Letter from the President

Wow! It is hard to believe my year as President of the Kentucky Chapter – HFMA has come and gone. In looking back over the past 12 months, I could not have asked for a better year as President of the Chapter. Although the year has not been finalized, I feel as though we accomplished all of the goals we set out to achieve. Our membership numbers have grown, we will hit our education hours goal, the chapter revamped the newsletter and we got many new faces involved in the chapter.

The theme for 2010-2011 as selected by the National Chair Debbie Kuchka-Craig was “Step Up.” I believe as a chapter, we did “Step Up” and make this past year one of the best years ever. Years like this are not made possible without the many hours of support and dedication of our chapter volunteers. To all of you who “Stepped Up” in 2010-2011, I thank you for all of your hard work. To all of our corporate sponsors, special thanks goes out to all of you. Our chapter would not be able to do the things we do without your support and continuous contributions.

Although my year as President of the Kentucky Chapter is complete, I am not leaving the volunteer ranks of HFMA just yet. As many of you know, I will be moving on to serve as the Region 4 Executive Elect in 2011-2012 and the Region 4 Executive in 2012-2013. One of the goals you establish when you volunteer for a position like this is to leave the organization stronger than when you took over. To all of the President’s who served before me and gave me advice along the way, I appreciate all you did and continue to do for HFMA. Whether you realized it or not, I have learned so much from all of you and I would not have been as successful without learning from each of you.

The other goal is to turn over the leadership to an individual who will make the chapter even stronger. As we move forward into 2011-2012, I am pleased to pass the President’s role to my great friend Chris Woosley. As you all know, Chris has been an instrumental member of the chapter for many years and I could not be turning over the leadership to a more capable or better leader than him. Next year’s HFMA theme is “Believe to Achieve.” I ask all of you to continue to believe in and support our chapter and to support Chris in his year as President. Although we have accomplished a lot the past several years, the Kentucky Chapter – HFMA is committed to becoming the best it can be. We recognize we have opportunities for improvement and will continue to work towards providing the high quality education and networking opportunities our chapter has come to expect.

Once again, it has been an honor to serve as the 2010-2011 President of the Kentucky Chapter – HFMA. I truly appreciate all of the support I have received in leading the chapter.

Andy Strausbaugh - President
Kentucky Chapter - HFMA
2010-2011
Proposed Rule for Accountable Care Organizations

Author: Mark Blessing and Brad Brotherton, BKD, LLP, interview and commentary added by Jennifer Williams, BKD, LLP

On March 31, 2010, Centers for Medicare & Medicaid Services (CMS) released its proposed rule for implementing the provisions of the Patient Protection and Affordable Care Act relating to the Medicare Shared Savings Program (MSSP) and associated accountable care organizations (ACO). Under these provisions, service providers and suppliers to Medicare beneficiaries can continue to receive their traditional Medicare reimbursement while also being eligible for additional payments for shared savings to an ACO. These regulations are currently being proposed, and final rules for implementation are expected this summer after CMS evaluates the comments received on these proposed regulations.

The MSSP is an attempt to redesign the delivery of health care intended to provide better care for individuals, better health for populations and lower growth in Medicare expenditures.

Eligibility & Governance

ACOs are legal entities comprising an eligible group of Medicare-enrolled ACO participants that work together to manage and coordinate care for Medicare beneficiaries. ACO professionals are physicians or mid-level practitioners, i.e., physician’s assistants, nurse practitioners or clinical nurse specialists. ACO participants can be ACO professionals in a group practice, networks of individual ACO professionals, partnerships or joint ventures between hospitals and ACO professionals or hospitals employing ACO professionals. All hospitals that employ ACO professionals and are paid under the prospective payment system (PPS), as well as critical access hospitals (CAHs) billing Method II for physician services, would be eligible to form an ACO. Rural health clinics (RHCs) and federally qualified health centers (FQHCs) are not eligible to form an ACO, but they are allowed to be part of an ACO formed by eligible participants; in fact, ACOs, including RHC/FQHC members, can receive an enhanced percentage of shared savings.

Assignment of Medicare Beneficiaries

Approved ACOs must have at least 5,000 Medicare fee-for-service beneficiaries (not Medicare Advantage) receiving the plurality of their primary care services (defined as allowable charges for billed evaluation and management Healthcare Common Procedure Coding System codes) from ACO professionals who are primary care physicians (defined as physicians with the specialty of internal medicine, general practice, family practice or geriatric medicine only). Plurality of primary care services will be based on which primary care physician provided services with the highest amount of allowed charges to a specific beneficiary regardless of whether it is a majority of such services or not. CMS will determine the Medicare beneficiaries assigned to an ACO in each year of participation on a retrospective basis based on National Provider Identifier (NPI) information for ACO professionals meeting the definition of primary care physicians and billing under a Tax Identification Number (TIN) of an ACO participant. While all physician specialties and mid-level practitioners are ACO professionals, the assignment of beneficiaries will be based only on primary care physicians and mid-level practitioners having ACO’s “linked or aligned” could be a good opportunity - Dr. Stone

ACOs must file an application with CMS to participate in the MSSP and agree to participate in the program under a three-year agreement. Due to the beneficiary assignment process, all agreement periods will start on January 1 of a given year. The ACO must have shared governance giving all ACO participants proportionate control over their decision-making process, including at least 75 percent control of the governing body, which also must include Medicare beneficiary representation. Additional structural and operational criteria must be met, such as requiring at least 50 percent of an ACO’s primary care physicians to be meaningful users of electronic health records.

ACOs with higher quality scores will be eligible for higher shared savings distributions. Year 1 payment distributions will be based on meeting reporting requirements rather than quality thresholds. For ACOs to participate in shared savings distributions, they must meet minimum quality and reporting requirements. Sixty-five data elements must be submitted, and beginning in Year 2 of the agreement, ACOs with higher quality scores will be eligible for higher shared savings distributions. Year 1 payment distributions will be based on meeting reporting requirements rather than quality thresholds.

CMS intends to monitor the quality of ACOs closely and has the ability to remove ACOs from the program (future participation also may be prohibited at CMS’ discretion) if quality measures are not at an expected level and are not improving.

In discussing ACO’s with all interviewees they were all consistent - providing better health care delivery while reducing Medicare expenditures is an advantage to the ACO.

“Low cost, high quality, decreasing the silos” - Sue Stout Tamme

Another advantage to the ACO’s is the reimbursement to the providers, now reimbursement will be “in line, consistent with everyone” - John Harrison

Quality & Reporting Requirements

For ACOs to participate in shared savings distributions, they must meet minimum quality and reporting requirements. Sixty-five data elements must be submitted, and beginning in Year 2 of the agreement, ACOs with higher quality scores will be eligible for higher shared savings distributions. Year 1 payment distributions will be based on meeting reporting requirements rather than quality thresholds.

ACO participants other than primary care physicians can be in multiple ACOs, but to avoid assigning beneficiaries to multiple ACOs, primary care physicians can only be in one ACO. It is important to note the assignment of a beneficiary to an ACO can have no effect on the beneficiary’s ability to seek services from any Medicare-enrolled provider whether in the ACO or not; improper restriction of this right can lead to termination of the ACO from the MSSP.

