**Burns:** Grants for burn treatment readiness in the amounts of $250,000 were made for both fiscal years 2011 and 2012 to the Burn Center at Arkansas Children’s Hospital. These grants allow the Burn Center to increase education to Trauma Centers across the state on the treatment of burns and to purchase needed equipment.

**Initiatives for FY 2013:**
- Contract with a qualified entity to provide quality improvement expertise to hospitals and other relevant components of the trauma system
- Continue to conduct site surveys for purposes of hospital trauma center designation
- Provide ongoing funding for hospitals, EMS providers, and EMS training sites
- Ensure the continued development of the seven TRACs to provide meaningful, beneficial impact on the trauma system
- Work with the Governor’s TAC to develop strategies for continued trauma system development and improvement
- Monitor grants to ensure proper utilization of funds and accountability
- Update Trauma Rules and Regulations to meet current American College of Surgeons’ standards.

We have the experience to assist you in determining why claims have been denied, the probable success of an appeal, and most importantly, how to minimize future denials. **Realize the benefits of managing claims denials before the denials take place.**

Call Ken Cole directly, Accounts Manager
(501) 210-9354 | khcole@pinnaclebsi.com

**www.pinnaclebsi.com**
Celebrating 20 Years of Arkansas’ Community of Quality

2013 AFMC QUALITY CONFERENCE

April 4–5 | Embassy Suites | Little Rock

for more information: www.qualityconference.org

Arkansas Foundation for Medical Care
www.afmc.org
Arkansas Medicaid Proposal Expands Current Initiative

The Arkansas Health Care Payment Improvement Initiative collaborative, under which the state Medicaid program, Arkansas Blue Cross and Blue Shield and QualChoice are working toward the use of an episodic care approach to cover healthcare claims, could get bigger if the Federal Centers for Medicare & Medicaid Services (CMS) approves a $60 million grant request which Medicaid submitted on October 1.

As part of the request, Arkansas is seeking Medicare’s participation as well, although there is no indication yet that CMS will agree to allow the 500,000-plus Arkansas Medicare enrollees to be a part of the experiment.

If the State Innovation Model (SIM) Testing proposal is eventually approved, funding would help Arkansas expand on current efforts to move the vast majority of care and payment across payer lines from a fee-for-service model to one that rewards and supports providers for delivering improved outcomes and high-quality, cost-effective care.

The application employs two complementary strategies to achieve results statewide across payer lines:

1. Population-based care delivery, including medical homes and health homes that would be in place by 2016 to give a majority of Arkansans access to a patient-centered medical home, which will provide comprehensive, team-based care, with a focus on chronic care management and preventive services.

   Persons with complex or special needs (e.g., developmental disabilities) will also have a health home, which will work with the medical home to coordinate across medical, community and social support services. Payments to the medical homes would include performance-based care coordination fees and, for medical homes, shared savings on total cost of care.

2. Episode-based care delivery to reward providers who deliver high-quality, cost-effective and team-based care across an entire episode. The retrospective episode payment approach that was rolled out July 1 would be expanded by 2016 to encompass most types of care.

   The project’s goal by the end of 2016 is to affect more than 90% of “participating payer spend,” subject to patient exclusions and outliers, impacting more than 3,000 providers and two million patients.

   Estimated savings in statewide healthcare spending could approach $1.1 billion over the three-year model testing period, and could be $8.9 billion through 2020, according to Medicaid’s application summary.

• Cardiac care: acute myocardial infarction, coronary artery bypass graft surgery, percutaneous coronary intervention (angioplasty)
• Orthopedic care: back pain, joint arthroscopy
• Behavioral health: depression, bipolar disorder
• Other specialty procedures: dialysis, hysterectomy
• Stroke
• Neonatal Intensive Care
• Preschool children with developmental delays

Then, from 2014 through 2016, episodes will be rolled out quarterly in groups of five or six. By the end of 2016, there should be around 90 operational episodes.

Selig also reported that alongside Wave 1 of the initiative, the Comprehensive Primary Care Initiative (CPC) kicked off across the state in October (2012). CPC will be the foundation of a broader effort to ensure that every Arkansan has access to a “Patient Centered Medical Home” within the next three to five years.

More than 60 providers involved in CPC already have received their first per member per month payments, and have held the first provider learning collaborative.

During Wave 2 of the initiative, rather than relying heavily on crafting the episode designs through a series of workgroup meetings, a team of clinicians from across the state will initially help to draft episode designs. Those drafts will then be provided at larger workgroup meetings for input and feedback.

The workgroup meeting schedule, location and videoconferencing locations can be found at http://www.paymentinitiative.org/calendar/Pages/default.aspx.

America’s hospitals are vital to meeting the healthcare needs of the communities they serve by providing a wide range of acute-care and diagnostic services, supporting public health needs, and offering myriad other community services to promote the health and well-being of the community. A new report and infographic from the American Hospital Association (AHA) show that while many of these services also are provided by other healthcare providers, three things make the role of the hospital unique:

• **24/7 Access to Care:** The provision of healthcare services, including specialized resources, 24 hours a day, seven days a week (24/7), 365 days a year;
• **The Safety Net Role:** Caring for all patients who seek emergency care, regardless of ability to pay; and
• **Disaster Readiness and Response:** Ensuring that staff and facilities are prepared to care for victims of large-scale accidents, natural disasters, epidemics and terrorist actions.
These critical functions – collectively known as the “standby” role – while often taken for granted, represent an essential component of our nation’s health and public safety infrastructure. However, the standby role is not explicitly funded and hospitals face increasing challenges in maintaining this role.

