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# Healthier Nebraska


## KEARNEY REGIONAL MEDICAL CENTER
*KEARNEY, NE*

Nebraska Hospital Association
The influential voice of Nebraska's hospitals

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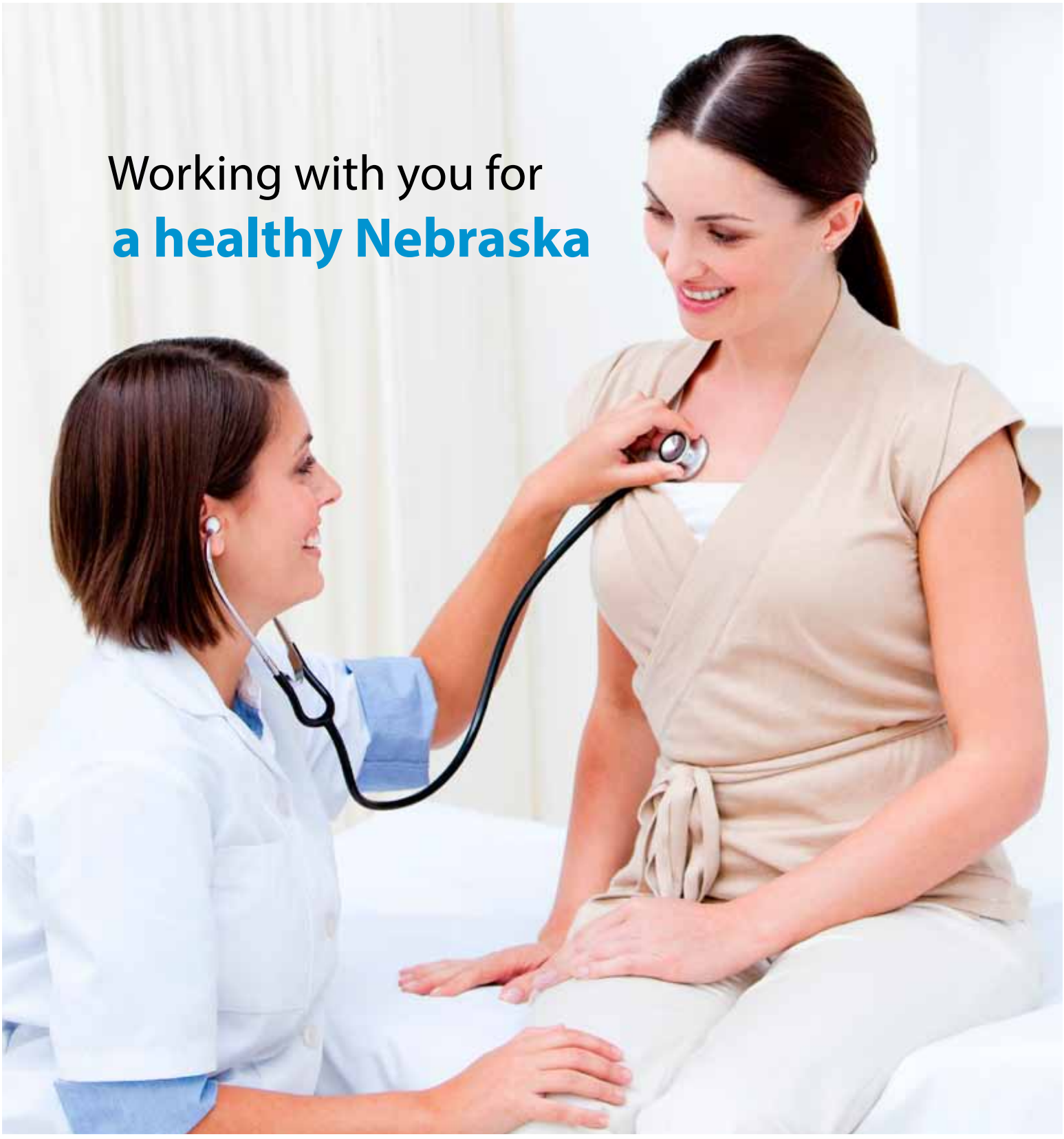


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# Healthier Nebraska
SPRING 2014

» A magazine for and about
Nebraska community hospitals and health systems





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NHA

# in this issue




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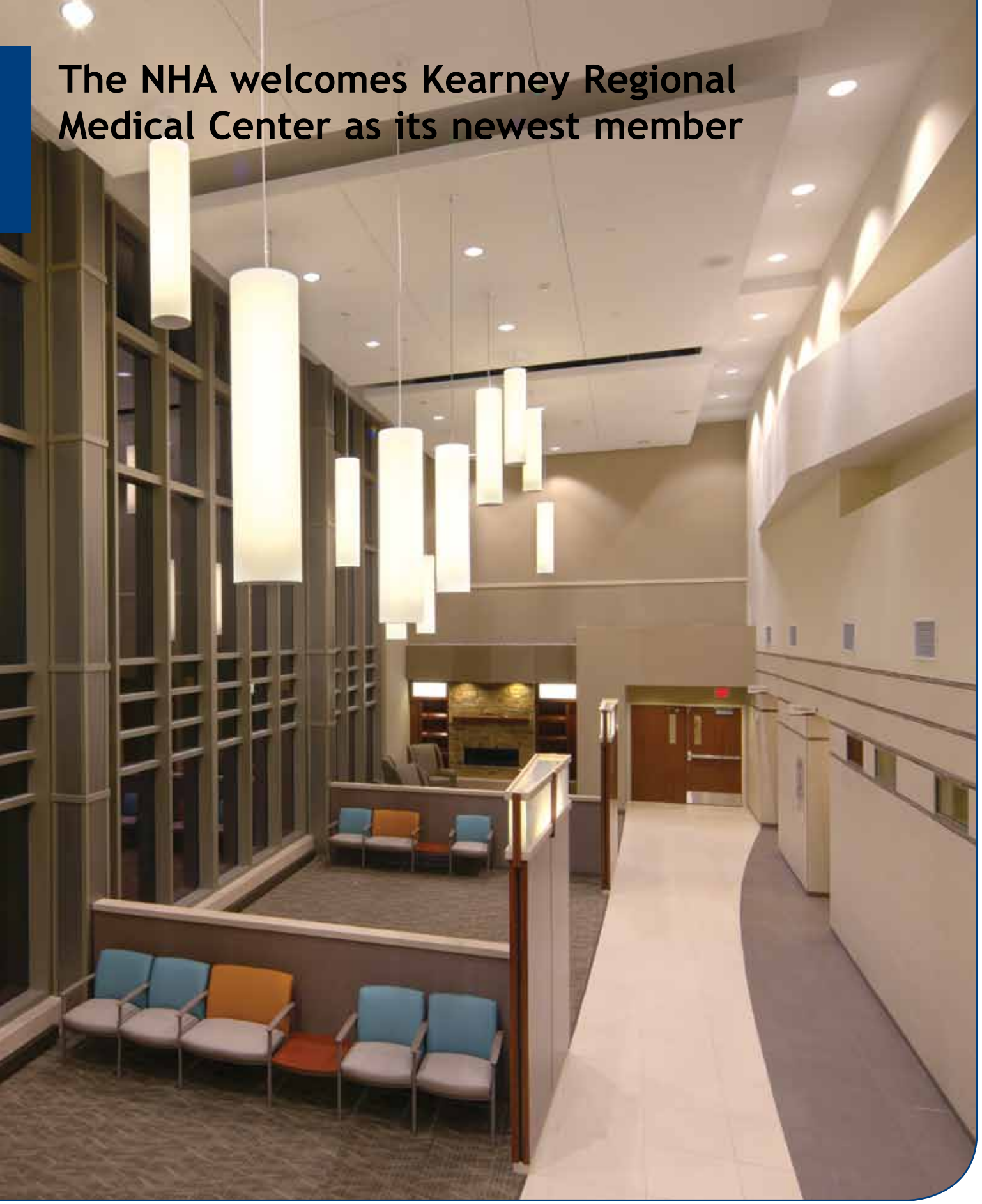
*Edition 68*

