Seven Hospitals Receive Governor’s Quality Awards

Associations, Auxilians and Advocacy

AHA 2011 Annual Meeting Roundup
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Funding Issues Weigh Heavy, Create Drag on Hospitals

Going into 2012, hospitals throughout the country are facing some very weighty issues in both state and national arenas. And, not unlike excess weight that creates drag and limits an aircraft’s ability to get off the ground, climb and soar, the combined weight of those challenges will severely limit hospitals’ ability to perform in the future.

The common thread running through the two sets of challenges is the uncertainty about future payments for hospital services, which mean Medicare and Medicaid. While both lie heavy on the minds of hospital execs and trustees, the Medicare side may be tipping the balance at the moment.

Since the Congress’ bipartisan supercommittee could not come up with a plan for reducing the nation’s budget by $1.2 trillion last November, the budgetary sequestration that nobody wanted has triggered. As of January 2013, a year from now, there will be an across-the-board 2 percent reduction in mandatory and discretionary spending for all federally supported programs, including Medicare. For now, Medicaid isn’t a part of that equation.

The 2 percent reduction to Medicare partly will come from reduced hospital reimbursements. Nationally, the Medicare program stands to lose around $143 billion in funding over 10 years. Hospital spending accounts for roughly $43 billion of the total. For Arkansas, that converts to a $37.9 million reduction in future funding for the state’s hospitals just in the initial year. Over 10 years the total impact of the sequestration is expected to be somewhere between $400-500 million on the state’s Medicare hospital fee-for-service payments.

The reductions will be especially hard on our 29 Critical Access Hospitals, which stand to lose at least a portion of their cost-based reimbursements; we will be fighting hard to help several of these keep their doors open.

That does not count the potential for added cuts related to the House’s last-minute pre-holiday 2011 vote to extend payroll tax cuts and unemployment payments. The new law includes another doc fix for physicians who treat Medicare patients. But the extension only applies through February 29. What happens next is the question.

Physicians who treat Medicare patients, and the patients themselves, are nervous about the next step, and rightfully so! But, no more than hospitals, which fear that a more long-term “fix” will be paid for with even deeper cuts to hospital reimbursements.

The harsh reality is that hospitals are probably going to endure more cuts, and we are going to have to find a way to reduce the drag and deal with them in the best manner possible.

There are two things the AHA asks our hospitals, their administrators, trustees, employees, auxiliaries and patients to do:

1. **Stay diligent in your contact with our senators and your congressional representative.** I know you are fatigued with this effort; and yet, failure to constantly remind our members of Congress what their actions mean to hospitals back home only bolsters the chance of more and more cuts to reimbursements. Be assured that the AHA staff is in constant contact with the Arkansas congressional delegation and each member’s aides, telling and re-telling the realities of what these actions mean to hospitals.

2. **Please take a good look at the AHA’s developing Quality Program.** The AHA is taking a leadership role in the area of quality in order to help our member hospitals deal with the many mandated initiatives, data submission requests and requirements, and demands being thrown at them. Our new Quality Program will offer more programs to help hospitals reduce healthcare acquired infections and will also focus on reduction of readmissions. This will not only help your hospital meet CMS mandates and give you the support you need as you develop your own interventions and initiatives, it should save every participating hospital thousands of dollars each year.

It’s a tough time for our country. It’s a tough time for our patients. And it’s an extremely tough time – and an uncertain one – for our hospitals.

Let’s keep talking, let’s be vigilant, and above all, let’s keep working together to keep our hospitals solvent.

Bo Ryall
President and CEO
Arkansas Hospital Association
January 6, Little Rock
CPT, HCPCS Level II and OPPS Workshop

January 18-20, Tunica, MS
Healthcare Financial Management Association Quarterly Workshop

February 3, Little Rock
Arkansas Association for Hospital Engineering Winter Quarterly Meeting

March (TBD), Little Rock
Arkansas Association for Medical Staff Services

March 2, Little Rock
Arkansas Society for Directors of Volunteer Services Winter Conference

March 8, Little Rock
Rural Hospital Compliance Collaborative

March 9, Searcy
Arkansas Healthcare Human Resources Association Spring Conference

March 18-21, Chicago, IL
Healthcare Financial Management Association Workshop

April (TBD), Little Rock
Crisis Communication Workshop

April (TBD), Little Rock
Hospital Preparedness Workshop

April 3, Little Rock
Hospital Staff Development Workshop

April 11-13, Hot Springs
Healthcare Financial Management Association Workshop

April 25-27, Hot Springs
Society for Arkansas Healthcare Purchasing and Materials Management Annual Meeting

May 6-9, Washington, DC
American Hospital Association Annual Meeting

Program information available at www.arkhospitals.org/events. Webinar and audio conference information available at www.arkhospitals.org/events.
Chris Barber, FACHE, president and CEO of St. Bernards Healthcare in Jonesboro, has been named the Northeast Hospital District’s delegate to the Arkansas Hospital Association’s board of directors. He succeeds Jamie Carter, FACHE, of West Memphis, who completed a four-year term in October. Barber also is president of the Arkansas Health Executives Forum.

Tim Bowen has been named CEO of Mena Regional Medical Center. Bowen has been with the facility since 2006 when he joined the hospital as director of nuclear medicine and was then promoted to assistant administrator. He has acted as interim administrator since the departure of Bob Ellzey, FACHE, in August.

Tom Fitz, FACHE, has been named interim administrator of St. Vincent Morrilton, succeeding Christy Hockaday who resigned in November. Fitz most recently led the transition of the Central Kansas Medical Center, a CHI facility in Great Bend, Kansas. He also served as CEO of St. Mary’s Health Care System in Athens, Georgia.

Jeramy Icenhower has been named administrator of DeQueen Medical Center (DMC), succeeding Angie House. Icenhower previously worked at DMC as an RN and manager of the emergency department before being named administrator of several nursing homes in the area.

Colonel Ray S. Jeter has been named Commander of the 19th Medical Group at Jacksonville. Col. Jeter most recently was Commander, Pentagon Tri-Service Dental Clinic in Washington, DC.

Mark Kenneday, vice chancellor of campus operations at UAMS in Little Rock, has been elected president-elect of the American Society for Healthcare Engineering (ASHE). He will become president in 2013. ASHE is a personal membership group of the American Hospital Association.

Luther J. Lewis, FACHE has accepted the CEO position at Five Rivers Medical Center in Pocahontas. John Tucker recently departed the hospital for a similar position at a Baptist Health Care System hospital in Alabama. Lewis was president and CEO of Medical Center of South Arkansas in El Dorado for 18 years during which time he also served as Treasurer, Chairman and past-Chairman of the Arkansas Hospital Association (AHA) board of directors. He was the 2004 recipient of the A. Allen Weintraub Memorial Award, the highest honor the AHA can bestow upon a hospital chief executive.

Joseph Mitchell has resigned as CEO of both River Valley Medical Center in Dardanelle and Eureka Springs Hospital after accepting a position as CEO of Trinity Hospital Twin City in Dennison, Ohio. Sondra Wear, CFO, will serve as interim CEO at both hospitals while a search for Mitchell’s successor is underway.

Ronald K. Rooney, FACHE, president/CEO of Arkansas Methodist Medical Center (AMMC) in Paragould since 1988, announced his retirement effective December 31. In his 42-year career, Rooney has served in leadership positions in healthcare organizations in New York, Massachusetts, South Carolina, Oklahoma, Louisiana and Arkansas. He served as chairman of the Arkansas Hospital Association board of directors in 1995-96 and was named recipient of the A. Allen Weintraub Memorial Award in 1998. He is the current chairman of the Voluntary Hospital Association of America’s regional network over Arkansas and Oklahoma. Barry Davis, FACHE, who currently serves as vice president of operations for AMMC, has been named interim president/CEO.

Robert Rupp has been named CEO at Harris Hospital in Newport. He previously held leadership positions with Community Health System hospitals in Louisiana, Texas and North Carolina.
Gary Sparks, administrator of CrossRidge Community Hospital in Wynne, has been elected chairman of the Northeast Hospital District. Other officers are vice-chairman Ralph Beaty, CEO of SMC Regional Medical Center in Blytheville, and secretary Barry Davis, FACHE, interim president of Arkansas Methodist Medical Center in Paragould.

The Arkansas Hospital Association Worker’s Compensation Self-Insured Trust named the following individuals to its board during the group’s October 21 annual meeting: Barry Davis, FACHE, interim president/CEO, Arkansas Methodist Hospital, Paragould, will succeed Randy Fortner of Benton on the board; and Sheila Williams, president/CEO, HSC Medical Center, Malvern, will succeed Scott Peek of Danville.

Kyle Swift has been named CEO of Medical Center of South Arkansas in El Dorado, effective October 3. He succeeds America Farrell, FACHE, who has accepted a new position as Project CEO/Acquisition Transition Coordinator at Tomball Regional Medical Center in Tomball, Texas. Swift was most recently assistant CEO at Brownwood (Texas) Regional Medical Center where he worked to expand medical services, recruit physicians and enhance the hospital’s reputation by focusing on quality and customer service.

Kim Thompson, senior executive director of finance, Ozarks Medical Center of West Plains, Missouri, has been named interim administrator of Fulton County Hospital in Salem. FCH has entered into a management contract with the Missouri hospital.

Sue Conley, FACHE, has been named CEO of Summit Medical Center (SMC) in Van Buren, succeeding Pam Tahan. Conley previously served as chief operating officer at Sparks Health System in Fort Smith and has held senior leadership positions in other hospitals in Nevada, Texas and Arkansas.

The AHA welcomes a new staff member, Nancy Robertson Cook, who has been named Director, Communications and Quality. Cook has worked for the AHA as a consulting writer for several years assisting with the quarterly magazine Arkansas Hospitals, the annual report and other publications.

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• Strategic Planning for Acquisitions, Sales, Mergers & Expansions
• Revenue Cycle Analysis
• Feasibility Studies
• IRS Form 990 Preparation
Arkansas Hospital Association 2011 Annual Meeting Roundup

The AHA annually presents several awards during its annual meeting, this year held October 5-7 at The Peabody in Little Rock. The AHA would like to congratulate all of these award recipients, and thank them for their constant support of and involvement with the hospitals, patients and communities of Arkansas.

In this section we also honor the vendors and exhibitors who took part in our annual tradeshow, held in conjunction with the annual meeting. This year once again saw a sold-out tradeshow, and a record turnout of attendees.

Jamie Carter Named 2011 Weintraub Award Recipient

James R. “Jamie” Carter, until recently the CEO of Crittenden Regional Hospital (CRH) in West Memphis since November 2005, received the Arkansas Hospital Association’s (AHA) A. Allen Weintraub Memorial Award during the Association’s Awards Dinner held in conjunction with the 81st Annual Meeting October 5-7 at the Peabody Hotel in Little Rock.

The AHA board selected Carter as the award recipient during its August 12 meeting in Little Rock.

Among his many accomplishments during his six years at the West Memphis facility, Carter developed the CARES program – Focused on Compassion, Accountability, Respect, Excellence and Smiles – among staff members, visitors and patients, to continually improve performance.

He also implemented a hospitalist program, digital diagnostic imaging, an automated pharmacy dispensing system throughout the hospital, an electronic health record for a majority of the hospital and area medical clinics, and hospital Trauma System designation.

During his tenure, the hospital opened an accredited Sleep Disorders Center and a Chest Pain Center. His employees also achieved multiple quality awards through the Arkansas Foundation for Medical Care, the Arkansas Hospital Association, American Heart Association, American Stroke Association, Arkansas Medicaid and others.

Carter represented the Northeast Hospital District on the board of the AHA until his December move to Methodist Le Bonheur Healthcare as CEO of Methodist’s Olive Branch (Mississippi) hospital. In addition, he will serve as interim chief operating officer for Methodist University Hospital in Memphis. During his time in Arkansas, he also served as a member of the Governor’s Trauma Advisory Council. He is a Fellow in the American College of Healthcare Executives.

A dedicated community member, Carter served on the boards of Hospital Wing Air Ambulance Services, the West Memphis Chamber of Commerce (2009 Chair), Steudlein Learning Center and the Ralph Hamilton Scholarship. He was a member of the City of Marion Volunteer Firefighters as a certified EMT, and a member of the West Memphis Rotary Club, a graduate of Leadership Arkansas, and was named a “Top 40 Under 40” by the Memphis Business Journal.

He was also selected as the 2010 West Memphis Chamber of Commerce Citizen of the Year.

In his nomination letter, CRH board member Rep. Keith Ingram said, “The consummate professional, Jamie has outstanding leadership skills and a compassionate heart. He desires the best for his employees, his patients and the community in which he lives. Jamie knows what he wants and is committed to his goals. He has a unique way of bringing out the best in those around him, thereby finding teamwork, forward thinking and good attitudes among everyone in his circle, creating a clear path toward excellence and success.”

