Hospital CEO/Trustee Forum, June 18-20

Join friends and colleagues from across the state for the Arkansas Hospital Association’s Executive/Trustee Leadership Forum (formerly the Arkansas Hospital Administrators Forum/Arkansas Health Executives Forum Leadership Conference) to be held June 18-20 at the Chateau on the Lake in Branson, Missouri. The summer conference this year will, for the first time, offer a venue for hospital executives and trustees to come together to forge a better understanding of hospital and healthcare issues.

The faculty is highlighted by Stephen Mayfield, senior vice president for quality and performance improvement for the American Hospital Association (AHA) and director of the AHA’s Quality Center, who will discuss collaborative leadership for quality and healthcare optimization. In addition, Carl Abraham, MD, an infectious disease specialist from Jonesboro, will cover community strategies for managing infectious disease risks, with a focus on his experience with MRSA containment, and a representative from the Centers for Medicare & Medicaid Services will provide an update on the Recovery Audit Contractor (RAC) Program – its future expansion schedule, how to prepare for the coming reviews, myths about the RAC experience so far and facts that should put to rest some concerns about the program.

Along with the planned educational activities, Branson offers many opportunities for family entertainment – golfing, outlet malls, fishing, boating, swimming, tennis, a full range of musical entertainment for all ages and tastes, and much, much more – which make the trip to Branson memorable.

Registration information will be available soon, but you are encouraged to make hotel reservations now by calling 1-888-333-5253. Mention the Arkansas Hospital Association for special room rates. Contact Beth Ingram at (501) 224-7878 or bingram@arkhospitals.org for additional information.

Arkansas Delegation Continues Hospital Support

Arkansas hospitals have again received outstanding support from the state’s entire congressional delegation on a matter that could dramatically affect their Medicare payments over the coming years. Both Arkansas senators and four congressmen are on record opposing the dramatic Medicare cuts that President Bush proposed on February 4 as part of his FY 2009 budget plan. Most signed letters circulated in their respective chambers urging their budget committee members to support Medicare and Medicaid and the senior citizens, disabled people and children who rely on these programs for healthcare, and to oppose proposed cuts to hospital services when forming a budget resolution this year.

The president’s budget proposal, which covers the five-year span FY 2009-FY 2013, included $182 billion in reduced Medicare spending and another $18 billion in Medicaid reductions. The hospital cuts under the Medicare part alone would total a staggering $135 billion nationally and more that $938 million for Arkansas hospitals. In addition, the state’s hospitals stand to lose around $75 million, or more, per year in Medicaid payments, if the administration is successful at
implementing the Medicaid changes in his proposal. Last Friday, February 29, was the final day for collecting signatures on letters circulated in the two legislative chambers urging their respective budget committee members to oppose the proposed cuts. Reps. Vic Snyder, John Boozman and Mike Ross joined 246 other congressmen who affixed their names to the House letter by the deadline. Rep. Marion Berry notified the Arkansas Hospital Association of his opposition to the president’s proposed cuts, but as a member of the Budget Committee, it is his policy to not send letters directly to other committee members. The Senate letter, which was co-authored by Senator Blanche Lincoln, garnered 61 names, including her’s and Sen. Mark Pryor’s.

Arkansas Medicaid Requires NPI May 19

The Arkansas Medicaid program recently contacted all its healthcare providers to remind them about the coming effective date for the National Provider Identifier (NPI). As of May 19, 2008 Arkansas Medicaid will accept only the NPI number on electronic transactions as required under the Health Insurance Portability and Accountability Act of 1996. Electronic transactions include billing, performing, requesting, attending, referring and prescribing provider numbers, as appropriate. The NPI must also be used on electronic eligibility verification transactions.

Failure to report an NPI to Arkansas Medicaid by May 18, 2008, and to use it for all electronic transactions beginning May 19, 2008, will result in claims being rejected and payment delays or complete denials. Enrolled providers must report their NPI to Arkansas Medicaid by May 18, 2008, to ensure the uninterrupted processing of electronic transactions. In order to report an NPI, go to the Medicaid Web site (https://www.medicaid.state.ar.us) and double click on the “Provider” icon to enter your Arkansas Medicaid Provider number and password. Proceed by following the steps to report your NPI. Identifier numbers for providers who have already reported them to Arkansas Medicaid have been successfully linked to the appropriate Arkansas Medicaid Provider number.