ACOs must file an application with CMS to participate in the MSSP and agree to participate in the program under a three-year agreement. Due to the beneficiary assignment process, all agreement periods will start on January 1 of a given year. The ACO must have shared governance giving all ACO participants proportionate control over their decision-making process, including at least 75 percent control of the governing body, which also must include Medicare beneficiary representation. Additional structural and operational criteria must be met, such as requiring at least 50 percent of an ACO’s primary care physicians to be meaningful users of electronic health records.

"The first priority is electronic medical records and meaningful use." - Sue Stout Tamme

Some challenges in the beginning are going to be on the IT side, it is critical to have IT up and going - Dr. Stone and John Harrison

Patients’ reaction to ACO’s will be positive as there will be more “coordination of care” for patients - Sue Stout Tamme

While improving and ensuring quality care, “nursing homes may require a doctor or nurse practitioner onsite at all times” - John Harrison

With the required quality measures, an entity can now “prove” to the community the quality of the facility versus the Company promoting it’s image through marketing and other methods. - Joe Steier
Shared Savings Distributions/Loss Repayments

ACOs can choose between two tracks during their first three-year agreement period. Track 1 will allow the ACO to participate in a maximum of 52.5 percent potential shared savings distributions during the three-year period and participate in a maximum of 47.5 percent potential shared loss repayments in the third year only. Track 2 will allow the ACO to participate in a maximum of 65 percent potential shared savings distributions while participating in a maximum of 35 percent potential shared loss repayments for all three years. Agreements beyond the initial three-year period will all be under Track 2. Track 1 ACOs that meet all quality and reporting standards can receive a 50 percent share of the savings achieved, and if the ACO has a RHC/FQHC in its organization, the distributions will increase by a maximum of 2.5 percent, depending on the percentage of beneficiaries with visits to the RHC/FQHC. Track 2 ACOs that meet all quality and reporting standards can receive a 60 percent share of the savings achieved, and if the ACO has a RHC/FQHC in its organization, the distributions will increase by 5 percent, depending on the percentage of beneficiaries with visits to the RHC/FQHC.

At the start of each three-year agreement period, a cost-per-beneficiary benchmark will be established for all beneficiaries that would have been assigned to the ACO (a second option provided for comment would change this to those beneficiaries actually assigned) for the prior three years using the actual expenditures from the prior three-year period weighted toward the most recent year. This benchmark will then be adjusted each year by an expense trend factor and a factor for variations in the complexity and severity of the beneficiaries, as well as to effect for changes in the assigned beneficiaries. In years where the ACO manages the CMS cost per beneficiary below the benchmark, the ACO will receive a share of these savings. For Track 2 ACOs, the ACO will pay a share of the losses in years where the CMS cost per beneficiary exceeds the established benchmark.

In establishing the benchmark, CMS has proposed to include all relevant Medicare costs, including enhanced payments for disproportionate share hospitals, indirect medical education payments, hospital specific rate payments and incentive payments for hospitals that achieve “meaningful use” of an electronic health record (physician bonus payments for electronic health record and other quality initiatives are excluded from the benchmark). Therefore, evaluating the Medicare reimbursement landscape for current and anticipated payments is an important factor to consider when deciding whether to enter into the MSSP.

To receive a shared savings distribution, the ACO must reduce cost by a “minimum savings rate.” CMS is concerned normal fluctuations in annual costs could result in a shared savings distribution when real change in efficiency of care did not occur. To adjust for this, they have established minimum savings thresholds, ranging from 3.9 percent for the smallest ACOs to 2 percent for the largest organizations and all Track 2 ACOs, which must be exceeded before distributions can be calculated. All ACOs exceeding their minimum savings rate threshold will receive sharing distributions on savings exceeding a 2 percent threshold. There are exceptions for ACOs with fewer than 10,000 assigned beneficiaries, which are entitled to sharing distributions on all savings if any of the following conditions apply:

- The ACO is comprised only of medical practitioners in group practice or networks of individual practices
- 75 percent of the assigned beneficiaries are in rural counties outside of Metropolitan Statistical Areas
- 50 percent of the assigned beneficiaries are related to primary care services from a Method II CAH
- 50 percent of the assigned beneficiaries had at least one encounter with an RHC/FQHC

The maximum amount of shared savings each year will be limited to 7.5 percent of an ACO’s benchmark for Track 1 ACOs. Track 2 ACOs, along with Track 1 ACOs that have transitioned to Track 2 in Year 3 of their agreement period, will have a maximum shared savings amount of 10 percent each year.

Each year, 25 percent of the shared savings distribution will be withheld by CMS to protect against their ability to be repaid in years where shared losses occur. At the end of the three-year agreement, the withheld amounts will be distributed to the ACOs as long as they do not have shared loss amounts that need repaid. If an ACO does not complete its three-year agreement, the ACO would forfeit any of the withheld amounts.

### Examples of ACO Shared Savings Calculations

<table>
<thead>
<tr>
<th></th>
<th>60,000-Member Urban ACO with no RHC/FQHC Participation Meeting All Quality/Reporting Standards – Track 2</th>
<th>6,000-Member Rural ACO with Large RHC/FQHC Participation Meeting 80% of Quality/Reporting Standards – Track 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS Cost per Beneficiary</td>
<td>$8,000</td>
<td>$8,000</td>
</tr>
<tr>
<td>Expense Growth Trend Factor</td>
<td>2.5%</td>
<td>2.5%</td>
</tr>
<tr>
<td>ACO Health Status Adjustment Factor</td>
<td>1.1</td>
<td>0.9%</td>
</tr>
<tr>
<td>Established ACO Cost Benchmark</td>
<td>$9,020</td>
<td>$7,790</td>
</tr>
<tr>
<td>Actual Cost per Beneficiary</td>
<td>$7,250</td>
<td>$7,250</td>
</tr>
<tr>
<td>Potential Shared Savings (Since Exceeded Minimum Thresholds)</td>
<td>$1,770</td>
<td>$540</td>
</tr>
<tr>
<td>Limited to Maximum Savings Rates (10%/7.5%)</td>
<td>$902</td>
<td>$540</td>
</tr>
<tr>
<td>2% Minimum Savings Threshold</td>
<td>$180</td>
<td>N/A</td>
</tr>
<tr>
<td>Adjusted Shared Savings</td>
<td>$722</td>
<td>$540</td>
</tr>
<tr>
<td>ACO Members</td>
<td>60,000</td>
<td>6,000</td>
</tr>
<tr>
<td>Potential Shared Savings</td>
<td>$43,320,000</td>
<td>$3,240,000</td>
</tr>
<tr>
<td>Maximum Shared Savings Percentage</td>
<td>60%</td>
<td>50%</td>
</tr>
<tr>
<td>Quality/Reporting Adjustment</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>RHC/FQHC Add-On</td>
<td>0%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Actual Shared Savings Percentage</td>
<td>60%</td>
<td>42.5%</td>
</tr>
<tr>
<td>Shared Savings Distribution</td>
<td>$25,992,000</td>
<td>$1,377,000</td>
</tr>
<tr>
<td>Interim 25% Withhold Applied</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>Estimated Annual Payment</td>
<td>$19,494,000</td>
<td>$1,032,750</td>
</tr>
</tbody>
</table>

“A disadvantage is the regulations and the formulas within this proposal are so complex” – Sue Stout Tamme

Another disadvantage is the potential for “a patient to go to a provider outside the ACO,” how does that impact the savings? – John Harrison
CMS strongly believes that, to get real and meaningful change in efficiency and care for patients, ACOs need to be exposed to some risk of shared losses. Therefore, it is requiring all ACOs to become exposed to some risk by at least the third year of their initial agreement period. In addition, while this proposed rule does not address any partial capitation models, it is clear the CMS Innovation Center will continue to design and test partial capitation models and may introduce those concepts in future rulemaking.