# The NHA welcomes Kearney Regional Medical Center as its newest member



Kearney Regional Medical Center (KRMC) employs 90 nurses, technicians and other staff.

Kearney Regional Medical Center (KRMC) has finally been realized. After more than four years in development, the physician-owned hospital began operating last fall.

The $22 million, 58,000-square-foot hospital was issued its state hospital license in December and KRMC was accepted as a member of the Nebraska Hospital Association (NHA) in January by the NHA board of directors.

The hospital features five operating rooms, a cardiac and catheterization lab, endoscopy suite, pharmacy, laboratory, triage room, four ICU beds, an observation room, 40 patient beds and an imaging department with X-ray, echocardiogram, ultrasound, MRI, CT scan and interventional radiology.

KRMC has a staff of 90 nurses, technicians and others, but that number is expected to reach 100 by early summer.

The project was initially announced in October 2009, when a group of 40 Kearney physicians announced plans to build KRMC. The first surgeries were performed last fall and, following a state inspection in November, KRMC was issued its state hospital license the following month.

Sean Denney, chair of the KRMC board of directors, gives a tour of the new facility.

During KRMC's grand opening celebration in February, Sean Denney, chairman of the KRMC Board of Directors, thanked the city and Kearney community for its support and encouragement. "There are a thousand people we could say thanks to," Denney said.

Denney said KRMC is proud to be locally owned and operated.

"We want to make sure that people are having decisions on their health care made by people that are actually providing their health care. Not an administration that lives in another state," Denney said.

The number is expected to grow to 100 in the coming months.

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The physician-owned hospital features 40 patient beds and will serve much of central Nebraska, northern Kansas and southern parts of South Dakota.

KRMC expects to serve a large swath of the state and even patients from bordering states, including northern Kansas and north to the South Dakota border.

"When you start including all the different needs and all those different communities, it gets complicated in a hurry. A place like this is able to focus on things like neurosurgery, cardio thoracic surgery," Denney said.

Larry Speicher, KRMC's first permanent CEO, was also publicly introduced at the event. Speicher was the administrator at Platte Valley Medical Group, which moved out of its offices adjacent to Good Samaritan Hospital and into the 48,000-square-foot medical office building adjoining KRMC.

Medical Development Management (MDM), a Wichita, Kan., based company, assisted Kearney physicians and other investors in building, equipping and licensing KRMC. MDM has established four other hospitals, 15 surgery centers and 10 imaging centers in Kansas, California and Nebraska, Ward Schraeder, CEO of MDM, said.

"This is a beautiful facility," Schraeder said. "We will do quality health care in a facility like this."

The facilities, including medical equipment, are leased by KRMC from Kearney Properties, LLC, a company primarily owned by Kearney area physicians. Later this year, the hospital plans to complete its emergency department and add more patient rooms. With health care at this facility just getting started, they're looking forward to the future.

"We have nothing but great expectations for this facility," Denney said. HN

By Kim Larson
director of marketing

# Symposium offers dynamic trustee education


Bernice J. Washington


Dr. Brian Siverstein


Rex Burgdorfer


Jordan Shields


Daniel J. Sinnott

Health care reform and other hot topics will be addressed during the 18th Annual Western Regional Trustee Symposium (WRTS) June 11-13, 2014, at the Green Valley Ranch Resort in Henderson, Nev. – just outside of fabulous Las Vegas!

Henderson touts itself as "A Diamond in the Desert." If it's the glamour of the Las Vegas Strip, the marvel of the Hoover Dam or the tranquil beauty of Lake Mead, Henderson is just minutes from it all. Its comfortable year-round temperatures and the surrounding beautiful landscape provide the perfect setting for outdoor adventures, relaxation, world-class restaurants, exceptional entertainment and unique attractions.

Henderson is the perfect place to unwind and escape from all the distractions, combining the ideal balance of adventure, leisure and business. Invite your trustees and other healthcare professionals to hear this fantastic lineup of speakers and network with peers.

The Western Regional Trustee Symposium is sponsored and presented by the state hospital associations of Arizona, Colorado, Idaho, Montana, Nebraska, Nevada, New Mexico, North Dakota, Utah and Wyoming. Most of the 10 associations take a turn to host the symposium in their home state. This year, Nevada is the lucky host.

Developed by trustees for trustees, the program is committed to providing relevant topics, quality speakers and networking opportunities. Registration materials will be mailed to hospital members in March and posted on trusteesymposium.org. Registration discounts are offered to hospitals registering four or more individuals.