The Weintraub Award, named for the late administrator of St. Vincent Infirmary Medical Center in Little Rock, is the highest honor bestowed upon an individual by the AHA.
AHA Distinguished Service Awards Presented to Three Arkansans

Three individuals were honored with 2011 Distinguished Service Awards by the AHA at its 2011 Annual Meeting October 5-7 at the Peabody in Little Rock.

Molly Harsh Burns, a trustee at Magnolia Regional Medical Center, was honored for her leadership on the Magnolia Regional Medical Center Board of Commissioners for 23 years. She was instrumental in helping to pass a sales tax and bond issue to finance a much-needed replacement facility which opened in February, 2010. She also is an active volunteer for many organizations in the city of Magnolia and in Columbia County.

Dave Morton, DrPH, FACHE, was honored upon his recent retirement as regional executive with the American Hospital Association. His service to Arkansas hospitals included his work with the American Hospital Association serving Arkansas, Oklahoma and Louisiana. He is appreciated for his leadership in national public healthcare policy and his understanding of the issues local hospitals face every day. He recently completed 38 years of healthcare service which included a career with the United States Navy as a Medical Service Corps Officer and as regional executive with the American Hospital Association. During his years with the American Hospital Association, Morton demonstrated leadership in national public healthcare policy and became a friend to Arkansas hospital CEOs.

Jane Texter, a 60-year hospital auxiliary volunteer, was honored posthumously for her many years of dedicated service and commitment to volunteerism at hospitals in Arkansas, Texas and Illinois. She served in many leadership roles in the Arkansas Hospital Auxiliary Association (AHAA) and as a member of the Arkansas Hospital Association (AHA) board of directors. Jane’s daughter, Catherine Baker, accepted her mother’s award, which was presented during the opening session of the AHA Annual Meeting when the AHAA joined our membership for the keynote address. It was a pleasure to present this award when Jane’s fellow auxiliaries could be present to honor her.

Young Administrator of the Year Award Goes to St. Bernards’ Michael Givens

Michael Givens, FACHE, administrator at St. Bernards Medical Center, Jonesboro, received the 2011 C. E. Melville Young Executive of the Year Award during the Arkansas Hospital Association’s annual meeting October 5-7 at the Peabody in Little Rock.

Givens is credited with and nationally recognized for reducing hospital expenses through cost-cutting measures arrived upon through value analysis.

He is also known for improving efficiencies in surgery and integrating specialized programs to improve patient safety, implementing an integrated system of healthcare technology across the continuum of care at the hospital, and helping develop the new Health & Wellness Institute at St. Bernards.

Givens is a Fellow in the American College of Healthcare Executives.
Representative Keith Ingram Earns AHA’s 2011 Statesmanship Award

The AHA’s 2011 Statesmanship Award was awarded to State Representative Keith Ingram, who actively supported Arkansas’ hospitals during his years as a member of the Arkansas General Assembly. Rep. Ingram also serves as a member of his local community hospital board of trustees at Crittenden Regional Hospital (West Memphis). In the 2011 legislative session, he championed legislation that fine-tuned hospitals’ self-imposed Medicaid Assessment Program.

James Magee Presents 2011 Chairman’s Award

The 2011 Chairman’s Award was presented to the executive team of Nabholz Construction Services, for its support of the AHA’s educational activities, as well as its participation in many charity events supporting hospitals across the state. Nabholz, which is based in Conway, is also recognized for its more than 60 years of dedication to quality and integrity in healthcare facility construction throughout the state.

The award, given at the AHA’s October 6 Awards Dinner at the Peabody Hotel in Little Rock, was accepted by Bill Hannah, CEO of Nabholz Construction Services.

Regent’s Awards Go to Early Career, Senior Career Professionals

American College of Healthcare Executives Regent Phil Gilmore and Arkansas Health Executives Forum President Chris Barber presented two Regent’s awards at the Arkansas Hospital Association’s annual meeting. The awards were presented at the ACHE breakfast held October 6 at the Peabody in Little Rock.

Receiving the Regent’s Award for Early Career was Sujay Kola, Clinical Effectiveness Specialist with the St. Vincent Health System.

Receiving the Regent’s award for Senior Career was J. Kevin Hodges, Vice President, Senior Services, St. Bernards Medical Center in Jonesboro.
AHAA Presents its Administrator of the Year Awards

The Arkansas Hospital Auxiliary Association (AHAA) presented its Administrator of the Year awards at the Arkansas Hospital Association’s (AHA) annual meeting October 5-7 at the Peabody in Little Rock. The AHAA awards were presented during the time set aside to honor auxiliaries, during the Opening Session of the AHA’s meeting.

President Mary Frauenhoff presented the Administrator of the Year awards to two chief executives, one serving a hospital with 100 or fewer beds, and the other serving a hospital with 101 or more beds.

Selected for the Administrator of the Year, 1-100 licensed beds, was Harold Mitchell of Bradley County Medical Center in Warren.

Selected for Administrator of the Year, 101+ licensed beds was Tripp Smith, Northwest Medical Center-Bentonville.

Tradeshow Participants

The Arkansas Hospital Association would like to thank all of the many companies exhibiting in this year’s annual Trade Show. Special appreciation goes to the 21 corporate sponsors of this year’s Annual Meeting, listed below in red.
The Arkansas Department of Human Services returned $4.2 million to Arkansas hospitals under the Medicaid Pay-for-Performance program in 2011. Here, Pam Brown, Assistant Vice President for the Health Care Quality Improvement Program at the Arkansas Foundation for Medical Care (AFMC) announces those hospitals that earned a portion of the $4.2 million. Shown with Dr. William Golden, Medical Director for the Arkansas Medicaid Enterprise at the Arkansas Department of Human Services (center) are St. Bernards representatives Vice President for Risk Management and Quality Susan Greenwood and Administrator Michael Givens.

Thirteen-year Marine veteran Ed Rush, author of Fighter Pilot Performance for Business, presented an all-day leadership workshop October 5 that helped attendees learn how to get more done in less time and with less waste. His focus was on the three keys to speed and success in the hospital field.

Presenting our national anthem at the opening session of the 2011 AHA Annual Meeting was a quartet from Conway Regional. Members included Dr. Melanie Smith, Ophthalmologist (soprano), Dr. Greg Kendrick, Internal Medicine and Hospitalist Program Chief (tenor), Alan Finley, COO (bass), and Lori Ross, Chief Development Officer (alto).

Members of the Baptist Health leadership team were among the group enjoying the ACHE/AHEF breakfast, presentation and awards ceremony.

Margaret West (center), CEO of Magnolia Regional Medical Center, with representatives of Magnolia Regional’s auxiliaries attending the AHA Annual Meeting.

Board Chairman James Magee presents outgoing AHAA President Mary Frauenhoff with a plaque honoring her years of service and her presidency of the auxiliaries’ volunteer group.

Representatives of Merritt Hawkins were among those exhibiting at the annual trade-show, a major part of each year’s annual meeting. Those vendors endorsed by AHA Services, Inc. are featured in their own specific aisle.
I got the help that I needed.

“Attesting to Meaningful Use for the EHR incentive program wasn’t a cakewalk. I’m grateful to HITArkansas for the support they provided. They removed all guesswork and made the process much smoother.”

— Dr. Richard Lochala, the first meaningful use attesee in Arkansas

Dr. Lochala, HITArkansas member since Oct. 2010, was one of the first Arkansas health care providers to receive a payment from the federal EHR incentive program. HITArkansas can help you do the same, and we’ll be here to help you through each step of EHR conversion.

Call or email us today to find out if you qualify for federal EHR incentive payments.

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Larry Morse, administrator at Johnson Regional Medical Center in Clarksville, became the new Chairman of the Arkansas Hospital Association Board of Directors during a ceremony that took place during the AHA’s annual meeting in October.

Morse, who holds a bachelor’s degree in business and economics earned at Hendrix College and a master’s of health administration earned at Georgia State University, has served as Administrator at Johnson Regional since June of 2002. “This year, I celebrate my 33rd year in the hospital administration field,” he said.

He served as director of project review in ambulatory care at University Hospital in Augusta, Georgia at the beginning of his career. After two years in that position, he moved to St. Bernards Healthcare in Jonesboro, Arkansas where he worked in various management positions including vice president of operations and senior vice president, new development during his 21-year career there. Since that time, he has been Administrator of Johnson Regional Medical Center, Clarksville.

His work at the 80-bed, 300-employee facility in Clarksville has brought positive change, with a 2005 $12.2 million, 35,000 square foot expansion that includes an enhanced emergency department, surgery theaters, radiology department, admissions department and power plant. He has also overseen the purchase of numerous equipment upgrades (totaling in excess of $2 million), and initiated the area’s sleep lab, intensive outpatient geriatric psych services, and physician practice acquisitions in the areas of surgery, orthopaedics and urology.

“My philosophy of hospital administration is to lead with the practical application of fair, honest management focused on the essential service of every hospital – patient care,” Morse says. He believes in the importance of participation in the Arkansas Hospital Association, saying, “the AHA provides a voice for our hospitals’ needs in the complex world of healthcare, provides a chance to learn from peers, particularly in the areas of better ideas, techniques and systems to improve [each local] hospitals’ patient care;” and says participation in the AHA allows him to join others to influence public policy at the state and federal levels.

Morse is a member of the American College of Healthcare Executives, has served as president of the AHA’s Health Executive Forum, was named the C.E. Melville Young Administrator of the Year in 1988, and has been a member of the AHA board of directors since 2004. From 2004-2009 he was the Arkansas Valley District delegate to the board, and served as chairman-elect of the AHA board of directors 2009-2011. He has also served as a board member on the AHA Workers’ Compensation Self-Insured Trust board since 2003, and has been its Chairman since 2005.

Morse succeeds James Magee, who served as board chairman from 2009-2011.

The co-chairs of the Joint Select Committee on Deficit Reduction on November 21 announced that the committee failed to come to an agreement on a deficit reduction strategy.

The bipartisan 12-member committee – chaired by Senate Democratic Conference Secretary Patty Murray (D-WA) and House Republican Conference Chairman Jeb Hensarling (R-TX) – was created by this summer’s Budget Control Act to craft a far-reaching plan by November 23 to reduce the national deficit by at least $1.2 trillion. The committee’s failure to reach an agreement means automatic spending cuts totaling $1.2 trillion split between defense spending and non-defense programs will take effect in January 2013. Under the trigger, reductions in Medicare payments to hospitals and other providers of 2 percent over nine years (2013 to 2021) will take effect.

“Sequestration means that arbitrary reductions in resources for patient care under Medicare will now be set to take effect under the law for the remainder of the decade,” said AHA President and CEO Rich Umbdenstock. “This will have an impact not just on the elderly and disabled beneficiaries of the program, but on their families. It will also have an impact on the ability of hospitals to provide essential public services to the communities they serve given the impact that Medicare has on the entire healthcare system.”

He added, “It is likely that Congress will reconsider whether this approach should take effect in January 2013 as required under current law. America’s hospitals will work with Congress as these discussions continue.”
Contractor Preparedness: The Key to Operating in Today’s Contractor Landscape

Over the years, the focus on program integrity has increased, transforming the regulatory environment in which providers and suppliers operate. A quick review of the current government contractor landscape underscores the current emphasis on program integrity. Providers and suppliers are currently subject to review by numerous entities, including Medicare Administrative Contractors (MACs), Recovery Auditors (RACs), Zone Program Integrity Contractors (ZPICs), Program Safeguard Contractors (PSCs), and Medicaid Integrity Contractors (MICs). Providers and suppliers will also be subject to Medicaid RAC reviews beginning January 1, 2012.

Medicaid RAC reviews will present additional challenges for providers and suppliers operating in multiple states given that the Medicaid RAC program design will be largely driven by the states. For example, while CMS requires that limitations be imposed for Medicaid RAC medical record requests, the states are afforded the flexibility of establishing such limitations. In addition, states are allowed to determine whether medical necessity reviews will be within the purview of Medicaid RAC reviews.

As the implementation of the Medicaid RAC program approaches, states are beginning to execute contracts with Medicaid RACs. Health Management Systems (HMS) is emerging as a large player in the Medicaid RAC landscape, as 11 states — Connecticut, Delaware, Maine, Nevada, New Jersey, New Mexico, New York, Oregon, South Carolina, Utah and Tennessee — have selected HMS as their Medicaid RAC. It is also important to understand the screening criteria being utilized by the various contractors, as challenging a contractor’s potentially inappropriate reliance on screening criteria can be effective during the appeals process. HMS recently signed a five year contract with Milliman and will utilize its clinical criteria in its review of Medicaid claims. HMS also currently performs audit MIC reviews. Thus, providers and suppliers

continued on page 17

Welcome to the Audit Era

**Medicare**
- Highmark Medicare Services* (Jurisdiction H)
- Pinnacle Business Solutions (FI / Carrier)
- CIGNA Government Services (DME MAC - Jurisdiction C)
- Palmetto GBA (Home Health & Hospice MAC - Jurisdiction 11)
- Connolly (A/B RAC Region C)

**Potential Fraud**
- AdvanceMed (NCI) (ZPIC - Zone 5)

*award currently under protest

**Medicaid**
- HMS (Audit MIC)
- AdvanceMed (Review MIC)
- Strategic Health Solutions (Education MIC)
- Arkansas Medicaid Fraud Control Unit (MFCU)
- Arkansas Medicaid Program Integrity - Field Audits
- Medicaid RAC (TBD)

* Little Rock
Anyone familiar with classic television series of the 1960s probably knows the story of Dr. Richard Kimble. He is the fictional Indiana physician who, unjustly accused of murdering his wife, was the target of a nationwide manhunt while simultaneously evading the authorities to seek out the real killer, the one-armed man.

