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Hospital *RACTrac* Participation Important!

As Medicare Recovery Audit Contractors (RAC) become more involved in the claims review process, the ability to closely monitor the RAC program is critical. For that reason, the Arkansas Hospital Association is asking all of its member hospitals to participate in *RACTrac*, a FREE Web-based program developed by the American Hospital Association (AHA) to help measure the program's impact on hospitals.

Since going "live," *RACTrac*, the only nationwide initiative collecting RAC experience data for advocacy and education purposes, has provided valuable information on a national level; however, Arkansas hospitals have been slow to register and submit data. Fewer than 1/3 of Arkansas hospitals are registered with *RACTrac*, and only about 13 are submitting information. (Even hospitals with no RAC activity are asked to respond to the survey noting the lack of activity, so we cannot assume that registered but non-responding hospitals have not seen RAC activity).

There is no charge for registered *RACTrac* users who are employees of hospitals or health systems regardless of whether the hospitals are members of the AHA. Hospitals can register at *www.aharactrac.org* to participate in the *RACTrac* survey. Once registered, a user can log onto the Web site and enter data manually on the screen or upload survey responses via a comma-delimited file upload (CSV file). For their effort, hospitals can gain valuable insight regarding review issues, appeals and outcomes through the experience of others.

In addition, the AHA has worked with several vendors that offer RAC audit tracking solutions to hospitals to ensure that data entered into their tracking tools can be summarized and exported on a quarterly basis to the *RACTrac* survey. These vendors are designated as "*RACTrac*-compatible" vendors. A list is available online at *http://www.aha.org/aha/issues/RAC/ractrac.html*. The AHA is willing to work with any vendor, so if your vendor is not on that list, please ask them to e-mail *ractracsupport@providercs.com* or call (888) 722-8712 for assistance in becoming "*RACTrac*-compatible."

Check today to make sure that your hospital is registered with *RACTrac* and that you are submitting data on a quarterly basis. If you have any questions regarding *RACTrac*, you may contact the AHA directly at ***RACTracSupport@providers.com*** **or contact Elisa White at the Arkansas Hospital Association at *elisawhite@arkhospitals.org* or (501) 224-7878.**

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Hospitals Applauded for CSEPP Participation

The Chemical Stockpile Emergency Preparedness Program, or CSEPP, was established in 1985 when Congress required the Department of Defense to dispose of its chemical weapons stockpiled at U.S. Army installations across the country. At that time, several facilities were established to destroy the agents and munitions, with one placed at the Pine Bluff Arsenal. As a part of the program hospitals in close proximity to the weapons destruction facilities received funds for equipment and training to prepare them to respond in the event of a chemical incident. Arkansas'

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CSEPP hospitals (located in Dallas, Jefferson and Pulaski counties) have received over $700,000, over the life of the program to prepare in case such an incident occurred at the Pine Bluff site. Equipment purchased included state-of-the-art communications equipment, decontamination equipment and supplies, trailers for storage and transport, and specialized training for hospital personnel in patient decontamination and mass casualty management.

The hospitals, in return, have participated in annual exercises to assess readiness, maintained their response capabilities through continuing education, drills, and in-house exercises, and whenever possible, served as controllers and evaluators for CSEPP exercises. Through this partnership, hospitals have worked with the Arkansas Department of Emergency Management (ADEM) to provide an appropriate response structure should there be an incident related to the destruction of chemical weapons at the Arsenal.

At a meeting with Metropolitan hospital representatives last week, David Maxwell, Director of ADEM, said, "With the impending completion of the CSEPP program, we are pleased that CSEPP will be leaving a legacy of community readiness with trained and equipped decontamination teams operating within the participating hospitals. Over the past two years, the CSEPP mission has transitioned from chemical incident response only to a response capability for multiple hazards, including training on biological and radiological incidents.

"We could not have developed this level of community readiness without the support of these hospitals and their emergency management personnel. CSEPP participation was one more item on an already full plate for these facilities, and I would like to take this opportunity to recognize their personnel for their partnership and a job well done."