Shared losses will be computed similarly to the above shared savings description, with the following exceptions:

- Minimum loss thresholds will be 2 percent for all ACOs.
- Maximum loss rates will be phased in starting at 5 percent in Year 1, 7.5 percent in Year 2 and 10 percent in Year 3; Track 1 ACOs will have a maximum loss rate of 5 percent in Year 3 of their agreement period.
- Shared loss percentage is equal to 1 minus the shared savings percentage.

After the first three-year agreement is completed, a new benchmark will be set for the next agreement period. It is important to realize that cost reductions in the initial agreement period will result in a lower benchmark for the next agreement period. Therefore, ongoing savings may be difficult to obtain while the ACO absorbs increased risk for shared losses. In addition, the proposed regulations preclude future participation in the MSSP for any ACO that generates a shared savings loss for the initial three-year term, so potential ACOs must be ready to effectively manage care when joining the program.

**Anticipated Impact**
CMS is predicting this proposed rule will result in 75-150 ACOs joining the MSSP, generating an overall savings to the Medicare program of $510 million over the 2012-14 period, covering up to 4 million Medicare beneficiaries. The first-year additional operating expense of an ACO is estimated at $1.7 million. The estimated shared savings distributions, net of shared loss repayments, are $760 million over three years.

Coordination of Proposed Regulations with Other Agencies Concurrent with the issuance of the MSSP proposed regulations, several other federal agencies issued proposed regulations regarding potential waivers and interpretations of portions of various statutes primarily related to the shared savings payments and coordination of services associated with participation in an ACO in the MSSP. These proposed regulations included a joint CMS/Office of Inspector General waiver design of the civil monetary penalties law, federal anti-kickback statute and the physician self-referral law; a proposed Antitrust Policy Statement issued by the Federal Trade Commission and Department of Justice; and an IRS notice soliciting comments regarding the need for additional guidance for tax-exempt organizations participating in ACOs. Organizations considering the formation of an ACO are encouraged to further investigate these proposals and consider potential risks associated with these statutes in consultation with their legal representatives.

**Conclusion**
This proposed rule for ACOs to participate in the MSSP may be the first step in significant change throughout the health care industry. Organizations contemplating participation in the program have many factors to consider, but some of the most critical include:

- How strong is the primary care physician complement of our proposed ACO? Primary care is the driver of the beneficiary assignment to an ACO. It will be difficult for an ACO to be successful without a strong primary care physician base.
- What does Medicare reimbursement for our potentially assigned beneficiaries look like over the next few years? Receipt of meaningful use incentive payments, wage index trends and other factors need to be considered when evaluating if future cost savings to the Medicare program can be achieved.
- How effective can your potential ACO be at controlling costs for organizations that are not components of your ACO but provide services to your potentially assigned beneficiaries?
- Is the benefit of shared savings distributions greater than the potential increased cost and oversight of an ACO and assumption of risk on shared losses? Each organization needs to evaluate this early in the process, as formations of ACOs are anticipated to require large time investments by individuals throughout an organization.
- Can my organization have at least 5,000 Medicare beneficiaries assigned based on the plurality of primary care without the ability to include RHC/FQHC services in the calculation?
- For hospitals that employ primary care physicians outside of an RHC, will we be allowed to participate in multiple ACOs under the proposed rules?

Editor’s Note: Jennifer Williams (manager with BKD and member of the KY HFMA newsletter committee) had the opportunity to interview local representatives to get their perspectives on ACO’s.

Signature HealthCARE, LLC
E. Joseph Steier III, President and CEO
John Harrision, CFO
Dr. Dennis Stone, Chief Medical Director

Baptist Healthcare System, Inc.
Susan Stout Tamme, President of the Louisville Market
One only sees trouble, another see opportunity.

During these turbulent times, let our healthcare team work with you to anticipate changes and identify new opportunities to help you successfully navigate to your goals.

DEAN||DORTON||ALLEN||FORD
Lexington Office
106 West Vine St.
Suite 600
Lexington, KY 40507
859.255.2341
For more information visit us at: www.ddafcpa.com
Louisville Office
200 South 5th Street
Suite 201 South
Louisville, KY 40202
502.589.6050

Spring Educational Institute

The HFMA – Kentucky Chapter Annual Spring Educational Institute was held at the Lexington Embassy Suites on March 17 and 18. The institute was well-attended with 132 members present. The opening session included L. Briggs Cochran, President of Benefit Insurance Marketing. Mr. Cochran spoke about the implications to both employees and employers for holding on to previously held health care financing paradigms versus the opportunity for new tactics and strategies. Thursday afternoon’s general session featured Jeanne Scott Matthews, known as “The Jeanne,” who is a frequent speaker at HFMA and provided us with further insight on the Patient Protection and Affordable Care Act.

Breakout sessions included topics such as healthcare strategy and how Reform is affecting providers’ strategies, the new CMS policy of disallowing provider taxes, costs of cybersecurity and its breaches and EHR compliance.

Friday’s general session featured Aaron Beam, a former Healthsouth founder who helped grow Healthsouth into a NYSE Fortune 500 company. This session was the ethics portion of the institute and found by many to be extremely interesting as Aaron Beam spoke about the fraud that occurred at Healthsouth and the corporate culture that allowed the fraud to continue for seven years.

The Thursday night social included trivia, pizza and NCAA basketball tournament action.

Kentucky Chapter HFMA 2011 – 2012 Officers and Directors

On March 17th, Bob Barbier (Past President and former Regional Executive) inducted the following individuals in as officers of the Kentucky HFMA for 2011-2012:

- **President**
  - Chris Woosley

- **President Elect**
  - Theresa Scholl

- **Immediate Past President**
  - Andy Strausbaugh

- **VP Education**
  - Scott Reed

- **VP Communications**
  - Tony Sudduth

- **VP Member Services**
  - Don Frank

- **Secretary**
  - Jeanene Whittaker

- **Treasurer**
  - Kourtney Nett

- **Director**
  - Shawn Adams

- **Director**
  - Joe Ruark

- **Director**
  - Nick Motta

- **Director**
  - Russ Ranallo

The HFMA – Kentucky Chapter Annual Spring Educational Institute was held at the Lexington Embassy Suites on March 17 and 18. The institute was well-attended with 132 members present. The opening session included L. Briggs Cochran, President of Benefit Insurance Marketing. Mr. Cochran spoke about the implications to both employees and employers for holding on to previously held health care financing paradigms versus the opportunity for new tactics and strategies. Thursday afternoon’s general session featured Jeanne Scott Matthews, known as “The Jeanne,” who is a frequent speaker at HFMA and provided us with further insight on the Patient Protection and Affordable Care Act.