American audiences became deeply invested in Kimble as both hunted and hunter over a four-season span. The series finale, aired in August 1967, reigned for more than a decade as the most watched TV series episode ever.

The story was updated 25 years later, moved to the big screen and retold in briefer fashion as a two-hour major motion picture. Today, fans of YouTube, who are really into brevity, can find an even more efficient rendering via a five-second video that captures the essence of the full story.

In the scene, Kimble stands teetering on the edge of a tunnel opening atop a dam, face-to-face with his nemesis, U.S. Marshal Sam Gerard. With only two options – surrender or escape by diving headlong into the water a hundred feet below – Kimble pleads, “I didn’t kill my wife.”

Gerard’s cold, three-little-word response reflects little sympathy: I don’t care! The End.

That might be a fairly accurate description of the way hospitals view the attitude of the nation’s Medicare Recovery Auditors (formerly, the RACs). The private contractor organizations have a job to do and caring about hospitals’ concerns isn’t a part of it, despite irrefutable proof that the RAC program adds enormously to the cost and complexity of hospital operations and duplicates other longstanding program integrity efforts already at CMS’ disposal.

In addition to the RACs, hospitals still must deal with an alphabet of claims review programs (CERT, PERM, MIC), conducted by Medicare Fiscal Intermediaries, Medicare Administrative Contractors, Zone Program Integrity Contractors and Medicaid Integrity Contractors. All are aimed at the same target – recovering money from hospitals.

As of September 2011, add one more to the lineup, Medicaid Recovery Audit Contractors, which generate a whole new set of worries.

Medicare’s RACs lose little sleep over that. It isn’t their job to think about the fact that dealing with RAC medical record requests and tracking RAC audits has become a full-time endeavor for hospitals, or that moves toward more medical necessity reviews and predictive modeling of claims data have the potential to add to those compliance costs, take even more staff time and resources, and damage hospitals’ reputations.

Not to mention the burdensome appeals process, which is often not worth pursuing even though there is ample reason to suspect the RAC determinations are inappropriate.

Not their problem. They aren’t paid to stress over communication shortfalls between themselves and other review contractors or the hospitals in their regions; that 55% of hospitals say they have yet to receive any education related to avoiding payment errors from CMS or its contractors; or that 48% of hospitals report problems with reconciling pending and actual recoupments due to insufficient or confusing information on the remittance advice.

Do hospitals continue to receive demand letters late and do the RACs continue to rescind medical record requests after a hospital has already submitted them? Well, stuff happens.

What if 85% of RAC decisions that go through the appeals process are overturned? It’s not personal, just business.

In their defense, the RACs have at least the tacit OK of the administration and Congress, who beefed-up the program’s legitimacy in the Patient Protection and Affordable Care Act. That’s not likely to change anytime soon with recent reports by CMS that the RACs returned about $75 million to Medicare coffers in FY 2010 and the amount is expected to increase to $170 million in FY 2012 and more than $250 million in FY 2013.

So, expect Medicare’s RAC pursuits to continue relentlessly, like Marshal Gerard.

Or, is their persistence more akin to that of another famous YouTube star whose antics have become legend?

The Honey Badger, tenacious and fearless, is unshakable going after its prey, regardless of the aftereffects. The narrator of the video explains humorously as the Honey Badger grabs a poisonous cobra, “Honey Badger don’t give a [hoot]” or words to that effect.

Ask the compliance officers in any of 4000-plus U.S. hospitals and they might say the same about their RACs.
Arkansas Hospital Education and Research Trust (AHEART) has received a $50,000 grant from the Arkansas Blue Cross and Blue Shield Blue & You Foundation for a Healthier Arkansas.

The grant was presented for continuation of the Best on Board Trustee Education and Certification program, which offers education, testing and certification for hospital trustees in the state of Arkansas.

The grant allows education for hospital trustees to be presented in two formats (live and online) with topics including hospital fundamentals of governance and quality initiatives. Because of this generous grant, hospitals can educate their trustees for an affordable fee that provides at least a 50 percent savings for each trustee.

It is estimated that with this grant and a former grant presented by Arkansas Blue Cross and Blue Shield, approximately 80 percent of Arkansas trustees will receive Best on Board trustee education and certification.

The Blue & You Foundation awards grants annually to non-profit or governmental organizations and programs that positively affect the health of Arkansans. In its 10 years of operation, the Blue & You Foundation has awarded nearly $14 million to 208 health improvement programs in Arkansas.

Best on Board Trustee Education Program Receives $50,000 Grant

winter 2012
Arkansas Hospitals

Reimbursement?

...Jamal is just a kid and doesn’t know what that is. He has never heard of Medicaid and he doesn’t know that The Midland Group helped his unemployed mother qualify for Medicaid to pay his hospital bills. He also doesn’t know that the hospital trusts Midland to provide caring, compassionate service to its uninsured patients.

What Jamal does know is he has important business to get back to at home, like playing baseball, XBox® and hanging out with his pet lizard, Spike.

The Midland Group has been dedicated to improving access to healthcare for people like Jamal and his mother since 1989.

Don’t your patients deserve that level of dedication, too? Let’s talk.

For information, contact Mario Garibay
(888) 233-8825 • midlandgroup.com
Seven Arkansas Hospitals Receive Governor’s Quality Awards; Baptist Health Rehabilitation Institute Takes Top Honors

Twenty-three organizations from throughout the state were presented Arkansas Governor’s Quality Awards by Governor Mike Beebe during the 17th Annual Awards Celebration for the Governor’s Quality Award Program Monday evening, October 17 at the Peabody Hotel Little Rock.

Taking top honors by receiving the Governor’s Award for Performance Excellence were the Baptist Health Rehabilitation Institute, Little Rock and the Arkansas Department of Information Systems, Little Rock.

Hospitals and healthcare organizations earning Achievement Level Awards were Pinnacle Pointe Behavioral HealthCare System, Little Rock; Saline Memorial Hospital, Benton; St. Vincent Health System, Little Rock; Stone County Medical Center, a Division of White River Health System, Mountain View; and White County Medical Center, Searcy.

Community Medical Center of Izard County, Calico Rock received a Challenge Level Award.

The awards ceremony includes four award levels of Performance Excellence (in descending order of qualifications): the Governor’s Award, the Achievement Award, the Commitment Award and the Challenge Award.

As well as the recognition, recipients receive an in-depth evaluation of their management systems and a written feedback report citing strengths and areas for improvement. Industry-specific seminars were held last year for manufacturing, healthcare and insurance/financial services.

The goal of the Governor’s Quality Award Program is to encourage Arkansas organizations to engage in continuous quality improvement, which leads to performance excellence, and to provide significant recognition to those organizations.

Created as a not-for-profit organization, the program is dedicated to assist in building a strong infrastructure for Arkansas businesses. That dedication is reflected in the program’s vision to contribute to the success of Arkansas organizations and the communities they serve. The Governor’s Quality Award program partners with the Arkansas State Chamber of Commerce.

Approximately 350 business and civic leaders from throughout Arkansas attended the celebration. Philip Singerman, the Associate Director for Innovation and Industry Services at the National Institute of Standards and Technology (NIST) in Washington, D.C., was the guest speaker.

Organizations and companies interested in participating in the program should contact Governor’s Quality Award Executive Director Sue Wcatter with the Arkansas State Chamber of Commerce by calling 501-372-2222 or go to www.arkansas-quality.org. ●

Baptist Health Rehabilitation Institute (BHRI) was one of two organizations in Arkansas to receive the Arkansas Governor’s Quality Award for Performance Excellence from Governor Mike Beebe October 17 during the 17th-annual awards celebration at the Peabody Hotel in Little Rock.

BHRI is the first rehabilitation hospital in the state to receive this level of award.

“Our team members have a clear mandate for continuous quality improvement and performance excellence that they consistently execute,” says Greg Crain, vice president for patient services at Baptist Health-Little Rock. “Their passion for delivering the highest-quality patient care and the best patient experience is the key to this phenomenal success. But the ultimate winners of the Arkansas Governor’s Quality Award are our patients and their family members, whose lives are positively impacted by all that BHRI provides to them in their time of need.” ●
2011 Touch Poll Results Show Overwhelming Trust in AHA, AHA Services, Inc.

For the third time in six years, the Arkansas Hospital Association (AHA) conducted a touch poll survey of annual meeting attendees’ opinions on AHA policy development, effectiveness and reliability. The poll was conducted October 6 during the AHA’s annual meeting.

Here, we compare results with the 2009 survey. Overall, results were extremely positive and improved from the previous survey.

A larger number of people participated in the 2011 survey, with the largest group coming from the North Central District (just as in 2009).

• 98% said the board of directors represented their best interests and viewpoints in developing policy
• 95% indicated that AHA is an effective representative on the state and federal levels
• 92% reported that the quality and content of AHA’s education programs was superior to programs sponsored by other organizations, with 96% reporting the AHA provides excellent programs to further management skills on all levels

We completely revamped the questions related to satisfaction with AHA Services, Inc. (AHASI), so cannot make a comparison to previous surveys. However, 2011 results indicated:

• AHASI endorsement greatly enhances the credibility of a service or supplier
• 72% were aware of AHASI
• 87% would recommend AHASI to a friend or colleague
• 78% said they consider the fact that AHASI provides non-dues revenue to the AHA when choosing a supplier or insurance provider

Troy Collins, who conducts the survey, said that the AHA’s survey generated the highest satisfaction percentages of any Association they survey across several states and industries. Needless to say, the AHA was very pleased to hear those words.

Today’s Top Issues in Healthcare; Valuable Data from the Estes Park Institute

The Estes Park Institute now introduces the Top Issues in Health Care – an online toolkit exclusively for hospital boards, executives, and physician leaders. In this report, the Institute sheds new light on the concerns of today’s hospital leadership.

Learn how the findings compare to previous years’, and how they reflect your own concerns and priorities. Download the free report, workbook, and moderator’s guide at http://www.estespark.org/TopIssues/?utm_source=EM&utm_medium=EM&utm_campaign=EM20110919.

New Arkansas Medicaid Director Named

The Arkansas Department of Human Services in late November announced Dr. Andy Allison has been named to head the state’s Medicaid program as the next Division of Medical Services (DMS) Director.

Allison, a PhD, currently works for the Kansas Department of Health and Environment as the Executive Director of the Division of Health Care Finance, overseeing that state’s Medicaid program, Children’s Health Insurance Program and state employee health plans.

He also is a founding board member and current President of the National Association of Medicaid Directors. He succeeds Gene Gessow.

The “Why” Behind the Health & Wellness Institute

St. Bernards recognized the need for preventive services because studies show that upwards of 70 percent of health issues are related to lifestyle choices. CDC data indicate that wellness and prevention of chronic diseases positively impact our long-term health.

A number of years ago, leadership at St. Bernards began looking at ways to impact the promotion of health and wellness throughout the north-east Arkansas region in unique ways. National trends were researched. Teams traveled to places where unique programs had been put into place. And St. Bernards sought out a knowledgeable partner to help develop a new approach to health and wellness. The national firm ALTER+CARE helped to guide St. Bernards as it sought to put together a premiere facility from which could be offered wide ranging health and wellness programs that are unique to residents in Northeast Arkansas and Southeast Missouri.

There are many health conditions that can be treated in part with proper diet and exercise – obesity, diabetes and heart disease come immediately to mind. Arkansas is following national trends in terms of the incidence of obesity and diabetes. Those chronic conditions impact health, longevity and quality of life.

We have the ability to prevent these for many people … and to prevent or help lessen the effects of these and other diseases by taking a wellness approach to life.

We know that exercise – proper exercise – is medicine for some conditions. And St. Bernards has put in place this Institute and its programs and services to serve as a catalyst for improving the health and wellness of the people in the communities it serves.

Interesting Facts about the Health & Wellness Institute

When the new St. Bernards Health & Wellness Institute opened in late October, it was the culmination of a number of years of research, planning and construction, ushering in a new era of wellness for residents of Jonesboro and Northeast Arkansas.

