AHA Annual Awards: Call for Nominations

Nominations are open for the 2014 Arkansas Hospital Association (AHA) awards program. The A. Allen Weintraub Memorial Award and Distinguished Service Award will be presented during the Arkansas Hospital Association’s 84th Annual Meeting Awards Dinner Thursday, October 9, at the Little Rock Marriott. Arkansas’ C. E. Melville Young Administrator of the Year will be recognized by the Arkansas Health Executives Forum, and the Diamond Awards, cosponsored by the Arkansas Society for Healthcare Marketing and Public Relations, also will be presented at the Awards Dinner. In addition, the ACHE Regent’s Awards will be presented at the ACHE Breakfast meeting that same morning.

Criteria for each award follows:

- **The A. Allen Weintraub Memorial Award**, named for Allen Weintraub, long-time administrator of St. Vincent Infirmary Medical Center in Little Rock, is the highest honor bestowed upon an individual by the AHA. Those nominated for this honor should be hospital chief executive officers who are contributing to their hospitals and communities in much the same manner as did Allen. Those who remember him always mention his care and concern, not only for hospital patients, but also for his employees; his passion for quality healthcare for Arkansans; his recognition of duty to the community; and his visionary influence.

- **The AHA’s Distinguished Service Award** is presented to individuals who, while not necessarily AHA members, have promoted a cause of the healthcare industry, thereby becoming entitled to special recognition. Examples of those eligible for this award are physicians, nurses, trustees, auxilians, community leaders and other deserving individuals.

The 2014 recipients of the Weintraub and Distinguished Service Awards will be chosen by the AHA board of directors from those nominated.

- **The C. E. Melville Young Administrator of the Year Award** is named for the late C. E. Melville, administrator of Jefferson Regional Medical Center in Pine Bluff. The award recipient is selected by the Arkansas Health Executives Forum’s Awards Committee. The award recipient must be age 40 or under in 2014, a resident of Arkansas for at least two years, employed by an Arkansas healthcare institution, and meet requirements for active membership in the Arkansas Health Executives Forum.

- **The 2014 Diamond Awards** honoring excellence in hospital marketing and public relations will be presented in several categories, such as advertising, annual report, Internet website, publications, special video production, and writing. Diamond Awards may be presented to hospitals with 0-25 beds (CAH), 26-99 beds, 100-249 beds and 250 or more beds. Entries will be accepted through May 16 and will be judged individually by a panel of judges not affiliated with any Arkansas hospital. Emphasis will be placed on the budget for each entry within each division.
• The 2014 ACHE Regent’s Awards will honor outstanding healthcare executive leadership in two areas – early career and senior level. The two recipients, selected by the Arkansas Health Executives Forum’s Awards Committee, will be presented their awards at the ACHE Breakfast during the AHA Annual Meeting and recognized at the annual Awards Dinner that same evening.

Nominations and entries (with the exception of the Diamond Awards), accompanied by appropriate documentation, must arrive at AHA headquarters no later than July 30, 2014.

Informational brochures providing details of all awards have been distributed to each hospital CEO and public relations/marketing officer. They also are available at http://www.arkhospitals.org/events/annual-meeting. Please contact Beth Ingram or Lyndsey Dumas at (501) 224-7878 with questions about the awards or award process.

Don’t Lose Momentum on ICD-10

While it is unfortunate that Congress voted to delay ICD-10, the Arkansas Hospital Association (AHA) encourages member hospitals to continue their training. With this delay comes the risk of losing momentum to prepare for the transition, as well as the opportunity to better address major concerns. Two of the more taxing concerns include decrease in productivity and having adequate documentation to support the increased needs for specificity. There is still much work to be done in these two areas.

Remaining undeterred, the AHA will continue its eight-part workshop series providing basic training on coding in the new system and will cover both issues. Studies have shown that productivity rates after implementing ICD-10 have dropped by 50%, which has the potential of severely impacting cash flow. Continuing this training will allow for greater understanding of the issues needed to be addressed including identifying key areas needing documentation improvement.

