Robert “Bo” Ryall Is AHA’s Incoming President

Robert “Bo” Ryall, Jr., executive vice president of the Arkansas Hospital Association (AHA), has been named by the AHA Board of Directors as the organization’s incoming president and CEO. He was named as incoming president during the board’s August 13 meeting. Ryall, 43, joined the AHA executive team in July 2005 as executive vice president and chief government relations officer. He will succeed Phil E. Matthews, who will retire as the AHA’s CEO effective October 31. Ryall will assume the duties of AHA president and CEO on November 1.

In making his announcement to the AHA’s membership, board chairman James Magee said, “The board is confident that a time-consuming nationwide search would yield no better qualified individual to succeed Phil than Bo Ryall. We look forward to great accomplishments from him and expect the AHA to continue registering great successes under his leadership in the years ahead.”

Ryall brings with him previous chief executive experience (having served as president of the Arkansas Home Care Association), a knowledge of the state’s hospitals and an understanding of state and federal challenges currently facing them, a positive relationship with other providers, payer organizations and state programs with which our hospitals must continuously interact, and immediate credibility not only with state government executives, program directors and lawmakers, but also with members of the Arkansas congressional delegation, all of whom share in decisions that will impact our state.

FY 2010 Medicaid IQI Payments

In May 2006, an Arkansas Hospital Association committee composed of quality review professionals from member hospitals began working with state Medicaid officials and representatives from the Arkansas Foundation for Medical Care (AFMC) to design Medicaid’s inpatient quality incentive (IQI) program. A pay-for-performance tool, the IQI was set up to tie bonus payments of up to $50 per eligible Medicaid inpatient hospital day of care to hospitals’ success in meeting pre-determined thresholds on certain quality measures. The program was officially implemented in March 2007 as part of the Arkansas Medicaid plan amendment that raised the cap on Medicaid’s hospital inpatient per diem.

Last week, 38 Arkansas hospitals received notice from the Medicaid program that they met or surpassed the quality-related standards to qualify for the fiscal year (FY) 2010 bonus payments. The hospitals will share in approximately $5.3 million that Medicaid will pay out under the IQI program for FY 2010, bringing the total quality-related distributions over the program’s four-year history to more than $17.5 million. Three critical access hospitals (CAHs) which are not eligible for the bonus payment met or exceeded the criteria and will receive recognition bringing the total to 41 Arkansas hospitals which met or exceeded the criteria.

Five of Medicaid’s FY 2010 measures continued from previous years as a subset of the national Hospital Quality Initiative (HQI), which is the source of Medicare’s Hospital Compare Web site.
But, for the first time, the criteria included three state-specific process measures aimed at improving patient handoffs and care coordination. None were a part of the HQI. Medicaid also included four new non-HQI obstetric reporting requirements for FY 2010. Due to concerns voiced by some hospitals about the new measures, the AHA earlier this year worked with AFMC and Medicaid officials to secure changes in certain reporting parameters for the qualifying criteria.

Some Arkansas hospitals, including the state’s 29 CAHs, UAMS Medical Center and Arkansas Children’s Hospital are ineligible for the incentive payment program because they are paid under a different Medicaid reimbursement category. A small number of out-of-state hospitals in bordering cities that treat Arkansas patients were eligible to take part in the initiative.

Deadline for Annual Meeting Reservations

Have you made your hotel reservations for the Arkansas Hospital Association’s 80th Annual Meeting and Trade Show at The Peabody Little Rock? The hotel room block for the October 6-8 Annual Meeting will expire September 14. We encourage you to call (800) 732-2639 or (501) 906-4000 today (mentioning the Arkansas Hospital Association) to reserve a room at The Peabody. While plenty of rooms were blocked, we want to make sure that our Annual Meeting attendees get into the headquarters hotel. So, don’t delay, call now! A copy of the October 6-8 Annual Meeting brochure containing registration information is available by calling (501) 224-7878 or at http://www.arkhospitals.org/events/annual-meeting.

Quality of Care Tracking and Trending Results

In late September 2010, the Arkansas Foundation for Medical Care (AFMC) will begin notifying hospitals of the results of their Medicaid quality of care tracking and trending activities. In December 2009, the AFMC Retrospective Review Department’s review staff began tracking documented quality of care issues identified on routine review that could warrant investigation and possible quality improvement intervention.

The current plan is to send hospitals their reports semi-annually (every 6 months). The criteria for hospital notification will be that the hospital has three identified issues, or two issues in the same category, within the six-month period. AFMC’s goal is to help Arkansas hospitals improve the quality of care they provide. A response to the reports will not be required; however, if the information leads to interventions and improvement efforts, AFMC would like to hear about them.

Arkansas’ RAC Begins Medical Necessity Reviews

Connolly Healthcare, the Medicare Recovery Audit Contractor (RAC) for Region C has begun medical necessity reviews for 18 types of inpatient hospital conditions, which are listed on its Web site, http://www.connollyhealthcare.com/RAC/pages/approved_issues.aspx. The Region C states are: Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia and West Virginia.

CMS’ New Issue Review Board gave its four regional RACs approval to begin medical necessity reviews for the 18 specified inpatient hospital conditions last month, but only after announcing the audits on their Web sites. To date, RACs in all but Region A have announced the medical
necessity review audits. The AHA encourages hospitals to continue monitoring their RAC’s Web site for newly emerging information on these and other RAC audits. Contact information for the four regional RACs can be found at www.aha.org/aha/issues/RAC/contractors.html.