Here are some interesting facts about the Health & Wellness Institute:

- Medically based and medically integrated
- Developed as part of a national focus on prevention
- Combines the best offerings available in the region for achieving long-term health and wellness
- Is a 55,000-square-foot, two-story structure
- Was constructed at a cost of approximately $15 million
- Contractor – Nabholz Construction in Jonesboro
- Has taken a little more than a year to complete
- Provided jobs for more than 300 construction and other workers, with most coming from Jonesboro and other nearby communities
- Worked with ALTER+CARE, a firm that specializes in developing health and wellness facilities nationally, while going through the process of planning the facility and its programs and services

All components in the Institute are related to lifestyle improvement

When the Health & Wellness Institute opened, St. Bernards created approximately 30 permanent new jobs in the Jonesboro community. And the payroll to fund just those new jobs will approach $1 million annually.

The Institute’s opening put into action not only a state-of-the-art fitness center but also a number of other programs and services, including some St. Bernards clinical departments which promote behavioral changes that enhance wellness.
**The Fitness Center**

The Fitness Center is truly set apart from all others in the region.

- Members undergo an initial health assessment performed by healthcare professionals.
- Assessments determine members’ body age (compared to their chronological age) and also show members what body age they can achieve with proper diet and exercise.
- Following health and risk assessments, members receive personalized exercise prescriptions.
- St. Bernards Health & Wellness Institute offers a level of professional expertise not available at any other fitness center in the region – it includes exercise physiologists, exercise specialists on the floor at all times, credentialed personal trainers and more.
- Green Revolution – this is a unique feature which is tied to the spin class area. Bikes in that area are wired into the power grid at the Health & Wellness Institute. Special adaptors on each bike convert energy from spinning into electricity. And that, in turn, feeds electricity into the building’s electrical system. While the cyclists are generating power, each can see how much energy he/she is providing … and at the same time a wall display shows the amount of energy generated by the class as a whole.
- Aquatics Center – This area includes a four-lane, 25-meter salt water lap pool, a large whirlpool and a warm water hydrotherapy pool. The pools will be used for group classes, individual and group swim classes, physical therapy and even special family swim hours.

**Other Programs and Services**

Other Programs and Services will be offered at the Health & Wellness Institute as well. All these components focus on behavior changes that enhance long-term health and wellness.

Some of the programs and services offered on-site include:
- Café on the Mile – Open to both members and non-members, this café is the perfect place for a light lunch, a snack or even dinner. Meals will be available for dining on site or for carryout.
- Kids’ Club – Babysitting is provided for a nominal fee for members who are exercising and for patients who have appointments within the Institute. Designed to accommodate children from 3 months to 11 years, this service will give parents peace of mind knowing their children are being watched in a safe environment that will provide age-appropriate activities.
- Parents who utilize the Kids’ Club will have access to special smart phone apps that will allow them to check on their children visually via security cameras in the Kids’ Club area. (The apps will work only within the confines of the Health & Wellness Institute).
- Senses Spa – This full-service spa will offer services such as massages, manucures, pedicures and more.
- Outpatient Physical Therapy – This service is located in close proximity to the clinical offices of Jonesboro Orthopaedics and Sports Medicine so that the physicians can be directly involved in rehabilitation of their patients.
- Clinical offices of Jonesboro Orthopaedics and Sports Medicine – The offices of Drs. Brian Dickson, Spencer Guinn and Jeremy P. Swymn will be located on the second level of the Institute with access by a dedicated stairway as well as by elevator. The physicians will see patients in a unique setting which has access to the rehab area their patients will use.
- Sports Performance Training – This program is designed to help athletes increase their speed, power and agility through innovative training techniques and state-of-the-art exercise systems. Athletes can take advantage of sprinting and footwork drills, plyometric exercises, dynamic core exercises and sports-specific agility training. A high-speed treadmill will be used in assessing running mechanics.
- Center for Weight Loss/HMR Program.
- Diabetes Management Center.
- Cardiac and Pulmonary Rehabilitation – Those taking part in rehab programs following cardiac procedures and those with lung diseases will be monitored carefully during exercise programs. When they complete rehab, they already will be familiar with equipment and with personnel at the Health & Wellness Institute, so they can make easy transitions as members of the Fitness Center.

Membership is open to the interested public, with information available from the Health & Wellness Institute sales office at the Institute at 1416 East Matthews Avenue, Jonesboro, Arkansas – 870-207-7700.
Healthcare Providers Should Prepare Now for the Version 5010/ICD-10 Transition ... Will You Be Ready?

Are you prepared for the U.S. healthcare system’s change from ICD-9 to ICD-10 diagnosis and procedure codes? The switch to ICD-10 takes effect on October 1, 2013. Leading up to the October 1, 2013, compliance date, there are other important dates:

- Beginning January 2011, providers began testing Version 5010 transaction standards with their trading partners.
- January 1, 2012, the date for Version 5010 compliance.

Prepare now to avoid potential reimbursement delays. If you do not use Health Insurance Portability and Accountability Act (HIPAA) Version 5010 transaction standards starting January 1, 2012, and ICD-10 codes when submitting claims with dates of service on or after October 1, 2013, your claims may not be paid.

What’s Changing and Who Is Affected?

Unlike ICD-9 codes, ICD-10 diagnosis codes are alphanumeric, have 3 to 7 digits, and are much more descriptive. ICD-10 will affect diagnosis and inpatient procedure coding for everyone covered by the HIPAA, not just those who submit Medicare claims. This change does not affect Current Procedural Terminology (CPT) coding for outpatient procedures.

In addition to the code set changes, standards for electronic administrative transactions (such as eligibility inquiries and remittance advices) are being updated from the current Version 4010/4010A1 to Version 5010 on January 1, 2012. Version 5010 accommodates both the ICD-9 and the ICD-10 code sets. To allow adequate time to meet the January 2012 implementation date, providers began testing Version 5010 with their trading partners starting in January 2011. Providers who use practice management software, a clearinghouse, third-party biller, or some other way to transmit information between themselves and a healthcare plan, will need to upgrade their software or work with a clearinghouse or billing service whose systems can accommodate both the Version 5010 standards and the ICD-10 code sets.

Preparing for the Version 5010/ICD-10 Transition

Start with a gap analysis to determine the impact on your organization of both Version 5010 and ICD-10. Use that information to develop an implementation plan, with a detailed timeline, and estimate of costs. Providers should take the following steps now:

1. Check with your billing service, clearinghouse, or practice management software vendor. Your third-party biller and clearinghouse need to make sure that you will be compliant by the deadlines. Software vendors should be developing and testing products that will enable Version 5010 testing with your payers and billing services. Testing with ICD-10 should start sometime after Version 5010 implementation in January 2012, to allow for full ICD-10 implementation on October 1, 2013.

2. Start planning to implement the ICD-10 transition. Meet with your professional and support staff. Discuss where codes are used within your organization to help you assess impact. Assign roles and responsibilities for addressing the transition.

3. Identify needs and resources. Consider changes that might be required. Develop a budget and timeline that take into account specific workflow needs, vendor readiness, and staff knowledge and training.

Version 5010/ICD-10 Resources

There are many professional, clinical, and trade associations offering a wide variety of Version 5010 and ICD-10 information, educational resources, and checklists. Check the websites of your associations and other industry groups, or call them, to see what resources are available.

The Centers for Medicare & Medicaid Services (CMS) website, www.cms.gov/ICD10/, has official CMS resources to help you prepare for Version 5010 and ICD-10. CMS will continue to add new tools and information to the site throughout the course of the transition.

Transition Date for Version 5010/ICD-10


- October 1, 2013: You must submit claims with ICD-10 codes only for services provided on or after this date.
AHA STRATEGIES:  
Primary Goals for 2011-2012

The Arkansas Hospital Association (AHA) each year sets forth strategies for the coming fiscal year, designed to benefit Arkansas hospitals and focusing on the AHA’s four major foundational tenets: Advocacy; Education; Data Collection, Reporting and Analysis; and Communication. Strategies for the operation of AHA Services, Inc. are also provided.

Primary Goals for Fiscal Year 2011-2012 Include:

**ADVOCATE**  
Actively Advocate for Arkansas’ Hospitals

- Maintain and improve on AHA’s positive relationships and communications with the members of Arkansas’ congressional delegation and their key health aides to gain support for retaining the state’s ability to collect and use Medicaid provider taxes to fund payments for hospitals and nursing homes.
- Protect Arkansas hospitals’ financial viability as Medicare and Medicaid move away from volume based, fee-for-service payments toward development and adoption of value-based purchasing approaches that combine hospital and physician care with episodes of care and change from quality-related process to outcome measures.
- Build stronger relationships with current members of the Arkansas General Assembly.
- Ensure that Arkansas hospitals have a voice in steps to implement health reform measures including a State Health Insurance Exchange, Accountable Care Organizations, statewide health information exchange capabilities and other programs.
- Advocate for state and national legislative, regulatory and judicial actions in support of accessible, cost-effective, high-quality healthcare.
- Continue to take advantage of opportunities to impact judicial actions involving member hospitals through filing amicus briefs addressing appropriate public policy issues.
- Meet at least once with officials of CMS’ Dallas Regional Office and develop a positive relationship with the state’s Medicare Recovery Auditor, Medicaid Integrity Program Contractor and Arkansas’ new Medicare Administrative Contractor once finalized by CMS.
- Increase contributions to the AHAPAC over the 2010 total.
- Enhance the value of AHA membership by creating new services, expanding the types of and access to information on issues including, but not limited to, reimbursement, quality and outcomes measures, and increasing the political power of the association.

**EDUCATE**  
Provide Educational Resources and Opportunities

- Establish a Physician Hospital Committee to provide educational workshops, conferences and webinars designed specifically to address physician issues.
- Maintain and sustain efforts surrounding multi-year hospital-based safety projects to implement the Comprehensive Unit-Based Safety Program (CUSP) model to reduce central-line associated bloodstream infections (in which more than 40 units at 25 Arkansas hospitals participate), and 39 Arkansas hospitals currently participating in the Stop CAUTI project, adding other infections to the project and increasing the number of participating hospitals, as appropriate.
- Publish an electronic version of Arkansas healthcare laws and regulations.
- Fully implement AHA’s new Best on Board trustee education program to provide healthcare governance education, testing and certification services.
- Offer additional continuing education programming hours for healthcare professionals (i.e., ACHE Category I, CNE, compliance, coding).
- Provide educational programming and opportunities designed to assist members with marketplace challenges and compliance with constantly changing regulatory requirements in the healthcare arena. Proposed topics will include the RAC program, Medicare and Medicaid Integrity Program, The Joint Commission, fraud and abuse, readmissions/patient safety, OPPS, compliance, CPT and ICD-9 and ICD-10 coding, financial and bundling ramifications for hospitals, operations efficiency, philanthropy, crisis communications, staff development, emergency preparedness, healthcare legal issues, governance education, in addition to other hot topics.
- Offer the AHA Mid-Management Healthcare Leadership Series for middle management candidates.
- Implement online registration for AHA educational events.
- Monitor potential union activities in the state and intensify educational efforts, if warranted.

**ANALYZE AND REPORT DATA; ANTICIPATE DATA NEEDS**  
Seek, Explain and Provide Healthcare Data; Address Data Reporting Issues

- Coordinate with AHA Services, Inc. to implement a benchmarking program to provide data for hospitals’ use in negotiating continued on page 24
tracts with private, third party health plans.
• Conduct a survey to measure vacancy rates for selected hospital positions.
• Monitor, address and resolve ongoing legislative, regulatory and policy issues concerning requirements for public reporting of hospital data. Communicate results to member hospitals.

COMMUNICATE
Communicate, Inform, Provide Idea-Sharing Opportunities
• Provide direct input for the Department of Human Services’ planned move to create new DRG methodology applicable to hospital inpatient and outpatient services.
• Build on the current relationships with officials of the state Departments of Health, Human Services and Insurance to ensure that hospitals’ concerns are heard and addressed in relation to programs, rules and regulations proposed and implemented under their authority.
• Ensure that Arkansas hospitals have a voice in steps to implement health reform measures including a State Health Insurance Exchange, Accountable Care Organizations, statewide health information exchange capabilities and other programs.
• Ensure that future Medicaid-specific quality measures for use in the state’s Quality Incentive Payment Program are reasonable and subject to input and agreement by the state’s hospitals.
• Work with private, third party payer organizations to ensure fair and equitable reimbursements for hospital care.

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Contact Paul Phillips today at (501) 978-6309 or 1-800-766-2000 and let our own team of healthcare professionals prescribe the proper capital structure for your organization.
The Arkansas Hospital Association (AHA) each year sets forth strategies for the coming fiscal year, designed to benefit Arkansas hospitals and focusing on the AHA’s four major foundational tenets: Advocacy; Education; Data Collection, Reporting and Analysis; and Communication.

