

## HEALTH CARE

## POSSIBILITIES



## inside

## Enterprise Risk Management Aligns With Strategy

### OVERVIEW

The health care environment is driving the need to align risk management with organizational strategy and incorporate practices into the management of day-to-day operations. This article explains how enterprise risk management can help executive management and boards of directors address all forms of risk that may affect an organization.

How prepared was your facility for the H1N1 outbreak? Do you have the proper safe guards within your information systems to protect your patients and enforce HIPAA requirements? How has your organization prepared for the growing population of uninsured and the associated rise of bad debt? Is the aging of your nursing or physician staff creating a concern for the ability to recruit fast enough in the midst of a health care provider and nursing shortage? What is the age of your current facility, and when will you need to consider a replacement?

Risks to a health care organization come from external and internal factors, and today's health care executives need to take a portfolio approach to

addressing these risks. Enterprise risk management (ERM) is an integrated approach for executive management and boards of directors to address all forms of risk within an organization. This process continues to evolve from the lessons learned in the insurance and banking industries as an answer to world events that demanded a compliance response.

Today, ERM is an internationally recognized method with tools and standards for organizations to apply based on their needs. ERM is breaking the traditional boundaries of how risk has been historically managed in silos within an organization. Traditional risk management utilized "reactive" approaches, which limited visibility throughout the organization to create a well managed strategy for addressing risks in a timely manner. ERM takes a "proactive" approach to managing risks at the top level of the organization, so the impact is minimized and the value maximized.

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## 2010 Medicare Physician Fee Schedule

### Same Song, Second Verse

#### OVERVIEW

This article provides an overview of annual updates to the Medicare Physician Fee Schedules, which bring significant changes to the conversion factor, work geographic practice cost indices, consult codes and the “Welcome to Medicare” exam.

The 2010 annual update to the Medicare Physician Fee Schedule (MPFS) was released as a Final Rule by the Centers for Medicare and Medicaid Services (CMS) on October 30, 2009. The 2010 fee schedule updates include a new payment conversion factor for 2010, significant code deletions and revisions to the Relative Value Units (RVUs). Expansive discussions are available in the medical management literature (and on the Internet) for each of these areas. The following information highlights a few of the changes with significant impact on physician reimbursement.

The Medicare payment conversion factor was initially set to receive a 21.2 percent reduction under the Sustainable Growth Rate (SRG) formula adopted by Congress in 1997. However, a two-month pay fix was passed by Congress and signed by President Obama on December 19, which holds the conversion factor at \$36.0846 until the end of February, 2010, close to the 2009 rate. The intent is Congress will pass a more permanent fix to the conversion factor reductions demanded by the SRG by this time, or the payment conversion factor will revert to the final rule amount of \$28.3895.

While Congress passed a two-month pay fix for the conversion factor, they let the minimum work geographic practice cost indices (GPCIs) floor of 1.000 expire on January 1. This will result in a reduction of the work GPCI for 54 of 90 localities. The table to the left details some of the more significant reductions. While the Senate’s version of the health reform bill would extend the 1.000 floor until 2011, the House version has no such provision. The outcome here remains uncertain, except that pay disparities between geographic localities will persist.

Also finalized was the elimination of inpatient and outpatient consult CPT codes in the 2010 Final Rule (CPT codes 99241 to 99245). CMS approached this as a budget neutral revision to the MPFS, so corresponding inpatient and office visit work RVUs received modest increases, with

an average increase in WRVUs for established office visits of 5.8 percent and inpatient visits of 2.1 percent. This change is binding only for Medicare patients, but other payers are expected to eventually follow. Providers should check with each payer to determine required codes for reimbursement. If Medicare is a secondary payer and consult codes were used when billing the primary insurer, Medicare will deny secondary payment.

Finally, CMS finalized the increase in payment for the Initial Preventive Physician Examination (IPPE), also known as the “Welcome to Medicare” exam. The work RVU for this service (HCPCS code G0402) will increase from 1.34 to 2.30, an increase of 71.6 percent. It should be noted that this exam must be provided within the first 12 months of enrollment in Medicare and includes several required services.

