Arkansas Hospital Association
Written Comments for the
Ad Hoc Subcommittee on State, Local, and
Private Sector Preparedness and Integration
Homeland Security Committee
U.S. Senate
Dirksen Office Building
July 22, 2010

Introduction:

Thank you, Mr. Chairman and members of the committee.

My name is Paul Cunningham and I am the Sr. Vice President of the Arkansas Hospital Association in Little Rock, Arkansas.

I am here today speaking on behalf of a dozen hospitals located in and around the Metropolitan Little Rock area which were, until June 1 of this year, voluntary participants with the National Disaster Medical System (NDMS) and were a part of the only activations in the NDMS' 25-yr. history of civilian hospitals for the combined purposes of patient evacuation and definitive medical care following disasters that occurred on U.S. soil.

During the most recent activation in 2008, our hospitals identified several problems in the system and we have been working for almost two years to resolve those issues, but without measurable progress.

The NDMS serves as a single integrated national medical resource for responding to mass casualty events. The original purpose was that NDMS would be available and employed to care for a massive number of casualties resulting from domestic disasters in any area of the country, such as a hurricane or earthquake, and also would be a reserve stateside resource to provide medical care for injuries suffered by civilians and troops in an overseas conventional war**.**

More recently, that purpose has been expanded to include the response to care for even greater numbers of casualties that could occur if ever a weapon of mass destruction is deployed as part of a terrorist somewhere in America. For that reason, the NDMS must be a key component of an overall Homeland Security strategy.

We believe this newest threat, which all Americans hope never occurs, makes it essential that the problems discovered during Arkansas' experience be addressed and corrected in order to strengthen the NDMS and ensure that it is a viable Homeland Security resource with capabilities to better respond to any type of future mass casualty events wherever they might occur in our country.

The Issue:

Almost two years ago, NDMS participating hospitals in and around Little Rock took in and cared for 225 patients who were included in an evacuation from southern Louisiana prior to the landfall of Hurricane Gustav. Our hospitals continued that care for nearly a month, or more in some cases, waiting for Gustav, and then Hurricane Ike, to clear the area to allow the return of those patients to their home state. During that time, it became clear that the NDMS

Memorandum of Agreement with its hospitals needs substantial revisions to make the program more viable for future events.

Efforts to get our concerns addressed date back to late September 2008. Other issues arose in 2005, when Arkansas' NDMS hospitals were placed on alert in the wake of Hurricanes Katrina and Rita, but received only a few patients from among the 1,800 who were evacuated by NDMS from Louisiana at that time. Many problems identified during the NDMS evacuation from New Orleans after Katrina were later dealt with, and that attention resulted in a smoother process when patients were transferred from hospitals along the LA Gulf Coast to Little Rock facilities in 2008, prior to Hurricane Gustav.

The failure to make similar progress in getting the concerns identified during the 2008 activation addressed prompted the Little Rock area hospitals to withdraw their NDMS participation last month, on June 1.

While there has been progress during the past few months, working with HHS Assistant Secretary of Preparedness and Response, Dr. Nicole Lurie, and Dr. Kevin Yeskey, Deputy Assistant Secretary, Office of Preparedness and Emergency Operations, there has been no specific action to address our proposed revisions that were submitted in June 2009, with hopes that at least some of the changes could be incorporated before the 2010 hurricane season began last month, on June 1. They were not.

While the Little Rock hospitals want to do the right thing by working in conjunction with the NDMS to care for inpatients subject to unexpected emergency evacuations from other states, they can't do so if it means placing patients in their own community or their own organizations at risk when doing so.

Operating under the existing Memorandum of Agreement during the 2008 activation, hospitals encountered situations which put the health of local patients in jeopardy by creating a need to postpone their elective admissions and procedures for days and weeks while trying to accommodate patients from Louisiana who experienced extended stays beyond their control.

At the same time, hospitals that are already laden with financial challenges related to inadequate payments from all sources, found themselves battling with NDMS, HHS and CMS to recoup even a portion of their costs associated with their good faith efforts.