- Continue active participation in the development of Arkansas Department of Health rules and regulations implementing the Arkansas Health Facility Infection Disclosure Act in order to ensure that appropriate national guidelines are followed in establishing the voluntary reporting of hospital infection data, and promote hospital compliance with those reporting standards.
- Fully implement the Small/Rural Hospital Compliance Collaborative.
- Assist member hospitals to better equip them to respond to natural and/or man-made emergency situations related to weather, disease outbreaks, chemical/nuclear/biological terrorist attacks and other forms of emergency situations.
- Improve relationships with the state’s business community and reposition hospitals as large employers that pay excellent wages and strongly influence economic development.
- Continue to offer a wide range of communication tools and resources for member hospitals’ use.

AHA SERVICES, INC.
- Coordinate with the AHA to implement a benchmarking program to provide data for hospitals’ use in negotiating contracts with private, third party health plans.
- Continue to educate member hospitals about the wide range of discounted services available through AHA Services, Inc.
- Assist members with recruiting and retaining qualified candidates through the online AHA Career Center.
- Continue to provide AHA with financial support for operations and educational events such as the summer leadership conference and annual meeting.
- Continue to negotiate with vendors for beneficial group purchasing discounts and value-added services for members.

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- Sole provider of blood products and services for every patient in 13 Arkansas hospitals
- Supplemental blood provider to other major Arkansas hospitals
- Immunohematology Reference Laboratory located in Fort Smith
- Ninth largest, independent, non-profit blood center in the U.S.

Arkansas Blood Institute

Locations
Fort Smith, 479-452-5880
Hot Springs, 501-624-0666

Del Holloway, Executive Director

www.arkbi.org
Monday, November 14 was a red-letter day for the more than 150 people traveling to Little Rock for the kickoff of the AHA’s On the CUSP: Stop CAUTI program. Representing 39 AHA member hospitals, those in attendance at the kickoff learned key components of this national collaborative from the national project team, streamed live simultaneously to all seven states in our cohort.

The objective of On the CUSP: Stop CAUTI is to use the nationally-proven Comprehensive Unit-based Safety Program (CUSP) to help unit teams develop effective, standardized methods of reducing catheter-associated urinary tract infections (CAUTIs).

The 18-month collaborative includes seven states. Joining Arkansas in national Cohort 3 are California, Connecticut, Kansas, Maryland, New Jersey and South Carolina.

Arkansas’ 39 participating hospitals (many with more than one participating unit) began collecting baseline data January 1. Teams are currently undergoing intensive training through the use of On-Boarding webinars and will soon begin coaching calls with members of the National Project Team.

**About the Project**

More than 600,000 patients develop urinary tract infections (UTIs) each year. UTIs account for 40 percent of all hospital acquired infections. Of these, 80 percent are catheter associated infections (CAUTIs).

The Arkansas Hospital Association’s member hospitals participating in On the CUSP: Stop CAUTI seek to reduce CAUTIs using evidence-based interventions and the Comprehensive Unit-based Safety Program (CUSP). CUSP is transforming care and patient safety in hospital units by improving patient safety culture and practices.

**Benefits**

- Learning: Hospital teams will learn how to implement the CUSP program and reduce CAUTIs in their units.
- Networking: Teams will be able to network on both state and national levels with other hospitals in the project.
- Expertise: Teams will have access to expert faculty and data collection and monitoring support throughout the state’s eighteen-month participation.

**Expected Outcomes**

- Increased awareness of appropriate urinary catheter (UC) use
- Reduced use of indwelling UCs
- Greater healthcare worker accountability to assess need for UC, and to discontinue UC when appropriate
- Reduced patient discomfort
- Reduced incidence of bacteriuria
- Reduced rates of symptomatic UTIs
- Shortened LOS and decreased cost per stay

**National Project Goals**

- Reduce mean CAUTI rates in participating clinical units by 25 percent, and
- Improve safety culture by disseminating CUSP methodology as evidenced by improved teamwork and communication

**Project Sponsor and National Project Team**

Funded by the Agency for Healthcare Research and Quality, the Health Research & Educational Trust (HRET) of the American Hospital Association coordinates this national initiative. Barb Edson, RN, MBA, senior director of clinical quality at HRET, is the project lead. HRET’s partners include the Michigan Health & Hospital Association’s Keystone Center for Patient Safety & Quality, University of Michigan Health System, St. John Hospital and Medical Center, and the Johns Hopkins Quality and Safety Research Group.

Expert Faculty include Sanjay Saint, MD, MPH, and Sarah Krein, RN, PhD, University of Michigan Health System; Mohamad Pakih, MD, MPH, St. John Hospital and Medical Center; Sam Watson, MSA and...
In 2009 Arkansas Hospitals provided over $592 million dollars in services to self pay Arkansas patients. Most of it was uncompensated.

In 2009 self pay Arkansans:
- Accounted for 30,000 hospital admissions annually.
- Cost $19,622 for the average hospital stay.
- Averaged 5.23 days length of stay.

ARHealthNetworks is a Department of Human Services program that can help your hospital get paid for the services it performs for hard-working Arkansans who don't have medical coverage.

We can show your hospital how to improve its collection rate with little or no financial investment!
- Call NovaSys Health's marketing department at (501)-219-4443 to tailor a plan for your facility.
- Visit our website to find out more information about this program - www.arhealthnetworks.com/hospital.
- ARHealthNetworks paid out over $23.7 million from 2/1/10 - 1/31/11.

Help reduce your bad debt by suggesting ARHealthNetworks to your patients who have no other way to pay!
Chris George, RN, MS, Michigan Health & Hospital Association; Chris Goeschel, RN, ScD, Johns Hopkins Quality & Safety Research Group. These senior faculty members will also work closely with other key professional groups including the Society of Hospital Medicine (SHM), the Association for Professionals in Infection Control and Epidemiology (APIC), and the Society for Healthcare Epidemiology of America (SHEA).

**Key Interventions**

- **CUSP:** 1) Educate on the science of safety, 2) Identify defects, 3) Assign executive to adopt unit, 4) Learn from defects, 5) Use teamwork and communication tools

- **CAUTI Prevention:** 1) Placement Interventions – determine appropriateness and sterile placement, 2) Care and removal interventions – remove unnecessary catheters and care properly for appropriate catheters

**Arkansas Hospital Association Participating Member Hospitals**

- Advance Care Hospital-Fort Smith
- Advance Care Hospital-Hot Springs
- Arkansas Heart Hospital (Little Rock)
- Baptist Health Medical Center-Arkadelphia
- Baptist Health Medical Center-Heber Springs
- Baptist Health Medical Center-Little Rock
- Baptist Health Medical Center-North Little Rock
- Baptist Health Medical Center-Stuttgart
- Baptist Health Extended Care Hospital (Little Rock)
- Baptist Health Rehabilitation Institute (Little Rock)
- Bradley County Medical Center (Warren)
- Baxter Regional Medical Center (Mountain Home)
- Central Arkansas Veterans Healthcare System (Little Rock)

- Chicot Memorial Medical Center (Lake Village)
- Crittenden Regional Hospital (West Memphis)
- CrossRidge Community Hospital (Wynne)
- Drew Memorial Hospital (Monticello)
- Five Rivers Medical Center (Pocahontas)
- Great River Medical Center (Blytheville)
- Howard Memorial Hospital (Nashville)
- Jefferson Regional Medical Center (Pine Bluff)
- Mena Regional Health System (Mena)
- Mercy Medical Center-Rogers
- National Park Medical Center (Hot Springs)
- North Arkansas Regional Medical Center (Harrison)
- Ouachita County Medical Center (Camden)
- Ozark Health Medical Center (Clinton)
- Saint Mary’s Regional Medical Center (Russellville)
- Saline Memorial Hospital (Benton)
- South Mississippi County Regional Medical Center (Osceola)
- St. Bernards Medical Center (Jonesboro)
- St. Edward Mercy Medical Center (Fort Smith)
- St. Joseph Mercy Health Center (Hot Springs)
- St. Vincent Infirmary Medical Center (Little Rock)
- St. Vincent-North (Sherwood)
- St. Vincent-Morrilton
- University of Arkansas for Medical Sciences; UAMS Medical Center (Little Rock)
- White County Medical Center (Searcy)
- White River Medical Center (Batesville)

For more information or questions about the project, please contact Nancy Robertson Cook, Director, Communications and Quality Services, Arkansas Hospital Association, 501-224-7878 or email Nancy at NRCook@arkhospitals.org.

**AHA, AFMC Working Together to Reduce Reporting Duplication**

The Arkansas Hospital Association (AHA) and the Arkansas Foundation for Medical Care (AFMC) are working together on the concurrent CMS-driven Stop CAUTI movement and the ARHQ/HRET-driven *On the CUSP: Stop CAUTI* national collaborative. Although baseline data timelines differ widely, baseline and outcomes data for each may be entered into the NHSN database. It is the hope of both the AHA and AFMC that entering of data in a non-duplicative way will be helpful to Arkansas hospitals.

For the AHA’s project, hospitals may choose to enter both outcomes and process data into the Care Counts database, or enter outcomes data into NHSN, from which it can be downloaded into Care Counts. All AHA process data must be entered into Care Counts.

More information on the On the CUSP: Stop CAUTI national collaborative is available from Nancy Robertson Cook, Director, Communications and Quality Services, AHA, 501-224-7878 or NRCook@arkhospitals.org.

More information on the AFMC CAUTI project is available from Mandy Palmer, Quality Specialist, AFMC, 501-212-8736 or MPalmer@afmc.org.
Reducing health care-associated infections: Zero is the target, now is the time

Strengthen your safety network by joining Arkansas’ Target Zero Learning Action Network to provide a higher level of quality health care for your patients. Target Zero members are hospitals committed to patient safety and quality that have come together to form a network to cooperate and share resources, tools and skills. Target Zero links the member hospitals and engages them in a collaborative group process to improve quality in their own institutions.

Target Zero offers your hospital:

- Discounted classes, webinars and free conference calls to facilitate networking, best practice sharing and mentoring partners
- Evidence-based HAI toolkits
- Assistance with implementation of hand hygiene and antimicrobial stewardship programs
- Low-cost Comprehensive Unit-based Safety Program (CUSP) training
- Education and training tools for patients, caretakers and families on preventing HAIs
- NHSN training and support
- Data support and analysis
- Statewide marketing and recognition program

The Learning Action Network Mission: To provide an all-teach, all-learn collaborative to assist Arkansas hospitals with the reduction of health care-associated infections.

Target Zero is facilitated by supporting partners including the Arkansas Department of Health (ADH), the Arkansas Foundation for Medical Care (AFMC), the Arkansas Hospital Association (AHA) and the Association for Professionals in Infection Control and Epidemiology, Inc. (APIC) Arkansas. Please join Arkansas’ finest hospitals as we target zero health care-associated infections. The time is now!
Medicare 10th Statement of Work: New QIO Program Aims for Bold Goals, System-Level Transformation

As Arkansas’s Medicare Quality Improvement Organization (QIO), the Arkansas Foundation for Medical Care (AFMC) has a long record of collaborating with the state’s healthcare providers to improve care in Arkansas.

Our newest contract with the Centers for Medicare & Medicaid Services (CMS) – the 10th Statement of Work (SOW), in effect from August 2011 through July 2014 – marks a dramatic departure from how QIOs have historically approached the task of improving healthcare.

This change is characterized by: bold goals; transformation at the systems level; a patient-centered philosophy; collaborative learning; and breaking down organizational, cultural and geographical barriers to quality improvement.

Using these new approaches, AFMC will focus its efforts on three critical areas: better patient care, better population health, and lowering healthcare costs through improvement. These areas of focus align with the U.S. Department of Health and Human Services’ National Quality Strategy, part of the Affordable Care Act, and the National Quality Strategy, part of Health and Human Services’ efforts to improve healthcare.

As part of the Health Resources and Services Administration’s Patient Safety and Clinical Pharmacy Collaborative, AFMC will work with a small group of communities in Arkansas to improve care coordination and medication reconciliation as beneficiaries move among care settings. This effort integrates evidence-based clinical pharmacy services into the care of high-risk, high-cost, complex patients.

**AIM 1: Make Care Beneficiary- and Family-Centered**

Patient-centered care is the QIO program’s top priority. AFMC will be working with providers to promote responsiveness to beneficiary and family needs, encourage listening to and addressing beneficiary and family concerns, and provide decision-making resources for patients and caregivers.

This aim has three main parts:

- **Empowering beneficiaries and families to be more engaged in healthcare decision-making.** The Patient and Family Engagement Campaign, set to begin Aug. 1, 2012, will include tools and strategies to help providers engage patients and families, as well as self-advocacy information for patients and families.

- **Contributing to safer, more effective care through quality improvement work with providers.** AFMC will use what we learn from reviewing quality complaints to improve the way providers deliver healthcare. We will also work to increase patients’ access to care regardless of socioeconomic, cultural or educational background.

- **Providing a streamlined process for making and reviewing quality-of-care complaints.** Instead of contacting AFMC directly to file complaints and appeals, patients and their advocates will go through the newly established Beneficiary- and Family-Centered Care National Coordinating Center (BFCCNCC). The center will then send the appropriate cases to AFMC for review or refer beneficiaries to another agency for help.