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Legal Note: 2011 OIG Work Plan

The United States Department of Health and Human Services (HHS), Office of Inspector General (OIG) has released its Work Plan for Fiscal Year 2011 outlining the new and ongoing audit and enforcement priorities of the OIG. For hospitals, there are a number of areas of focus, including, without limitation, the following:

- Reviewing Medicare claims with high payments to determine whether they were appropriate;
- Examining outlier payments to determine whether CMS appropriately reconciled the payments;
- Assessing the effectiveness of procedures in preventing inappropriate Medicare payments for beneficiaries with other insurance coverage;
- Reviewing hospitals' controls for ensuring the accuracy of data related to quality of care that they submit to CMS for Medicare reimbursement;
- Reviewing the appropriateness of payments for non-physician outpatient services that were provided to beneficiaries shortly before or during Medicare Part A-covered stays;
- Determining whether hospitals reported occupational-mix data used to calculate inpatient wage indexes in compliance with Medicare regulations;
- Examining Medicare claims to determine trends in the number of hospital readmission cases;
- Reviewing Medicare claims to determine which types of facilities are most frequently transferring patients with certain diagnoses that were coded as being present when patients were admitted;

- Reviewing the early implementation of CMS's hospital-acquired conditions (HAC) policy and verifying the accuracy of present on admission indicators, which are used for identifying HACs;
- Determining whether hospitals submitted inpatient and outpatient claims that included procedures for the insertion of replacement medical devices in compliance with Medicare regulations; and
- Reviewing Medicare payments for observation services provided during outpatient visits in hospitals.

Hospitals are advised to review the 2011 OIG Work Plan when formulating their own annual compliance audit plans. The 159-page 2011 OIG Work Plan is available in PDF format on the OIG Web site at *http://oig.hhs.gov/publications/workplan/2011/FY11_WorkPlan-All.pdf*.

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.

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Draft Recommendations for Deficit Reduction

The co-chairs of the National Commission on Fiscal Responsibility and Reform, an 18-member bipartisan committee tasked with making recommendations for reducing the federal deficit by 2015 and improving the nation's long-term fiscal outlook, last week released a draft proposal calling for reductions in discretionary and mandatory spending, as well as reforms to the tax code.

Among the health-related measures, the draft proposal recommends extending the authority of the Independent Payment Advisory Board created by the Patient Protection and Affordable Care Act to all hospitals; accelerating the phase-in of the disproportionate share hospital, Medicare Advantage and home health cuts enacted by the reform law; and cutting Medicare bad debt payments, as well as spending on graduate and indirect medical education.

The chairs also suggest identifying an additional $200 billion to cut from federal health spending, as well as establishing a process to evaluate cost growth and "take additional steps as needed" if growth in total federal health spending is not contained to GDP+1% after 2020. In addition, they recommend implementing comprehensive medical liability reform to lower costs. Click on *http://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/CoChair_Draft.pdf* to see the draft proposal.

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AHA Board Highlights

During its regular monthly meeting on November 12, 2010, the Arkansas Hospital Association (AHA) board of directors discussed the following items and acted where necessary:

- **Update on the Arkansas Foundation for Medical Care (AFMC):** Ray Hanley, the new CEO of AFMC met with the board to review his plans for the organization in the coming years. He also reviewed a proposal which AFMC has submitted to the Arkansas Medicaid program concerning possible improvements to Medicaid's current ConnectCare program and asked for the board's endorsement.
- **Washington Update:** The Senate is projected to have 53 Democrats and 47 Republicans when the 112th Congress convenes in January 2010. The House will have 240

Republicans and 189 Democrats (six seats still undecided). With neither party holding a workable majority, there is a strong potential for gridlock. Arkansas' Washington delegation features a new U.S. Senator and three new members of the House. AHA staff has an existing good relationship with Senator-elect John Boozman and have met with Steve Womack, the new 3rd District congressman. Executive team members will travel to D.C. in mid-January and plan to visit with all the new members and meet their staffs. All hospital CEOs should begin meeting with their new congressmen and educating them on importance of hospitals as employers and healthcare providers.

