EMTALA Allows Flexibility During Disasters

The Centers for Medicare & Medicaid Services (CMS) issued an August 14 memorandum to State Survey Agencies regarding Emergency Medical Treatment and Labor Act (EMTALA) requirements and the flexibility allowed under the law during disasters. The memo was sent in anticipation of a possible significant increase in demand for emergency services due to an expected H1N1 influenza resurgence this fall. CMS stated in the memo that federal agencies, state health departments and hospitals have expressed concerns about compliance with EMTALA requirements in case there is an outbreak of the virus.

The correspondence seeks to dispel a common perception that EMTALA imposes heavy restrictions on hospitals’ ability to provide adequate care when emergency departments (ED) experience extraordinary surges in demand. Along with the memo, CMS included a fact sheet clarifying permissible options for EMTALA compliance should the increased demand occur.

Among other things, the fact sheet notes that an EMTALA-mandated medical screening examination (MSE) does not need to be an extensive work-up in every case, and that it may even be conducted outside the ED. For example, hospitals may set up alternative screening sites on campus or at off-campus, hospital-controlled sites, and communities may set up screening clinics at sites not under the control of a hospital. Further, the law provides for waivers of certain EMTALA requirements in a declared public health emergency.

Surveyors and managers responsible for EMTALA enforcement are instructed to be aware of the flexibilities hospitals are currently afforded under EMTALA and to assess incoming EMTALA complaints accordingly in determining overall compliance and whether an on-site investigation is required. CMS’ memo and fact sheet can be found by clicking on the following link: http://arkhospitals.org/disasterpdf/SCLetter09_52.pdf.

Healthcare Executive Leadership Luncheon, October 8

Immediately following the opening session and House of Delegates Meeting of the Arkansas Hospital Association (AHA) on October 8, attendees are invited to a special Executive Leadership Luncheon and a discussion of healthcare, politics and economics. Moderator Roby Brock, executive producer and host of the weekly Talk Business program which airs on Sunday nights, will engage Representative Robbie Wills, Speaker of the House, and Dr. Joe Thompson, Arkansas’ Surgeon General, in a lively discussion of the three topics.

The luncheon precedes the AHA’s annual Trade Show where over 100 companies will share the latest innovations in healthcare products and services all under one roof. The AHA Trade Show is the perfect place to visit with vendors, see and compare products and services, discover new technologies, while saving time by visiting suppliers in one convenient location. A copy of the October 7-9 Annual Meeting brochure containing registration information is available at http://www.arkhospitals.org/calendarannual.htm, or by calling (501) 224-7878.
The Centers for Medicare & Medicaid Services (CMS) recently announced adjustments to fiscal year (FY) 2010 payments for the care Medicare beneficiaries receive in Skilled Nursing Facilities (SNF) and Inpatient Rehabilitation Facilities (IRF). In its final rule for Medicare SNF services, CMS provides a full market-basket update of 2.2%, but then calls for a 3.3% “recalibration” in payments to adjust for case-mix index payments made during FY 2010, yielding net 1.1% reduction, or $360 million, from FY 2009 payment levels. The final rule that updates IRF payment rates for FY 2010 adopts a new regulatory framework that clarifies the coverage criteria (including provisions regarding patient selection and care) for IRFs that will be effective on January 1, 2010.

According to CMS, the SNF adjustment is an effort to rebalance an earlier adjustment to the case-mix indexes (CMIs) and better align Medicare payments with costs. It is based on the agency’s conclusion that the expanded Resource Utilization Groups (RUGs), implemented in FY 2006, resulted in an unexpected and inappropriate increase to SNF payments because more patients were classified into the newly created RUGs than expected. In the rule, CMS states that much of the increase was due to coding behavior changes and not actual changes in SNF patient acuity.

To compensate, CMS will apply a “parity” adjustment next year, in FY 2011, to neutralize for utilization changes that are expected to be caused by moving to a RUG-IV model from a RUG-III model. CMS’ projections of future utilization patterns indicate that the new RUG-IV model would lower overall SNF payments compared to the current RUG-III. CMS believes the parity adjustment applied to the nursing weights would be an upward adjustment of around 59.4%. The final rule was published in the August 11 Federal Register.

The IRF Final Rule adopts CMS’ original proposals, with some modifications, which change specific IRF coverage requirements for patients. Those changes include provisions requiring:

- An admission criterion that the patient can actively participate in an intensive rehabilitation program, with an expectation that measurable improvements will occur in a patient’s functional capacity or adaptation to impairments.
- IRF services be ordered by a rehabilitation physician with specialized training and experience in rehabilitation services and be coordinated by an interdisciplinary team.
- A post-admission evaluation to document the status of the patient after admission to the IRF, and requires the comparison of this to the pre-admission documentation. Based on this information, facilities can begin to develop a patient’s overall plan of care by the end of the fourth day following a patient’s admission. CMS did not adopt a requirement that a rehabilitation physician needs to consult with the interdisciplinary team when developing the post-admission evaluation.
- An interdisciplinary team to meet weekly to review a patient’s progress and make any modifications necessary to the patient’s plan of care.

The final rule applies to more than 200 freestanding IRFs and just under 1,000 IRF distinct-part units in acute care hospitals, and, except under special circumstances, is effective for discharges occurring on or after October 1, 2009. However, CMS will delay implementation of the adopted coverage policies until January 1, 2010 to allow IRFs time to adjust internal processes and procedures.