This report and executive summary explore the standby role and its critical importance to the healthcare system; analyze the nature of demand and the basic and specialized resources required to meet it; outline the capacity and financing pressures hospitals face in maintaining the standby role; and frame critical economic and policy questions that must be addressed to ensure future hospital standby capacity can meet the growing health and public safety challenges.

To view the report and an accompanying infographic that details why hospital outpatient departments have higher costs than physician offices due to their standby and teaching roles, sicker patient population and greater regulatory requirements, please visit www.aha.org/preparedtocare.
2012-2013 GOALS AND STRATEGIES

The Arkansas Hospital Association (AHA) each year sets forth strategies for the coming fiscal year, designed to benefit Arkansas hospitals and focusing on the AHA’s major foundational tenets: Advocacy, Education and Quality, Data Collection, Reporting and Analysis, and Communications. Strategies for the operation of AHA Services, Inc. also are provided.

ADVOCACY
Actively Advocate for Arkansas’ Hospitals
• Maintain and improve on AHA’s positive relationships and communications with the members of Arkansas’ congressional delegation and their key health aides to gain support for retaining the state’s ability to collect and use Medicaid provider taxes to fund payments for hospitals and nursing homes.
• Protect Arkansas hospitals’ financial viability as Medicare and Medicaid move away from volume-based, fee-for-service payments toward development and adoption of value-based purchasing approaches that combine hospital and physician care with episodes of care and change from quality-related process to outcome measures.
• Build stronger relationships with current and new members of the Arkansas General Assembly.
• Ensure that Arkansas hospitals continue to have a voice in steps to implement health reform measures including a State Health Insurance Exchange, statewide health information exchange capabilities and other programs.
• Ensure that future Medicaid-specific quality measures for use in the state’s Quality Incentive Payment Program are reasonable and subject to input and agreement by the state’s hospitals.
• Advocate for state and national legislative, regulatory and judicial actions in support of accessible, cost effective, high-quality healthcare.
• Continue to take advantage of opportunities to impact judicial actions involving member hospitals through filing amicus briefs addressing appropriate public policy issues.
• Increase contributions to the AHAPAC over the 2011 total.
• Enhance the value of AHA membership by creating new services, expanding the types of and access to information on issues including, but not limited to, reimbursement, quality and outcomes measures, and increasing the political power of the association.

EDUCATION AND QUALITY
Provide Educational Resources and Opportunities; Assist Arkansas Hospitals in Their Efforts to Improve Quality and Patient Safety
• Establish a Physician Hospital Committee to provide educational workshops, conferences and webinars designed specifically to address physician issues.
• Develop a Quality and Patient Safety program to include the CMS Hospital Engagement Network, On the CUSP: Stop CAUTI and other hospital quality incentive programs.
• Maintain and sustain efforts surrounding a multiyear hospital-based safety project to implement the Comprehensive Unit-Based Safety Program (CUSP) model to reduce central-line associated bloodstream infections in which more than 80 units at 38 Arkansas hospitals participate, adding other infections to the project and increasing the number of participating hospitals, as appropriate.
• Educate hospital governance leaders utilizing the $50,000 Blue & You grant for AHA’s Best on Board trustee education program to provide healthcare governance education, testing and certification services.
• Provide educational programming and opportunities designed to assist members with marketplace challenges and compliance with constantly changing regulatory requirements in the healthcare arena. Proposed topics will include compliance issues, readmissions/patient safety, OPSS, CPT and ICD-9 and ICD-10 coding, financial and bundling ramifications for hospitals, operations efficiency, philanthropy, crisis communications, emergency preparedness, healthcare legal issues, governance education, mental health issues, etc.

ANALYZE AND REPORT DATA
Seek, Explain and Provide Healthcare Data; Address Data Reporting Issues
• Continue coordinating with AHA Services, Inc. to implement a benchmarking program to provide data for hospitals’ use in negotiating contracts with private, third-party health plans.
• Conduct a survey to measure vacancy rates for selected hospital positions.
• Monitor, address and resolve ongoing legislative, regulatory and policy issues concerning require-
ments for public reporting of hospital data. Communicate results to member hospitals.

COMMUNICATE

- Build on the current relationships with officials of the state Departments of Health, Human Services and Insurance to ensure that hospitals’ concerns are heard and addressed in relation to programs, rules and regulations proposed and implemented under their authority.
- Work with private, third-party payer organizations to ensure fair and equitable reimbursements for hospital care.
- Continue active participation in the development of Arkansas Department of Health rules and regulations implementing the Arkansas Health Facility Infection Disclosure Act in order to ensure that appropriate national guidelines are followed in establishing the voluntary reporting of hospital infection data, and promote hospital compliance with those reporting standards.
- Fully implement the Small/Rural Hospital Compliance Collaborative.
- Meet at least once with officials of CMS’ Dallas Regional Office and develop and maintain a positive relationship with the state’s Medicare Recovery Audit Contractor, Medicaid Integrity Program Contractor and the Medicare Administrative Contractor.
- Publish electronic version of Arkansas healthcare laws and regulations.
- Assist member hospitals to better equip them to respond to natural and/or man-made emergency situations related to weather, disease outbreaks, chemical/nuclear/biological terrorist attacks and other forms of emergency situations.
- Improve relationships with the state’s business community and reposition hospitals as large employers that pay excellent wages and strongly influence economic development.
- Continue to offer a wide range of communication tools and resources for member hospitals’ use.

AHA SERVICES, INC.

- Continue coordinating with the AHA to implement a benchmarking program to provide data for hospitals’ use in negotiating contracts with private, third party health plans.
- Continue to educate member hospitals about the wide range of discounted services available through AHA Services, Inc.
- Continue to provide AHA with financial support for operations and educational events such as the summer leadership conference and annual meeting.
- Continue to negotiate with vendors for beneficial discounts and value-added services for members.