The Memorandum of Agreement between the NDMS and its participating hospitals needs to be revised because the success of the federal/state partnership hinges on an arrangement which creates no obstacles to hospitals' voluntary participation. The array of problems incurred by Arkansas hospitals during NDMS patient evacuations in 2008 ought to be sufficient grounds to conclude that the current MOA fails to meet that standard. We think our suggestions are reasonable and would resolve many of those concerns.

NDMS Purpose

As you know, the NDMS was created in 1983 by Executive Order of President Ronald Reagan with the intent to:

- Create a system whereby civilian hospital beds could be used in the event of a disaster within the U.S. and
- Create Disaster Medical Assistance Teams (DMATs) who could respond to those disasters.

Originally, the system was placed under the administrative authority of DHHS' Public Health Service and assigned two specific missions:

- Primary: Backup medical support for DoD and VA during conventional overseas conflicts
- Secondary: Supplement state and local emergency resources during disasters and emergencies

After 9/11, the mission was expanded to include medical response to terrorist attacks.

NDMS remained there a part of the PHS until 2002, when Congress gave it statutory legitimacy under the *Public Health Security and Bioterrorism Preparedness and Response Act of 2002*, and transferred it from DHHS to FEMA; then, in early 2003, FEMA (along with NDMS) was moved to the Department of Homeland Security.

After Hurricane Katrina in 2005, NDMS moved again on January 1, 2007 via the *Pandemic and All-Hazards Preparedness Act of 2006* and was placed under DHHS once more with a new mission to *"Lead the Nation in preventing, preparing for, and responding to the adverse health effects of public health emergencies and disasters"*

Currently, NDMS located in the DHHS Office of Preparedness and Emergency Operations (OPEO) which reports to Assistant Secretary for Preparedness and Response (ASPR) Nicole Lurie, M.D. It includes around 1,800 U.S. hospitals and 100,000 beds; although in any given year the actual involvement typically is very small.

NDMS Activations

NDMS deployments may only be activated by the President via a Stafford Act declaration, or by DoD, or by the HHS Secretary. These activations include three program components:

- **Deployable medical response teams** for the deployment of response teams that provide assessments of medical and health needs, primary and emergency medical care, health and medical equipment and supplies, victim identification and mortuary services, veterinary services, and other auxiliary services at the site of an emergency. Examples of NDMS response teams are DMATs—disaster medical assistance team, DMORTs—disaster medical disaster mortuary operational response teams, and DVATs—disaster veterinary assistance teams. (3, 4-6) Incidentally, NDMS documents curiously define the term "auxiliary services" as "mortuary services, veterinary services, and other services.
- **Patient evacuation** involves communication, transportation, and a medical regulating system by NDMS to evacuate patients from a mobilization center near the disaster site to reception facilities where they may receive definitive medical care, and to communicate evacuation information to federal, state, and local authorities. The first time the NDMS was used for evacuation of a very large number of patients from hospitals and nursing homes was during the Hurricane Katrina disaster.
- **Definitive medical care** (through NDMS Hospitals) is the component for providing public health emergency, medical treatment or services beyond emergency medical care, initiated upon inpatient admission to an NDMS hospital and provided for injuries or illnesses resulting directly from a specified public health emergency, or for injuries, illnesses and conditions requiring non-deferrable medical treatment or services to

maintain health when such medical treatment and services are temporarily not available as a result of the public health emergency. Definitive medical care is provided through a nationwide network of voluntarily participating, pre-identified, private and federal hospitals. The NDMS reimburses the private hospitals that provide the care, but only partially, subject to the availability of funds.

While there have been numerous NDMS activations over the years, there have been only three activations involving a combination of the Patient Evacuation and Definitive Care components. All were non-Department of Defense activations, two related to Hurricanes Katrina/Rita (2005) and Hurricanes Gustav/Ike (2008), and one following the earthquake in Haiti earlier this year.