The remaining workshops in the series are:

April 30 – Session IV: Circulatory and Respiratory
May 21 – Session V: Musculoskeletal, Skin and Subcutaneous
June 25 – Session VI: OB/Newborn/Congenital
July 23 – Session VII: Digestive, Genitourinary
August 27 – Session VIII: Signs and symptoms, Injury and Poisonings, External Causes, Factors Influencing Health Status

The AHA is providing this training at a very affordable rate to allow our members to move forward with continued progression toward the goal of being ready for this important transition. Workshop details and registration information is available at www.arkhospitals.org/events.

AHA’s 2014 Advocacy Agenda

The American Hospital Association (AHA) has released its annual advocacy agenda outlining the Association’s key advocacy priorities for 2014. The agenda, which members will use to explain the hospital field’s concerns to their legislators over the coming months, will be highlighted at the AHA Annual Membership Meeting, May 4-7, in Washington, D.C. Topics include: delivery system reform programs; improving quality and patient safety; quality reporting and pay-for-
performance programs; health coverage; health information technology; hospital price transparency; hospital field realignment; Medicare; Medicaid; the 340B drug pricing program; small or rural hospitals; post-acute care providers; physician issues; annual appropriations; workforce; hospital emergency preparedness and response; hospital tax exemption; program integrity; administrative simplification; regulatory relief; and medical liability reform.

The Arkansas Hospital Association’s own version of the agenda, which prioritizes many of the issues found in the AHA’s advocacy blueprint, leads with addressing the multiple problems and issues of claims reviews and payment denials and recoveries related to Recovery Auditor organizations and the Medicare Administrative Contractor.


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**Court Challenge of Two-Midnight Policy**

The American Hospital Association, four hospital associations and a number of individual hospitals have teamed together on a federal court challenge to the Centers for Medicare & Medicaid Services’ new two-midnight rule and a related offset to Medicare payments, which they claim burden hospitals with arbitrary standards and documentation requirements and deprive them of Medicare reimbursement to which they are entitled.

The rule requires for inpatient payment the admitting physician’s expectation that a beneficiary’s stay will last at least two midnights, which the group claims is “arbitrary” and “capricious” and therefore invalid under federal law and regulation. It applies regardless of the “level of care” the physician expects the patient to need and “unwisely permits the government to supplant treating physicians’ judgment.”

The group also says it is arbitrary for CMS to apply a one-year time limit from the date of care to requests for outpatient payment when inpatient payment is denied by a Recovery Audit Contractor, and to require, in direct contradiction of Medicare law, a written physician order for every inpatient stay as a condition of Medicare payment. A separate but related complaint contends that CMS’ decision to cut Medicare reimbursement rates in response to alleged increased costs from the two-midnight rule violates federal law and regulation.

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**Advisory Details IRS Rules on Healthcare Coverage**


The Affordable Care Act (ACA) requires each employer with at least 50 full-time equivalent employees to provide information to the IRS on its employee health benefits program. The information will be used to verify that employees were receiving minimal essential health coverage and determine whether their coverage is in compliance with the employer shared responsibility requirements of the ACA.

In some cases, the employer’s health insurance carrier will provide a portion of this information to the IRS on the employer’s behalf. These final rules provide guidance on meeting the requirements.
beginning in 2016 for employee coverage offered in 2015. Most hospitals will be required to report information on their employee benefit plans in 2016 for coverage offered to employees in 2015. In addition, some hospitals may opt to provide information in 2015 for benefits offered in 2014, though no penalty will be assessed for not reporting in 2015.

On April 23, the American Hospital Association sent all member hospitals a detailed Regulatory Advisory of the final rules, prepared by Health Policy Alternatives, Inc.

OIG Site-Neutral Policy Recommendations

The outlook that Congress will eventually reduce Medicare hospital outpatient payments to the rate paid for some procedures when performed in ambulatory surgical centers (ASC) became more ominous last week. In a new report requested by Congress, the Department of Health and Human Services' Office of Inspector General (OIG) said that CMS should reduce Medicare payment rates under the hospital outpatient prospective payment system for low- and no-risk patients receiving procedures that could be performed in ASCs, and should seek authority from Congress to exempt the savings from budget neutrality requirements.