Providers who do not have access to the Medicaid Web site and who reported NPI numbers using a NPI Reporting Form, can use that form for referencing the information. Anyone who failed to keep a copy of the information and would like one, should contact Provider Enrollment. For problems regarding NPI numbers, contact Provider Enrollment at (501) 376-2211 (for local or out-of-state calls) or at (800) 457-4454 (toll free).

Guidance For Appealing Payment Denials

The Centers for Medicare & Medicaid Services (CMS) has issued guidance effective July 1 for hospitals that are appealing payment denials by the agency and its contractors. Authorized by the 2003 Medicare Modernization Act, the guidance affects all Medicare appeals activity, including appeals of medical necessity review denials by fiscal intermediaries and Medicare administrative contractors, and appeals of payment denials by recovery audit contractors.

It prevents funds from being recouped during the first two stages of the five-stage appeals process. Interest on denied payment will continue to accrue, but will not be assessed if the denial is overturned in favor of the provider. The vast majority of appeals are concluded during the first three levels of the appeals process. Read the details at http://www.cms.hhs.gov/transmittals/downloads/R314OTN.pdf.
Legal Note: Non-Monetary Compensation Under Stark Law

Unless an exception applies, the Stark law prohibits a physician’s referral of designated health services (DHS) payable by Medicare or Medicaid to an entity, including a hospital, that furnishes the physician with any type of remuneration, including in-kind compensation. The Stark regulations, however, contain an exception allowing a DHS entity to offer certain relatively low valued, non-monetary compensation – such as occasional gifts or meals – to a physician without triggering the Stark law referral prohibitions. See 42 C.F.R. §411.357(k).

In order to satisfy this exception, the compensation cannot be cash or cash equivalents and cannot exceed $300 in value per year. This upper limit is adjusted annually based upon the percentage increase in the CPI-U; for 2008, it is $338. It cannot be aggregated among physicians within a medical group for purposes of furnishing a more expensive item or service to the group. In addition, the following criteria must be satisfied:

- The compensation cannot be determined in any manner that takes into account the volume or value of referrals or other business generated by the physician that receives it.
- The compensation cannot be solicited by the physician or his or her practice, or their employees or agents.
- The compensation arrangement cannot violate the federal Anti-Kickback Statute (42 U.S.C. §1320a-7b) or any other law or regulation governing billing or claims submission.

The recent Stark Phase III regulations revised this exception to allow physicians to repay the compensation if the hospital inadvertently exceeds the annual limit. As long as the value of the excessive non-monetary compensation is no more than 50% of the limit and the physician repays that excess amount before the earlier of the end of the calendar year or 180 calendar days following the date the compensation was paid. This section provides a safety net for hospitals, but it may be used only once every 3 years with respect to the same referring physician.

Finally, a hospital may provide one local medical staff appreciation event per year for the entire medical staff, which will not count toward the non-monetary compensation limit for the year. However, any gifts or gratuities provided in connection with the event are subject to the limit.

Suggested topics for the Legal Note may be submitted to elisawhite@arkhospitals.org. The Legal Note is provided solely for informational purpose and does not constitute legal advice. Readers are encouraged to consult with their own attorneys about any legal issues, including those discussed in this article.

Subcommittee Hears MA Concerns

At a February 28 hearing on the Medicare Advantage (MA) program, the CEO of a small, rural hospital told the House Ways and Means Health Subcommittee that “the unexamined growth of Medicare Advantage plans and their rapid displacement of traditional Medicare is disrupting the healthcare mission of physicians and hospitals and hurting, not helping, the patients we serve.” James Mattes, president and CEO of Grand Ronde Hospital in La Grande, OR, voiced the concerns of many hospitals, saying that many MA enrollees his hospital counsels do not realize they have opted out of traditional Medicare and can be upset to learn that their plan requires them to pay more out of pocket. He said his hospital also has experienced high payment and coverage error rates on MA claims, which “increases costs for everyone,” and expressed concern that the plans will force discounts in payment rates as their enrollment grows, hurting providers and patients.
RACs Panned, Praised Almost Simultaneously

A representative of the American Hospital Association appeared before the House Small Business Committee on February 27, urging Congress to quickly relieve hospitals from the most burdensome and ineffective regulations, including the Medicare Recovery Audit Contractor (RAC) program. The testimony was provided during a hearing on the Paperwork Reduction Act. Linda Brady, M.D., president and CEO of Kingsbrook Jewish Medical Center in Brooklyn, NY, remarked that RACs, one of which has been operating in New York for a couple of years, are “duplicative oversight mechanisms,” that “only increase confusion and drive up costs for both hospitals and healthcare systems as a whole, as well as the government.”