Background to Arkansas Experience

Arkansas' NDMS facilities went on alert August 30, 2008, when patients from hospitals in New Orleans and other points in south Louisiana were evacuated to safer places as Hurricane Gustav bore in on the Louisiana Gulf Coast. Eventually, 225 Louisiana hospital inpatients were transported by NDMS to Little Rock and dispersed among 12 Central Arkansas hospitals. Fewer than 10 patients were evacuated to Oklahoma, the only other state involved in the evacuation.

The evacuations, transfers and placement of Louisiana patients into the Little Rock hospitals went relatively smoothly. Most of Hurricane Katrina's lessons from three years earlier were learned well.

Problems began to surface when Gustav had tracked away from southern Louisiana. Although, NDMS had resolved most issues associated with evacuating patients from Louisiana into Arkansas, the details for moving those same patients back to Louisiana were seemingly overlooked. That failure had several consequences that were made worse by the approach of Hurricane Ike quick on the heels of Gustav. By that time, even in cases where there was a way to send patients back to the original transferring hospital, many Louisiana facilities refused to take them back because another hurricane was headed for landfall.

Generally, the problems encountered can be separated into two categories: repatriation and reimbursement.

Repatriation

On August 31, 2008 Hurricane Gustav was predicted to hit the Louisiana Gulf coast within 36 hours. At that time, the State of Louisiana requested activation of the National Disaster Medical System to evacuate hospitals in the storm's path. Eventually, around 225 patients from various Louisiana hospitals were received at 12 hospitals in the central Arkansas area which had agreed by signature of a memorandum of agreement to accept evacuation patients through the NDMS.

This marked only the second time that NDMS had been used to move patients in such a manner. The numbers of patients received in Little Rock at the time compares to the Hurricane Katrina/Rita response for the cities of Atlanta (200) and Dallas (588). Arkansas hospitals received about 30 patients during that 2005 disaster.

When Gustav had cleared the targeted areas in LA, Arkansas' NDMS facilities were ready to discharge the patients and "repatriate" them to LA and the transferring hospitals there. That is when our hospitals first realized that the MOA with does not include repatriation of transported patients. Although the US Air Force is directly involved with evacuation of patients from a

disaster area to a host state, it is not an NDMS resource for getting those same patients back to their home states.

At that time, there was no signed agreement in place with the NDMS contractor, Careflite, which was supposed to return the patients to Louisiana hospitals when it was safe to do so and the patients and their families were ready to return. Once a contract was signed, the contractor apparently did not have sufficient resources to mass transport such a large number of patients (and family members who had made their way to Arkansas and were staying in the hospital with them), in a short span of time, nor was there an interagency agreement with FEMA to support medical transportation for patient return. The brief window was soon closed.

Two weeks into the event weather conditions in Louisiana deteriorated again due to the September 13 onset of Hurricane Ike, extending the patients' stays in Arkansas hospitals even longer.

By the time Hurricane Ike tracked away from LA, almost four weeks after the initial patient evacuation from LA, most patients still remained in Arkansas hospitals. The first patients under the Careflite contract were taken back to LA on September 15. The contractor reported that the company would fly 24 hours a day and transport up to ten patients a day. At this rate, it was estimated take up to eleven days to get the patients home. Instructions from HHS and Careflite changed almost daily, making it confusing for patients, hospitals, and their families.

The delay also increased the workload on hospitals trying to serve the patients to ensure a safe discharge plan for them. Hospitals were forced to make other arrangements in many cases. Those included choices about whether to move the Louisiana patients to local shelters or hotels, or return them to Louisiana using methods outside what was to be provided by NDMS.

Arkansas hospitals were dramatically impacted by this event both in the amount of costs incurred (for much of which they were never compensated), changes in surgery schedules for local patients to accommodate the evacuated patients for longer-than-intended stays and staffing additions, as well as countless hours expended by each hospital's discharge staff trying to arrange for these patients to be discharged.

The delay and NDMS' inability to return patients to LA caused our hospitals to incur unexpected expenses related to commercial air transportation, ambulance transports, rehabilitation care when the patient should have been sent back to their originating hospitals long before they made it to rehab, doubling of staff to meet the needs of patients, medications sent with patients in ambulances, and family members' costs (non-medical meals, clothing and accommodations).