Unfortunately, this year’s updates may sound like the same old song of shrinking Medicare payments. Many other changes to the MPFS have been implemented over the past three months, so it is important to keep up with these changes through Medicare carrier updates or your professional journals. Also, remember that while Medicare is a significant payer for only some physician groups, where Medicare leads, other payers often follow. ■

Locality	Cut
Puerto Rico	9.6%
South Dakota	5.8%
North Dakota	5.3%
Rest of Missouri	5.1%
Montana	5.0%
Wyoming	4.4%
Mississippi	4.1%
Nebraska	4.1%
Arkansas	3.9%
Rest of Maine	3.8%
Oklahoma	3.6%
Iowa	3.5%
Idaho	3.3%



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## Are You Compliant with the Latest Credit Card Data Security Standards (PCI Compliance)?

Health care providers are certainly no stranger to data privacy and security standards, especially those standards related to HIPAA. While many health care providers are well versed in the HIPAA security standards, very few are aware of another major compliance standard they must comply with if accepting credit cards for payment, which is the Payment Card Industry Data Security Standard, commonly referred to as PCI compliance.

The Payment Card Industry Data Security Standard (PCI DSS) was designed by five major card brands which include Visa, MasterCard, American Express, Discover and JCB. The objective of the standards is to protect customer privacy and credit card information. Traditionally, PCI compliance has only received attention from the major retailers. However PCI compliance is not only for retailers—it affects any organization that takes credit cards for payment, including health care organizations.

Many health care organizations may not realize the large quantity of credit card transactions they are processing across the many different areas of their organization. Health care organizations may process credit card information at registration and admittance areas, pharmacies, gift shops, cafeterias, in-room services and/or online billing and payment processes. Regardless of how, when or why they are taking a credit card for payment, health care organizations must be PCI compliant.

The requirements for PCI compliance vary by organization. The variance is based on the number of transactions processed in addition to how the transactions are processed, transmitted or stored. Any health care organization that processes more than 6 million card transactions per year is considered a Level 1 merchant (L1) and must complete an annual on-site assessment, an annual external vulnerability scan (performed

by an Approved Scanning Vendor) and submit a Report on Compliance (signed by a PCI-DSS Qualified Security Assessor (QSA) Company or a C-level officer of the company). Organizations which fall within Levels 2 through Level 4 (L2-L4) are required to audit their card processing environment and submit an annual self-assessment questionnaire indicating compliance, as well as complete an external network vulnerability scan (performed by an Approved Scanning Vendor).

The last thing most health care organizations want to be concerned about is another compliance regulation; however, because the data security standards for PCI compliance are built upon security best practices, some of the requirements of PCI DSS are likely being met if the health care organization is complying with the HIPAA Security Rule.

*Credit Card—continued on page 8*



### OVERVIEW

PCI compliance affects any organization that takes credit cards for payment—including health care organizations. This article explains the requirements, and how your organization can ensure compliance.



*Traditionally, PCI Compliance has only received attention from the major retailers. However PCI Compliance is not only for retailers—it affects any organization that takes credit cards for payment, including health care organizations.*

## What are the Next Steps for 403(b) Plans?

### OVERVIEW

Over the past year, changes in the Internal Revenue Code (IRC) have had a major impact on 403(b) plans. This article discusses procedures and protocols employer sponsors should establish to ensure the plan remains in compliance.

Over the past year, changes in the Internal Revenue Code (IRC) have had a major impact on 403(b) plans. These 403(b) regulation changes became generally effective for plan years beginning after December 31, 2008. By now, employers sponsoring a 403(b) plan should have completed the following:

- Adopted a written plan.
- Implemented contribution limits as defined in IRC 401(k).
- Complied with timely contribution remittance regulations (transferring employee deferrals to the plan within 15 business days following the month in which they were deducted).

With the new regulations, the employer sponsor will want to make sure procedures and protocols have been established to ensure the plan remains in compliance, in order for its tax-deferred status to be maintained. Plan sponsors should review the following to ensure their current practices are in compliance: written plan, universal eligibility, contribution limit, nondiscrimination rules and distributions.

### Written Plan

Effective December 31, 2009, all 403(b) plans must have a written plan that contains all the terms and conditions for eligibility, limitations

and benefits under the plan. This written plan can be comprised of several documents, including salary reduction agreements, various contracts that fund the plan and administrative procedures. If several documents from different sources are incorporated in the written plan, it is important to ensure there are no conflicts between documents incorporated by reference. If the plan offers loans or hardships, this documentation should include the requirements for such distributions and the protocols for processing them.