Breakout sessions included topics such as healthcare strategy and how Reform is affecting providers’ strategies, the new CMS policy of disallowing provider taxes, costs of cybersecurity and its breaches and EHR compliance.

Friday’s general session featured Aaron Beam, a former Healthsouth founder who helped grow Healthsouth into a NYSE Fortune 500 company. This session was the ethics portion of the institute and found by many to be extremely interesting as Aaron Beam spoke about the fraud that occurred at Healthsouth and the corporate culture that allowed the fraud to continue for seven years.

The Thursday night social included trivia, pizza and NCAA basketball tournament action.
Kentucky Medicaid Receives $2.6 Million to Implement EHR Incentive Program

The Centers for Medicare & Medicaid Services (CMS) awarded the Kentucky Medicaid program approximately $2.6 million in federal matching funds for state planning activities necessary to implement the electronic health record (EHR) incentive program established by the American Recovery and Reinvestment Act of 2009 (Recovery Act).

The Recovery Act provides a 90 percent federal match for state planning activities to administer the incentive payments to Medicaid providers to ensure their proper payments through audits and to participate in statewide efforts to promote interoperability and meaningful use of EHR technology statewide and, eventually, nationwide.

Kentucky will use its federal matching funds for planning activities, including a comprehensive analysis to determine the current status of health information technology (HIT) activities in the state. As part of that process, Kentucky will gather information on issues such as existing barriers to using EHRs, provider eligibility for EHR incentive payments and the creation of a State Medicaid HIT Plan, which will define the state’s vision for its long-term HIT use.

Additional information on implementation of the Medicaid-related provisions of the Recovery Act’s EHR incentive payment program may be found at http://www.cms.hhs.gov/Recovery/11_HealthIT.asp#TopOfPage

Payment Reform: Complexities to Consider

Author: Michael E. Nugent

At a Glance

- Providers and payers should take the following actions to prepare for imminent payment reforms from CMS and commercial payers:
  - Adopt industry standard value-based pricing principles.
  - Identify variations in costs, reimbursement rates, and payment terms within your managed care contracts and day-to-day operations.
  - Establish core, evidence-based costs and payments to cover those core, evidence-based costs.
  - Adopt new delivery tactics to manage a sustainable margin on lower unit reimbursement increases.

Providers and payers alike are concerned about payment reform—both how care will be paid for in the future and what healthcare services will be paid for. Although many agree that the current “pay for production” method will be replaced with “pay for outcomes,” each party seems to be waiting for the other one—or the Centers for Medicare & Medicaid Services (CMS)—to somehow deliver the “magic” value-based fee schedule, bonus structure, or capitation arrangement to get reform moving. With few exceptions, both payers and providers seem to be in a waiting mode. But individual payers and providers cannot simply wait for each other to make the first move. Rather, they need to familiarize themselves with major CMS changes including 30-day bundled readmissions (www.hfma.org/reform), cooperate in an organized fashion to rally around a few core issues, and together begin to implement payment and delivery reforms in their own communities.

Key Barriers to Payment Reform

Providers and payers are hindered, in part, by the immensity of the task.

Provider issues. Consider the magnitude of work providers need to undertake to change what services they are paid for and how they are paid. Most providers have hundreds of contracts with different payers, and the payment methods vary considerably from contract to contract—ranging from cost-based payment to per diems, percentage of charge, and case rates. To complicate matters further, how terms such as case rate are used varies among payers, given the myriad proprietary groupers in place for inpatient services (e.g., APR-DRG, MS-DRG, and DRG), let alone outpatient services (e.g., EAPGs, APCs, and ASCs).

To make matters worse, the managed care staffs of even the largest U.S. health systems are contending with constrained resources and spending the majority of their time tracking down unpaid claims rather than standardizing what and how they are paid. As a result, many
managed care teams simply move from one payer issue or renegotiation to the next without delving into substantive change, thereby introducing even more variability into what and how they are paid by different payers for the same service.

For example, one provider had literally 100 different ways to be paid for an emergency department (ED) visit for a broken leg. The hospital’s unit payment varied widely, depending on the payer, for an identical set of services. At the low end, one payer bundled all the services into a single, low payment of approximately $100, while at the high end, another payer paid the equivalent of $3,500 for a standard 99283 CPT code once all the ancillaries, supplies, and physician and hospital services were added in. In between, dozens of complex payment formulas and grouping logic were applied by various payers, much of which neither the provider nor the payers could audit or monitor to determine whether the correct payment had been made.

One payer paid all imaging, laboratory, supplies, and pharmaceuticals related to the ED visit payment on a percentage-of-charge basis, with an end-of-year settlement based on costs. Other payers used a tiered payment schedule for the ED visit, whereby they would pay 90 percent of charges for the first procedures performed during the ED visit, 50 percent for second procedures, 30 percent for third procedures, and so on.

The chaos came to a head when the provider attempted to pilot some “next-generation” payment approaches, such as shared savings and bundled payments, with some of its commercial payers. In doing so, the provider uncovered many instances of overpayments and underpayments from several of its payers. Correcting these errors took so much time that the provider had to put the well-intentioned “pay-for-outcomes” pilots on hold while it dealt with more pressing issues related to the current payment system.

Payer issues. On the flip side, payers also need to undertake considerable work to change their part in the payment system. Many payers have hundreds, if not thousands, of different ways to determine what they pay for and how they pay providers.

For example, one payer had hundreds of ways it contracted and paid for simple lab tests. For tests processed at large reference laboratories, the payer reimbursed those labs a relatively low percentage of Medicare rates in return for “steering” volume from high-cost, hospital-based labs to these lower paid reference labs. For smaller labs owned by physicians, the payer had negotiated hundreds of different prices, from less than 100 percent of Medicare rates to several times Medicare rates, depending on the physician lab and when the contract was last updated. When these lab tests were combined with other services, such as ED services, the payment became significantly more complex and variable, even though the basic cost and resources used to perform the tests were the same. As a result, the payer paid from a few dollars to several hundred dollars for the exact same service, depending on the provider, how the service was billed, and how the service was delivered to the patient.

When this issue came up as part of the payer’s annual rate setting and planning process, value-based payment for lab services received less priority than other, more pressing opportunities to renegotiate rates that had a larger ROI than establishing lab rates that paid for outcomes.

Payment Reform: The Need for Common Ground
The barriers to payment reform, such as lean staff and complex contracts and fee schedules, are quite real. Despite good ideas and even better intentions, neither providers nor payers can change the system overnight. Rather, a multifaceted approach to payment reform is needed. Providers and payers should work together to achieve payment reform by taking the following actions.

