The Financial Diagnosis

APRIL 2013

Letter from the President

The 2012 - 2013 HFMA year and my journey as the Kentucky Chapter President began June 1, 2012 and now both are quickly approaching the end which is May 30, 2013. It truly is amazing how fast the year has gone by. It has been a rewarding experience, fun and more enjoyable than I could have ever imagined. I have had the opportunity to work beside and with the BEST board members, the BEST volunteers, and BEST Chapter of HFMA members. I would also like to recognize our Region IV Regional Executive for 2012-2013, Andy Strausbaugh for his leadership and support to the chapter. The team has been remarkable!

HFMA's vision is: “To be the indispensable resources for healthcare finance.” The Kentucky Chapter leaders have continued to focus on this vision and certainly worked very hard to offer you education and networking opportunities throughout the entire year. The Chapter exceeded goal in every category, membership, education and certification. You will find the Chapter’s scorecard posted in the newsletter; however, I’m so proud of the team I want to give you a quick summary now. The Kentucky Chapter membership growth exceeded 3%, from 604 members to 624. Over 13,000 education hours were provided. From a personal accomplishment we had six (6) individual members pass their certification exam, bringing the total to 59 certified members. I offer my sincerest THANK YOU to all of the HFMA members and chapter leaders for a successful year.

Last year at the Annual National Institute (ANI), Ralph Lawson, HFMA National Chair announced his theme of Leadership Matters. I can’t begin to name everyone but I can assure you there are all types of leaders in our chapter. In addition to the members that held a position on the board, I also want to comment on the other leaders within the chapter too. Members provided topic ideas, personally presented at an education session, suggested speakers, captured pictures, provided us your thoughts, introduced a speaker, participated on a panel discussion, set up rooms, moved tables, created KY HFMA face book page, staffed the HFMA exhibit table and shared the value of being an HFMA member, review of Yerger entries and the list goes on…. Kentucky was up for the challenge and lived the theme of Leadership Matters! We made a great team of volunteers!

During the Spring Institute your new Chapter leaders were installed so please join me in congratulating my friend, your 2013 - 2014 Kentucky Chapter HFMA President, Scott Reed. With Scott’s past experience and valuable contributions as the Treasurer and Vice President of Education he is very familiar with the Chapter; he has some new ideas and I assure you the Chapter is in very good “hands”. Congratulations Scott!

It truly has been my pleasure to serve the KY HFMA Chapter.

Theresa Scholl, President
Kentucky Chapter – HFMA
2012-2013
A Final Thought From Region 4 Executive

Wow! HFMA Regional Executive. That is a title I thought I would never have. As my two year commitment as HFMA Region 4 Regional Exec-Elect and Regional Executive comes to an end, there are several thoughts I want to share.

First, I need to say thank you to all of the chapter leaders for all of your hard work and dedication to HFMA. The 5 chapters that make up Region 4 (NC, MD, KY, VA/DC, and WV) are outstanding chapters with excellent leaders. The performance of our chapters compared to the other regions across the country stacks up very well and further demonstrates what an awesome group of HFMA members and volunteers can accomplish.

As we all know, healthcare is changing daily. The one thing we know for certain is that tomorrow will look different than today. I know all organizations including the one I work for are focused on cost reduction efforts. Sometimes, an organization must spend a little money to recognize a larger return on their investment. For the small price of an HFMA membership, I believe the returns and benefits are much greater than the expense. From the HFM magazine to the many electronic resources on the HFMA website to the networking and benefits of the many HFMA educational opportunities, the rewards of an HFMA membership are incredible and will certainly pay for itself.

Finally, I encourage all members to get involved. Members of HFMA will get out of their membership what they put into it. As a chapter volunteer, a chapter President and now a Regional Executive, my leadership experiences within HFMA have made me a better person, a better healthcare professional and a better leader. Leadership matters, so I encourage all members to step up and get involved. It is well worth your time.

In summary, I want to thank all of our members for being a part of our HFMA families. I also want to thank all of our corporate sponsors and vendors for their support as well. Without your commitment to our chapters, we would not be able to do the things we do. I know all of us will continue to confront the many challenges ahead in the healthcare industry. I wish all of you the best of luck and many successes as you move forward.