### Universal Eligibility

The nondiscrimination rule for eligibility to defer income in a 403(b) plan is known as universal eligibility. Generally, all employees must be eligible to make contributions, and everyone must receive notice that they have the right to make a deferral. A limited number of allowable exclusions exist:

- Individuals that have the right to defer under another plan, such as another 403(b) plan, 457(b) or 401(k) plan.
- Work study students.
- Non-resident aliens with no U.S. income source.
- Individuals who normally work less than 20 hours per week.

If employers have implemented exclusions for individuals who normally work less than 20 hours, they should implement procedures at hire date and annually to verify employees' eligibility. At hire date, the employer must reasonably expect that the employee work less than 1,000 hours during 12 months. For each succeeding plan year (or hiring anniversary, if designated by the plan) the employer must verify that the employee worked less than 1,000 hours. Caution must be used in adopting an eligibility exclusion related to hours. If an organization waits and uses a year-end determination of the hours and, based on this determination, any employee becomes eligible based on these hours, then the organization can no longer use the hours exclusion for any employee who normally work less than 20 hours.

Certain other exclusions are no longer allowed under the new regulations, including exclusion for collectively bargained employees, visiting



professors and individuals who made a vow of poverty. Plans that excluded collectively bargained employees have until the earlier of either the date the collectively bargained agreement terminates, or July 26, 2010, to make these changes. Plans that excluded visiting professors or individuals making a vow of poverty may continue the exclusion until plan years beginning on or after January 1, 2010.

### Contribution Limits and Timing on Contributions

Several contribution limits apply to 403(b) plans. In 2010, employee deferrals are limited to \$16,500. In addition, educational organizations, hospitals, health and welfare agencies and church-related organizations are allowed a special 403(b) catch up contribution. 403(b) plans may also provide catch-up contributions after age 50, but these catch-up contributions only apply after contributions are made under the \$16,500 limit, and the special 403(b) catch up provisions, if applicable.

In 2010, the limit for the combination of employee and employer contributions to a participant's account is \$49,000. In addition, compensation for determining employee and employer contributions is limited to \$245,000 for 2010.

The 403(b) regulations also require that employee deferrals be remitted to the participant's account within 15 business days following the month in which the deferral was made. Plans covered by the Department of Labor's Employee Retirement Income Security Act of 1974 (ERISA) are required to remit contributions as soon as administratively feasible.

### Nondiscrimination Rules

In addition to universal eligibility, several other nondiscrimination rules apply to 403(b) plans. As required by IRS regulation, 403(b) plans must offer benefits, rights and features to participants in a fashion that does not discriminate in favor of

highly compensated employees. This means that if the plan offers a benefit (i.e., loans), it must be offered uniformly, not just to certain employee groups. In addition, the new 403(b) regulations require that at least 70 percent of the entities' non-highly compensated individuals be covered by the plan.

### Distributions

Distributions of amounts related to employee deferrals may not be paid out until the participant has a severance of employment, experiences a hardship, becomes disabled, attains age 59 ½ or is deceased. Amounts attributed to employer contributions are not available for hardship distributions, and hardship distribution rules are the same as a 401(k) plan. These rules include the following:

- For those plans with after-tax employee contributions, these are not subject to any in-service distribution restrictions.
- Plans are required to make minimum distribution to participants upon the participant's attainment of age 70 ½. The minimum required distribution should be calculated for all of the individual's contracts in the plan, and the aggregate of the required distributions can be taken from any or all of the contracts.

In general, participants are permitted to rollover amounts from the 403(b) into another 403(b) plan, 401(k) plan or other qualified retirement plan. The plan and any contracts under the plan must allow for such rollovers, and participants must be provided a notice that they have the right to make this rollover distribution. Plan sponsors should ensure that they review all their contracts for this provision and ensure that participants are receiving a timely notification of their rights to elect a rollover distribution. ■



*In 2010, the limit for the combination of employee and employer contributions to a participant's account is \$49,000. In addition, compensation for determining employee and employer contributions is limited to \$245,000 for 2010.*



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## Changes to the SNF MDS (Minimum Data Set) Set for Implementation October 1, 2010

### OVERVIEW

Centers for Medicare & Medicaid Services (CMS) plans to implement MDS 3.0 changes nationally on October 1, 2010. This article highlights steps your facility can take now to prepare for the changes.



