Governor Recognizes Hospitals’ Quality Successes

Governor Mike Beebe hosted a ceremony today at the State Capitol recognizing 32 Arkansas million in bonus payments through the Arkansas Medicaid Inpatient Quality Incentive (IQI) program. Hospitals earned the bonus payments by meeting certain quality standards aimed at improving care for heart failure and pneumonia patients over a one-year period.

To receive bonus payments, which amount to 5.8% of the hospital’s Medicaid per diem rate for paid days of care provided Medicaid patients aged one-year or older, hospitals had to pass specific requirements for at least five out of seven quality measures. The measures are specific aspects of care proven to better the outcomes for patients. The hospitals also had to pass validation to receive payment. Eleven of the 34 hospitals met the criteria for all seven indicators. As a result, participating hospitals are better able to strengthen healthcare quality, accountability and financing in the state. Hospitals sharing the bonus payments include:

- Arkansas Heart Hospital
- Arkansas Methodist Medical Center
- Baptist Health Medical Center-Little Rock
- Baptist Health Medical Center-NLR
- Baxter Regional Medical Center
- CHRISTUS St. Michael Health System (Texarkana, TX)
- Conway Regional Medical Center
- Crittenden Regional Hospital
- Forrest City Medical Center
- Great River Medical Center
- Harris Hospital
- Helena Regional Medical Center
- HSC Medical Center
- Jefferson Regional Medical Center
- Magnolia Hospital
- Medical Park Hospital
- National Park Medical Center
- NEA Baptist Memorial Hospital
- North Arkansas Regional Medical Center
- North Metro Medical Center
- Ouachita County Medical Center
- Saline Memorial Hospital
- St. Bernards Regional Medical Center
- St. Edward Mercy Medical Center
- St. John’s Regional Health Center (Springfield, MO)
- St. Joseph’s Mercy Health Center
- Saint Mary’s Regional Medical Center
- St. Vincent Infirmary Medical Center
- St. Vincent Infirmary Medical Center/North
- Stuttgart Regional Medical Center
- Summit Medical Center
- Washington Regional Medical Center
- White County Medical Center
- White River Medical Center

Eight Arkansas critical access hospitals and a Memphis teaching facility which were not eligible to receive payments from the program, chose to participate and work toward the IQI goals. These hospitals did not receive bonus payments, but were recognized during the ceremony. They are Baptist Health Medical Center-Arkadelphia, Bradley County Medical Center, CrossRidge Community Hospital, DeWitt City Hospital, McGehee/Desha County Hospital, Ozark Health Medical Center, South Mississippi County Medical Center, St. John’s Hospital and Methodist University Hospital located in Memphis. The Arkansas IQI is the first pay-for-performance program for hospitals in the nation to include a validation component and has received national recognition for its innovation and healthcare community involvement.
AHEF to Meet September 4

The relationship between the medical staff and administration is critical to the success of healthcare organizations. To be successful, executives must identify strategies for involving the medical staff in decision making and planning, as well as determining how to align the medical staff with organizational strategies. Healthcare consultant Tom Atchison will lead a discussion of “Medical Staff Relations” during the September 4 Arkansas Health Executives Forum (AHEF) quarterly meeting.

Joining Atchison as panelists focusing on medical staff relations will be: Christy Hockaday, FACHE, CEO/Administrator of St. Anthony’s Medical Center in Morrilton, and Dr. Pete Marvin, Vice President for Clinical Affairs, Baptist Health Medical Center – North Little Rock. They will discuss the perspective of the physician executive in managing medical staff relations, involvement of the medical staff leadership in strategies and operational decision making, and setting up physician leaders for success while giving them the tools to be effective leaders.

The luncheon meeting begins at 10:45 a.m. at the Crowne Plaza in Little Rock. A program with registration information is available at http://www.arkhospitals.org/calendareducworkshops.htm. Please note that there is a $25 registration fee for this particular AHEF meeting, because the program qualifies for 1.5 hours of Category I continuing education by the American College of Healthcare Executives (ACHE) – an easy and very cost-effective way for ACHE members to pick up one hour of credit! AHEF is an independent chapter of the ACHE.

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Legal Note: IRS Releasing Form 990 Instructions

The Internal Revenue Service (IRS) has announced that it will release “the complete revised draft of instructions” for the Form 990, Return of Organization Exempt from Income Tax, later this month. Private not-for-profit hospitals and other tax-exempt organizations use Form 990 to report information about their operations. The IRS overhauled the tax form in December 2007 and released for public comment a draft of the instructions in April. The IRS anticipates posting the revised instructions for the core form and all schedules on its Web site by August 15, 2008.

In an August 5, 2008 statement, available at www.irs.gov/charities/article/0,,id=185428,00.html, the IRS stated that the revised instructions will include the following changes, among others, which were made in response to public comment:

✓ A revised definition of key employee for purposes of reporting executive compensation, transactions with interested persons and other items;
✓ A list of foreign countries within each of nine geographic regions to be used for reporting foreign activities on the Form 990, Schedule F, Statement of Activities Outside the United States;
✓ Specific reporting requirements for which the reporting organization may rely on reasonable efforts to obtain information required from interested persons or third parties along with examples of how the organization may satisfy the reasonable efforts standard with respect to each of these reporting requirements;
✓ A revised standard for determining independence of a voting member of the organization’s governing body; and
✓ For Schedule H, Hospitals, a revised definition of facility for purposes of completing Part V, Facility Information, for 2008 tax years (2009 filing season).

A copy of the redesigned Form 990 for tax year 2008 (to be filed in 2009 and later years) is available on-line at www.irs.gov/charities/article/0,,id=176637,00.html.
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.