Your Own Customized Hospital Patient Guide

No Cost To You.

Fiscal restraints and budget line item cancellations have hospitals cutting back in all areas. Here’s help. Our Patient Guides are an excellent perceived patient benefit saving your hospital time and money while informing and educating patients about your facility and their care. Best of all, there’s no effect on your bottom line, we produce them at absolutely no cost to you.

- Your full-color, glossy, Patient Guide is completely customized for your hospital.
- You also get an easy-to-use ePub version to send to patients with email—also at no cost.
- Inform and educate your patients quickly and efficiently. Your professional staff can now spend less time answering routine questions.

Your hospital needs one and you can get it free.

For complete, no obligation, information on how we can provide your Hospital Patient Guide, call or email today.

Gary Reynolds 1-800-561-4686 ext.115 or greynolds@pcipublishing.com
Nearly 50 million people have surgery each year in the U.S., approximately one million develop serious complications, and more than 150,000 patients die within 30 days. Through its ACTION II partnership, the Agency for Healthcare Research and Quality (AHRQ) is funding a national Surgical Unit-based Safety Program (SUSP) to reduce surgical site infections (SSI) and other surgical complications.

The National Project team includes world-renowned experts from the Armstrong Institute (Johns Hopkins University Medicine), the American College of Surgeons, the University of Pennsylvania and the World Health Organization Patient Safety Programme. In addition, the National Project Team includes faculty who helped develop and implement the Department of Defense and AHRQ-funded TeamSTEPPS program.

Who is leading SUSP?
The Johns Hopkins Medicine Armstrong Institute for Patient Safety and Quality is the primary lead for this work and is accountable to AHRQ for program design, implementation and evaluation under terms of the contract. Subcontractors that add tremendously to the value of this project include Dr. Clifford Ko, (Director of the American College of Surgeons National Surgical Quality Improvement Program [ACS, NSQIP], and Professor of Surgery) from the University of California, Los Angeles and Dr. Charles Bosk, (Professor of Sociology and Medical Ethics) from the University of Pennsylvania. The Johns Hopkins team includes many of the leaders of the Michigan and national CLABSI projects and similar large-scale initiatives including Peter Pronovost, Sean Berenholtz and Marty Makary.

SSI reduction remains an elusive goal. This is understandable; SSIs are multifactorial in etiology and a single “SSI Prevention Bundle” is unlikely to reduce SSIs.

What is the Surgical Unit Safety Program (SUSP)?
SUSP is a project funded by the Agency for Healthcare Research and Quality (AHRQ) to measurably improve clinical outcomes, teamwork culture and patient safety in surgery. The project is designed to build on the success of previous programs (CUSP/CLABSI) by applying new methods and tools to effectively assist teams with quality improvement in the complex surgical environment.

What is CUSP?
CUSP is the acronym for the Comprehensive Unit-based Safety Program. CUSP was designed to improve safety culture and learn from mistakes by integrating safety practices into the daily work of a unit or clinical area. The implementation of CUSP is associated with improvements in patient safety, clinical outcomes and safety culture. CUSP has been applied in a number of clinical areas and quality improvement initiatives, most notably the Michigan Keystone ICU project and the national On the CUSP: Stop HAI project.

Key Interventions
SSI reduction remains an elusive goal. This is understandable; SSIs are multifactorial in etiology and a single “SSI Prevention Bundle” is unlikely to reduce SSIs. Together, we can reduce SSIs.

In this program, participants will work together to:
2. Review other tools focused on improving adherence with evidence-based practice and explore opportunities to implement selected tools based on the types of defects identified by participating sites.
3. Review, adapt and implement the Comprehensive Unit-based Safety Program (CUSP) and selected TeamSTEPPS tools to improve teamwork, communica-
Since its beginning as Arkansas’ first hospital, Sparks Regional Medical Center has been the River Valley’s foremost medical pioneer, providing the most advanced and compassionate health care for the entire region.

- Nationally recognized in Stroke Care and Telemedicine
- The region’s only accredited Chest Pain Center
- Area’s only provider of minimally-invasive robotic surgery
- New state-of-the-art surgical suites

Our mission is to provide superior, quality and comprehensive patient-centered health care services.
Heart disease and stroke are among the most serious and costly health problems facing the nation today. Despite the fact that mortality from cardiovascular disease (CVD) has declined over the past 40 years, it remains the leading cause of death nationwide. Each year, about 2 million Americans suffer a heart attack or stroke, and 812,000 die from heart disease. A total of 3 million people report being disabled because of heart problems or stroke.

In Arkansas, heart attack and stroke are the number one and number three causes of death, respectively. The death rate from cardiovascular disease in Arkansas is the fifth highest in the United States: The age-adjusted rate in 2009 was 218.8 per 100,000 population, compared with a national rate of 180.1. The state’s death rate from stroke is the second highest in the country, at 50.8 per 100,000 population compared with 38.9 nationwide.

In addition, heart disease and stroke accounted for more than $444 billion in healthcare costs and lost economic productivity in 2010, and that figure is estimated to top $1 trillion by 2030.

The Centers for Disease Control and Prevention (CDC) and the Centers for Medicare & Medicaid Services (CMS) are conducting a national initiative called the Million Hearts campaign to improve cardiovascular health through a combination of clinical and community-based efforts. The goal of the campaign, which began on Jan. 1, 2012, is to prevent 1 million heart attacks and strokes through 2017. The initiative emphasizes cardiovascular health across patients, providers, communities and other stakeholders. It brings together a number of programs, policies and campaigns designed to make a positive impact across the spectrum of prevention and care.

As the Medicare Quality Improvement Organization for Arkansas, the Arkansas Foundation for Medical Care is working with CMS to promote the Million Hearts initiative in our state.