Brady’s comments may have been overshadowed by an almost simultaneous announcement from CMS that the RAC demonstration projects in California, Florida and New York “collected $357 million from healthcare providers and suppliers in improper Medicare payments in 2007.” Hospitals provided more than 90% of the recovered overpayments. Acting CMS Administrator Kerry Weems said in a February 28 press release, “The RAC demonstration program has proven to be successful in returning overpayments to the Trust Fund and identifying ways to prevent future improper payments.” Nearly $440 million has been collected since the program began in 2005.

To view the CMS announcement, and see details on erroneous payments identified by the RACS click on http://www.cms.hhs.gov/apps/media/press_releases.asp.

Court Rules HHS Unlawfully Updated AWI

The U.S. District Court for the District of Columbia last week ruled that the method the Department of Health and Human Services (HHS) used to update the area wage index for Medicare reimbursement to all participating hospitals was unlawful. In a lawsuit brought by 62 Massachusetts hospitals, Judge Gladys Kessler found that HHS failed to “update the index based on an accurate survey of hospital wages.”

HHS exceeded its “authority by cherry-picking data from hospitals …,” Kessler wrote in her opinion. “The statute does not give the Secretary discretion to exclude from the survey an entire category of hospitals … nor to choose to exclude those same hospitals when updating the area wage index ….” The district court ordered that the Secretary’s action be set aside. See https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2005cv0625-34 to read the ruling.

Bills Address Medicare Funding Warning

As required by the 2003 Medicare Modernization Act, House and Senate leaders have introduced legislation proposed by the administration to respond to a Medicare funding warning issued by the program’s trustees last April. According to the administration, the legislation (H.R.5480/S.2662) takes an approach to strengthening Medicare that includes limits on means testing for Part D premiums and medical liability costs; improved health information technology and electronic medical records; transparency in price and quality information; and incentives for providers to deliver and Medicare beneficiaries to choose high-quality, low-cost healthcare.
**Document IDs HIPAA-Related Info Requests**

The Centers for Medicare & Medicaid Services’ Office of E-Health Standards and Services has issued a document to help health plans, healthcare clearinghouses and certain healthcare providers understand the types of information that may be requested of them for potential Health Insurance Portability and Accountability Act security rule violations. The document details which personnel may be interviewed and which documents may be reviewed by the contractors responsible for conducting onsite investigations. The document is available at [http://www.cms.hhs.gov/Enforcement/Downloads/InformationRequestforComplianceReviews.pdf](http://www.cms.hhs.gov/Enforcement/Downloads/InformationRequestforComplianceReviews.pdf).

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**Imaging Service Growth Causes Concerns**

The Center for Studying Health System Change (HSC) issued a February 25 report saying that health plans are stepping up efforts to slow the growth of advanced imaging services, such as computed tomography (CT) and positron emission tomography (PET) scans. HSC said that in addition to the added costs to the healthcare system, the rapid expansion of the imaging units create concerns related to patient safety and quality of care.

According to the study, the number of CT scans performed in the U.S. grew from 12 scans per 100 people in 2000 to 22 scans per 100 in 2005. One reason for the growth could be repeated scans resulting from poor-quality images generated by substandard equipment or from inaccurate interpretation of results by inadequately trained physicians. Beyond the actual numbers, repeated use of CT scans, for example, can expose patients to excessive amounts of radiation, because these scans generally emit significantly larger amounts of radiation than traditional X-rays. Read the report at [http://www.hschange.org/CONTENT/968/](http://www.hschange.org/CONTENT/968/).

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**Newsnotes About Arkansas Folks**

Joyce Hedden, wife of former AHA Chairman Bill Hedden of Magnolia, died Friday, February 29 at Magnolia Hospital. Funeral services were held Monday, March 3. Memorials may be made to St. Jude’s Children’s Hospital in Memphis or to the Magnolia Boys and Girls Club.