The report estimates that this type of site-neutral payment for hospital outpatient departments and ASCs could save Medicare up to $15 billion and beneficiaries $2-$4 billion over six years. CMS, however, did not concur with the recommendations, in part because the OIG did not suggest specific clinical criteria to distinguish patients that can be adequately treated in an ASC relative to a hospital outpatient department.

Hospital Compare to Share IPF Data

On April 17, CMS announced that quality measures from inpatient psychiatric facilities will be publicly reported on Hospital Compare, the consumer-oriented website that provides information on the quality of hospital patient care. Data reported on Hospital Compare are collected as part of the CMS Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program, under the Affordable Care Act.

The website will show data from 1,753 inpatient psychiatric facilities on patient care for the period of October 1, 2012 through March 31, 2013. The public reporting will allow consumers to directly compare facilities based on data collected for hours of physical restraint use, hours of seclusion use, post-discharge continuing care plan created and post-discharge continuing care plan transmitted to next level of care provider upon discharge.

CDC: Needs of Rural Hospital Patients Differ

Inpatients at rural hospitals are more likely to be over age 65 and on Medicare than those in urban hospitals, according to a new report by the National Center for Health Statistics at the Centers for Disease Control and Prevention.

Rural inpatients also are less likely than their urban counterparts to have procedures performed during their hospitalization, possibly due to a shortage of specialty physicians in rural areas, and are more likely to be discharged to other short-term hospitals or long-term care facilities, the
report states. About 12% of U.S. hospitalizations are in rural hospitals, the report notes. Congress this month extended the Medicare-dependent Hospital Program, low-volume adjustment and ambulance add-on payment for rural hospitals until April 2015 as part of legislation to stave off scheduled cuts to Medicare physician payments. AHA advocated for the provisions and continues to urge Congress to remove a 96-hour physician certification requirement for critical access hospitals (CAHs), and to suspend enforcement of the direct supervision policy for outpatient therapeutic services furnished in CAHs and small rural hospitals. See the full report at http://www.cdc.gov/nchs/data/databriefs/db147.htm.

HFMA Report on Price Transparency

A Healthcare Financial Management Association (HFMA) task force has issued a set of price transparency recommendations for health plans, healthcare providers and others, and a guide to help consumers estimate the cost of care. Health plans should serve as the principal source of price information for insured patients, and providers for uninsured patients and those seeking out-of-network care, the task force said.

Among other information, price transparency tools for insured patients should include the estimated total price and out-of-pocket costs for the service being sought and whether particular providers are in the health plan’s network, while tools for uninsured and out-of-network patients should clearly communicate pre-service price estimates and which services are/are not included in the estimate, the panel said. Read the report at http://www.hfma.org/Content.aspx?id=22305. The consumer guide is on the HFMA web site at www.hfma.org.

The AHA Calendar

April 2014
29 Magnetic Resonance Imaging (MRI): Patient Safety Issues – Webinar T2902
30 ICD-10 Series: Don’t Become an ICD-10 Zombie – Course IV: Circulatory and Respiratory, AHA Classroom, Little Rock
30-2 HFMA Annual Spring Conference, Embassy Suites, Hot Springs

May 2014
1 ASHMPR 2014 Spring Conference, Crowne Plaza, Little Rock
1 Making the Transition to Management – Webinar T2903
1-2 2014 CSR 2-Day Workshop, Double Tree Hilton, Murfreesboro, TN
2 ArkAMSS Spring Conference, AHA Classroom, Little Rock
6 Medical Necessity Updates 2014 – Webinar T2905
6 CMS Surgery, Post-Anesthesia Care Unit (PACU) and Anesthesia Guidelines: Extensive Revisions Taking the Confusion Out – Webinar T2904
7-9 AAHE Annual Meeting, Holiday Inn, Little Rock Airport Conference Center