There are two key components to the campaign: clinical prevention and community prevention. Clinical prevention strategies include focusing on the “ABCS” – Aspirin therapy, Blood pressure control, Cholesterol control and Smoking cessation. Research has shown that improving the management of these four aspects of care can reduce the mortality rate from CVD in this five-year time frame. This means that physicians must collectively strive to increase the use of appropriate aspirin therapy, improve the control of high blood pressure and high cholesterol levels, and decrease the prevalence of smoking in their patient populations.

AFMC QIO staff members are providing technical assistance to providers across Arkansas to improve the delivery of services.
needed to manage the ABCS, such as maximizing health information technology functionality; helping physician practice staff with data capture to enable physicians to monitor improvement; benchmarking; and identifying best practices.

AFMC’s quality specialists are designing Learning and Action Network (LAN) activities that provide opportunities for peer-to-peer education.

Participating practices also will collect clinical data related to cardiovascular health measures, including:

- **Percentage of CVD or peripheral vascular disease (PVD) patients** whose most recent blood pressure during the measurement year is <140/90 mmHg
- **Percentage of ischemic vascular disease (IVD) patients** whose most recent LDL-C screening was <100
- **Percentage of IVD patients** who have documentation of use of aspirin or other antithrombotic during the measurement year
- **Percentage of patients who smoke** that have received smoking cessation counseling

AFMC, in turn, will work with participating practice staff to help align competing priorities and initiatives, and to help assess, develop, and implement interventions needed to support sustainable organizational and/or practice-level processes to improve cardiovascular health in the practices’ patient populations and communities.

Participating practices sign a pledge to increase patient awareness of heart disease and stroke; empower patients to take control of their heart health; help patients manage their conditions effectively and increase activity levels; promote smoking cessation efforts; and support patients’ efforts to reduce sodium and cut trans fats from their diets.

Community prevention efforts target smoking cessation and dietary changes to reduce sodium and eliminate trans fats. AFMC quality specialists assist communities with activities to raise awareness of the need to improve heart health and prevent heart attack and stroke. Among the tools developed for community use is a kit designed specifically for religious congregations to use in their health ministry activities.

To learn more about the campaign, go to www.millionhearts.hhs.gov. For more information about how AFMC can assist you or your community, please contact Jo Nycum at jnycum@afmc.org or Greg Green at ggreen@afmc.org.

Preventing one million heart attacks in the next five years will require healthcare professionals, physicians, family friends and communities to work together to improve both clinical practice and community health.

Michelle Murtha, RN, is a quality specialist at the Arkansas Foundation for Medical Care.

**REFERENCES**

Today’s healthcare environment is forcing hospitals to find highly efficient ways to collect payments from patients. It’s a critical national issue because much of the revenue once paid to hospitals from insurance companies has been passed to patients through co-payments and high deductibles. Furthermore, the numbers of uninsured and underinsured patients continue to rise, putting further financial pressures on all involved.

nTelagent, Inc., an AHA Services Endorsed Vendor, is helping hospitals across the country increase collections upfront while improving patient satisfaction. Two case studies published in Healthcare Business Insights highlight the success of the company’s Retail Application for Healthcare, a point-of-service solution for managing accounts receivable.

Rush Health System, a Mississippi-based group with 7 hospitals and 33 clinics, implemented the nTelagent solution in April 2012. In the first five months, the hospital reported a significant increase in collections. RegionalCare Hospital Partners, a 7-hospital system with locations in Alabama, Ohio, Iowa, Texas and Connecticut, also reported notable improvements with nTelagent.

nTelagent is also impacting hospitals close to home in Arkansas.

Crittenden Regional Hospital was looking for ways to reduce costs and preserve cash at a time when healthcare providers began to feel the impact of healthcare reform, a declining economy and an increase in uninsured. In November of 2011, the hospital’s administration recognized the critical necessity of reducing costs. They realized they had to work smarter and make wiser decisions in order to maintain financial viability.

Brad McCormick, CFO of Crittenden Regional, says purchasing nTelagent as its point-of-service collections system was a major step forward for the hospital.

“The nTelagent system has allowed our staff to streamline the registration process to overcome staff shortages,” McCormick says. “In addition, it’s provided better information regarding our accounts receivable – much better than we’ve had in the past.”

How does it work? Earl Winter, CEO of nTelagent, explains: “Healthcare providers have traditionally discussed payment options with patients in the least efficient way – on the back end of the process after the patient has already been discharged. nTelagent helps hospital systems settle patients’ accounts on the front end.

“Registrars are able to quickly validate the patient’s address, verify insurance, find out what approved benefits are available, provide deductible, copayment and/or co-insurance amounts and, when appropriate, process medical necessity,” Winter adds. “Online scripts are customized to the hospital’s specific policies and sensitive to each patient’s individual situation.”

Healthcare providers often praise nTelagent’s training component as much as its technology.

“If you are interested in finding out more about nTelagent or would like copies of the recent case studies published in Healthcare Business Insights contact nTelagent at (800) 973-3957, salesinfo@ntelagent.com, or contact Tina Creel, AHA Services, Inc. Vice President, at (501) 224-7878 or tcreel@arkhospitals.org.”
OIG Criticizes HHS Oversight of Medicare EHR Incentive Payments

The Department of Health and Human Services’ Office of Inspector General in late November recommended that the Centers for Medicare & Medicaid Services (CMS) strengthen oversight of Medicare incentive payments for meaningful use of electronic health records.

Specifically, OIG said CMS should conduct pre-payment review of documentation from selected “high risk” professionals and hospitals to verify the accuracy of their self-reported information.

In comments in the report, CMS disagreed, stating that prepayment reviews would increase the burden on practitioners and hospitals and could delay incentive payments.