Sincerely,

Andy Strausbaugh – Kentucky Chapter
Regional Executive – Region 4
2012 - 2013
Insurance Market Reform: The Grand Experiment

Chad Mulvany

Some commentators believe the insurance reforms advanced by the Affordable Care Act (ACA) could significantly disrupt the individual and small-group insurance markets. What are the risks, and what can we glean from previous experiences in other states that have attempted similar changes? To expand coverage, the ACA makes unprecedented changes to the rules governing insurance plans not subject to the Employee Retirement Income Security ACT (ERISA). Payers and ideological critics of the ACA have rightly highlighted the unintended consequences experienced by states that attempted to implement some of the ACA changes on a more limited scale. Health systems should monitor the outcomes for states that have implemented reforms most analogous to the ACA. Understanding how coverage expansion has affected budgets and cost control efforts at the state level can provide clues to federal cost control efforts in the coming years.

The ACA's Insurance Market Reforms
The ACA contains a number of provisions designed to expand access to coverage for the uninsured. Some provisions and related regulatory activities—such as the insurer tax, health insurance exchange funding tax, and temporary reinsurance assessment—are designed to help make insurance affordable for lower-income individuals, to ensure that health insurance marketplaces are funded, and to ensure that a plan sold within a marketplace is not harmed by adverse beneficiary selection.

Other provisions are intended to make comprehensive coverage available to those who have been excluded due to preexisting conditions or priced out of the market due to health status, or to protect those who purchased policies that exclude services for relatively common medical needs. Examples include provisions that guarantee access to health insurance (guaranteed issue), end coverage rescissions, standardize the community rating from an average of 5:1 to 3:1, and establish a minimum essential health benefits package.

Potential Unintended Consequences
Critics contend that the revenue provisions to support expansion, combined with insurance market reforms, could have severe unintended consequences. Such concerns are grounded in the experiences of states that implemented limited insurance market reforms and in predictions that the ACA’s revenue provisions supporting coverage expansion will be passed to consumers as higher rates.

Eight states have attempted to implement some combination of guaranteed issue and/or a narrower community rating. A study of these efforts performed by the actuarial consulting firm Milliman found that premiums generally increased, insurance providers exited the market, and enrollment in the individual insurance markets in these states tended to decrease. At its most extreme, a phenomenon called an insurance market “death spiral” occurred as community rating compressed rates made it more expensive for the relatively young and healthy to obtain coverage. Because of guaranteed issue, those who didn’t have an immediate need for coverage exited the insurance market, leaving fewer lives over which to spread the risk and incurred claims cost.

Critics’ concerns about guaranteed issue and community ratings provisions within the ACA triggering a “death spiral” are exacerbated by predictions of increases in health insurance premiums. Although older individuals and those with one or more chronic diseases may see rates fall, some insurance industry executives and investment analysts who watch the sector predict that rates will rise 20 to 30 percent, on average, as shown in the exhibit above, with those who are young and relatively healthy facing rates that could double due to the revenue provisions and expanded benefits package.

Supporters of the law downplay these concerns. They point out that the ACA couples the insurance

Continues on page 4
market reforms and revenue provisions with subsidies—available to individuals whose incomes are up to 400 percent of the federal poverty level (FPL)—that tie premium payments to an eligible individual’s income level, thereby absorbing much of the “rate shock.” Further, the law includes penalties that should compel individuals to purchase insurance. This approach has been used in only one market—Massachusetts, where 98 percent of eligible residents have health insurance.

Comparison with Massachusetts

Although Massachusetts provides the best available example of what could happen, its validity for comparative purpose is limited because the Bay State’s overhaul does not exactly match the major provisions of the ACA for revenue, insurance market reform, and penalties/subsidies.

Revenue. Like the ACA, Massachusetts’ healthcare reform approach funds its exchange operations (the Massachusetts Connector) through an assessment on premiums for health insurance products sold through the marketplace. Unlike the ACA, Massachusetts’ approach does not levy a tax on insurers to fund coverage expansion, nor does it include an assessment to fund reinsurance for plans sold in the marketplace.

If the fees under the ACA are passed on to individuals purchasing health insurance in the marketplaces, as insurance industry analysts and executives predict, the cost of coverage could increase by 6 percent. Although individuals receiving subsidies will be sheltered to some degree from these and other cost increases, they will ultimately drive up subsidy expenditures, and the resulting increased overall cost of expansion will put additional pressure on the federal budget and, ultimately, taxpayers.

Although Massachusetts has not experienced a significant rate shock, concerns about the affordability of care have driven multiple legislative attempts to control costs.