- **Arkansas Legislative Changes**: The newly elected 88th General Assembly will be comprised of a Senate with 20 Democrats and 15 Republicans, and House with 55 Democrats and 44 Republicans (with one seat still to be determined in a special election). In addition, of the 100 House members, 44 will be serving their first term, 31 will be serving their second term, and 25 will be serving their last term. Of the 35 members of the Senate, 12 are serving their first Senate term and of those 12, only 6 served in the House prior to this election.
- **State Budget Summary**: The Governor's budget proposal for the 2012-13 biennium projects net available revenues for FY2012 at $4.6 billion (a 2.8% increase over FY2011) and $4.8 billion in FY2013 (a 5.3% increase over FY2012). Funding of education remains the number one priority for Governor Beebe, who also has requested to further reduce the tax on groceries by another ½ cent. That reduction is expected to decrease state general revenue by approximately $15.5 million.
- **State Medicaid Budget:** The Arkansas Department of Human Services (DHS) expects Medicaid spending growth to be approximately $100 million per year. With no new money provided for the Medicaid program, by FY2014, Medicaid would have more than a $500 million deficit. Medicaid did not ask for additional general revenue funding in FY2012, leaving a shortfall of approximately $260 million for FY2013. However, Medicaid only requested state general revenue in the amount of $175 million for the second year (FY2013).
- **Medicaid Hospital Assessment Program:** The Arkansas Medicaid program mailed formal notice to the state's hospitals about their annual Medicaid hospital assessment amount for Year 2 of Arkansas' Hospital Assessment Program (HAP) and the expected payments related to the program they should receive for SFY 2011. There is a 30-day comment period. Plans are for the distribution of funds for the initial quarter of FY 2011 (July-September) to be made around Christmas.
- **Council on Government Relations Meeting:** AHA's agenda for the upcoming session of the state legislature was set by the association's Council on Government Relations on October 27. The primary item involves addressing a few minor changes in AHA's Hospital Assessment law. AHA will be watchful for bills that could be introduced involving requirements that hospitals provide annual reports of charity care within 150 days after the end of each fiscal year and mandatory reporting of healthcare associated infections.
- **ConnectCare Proposal:** The board voted to endorse the ConnectCare proposal which AFMC is submitting to Arkansas Medicaid as a way to improve the current ConnectCare program with the possibility of associated long term savings related to better management of patients with chronic conditions.
- **Quality Report:** AHA is planning to begin participation in a Stop CAUTI initiative in March of 2011. The current Stop BSI initiative has received such good participation from critical access hospitals (CAH) that three of them have been asked to participate in a national critical access hospital recruiting call for the project on December 2nd (Ozark Health Medical Center, Lawrence Memorial Hospital and Bradley County Medical Center). Also, the AHA has received a $35,000 grant from HRET for project

coordination and support activities for the Stop BSI project. The funds will primarily be used for outreach and onsite support to the participating hospitals.

- **RN Pronouncement of Death:** The Arkansas Medical Society has agreed to join with the AHA to recommend revisions to the *Rules and Regulations for Hospitals and Related Institutions* that would allow RNs to make a pronouncement of death in a hospital under certain circumstances. The next step in the process is to confer with the nursing association and the nursing board before taking the proposal to the Department of Health.
- **NDMS Update:** Dr. Kevin Yeskey, Deputy Assistant Secretary for Preparedness and Response, in Washington informed the AHA that HHS has signed a two-year contract with a company to provide return transportation for patients evacuated by NDMS. Also, Service Access Teams (acting as case managers) have been formed and trained to deploy simultaneously with an NDMS activation. The revised NDMS Memorandum of Understanding is making its rounds through HHS committees and should be ready by the end of the year. At that time, Arkansas hospitals will have the opportunity to sign and once again be part of the NDMS.

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Newsnotes About Arkansas Folks:

Rob Lake, president and CEO of North Arkansas Regional Medical Center in Harrison, has resigned his position effective late January 2011. He has accepted a position as president of ProCure's Oklahoma City Center. **Richard McBryde**, senior vice president and COO, will serve as interim CEO while a search is conducted.

Christopher Comer has been named chief financial officer at Magnolia Regional Medical Center. Comer, a Magnolia native, joins MRMC with more than four years accounting experience as well as six years with the United States Air Force.

Angie House has been named interim CEO at DeQueen Medical Center, succeeding **Mandy Hooker** who resigned last week.