Kicking off the symposium is keynote speaker, Bernice J. Washington, a veteran trustee, having served on Texas Health Resources Boards for nearly 20 years. In addition to Texas Health Resources, she has served on 18 other boards of directors and has held major leadership roles in six multi-million dollar fundraising campaigns.

She is president and CEO of BJW Consulting Group, LLC, and is a nationally recognized successful businesswoman with more than three decades of experience in sales, marketing and management. Washington is a retired executive from Bayer HealthCare, an international health care company. Her responsibilities included sales and marketing of more than $50 million annually of diagnostic health care products to key clients.

She draws upon her own personal experience as a trustee, health care executive and Certified Master Coach to deliver behavior changing keynotes, facilitate board discussion and enhance problem-solving skills. Washington is a highly regarded

keynote presenter and effective facilitator.

Other keynote speakers include population health expert, Dr. Brian Silverstein; Jordan Shields and Rex Burgdorfer from Juniper Advisory will present their perspective on hospital mergers and acquisitions; and Daniel J. Sinnott, CEO of Sinnott Executive Consulting, will close out the symposium by discussing new strategies for trustees in an era of health care reform.

Jim Parrish, CEO of Humboldt General Hospital in Winnemucca, Nev., and chair of the 18th Annual Western Regional Trustee Symposium Program Planning Committee said, "This year's theme 'Healthcare: A High Stakes Business' reminds us that as stewards of health care governance, having the right information is critical to making informed decisions when so much is at stake. Each WRTS session was selected by hospital trustees and association staff to address the issues you face today and to prepare you for what lies ahead.

In these challenging times, you can count on the WRTS to deliver timely, relevant and balanced education on the trends, issues and future direction of health care governance. All trustees, whether new to their position or a seasoned veteran, are offered the opportunity to strengthen their roles as leaders and meet the challenges of improving patient care, focusing on quality, ensuring fiscal stability and charting a course for tomorrow.

We are excited about this year's content which includes keynote speakers who will address such topical issues as strategies for trustees in the new era of health reform and population health management. In addition, a wide selection of breakout sessions will offer timely topics such as rethinking executive compensation, making difficult decisions about services and programs, perfecting the patient experience, creating value through lean leadership and a workshop designed for new trustees."In addition to these keynote sessions, breakout educational sessions are scheduled, as well as multiple opportunities for networking and information sharing.

If you would like more information about the Western Regional Trustee Symposium, visit trusteesymposium.org or contact Jon Borton, NHA vice president, educational services, at (402) 742-8147 or jborton@NebraskaHospitals.org. HN

By Bruce Rieker, J.D.
vice president, advocacy

# Meciaid expansion would have been a 'WIN' win for Nebraska

When the Affordable Care Act (ACA) was enacted in 2010, Nebraska's hospitals were forced to surrender 6 percent of their Medicare revenues in exchange for gains expected from more people with health insurance and Medicaid coverage. Since 2010, Medicare reimbursements have been reduced by an additional 2 percent; and as Congress wrestles with our nation's fiscal deficit, an additional 10 percent in reductions is currently under consideration.

Expansion of Medicaid eligibility is intended to provide greater health insurance coverage. To date, the nation is split with half of the states expanding eligibility and half undecided. If Nebraska expands Medicaid to 133 percent of the federal poverty level, $15,856 for an individual and $32,499 for a family of four, many more adults will gain coverage. This coverage is important across the state, especially for working people in rural areas where employer-provided health insurance is less common and where poverty is more prevalent.

The Wellness in Nebraska (WIN) Act was introduced and prioritized this year by State Sen. Kathy Campbell, chair of the Legislature's Health and Human Services Committee. Unfortunately, efforts to garner 33 votes in the Legislature to overcome a filibuster fell short, 27-21, and the next opportunity to debate this important issue will be in 2015.

The WIN Act would have provided a strong foundation for good health care policy. It incorporated many good ideas from around the country and tailored them to meet the needs of Nebraska. It maximized enhanced federal funding, strengthened the private marketplace, supported employer insurance and enhanced stakeholder engagement. Through the utilization of an oversight committee, it would have provided the groundwork for much needed Medicaid reform that included more primary care focus through the utilization of patient centered medical homes (PCMHs) and integrated care for chronic conditions. WIN provided the legislature with the ability to respond if the federal government failed to meet its financial responsibilities.

The patient was at the center of that comprehensive plan to deliver cost conscious quality care. It incorporated wellness incentives and personal responsibility and incorporated provisions to reduce the inappropriate use of emergency rooms by requiring co-payments in those situations. Monthly contributions of 2 percent of income for newly eligible adults would have been required and there were incentives for members to engage in health and wellness activities. Initially, the preventive services and wellness activities would have included an appointment with a primary care physician and a health risk assessment.

Medicaid funding would be provided through federal and state funds. For 2014-2016, 100 percent of the costs would be covered by federal funds and reduced to 95 percent for 2017, 94 percent for 2018, 93 percent for 2019 and 90 percent for 2020 and beyond. The administrative costs are shared equally by the state and federal governments. Information technology costs would be 90 percent federally funded with 10 percent funded by the state. Aside from providing coverage and care to more people, strengthening the health care provider network, reducing the demand for ER services, creating a stronger, healthier work force, and helping children be more capable of learning; it is unconscionable for Nebraska to turn its back on this federal assistance, which is estimated to amount to $2.3 billion between now and the end of 2020. That is more than $360 million per year, or more than $990,000 per day, money paid by Nebraska taxpayers to the federal government that should come back to our state to improve the health of Nebraskans. Nebraskans are willing to accept federal assistance for highway construction, education, agriculture and education; however, there seems to be a different standard when it comes to health care.

There would have been costs and savings for Nebraska if the Legislature had expanded Medicaid. After calculating the additional costs of providing coverage to the newly eligibles, administrative costs and managed care fees; and then reducing that amount by the savings the state would have experienced through the elimination of various programs such as the Comprehensive Health Insurance Program (CHIP), the Legislature's Fiscal Office determined the net cost to the state for the next six years would have been $16 million – not per year, but for the entire period.

The net effect of the WIN Act would have been the improvement of the public's health. For those that contend that $16 million was too much for the state to pay for this coverage, the economic activity stirred by the infusion of $2.3 billion of federal funds over six years alone would more than offset those costs. According to University of Nebraska's Center for Health Policy, a conservative estimate of the additional revenues for the state generated from $2.3 billion over six years would have exceeded $100 million.

