The end of the world may not come October 1, 2014, but ICD-10 will.

New Fiscal Cliffs Put Hospitals at Risk Again

When Congress agreed to temporarily reopen the government and lift the debt ceiling after a 16-day shutdown in October, it set up several new fiscal cliff deadlines – and more opportunities for Medicare funding cuts. It’s déjà vu all over again for healthcare organizations which rely on government funding for their payments, but none more than hospitals.

By December 13, a budget conference must resolve differences between the House and Senate budget resolutions passed earlier. Sequester relief for the coming year is possible, but that isn’t all good news if hospital payments are used to bankroll the replacement savings. Congress also must reach other agreements on funding the government after January 15 and lifting the debt ceiling after February 7; plus another fix for Medicare physician fees comes due December 31 this year.

Hospitals’ payments are at risk on several fronts, but the most immediate concern lies in three site-neutral payment changes that could cost them $900 million annually. Those proposals are:

- Paying hospitals for evaluation and management (E/M) services in the hospital outpatient department (HOPD) setting at the physician fee schedule (PFS) amount;
- Paying hospitals for 66 specified ambulatory payment classifications (APCs) at the PFS amount; and
- Capping hospital payments for 12 proposed APCs at the ambulatory surgery center (ASC) rate.

And, there is more. If history is a barometer, then America’s hospitals are as likely to have their necks on the chopping block during any upcoming negotiations this holiday season as are a rafter of Tyson Thanksgiving and Christmas turkeys, because these Medicare “savings” options, which always get an unusual amount of attention, are once again being touted:

- Further reductions in payments to hospital Medicare bad debt payments,
- Reductions to payments for graduate medical education,
- Additional cuts to Medicare inpatient rates through yet another round of coding adjustments,
- Reductions to rural hospital program support, including critical access hospitals, and
- Changes to the 340B program.

Hospitals have already been subjected to about $100 billion in payment reductions over and above those included in the Affordable Care Act (ACA). For Arkansas hospitals, that converts to about $2.5 billion in combined cuts since 2010, including the ACA measures. Because more cuts will further jeopardize the future for hospitals of all types, Arkansas hospital representatives are encouraged to take every opportunity to reach out to the state’s members of Congress, informing them how further cuts will impact their facilities’ long-term viability and asking that they oppose the above changes as budget-balancing and deficit-reducing measures.
**OHIT Efforts Could Ease MU-2 Decisions**

In 2012, the state Office of Health Information Technology (OHIT), with the help of a committee of hospital chief information officers, explored the feasibility of purchasing and offering a statewide patient portal to help Arkansas healthcare providers comply with criteria under Stage 2 of the Medicare/Medicaid Meaningful Use program (MU-2). Under Stage 2, healthcare providers must more actively engage patients by providing them with the capability to electronically view, download, and transmit relevant information from their provider’s electronic health records. This could include information such as lab test results, a list of current medications and hospital discharge instructions.

The underlying purpose is to give patients access to their health information and provide them with tools to electronically communicate with their clinical care team, making healthcare more patient-centered. Conceptually, the patient portal functions could be facilitated through the State Health Alliance for Records Exchange (SHARE) system for participating SHARE providers.

In the end, OHIT didn’t purchase a system after reviewing demonstrations from three vendors, but did negotiate a tiered pricing plan with Get Real Health (GRH), which was deemed the preferred patient portal solution that both meets the MU-2 requirements and can interface with SHARE. OHIT is not managing or implementing this solution, nor will it receive any fees from GRH. Basically, OHIT vetted the product as one which providers could choose to use with a high degree of confidence and negotiated a tiered pricing structure for Arkansas providers that choose GRH. OHIT has distributed information about GRH and its tiered pricing, but is not requiring use of GRH or any other product.

OHIT director Ray Scott clarified that while the GRH solution is compatible with SHARE, hospitals and other providers may choose to use any MU-2 solution, if they find options which are more cost effective or otherwise prove a better fit to meet their particular patient portal needs.