Upon request, AFMC will also assist providers who are required to perform a root cause analysis, implement systems change or develop a quality improvement plan to resolve any quality of care concerns identified.

**AIM 2: Improve Individual Patient Care**

This aim has four main goals:

- **Reduce healthcare-acquired infections (hospitals).** Work will begin with central line-associated bloodstream infections (CLABSI) and then move on to other HAIs, such as Clostridum difficile infections (CDIs) and surgical site infections.

- **Reduce healthcare-acquired conditions (HACs) by 40% (nursing homes).** The first phase (through January 2013) will focus on reducing pressure ulcers and the use of physical restraints. The second phase (January 2013-July 2014) will take on other HACs such as catheter-associated urinary tract infections and falls.

- **Eliminate adverse drug events.** As part of the Health Resources and Services Administration’s Patient Safety and Clinical Pharmacy Collaborative, AFMC will work with a small group of communities in Arkansas to improve care coordination and medication reconciliation as beneficiaries move among care settings. This effort integrates evidence-based clinical pharmacy services into the care of high-risk, high-cost, complex patients.

- **Quality reporting and improvement.** Data can tell us much about the state of quality and safety in hospitals. In the 10th SOW, AFMC will continue to provide technical support in reporting clinical data to Medicare’s Hospital Inpatient Quality Reporting Program, and will assist with the Hospital Outpatient Quality Reporting Program as well. These programs both include financial incentives for successful participation – as much as 2% extra payment from Medicare. In addition, the Medicare Value-Based Purchasing Program will incentivize hospitals based on quality as of Oct. 1, 2012. Hospitals will be paid not just for the services they provide, but for how well beneficiaries fare under that care. These payments will be...
calculated using data from the quality reporting programs.

**AIM 3: Integrate Care for Populations**

Avoidable hospital readmissions strain patients and families and increase costs unnecessarily. Beginning Oct. 1, 2012, more of those costs will be shifted to hospitals: Under the Readmissions Payment Reduction Program, hospital DRG rates will be decreased if hospitals meet CMS criteria for “excess readmissions.”

AFMC will work with hospitals and other healthcare facilities to improve care transition processes and reduce readmissions within 30 days of discharge by 20% over three years. We will use proven interventions and focus on communities with the highest 30-day hospital readmission rates. We will also work with community groups to encourage wider adoption of improved practices.

**AIM 4: Improve Health for Populations/Communities**

The goal of this aim is to improve health at the community level – to keep Medicare beneficiaries as healthy as possible for as long as possible through system-wide changes to processes of care in physician practices.

AFMC will work with physicians on three areas:

- **Using electronic health records (EHRs) to improve preventive care.** EHRs can be used to coordinate preventive services, increase utilization rates, and report data to CMS’ Physician Quality Reporting System (PQRS — formerly PQRI), which ultimately will help boost the quality and safety of ambulatory care. Medicare is providing financial incentives for physician practices to participate in PQRS: up to 2% of estimated Part B charges, in addition to standard Physician Fee Schedule rates. Starting in 2015, Medicare will penalize practices that don’t report data to PQRS. For more information, visit [www.cms.gov/pqrs](http://www.cms.gov/pqrs).
- **Reduce cardiac risk factors.** AFMC and other QIOs will be launching a national campaign to improve cardiac health through aspirin use, blood pressure monitoring, lipid management, and smoking cessation.
- **Integrate health information technology into clinical practice.** AFMC will collaborate with HITArkansas, the state’s Health IT Regional Extension Center, to promote physician office EHR adoption and participation in CMS’ EHR incentive program. For more information about this program, visit [www.cms.gov/ehrincentiveprograms](http://www.cms.gov/ehrincentiveprograms).

**Drivers of Change**

Under the 10th SOW, AFMC will be using some new approaches in our work. We will be de-emphasizing the technical assistance model, focusing instead on the creation of topic-specific “learning and action networks.” These networks will bring providers, beneficiaries and other stakeholders together to spread best practices and spark change through peer-to-peer learning and sharing of solutions.

We will also be using the CRISP model – Care Reinvention through Innovation Spread – to integrate strategic communications into the 10th SOW initiatives. One example of a CRISP activity is identifying project successes and channels for rapidly sharing those successes.

In the 10th SOW, AFMC will be working on goals and priorities shared by a number of national groups. The participation of Arkansas’ providers and stakeholders is crucial to this effort, and AMFC looks forward to building on our existing relationships in the 10th Statement of Work.

*Pam Brown is assistant vice president for the Health Care Quality Improvement Program (HCQIP) at the Arkansas Foundation for Medical Care.*

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**Winter 2012 | Arkansas Hospitals**
Medefis, Inc. ("Medefis") is the nation’s easiest-to-use and fastest-to-engage clinical workforce solutions provider. Medefis provides healthcare organizations with comprehensive Vendor Management Services (VMS) for the procurement of nursing, rehabilitation, laboratory and allied healthcare personnel.

With more than 1200 health systems, community and critical access hospitals, specialty facilities and healthcare organizations as clients, Medefis has become the nation’s preferred VMS technology, providing end-to-end management of the supplemental staffing process.

When working with Medefis, clients can expect to achieve clinical, operational and financial improvements throughout the staffing process. Medefis works to improve the time-to-fill and position fill-rates; deliver standardization and simplicity to the staffing procurement process and drive financial savings for their clients.

The Medefis technology platform is powered by proprietary bidding and talent ranking (BidMatch and TalentMatch) engines that ensure healthcare organizations receive the best-qualified clinical professionals at a true market rate.

In addition, the Consolidated Services offerings (consolidated billing and contracting, credentialing management and dashboard reporting), provide healthcare organizations with 360 degree access into the staffing management process.

The Medefis technology is a powerful procurement tool and with Medefis managing the staffing procurement process, its clients can focus on their core commitment: delivering exceptional care to their patients.

For more information, visit www.medefis.com or contact Bryan Groom, Account Manager, at 866.711.6333 x 114 or Tina Creel, AHA Services, Inc., at 501-224-7878 or email her at tcreel@arkhospitals.org.
ASSOCIATIONS, AUXILIANS AND ADVOCACY
How the Arkansas Hospital Association and its Auxilians Team Together for Results, and Have for More Than 55 Years!

Since its inception, the AHAA has held its annual meeting concurrently with the annual meeting of the AHA. AHAA members attend parts of the AHA meeting so they can both be recognized for their hard work and take part in the learning sessions that keep us all abreast of core healthcare issues in our state.

Arkansas was the second state to grant a permanent seat on the association board of directors to its auxiliary president. AHAA district legislative chairs also are a vital part of the association’s regional district meetings. And with each local auxiliary having its own legislative chair, Arkansas auxilians’ part in healthcare advocacy has become vital as they raise their voices, singly and collectively, on behalf of their local hospitals and healthcare in Arkansas.

“Through the voterVOICE tool, many of our auxilians do an outstanding job articulating their support for and concerns about various healthcare-related proposals to our elected officials. Their voices made a huge, positive impact for Arkansas hospitals in 2011, and have for many, many years.”
voices made a huge, positive impact for Arkansas hospitals in 2011, and have for many, many years.”

A hometown hospital illustration of the importance of AHAA to Arkansas hospitals and the AHA’s advocacy efforts comes from the city of Berryville, located near the Missouri border in northwest Arkansas. There, chief executive officer of St. John’s Hospital, Kristy Estrem, sees the members of her hospital’s auxiliary not only as a part of the hospital team, but as an important hub of its advocacy efforts.

“It’s important to keep our auxiliaries well-informed about what proposed legislation will mean to local hospitals,” Estrem says. “So I hold briefings for our AHAA members. We help them sign up for voter-VOICE so that they may easily contact their elected officials directly. But there are many who don’t feel comfortable using computers. So, we have also set up a phone tree, where one auxiliary calls another, and so on, explaining the issues at hand and how to contact their state legislator or member of Congress. These auxiliaries really tell it like it is, and our elected officials tend to listen to their stories and benefit from their wisdom. Auxiliaries’ impact on our political process cannot be underestimated.”

Every year, the AHAA president accompanies Arkansas hospital administrators, trustees, physicians, nurses and AHA staff to Washington, D.C. for Hill Day, taking part in individual visits with each member of our congressional delegation. And at every AHAA board meeting, senior members of the AHA Executive Team bring state and federal legislative updates to the board members, which they then share with their area auxiliaries back at home.

In fact, at a recent gathering of multi-state auxiliary officers, a request was voiced seeking information on how state auxiliaries can become more involved in advocacy. “Our state president was able to tell other states how to get involved. Though we may think our efforts are in place everywhere, we have learned that our unique relationship can indeed be a beacon to others,” says Don Adams, AHA vice president and liaison with the AHAA.

The total integration of the AHAA with the AHA is what makes our relationship so unique, says AHA vice president for government relations, Jodi-anee Tritt. “Things other associations see as exemplary, we find to be ‘business as usual,’” she says. “The simple truth is, the Association, Auxiliaries and our combined work for Advocacy truly work for Arkansas.”
Educational Grant to Help Rural Hospitals with ICD-10 Training

The Arkansas Hospital Association (AHA) and the Arkansas Department of Health’s Office of Rural Health and Primary Care are happy to announce the receipt of an educational grant from the Federal Health Resources and Services Administration Office of Rural Health Policy. These grant funds will provide partial support to assist all 36 Arkansas hospitals that are a part of the federal Small Rural Hospital Improvement Program (SHIP) in receiving ICD-10 training through the AHA.

Each SHIP hospital is entitled to a **one-time voucher of $128** to be used for any AHA workshop or webinar focusing on ICD-10 education. The voucher will pay partial payment toward the registration fee for the workshop or webinar training. For example, if the registration fee for a webinar is $190, the hospital may use the voucher to decrease the fee by $128, thereby paying only $62 as the registration fee.

Several ICD-10 educational events are on the AHA calendar for 2012. All workshops and webinars may be found on the AHA online calendar at [http://www.arkhospitals.org/events](http://www.arkhospitals.org/events).


Please note that all funds must be used prior to August 31, 2012. And, remember that the voucher must accompany the registration form and may be used by each hospital only one time.

Questions should be directed to Beth Ingram at bingram@arkhospitals.org.

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A Process, as in Healthcare, is Essential for Optimal Financial Health

In the late 1950s, Ida Jean Orlando developed a nursing theory with the patient as the central theme, in which she outlined a deliberate process for patient care. Her original theory has been expanded to five steps: assessment, diagnosis, planning, implementing, and evaluating. Sound financial planning follows a similar process.

Dr. Atul Gawande, in his *New York Times* best-seller, *The Checklist Manifesto*, regards a defined and prescribed process (i.e. a “checklist”) as an essential tool in maintaining order amidst extraordinarily challenging circumstances. If the ever-changing economic headlines, the political and financial instability in Europe, job security and unemployment concerns, or conflicting media-driven investment advice are causing you uncertainty and anxiety, market hypochondria, or even outright investment paralysis, consider meeting with a CERTIFIED FINANCIAL PLANNER™ professional to help you structure a process-driven plan for your family’s financial present and future.

An important first step in the financial planning process is to establish and define the client-planner relationship. During a first meeting with a planner, you should expect him or her to clearly explain or document the services to be provided to you and define both his and your responsibilities. The planner should explain fully how he will be paid and by whom. This introduction should also include an agreement between you and the planner as to how long the professional relationship should last and about how decisions will be made. The value of this step is that this first meeting allows both the consumer and the planner to determine if this is a relationship that is a good fit, without obligation, and free of sales pressure.

**Healthcare Process; Financial Planning Process**

Using the nursing process as a guide, I’ll draw some comparisons between the two planning processes and suggest that as in healthcare, applying a deliberate process in your financial planning can help you not just create financial stability for yourself and your family, but also can lead to optimal financial health.

*continued on page 36*
An important first step in the financial planning process is to establish and define the client-planner relationship. During a first meeting with a planner, you should expect him or her to clearly explain or document the services to be provided to you and define both his and your responsibilities.

Despite the apparent chaos surrounding us, focusing on individual tasks, and following a sequential and rational checklist or process can lead to better outcomes.

### Assessment
In the assessment stage, the nurse completes an aggregate assessment of the patient, collecting both subjective and objective data about the patient. Just as you constantly assess patients, your assessment essentially involves collecting and analyzing the data to determine your patient’s health status, coping mechanisms and his ability to use them, and to identify problems.

In the financial planning process, the financial planner asks for information about your financial situation. You and the planner should mutually define your personal and financial goals, understand your time frame for results and discuss, if relevant, how you feel about risk. The financial planner should gather all the necessary documents before giving you the advice you need.

### Diagnosis
The diagnosis stage uses the nurse’s clinical judgment about health problems, confirmed using links to defining characteristics, related and risk factors found in the patient’s assessment. The diagnosis restates not only the problem, but helps to identify the root causes. It also provides the basis for selecting the appropriate interventions to deal with the patient’s health status. It is also influenced by your clinical judgment about how the patient, his family, friends and community, respond to his issues.