Contrary to the claim made by opponents, expansion would not have taken money away from education. Some of the savings achieved through the elimination of the CHIP have already been earmarked for state aid to education. In fact, education would have benefited by having healthier children living in healthier households – children that are more ready to learn, helping our state's education system to achieve even greater efficiencies and outcomes.

In response to those who feared that the federal government would not be able to honor its financial obligations pursuant to the enhanced federal Medicaid match under the ACA, the WIN Act contained a provision that required legislative action should the federal match drop below 90 percent. A related concern was the possibility that expansion may have only been a temporary benefit. Wouldn't it have been better to provide a temporary benefit that could have improved one's health than to have provided no benefit at all?

The WIN Act created the opportunity and incentives for providers to redirect more individuals to preventive care through PCMHs, accountable care organizations, federally qualified health centers and other sources of health care services that are much less costly. Through that coverage, the current health care system would have redirected those non-urgent care patients to clinics for their primary care needs at lower costs. Those efforts would have reshaped Nebraska's health care delivery system into one focused on reducing costs and producing higher quality outcomes while meeting the growing demands – a system that could have accommodated both the newly eligibles they are already treating and the individuals who would have been seek care for the first time.

The consequences of the Legislature's failure to expand Medicaid eligibility will create a significant health care urgency. Without that crucial coverage, some people will die. More than 54,000 people will fall into the health insurance "coverage gap," leaving them without health insurance coverage or options for coverage for needed health services.

Driving people into the coverage gap will result in less healthy people as medical issues and conditions go untreated at early, less expensive stages. That will exacerbate the health disparities in areas where higher rates of nearly every disease and condition exist, due in some measure to the lack of health insurance coverage.

Without the WIN Act, the health care provider network will be stretched, possibly to the breaking point. Communities will be left without critical pieces of the health care foundation, residents will be left without institutions to attend to their health care needs, and communities will lose jobs and economic activity.

The WIN Act would have created good, fiscally responsible health care policy based on sound principles and analysis. It is unfortunate that not enough members of the Legislature could see that.

For more information, contact Bruce Rieker, NHA vice president, advocacy, at brieker@NebraskaHospitals.org or (402) 742-8146. HN

By Jon Borton, MS, vice president, educational services

# NHA member hospital trustees earn education certification

A hospital's board of trustees is entrusted with the great responsibility of overseeing one of the community's most important institutions — one that exists for the treatment and protection of the health care needs of the community's citizens.

For this reason, the Nebraska Hospital Association (NHA) Research and Educational Foundation developed a hospital governance community education certification process, entitled the Hospital Trustee Community Accountability Education Certification Program.

This Trustee Education Certification Program was designed to enable hospitals to utilize governance best practices, to promote the coordination of care and the best use of resources, and to demonstrate to their community, lawmakers, regulators, physicians, employees, business and other community stakeholders that Nebraska hospitals are dedicated to the well-being of its citizens.

Hospital boards benefit by having consistent standards and an ability to communicate compliance with those standards to build reputation, confidence and loyalty, and be better prepared to address the health care needs of special populations, such as the uninsured, underinsured, chronic diseases, etc. The education requirements of the certification program assist hospital trustees to have a better understanding of expectations for individual and overall governing leadership excellence, and have a structure for improving their individual knowledge and leadership potential.

More than 60 trustees from eight hospitals and health systems in Nebraska have dedicated the time and effort to governance practices and participated in the quality education programs that demonstrate a commitment to improving performance of their boards, encouraging trustees to pursue ongoing education and educating trustees about their responsibility in serving their communities.

## Individual Certified Trustees

Brown County Hospital, Ainsworth — Certified annually since 2012

- Ryan Welke
- Mike Schrad
- Ann Fiala
- Mike Kreycik
- John Gross

Butler County Health Care Center, David City — Certified annually since 2010

- John Klosterman
- James Egr
- Jerry Roh
- Diane Moravec

Gothenburg Memorial Hospital, Gothenburg — First year of certification

- Larry Gill
- Monty Bowman
- Dr. Carol Shackleton Skinner

Memorial Health Care Systems, Seward — Certified annually since 2009

- Donna Havener
- Mike Hecker
- Steve Kayton
- Larry Lindquist
- Marlin Pozehl
- James Swanson
- Tammy Wissing

Valley County Health System, Ord — First year of certification

- Michelle Zannger
- William Sugg
- Gary Garnick
- Nathan Flessner
- Dr. Charles Blaha
- Garry Miska
- Carl Streeter
- Roger Lansman

## Board-Certified Organization

Three hospitals and health care systems have taken the additional steps to certify their entire board of trustees to become an NHA Board-Certified Organization. They have **a**dhered to specific, predefined governance standards that exemplify community accountability and outreach, responsibility for quality and safety of care to address identified needs, and the characteristics of a high-performance board.

- Bryan Health Board of Trustees, Lincoln – certified annually since 2009
- Bryan Medical Center Board of Trustees, Lincoln – certified annually since 2009
- Valley County Health System Board of Trustees, Ord

**Kimberly A. Russel**, president and CEO of Bryan Health in Lincoln said, "The Bryan Health Board of Trustees has always placed great value in ongoing education. Our board members believe that governance education is an important investment that supports the fiduciary responsibilities of trustees. We are proud that the Bryan Health Board of Trustees and Bryan Medical Center Board of Trustees have each achieved certification by NHA."

**Mike Hecker**, chairman of the board of Memorial Health Care Systems in Seward, says, "The Board of Directors of Memorial Health Care Systems adopted board certification standards in 2009. The board feels that it is very important to complete the NHA Hospital Trustee Certification annually through the use of internal and external training. Completing the certification requirements has given our board better understanding of their responsibilities and we feel it demonstrates to the community and MHCS staff our commitment to MHCS. An unexpected benefit to the certification process is that it has brought our board closer and further opened lines of communication."

**William T. Sugg**, president & CEO of Valley County Health System in Ord, said, **"**Having each Trustee become NHA board-certified has endorsed each trustee on their

own commitment to serve our community and outlying region of the patients that we serve. To keep abreast of the changing health care laws, rules and regulations is an ongoing process. The Valley County Health System Board of Trustees has exemplified their desire and willingness to keep VCHS current with these changing times. The united bond that each of us share in the certification process has only deepened my dedication and commitment to VCHS and our community."