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EHR Certification Bodies OK’d

The Department of Health and Human Services (HHS) authorized the Certification Commission for Health Information Technology and the Drummond Group, Inc. to test and certify electronic health record systems (EHRs), adding that applications for additional authorized testing and certification bodies are under review. To qualify for EHR incentive payments from Medicare and Medicaid beginning in May 2011, hospitals and physicians must adopt EHR systems certified to meet HHS criteria for “meaningful use” of EHRs. The HITECH Act of 2009 provides more than $17 billion in Medicare and Medicaid incentive payments to promote the adoption of EHRs. The Centers for Medicare & Medicaid Services is working to create an online system for providers to register and attest for the EHR incentive programs. Please see http://www.hhs.gov/news/press/2010pres/08/20100830d.html for more information.

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OIG Option on Free Pre-authorizations

Hospitals that offer free insurance preauthorization services to physicians and patients could be relieving physicians of a financial obligation – and “could potentially generate prohibited remuneration under the Federal anti-kickback statute,” according to a recent Advisory Opinion from the Office of Inspector General (OIG) (http://www.oig.hhs.gov/fraud/docs/advisoryopinions/2010/AdvOpn10-13.pdf). The opinion was issued in response to a hospital’s inquiry about providing free pre-authorizations for diagnostic imaging services. The OIG said, “When a party in a position to benefit from referrals provides free administrative services to an existing or potential referral source, there is a risk that at least one purpose of providing the services is to influence referrals.”

However, the OIG stresses that it depends on the circumstances. For instance, if a physician’s contract with a payer does not allocate responsibility for pre-authorizations to any particular party, then an imaging provider that provides free pre-authorizations is not relieving the physician of an explicit financial obligation.

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The AHA Calendar

September 2010
14  Reward and Recognition on a Limited Budget: Surface vs. Substance – Webinar 2611
14  The Arkansas Association for Healthcare Quality (AAHQ) CPHQ Review Course

Information on these and all AHA educational activities is available at www.arkhospitals.org/events.
Final Thoughts by Paul Cunningham

“These are the times that try men’s souls.” (Thomas Paine, *The Crisis*, 1776) …

Last week the Kaiser Family Foundation released a report showing that the average group insurance premium cost for family health coverage ballooned this year to $13,770. That represents a 114% increase since the year 2000, when average premium costs for employer sponsored family coverage checked-in at $6,840. The math is easy. Over the past 10 years, premium costs for family coverage have climbed 11.4% per year, including a modest 3% jump from 2009 to 2010. Anyone still wondering why the health reform law dwells so much on coverage issues need look no further.

To counter the skyward trend and put the brakes on their own healthcare costs, employers have stepped up the adoption of consumer driven health plans like health savings accounts (HSA) and other high deductible health plans (HDHP) for their employees. Twenty-seven percent of covered workers are now in a plan with a deductible of at least $1,000 for single coverage and double that for families. But, the lower cost plans are a two-edged sword. They make possible the continued offering of healthcare benefits, but they also put employees at risk for a larger share of the costs to come out of their own pockets, which has a residual effect on healthcare providers.

As Kaiser reports, American families are now paying about $4,000 out-of-pocket per year just to obtain health insurance coverage, the most on record. Those costs jumped by $482 for the year, a 14% increase over the 2009 average, and more than doubled since 2000, when workers’ share averaged paying $1,619. During the same time span, the inflation-adjusted median family income fell from about $52,000 to $48,000.

To make matters worse, the cost of coverage itself, even the low-end variety, is only part of the equation. By definition, HDHPs come with higher deductibles and co-pays. The deductible for an HSA must be at least $1,200 for individuals or $2,400 for families and total out-of-pocket expenses can go as high as $5,950 for self-only coverage or $11,900 for family coverage, including the deductible and co-payments. That’s on top of the premium cost. Other non-HSA high-deductible policies available through employers bear similar out-of-pocket costs, or worse.

It all means that today families are spending more than 8% of their gross annual income on health insurance. Take out the income, Social Security and Medicare withholdings and health insurance might exceed 10% of the average family’s take home pay. The choice between paying for coverage and going without gets easier by the year.

Drew Altman, president and CEO of the Kaiser Family Foundation, summed up the situation, saying “Shifting the costs to workers during a terrible economy is bad news for working people.” It doesn’t shape up as a cake walk for healthcare providers, either, especially for hospitals which are particularly susceptible to other consequences from the growing use of HDHPs.

In addition to lowering employers’ costs, HDHPs are supposed to make consumers more aware of their healthcare spending. Ideally, they will be more careful not to overuse services. The most direct route to that point is to skip needed care or opt for the least expensive choice, such as asking for nonsurgical treatments even when physicians suggest that surgery is needed, which some say is exactly what’s going on.

If coverage via a HSA or other form of HDHP plays a part in putting off needed care, then it is only marginally better than having no insurance. The results are the same. Elective services, both inpatient and outpatient, are put off until patients’ conditions become more critical. Those patients then show up in hospital ERs, where it costs more. Deductible and co-pays rise to a point where they can’t be covered, causing an increase in hospitals’ bad debt amounts.

Those dominoes then topple others related to the overall impact that hospitals are feeling from the recession due to otherwise rising amounts of charity care and bad debt related to uninsured patients. The next thing you know, hospitals which historically have been among the economic “anchors” in their communities, are forced to lay off workers and delay capital improvement projects, making local economic problems even worse.

In healthcare circles, these really are the times that try men’s souls.