These issues can be actual problems, or potential ones, or any combination.

During this step in the financial planning process, the financial planner analyzes your information to assess your current situation and determine what you must do to meet your goals. Depending on what services you have requested, this could include analyzing your assets, liabilities and cash flow, current insurance coverage, investments or tax strategies.

### Planning
The planning stage addresses each of the problems identified in the diagnosis. Each problem is given a specific goal or outcome, and each goal or outcome is given nursing interventions to help achieve the goal. By the end of this stage, the nurse will have a nursing care plan. In this stage, the LPN and nurse’s aide, UAP, and other team members are given directions about the plan.

At this point, it may be formal and written or it may be flexible and continually adapted. Your plan incorporates nursing interventions and goals to improve the patient’s outcomes and the means to implement the plan. Objectives are expected to be measurable, specific, and patient oriented.

In the financial planning process, the financial planner should offer specific and measurable financial planning recommendations that address your goals, based on the information you provide. The planner should go over the recommendations with you to help you understand them so that you can make informed decisions. The planner should also listen to your concerns and revise the recommendations as appropriate.

### Implementation
In the implementation stage, the nurse begins using the nursing care plan, delegating certain functions and supervising other team members.

In the financial planning process, you and the planner should agree on how the recommendations will be carried out. The planner may carry out the recommendations or serve as your “coach,” coordinating the whole process with you and other professionals such as an attorney, tax advisor, investment managers or your insurance agents.

### Evaluation
Finally, in the evaluation stage, the nurse looks at the progress of the patient based on the goals of the plan regularly evaluating its effectiveness and making needed revisions. The RN delegates certain functions and supervises other team members to ensure implementation, regularly evaluating the effectiveness of the plan and making revisions as needed.

In the financial planning process, you and your planner should agree on who will monitor your progress toward your goals. If the planner is in charge of the process, she should report to you periodically to review your situation and adjust the recommendations, if needed, as your life changes.

The goal of each process is to act deliberately rather than automatically. This way, both the healthcare provider and the financial planner will have a defined meaning behind each action, which means the patient (or client) receives care that is geared specifically toward his or her needs at that particular time. Both processes may be easily adapted to different patients (or financial planning clients) with different problems, and may be ended.
at anytime, depending on progress and health. They both require flexibility, and need to be able to change when and if complications arise.

Improvement is the resolution to the patient's situation. In the financial planning process, improvement may be reflected in a healthier personal financial statement (a reduction in debt, an increase in personal savings) or an improved retirement savings plan (an investment mix that is in line with an investor’s time-frame and risk tolerance), improved cash flow (sufficient income to satisfy your financial wants and needs), or an estate plan (that outlines a succession plan of your assets to future generations or charitable causes).

With each patient, the nurse repeats a process of learning how he or she can help the patient, shaped by the nurse’s own individuality, as well as that of the patient.

So, too, the planner repeats the process and adapts as needed to the client’s unique financial situation, experience, wants, and needs.

While the popular trend is to self-diagnose and self-treat both medical and financial issues, I believe (based on experience bias) that these processes are best executed with an objective and trained professional, and that this is the best exercise to produce improved outcomes.


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Arkansas Hospitals

Arkansas Workers’ Comp Dividends

The board of the Arkansas Hospital Association Workers’ Compensation Self-Insured Trust met July 29, 2011. After reviewing the financial solvency of each fund year since inception of the Trust in 2003, we are proud to announce the board voted to return anticipated unused premiums for the fund years of 2006 and 2009 to current members that were members of the Trust in each of those fund years, respectively.

A total return of $200,000 for fund year 2006 and $300,000 for fund year 2009 was unanimously passed by the board. A percentage of the surplus has been returned to members based on each member’s contribution to the surplus of each fund year.

The contribution to the surplus is based on the premium paid and the incurred losses of each member. The Trust is committed to providing a workers’ compensation program of excellence, in which its members share the success and unused premiums.

As a member of the Trust, controlling losses and maintaining an aggressive workers’ compensation program in a proactive manner allows the Trust to return unused premiums to the member, as opposed to an insurance carrier that retains those profits for the company.

Percentages of the Trust’s income returned have averaged from 23% to 27% over the years while maintaining a healthy fund balance to meet our workers’ compensation obligations.

To date, the Trust has returned $5,821,164 to its members.

In addition to the approved dividend distribution, the Board voted unanimously to use the 2011 rates for the 2012 fund year rather than increasing those rates as prescribed by the National Council on Compensation Insurance.

Hospitals interested in participating with the program should contact Tina Creel, vice president of AHA Services, Inc. at (501) 224-7878. Or, contact Floyd McCann, RMR’s Arkansas representative, at (800) 690-4540.

AHE, APIC Partner to Combat HAIs

The Association for the Healthcare Environment (AHE) and the Association for Professionals in Infection Control and Epidemiology (APIC) have announced “Clean Spaces, Healthy Patients,” a joint educational campaign to help infection prevention and environmental services professionals combat healthcare-associated infections.

In a recent survey, AHE and APIC members expressed support for additional education and resources to facilitate successful prevention of HAIs. “Strengthening collaboration between infection prevention and environmental services staff will advance this goal and contribute to reducing infections and improving patient outcomes,” said Ruth Carrico, associate professor at the University of Louisville (KY) School of Public Health and Information Sciences and clinical advisor to AHE, an American Hospital Association personal membership group.

A joint educational campaign, titled “Clean Spaces, Healthy Patients: Leaders in Infection Prevention and Environmental Services working together for better patient outcomes,” will provide free educational resources, training materials, and other solutions to assist IP and EVS professionals combating the spread of HAIs.

Find the campaign and other resources at http://www.apic.org/Content/NavigationMenu/Links/CleanSpacesHealthyPatients/Clean_Spaces_Healthy.htm.

Quality/Patient Safety
THE NATIONAL PATIENT SAFETY FOUNDATION ANNOUNCES 2012 PATIENT SAFETY AWARENESS WEEK CAMPAIGN

Be Aware for Safe Care — March 4-10, 2012

In an effort to raise awareness and encourage the engagement of patients, families, healthcare providers, and the public, the National Patient Safety Foundation (NPSF) announces its 2012 Patient Safety Awareness Week campaign, Be Aware for Safe Care.

Patient Safety Awareness Week will take place March 4-10, 2012. NPSF is the founding sponsor of Patient Safety Awareness Week and has led the event since 2002.

This year’s theme highlights the need for everyone to understand the importance of patient safety and to recognize the range of efforts being made to improve health safety in the US and worldwide. Moreover, the campaign seeks to make patients, providers, and the public aware of the ways they can participate in these efforts and partner to improve patient safety.

While efforts of the past decade have brought improvements, recent studies indicate that much work remains to be done – and can be done most effectively through the involvement of all parties.

NPSF encourages creative collaboration among provider groups, patient advocates, and other community organizations to help patients and consumers understand how they can participate to be part of the solution.

The campaign is in alignment with the national Partnership for Patients, a groundbreaking initiative launched earlier this year by the U.S. Department of Health and Human Services to improve care and reduce costs, in part by reducing all causes of harm in healthcare.

Each year, NPSF produces educational resources for providers, patients and communities who wish to take part in Patient Safety Awareness Week, which is recognized internationally. An array of NPSF educational toolkits, brochures, buttons, posters and booklets for use by hospital staff and patients are available at the Patient Safety Awareness Week website http://www.npsfstore.com/categories/Patient-Safety-Awareness-Week/

Now more than ever in healthcare, a focus on empowering patients and strengthening patient-provider communications are seen as paramount to reducing errors. We all need to Be Aware for Safe Care.

For more information on Patient Safety Awareness Week visit www.npsf.org.

EHR Attestation Requirements Clarified

CMS issued guidance in mid-October clarifying meaningful use attestation requirements for Clinical Quality Measures (CQM) under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs.

CMS said it will consider CQM information to be accurate and complete “to the extent that it is identical to the output that was generated from certified EHR technology,” without need for additional data validation.

Hospital leaders have expressed concern about the accuracy of the CQM data generated by their certified EHR products, their certified EHR products can still attest, but should also work with their vendors and the Office of the National Coordinator for Health Information Technology to improve the accuracy of the individual products.

In addition, CMS recommends that hospitals print or save an electronic copy of the CQM report generated by their certified EHR at attestation, which will be used in the event of an audit to validate that the hospital accurately attested and submitted CQMs.

For more resources on EHR meaningful use, visit www.aba.org/advocacy-issues/ifti/mul/index.shtml.
In addition to millions of dollars in damage to homes and communities after the recent disasters in Joplin and Tuscaloosa, healthcare institutions also suffered loss: their image data. At Southeast Imaging, we have the tools to help you get back to work in times where you’re needed most – like our Disaster Recovery Service. Our state-of-the-art, HIPAA-compliant archive stores patient images remotely – no matter what kind of PACS system you’re using. So if disaster strikes your facility, our digital storage is untouched and ready to be reconnected when you are.

For more information, call Joel Studt at (501) 607-1464.
Healthcare Crisis Response Team Formed

On October 26, the Arkansas Hospital Association’s (AHA) Healthcare Crisis Response Team held an organizational meeting with 10 individuals representing seven hospitals that expressed interest in being part of the group. John Sontag, safety officer with Fulton County Hospital in Salem, agreed to serve as the group leader.

The team is built on fundamentals of crisis and trauma response taught during recent AHA workshops and training sessions focused on techniques for “peer-to-peer” crisis intervention. The goal of the training was to provide emotional first aid and crisis response training to hospital professionals and support staff.

With 40 healthcare representatives trained, it is anticipated that this will be one of the largest teams affiliated with the broader umbrella organization, Arkansas Crisis Response Team (ARCRT). It will be available to assist when healthcare workers experience a crisis (i.e., death of an employee, domestic disturbance, shooting, traumatic death or event involving a department).

If ever it is determined that an outside team is needed for crisis intervention, a hospital representative should contact Ginger Bailey, executive director of ARCRT, at (501) 766-3360, and she will deploy the healthcare team.

For more information about the Healthcare Crisis Response Team or how to become a member, please contact Beth Ingram at (501) 224-7878 or bingram@arkhospitals.org.

Stone County Medical Center Reopens After Massive Tornado Damage

The F4 tornado that tracked on the ground for 123 miles across North Central Arkansas in early February 2008 left a path of destruction from the Arkansas River Valley northeast to the Missouri border.

Among the hardest hit areas was the small community of Mountain View, Arkansas where Stone County Medical Center (SCMC), a 25-bed Critical Access Hospital (CAH) and a part of Batesville’s White River Health System (WRHS), suffered major damage.

In the months that followed, while the hospital continued to operate and care for area residents in temporary buildings, WRHS and SCMC officials began the process of planning for a new facility that would add space to replace structures lost to the destruction.

The only original buildings remaining are the Surgery Center and Maintenance.

Now complete, the CAH is back stronger than ever. The hospital celebrated its grand re-opening Thursday, October 20. The 36,000 square feet of new construction includes a new Emergency Department with a three-bed trauma room, four exam rooms, nursing station, waiting/admissions and triage.

A new larger lobby, admissions area and gift shop were added to the hospital, as were a dining area, chapel, physician lounge and meeting room facilities. A clinic near the front lobby accommodates the specialty physicians that visit the community frequently as well as a six-bed observation unit.

New space was constructed to accommodate the Radiology Department (CT, Radiology and Fluoroscopy and MRI services), and the second floor now features 25 private patient rooms with a nursing substation in each of the four corners. Respiratory and Inpatient Physical Therapy/Occupational Therapy occupy the inpatient floor.
ACO Rule Finalized; Legalities Spelled Out

The Centers for Medicare & Medicaid Services (CMS) on October 20 released its Final Rule governing the creation of accountable care organizations (ACOs).

At the same time, the agency joined with the Department of Health and Human Services’ (HHS) Office of the Inspector General (OIG), the Department of Justice (DOJ), in conjunction with the Federal Trade Commission (FTC) and the Internal Revenue Service (IRS) to issue accompanying documents regarding legal issues around establishment of ACOs and clinical integration.

Key provisions of the Final Rule, which can be found at http://www.ofr.gov/OFRUpload/OFR-Data/2011-27461_PI.pdf, involve:

Patient Assignment. CMS will assign patients based on historical claims. Originally, CMS planned to retrospectively assign beneficiaries to an ACO, which would have meant that ACOs would not know, in real time, which beneficiaries they were responsible for managing. Under the Final Rule, participating ACOs will get a preliminary list of the beneficiaries to be covered by the ACO with quarterly data updates and reconciliation at year end.

