AHA Annual Meeting, Washington, DC, April 10-13

Registration is now open for hospital executives, managers and trustees who plan to attend the American Hospital Association’s (AHA) 2011 Annual Membership Meeting April 10-13 in Washington, D.C. This meeting will provide an excellent opportunity to learn firsthand about AHA’s advocacy agenda for the 112th Congress and to visit personally with members of Arkansas’ congressional delegation about the expected impact of federal legislative and regulatory issues on their hospitals and communities.

Those visits will be as important in 2011 as for any year in recent memory, given that Arkansas’ D.C. delegation includes three new Congressmen and a new Senator who has moved over from the House of Representatives to now represent all Arkansas hospitals. They and their new aides are in the process of learning about their hospitals’ needs as healthcare providers and employers, and how proposals affecting revenues and payments may impact them. There is no better way to help them understand than via face-to-face communication.

As it has for the previous three years, the Arkansas Hospital Association will reimburse each CEO of a member hospital up to $1,000 to help offset the costs of attending the meeting. However, to receive the stipend, attendees must participate in all Arkansas activities, including the visits with our congressional leaders. Meeting and registration information is available online at the AHA Web site, http://www.aha.org/aha/advocacy/annual-meeting/11-registration.html. Those making plans to attend the meeting should fax a copy of their meeting registration form to Beth Ingram with the Arkansas Hospital Association at (501) 224-0519 to receive special mailings detailing Arkansas events. Or, e-mail your attendance plans to bingram@arkhospitals.org.

System Problems Delay Medicare Claims

Pinnacle Business Solutions, Inc. (PBSI), the local Medicare Fiscal Intermediary, notified hospitals under its jurisdiction last week that the processing of many Medicare claims submitted subsequent to December 31, 2010 has been delayed due to problems related to the implementation of the January 2011 Part A systems release. PBSI informed hospitals about specific reasons for the delay. Several involve issues related to Present on Admission (POA) codes. The system is also wrongly editing an error indicating a Medicare Advantage code error when one does not exist and incorrectly returning to provider (RTP). Fixes for some of the issues listed were to have been installed on January 14, while PBSI was hopeful the other issues would be resolved by January 20.

According to PBSI, the delays should not have an effect on the normal 14-day hold on paying claims. The hold count for claims already in process when the delay was put in place should pick up where it left off and not revert to the beginning of the hold period. PBSI will track each issue and post updates to its Web site and listserv as they become available. As a reminder, once a fix has been put in place, there will be a two to three day lag time before payment is received on “clean claims” and those which have meet the payment floor.
MedPAC Recommends PPS Updates

The Medicare Payment Advisory Commission (MedPAC) last week recommended that Congress provide an update of 1.0% for fiscal year (FY) 2012 inpatient hospital payments, and rejected the productivity cut currently in law. The update represents a 2.5% update with a 1.5 percentage point reduction to reflect a documentation and coding offset, for a final update of 1.0%. The commission also said that Congress should direct the Secretary of Health and Human Services (HHS) to fully recover all overpayments due to documentation and coding, rather than just overpayments made in FYs 2008 and 2009.

In addition, MedPAC recommended a 1.0% update for the next round of outpatient hospital and physician payments and a 0.5% update for ambulatory surgery centers. Inpatient rehabilitation facilities, long-term care hospitals, skilled nursing facilities or home health providers would get no payment update in FY 2012 if MedPAC’s recommendations are implemented.

For home health, the commission said Congress also should direct the HHS Secretary to begin a two-year rebasing of rates to reflect the average cost of providing care in 2013; revise the home health case-mix system to rely more on patient characteristics; implement a per-episode co-pay for home health episodes not preceded by hospitalization or post-acute service; and allow CMS to suspend payment or enrollment of new providers if it finds significant problems. The commission recommended that dialysis facilities and hospice providers each receive a 1.0% update.

More on Proposed Hospital VBP Program

CMS’ recent proposal for implementing a value-based purchasing (VPB) (aka: pay-for-performance) program beginning in FY 2013 links Medicare inpatient payment to quality performance for acute care hospitals paid under the inpatient prospective payment systems (IPPS). As required by the Affordable Care Act, the VBP program will be budget-neutral with all funds distributed in the same year they are collected.

To make that possible, the pool of dollars to be redistributed among hospitals based on their quality-performance is to be funded through an across-the-board reduction to the IPPS standardized amount for the respective year. The reduction is scheduled to be 1.0% in FY 2013, increasing by 0.25% each year until the reduction reaches 2.0% for FY 2017 and subsequent years. Under the proposal, hospitals will earn points toward a VBP score, and will receive the higher of an achievement or improvement score for each quality measure that is used for the program. A total VBP score for each hospital is calculated and will determine a hospital’s gain or loss.

Initially, CMS hopes to use 17 clinical “process of care” measures and eight patient satisfaction measures for the VBP scoring. The measures reflect a subset of those currently reported under the Hospital Inpatient Quality Reporting (IQR) program. Twenty-three “outcome” measures would be added in FY 2014. In addition, there would be a process to expedite the timeline for adding measures in the future. Critical Access Hospitals and certain other hospitals are to be excluded from the program. Additional information about the proposed rule will be distributed to Arkansas Hospital Association member hospitals this week.