Local patients also suffered the effects of the repatriation problems from having to postpone or delay elective procedures because beds or staffing were not available due to the demands of evacuated patients. The unexpected costs also affected Medicare patients who were among the medical evacuees.

Many of them surpassed their limit of medically necessary days, meaning Medicare would not pay for any care rendered beyond that point. Others may still have been in need of hospital care, but surpassed their benefit period allowable days. (Medicare covers up to 90 days in a hospital per benefit period and offers an additional 60 days of coverage with a high coinsurance. These 60 reserve days can be used only once during a beneficiary's lifetime.) It is reasonable to assume that some may have chosen to dip into their "banked" lifetime reserve days due to the circumstances, forever wasting those covered days.

It is our understanding that ASPR officials are working with FEMA on an interagency agreement to support medical transportation for patient return. Their goal is to have multiple vendor contracts in place well ahead of a disaster. That would be helpful, but it has not been done yet.

Reimbursement

The NDMS agreement is clear regarding reimbursement and offers a reasonable approach for helping to pay for the care of uninsured patients, those on Medicaid and even patients with private insurance coverage. But it fails to understand and adjust for the idiosyncrasies of Medicare rules, particularly those involving patient transfers.

The MOA stipulates that NDMS reimburses up to 110% of the amount Medicare would pay for hospital inpatient care provided to NDMS-evacuated patients who have no health-insurance coverage and whose coverage is limited to Medicaid or other payers of last resort.

For individuals with private coverage (e.g., employment-based coverage), the NDMS Reimbursement Program may make a secondary payment to cover the difference between the full NDMS payment amount and the other payer's (or payers') allowance(s). (Except, NDMS does not cover deductibles and coinsurance associated with patients' private coverage.)

However, if an evacuated patient is covered by Medicare or TRICARE, the hospital must bill the applicable program(s) and accept that reimbursement as full payment. The policy leaves payment for care provided to Medicare patients involved in such evacuations subject to Medicare payment rules, regardless of exigent circumstances. If Medicare doesn't pay, then hospitals are left to absorb the costs, as balance-billing is prohibited, except in specific situations.

Medicare's rule regarding temporary patient transfers, such as those which can occur during evacuation periods, creates a major payment issue. Typically, for transfers between hospitals, the transferring hospital is paid based upon a per diem rate, not the full DRG rate. The payment to the final discharging hospital is made at the full Medicare rate. That works, because the patient does not return to the first hospital.

But, in cases where the patient goes from Hospital A to Hospital B and then back to Hospital A, the full payment still goes to the final discharging hospital (A), while there is no provision to pay an additional amount to the receiving hospital which later returns the patient to the first facility. In those cases, payment to Hospital B is made "under arrangement" with Hospital A. In other words, Hospital B can expect only an amount negotiated with Hospital A for the care provided. During emergency evacuations, there is little time for those negotiations.

In Arkansas' case, HHS eventually ruled that both the hospitals in Arkansas and Louisiana could be paid the full DRG amount for Medicare patients involved in the evacuation, but those decisions did not come until well after the fact. It was not until mid-November that the Arkansas Hospital Association learned that CMS, via authority granted the HHS Secretary through the Stafford Act, had reconsidered its position that its "….policy is that payment is 'under arrangement' only for brief evacuations where the patient returns to the originating hospital. In these cases, we believe the patient has only been temporarily moved to another hospital to allow the emergency to subside and it is still responsible for and directing the patient's care." CMS went on to state, "We have understood that in the AR/LA situation, the evacuating hospital has transferred care to the receiving hospital for an extended stay and the receiving hospital would receive a transfer payment up to the full DRG amount."

Unfortunately, that is not a general policy covering all such situations. HHS must decide whether it applies in each individual emergency event.

The decision came only after Arkansas officials made pleas with CMS to remedy the problem. The lengthy delay could have been averted had Arkansas received a Stafford Act declaration and a so-called §1135 waiver as a disaster area, allowing for such Medicare flexibilities, or, more expeditiously, had Arkansas as a host state been covered for the flexibilities under Louisiana's waiver.