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**The AHA Calendar**

**March 2008**

6 Nursing Intensity Billing and Nursing Quality Impacts on the Hospital Revenue: State of the Science – Webinar #T2376

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7 UALR/UAMS 2008 Healthcare Management Institute “Leadership at the Speed of Trust” University of Arkansas Cooperative Extension Center

11 Solutions to Emergency Department (ED) Call Coverage Issues: The Office of Inspector General Provides Hospitals with Its First Guidance to Payment Solutions – Webinar #T2378

12 High Stakes Communication Series – 7-Part Audioconference Series – Part 2: Patient Family Involvement
Final Thoughts by Paul Cunningham

The span of Arkansas 167 between Bald Knob and Batesville might be the most perfect stretch of highway in the state. It boasts four wide lanes of glass-smooth pavement and relatively long runs of straight road surrounded by scenic vistas, and the traffic isn’t horrible. It is, in other words, a place where drivers can easily find themselves pushing cars and trucks a little beyond the limits of the law, something they shouldn’t do.

It was a lesson learned the hard way on a Saturday afternoon nine days ago as I was making my way back to central Arkansas, somewhere between Pleasant Plains and Velvet Ridge. In my own defense, it was an inadvertent violation. I got caught up in the drive, cruising, taking in the sights, munching on bites of Sonic’s popcorn chicken, listening to tunes of the late ‘60s and early ‘70s (music my 17-year old daughter simply fails to appreciate when riding with me; and, yes, it was a bit loud) and enjoying the fact that mine was the only vehicle in sight.

Okay, I was a little distracted and inattentive, but certainly not enough to think that I didn’t have everything well under control… until the surprising other car traveling in the opposite direction appeared over the rise in front of me. Once I saw those darned blue lights come on and the U-turn in the middle of the highway behind me, I made a quick jump back into the moment. But, it was too late. Caught! The only acceptable option was to slow down and pull onto the shoulder.

As the Trooper walked toward the back of my Honda Pilot, I considered trying to ‘splain myself, but then imagined his response would be like Marshal Sam Gerard’s in the movie The Fugitive, when man-on-the-run Dr. Richard Kimble tried to plead his innocence of a crime. Gerard’s reply? “I don’t care.” Knowing that a ticket was coming, I braced for it.

To his credit, the very understanding State Trooper exercised some discretion and opted to leave me with only written and verbal warnings. I got lucky. Life isn’t always subject to such flexible choices. A couple of Arkansas hospitals recently learned that awful truth on a matter related to clinical laboratory services that has surfaced in the state. It’s one that can result in serious consequences for inattentive hospitals by jeopardizing lab certification and putting guilty hospitals’ Medicare reimbursements – for lab and all other services – at risk.

The issue involves the violation of a rule included in the regulations implementing the 1988 Clinical Laboratory Improvement Amendments (CLIA). Under the rule, certified labs must not refer samples, or portions of samples, to another laboratory for any analysis that it is certified to perform in its own laboratory.

Such sharing or conveying proficiency testing samples or results between two separately certified labs (in-house, external, or reference) is considered “proficiency testing referral” which is not allowed under the Medicare Conditions of Participation. This includes verifying results with another lab by phone or by sending samples to be tested at another lab. According to the Arkansas Department of Health, the two Arkansas hospitals recently were found out of compliance with the rule during routine surveys.

Health Department officials want to ensure that all hospitals understand that any laboratory found to have conducted proficiency testing referral is subject to immediate CMS action to suspend the CLIA certificate for one year. That carries with it the cancellation of Medicare reimbursement for lab services. The kicker is that punishment is not only swift, but also absolute. There is neither a warning issued nor any opportunity to correct the violation and avoid the suspension. Whether it was intended or a mistake is immaterial. Like Marshal Gerard, CMS doesn’t care.

Plus, if CMS invalidates the non-compliant lab’s certification, it will also cause all other CLIA certificates owned by the violating hospital to be revoked for not one, but two years. Because many hospitals have multiple CLIA certified labs within the facility or system, there is more than a slight opportunity that one could inadvertently share proficiency testing samples or results. Hospitals having questions should call Laura Moody, the department’s CLIA Program Manager or Connie Melton, Section Chief Health Facility Services (501) 661-2201.