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**Get Smart about Antibiotics**

New pediatric dosing instructions for children with bacterial upper respiratory infections are being released today in the journal *Pediatrics.* In an article titled, “Principles of Judicious Antibiotic Prescribing for Bacterial Upper Respiratory Tract Infections,” the new protocols are outlined as a part of the international “Get Smart about Antibiotics Week,” which begins today and runs through November 24.

Arkansas participants in “Get Smart Week” include the Arkansas Hospital Association (AHA), the Arkansas Chapter of the American College of Clinical Pharmacy, the Arkansas Foundation for Medical Care (AFMC) and the Arkansas Department of Health (ADH), which is leading the effort. Flyers, badges, fact sheets, posters and tool kits for this antimicrobial stewardship event can be found at [www.cdc.gov/gets smart](http://www.cdc.gov/gets smart).

Other special events to be held this week include a CDC Public Health Grand Rounds presentation on Tuesday, November 19, noon-1:00 p.m. (CST): from your computer, watch this Grand Rounds session focused on inpatient and outpatient antibiotic use live via the web; and join in the Get Smart Twitter Chat Friday, November 22, noon-1:00 p.m. (CST) to interact with CDC Director Dr. Thomas Frieden. Follow along at @CDCgov and be sure to use the hashtag, #SAVEABX, whenever you participate in the chat. Participating Arkansas hospitals can share what their “Get Smart about Antibiotics Week” activities have included and what plans are being made for better future antimicrobial stewardship.
Raising the Number of Arkansas’ Patient Safety Certified

The Arkansas Hospital Association (AHA), through its Hospital Engagement Network (HEN) collaborative, has partnered with the National Patient Safety Foundation (NPSF) to provide AHA member hospitals an exciting opportunity to expand their Patient Safety expertise. This past Friday, 110 AHA member hospital quality professionals received welcome letters and packets that mark the beginning of their journey toward Patient Safety Certification. Currently, there are only two people in the state holding this certification.

Participation in the NPSF/AHA program includes access to a new, 10-module course of study in Patient Safety, access to the practice test to pursue certification and a one-year membership in the American Society of Professionals in Patient Safety. NPSF is reducing the cost of the program for the American Hospital Association’s Hospital Engagement Networks and has allowed the Arkansas Hospital Association to provide this to our member hospitals. Also, those who take and pass the certification test by March 30, 2014 also will have the opportunity for the cost of the certification exam reimbursed. Forty-five hospitals are participating in this cohort. AHA is hoping to repeat this opportunity in 2014.

Physician Certification Requirements for CAHs

During a Special Open Door Forum on rural health issues last week, CMS officials clarified physician certification requirements for critical access hospitals (CAH) under inpatient admission and review criteria included in the final rule for the FY 2014 Medicare hospital inpatient prospective payment system. CMS said a physician must certify that the beneficiary may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH.

According to the agency, CAHs may satisfy this condition of payment by including a physician certification form or statement in the medical record. If physician certification forms or statements are not included in the medical record, CMS’ guidance also specifies that this condition of payment may be met by either physician notes or by actual discharge within 96 hours. The American Hospital Association posted a set of Talking Points on the issue at http://www.aha.org/content/13/cah_physician_certification_talking_points_11062013.pdf.

The AHA Calendar

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<td>December 2013</td>
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<td>CPT 2014 Coding Update, AHA Headquarters, Little Rock</td>
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<td>4</td>
<td>CPT 2014 Coding Update, Hilton Garden Inn, Jonesboro</td>
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<td>5</td>
<td>CMS Inpatient Prospective Payment System Final Rule for 2014: Ensuring Compliance – Webinar T2880</td>
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<td>6</td>
<td>When MACs and RACs Attack! Workshop, Crowne Plaza, Little Rock</td>
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<td>Legal Issues in Surgery: CMS and The Joint Commission Requirements Preventing Adverse Events in Patients Undergoing Surgical Procedures – Webinar T2881</td>
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<td>HFMA December CPE Seminar, AHA Classroom, Little Rock</td>
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Information on all AHA educational programs and activities is available at http://www.arkhospitals.org/events.
Final Thoughts by Paul Cunningham