Linda Fishman, American Hospital Association (AHA) senior vice president of public policy, concurs. “The OIG report contains no evidence of improper payments,” Fishman said. “Hospitals take seriously their obligations to provide accurate reports to Medicare, and are working diligently to comply with the highly complex regulatory requirements in the meaningful use program. In addition, CMS is currently conducting audits of hospitals that have received meaningful use payments.”

The report reviews CMS oversight of self-reported meaningful use of certified EHR technology in 2011, before CMS began its audit program.

OIG also recommended that CMS provide better guidance on documentation to support compliance and made recommendations to the Office of the National Coordinator to improve the meaningful use reports generated by certified EHRs to better document compliance.


Next Round of Regional Quality Forums January 29, 30, 31

TeamSTEPPS™, the highly regarded team building training program, will be the focus of the Arkansas Hospital Association’s ARbest Health regional Quality Forums January 29, 30 and 31.

The January 29 meeting will be held in Jonesboro at the Hilton Garden Inn. Little Rock’s Holiday Inn Airport is the site of the January 30 meeting, and the meeting on January 31 will be held in Fort Smith at the Courtyard. The same program is repeated at each site.

Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS™) is a systematic approach developed by the Department of Defense (DoD) and the Agency for Healthcare Research and Quality (AHRQ) to integrate teamwork into practice. It is designed to improve the quality, safety, and the efficiency of healthcare. TeamSTEPPS is based on 25 years of research related to teamwork, team training, and culture change.

Several Arkansas hospitals have sent quality team members to receive TeamSTEPPS master training, and some of these quality leaders will conduct the day’s sessions.

As always, there will be the “not your normal round table discussions” that have become the highlight of these meetings for hospital quality team members, HEN hospital contacts, infection preventionists, nursing and medical staff, data staff and representatives of hospital G-suites.

The meetings will be led and facilitated by Pam Brown, AHA Vice President for Quality and Patient Safety, Mandy Palmer, the Arkansas Foundation for Medical Care’s Hospital Quality Manager and Megan Berley, HAI Program Director at the Arkansas Department of Health.

There is no cost for the all-day workshop, and 4.6 nursing contact hours are available to those nurses who stay for the entire session. Lunch is provided.

Registration is required. For more information, please contact Nancy Robertson Cook (nrcook@arkhospitals.org) or Cindy Harris (charris@arkhospitals.org) who can provide you with a full course outline and registration form.
Care Transitions/Readmissions Drilldown Group

Arkansas has been chosen as one of only three states to participate in a national pilot program, “Creating a Winning Care Transitions Team.” This program is meant to be value-added to our work with the Hospital Engagement Network and to reduce hospital readmissions. It is entirely free of charge to the 18 participating AHA HEN hospitals. The program is sponsored and funded by the Health Research and Educational Trust, a division of the American Hospital Association. It is anchored by David Schulke, vice president of research for HRET and Dr. Matt Schreiber, CMO of the Piedmont Hospital, Piedmont Healthcare System in Georgia.

The goal is to be able to bring community agencies and hospital care transitions teams together to significantly reduce hospital readmissions.

Dr. Schreiber led an all-day workshop for hospital care transitions teams December 18. Many hospital teams brought community partners in the care transition process: nursing home leaders, home health nurses and others involved with helping patients leave the hospital and successfully continue their recovery at home or in a site where assistance is offered. More than 100 people representing the 18 teams were in attendance.

The pilot also involves direct phone conversations between participating hospitals and both Schulke and Schreiber. Toolkits and expertise are shared; what works and what has NOT worked – the peer-to-peer help offered freely – all are a part of this three-state pilot.

The goal is to be able to bring community agencies and hospital care transitions teams together to significantly reduce hospital readmissions. Patients, their families, communities and all caregivers, whether from hospitals or other healthcare organizations, can only benefit from this focused collaboration and building of new skill sets.

Hospital Engagement Network Enters Second Year

The Health Research & Educational Trust (HRET), an affiliate of the American Hospital Association (AHA), is entering the second year of a contract by the Centers for Medicare & Medicaid Services (CMS) to support their Partnership for Patients (PfP) campaign.

PfP is a public-private partnership that intends to help improve the quality, safety and affordability of healthcare for all Americans. The project assists hospitals with adopting new practices that have the potential to reduce inpatient harm by 40 percent and readmissions by 20 percent by the end of 2013.

The PfP focuses on ten areas for quality improvement. Within these areas, HRET supports the implementation of proven best practices and lessons learned through the use of webinars and educational sessions to hospitals participating in the partnership.

HRET provides this education and training with more than 1,600 hospitals recruited by its 31 state hospital association partners in support of their quality improvement efforts in the targeted areas:
- Adverse drug events (ADE)
- Catheter-associated urinary tract infections (CAUTI)
- Central line-associated bloodstream infections (CLABSI)
- Injuries from falls and immobility
- Obstetrical adverse events
- Pressure ulcers
- Surgical site infections
- Venous thromboembolism (VTE)
- Ventilator-associated pneumonia (VAP)
- Preventable readmissions

As a Hospital Engagement Network (HEN), HRET is assisting to identify solutions already working to reduce healthcare acquired conditions, and establish ways to spread them to other hospitals and healthcare providers.

Arkansas is a participating state with the HRET HEN. Through the Arkansas Hospital Association, 46 hospitals are working toward the 40/20 goal.

AHA/HRET HEN has developed learning collaboratives for hospitals and provides a wide array of initiatives and activities to improve patient safety. Intensive training programs are being conducted to teach and support hospitals in making patient care safer, provide technical assistance so that hospitals can achieve quality measurement goals, and establish and implement a system to track and monitor hospital progress in meeting quality improvement goals.
A Vacci-what-omer?