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The AHA Calendar

November 2010

16 RAC Vulnerabilities: No Documentation or Insufficient Documentation – What's In Your Documentation? – Webinar T2632

16 Key Issues on Physician Supervision and Observation Services: A Two-part Webinar Series – Session 2 – Observation Services: Special Topics

19 Chargemaster Coding Compendium 2010: A Five-part Webinar Series; Session 5 – Understanding Revenue Codes Workshop

December 2010

2 CPT 2011 Coding Update, Hilton Garden Inn Jonesboro

7 Medicare Ambulatory Payment Classifications (APCs): Update for 2011 – Learn significant changes to APCs under the Outpatient Prospective Payment System – Webinar T2633

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

Final Thoughts by Paul Cunningham

The November elections are finally behind us. While a slew of incumbent House members and a handful of senators are making plans for life after the tsunami, the full lineup of current federal lawmakers is back together one more time to wrap up loose ends in the last days of the 111th Congress, better known as its "lame duck" session.

What remains to be seen is just how much they can accomplish in the next six weeks and which of the hot potato issues they will toss to the 112th Congress, which begins January 3, 2011 with a brand new dance card. Conventional thinking is that next year's returning members and their newbie colleagues would be wise to wear their oven mitts. The long list of unfinished business is overshadowed by the obvious. There is no way to complete the amount of work left on the plate before Christmas, so expect another look at many controversial matters next year.

That's pretty typical of these brief lame duck sessions, which are not at all unusual. There have been 17 of them since 1935 when the 20th Amendment to the U.S. Constitution took effect. It set the start date for a congressional session on January 3 of odd-numbered years (unless a law is passed to change the date) with the provision that any meeting of Congress between the mid-term elections in an even-numbered year and the following January 3 is considered a lame duck session.

It was a good move. Prior to 1935, lame duck sessions could last well over three months, since new Congresses did not convene until early March. That gave a lot of time for members who lost elections four months earlier and others headed toward retirement to act without accountability to the folks who once elected them; or worse, to punish those who more recently booted them out of office. That's less of a problem today, but it doesn't diminish the fact that most lame duck sessions have been marginally productive at best.

The top item on Congress' lame duck "to do" list now is passing a series of spending bills to avoid a government shutdown. Other items that could be addressed involve energy and the Strategic Arms Reduction Treaty. There's also the matter of dealing with the Bush tax cuts which expire at year's end. That may grab the lion's share of attention.

If any health issue is to be considered, the most likely candidate is the looming Medicare physician fee cut. Under CMS' final rule covering the 2011 Medicare Physician Fee Schedule, docs face a 25% reduction in their fees next year. The effective date of the rule is January 1, 2011, less than two months away. But, it's more urgent than that.

A 21% reduction was to have occurred last summer. Instead, Congress granted an eleventh-hour reprieve boosting rates 2.2% last June, but only thru the end of this month. The final rule assumes that the current update won't be extended past November 30 and adds to the cut for 2011. That would mean a total scheduled reduction in Medicare payments to doctors of 25%, with the first 23% slice being taken December 1 unless Congress intervenes.

Since 2003, Congress has overridden projected cuts in Medicare physician payments almost annually, pushing the problem ever further down the road. The odds-on bet is that the same thing will happen again during the lame duck session. But, there are no guarantees.

A permanent fix that does away with the sustainable growth rate (SGR) formula to which physician fees are inextricably tied is more than unlikely any time soon. It may be the root cause of the problem, but pulling out that particular root would cost around $276 billion over 10 years. The American Hospital Association hopes physician rates can be raised, but the extra money to pay docs can't be taken from hospitals. So, where will it come from?

There was no misunderstanding the message from the electorate three weeks ago: cut taxes and reduce spending. That makes the prospects of an SGR fix without budget-neutral offsetting revenues practically nonexistent for this Congress or the next. Some think it may not bode well for another temporary fix either. For the newly elected, that brief succinct message rings as clear as Peter Clemenza's directions to his gun-wielding protégé Rocco Lampone in *The Godfather* as the two prepared to depart the scene of some nasty Family business. Clemenza, a feared capo, yet the ever dutiful husband on an errand to buy pastries for his wife, instructed Rocco, "Leave the gun. Take the cannoli." Understanding who issued the order, that's exactly what Rocco did with unquestioned loyalty.