The term “unintended consequences” usually implies that there’s a big “UH-OH!” in the offing. It typically is used to indicate that actions which accomplished specific purposes also had some unanticipated, questionable effects elsewhere. Not quite so surprising, the original actions far too often seem to be instigated by government leaders at some level. Read any article published over the past six weeks about people who have lost their existing insurance coverage because their plans didn’t meet the standards for coverage set up under the Affordable Care Act (ACA) and you get the gist. Those particular unintended consequences stemmed from the highest level.

“Collateral damage” can be used in similar situations, but there actually is a difference that hinges on expectations. With collateral damage, the ill effects might be incidental, but aren’t necessarily unanticipated. Instead, they’re rationalized as acceptable losses under the circumstances, like inadvertent casualties among civilians or friendly forces in the conduct of military operations.

Both terms carry negative connotations, for good reason. Not that we never hear talk about unintended benefit or collateral advantage, but those conversations are few and far between. Not so with their counterparts, both of which can be aptly applied to concerns about the fallout radiating from a relentless series of assaults on hospital finances, with both Congress and CMS leading the charge (i.e. the government leaders).

Each time an Arkansas hospital announces a round of layoffs, local media start sounding like a bad parody of the recurring Saturday Night Live “What Up with That?” sketch, asking why. They don’t understand that the answer is far too complicated for a sound bite or brief quote.

The fact is that hospitals across Arkansas are struggling to deal with the affects of some very damaging Medicare payment reductions already in place. The cuts, both deep and wide, are creating a cluster of operational challenges. Too many hospitals are walking a fine line between needs, on one hand, to cut costs – most visibly on the largest component of their budgets, their workers – and on the other, to spend considerably more on things like quality improvement and information technology to safeguard against revenues falling off at a faster pace in the future.

At the same time, patient volumes are slipping, for an assortment of reasons. That worsens the financial woes, which are heightened when a hospital feels pressure to invest time and money outrageously just to hang onto payments already booked for care already provided that government reviewers are trying to pry away. Then, after hospitals spend the resources and win their appeals, everybody ends up back at square one. Despite the handicaps, hospitals continue to retain a focus on serving their patients and communities, which isn’t as easy as it sounds.

But, it seems far too easy for congressional leaders and CMS officials, who publicly lament job losses resulting from the massive cuts, to callously shrug them off as unintended consequences. How could they possibly have predicted it?

The biggest clue might be found in a memo from CMS’ Office of the Actuary. The April 2010 memo, written one month after the ACA was enacted, analyzed the devastating impact of law’s provisions to take $155 billion from hospitals’ Medicare payments. The saving grace for hospitals was the hope offered by the ACA of getting 31 million newly insured people to help ease the pain. It was the primary reason why the major hospital groups supported the legislation.

Generally, hospitals were prepared to cope with the ACA, but they didn’t foresee an additional $100 billion Medicare funding blow coming in 2012. That’s the combined effect of the Middle Class Tax Relief Act and the American Taxpayer Relief Act. The hole got considerably deeper, backfilling it became much more difficult, timing for new insured patients grew extremely sensitive and prospects for the viability and survival of some hospitals dimmed.

So, when do the unintended consequences of those actions that were chosen over other viable budgeting options become collateral damage? Is it when hospital layoffs turn into hospital closures? When the closures lead to loss of physicians in small towns? When the loss of physicians and ancillary services begins to affect business development and retention? Or, when abandoned businesses induce a death rattle from entire communities?

If and when hospitals begin to close in the name of spending cuts, the same leaders whose actions set things in motion will show regret for the unintended consequences. However, the systematic targeting of hospital payments comes across like a conscious decision to accept the collateral damage and let the losses mount, especially in rural states like Arkansas.