You’ve heard about the 35 AHA hospitals that are taking part in a special Healthcare Worker Immunization project...with a goal of immunizing 10% or more healthcare workers at all levels of the hospital this flu season over last. We lovingly call this the “Immie Project.”

The percentage of healthcare workers immunized is indeed on the upswing. And to help hospitals show their patients and families just how much they care, they are using Vaccimometers to illustrate how many of their workers said, “G-Immie That Shot! I want to protect our patients from the flu!”

Trust Your Beauty to the Best

Dr. Suzanne Yee combines passion and artistic sensibilities with years of extensive study and meticulous training in medicine. As the state’s leading female cosmetic surgeon, Dr. Yee’s comprehensive training, professional memberships and awards paint an impressive picture.

In addition to cosmetic surgery procedures for the body and face, Dr. Yee specializes in the following beauty treatments:

- Laser Treatments
- Injectables
- Non-Invasive Skin Tightening
- Non-Invasive Body Sculpting & Weight Loss
- Skin Care Products – featuring the Obagi Skin Care System available only in physician offices.

Amber Estrada, AHA Administrative Assistant/Webmaster works with the Immie Project. The project is made possible under a CDC technical services agreement with the Arkansas Department of Health which provides funding for hospital implementation and resources.

Amber Estrada, AHA Administrative Assistant/Webmaster works with the Immie Project. The project is made possible under a CDC technical services agreement with the Arkansas Department of Health which provides funding for hospital implementation and resources.

The professional liability and property protection for your healthcare facility deserves the expertise of specialists. The Healthcare Division of Ramsey, Krug, Farrell & Lensing is one of the largest and most experienced group of medical professional liability and property specialists for hospitals, PHOs, IPAs, surgery centers, clinics, physicians, surgeons, and nursing homes in the Southeast. Call Tom Hesselbein today for more information at 501-614-1134.

BancorpSouth Insurance Services Inc. is a wholly owned subsidiary of BancorpSouth Bank. Insurance products are • Not a deposit • Not FDIC insured • Not insured by any federal government agency • Not guaranteed by the bank • May go down in value.
Flu Cases Widespread, Rising in Arkansas

It’s Not Too Late to Get a Flu Vaccination!

The Arkansas Department of Health (ADH) is currently receiving large numbers of reports of flu infections and hospitalizations from all regions of the state and is aware of seven deaths from the flu. ADH encourages everyone six months of age or older to get a flu vaccine.

The flu vaccine is the single best protection against the flu and is very effective in preventing flu infections, hospitalizations, and deaths. The vaccine provides 60-80 percent protection against the flu and provides roughly 70-90 percent protection against flu-related hospitalization.

Those most at risk for severe flu-related complications include:
• pregnant women
• children under the age of 5
• people 65 years or older
• people with chronic conditions such as asthma, COPD, heart disease, or weakened immune systems

The flu vaccine takes 10 days to two weeks to become effective and it is not too late to get vaccinated. Flu vaccines are available at local health units, private doctor’s offices, pharmacies, and major retailers statewide.

For more information visit the ADH website at www.healthy.arkansas.gov or visit www.flu.gov.
In the last week of October, Superstorm Sandy caused a path of destruction over 20 states. While many of us followed the various news outlets for details of the storm, hospitals have experienced some unique problems and concerns – some of which hospitals have drilled often and some we’ve never drilled.

To date (and these figures change at least daily), HHS has announced critical infrastructure problems in nine states (Connecticut, Delaware, District of Columbia, Maryland, Massachusetts, New Jersey, New York, Pennsylvania and Rhode Island). There are 121 confirmed deaths in the U.S. At one point, 257 shelters were set up housing approximately 13,000 people in 15 states.

The main problem for hospitals focused – and for some, continues to focus – on energy: lack of power, how to power, failure of power. We learned that FEMA has an emergency fuel contract that state hospital associations can access through their health department and the FEMA Federal Coordinating Center.

During the storm and its aftermath, at least six hospitals were evacuated, 24 hospitals were on generators, 18 long-term care facilities were evacuated, and 122 long-term care facilities were on generators.

In a call with state hospital association emergency preparedness contacts after the storm, the following information and lessons learned were shared from states impacted by the superstorm:

• The medical supply chain went pretty smoothly, with no delays in production. The only delays were with shipping and distribution due to lack of fuel and road or pathway problems. There was some looting of medical supplies, but no emergency support was requested.

• Generator failures for the following reasons:

  □ Usually when hospitals drill, generators run for approximately 30 minutes. These generators ran fine for one or two days, then they were overheating or experiencing oil leaks that necessitated shutting them down.

  □ Generators were placed in basements that flooded.

  □ Generators were placed on upper floors or rooftops, but the fuel oil was stored in the basement. That fuel oil had to be pumped to the generator. Pumps failed due to excess water.

  □ There were extreme electrical surges and hospital generators were simply not prepared for that type of disaster.

• Questions: Should we look at the infrastructure of our generators and their back-ups? Are we adequately testing our generators for a true disaster? What about mechanical reliability issues? Some generators had to be taken offline before they damaged the entire system.

• Staffing problems: Trouble getting staff to the hospital from flooded areas, and then the challenge of housing additional staff. New York and other states had the added problem that the subway system relied upon heavily by employees was out of service.

• As expected, communications problems existed without power. Impacted hospitals had to evacuate patients to hospitals out of the area, causing some travel problems for ambulances.

• Hospitals were approached by other entities to house meds and people in the community came to the hospitals to resupply oxygen and to use as a portable “power station.” (Arkansas hospitals experienced this during the most recent crippling ice storm.)