*Review your billing software system to be sure it has been updated to accommodate the new MDS 3.0 information. The cross-over will occur on October 1, 2010, without transition, so your billing system will be required to be updated by September 30, 2010, in order to bill any claims.*

The Minimum Data Set (MDS) is part of the federally mandated process for clinical assessment of all residents in Medicare or Medicaid skilled nursing facilities (SNFs). The entire process, called the Resident Assessment Instrument (RAI), provides a comprehensive assessment of each resident's functional capabilities and helps nursing facility staff identify health problems.

MDS assessment forms are completed for all residents in skilled nursing facilities, regardless of source of payment for the individual resident. MDS assessments are required for residents on admission to the nursing facility and then periodically, within specific guidelines and time frames. The information filled out on the MDS determines the Resource Utilization Group (RUG) category, which ultimately determines the per diem rate paid to the facility for a resident whose stay is covered under Medicare Part A.

The MDS data also feeds into the facility's quality indicator and quality measure reports, some of which are publicly reported, and some of which are used by surveyors during the survey process. How a facility implements the MDS 3.0 will affect all of the critical aspects of the nursing home operations, determining how accurate the resulting care plans will be, how representative of the quality of care in the facility the Quality Indicators and Quality Measures will be, and whether Part A reimbursement will be consistent with the intensity of care the facility provides.

MDS 2.0 is the version currently used in the industry. However, CMS plans to implement MDS 3.0 changes nationally on October 1, 2010. MDS 3.0 has been designed to improve the reliability, accuracy and usefulness of the MDS, to include the resident in the assessment process, and to use standard protocols used in other settings.

Based on this information, the most obvious question is, "What should we be doing right now?" The following is a list of items that can be implemented immediately, if they haven't already been put in place.

- Develop a plan for implementation, utilizing all key staff members from your SNF.

- Educate all staff on the new MDS 3.0 assessment form. There is already a considerable amount of information on the CMS website related to this. In addition, CMS will also be sponsoring a train-the-trainer session to educate as many people as possible about the new process. This is tentatively scheduled for May or June, 2010.
- Ensure your SNF administrator and/or director of nursing know the SNF reimbursement process, including how the RUG categories are derived, the new MDS 3.0 assessment tool and the new regulations.
- Ask about your software vendor's transition plan. It is critical for your facility to be aware of your vendor's plan well in advance, to create a joint plan to integrate the new software into your facility (including plenty of time for staff training).
- Review your billing software system to be sure it has been updated to accommodate the new MDS 3.0 information. The cross-over will occur on October 1, 2010, without transition, so your billing system will be required to be updated by September 30, 2010, in order to bill any claims.
- Update all policies and procedures that may be affected by the conversion from MDS 2.0 to MDS 3.0, including procedures on any assessment tools that will be used, any updates to billing processes and how the MDS 3.0 will be utilized for quality measures and risk adjustment purposes.

Meeting these above items initially should put you well on your way to a smooth conversion to the revised MDS 3.0 process. To access an electronic version of the revised MDS 3.0, as well as a host of other pertinent information on the MDS, go to [http://www.cms.hhs.gov/NursingHomeQualityInits/25\\_NHQIMDS30.asp](http://www.cms.hhs.gov/NursingHomeQualityInits/25_NHQIMDS30.asp) and follow the links. ■



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*Enterprise Risk Management—from page 1*

Historically, risk management in a health care organization has focused primarily on the narrow silos of financial risk and patient safety. Health care organizations today are facing a turbulent environment, rich with changes in regulation, consumer needs, environmental factors and challenges to operations.

Upon the passage of new health care legislation expected in 2010, health care organizations and providers will face challenges to reimbursement, operational requirements and quality standards. Consumers are taking more active roles in their health care choices in the midst of an economic downturn and taking on more financial burden as employers cut insurance benefits. An aging population continues to challenge the capacity of the health care system at a time when many facilities in rural areas, with the highest aging population, are weighted with outdated facilities that require renovations or rebuilds. For a health care organization, these risks are what may prevent them from achieving their objective of delivering the highest quality of care to their patients and communities.