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

Editor’s Note: The Notebook will not be published May 5 due to the American Hospital Association’s Annual Membership Meeting taking place in Washington, D.C. May 4-7. The next issue of The Notebook will be published on Monday, May 12, 2014.
Final Thoughts by Paul Cunningham

Did the Arkansas Legislature make a difference for the good in the lives of thousands – make that tens of thousands – of Arkansans by giving its nod on two occasions for the state’s unique Private Option (APO) plan to expand health insurance? So far, the signs point to “yes.” Three months into the operational phase of the APO, all systems are still on “go.” Everything in play thus far appears to be working as it should, meeting the expectations and even surpassing them.

The success begins with enrollment into the APO plans available for the choosing. According to an April 21 report from the Department of Human Services, more than 155,500 people had applied for and been determined as eligible for APO coverage as of March 31, a full quarter of a year since the program went live. If all of them had not actually selected a plan by that date, then they should have private insurance coverage by the end of April, or be added to the rolls of the traditional Medicaid program, assuming it would serve them better due to their current medical conditions. Altogether, that’s 70% of the number of potential APO enrollees estimated more than a year ago who would qualify to take the opportunity to obtain health insurance being offered through four private health plans. It exceeds even the most optimistic projections over such a short span. The total doesn’t count another 45,000 people with incomes above 138% of the federal poverty level who have enrolled with subsidized health plans offered via the Insurance Department’s Health Insurance Marketplace.

Keep in mind that the bulk of the new APO enrollees hold jobs and go to work every day, managing to eke out a living either at, below or marginally above the official poverty line. Eightytwo percent have incomes less than 100% of the poverty level and are actually too poor to qualify for federal subsidies under the parameters of the Affordable Care Act (ACA), as if that makes any sense. Such low incomes pretty much negate any reasonable idea that they’d be able to afford health insurance on their own after paying for their basic needs like food, clothing and shelter. And, with the APO there should be few concerns about their out-of-pocket cost-sharing, which is very limited.

Another positive is the age breakdown of the APO enrollees. The fact that 43% are in the 19-34 age range will serve to mitigate pricing for all Marketplace plans, including those purchased under the APO umbrella, as well as the subsidized plans. Those “young invincibles” seldom worry about taking care of themselves, yet are generally a healthier lot that the rest of us. Oh, to be young again! Get enough of them enrolled and it brings down the premium price for everyone.

The numbers mean that the APO is delivering on its promises, turning folks’ hope for healthcare coverage into a reality. But, what about healthcare providers, especially the hospitals that need the APO to serve as a pathway to both to a reduction in the growth of uncompensated care and new revenues to offset the painful Medicare payment cuts from the combined clout of the ACA, two tax acts passed in 2012, budget sequesters and a bevy of CMS rules and regulations piled on them over the past few years? In short, there’s good news on that front, too.

Over the course of only three months, hospitals statewide already are experiencing a marked reduction in the number of self-pay patients. Consistently, reports are that the inpatient self-pay volumes have fallen around 30%, based on 2013 versus 2014 year-to-date comparisons, while the number of self-pay patients presenting to emergency departments (ED) for care are down 23% at the same time that overall ED volumes have remained relatively flat. So, it does not seem that EDs are being swamped as many feared. It’s still too early to assess the financial impact, but considering that APO enrollees outnumber those with new subsidized plans who are more likely to experience out-of-pocket cost sharing difficulties by roughly a 3.5:1 ratio, it’s easy to assume noticeable turnarounds are happening.

A few legislators who reluctantly voted last month to allow the APO another year to prove itself, also emphasized that their support going forward depends on whether it delivers on the promises. For now, things are pointing in that direction. Others never wavered. They took a risk to make a difference and to help others. From the outset, they were guided, probably unknowingly, by the wisdom of American financier J.P. Morgan, who once said, “The first step towards getting somewhere is to decide that you are not going to stay where you are.” That’s why Arkansas is moving forward toward being a healthier state of mind and body.