• Several northeast hospital association CEOs reported getting calls from the MS-ISAC (Multi-State Information Sharing & Analysis Center now called the Center for Internet Security), which is designated by the Department of Homeland Security and concerned about cyber security and generator power.

• News organizations were looking

continued on page 42
Arkansas’ hospital emergency and disaster preparedness teams can learn a lot from Superstorm Sandy and how it impacted the hospitals in the Northeast. By adapting from these lessons learned, our hospitals can be better prepared to handle the next disaster that impacts our region.

Beth Ingram is Senior Vice President at the Arkansas Hospital Association. You may reach her at bingram@arkhospitals.org

New York’s Public Health Emergency Carries Reminders for All States

When Health and Human Services Secretary Kathleen Sebelius declared a public health emergency for New York in the aftermath of Superstorm Sandy, that action enabled the Secretary to ensure that beneficiaries of Medicare, Medicaid, and the Children’s Health Insurance Program (CHIP), continued to receive services as New York communities responded and recovered from this emergency.

The public health emergency is declared under section 319 of the Public Health Service Act and is necessary so that HHS may waive or modify certain Medicare, Medicaid and CHIP requirements under section 1135 of the Social Security Act in an area where there has been a declaration of an emergency or disaster under the Stafford Act. The state can submit waiver requests through Centers for Medicare & Medicaid Services (CMS) Regional Offices.

Under section 1135, HHS may permit affected healthcare facilities to adjust certain operating procedures temporarily and continue to be reimbursed under Medicare, Medicaid and CHIP. For example, a healthcare facility can quickly establish an emergency temporary location to provide healthcare services and be assured that it will be reimbursed for providing those services.

HHS agencies worked diligently with state agencies and regional networks to respond to public health, medical and human services needs of impacted communities after the storm. More than 500 HHS personnel were deployed to provide assistance in response to state requests.

An Incident Response Coordination Team made sure federal public health and medical teams had what they needed to assist storm-affected states at that critical time. This team is the on-the-ground command-and-control for federal public health and medical assets.

HHS information on protecting health immediately after a hurricane or to prepare for disasters is available at www.phe.gov/emergency.
Recovery audit contractors (RAC) are “often wrong but not penalized for their numerous inaccuracies.” That’s the message sent to the Department of Health and Human Services’ (HHS) Office of the Inspector General (OIG) in late October in a letter from the American Hospital Association (AHA) to HHS Inspector General Daniel Levinson.

AHA executive vice president Rick Pollack recommended halting inappropriate payment denials by RACs, streamlining the Centers for Medicare & Medicaid Services’ (CMS) integrity programs and eliminating duplicative audits, and investing in provider education and payment system fixes to prevent payment mistakes.

Pollack urged that “OIG’s review of the effectiveness of the RACs and CMS-related oversight efforts pay particular attention to the extent to which RAC determinations result in inappropriate denials of payment for services that are medically necessary and reasonable for the care of patients, not solely on whether these contractors are identifying improper payments and referring potential fraud cases to law enforcement.”

The letter, which can be found at http://www.aha.org/advocacy-issues/letter/2012/121024-let-oig-audits.pdf, shares relevant data from the AHA’s RACTrac quarterly survey of hospitals, which consistently shows that 75% of appealed RAC decisions are ultimately reversed.

## Improvements Made to PECOS System

Based on information received from healthcare providers about CMS’ Internet-based Provider Enrollment, Chain and Ownership System (PECOS) the agency has made improvements to increase access to more information. The following PECOS upgrades are now available:

- The electronic signature e-mails to the Authorized Officials have been updated. The new e-mails will include the Provider/Supplier’s name as well as the descriptor “1 of 2 emails” or “2 of 2 e-mails” in the subject line. E-mail 1 of 2 will contain the web Tracking ID to be entered on the PECOS E-Signature page and e-mail 2 of 2 will contain the PIN for the PECOS E-Signature page. The body of the e-mail also contains additional information about the application, including LBN or First Name/Last Name, Provider/Supplier Specialty, State, Form Type, Practice Location, NPI and SSN/EIN (Last 4 Digits Unmasked).
- Providers/Suppliers are now able to see all of their Medicare IDs in Internet-based PECOS, including Medicare IDs (Provider Transaction Access Numbers [PTANs]) associated with reassignment of benefits, practice locations and Other Medicare IDs.
- Individual providers that are currently enrolled in Medicare solely to order but wish to enroll to be reimbursed by Medicare for services furnished can convert their existing CMS 855O enrollment application into a CMS 855I enrollment application. Please refer to the “Converting Existing CMS 855O enrollment to CMS 855I” guide on the CMS website at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProvider-SupEnroll/Downloads/Converting855Oto855I-HowToGuide.pdf.
- Providers and Suppliers completing a CMS 855B enrollment will now be able to designate their practice location type as a Critical Access Hospital (CAH) or a Skilled Nursing Facility (SNF).
- Federally Qualified Health Center (FQHC) applications will now be routed to the correct Medicare Administrative Contractor (MAC). A new question has been added asking if the provider is a Tribal Owned FQHC. Based on the provider’s selection the Internet-based PECOS application will be routed to the correct MAC.

