AFMC TIMELINE

1972 – Congress authorized the formation of Professional Standards Review Organizations (PSROs) to monitor the appropriateness, quality and outcome of the services provided to beneficiaries of the Medicare, Medicaid, and Maternal and Child Health programs. The Arkansas Medical Society (AMS) responded to this legislation with the formation of an independent board committee to monitor utilization efficiency in the state's hospitals.

Later that same year, it became known that the Medical Society could not qualify as a PSRO. Therefore, a separate entity was formed: the Arkansas Foundation for Medical Care, Inc. (AFMC).

1973 – AFMC's first governing board was elected. With a $500 loan from the Arkansas Medical Society, the board applied to the Department of Health, Education and Welfare (DHEW) to become the PSRO for Arkansas.

1983 – With the enactment of the Tax Equity and Fiscal Responsibility Act (TEFRA) and the Social Security Amendment, the concept of medical peer review was expanded. The scope of the Prospective Payment System radically changed the way hospitals were reimbursed by introducing the Diagnosis Related Group (DRG) payment system, and PSROs became Peer Review Organizations (PROs). AFMC became a single, statewide organization employing safeguards to prevent conflict-of-interest reviews and, with the aid of federal legislation, enacted protections for the confidentiality of the identity of physician reviewers.

1985 – AFMC was awarded its first contract with Arkansas Medicaid as the Arkansas PRO.

1986 – AFMC was the first PRO in the nation to sign for extension of the two-year cycle of review.

1992 – The Health Care Financing Administration, or HCFA (the predecessor of the Centers for Medicare & Medicaid Services), directed PROs to expand their roles by implementing systems-based quality improvement initiatives by working directly with providers and educating beneficiaries. To formalize this role, CMS launched the Health Care Quality Improvement Program (HCQIP) in the mid-1990s.

1997 – AFMC formed the Medicaid Managed Care Services division.

2000 – AFMC was awarded its first out-of-state contract in Mississippi.

2002 – HCFA renamed itself Centers for Medicare & Medicaid Services (CMS) and changed the PRO program name to Quality Improvement Organization (QIO).

2009 – AFMC named the state's Regional Extension Center by the Office of the National Coordinator for Health Information Technology.

2013 – CMS announced significant changes to the traditional QIO program. What was once a state-based QIO leading the quality improvement and utilization review efforts was reconfigured into a Quality Improvement Network (QIN) that includes state consortiums comprised of at least three but not more than six states.
Arkansas Medicaid expansion, launch of AFMC's service center.

2014 – TMF Health Quality Institute secured the five-year QIN-QIO contract with CMS for Texas, Arkansas, Missouri, Oklahoma and Puerto Rico. To carry out this work, TMF subcontracted with AFMC and Missouri-based Primaris.

2015 – With the changing health care marketplace and a desire to expand its geographic footprint, AFMC conducted market research and launched a new corporate brand identity.
Conversion from 501c6 business league or trade association to 501c3 public benefit corporation.

2017 – Launch of AFMC ReviewPoint portal; AFMC hosts first Adverse Childhood Experiences summit; AFMC awarded DHS ConnectCare contract.

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