Another problem relates to Medicare's DRG payment system, which limits payment for an admission to a predetermined amount, depending on the patient's reason for being hospitalized, regardless of how long the hospitalization takes.

Following Hurricanes Gustav/Ike, many Medicare patients who were evacuated from Louisiana were hospitalized in Little Rock facilities well beyond their DRG length of stay. Medicare could not reimburse anything for those extra days, unless the patient reached "outlier" status. Nor did Medicare pay for any days that were determined to be medically unnecessary, despite the fact that the patient(s) could not be discharged to home or any other setting, in most cases.

The NDMS payment criteria seem to be the function of policy decisions rather than law or regulation, according to the NDMS Federal Coordination Center Guide (July 2007), which states, "Compensation for NDMS related claims will be paid at rates *contracted* at the time of the disaster for the disaster related Diagnoses."

Other than the shortage of funds, there does not appear to be any reason why NDMS could not also pay for care provided to Medicare (or TRICARE) patients, but which goes beyond the Medicare or TRICARE limits in normal situations (i.e. inpatient days beyond the medically necessary covered days in cases where patients can't be discharged to their home or a post-acute service.)

Ideally, it would make sense to move toward a single policy designed for covering medical costs associated with massive evacuation or disaster responses for all patients. In addition, although NDMS is not responsible for non-medical costs incurred during evacuations, it should work more closely with FEMA to facilitate a process for reimbursing those costs.

It's interesting to note that following the earthquake in Haiti last January, NDMS guaranteed reimbursement to hospitals in Florida, where many injured Haitians were transported for care, at 110% of the Medicare rate for those patients. It seems that international patients are afforded more regard than is extended to Medicare patients, America's senior citizens, who are evacuated for care.

Timeline of Arkansas Efforts to obtain MOA changes:

Following a series of meetings and debriefings about the Gustav/Ike experience, the Arkansas NDMS hospitals initiated actions to obtain changes in the Memorandum of Agreement to be effective before the 2010 hurricane season.

June 5, 2009: Phil Matthews, President, Arkansas Hospital Association, wrote to Rex Oxner, Emergency Management Director for Region VI (and copied to the Assistant Secretary for Preparedness and Response) requesting revisions to the NDMS Memorandum of Agreement and suggesting termination of the NDMS MOA.

August 7, 2009: HHS, CMS, ASPR, OPEO officials met with Arkansas hospital representatives to discuss revisions to the NDMS MOA and reimbursement problems with Hurricane Gustav/Ike patients. Hospitals felt very positive after the meeting that they had been heard, changes would be made and reimbursement issues would be resolved.

August 27, 2009: Mr. Matthews wrote a second letter to Mr. Oxner (and copied to federal officials) stating that hospitals were pleased with actions at August 7 meeting, therefore rescinding their threat of termination of NDMS MOA for the 2009 hurricane season.

Virtually nothing happened during the ensuing period, except that hospitals were finally reimbursed for all NDMS reimbursable expenses (although it took 1.5 years to accomplish this). We received no word that action was being taken on the MOA or other issues raised.

On or about March 1, the AHA contacted our ASPR contact in Region VI asking about MOA. This started some conversation about a possible meeting to discuss issues.

April 7, 2010: Arkansas Metro (NDMS) hospitals passed a motion saying that without resolution on the requested revisions to the NDMS Memorandum of Agreement, the Metropolitan Hospital Association of the Arkansas Hospital Association will rescind their agreement with NDMS effective June 1, 2010.

April 12, 2010: Dr. Nicole Lurie, Assistant Secretary for Preparedness and Response, Emergency Managers for Region VI, and HHS Field Supervisor, Regional Emergency Management, met with Arkansas hospitals to continue discussion. Hospitals were told that no changes would be made to the MOA this year, but that there was a possibility of a "side letter" to "offer an assumption of responsibility and a level of protection for Arkansas hospitals" written in the next few weeks. However, the letter would have to go through ASPR/HHS legal channels, therefore a "status report" on the letter would be written within two weeks.