To access Internet-based PECOS, go to the PECOS website at https://pecos.cms.hhs.gov/pecos/login.do.
CMS issued a November 1 release of two Medicare final rules for calendar year (CY) 2013: the outpatient prospective payment system (OPPS) and ambulatory surgical center (ASC) rule and the physician fee schedule (PFS) rule. Key elements of the OPPS/ASC rule are:

- **Payment Update:** Including ACA-required productivity and other reductions, the rule allows a market-basket update of 1.8% for those hospitals that publicly report data on 22 quality measures.
- **Geometric Mean-Based Relative Payment Weights:** CMS finalizes the use of geometric mean costs of services within an Ambulatory Payment Classification to set the relative payment weights of services, rather than the median costs that have been used since the inception of the outpatient PPS.
- **Physician Supervision:** The rule delays for an additional year enforcement of the direct supervision policy for outpatient therapeutic services provided in critical access hospitals (CAHs) and small and rural hospitals through CY 2013.
- **Payment for Drugs:** CMS will pay for separately payable drugs and biological products at the statutory default rate of average sales price (ASP) plus 6% – an increase from the CY 2012 rate of ASP plus 4%. This rate is intended to include drugs acquisition and pharmacy overhead costs. The American Hospital Association (AHA) has repeatedly requested that CMS adopt this policy.

The new rule covering Medicare physician fees includes policies covering:

- **Payment Update:** Without congressional action, Medicare physician payments will decline by a mandated 26.5% in CY 2013.
- **Primary Care and Care Coordination:** CMS will explicitly pay physicians and qualified non-physician practitioners for post-discharge transitional care management services in the 30 days following a hospital, skilled nursing facility, outpatient observation or community mental health center discharge.
- **Value-Based Modifier (VBM):** Beginning in 2015, CMS will implement a new VBM for groups of physicians with 100 (up from a proposed 25) or more eligible professionals.
  
  The groups would have the option to participate and place 1.0% of their payments at risk for upward or downward adjustment based on the quality and cost of care they provide.
  
  CMS will not move forward with a VBM program option that is specifically tailored to hospital-based physicians at this time.
- **Certified Registered Nurse Anesthetists (CRNA):** Beginning January 1, 2013 CRNAs may directly bill and be reimbursed by Medicare for services determined by the state to be within their scope of practice, including chronic pain management services.
- **Multiple Procedure Payment Reduction (MPPR) for Imaging Services:** The rule will apply a 25% MPPR to the technical component (TC) of diagnostic cardiovascular services, and a 20% (down from a proposed 25%) MPPR to the TC of diagnostic ophthalmology services provided by the same physician (or group practice) to the same patient on the same day.
CMS Issues ICD-10 Reference Tool

CMS’s ICD-10 Project recently released a definitions manual and code reference tool available under “downloads” on the project website. The reference tool is intended for healthcare providers to better understand the impact of the ICD-10 diagnosis and procedure codes on the MS-DRG system. Hospitals and other entities covered by the Health Insurance Portability and Accountability Act must convert to the ICD-10 coding system by October 1, 2014. Meanwhile, the American Medical Association (AMA) continues to urge that CMS completely abandon plans to implement ICD-10. The AMA has expressed concerns about the costs and burdens of ICD-10 and questions whether there is any direct benefit to patients. To view the tool page, go to http://www.cms.gov/Medicare/Coding/ICD10/ICD-10-MS-DRG-Conversion-Project.html.

Home Health PPS Final Rule for 2013

CMS’ final rule covering the Home Health Prospective Payment System (HHPPS) Rate Update for Calendar Year (CY) 2013 was put on display at the Office of the Federal Register November 2, 2012. The rule updates Medicare’s HHPPS payment rates for CY 2013. Payments to home health agencies (HHAs) are estimated to remain virtually unchanged (decreasing by...continued on page 46

Contagious: adjective (kohn-tey-juhs).
1. Capable of being transmitted by bodily contact with an infected person or object: contagious excitement.
2. Carrying or spreading a contagious brand.
3. Tending to spread from person to person: contagious enthusiasm.

mass ENT HUS I AS M
inthooz.com | 501.821.8746
CMS Eases Supervision for 22 Outpatient Therapeutic Services

The Centers for Medicare & Medicaid Services (CMS) has issued a final decision reducing the supervision level for 22 outpatient services from direct to general supervision effective January 1. This is an increase from the 15 services included in the agency’s preliminary decision in September, 2012 but fewer than the 28 recommended by the Advisory Panel on Hospital Outpatient Payment (HOP).

The seven additional services include wound care and bladder irrigation services, as well as certain flu and other drug or therapeutic injections.

The HOP Panel, which reviews and advises CMS regarding the appropriate level of supervision for individual hospital outpatient therapeutic services, will hold its next semiannual meeting in March 2013. The American Hospital Association (AHA) strongly encourages interested hospitals to identify outpatient therapeutic services that require only general supervision and request an opportunity to provide testimony during the meeting.


Rule Covers Medicaid Primary Care Payments

CMS in late October finalized its rule implementing an Affordable Care Act provision requiring Medicaid to reimburse primary care providers at parity with Medicare rates in calendar years 2013 and 2014.

The rule applies to Medicaid fee-for-service and managed care payment for primary care services delivered by physicians with a specialty in family medicine, general internal medicine or pediatric medicine; related subspecialists; and practitioners, such as nurse practitioners, working under the personal supervision of a qualifying physician.

The difference between the Medicaid state plan payment amount, as of July 1, 2009, and the applicable Medicare rate would be fully financed by the federal government.

The rule also updates provider payment rates for administering pediatric vaccines through the federal Vaccines for Children Program.
Every day is a challenge in the world of health care.

At HORNE, we’re more than an accounting firm — we know the business of health care. Since 1962, HORNE has been a trusted advisor and business partner to health care organizations across the country, delivering customized business strategies to solve today’s problems while looking to the future. HORNE built its foundation in health care, and today we’re one of the largest firms dedicated to your industry.

Visit us at www.horne-llp.com to meet members of our health care team and discover more about our comprehensive services for hospitals, health systems and physician practices. For additional information, contact Partner James Cagle, CPA, FHFMA, at james.cagle@horne-llp.com.
 Putting our 63 years of construction experience to work for you.