Adopt common value-based pricing principles. Payers and providers should review two HFMA reports: Reconstructing Hospital Pricing Systems (2007) and Healthcare Payment Reform: From Principles to Action (2008). In Reconstructing Hospital Pricing Systems, HFMA describes several characteristics of a rational and transparent pricing system to guide the national payment reform effort, including:

- Meaningful, timely, and relevant information
- Simplicity
- Comparability of price and quality
- Ease and equity of administration
- Equity for providers
- Defensibility
- Protection of community benefit activities
- Fairness to consumers

In Healthcare Payment Reform: From Principles to Action, HFMA discusses five principles of a new payment system:

- Quality
- Alignment
- Fairness/sustainability
- Simplification
- Societal benefit

Now Tracking Your Cash is Easier.

NPAS NATIONAL PATIENT ACCOUNT SERVICES

www.npasweb.com/hfma OR CALL 1-866-882-3582
These characteristics and simple principles support payment reform efforts by encouraging providers and payers to put patients first and seek ways to reward top providers for strong performance.

Identify cost, rate, and payment term variations within your contracts and day-to-day operations. Payers and providers should work together to review their current contracts and identify which contract language, terms, utilization, and rates are “outliers”—that is, things that would not stand up well to public scrutiny.

For example, they should identify:

- Huge discrepancies in how payment is calculated for the same service or the amount paid and collected (e.g., charging some patients $50 and others $5,000 for the same service, depending simply on what insurance they have)
- Obvious areas of overuse, misuse, and underuse of resources, such as duplicative tests, excessive inpatient days, and use of high-cost sites of care when lower-cost sites exist
- Onerous payment and/or prior authorization terms that impede patient care more than they deter abuse

Beyond reviewing their contracts, payers and providers should also analyze their claims data to identify and then quantify the cost and revenue implications of overuse and misuse of resources, and very high reimbursement rates compared with the rest of the market.

Establish core, evidence-based costs and payments to cover those costs, rather than paying for avoidable costs and complications. Providers and payers are increasingly adopting new algorithms such as PROMETHEUS to quantify avoidable costs and complications across the care continuum for particular high cost episodes. These algorithms are allowing providers to look beyond traditional variable cost-cutting opportunities in supplies and begin to quantify the cost and revenue implications of excessive days, readmissions, complications, and errors. This effort in turn will allow payers and providers to begin to establish core, evidence-based costs to cover particular conditions on a risk adjusted basis. These analytics also help payers and providers jointly identify specific tactics to reduce avoidable costs and complications over time and share the benefits of lower costs with the purchaser of the insurance and patients. For example, payers and providers are working together to lay out standard protocols for various joint procedures, quantifying the input costs to deliver those procedures, and then putting together a fair and reasonable market-based price and incentive plan to improve both efficiency and quality.

Adopt delivery tactics to manage a sustainable margin on payment rates that cover core, evidence-based costs. Payment reform and delivery reform need to occur in a coordinated fashion if payers and providers are to bend the trend in a sustainable manner that generates adequate margins. Unfortunately, providers are struggling to implement the delivery changes necessary to survive on lower unit payment increases. Although many are saying they have all the pieces in place to manage under a new payment model, such as shared savings and capitation, in reality, only a few appear to have the delivery system to systematically reduce avoidable costs and complications and in return, reduce the size of cost increases in a sustainable manner.

To illustrate this point, think of the car you drive. The car consists of myriad parts. The parts, however, do not constitute a useful mode of transportation, unless they are configured to specification, tuned, fed, and cared for. But if you put bad fuel in the tank, even the best-configured car will fail to operate properly. That is the case with the current payment and delivery system. Even the best-tuned health systems find that the fuel—payment—gums up the delivery of care, in part due to the incentives it creates.

But payment aside, much of the current delivery system operates as a series of independent components (e.g., physician-hospital organizations, multispecialty groups, primary care physicians, skilled nursing facilities, home health agencies, and inpatient hospitals). Even the most rational payment model (fuel) cannot enable the delivery system to reform itself overnight. Until providers’ and payers’ finance executives start to reform payment and delivery simultaneously, with a focus on patient and caregiver, payment reform will continue to exist in its own silo, resulting in further fee schedule cuts rather than a major move toward true value-based payment.
Energy Management: Opportunities and Challenges for the Healthcare Industry

Author: Richard Smith

The recession has forced everyone in healthcare organizations, from C-level executives to facility operations and finance executives, to keep closer tabs on where operating dollars are invested. Many healthcare organizations have implemented cost savings measures that have forced them to make important decisions related to building maintenance and staffing.

Despite economic ambiguity, one area of operations that continues to be top of mind with senior leaders is energy management, according to a recent survey.

In partnership with the International Facility Management Association (IFMA) and the American Society of Healthcare Engineering (ASHE), the Johnson Controls Institute for Building Efficiency conducted the fourth annual Energy Efficiency Indicator (EEI) survey in March 2010. The EEI study polled 2,882 CEOs, CFOs, real estate leaders, and facility managers from a range of organizations, including small businesses, public sector institutions, and healthcare organizations.

Healthcare Organizations Focus on Energy Efficiency

What the survey found is quite simple. Across all industries, organizational energy management remains a top priority for leaders. In fact, across all industries surveyed in North America, 52 percent of respondents indicate energy management to be very or extremely important to their organization. In the healthcare industry, the topic was of even greater concern, with 58 percent of respondents indicating energy management at this same level of importance.

The healthcare segment comprised 20 percent of all North American respondents. Of these, 85 percent were members of ASHE. According to the study, the majority of healthcare professionals not only believe energy management should be a priority, but also plan to make facility improvements over the next year to support these priorities. Sixty-seven percent reported that they are planning to make a capital investment in energy efficient facility improvements over the next 12 months, compared with only 52 percent of all North American respondents.

Motivating Factors for Energy Efficiency Improvements

Why the sudden focus on energy efficiency? The answer is twofold. First, healthcare organizations, like other institutions, have seen the green movement take off. Employees and the community expect hospitals and health systems to have standards for increased sustainability in place and to be committed environmental citizens.

Second, healthcare organizations know that energy efficiency, when implemented in a strategic manner, can reduce long-term costs and create a safer and more comfortable environment for patients.

According to the EEI survey, 65 percent of respondents reported they are paying more attention to energy-efficiency-related topics than they were one year ago. They are looking closely to identify which solutions are worth exploring to continue to provide the finest patient care while finding ways to reduce costs and environmental impact.

A growing number of healthcare organizations are also aiming to either certify their buildings to a recognized green building standard such as those available by the United States Green Building Council, or incorporate green elements into their new construction projects. Since 2008, the percentage of organizations that consider this certification a priority has risen from 72 to 80 percent.

Healthcare leaders recognize what colleges, universities, schools, and major corporations have learned from improving and leveraging their green initiatives. These programs help enhance brand image. Being able to promote a facility—whether a small community hospital or a regional player—as energy-efficient, sustainable, and state-of-art helps attract the staff, patients, and donors who want to be a part of a progressive organization. Seventy-two percent of respondents indicated this to be a major motivator for investing in energy efficiency.