Final Rule Addresses Self-Referral issues

Several provisions related to physician self-referral were addressed in the Fiscal Year 2009 inpatient prospective payment system final rule released July 31. Under the rule, only physicians with an ownership or investment interest in a physician organization are deemed to “stand in the shoes” of that organization for purposes of analyzing a financial arrangement under the self-referral law. However, the provisions do not apply to physicians without the ability or right to receive financial benefits – such as distribution of profits, dividends, sale proceeds or similar returns on investment – and arrangements meeting the requirements of the academic medical centers exception.

The rule also expands protections for malpractice insurance subsidies provided by hospitals, federally qualified health centers and rural health clinics to physicians who regularly provide obstetrical services in rural areas and areas determined to have a “demonstrated need;” prohibited the use of “per click or per use” payments in certain rental agreements for office space and equipment; and prohibited the use of percentage-based compensation in rental agreements for office space and equipment. The final rule takes effect October 1.

NewsNotes About Arkansas Folks

Stephen C. Smart, DDS, has been appointed Chair-elect of the American Hospital Association’s Committee on Governance. His three-year term begins January 1, 2009 and expires December 31, 2011. Smart, is chairman of the board of the Medical Center of South Arkansas in El Dorado. He is immediate past president of the Arkansas Association of Hospital Trustees and represented the AAHT on the board of directors of the Arkansas Hospital Association.

John Phillips has been named vice president and COO at CHRISTUS St. Michael Hospital in Texarkana, TX. Phillips is a former COO for Davis Regional Medical Center in Statesville, NC and has served in executive positions at two hospitals in Texas.

The AHA Calendar

August 2008
13 AHA Mid-Management Certificate Series: Financial Skills for Managers, Crowne Plaza, Little Rock
13 How to Protect Your Hospital from the Anesthesia Shortage – Webinar #N071308
14 Creating an Operational Early Warning System – Webinar #N071408
19 Medicare Conditions of Participation and Joint Commission Standards: Crosswalk to Continuous Compliance – Three-part Audioconference Series: Part 2
21 Hospital Discharge Planning: Best Practices to Reduce Preventable Readmissions – Lost in Transition – Avoiding the Black Pits – Webinar #T2422
22 Managing Joint Commission Standards for Environment of Care® EC Webinar Series: Fire Safety (EC.5.10-EC.5.50)
Final Thoughts by Paul Cunningham

Word on the street has it that CMS is pushing an expansion of its Medicare policies concerning non-payment of “never events” onto state Medicaid programs. CMS’ final Medicare acute care inpatient prospective payment rule for FY 2009 includes provisions to reduce payments for a select list of never events – preventable medical errors that result in serious consequences for the patient – that occur in hospitals. Their consequences often jeopardize patient safety and result in unnecessary costs.

Beginning October 1 of this year, Medicare no longer will pay for 10 conditions specified either in law or the Final Rule that were not present on admission when the patient entered the hospital. These hospital-acquired conditions, or HACs, are, in Medicare’s eyes, preventable and should not lead to higher Medicare payments. It’s a valid principle even though some of the chosen conditions are a little suspect.

While everyone else was focusing on how the HACs would impact Medicare payments, CMS used a wider lens to bring Medicaid into the picture. Barely had the ink finalizing the Medicare rule dried before Herb Kuhn, CMS Deputy Administrator, sent a July 31 letter to state Medicaid directors “encouraging” them to adopt the same non-payment policies for their programs, given the large number of Medicare beneficiaries who are also eligible for Medicaid. CMS wants to close the door on any chance that Medicaid could be billed as a secondary payer.

According to Kuhn’s letter, states wishing to avoid Medicaid payment liability for treatments and care for which Medicare will not pay may do so via a simple State Medicaid Plan (SMP) amendment. The amendment should indicate that such policy applies to all Medicaid reimbursement provisions, including supplemental or enhanced payments and Medicaid disproportionate share hospital payments. The odds probably are skewed in favor of CMS not taking its fully allotted 90 days to deal with those SMP amendments. Look for CMS to put them on a fast track for approval.

Kuhn then took another giant step, encouraging the states to “consider the entire Medicaid population (not just dual eligibles) and all of the National Quality Forum’s (NQF) 28 Never Events in the creation of individual state policies.” Since a handful of the almost 20 states which already have “never event” policies cover all NQF conditions, CMS believes all states should follow suit.

The fact that not every state may choose to adopt a policy covering all NQF conditions doesn’t end the conversation of expanding the list beyond those published for Medicare. When CMS crafted its list of never (pay?) events, it included a couple of questionable conditions and left off others that would seem to be no-brainers. Three omissions relate directly to surgeries that patients neither sought nor should have received: surgery on the wrong body part, surgery on the wrong patient and the wrong surgery performed any time on any patient. Quite an oversight. But, not to worry, where there’s a will, as they say, there’s a way; and few would accuse CMS in recent years of lacking will to scale back federal healthcare spending.

So, Kuhn also revealed that Medicare found a way to cover – or not to cover, as the case may be – those three types of surgeries through development of National Coverage Determinations (NCD) and has opened a 30-day public comment period for that purpose. The NCDs set national policy on whether Medicare will cover an item or service and under what conditions. They’re intended to ensure that Medicare contractors which process and pay claims are all singing from the same songbook across the land on those cases.

The process for the newly proposed NCD began July 31. Following the comment period, CMS will issue a proposed decision around February 1, 2009. That will be subject to another round of public comments before the final NCD is issued in the spring, most likely no later than April 30, 2009. It’s reasonable to expect others to follow.