April 15, 2010: AHA president Phil Matthews wrote to Dr. Lurie, "While Little Rock area hospitals want to do the right thing in assisting with care for inpatients subject to unexpected emergency evacuations from other states, they can't place patients in their own community, or themselves, at risk when doing so. The MOA must get closer attention because the success of NDMS' federal/state partnership hinges on an agreement which creates no obstacles to hospitals' voluntary participation. With that said, please accept this letter as official notice of the Metropolitan Little Rock hospitals' intent to withdraw from NDMS participation, effective June 1, 2010."

May 6, 2010: Dr. Kevin Yeskey, Deputy Assistant Secretary, Office of Preparedness and Emergency Operations, meets with Arkansas NDMS hospitals to review issues and report progress. He states that the MOA can't be changed at this time.

May 17, 2010: Dr. Yeskey issues a side-letter indicating actions that his office can take to resolve many of the issues encountered during Gustav/Ike.

May 24, 2010: Phil Matthews responds to Dr. Yeskey, noting areas where more specific details are needed to convince the Arkansas hospitals to continue NDMS participation.

June 1, 2010: Dr. Yeskey responds to address questions raised by Mr. Matthews.

June 25, 2010: Mr. Matthews send a letter to Dr. Yeskey asking the following:

1. That transportation contracts be signed and in place.

2. That NDMS have a written plan of action for a Federal Medical Shelter clearly stating that if Arkansas hospitals cannot transport patients back to their original hospital or community, NDMS will be responsible for setting up the transfer to Louisiana, or that NDMS will set up and staff a FMS in Little Rock.
3. Additional details about access to patient tracking information.
4. That a meeting be held between service access teams and Arkansas hospital case managers to develop communication lines and build relationships before a disaster occurs.
5. That Dr. Yeskey continue a dialogue with CMS regarding reimbursement options for non-covered Medicare days.

Ramifications of Arkansas Action:

The withdrawal by Metro Little Rock hospitals from NDMS could have broader implications for the program. Most immediate will be the cost of evacuations. Currently, if patients are evacuated from LA, (a strong probability for any hurricane headed for the Louisiana coast line after the issues which occurred during and after Hurricane Katrina in 2005) they are taken to Little Rock, a short one-hour flight from practically any point in southern LA. Not have those resources puts Oklahoma City as the primary evacuation destination, adding another hour to the flight time. El Paso, TX is the next default city and it is further removed than OKC.

NDMS also stands to lose the experience in such patient movements available with the LR hospitals, and there is a possibility that hospitals in other states may also end their NDMS participation if the Agreement is left as is.

Recommendations: Overall NDMS Funding and Operations

NDMS currently operates on an annual budget appropriation of approximately $60 million. According to a 2008 report from an NDMS Assessment panel (http://www.hhs.gov/aspr/omsph/documents/nbsb-ndms-rpt-0809.pdf) the funding level for NDMS is inadequate to support even the current level of the NDMS operation. Every effort should be made to secure adequate, sustained increased funding for the NDMS so it may successfully accomplish its national mission.

The assessment recommended that a minimum of an initial 15 per cent increase in budget should be sought, especially with the increased expectation that NDMS "lean forward" for improved response to potential disasters. Many members of the Panel felt that NDMS would require at least a doubling of its budget to properly achieve its expected level of function. As part of increased funding, serious consideration should be given to performing a systems analysis of the various complex NDMS logistics and systems operations with the intent of improving the efficiency and decreasing the cost of many of these components.

Recommendations by the Center for Biosecurity (http://www.upmc-biosecurity.org/website/resources/hearings/2006/20060405allhazardsmedprep.html) include modifying the Stafford Act to allow for direct reimbursement of hospitals for uncompensated costs and extraordinary hospital care in the event of major catastrophes.