**Gary Garnick**, chairman of the Valley County Health System board of trustees, said, "I really wanted to demonstrate to the community our commitment and dedication to doing the best job possible in overseeing our county's greatest asset."

**Carl Streeter**, vice chairman of the Valley County Health System board of trustees, said, "I believe achieving NHA certification as a member of the Valley County Health Systems board of trustees sends a clear signal to those we serve, and others around the state, that VCHS is serious about moving this organization forward. Forward, not just in new, state-of-the-art facilities and in services provided, but in changing and improving the culture, as well. The example set by the entire board of trustees in achieving NHA certification is hard to miss. With so many uncertainties at the national level as we look to the future of health care, it is imperative that we do all we can to position ourselves to adapt to change. With the associates, providers and board of trustees, working together great things can be accomplished. It is my hope and my desire that VCHS does not just survive, but that it thrives as we move forward. NHA certification is an integral part of that process."

**Garry Miska**, treasurer of the Valley County Health System board of trustees, said, "Becoming board certified has strengthened each of us in the knowledge of our duties. It has also united us in our commitment to the patients that Valley County Health System cares for and our community needs. Completing the requirements for the certification process has informed myself and the other board of trustees members, the compliance of hospital governance."

**Michelle Zangger**, PhD, secretary of the Valley County Health System board of trustees, states, **"**I am excited to have gone through the certification process as a member of the Valley County Health System board of trustees. The education that comes with certification allows us as a board to put best practices in place and truly recognize our role as board members, and allows us to function effectively as a board. Through education, we can continue to improve governance of VCHS which will in turn improve VCHS as a whole. The associates of VCHS, as well as those who support and utilize the services offered at VCHS, deserve to have a successful, effective organization which will provide top notch services to the community for years to come."

**Roger Lansman**, member of the Valley County Health System board of trustees, state**s, "**As board members for our rural county hospital, we have been entrusted with the duty to oversee the operations and mission of our institution. Board members bring varied skills and expertise to the table, but are not necessarily medical experts or well versed in hospital governance issues. The board certification process provides an important educational opportunity for board members to enhance their abilities in all aspects of hospital governance."

**Dr. Charles Blaha**, member of the Valley County Health System board of trustees, states, "It is important that we as a board of trustees show our commitment to the associates and the community that we are dedicated to Valley County Health System, and we will do our very best to stay current on the ever- changing health care issues."

**Nathan Flessner**, member of the Valley County Health System board of trustees, says, **"**The process to become board certified began shortly before I joined the VCHS board of trustees. I quickly learned that this achievement would be an awesome accomplishment. I think it shows a dedication to the staff and the community of our board. We are taking that "extra step" to make our hospital a great choice in our region."

For more information contact Jon Borton, NHA vice president, educational services, at jborton@NebraskaHospitals.org or (402) 742-8147. HN

By David Burd, FHFMA
vice president, finance

# Congressional delegation steps up in defense of Nebraska's hospitals

Nebraska hospitals are working hard to improve the value of health care services – increasing the quality of care provided while also reducing the cost of providing that care. However, numerous challenges stand in the way of accomplishing that goal. Excessively burdensome federal regulations and significant cuts in reimbursement for the services provided to Medicare patients create major road blocks. The Nebraska Hospital Association (NHA) and our member hospitals work with the Centers for Medicare & Medicaid Services (CMS) and other stakeholders to address these challenges. However, when a resolution cannot be achieved, often times we turn to Congress to step in and pass legislation that forces a change. Support from our congressional delegation is critical to ensuring that high quality health care is accessible to the residents of Nebraska.

Nebraska's congressional delegation has shown support for a number of bills that address several areas of significant concern for hospitals. In recent months, our delegation has introduced and cosponsored several important bills. Although not a complete list, some examples are listed below.

## Physician supervision of outpatient therapeutic services

In 2009, CMS mandated a new policy for direct supervision of outpatient therapeutic services. CMS characterized the change as a "restatement and clarification" of existing policy going back to 2001. Direct supervision means that a physician or non-physician practitioner (NPP) must be "immediately available" to furnish assistance and direction throughout the procedure. Hospital outpatient therapeutic services have always been provided by licensed, skilled professionals under the overall direction of a physician. While hospitals recognize the need for direct supervision for certain outpatient services that pose a high risk or are complex, CMS' policy generally applies to services with the lowest amount of risk.

In an environment of continuing shortages of health care professionals, especially in rural areas, the direct supervision requirement is difficult to implement for hospitals, could ultimately reduce access to care and is clinically unnecessary. The requirement would make hospitals engage more physicians and NPPs for direct supervisory coverage without a clear clinical need and create patient access problems if hospitals are forced to discontinue or limit the hours of certain outpatient services.

Several bills have been introduced to address concerns related to the physician supervision requirements for outpatient therapeutic services. Bills that have been introduced to extend the moratorium on enforcing the requirements include:

- S. 1954: Senate passed by unanimous consent on Feb. 10.
- H.R. 4067 (companion bill to S. 1954): Introduced by Rep. Jenkins of Kansas on Feb. 18.
- **H.R. 3769: Introduced by Rep. Adrian Smith.**

Bills that have been introduced to permanently address the physician supervision requirements include:

- S. 1143 & H.R. 2801: Protecting Access to Rural Therapy Services Act **(Cosponsored by Sen. Mike Johanns, Sen. Deb Fischer and Rep. Jeff Fortenberry respectively).**

## 96 hour rule for critical access hospitals (CAHs)

CMS has established conditions of participation and conditions of payment that providers must adhere to in order to participate in the Medicare program and to receive payment for services provided to Medicare patients. In most cases, provisions within the conditions of participation and the conditions of payment are in sync with each other. However, that is not always the case. An example of where they are not in sync involves the length of stay for patients at a CAH. The conditions of participation allow a CAH to provide acute inpatient care for a period that does not exceed, on an annual average basis, 96 hours per patient. However, the conditions of payment require that a physician certify that the patient may reasonably be expected to be discharged or transferred to another hospital (paid under the prospective payment system) within 96 hours after admission to the CAH (applies to each patient individually instead of on an average basis).