But according to respondents, the most important factor motivating the healthcare industry to explore energy efficiency investments is cost reduction. Nearly all respondents (99 percent) indicated this is the primary reason to invest in energy efficiency.

For hospitals with sophisticated medical equipment critical to patient care, energy costs can be astronomical. Administrators are constantly exploring ways to reduce costs, exploring myriad options—from more efficient lighting to renewable energy solutions such as solar panels—to help defer costs.

Although current energy costs are high, respondents also believe they haven’t hit their peak yet. The survey found that 60 percent of healthcare decision makers expect energy costs to rise over the next 12 months.

What’s Being Done to Keep Costs Down?

The survey asked respondents to indicate measures they have implemented over the past 12 months to reduce costs. By far the most popular measure among healthcare leaders was to switch to more energy-efficient lighting, ballasts, and lamps in their facilities, with 73 percent of respondents indicating they have begun these improvements, as shown in the exhibit below. In facilities that are open all day and night, inefficient lighting can easily cause energy costs to soar. By installing energy-efficient bulbs, facilities can quickly reduce costs.

Many facilities also have focused on improving their heating, air conditioning, and ventilation (HVAC) systems and lighting systems account for approximately 60 percent of all energy used in traditional buildings. So it is no surprise that improvement to HVAC controls is the second highest priority for facilities, with 57 Energy Management: Opportunities and Challenges for the Healthcare Industry percent of respondents indicating they have made improvements over the past year.

These top two improvements alone can help healthcare facilities move a long way toward energy efficiency. Additional improvements that respondents have implemented over the past 12 months include upgrades or improvements of building automation systems (56 percent), which can help all lighting, security, and temperature controls to operate under a single platform, eliminating redundancies. Replacement of inefficient equipment (41 percent) and installation of occupancy sensors (56 percent) were among the more common improvements made in the past year. Retrocommissioning, which identifies low-cost operational and maintenance improvements in existing energy-using systems such as lighting and mechanical equipment to optimize system performance rather than overhauling major equipment, continues to gain traction in health care. Nearly a quarter (23 percent) of respondents have implemented retrocommissioning of these systems in the past 12 months, up 7 percent from 2008.

Healthcare facility managers have also begun embracing new technologies that continue to grow in popularity and align with...
clean energy solutions. Seventeen percent of respondents indicate they’ve invested in personal computer or IT management in the past 12 months, 9 percent have installed energy and carbon information management systems, 5 percent have turned to an on-site renewable energy system, and 4 percent even have vegetative green roofs to further support their environmental missions. The evolution of these products is likely to continue.

The Challenge: Financing
The EEI study found that energy efficiency investments remain top of mind with healthcare leaders, and many have taken initial steps over the past year to begin the process toward energy efficiency. However, organizations face several barriers preventing them from investing to their desired extent to reach the full savings potential. The largest of these barriers is financing.

Nearly half (45 percent) of healthcare respondents cited a lack of capital budget as the primary barrier to making increased energy-efficiency investments. Additional dollars that could be used toward efficiency and greening investments simply do not exist, which can make paying for energy-efficient improvements challenging.

Also, most healthcare organization boards want to see an ROI. The survey found that 35 percent of leaders say a primary barrier to investing in energy efficiency is insufficient paybacks or uncertainty that the projected ROI would be realized, which is magnified even more in the current difficult credit environment. From 2008 to 2010, the average maximum allowable payback for investments dropped from 3.8 years to 3.4 years. This tough credit environment and narrowing hurdle rates within healthcare organizations will continue to impede investment.

Financing Options to Make It Work
Among these challenges, optimism exists to make energy efficiency a priority. More than three-fourths (76 percent) of respondents plan to pay for energy efficiency improvements over the next 12 months through the capital budgets of their facilities. Planning will be key in these instances to identify what can be done in the short term.

Yet to finance longer-term improvements, new financing vehicles are now on the table for industry facilities. Twenty-one percent of respondents hope to turn to grants or tax credits to pay for improvements, but other options need to be considered to help remove some of the barriers for building upgrades.

Today, retrofit projects that replace older building equipment with more energy-efficient systems are easier to capitalize, less risky for building owners and lenders, and mutually beneficial for building owners, tenants, and, in the case of healthcare facilities, the community. Several options that are viable and of different levels of interest, based on the survey, require no up-front capital.

Energy savings performance contracts were the most popular option being considered by respondents after grants, with 18 percent indicating they would explore this option. These contracts help building owners guarantee energy savings over the term of the contract that can repay capital costs, in most instances. The energy service company repays any savings not offset by reduced energy and operating costs.

Power purchase agreements allow businesses to receive money for capital improvement projects that improve energy efficiency with no up-front cost. A hospital would agree to the installation of third-party photovoltaic panels or a high-efficiency central heating and cooling plant in exchange for purchasing the resulting energy or chilled and heated water. The third party would incur the construction costs. Ten percent of respondents planned to consider this financing option over the next 12 months.

A third option some healthcare professionals indicated they would explore is shared savings agreements (7 percent). With this option, the energy service company sells a portfolio of building improvements to a third-party ownership company. The owner receives the energy and operational savings and remits a set percentage in monthly payments back to the third-party company, which retains the balance of the savings.

The typical term of a shared savings agreement is 10 to 12 years, after which the building owner takes possession of the improvements and retains all consequential savings. Customer benefits include improved environmental stewardship, improved facilities performance, and improved financial performance.

Other financing options include capital or municipal leases, property assessed clean energy (PACE) tax lien financing, and utility on-bill financing (OBF). Each has its own pros and cons that may be appropriate for healthcare professionals. Healthcare finance executives should explore the options to determine which might best meet their organization’s needs.

What the Future Holds
The healthcare sector, like many other sectors, faces a number of challenges. Rising energy costs, financing questions, and the increased importance of meeting the demand to do good while saving money and the environment can be daunting to healthcare leaders.

The light at the end of the tunnel is that energy efficiency can be both rewarding and financially beneficial to any healthcare system. The EEI survey shows that energy efficiency remains a priority and something that is not going away in the United States or around
Focus on Quality: How Value-Based Purchasing Will Affect Hospitals

Author: Andy Williams, BKD, LLP

With the passage of the Affordable Care Act (ACA) in 2010, Congress directed the Centers for Medicare & Medicaid Services (CMS) to implement a Value-Based Purchasing (VBP) program. The goal of VBP is to revamp how Medicare services are paid to better reward value, outcomes and innovations instead of basing payment merely on volume. Proposed regulations released by CMS in the January 13, 2011, Federal Register give providers a first look at how CMS plans to implement VBP and provide quality incentives.

As proposed, the VBP program generally applies to all short-term acute care hospitals other than critical access hospitals. Other hospital types excluded from VBP include psychiatric, rehabilitation, long-term care, children’s and cancer hospitals. The VBP program also does not apply to hospitals that have not reported quality data under current regulations and, therefore, already have received a 2 percent Medicare payment reduction.