- Hospitals' revenues will decrease dramatically during a pandemic or in other catastrophes, even though they will be experiencing record-high patient volumes. Hospitals will need to provide care to many patients who are uninsured and/or unable to

pay; at the same time operating costs will be extraordinarily high. According to the AHA, the average hospital has only 41 days of cash on hand. Many hospitals would have insufficient cash reserves to survive a severe pandemic or other crisis that significantly interrupts operations for weeks.

- Under current healthcare reimbursement schemes, hospitals lose money on nearly every illness-related hospital admission—especially those, like pneumonia, that are likely to result from flu. Normally, hospitals offset these losses with profitable elective procedures, but these elective cases will be among the first services to be cancelled or deferred in an attempt to respond to the demands of flu patient care during an epidemic.

Reimbursement should continue at 110% of the Centers for Medicare and Medicaid Services' rate. Failure to consider this would severely jeopardize the continued good-faith efforts of the private health care industry to provide immediate post-event care for disaster victims.

Arkansas Request

The Arkansas Hospital Association is seeking assistance in getting NDMS to agree to all or part of its suggested changes to the MOA (attached

At a minimum, our hospitals need NDMS to agree to the following actions:

1. Have contracts for moving patients back to their home state signed and in place prior to an emergency event. This is a huge part of the problem. We appreciate the movement that ASPR has made towards that end, but feel that the contract *must* be in place or our hospitals will continue to be in the same situation as they were in 2008.
2. A written plan of action for the Federal Medical Shelter to be operated in Little Rock during NDMS evacuations clearly stating that if Arkansas hospitals cannot transport patients back to their original hospital or community, NDMS will be responsible for setting up the transfer to Louisiana, or that NDMS will set up and staff a FMS in Little Rock. That written statement would greatly ease our hospitals' concerns about having no option but to keep patients who cannot be discharged to another accountable healthcare organization or setting.
3. Specifics about training Little Rock hospital personnel on patient tracking and allowing them access to the NDMS JPATs.
4. NDMS' commitment for a meeting between the SATs and Arkansas hospital case managers to develop communication lines and build relationships before a disaster occurs. The AHA would be willing to coordinate such a meeting as early as possible.

In addition, if NDMS can't fully cover Medicare patients, then it should agree to reimburse hospitals for the non-covered services provided to Medicare patients up to the same maximum allowed for uninsured, Medicaid and privately insured patients, 110% of the Centers for Medicare and Medicaid Services' rate for all. Failure to consider this would severely jeopardize the continued good-faith efforts of the private health care industry to provide immediate post-event care for disaster victims.

If that absolutely can't be arranged, we ask that HHS and NDMS continue working with CMS regarding reimbursement options for non-covered Medicare days, especially in those cases when a patient is ready for discharge, but must remain in a hospital due to mitigating circumstances.

According to Medicare rules, hospitals are permitted to issue notices of non-coverage to Medicare beneficiaries if the hospital believes that the care a beneficiary is receiving, or is about to receive, wouldn't be covered because it would not be medically necessary, would not be delivered in the most appropriate setting, or would be custodial in nature. On the effective date as specified in this hospital-issued notice of non-coverage (HINN), the hospital may balance bill the patient for the medically unnecessary care.

We believe that, assuming such HINNs are issued by the hospital and signed by the patient, and if the MOA allows for it, then hospitals would be able to bill NDMS (and NDMS pay) for the uncovered days.

The NDMS needs to be a reliable resource for responding anytime, anywhere to mass casualty events in the U.S. It also must be able to stand as a reserve stateside resource to provide medical care for injuries suffered by civilians and troops in an overseas conventional war**,** or for even greater numbers of casualties that could occur if ever a weapon of mass destruction is employed as part of a terrorist act somewhere in America.

Our intent in trying to amend the NDMS Agreement is meant to safeguard those capabilities.

We hope you agree and will encourage HHS and NDMS to work in tandem with other disaster response groups and with us to make its policies governing patient evacuation and definitive medical care activations less burdensome.

We sincerely appreciate your efforts to move this discussion forward and to look for ways to improve the system both for the impacted state and host state. We look forward to your response and the hope that once again Arkansas hospitals will participate in NDMS patient movement.