Other IRF changes include a full market-basket update of 2.5% for FY 2010. The update, combined with all of the budget-neutrality adjustments, means the final FY 2010 standard payment conversion factor will increase 5.4%, from $12,958 in FY 2009 to $13,661 in FY 2010. In addition, CMS will update the FY 2010 facility-level adjustments for rural IRFs, low-income patients (LIPs) and teaching IRFs using three-year averages that are based on Medicare claims.

- Decrease the rural adjustment from 21.3% in FY 2009 to 18.4% in FY 2010;
- Decrease the LIP adjustment from 0.6229 in FY 2009 to 0.4613 in FY 2010; and
- Decrease the teaching adjustment from 0.9012 in FY 2009 to 0.6876 in FY 2010.

CMS states that the teaching adjustment is significantly lower than the originally-proposed adjustment of 1.0494 due to the extreme volatility that occurs year-to-year in the teaching data. The final rule was published in the August 7 Federal Register. Fact sheets on both final rules at http://www.cms.hhs.gov/apps/media/fact_sheets.asp.

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**Comments On Proposed Cardiac Outcomes Measures**

Yale New Haven Health Services Corporation/Center for Outcomes Research and Evaluation (YNHHSC/CORE) is working in conjunction with the American College of Cardiology under a contract with CMS to develop two cardiac outcomes measures for potential use in public reporting and pay for reporting of hospital quality. The measures are:

- Complications following Implantable Cardioverter-Defibrillator (ICD) implantation. This measure uses data from the ACC National Cardiovascular Disease Registry (NCDR) ICD Registry for risk adjustment and Medicare Part A inpatient and outpatient administrative claims data to assess complications; and
- Readmission following Percutaneous Coronary Intervention (PCI). This measure uses data from the ACC National Cardiovascular Disease Registry (NCDR) CathPCI Registry for risk adjustment and Medicare Part A inpatient and outpatient administrative claims data to assess readmissions.

CMS is now in the process of accepting public comments on these measures, particularly as they relate to outcome definitions and time period of assessment, risk adjustment strategy, the Technical Expert Panel (TEP) feedback. Comments must be received by August 25, 2009, 4:00 p.m. CST and may be general or specific to either measure. Please use the following link to access the CMS public comment system: https://www.cms.hhs.gov/apps/OQMS/publicComment.asp.

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**Deadline For Physician Supervision Comments**

The American Hospital Association (AHA) is urging comments from hospitals on the proposed 2010 Medicare outpatient prospective payment system rule which affects the physician supervision requirement for therapeutic outpatient services for 2010 and beyond. At issue is whether the proposal fully meets the needs of hospitals and their patients.

The proposal, according to CMS, would eliminate the requirement that a supervising physician (or certain non-physician practitioners who would now be permitted to provide supervision as part of the proposed rule change) must be present in the department for therapeutic outpatient services when the procedure is performed. Instead, “direct supervision” for such services requires that the supervising practitioner must be present “on the same campus, in the hospital or CAH or on-campus provider-based departments of the hospital or CAH” and “immediately available to furnish assistance and direction while the procedure is being performed.” There is concern that the change wouldn’t offer hospitals any greater compliance flexibility than the current requirement
because CMS’ preamble discussion suggests that the “general definition of immediate” means “without interval of time.” AHA members are encouraged to e-mail their feedback to docsupervisionrule@aha.org in time to meet the August 31 comment deadline. See http://www.cms.hhs.gov/HospitalOutpatientPPS/HORD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=3&sortOrder=descending&itemID=CMS1224005&intNumPerPage=10 to find a copy of the proposed rule.

Breach Notification Rule For EHI

The Federal Trade Commission last week released an interim final rule implementing the Information Technology for Economic and Clinical Health Act’s breach notification requirements. The Act obligates hospitals and other HIPAA-covered entities and their business associates to notify individuals when the privacy of their “unsecured” personal health information is breached. The notice obligations are effective for breaches occurring on or after September 24. However, because covered entities may require time to implement compliance programs, HHS will use its “enforcement discretion to not impose sanctions for failure to provide [notices] for breaches that are discovered before 180 calendar days” from the rule’s August 24 publication in the Federal Register. To access more information, see the HHS press release at http://www.hhs.gov/news/press/2009pres/08/20090819f.html.

NewsNotes About Arkansas Folks

Timothy E. Hill has resigned as president and CEO of North Arkansas Regional Medical Center in Harrison, effective October 28. He has accepted the position of president and CEO of the Arkansas Heart Hospital in Little Rock and will begin that position on November 1. Hill is a member of the Arkansas Hospital Association Board of Directors, currently serving as delegate to the American Hospital Association Regional Policy Board 7. He also is a past-chairman of the AHA board. Hill will succeed Charlie Smith, who is retiring as president and CEO of Arkansas Heart Hospital, a position he has held for the past five years.

Tripp Smith has been named chief operating officer at Northwest Medical Center – Bentonville. Prior to accepting his new position, Smith served in administrative roles with hospitals in Louisiana, Tennessee and Alabama.

The Arkansas Hospital Association welcomes two new staff members. Anna Sroczynski of Benton has been named administrative assistant in the education department and Kathy Wewers of Little Rock is the new receptionist.

The AHA Calendar

August 2009
27 Stop Blood Stream Infections (BSI) Conference, Crowne Plaza, Little Rock

September 2009
1 Reward and Recognition on a Limited Budget: Surface vs. Substance – Webinar T2522
3 RAC Provider Outreach Workshop, Crowne Plaza, Little Rock
8 Critical Access / Rural Hospital Quarterly Meeting, AHA Classroom, Little Rock