The conditions of payment requirement means CAHs are not paid for Medicare procedures and treatment that take longer than 96 hours, unless the physician expected the patient to be discharged within 96 hours at the time of admission but, for some reason, required care exceeded 96 hours. There are many procedures that CAHs are qualified to provide where clinical protocol would dictate a stay of longer than 96 hours. If patients are unable to obtain treatment in these situations at their local CAH, they could face long drives to another hospital, ambulance or helicopter fees to be transferred to another hospital or potentially, health risks (including death) due to the delay in treatment. Due to this requirement, Medicare patients face significant inconveniences at the least and potential health complications at the most.

Bills that have been introduced to remove the condition of payment requirement that a physician certify that a patient can reasonably be expected to be discharged or transferred within 96 hours include:

- **H.R. 3991: Introduced by Rep. Smith (Cosponsored by Rep. Fortenberry)**
- S. 2037 (companion bill to H.R. 3991): Introduced by Sen. Roberts of Kansas and Sen. Tester of Montana **(Cosponsored by Sen. Johanns and Sen. Fischer)**.

## Medicare Recovery Audit Contractors (RACs)

CMS created the Medicare RAC program to identify improper Medicare payments, which includes both overpayments and underpayments made to providers. RACs are paid on a contingency fee basis and receive a percentage of the improper payments they identify and collect. While no one disputes the need to ensure that Medicare claims are paid correctly, inappropriate payment denials and unmanageable medical record requests have imposed a significant financial cost and administrative burden on hospitals.

The federal Department of Health and Human Services recently sent a letter to providers that had a significant number of Medicare appeals pending before the Office of Medicare Hearings and Appeals (OMHA). According to the letter, the OMHA has suspended the assignment of new requests for an Administrative Law Judge (ALJ) hearing due to being overwhelmed by an exponential growth in appeals, which is primarily due to challenges to Medicare RAC payment denials. The delay in scheduling ALJ hearings is expected to take at least 24 months.

CMS recently announced a "pause" in RAC operations until the next round of contracts is awarded. CMS has also announced some changes to the RAC program that are intended to address concerns that have been voiced by hospitals. While these changes are a step in the right direction, they do not go far enough. Bills that have been introduced to improve the Medicare RAC program include:

- S. 1012 and H.R. 1250 **(Cosponsored by Rep. Lee Terry)**

## Two-Midnight Rule

In August 2013, CMS finalized its two-midnight rule policy, which generally considers hospital admissions spanning two midnights as appropriate for payment under the inpatient prospective payment system. In contrast, hospital stays of less than two midnights are generally considered outpatient cases, regardless of clinical severity.

CMS recently announced an additional delay on enforcement of the policy through Sep. 30, 2014. In my opinion, this step was the result of concerns voiced by Congress. While the additional delay is appreciated, pressure needs to continue to be applied to CMS to fix the critical flaws of this policy and address inpatient hospital services that do not span two midnights. The following bill has been introduced to address the two-midnight rule policy (additional bills are also expected to be introduced):

- H.R. 3698: **(Cosponsored by Rep. Fortenberry)**

There is no shortage of complicated and burdensome regulations in the health care industry. Hospitals strive to provide the highest quality of care while also complying with all applicable statutes and regulations. However, when regulations as discussed in this article interfere with hospitals' ability to best serve their patients and communities, support from Nebraska's congressional delegation is critical. Nebraska's congressional delegation has introduced and cosponsored several bills that would improve health care in our state and their leadership and support is appreciated.

For more information, contact David Burd, NHA vice president, finance, at dburd@NebraskaHospitals.org or (402) 742-8144.

By Monica Seeland, RHIA
vice president, quality initiatives

# Quality data can lead to quality health

Nebraska hospitals participate in a variety of quality initiatives designed to improve health care. Information about the results of these initiatives is available online to the public. When reviewing the information, it is also important to read about how the data was collected and any limitations that may be inherent in the data. When a site publishes quality rating data, remember to look at how many cases were included in that rate because small numbers can cause a large swing in results. To get questions answered about the information on any of these sites, consult with a physician or other health care professional and ask them to help you interpret the information.

Medicare's Hospital Compare, www.medicare.gov/hospitalcompare, enables users to search for a specific health care facility to determine its compliance with certain quality indicators. For example, a search can be conducted for process of care measures for patients with heart failure, acute myocardial infarction, pneumonia or selected surgical procedures. Outcome measures, such as readmission rates and mortality rates or review rates of certain infections that may occur can also be reviewed. This site can also contains links to information about nursing homes, physicians, home health services and dialysis services.

Why Not the Best, whynotthebest.org, was created and is maintained by The Commonwealth Fund, a private foundation working toward a high performance health system. It is a free resource for health care professionals interested in tracking performance on various measures of health care quality. It enables organizations to compare their performance against that of peer organizations, against a range of benchmarks and over time. Case studies and improvement tools spotlight successful improvement strategies of the nation's top performers. A regional map shows performance at the county, region, state, and national levels.

The Joint Commission, jointcommission.com, provides information about hospitals that voluntarily choose to undergo an accreditation review. The Joint Commission's Quality Check is a comprehensive listing of health care organizations. Joint Commission accreditation/ certification is recognized nationwide as a symbol of quality and safety that reflects an organization's commitment to meeting certain performance standards. On Quality Check, users can search for health care organizations (Joint Commission-accredited and certified organizations will display a Gold Seal of Approval) and view and download a Quality Report for all Joint Commission-accredited and certified organizations.

Another site maintained by the Centers for Medicare & Medicaid Services (CMS) is data.medicare.gov. This site contains the same information as the Hospital Compare website, but allows users to easily download and explore the Hospital Compare data.

The NHA Care Compare website, nhacarecompare.org, is a site maintained by the Nebraska Hospital Association. This website provides information on hospital pricing and quality, provides links to hospitals in Nebraska, and answers commonly asked questions about bills for health care services.

**No one knows more about you than you do!** Adopt healthy behaviors and visit your doctor regularly. Follow your doctor's instructions about lifestyle issues, such as smoking, diet and exercise; become knowledgeable about preventive health care measures such as mammograms, screenings for colorectal cancer and prostate cancer; if you have a particular medical condition, become proactive about steps you can take to manage your condition. Use sites like those listed above to help you become more knowledgeable about your health.

For more information contact Monica Seeland, vice president, quality initiatives, at mseeland@NebraskaHospitals.org or (402) 742-8152.