CMS proposes that, beginning with federal fiscal year (FFY) 2013, i.e., payments for discharges on or after October 1, 2012, hospital operating diagnosis related group (DRG) payments will be reduced by 1 percent to create a VBP payment pool. The reduction will increase 0.25 percent per year to a full reduction of 2 percent in FFY 2017. This reduction will be reallocated to hospitals in a budget-neutral manner based on each hospital’s total performance score under the proposed VBP measurement criteria. The VBP payment will be made by increasing each hospital’s base DRG payment amount by its VBP incentive payment add-on. CMS proposed using the “Three Domains of Care” approach to assess quality, which includes clinical process of care measures, outcome measures and patient experience survey results. For FFY 2013, the program will only include the clinical process of care and the patient experience survey domains, with the outcome measures domain starting in FFY 2014. CMS will determine a hospital’s “total performance score” based on its results in each of the three domains.

Clinical Process of Care & Outcome Measures
Under the clinic process of care and outcome measure domains, hospitals will earn two scores for each performance measure an achievement score and an improvement score. The achievement score will be based on a hospital’s performance on each measure compared to other hospitals during that reporting period, while the improvement score will compare the hospital’s current measures to those achieved in the baseline period.

The clinical process of care and outcome measures will focus on four topics: Acute Myocardial Infarction (AMI), Heart Failure (HF), Pneumonia (PN) and Surgical Care Improvement (SCIP). For a complete listing of clinical processes included, Seventy percent of a hospital’s total performance score will be based on the 17 clinical processes of care and outcomes measures (once implemented). In instances where the hospital has fewer than 10 cases in any measurement category, that category is excluded from the total possible points. Because CMS must determine each hospital’s VBP incentive add-on before the start of an FFY, it has proposed to use measurement and baseline periods for the nine months ending March 31 of each year. The initial baseline period is July 1, 2009, to March 1, 2010, and the initial performance period is July 1, 2011, to March 31, 2012.

For each measure, CMS will set an achievement threshold and benchmark threshold. The achievement threshold represents the median score of all hospitals on a particular measure during the performance period. The benchmark threshold represents the performance mark equal to the mean of the top decile of hospitals for that measure during the performance period.

For the achievement score, CMS will use a 10-point scoring method for each measure. Hospitals exceeding the benchmark would receive 10 points for the measure. Hospitals scoring above the achievement threshold but below the benchmark would receive between one and nine points, depending on its location within that range. Hospitals failing to reach the achievement threshold would receive no points for the achievement score.

For the improvement score, CMS will also use a 10-point scoring method. Hospitals exceeding the benchmark will receive a 10-point score. In addition, CMS will establish a hospital-specific improvement range using a hospital's baseline performance. A hospital improving its score on a measure will receive one to nine points, based on a sliding scale between the performance in the baseline period and current period benchmark.

Hospitals will receive the higher of the achievement or improvement score for each measure. The sum of these scores is aggregated and divided by the possible total points—10 points for each category that applies to the hospital.

CMS intends to expand the clinical process of care measurements in future years. Beginning in FFY 2014, it will include three mortality outcome measures currently reported on the Hospital Compare website: MORT-30-AMI, MORT-30-HF and MORT-30 PN. Additional current and long-term priority topics include prevention and population health, safety, chronic conditions, high-cost and high-volume conditions, elimination of health disparities, healthcare associated infections and other adverse healthcare outcomes, improved care coordination, improved efficiency, improved patient and family experience of care, effective management of acute and chronic episodes of care, reduced unwarranted geographic variation in quality and efficiency and adoption and use of interoperable health information technology.

Before additional topics can be added to the specific clinical process of care and outcomes, each must be published on the Hospital Compare website (www.hospitalcompare.hhs.gov) for one year. CMS has suggested new measures will be implemented to have their respective performance period begin immediately after the display period on the website is complete.

Patient Experience Score
The remaining 30 percent of the VBP payment will be based on a patient experience score as determined through a survey. CMS will
use the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey (www.hcahpsonline.org), which contains 18 core questions about critical aspects of patients’ hospital experiences. These items include communication with nurses and doctors, responsiveness of hospital staff, cleanliness and quietness of the hospital environment, pain management, communication about medicines, discharge information and overall rating of the hospital.

The random survey is administered to a sample of adult patients across medical conditions between 48 hours and six weeks after discharge and is not restricted to Medicare beneficiaries. Each of the questions is grouped into eight dimensions and compared to the related achievement performance standards of the 50th and 95th percentile. Hospitals with ratings above the 95th percentile will receive 10 points. Ratings between the 50th and 95th percentile will receive one to nine points, and those below the 50th percentile will receive no points. Hospitals also will be scored based on improvement; hospitals will be awarded between one and nine points if their scores improve over their baseline period. The higher of a hospital’s achievement or improvement score will be awarded, with a maximum of 80 points.

The scoring process also includes a consistency variable, where hospitals earn consistency points ranging from zero to 20 points based on how many of their dimension scores meet or exceed achievement thresholds. If all dimensions are above the 50th percentile, the hospital will receive 20 points. The total patient experience score is equal to the sum of dimension points and consistency points, for a total of 100 possible points.

**Total Performance Score**

The total performance score is determined by combining the clinical process of care and outcomes score (weighted at 70 percent) and the HCAHPS survey results (weighted at 30 percent). The total performance score is then ranked in linear scale with other hospitals to determine incentive payments. Hospitals with a higher total performance score will receive higher incentive payments than those with lower scores. Currently, all hospitals will be ranked together. There is no differentiation between hospitals for size or Medicare designations such as urban, rural, sole community or Medicare dependent hospitals.

**Other Matters**

Hospitals will be notified of their preliminary VBP score no later than August 1, 2012, via CMS QualityNet accounts. CMS will notify hospitals of their final VBP score by November 1, 2012, and hospitals will have 30 days to review and submit correct information. CMS will adjust payment rates for the VBP incentive amount starting January 1, 2013, with retroactive adjustments for any FFY 2013 discharges paid prior to January 1, 2013.

CMS proposes to validate the accuracy of quality data submissions through random selection of hospitals and will select approximately 20 percent of hospitals and request 12 cases per quarter. CMS will re-abstract the quality measure data elements and compare the results to information submitted by the hospital. The hospital must achieve a correlation of at least 75 percent for its data to be considered reliable. If the hospital fails to meet this 75 percent mark, CMS will treat the hospital as if it did not report quality data and reduce payments by 2 percent.

Hospitals should take the following steps now to prepare for VBP:

- Review current hospital clinical care and outcome measures and survey of patients’ hospital experiences as submitted and reported on the Hospital Compare website to national averages.
- Identify those clinical care and outcome measures below national averages and focus on how to increase these measures for the upcoming performance period beginning in July 2011. Remember hospitals are not only awarded for absolute outcomes, but also improvement compared to the baseline period.
- Review quality data submitted for accuracy and completeness as presented on the Hospital Compare website. Hospitals may want to engage outside assistance to validate their information.

**Energy Management: Opportunities and Challenges for the Healthcare Industry, Continued from page 10**

As leaders in the industry, healthcare finance executives have an opportunity to continue to lead the way as pioneers for energy efficiency. They should realize the challenges ahead, but also appreciate the opportunities that energy efficiency and, ultimately, energy independence can mean to their organizations. Their livelihood and ability to continue to deliver the best patient care will continue to grow when energy efficiency is realized.