ERM provides health care leadership teams a practical approach to managing the day-to-day operations while aligning risk management with the strategic goals for the organization. Specifically, health care organizations are able to design a structure that enables leadership to make more effective and timely decisions based on improved

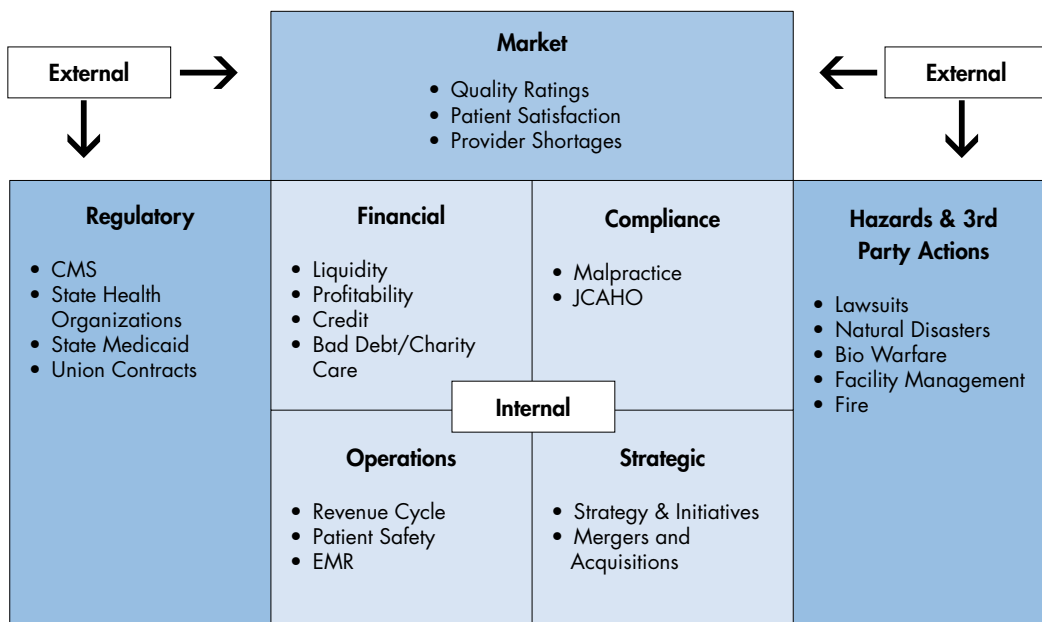
information and an enterprise-wide understanding of the impact. Successful implementation of an ERM program can lead to the improvement of operational metrics, such as a reduced number of patient incidents, and an impact to intangible metrics, including improved perception of leadership and increased competitive advantage in the marketplace.

There is no better time for health care organizations to turn their focus to a proactive risk management approach. The health care legislation is expected to create significant change in the marketplace throughout the industry over the next decade. Rating agencies, such as *Standards & Poors*, have broadened their focus toward enterprise risk considerations in ratings to non-financial industries, including health care. Demographic, socio-economic and consumer dynamics are changing and challenging health care delivery, presenting new risks. A structured enterprise approach that applies a practical process for day-to-day management will be the competitive differentiator for organizations to grow and prosper in this environment. ■



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## Health Care Risk Universe



A Health Care Risk Universe illustrates industry specific risks in a top-down view, considering both internal and external factors across the organization. This tool provides the basis for identifying individual and categories of risks, and how they may be interrelated. Approaching risk from this vantage point begins a dialogue of how risks are currently being managed and what opportunities may exist to align risk strategies. It provides a dynamic way to bring Enterprise Risk Management for the health care industry into focus.

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*Credit Card—from page 3*

Timing is of the essence; the push for PCI compliance was initiated in 2006. The deadlines for complying with PCI compliance have long since passed. Companies that missed this deadline are potentially subject to great risk, including:

- Fines and penalties for non-compliance with PCI and other regulations;
- Termination of the ability to accept payment cards;
- Fraud losses;
- Cost of reissuing new payment cards;
- Cost of legal settlements or judgments;
- Higher costs for PCI Assessments if a breach occurs; and
- Loss of customer confidence.

In order to best mitigate a health care organization's risk and protect the information of its patients and patrons, it is important that the appropriate level of action is taken to prepare the organization for PCI compliance.

Where do you start? Begin by determining your merchant level, which is based on the number of credit card transactions you process annually. Then determine your PCI compliance scope, complete a gap assessment and outline a road map to PCI compliance. If you need help understanding the requirements, developing your path to compliance, or completing the testing and questionnaires for compliance submission, a professional consultant can help you to become compliant based on your specific operations and needs. ■



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