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By Marty Fattig, ACHE, CEO
Nemaha County Hospital in Auburn

# Advocating for more than Nemaha County Hospital

Ten years ago I never would have believed that I would be as involved in health care policy efforts as I am today. Like so many others, I thought politics were a waste of time and money and that someone else could deal with those issues because I simply didn't have the time. I always voted in every election, but that was about the extent of my political involvement.

One day a friend of mine said, "With the right to complain, comes the responsibility to participate." Now, I do my fair share of complaining about things, so if I believed what my friend said, I either needed to stop complaining or become involved in advocating for the changes that I believed were necessary and important.

In 2004, I became a member of the Rural Health Advisory Commission and began to work with a group of committed health care professionals from across the state. As I became more and more involved with the commission, it became necessary for me to advocate for legislation that would benefit rural health and health care in Nebraska and across the nation. I began to testify at legislative hearings on bills dealing with health care issues and found that I enjoyed it. I also discovered that many of the state senators really didn't understand health care and were searching for a source of accurate information. I found that if I would provide accurate information at a time when I wasn't trying to persuade them to see my point of view, they were much more willing to listen to me when I did have a concern.

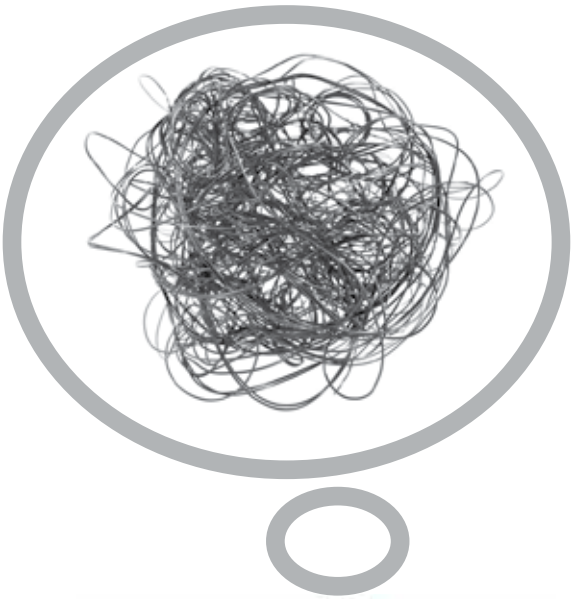
My work at the state level led to becoming involved at the federal level and working with our congressional delegation to promote health care policy that impacted our state. Again, I have tried to be a source of accurate information to our members of Congress and to their staff. I have found that most of the congressional staff are open to discussing health care policy, especially how it impacts their constituents. If you don't have the respect of congressional staff, you will have a very difficult time ever getting to visit with any member of congress or the senate. I love to invite the Congressional staff to our facility whenever they are in the state, so that they can see firsthand what we do and how a particular piece of legislation will impact us.

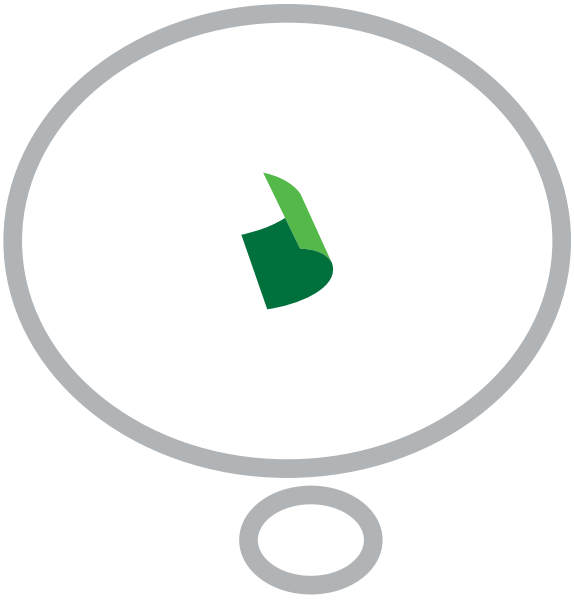
My advocacy efforts combined with my work with the electronic health record led to my being appointed by Centers for Medicare & Medicaid Services (CMS) to the Health IT Policy Committee Meaningful Use Workgroup in 2010. In addition to advocating for or against health care policy, I am now involved in the development of policy. I have found by working with the Meaningful Use Workgroup to be very rewarding, although at times it can be quite frustrating. I am the only member of the workgroup that understands small and rural hospitals so. While sometimes my voice gets drowned out by representatives of large hospitals and special interest groups, at least Critical Access Hospitals (CAH) have a seat at the table.

I am currently working as a member of the workgroup to help transform Nebraska health care system, approved as part of LR 22. The group is charged with developing a plan to transform health care in the state that works better and costs less than the current plan. I enjoy working with State Sens. Kathy Campbell of Lincoln and Mike Gloor of Grand Island and the other members of the workgroup, I hope that plan we develop will at least become an initial step toward the transformation of health care so that people much smarter than me can continue to help the plan evolve.

I am sure that many of you are wondering, how does all of this benefit the organization that I work for? With the assistance of the Nemaha County Hospital board of directors and the hospital executive team, we have created an organization were I have limited responsibilities for day-to-day activities. This allows me to think more strategically and less operationally. My advocacy work keeps me well informed about the direction health care is moving, which is a tremendous advantage when I am working on strategic planning. My advocacy efforts also connect me with some of the best minds in health care, which allows me to learn from them and adopt best practices from all over the nation. In my opinion, the value our organization receives from my advocacy efforts far outweighs the cost. I also believe that advocating for the industry is one of the core duties of all health care leaders. I cannot expect someone else to do what I am unwilling to do myself.

I encourage everyone to become an advocate for their profession and their organization. It can be very enlightening and it has never been more necessary that it is today. Every interest group in the nation is competing for limited dollars. Our voices need to be heard so that health care does not get what is left over, but what it deserves. HN





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By Adrian Sanchez, director of communications

# Nebraska hospitals contribute $1B to benefit communities

Nebraska's nonprofit hospitals provided more than $1 billion in community benefits in 2012, according to the Nebraska Hospital Association's "2013 Nebraska Hospitals Community Benefits Report."

Hospitals care for the sick and injured, regardless of an individual's ability to pay or the net cost to the hospital. As a result, in 2012, hospitals shouldered more than $246.9 million in bad debt. Bad debt is incurred by a hospital when patients decline to apply for charity care and are unable or unwilling to pay for the health care received.