Incentives. The potential for incentives for ACOs have been improved from the proposed rule. ACOs now will be eligible to receive a shared savings payment if their actual spending is below the applicable benchmark. Specifically, the Final Rule allows all ACOs to share in first dollar savings (in the proposed rule, CMS proposed allowing only participants in track two [high-risk] to share in first-dollar savings); eliminates down-side risk for low-risk ACOs (a departure from the idea of subjecting track one ACOs to down-side risk in the third year of the program); and, CMS will not annually withhold any portion of an ACO’s earned bonus.

While it appears to clarify some of the ambiguities and provide more flexibility, hospitals will need to consult with tax counsel to navigate both guidance documents.

CMS originally proposed to withhold 25% of any earned bonus each year. However, there is no increased sharing rate for track one or track two ACOs, which continue to be set at a maximum of 50% and 60%, respectively, based on quality measurement performance.

Operations. In the Final Rule, CMS allows a traditional marketing guideline protocol, rather than having to approve all marketing materials; and the rule permits limited flexibility in an ACO’s governance structure. CMS maintains its proposal to require 75% of an ACO’s board consist of ACO participants, but there is some flexibility for existing ACOs to meet these criteria, although it is unclear exactly what factors will allow them to do so.

Quality Measures. CMS finalized 33 measures as part of the ACO rule, a substantial reduction from the 65 it first proposed. The chosen measures include seven derived from the CAHPS survey, which is the health plan version of the HCAHPS survey used by hospitals; six measures that would indicate problems with care coordination; eight measures that assess provision of preventive services and screenings; and 12 measures that assess the provision of early interventions to individuals with known risks for major diseases.

ACOs will have to report these measures for all years of the program. In the first year, they only need to successfully report the measures to meet the quality standard needed to qualify for a bonus. In subsequent years of the program, their performance on all of the above measures will be used to determine their qualification for a bonus.

In a joint release regarding ACO Barriers to Clinical Integration, the DOJ’s Antitrust Division and the FTC released a final Statement of Antitrust Enforcement Regarding Accountable Care Organizations in which the agencies abandon their proposed mandatory antitrust review before hospitals could even apply for the ACO program and replaced it with guidance applicable to all ACOs, promising to “vigilantly” monitor complaints about anti-competitive behavior.

Also, responding to a call for expanded protection from fraud and abuse laws for hospitals and other providers considering participation in the ACO program, CMS and the HHS OIG issued an interim final rule with comment period (http://www.ofr.gov/OFRUpload/OFR-Data/2011-27460_PI.pdf) creating waivers for ACOs that go beyond the very limited protections offered in the proposed rule.

The agencies created five instead of two waivers, including waivers from the Physician Self-Referral Law, the federal anti-kickback statute, the “Gainsharing Civil Monetary Penalty (CMP),” and the Beneficiary Inducements CMP, that greatly expand the universe of transactions and relationships protected from prosecution as long as they are “reasonably related” to the purposes of the ACO program.

Waiver protections will be available from formation through operation of the ACO and cover more than distribution of potential shared savings received from CMS. In addition, a waiver will protect the use of incentives for beneficiaries to encourage preventive care and compliance with treatment programs.
For its part, the IRS issued a Fact Sheet (http://www.irs.gov/pub/irs-drop/n-11-20.pdf) in connection with the final ACO rule. While it appears to clarify some of the ambiguities and provide more flexibility, hospitals will need to consult with tax counsel to navigate both guidance documents.

CMS estimates that between 50 and 270 ACOs will participate in the shared savings program versus the 75 to 150 ACOs predicted in the proposed rule.

Actually, very few groups previously indicated an interest in moving toward an ACO due to the many concerns that surfaced after the proposed rule was published. CMS continues to estimate that providers would need to invest $1.8 million, on average, to become an ACO, despite an American Hospital Association-sponsored study showing that startup costs for the program more likely will range between $11.6 million and $26 million.

Advanced Payment ACO Model Provides Upfront Capital for Some

Hoping to generate some enthusiasm for accountable care organizations (ACO) by assisting with the high up-front costs, CMS has created an Advanced Payment ACO Model (APM) through its Center for Medicare and Medicaid Innovation that will provide upfront capital resources for certain physician-based and rural ACOs.

The APM is designed to provide support to organizations participating in the new ACO Shared Savings Program that need additional access to capital. It is open only to two types of organizations participating in the Shared Savings Program:

- ACOs that do not include any inpatient facilities AND have less than $50 million in total annual revenue.
- ACOs in which the only inpatient facilities are critical access hospitals and/or Medicare low-volume rural hospitals AND have less than $80 million in total annual revenue.

Under the Advanced Payment Model, participating ACOs will receive three types of payments: (1) an upfront, fixed payment; (2) an upfront, variable payment based on the number of its historically assigned beneficiaries; and (3) a monthly payment based on the number of its historically assigned beneficiaries.

Advanced payments will be recouped from the shared savings the ACO earns.

Organizations applying for the APM must complete applications for both the ACO program and the APM. Both applications must be submitted by deadlines consistent with the ACO program.

More information on how to apply will be available soon.

CMS Updates Medicare Recovery Auditor Agreements

The Centers for Medicare & Medicaid Services has updated its Statement of Work (SOW) for the Medicare Recovery Auditor (RAC) program to address calls by policymakers to increase program collections.

The new SOW increases CMS oversight of the RACs to ensure workloads are met, clarifies that the program should review all types of Medicare claims and providers, and requires RACs to review all healthcare providers referred by CMS and other government auditors.

The statement also officially establishes semi-automated review, which allows RACs to obtain additional information from providers before making automated denials that may be inappropriate.

The statement addresses several concerns which the American Hospital Association has raised with CMS by requiring better organization of RAC websites; more appropriate notification of the reasons for denials; and a guaranteed RAC discussion period for all claim denials, giving providers an opportunity to reverse denial decisions without entering the formal appeals process.

In related news, CMS has published a Medicare Learning Network article on the new Electronic Submission of Medical Documentation (esMD) pilot, which gives some providers a new mechanism for submitting medical documentation to RACs.

The pilot, which is voluntary and began in September 2011, seeks to reduce provider costs and cycle time by minimizing and eventually eliminating paper processing and mailing of medical documentation to review contractors.

A list of review contractors that will accept esMD transactions can be found at go.usa.gov/kr4. Read the Medicare Learning Network article at http://www.cms.gov/MLNMattersArticles/Downloads/SE1110.pdf.
Final Medicaid RAC Rule

A September 14 final rule from CMS requires state Medicaid agencies to implement a Recovery Audit Contractor (RAC) program by January 1. The Patient Protection and Affordable Care Act requires states to contract with RACs to audit payments to Medicaid providers. The final rule includes a number of provisions that respond to concerns previously expressed by the American Hospital Association. For example, it limits Medicaid RACs to a three-year look-back period; prohibits them from auditing claims that they or others have already audited; and requires them to notify providers of overpayment findings within 60 days.

The final rule also requires states to set limits on medical record requests and coordinate their RAC efforts with other auditor programs. It also allows states to seek exemption from the Medicaid RAC program and exclude Medicaid managed care claims from RAC review. The RACs must employ at least one medical director, and their contingency fees may not exceed the highest Medicare RAC fee. The final rule is available at http://www.ofr.gov/OFRUpload/OFRData/2011-23695_PI.pdf.

AFMC Value-Based Purchasing Tool

The Arkansas Foundation for Medical Care (AFMC) is providing a new tool to assist Arkansas hospitals in evaluating their performance on value-based purchasing (VBP) measures. The tool, which was developed by Qualis Health of Washington and co-branded with AFMC, is a worksheet that:

- Helps identify areas for process improvement prior to the start of the performance period
- Gives flexibility to update performance data in “real time” once the performance period begins
- Allows the user to monitor progress and assess potential risk throughout the performance period
- Facilitates ongoing communication among the quality department, hospital leadership and front-line employees

“With the push from the Centers for Medicare & Medicaid Services to reward performance, it’s become critical for hospitals to master the art of internally monitoring their efforts,” said Ray Hanley, AFMC’s president and CEO.

Proposal to Modify Medicare CoP

A proposed rule revising the existing Medicare Conditions of Participation (CoP) for hospitals and critical access hospitals would recognize a single governing body over multiple hospitals within a health system, changing CMS’ previous position that each hospital within a health system must have its own board. The proposal may be found at http://www.ofr.gov/(X(1)S(0)fibimlizkdoryd51vauts04))/OFRUpload/OFRData/2011-27171_PI.pdf. The change also would allow CAHs to provide certain services, such as diagnostic, therapeutic, laboratory, radiology and emergency services, under service arrangements and allow advanced practice practitioners to serve in an expanded role. CMS also released a proposed rule at http://www.ofr.gov/(X(1)S(0)fibimlizkdoryd51vauts04))/OFRUpload/OFRData/2011-27176_PI.pdf that addresses regulatory requirements for a broader range of providers under the Medicare and Medicaid programs, and a final rule at http://www.ofr.gov/(X(1)S(0)fibimlizkdoryd51vauts04))/OFRUpload/OFRData/2011-27177_PI.pdf making changes to the patient rights conditions for coverage for ambulatory surgical centers.

CMS says the three rules aim to promote efficiency and transparency, and reduce healthcare providers’ overall regulatory burden. The agency estimates a combination of the three rules will save $5 billion over five years.
Changes to Medicare Overpayment Notifications

CMS has made some notable changes to its Medicare Overpayment Notification Process. In the past, if an outstanding balance has not been resolved, providers received three notification letters regarding the overpayments, an Initial Demand Letter (1st Letter), a Follow-up-Letter (2nd Letter) and an Intent to Refer Letter (3rd Letter).

CMS would send the second demand letter to providers 30 days after the initial notification of an overpayment. Recent review has determined that this is not efficient, since most providers respond to the initial demand letter and pay the debt.

Currently recoupment action happens 41 days after the initial letter. The remittance advice which describes this action serves as another notice to providers of the overpayment. Therefore, effective November 1, 2011, CMS ceased sending providers the second notification letter.

Provider appeal rights remain unchanged.

If an overpayment is not paid within 90 days of the initial letter, providers will continue to receive a letter explaining CMS’ intention to refer the debt for collection.

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Medicare Provider Revalidation is Required; Check Your Dates

All providers and suppliers who enrolled in the Medicare program prior to March 25, 2011, will be required to revalidate their enrollment under new risk screening criteria required by the Affordable Care Act.

Providers and suppliers who enrolled after March 25, 2011, have already been subject to the screening process.

CMS added new screening criteria to the Medicare provider/suppliers enrollment process beginning March 2011, in effort to reduce fraud, waste and abuse. Newly enrolling and revalidating provider/suppliers are placed in one of three screening categories: limited, moderate or high. Each category represents the level of risk to the Medicare program category of provider/supplier and determines the degree of screening to be performed by the Medicare contractor processing the enrollment application.

Beginning now through March 2013, Pinnacle Business Solutions, Inc. (PBSI) or another entity will be sending notices to individual providers/suppliers, encouraging them to begin the revalidation process as soon as possible. Upon receipt of the revalidation request, providers/suppliers have 60 days from the date of the letter to submit complete enrollment forms.

Failure to submit enrollment forms as requested may result in deactivation of the provider’s Medicare billing privileges.

The most efficient way to revalidate the enrollment information is by using the internet-based PECOS (Provider Enrollment, Chain and Ownership System), which allows the review of information currently on file, during the update and submission of revalidation via the Internet.

Once submitted, the provider must print, sign, date and mail the certification statement along with all required supporting documentation to PBSI immediately.

The new criteria require institutional providers/suppliers to pay an application fee when enrolling or revalidating. The application fee is $505 for Calendar Year 2011.

CMS has defined “institutional provider” to mean any provider or supplier that submits a paper Medicare enrollment application using the CMS-855A, CMS-855B (except physician and non-physician practitioner organizations) or associated Internet-based PECOS enrollment application. These fees may be paid via www.pay.gov.

For more information regarding the revalidation process, please reference the following links:

- http://www.pinnaclemedicare.com/provider/partb/enrollment

A New MAC for Arkansas

The website FedBizzOpps.Gov, in a posting on November 8, showed that Highmark Medicare Services, Inc. has been named the Part A/Part B Medicare Administrative Contractor (MAC) for the newly formed Jurisdiction H, which includes the consolidated A/B MAC Jurisdiction 4 states of Colorado, New Mexico, Oklahoma and Texas (currently serviced by Trailblazer Health Enterprises), as well as the states of Arkansas, Louisiana and Mississippi, which once formed Jurisdiction 7.

However, on November 28, Trailblazer Health Enterprises, LLC filed a protest to the award. The Government Accounting Office will make a determination within 100 calendar days of the protest date.

Pinnacle Business Solutions, Inc. (PBSI), a subsidiary of Arkansas Blue Cross and Blue Shield, is currently the long time Medicare Part A Fiscal Intermediary (FI) for most Arkansas hospitals, but is not included in this new award. PBSI will continue in its current role until a final determination and transition occurs.

Highmark Medicare Services was previously named the MAC for Jurisdiction 12, which includes Delaware, New Jersey, Pennsylvania, Maryland and the District of Columbia.

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