**Article Details HHA/Hospice Certification Policy**

The Medicare Learning Network has released an article detailing the new Medicare requirement for home health and hospice care certification that became effective on January 1. Enforcement has been delayed until April 1. As a condition for payment, hospital and other physicians certifying a patient’s eligibility for the home health and/or hospice benefit must document that they or an allowed non-physician practitioner has had a face-to-face encounter with the patient. The encounter must occur within 90 days prior to the start of home healthcare or within 30 days after the start of care.

CMS will allow physicians who attend to the patient in acute and post-acute settings to certify the need for care, initiate the orders and “hand off” the patient to their community-based physician to review and sign off on the plan of care, the article notes. For more information, go to [http://www.cms.gov/MLNMattersArticles/downloads/SE1038.pdf](http://www.cms.gov/MLNMattersArticles/downloads/SE1038.pdf).

**Final Rule on Permanent EHR Certification**

The Office of the National Coordinator for Health Information Technology (ONC) on January 4 issued its final rule establishing a permanent certification program for electronic health record technology and other health information technology. ONC’s current temporary certification program will be replaced by the provisions in this regulation. ONC will accept applications beginning this spring from organizations that want to conduct certifications under the permanent program. Testing and certification under the permanent certification is expected to begin January 1, 2012. For more information about the permanent certification program and the final rule, please visit [http://healthit.hhs.gov/certification](http://healthit.hhs.gov/certification).

**AHA Board Highlights**

During its regular monthly meeting on January 14, 2011, the Arkansas Hospital Association (AHA) board of directors covered the following items:

- A planned House vote to repeal the Affordable Care Act (ACA) was delayed until the week of January 17 due to the shooting in Tucson, AZ. The attempt will not progress beyond the House as necessary votes in the Senate are not there.
- CMS has released a proposed regulation for the new hospital value-based purchasing (VBP) program. The ACA requires the Secretary of Health and Human Services to establish a VBP program to pay hospitals for their actual performance on quality measures, rather than just the reporting of those measures, beginning in fiscal year 2013. The VBP program will apply to all acute-care prospective payment system hospitals.
- The American Hospital Association will work to keep the victories won on a number of critical legislative and regulatory issues during the 110th Congress, including the retention of coverage requirements in the ACA, the lynchpin for offsetting huge Medicare cuts in the law.
- The Arkansas General Assembly convened on January 10. Progress is being made to finalize and get consensus on language to modify Act 562 of 2009, the AHA-supported Medicaid assessment law. Plans call for the amendments to be introduced before the end of January. The AHA is following other bills and will keep the membership updated via special updates and Legislative Bulletins throughout the session.
• Healthcare Reform Advisory Committee: Arkansas Blue Cross and Blue Shield officials met with the AHA, the Arkansas Medical Society, the Arkansas Pharmacy Association, representatives of the Arkansas Insurance Department and officials from QualChoice and United Health Care in December to discuss the department’s plans to fulfill its responsibilities under the health reform law and how they may impact hospitals, physicians, pharmacists and payers.

• Arkansas Medicaid Advisory Committee: The Department of Human Services has appointed a Medicaid Advisory Committee to guide the state Medicaid program on activities related to its responsibilities under health reform. Gary L. Bebow, FACHE, administrator/CEO of White River Medical Center and Jonathon R. Bates, MD, president/CEO of Arkansas Children’s Hospital are committee members.

• Arkansas Disaster Preparedness Issues: Arkansas is one of three states to score a perfect 10 out of 10 on a survey of Public Health and Disaster Response Preparedness. Hospitals and the Department of Health have worked collaboratively for the past decade to improve the state’s capabilities.

• On January 25, the AHA and Central Arkansas hospitals will host a dozen state Health Department and high ranking federal HHS officials to discuss lingering disaster response issues including changes in the NDMS Memorandum of Agreement which the AHA and hospitals have been working toward for two years.

• The Department of Health and Human Services has asked a representative of the AHA to attend a January 28 meeting of an NDMS Senior Policy Group to discuss issues related to the 2008 activation of central Arkansas NDMS hospitals. Greg Crain, FACHE, vice president of Patient Services at Baptist Health Rehabilitation Institute, will attend.

• The board discussed and expressed concerns about a proposed change in Medicare home health law that would have physicians to meet face-to-face with Medicare home care patients within certain timeframes to document that the patient’s condition merits home care. The law applies to hospice care as well. The board instructed staff to convey the concerns to the state’s congressional delegation.

• An update to the Medicare claims processing system software has caused Pinnacle Business Solutions, Inc. to notify hospitals that claims submitted subsequent to December 31, 2010 will be subject to a processing delay. Part of the problem should have been resolved by January 14, 2011 and the remainder was expected to be fixed by January 20. The delay should not affect the 14-day hold on claims. The day count for claims in process when the delay was imposed would resume at the time the fix is in place and processing resumes.

The AHA Calendar

January 2011
19-21 Healthcare Financial Management Association (HFMA) Arkansas Chapter Tri-State 2011 Winter Institute, Gold Strike Casino Resort, Tunica, MS
20 The Coder’s Guide to Value-Based Purchasing (VBP): Present on Admission (POA), Hospital Acquired Conditions (HACs) & Serious Reportable Events (SREs) – Webinar T2639

Information on all AHA educational programs and activities is available at www.arkhospitals.org/events.