Additional efforts by Nebraska's hospitals to ensure everyone in the state has access to high quality care resulted in hospitals incurring costs of nearly $108.6 million in 2012 to provide charity care to patients who could not independently afford treatment because they have inadequate resources and are either uninsured or underinsured. Charity care, which is reported in direct costs to hospitals and not charges, is free or discounted services offered to patients who apply and qualify for financial assistance.

The largest community benefit provided by hospitals is the unpaid cost of providing health care for beneficiaries of public programs, such as Medicaid and Medicare. In 2012, Nebraska's hospitals incurred more than $507.7 million in costs to care for Medicaid and Medicare patients that were not reimbursed by the government. On average, Nebraska hospitals experience negative margins of 11.9 percent for Medicare and 17 percent for Medicaid when they receive Disproportionate Share Hospital (DSH) payment, or 27 percent when not receiving DSH payments. DSH payments are additional payments received by hospitals that have a disproportionately large number of low-income patients. In addition to the unreimbursed costs of providing care for Medicaid and Medicare beneficiaries, an additional $9 million was incurred by other public assistance programs.

Along with bad debt, charity care and reducing the government's financial costs for Medicaid, Medicare and other public programs, many hospitals also make services available at a net cost. Examples of services that result in a financial loss include operating a 24-hour emergency room 365 days a year, operating a neonatal intensive care unit and providing specialized services, such as burn units, trauma care and palliative care, to name a few. While many industries can choose to eliminate products or services that fail to return a profit, it is the mission of hospitals to fulfill the health needs of their communities. Hospitals must have the space, equipment and highly educated and trained employees to meet those needs. These are costs incurred whether these health services are utilized frequently or sparsely.

Hospitals also contributed millions to educate the future health care workforce of Nebraska, to improve community health and aid the less fortunate through education, outreach and community-building activities, as well as conducting research and other community benefit operations in 2012.

Hospitals also continue to be economic engines in the state, employing nearly 42,000 Nebraskans and contributing millions of dollars into community economies, buying goods and services from other local industries and having a residual impact that supports an additional 29,000 jobs throughout Nebraska.

While Nebraska's hospitals have always worked to provide the best care at a reasonable price, federal reimbursement cuts, the rising amount of bad debt and the shift to performance pay under the Affordable Care Act, a concerted effort has been made to further identify where quality improvements can be made through implementation of innovative and best practices while managing to reduce costs. Through the Hospital Engagement Network (HEN), which is a public-private partnership among the Nebraska Hospital Association, 35 Nebraska hospitals and the Center for Medicare & Medicaid Services, hospitals that participated in the HEN have achieved the goal of reducing early elective deliveries, pressure ulcers and a number of hospital acquired conditions by at least 30 percent.

Nebraska hospitals also made non-labor cost reductions through implementation of patient-centered medical homes to maximize health outcomes in a cost efficient manner, evaluating staff ratios, implementing more efficient technologies and improvements in clinical documentation and analyzing group purchasing agreements to identify the most cost effective partnerships.

These are just some of the highlights contained in the 2013 Nebraska Hospitals Community Benefits report. For a complete copy of the report, visit www.NebraskaHospitals.org.

For more information, contact Adrian Sanchez, NHA director of communications, at asanchez@NebraskaHospitals.org or (402) 742-8151.

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By Al Klaasmeyer, vice president
NHA subsidiaries

# CMS releases proposed emergency preparedness conditons of participation

The Centers for Medicare & Medicaid Services (CMS) posted in the Federal Register a proposed rule that would establish emergency preparedness conditions of participation and conditions for coverage that hospitals, critical access hospitals (CAH) and other providers and supplier types would have to meet to participate in the Medicare and Medicaid programs.

CMS consulted with experts in emergency response and health care facilities and identified four areas that the agency believes are central to an effective emergency preparedness system. The proposed rule would require participating providers and suppliers to meet these four standards, although the specific proposed requirements are adjusted to reflect the characteristics of each type of provider and supplier.

1. **Emergency Plan**: Based on a risk assessment, develop an emergency plan using an all-hazards approach focusing on capacities and capabilities.
2. **Policies and Procedures**: Develop the implementation policies and procedures based on the plan and risk assessment.
3. **Communication Plan**: Develop and maintain a communication plan that complies with both federal and state law. Patient care must be well-coordinated within the facility, across health care providers and with state and local public health departments and emergency systems.
4. **Training and Testing Program**: Develop and maintain training and testing programs, including initial and annual trainings, conducting drills and exercises or participating in an actual incident that test the plan.

**CMS SUMMARY:** This proposed rule would establish national emergency preparedness requirements for Medicare and Medicaid-participating providers and suppliers to ensure that they adequately plan for both natural and man-made disasters, and coordinating with federal, state, tribal, regional and local emergency preparedness systems. It would also ensure that these providers and suppliers are adequately prepared to meet the needs of the patients, residents, clients, and participants during disasters and emergency situations.

**CMS is soliciting comments on the following points:**

1. The provision of subsistence needs for staff and patients, whether they evacuate or shelter in place.
2. The regulatory impact analysis on the annual testing requirement for disaster drills and tabletop exercises and the annual generator testing requirements for Hospitals and CAHs and long-term care facilities. The Burden and Cost Estimate for Hospitals is projected at $7,968 per hospital, $6,308 per CAH and $4,740 per rural health clinic.
3. Targeted approaches to emergency preparedness. Should CMS cover one or a subset of provider classes to learn from implementation prior to extending the rule to all groups?
4. A phase in approach. Should CMS implement the requirements over a longer time horizon, or differential time horizons for respective provider classes? CMS proposes to implement all of the requirements one year after the final rule is published.
5. Variations of the primary requirements. CMS has proposed requiring two annual training exercises. Should both be required annually, semiannually, or should training be an annual or semiannual requirement?
6. Integration with current requirements. How can the proposed requirements be integrated with, or satisfied by, existing policies and procedures which regulated entities may have already adopted?
7. What hurdles do you anticipate in creating a system to track the location of staff and patients in the hospital's care both during and after the emergency?

The Nebraska Hospital Association encourages its members to provide comments on the proposed rules. For more information, contact Al Klaasmeyer, NHA vice president, subsidiaries, at aklaasmeyer@NebraskaHospitals.org or (402) 742-8162.

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