Richard Smith is director, energy solutions healthcare, Johnson Controls, Milwaukee (richard.w.smith@jci.com).
Gathering Occupational Mix Survey Data
By Jeff Vanek, BKD, LLP

The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000, requires the Centers for Medicare & Medicaid Services (CMS) to collect data every three years on the occupational mix of employees for all short-term acute care hospitals participating in the Medicare program. Please note occupational mix survey (OMS) data collection is not required for critical access hospitals, no- or low-Medicare utilization hospitals or hospitals that terminated participation in the Medicare program before January 1, 2010. The purpose of the data collection is to construct an occupational mix adjustment factor (OMAF) that will be applied to the federal fiscal year (FFY) 2013 wage index.

This year’s OMS is due to your Medicare Administrative Contractor (MAC) by July 1, 2011. The OMS will include data for a 12-month period and must include only pay periods ending between January 1, 2010, and December 31, 2010. Accrual basis accounting and your fiscal year-end must be ignored in completing the OMS. The OMS form and instructions are available on the CMS website. (Note: CMS included the instructions as the second tab of the survey.) It is important to carefully follow the instructions and apply the instructions for Worksheet S-3, Part II, “Medicare wage index form,” in completing the OMS.

The OMS requires hospitals to report salaries and hours for the following occupational categories:

- Registered nurses
- Licensed practical nurses and surgical technologists
- Nursing aides, orderlies and attendants
- Medical assistants
- All other occupations

In addition, the OMS requires contract labor and home office information to be reported as appropriate within these categories. Note the survey does not include all hospital departments/cost centers, so the instructions need to be reviewed carefully.

The OMS is an integral part of the wage index. Nursing salaries as a percentage of nursing and all other salaries are the portion of the adjusted wage index adjusted by the OMAF. The nursing hours are used to compute the overall nursing average hourly wage (AHW). Hospitals reporting a nursing AHW higher than the national AHW will have an OMAF less than 1. Hospitals with a nursing AHW lower than the national AHW will have an OMAF greater than 1. It is beneficial to have an adjustment factor greater than 1. Until the OMS is computed for all hospitals, the adjustment factor will not be known. However, information from the FFY 2011 inpatient rules regarding the average hourly wage for the nursing categories, as well as the previous OMS calculator on the CMS website, are useful tools in estimating OMAF.

CMS estimates it will take more than 400 hours to complete the OMS, so we encourage all prospective payment system (PPS) hospitals to begin this process soon. Small changes in the calculated occupational mix can strongly affect a hospital’s PPS payments. Therefore, we recommend careful completion of the data with consideration given to the OMS instructions and the wage index instructions.
KY HFMA Chapter Leadership
2010 - 2011
Officers and Directors

President
Andy Strausbaugh
Norton Brownsboro Hospital

President Elect
Chris Woosley
Baptist Healthcare System, Inc.

Immediate Past President
Bill Jones
Methodist Hospital

VP Education
Theresa Scholl
Clark Memorial Hospital

VP Communications
Elaine Younce
University of Kentucky Hospital

VP Member Services
Mike Yadav
St. Elizabeth Medical Center

Secretary
Jeanene Whittaker
Bottom Line Systems, Inc.

Treasurer
Scott Reed
Blue & Co., LLC

KHA Liaison
Steve Miller
Kentucky Hospital Association

Regional Executive
Catherine Zito
FHFMA, CPA Region IV

Director
Shawn Adams
Clark Memorial Hospital

Director
Autumn McFann
King’s Daughters’ Medical Center

Director
Rob Moore
Appalachian Regional Healthcare, Inc.

Director
Carl Herde
Baptist Healthcare System, Inc.

Committee Chairs

Certification/Career Advancement Chair
Cindy Sharp
cshart@fmhhhs.com
(812) 949-5690

Corporate Sponsorship Chair
Tony Sudduth
tsudduth@tjsamson.org
(270) 651-4114

Entertainment Chair
Meg Edwards
megedwards@credit-bureau.com
(859) 252-0011 ext 239

Information Systems Chair
Chris Graff
cgraff@bkd.com
(502) 581-0435

Membership Directory Chair
Don Frank
dfrank@onlinebls.com
(859) 578-6858

Newsletter Chair
Jeff Presser
jpresser@ddafhealthcare.com
(502) 244-6440

Outreach & PR Chair
Tony Miranda
tmiranda@seniorcare-corp.com
(502) 753-6034

Rural Healthcare & Reimbursement Chair
Dan Rice
drice@blueandco.com
(502) 992-3500

Student Membership Chair
Matt Fulton
mfulton@healthcarestrategygroup.com
(502) 814-1191

Yerger Awards Chair
Katie Black
katie.black@na.firstsource.com
(502) 499-0855 ext 3117
EDITORIAL POLICY
Opinions expressed in articles or features are those of the author and do not necessarily reflect the view of the Kentucky Chapter, the Healthcare Financial Management Association, or the Editor. The Editor reserves the right to edit material and accept or reject contributions whether solicited or not. All correspondence is assumed to be a release for publication unless otherwise indicated.

EDITORIAL MISSION
The Financial Diagnosis supports the mission of the Kentucky Chapter by serving as a key source for individuals involved in or interested in the financial management of healthcare.

PUBLICATION OBJECTIVE
The Financial Diagnosis is the official publication of the Kentucky Chapter HFMA and is written and edited principally to provide members with information regarding Chapter and national activities, current and useful news of both national and local significance, information about seminars and conferences and networking with colleagues, and to serve as a forum for the exchange of ideas and information.

ARTICLE SUBMISSION
The Financial Diagnosis encourages submission of material for publication. Articles should be typewritten and submitted electronically to the Editor by the deadlines listed below. The Editor reserves the right to edit, accept or reject materials whether solicited or not.

HFMA - Kentucky Chapter Sponsors
HFMA of Kentucky thanks the following sponsors who have made this year’s newsletter possible:

**Platinum Sponsorship**
- BKD, LLP
- Blue & Co., LLC
- Commerce Bank *
- Dean Dorton Allen Ford, PLLC
- HCA – National Patient Account Services (NPAS)
- MedAssets *

Gold Sponsorship
- Chamberlin Edmonds & Associates, Inc.
- Credit Solutions
- Ernst & Young, LLP
- MedShield, Inc.
- Wyatt, Tarrant & Combs, LLP

Silver Sponsorship
- ClaimAssist
- Cleverly & Associates *
- Franklin Collection Services, Inc.
- McBee Associates, Inc.
- PNC Bank *
- TechSolve

Bronze Sponsorship
- Baker Healthcare Consulting, Inc. *
- Bank of America
- Credit Bureau Systems, Inc.
- DECO
- Dressman, Benzinger & LaVelle, PSC
- Franklin Collection Services, Inc.
- GLA Collection Company
- Healthcare Strategy Group, LLC *
- Harris & Harris
- Helvey & Associates
- Mountjoy Chilton Medley, LLP
- Principal Group *
- Quadax

* Kentucky Chapter HFMA would like to give a special thanks to these new Sponsors for 2010-2011