Insurance market reforms. Both coverage expansion plans include guaranteed issue, a mandated benefits package, and community rating. Insurance executives estimate that the ACA’s essential health benefit mandate could increase the cost of insurance by 7 percent or more. By contrast, the most recent analysis of the impact of Massachusetts’ mandated benefit package estimates it has increased costs by 1 to 4 percent. Estimating the actual cost impact on a given marketplace is difficult. It will depend on the state’s choice of benchmark plan (or decision to default to the federal benchmark) and any additional state-mandated benefits beyond the federal requirements.

Massachusetts’ community rating, at 2:1, is narrower than the ACA’s 3:1. In theory, younger, healthier individuals should have seen premiums spike, but this effect has not been widely reported or attributed to the community rating provision. Much of the pressure was probably absorbed by increased subsidies (with the costs picked up by the state budget) for those under 300 percent of FPL or by the widespread willingness of those younger than 26 to purchase catastrophic policies similar to what is envisioned in the ACA for those under 30.

Subsidies and penalties. Although the ACA provides subsidies to individuals living at 133 to 400 percent of FPL, which represents a greater segment of the population than receives subsidies in Massachusetts (i.e., individuals living at 150 to 300 percent of FPL). But the ACA’s subsidies are not as generous. For an individual living at 300 percent of FPL, the out-of-pocket premium contribution is capped at 4.23 percent of income in Massachusetts. Under the ACA, individuals living at 255 percent of FPL would be exposed to that level of out-of-pocket premium expenditure.

All things being equal, the penalty under ACA would need to be significantly greater than in Massachusetts to compel coverage purchase if the decision were based solely on the individual out-of-pocket cost of coverage versus the penalty.

The ACA’s penalties are nominal in 2014 and 2015 compared with those exacted by Massachusetts. Starting in 2016, the ACA’s penalties increase significantly, particularly for the lower end of the income spectrum.
In March 2012, Milliman performed an analysis to gauge the strength of the individual mandate, comparing the penalties with the out-of-pocket cost of insurance after subsidies for individuals and families of various ages and income levels.

Milliman’s analysis provides interesting insight into how the combination of penalties and subsidies might influence individual behavior related to insurance purchase.

For example, for households below 200 percent of FPL (about 27 percent of the uninsured), the penalty is greater than the out-of-pocket cost of purchasing coverage. Meanwhile, for households between 200 and 250 percent of FPL (about 23 percent of the uninsured), the penalty does not exceed the out-of-pocket cost of purchasing insurance, but is still significant enough to compel participation.

As individuals approach 300 percent of FPL, the penalty amount becomes smaller compared with the out-of-pocket cost of insurance, weakening the influence of the mandate as a purchase driver among these individuals and households, particularly the young. Surprisingly, at 400 percent of FPL or greater, the affordability exemption may impact a significant number of households, as is seen particularly in the over-50 segment. Given the relatively high healthcare needs of this population, qualifying for the affordability exemption may not diminish participation in exchange plans.

Milliman’s analysis also suggests enrollment in catastrophic plans may be greater than anticipated. Although the plans were envisioned primarily as a coverage mechanism for individuals under 30, they will likely include a significant mix of older, relatively affluent households whose income level qualifies them for the affordability exemption and are looking for a lower-cost alternative to subsidized plans offered on the health insurance marketplaces.

Implications for the Future of Reform
Given the impact of the mandate and subsidies after 2015 for those under 250 percent FPL (a significant portion of the uninsured), concerns about a full-scale insurance market death spiral may be overblown. However, some form of significant disruption in one or more of the exchanges remains a distinct possibility, given the combination of a relatively weak mandate and meager subsidies for those with incomes starting around 250 percent of FPL. The likelihood of disruption also increases if there is significant upward pressure on premiums (due to rate shock related to the ACA’s provisions or an increase in utilization of healthcare services). Increases in premiums would not only push more individuals and families over the threshold for the affordability exemption, but also increase outlays for subsidies, putting further pressure on the federal budget. As a baseline, the Congressional Budget Office projects federal healthcare spending will grow from 23 percent of the budget in 2012 to 32 percent in 2020.

Although insurance markets in Massachusetts are stable thus far, the state has experienced a similar phenomenon. Healthcare costs in 2013 are projected to consume 41 percent of the state budget (up from 29 percent in 2005). Last August, after considering a multitude of ideas for controlling cost, the Massachusetts state legislature passed a global cost-control package that anchors cost growth to gross state product (GSP, the state equivalent of GDP), among other strategies to constrain healthcare expenditures. Although the enforcement mechanism is admittedly weak, the threat of reintroducing provisions that were stripped out of the law before passage—including a luxury tax on high-cost hospitals, forcing component providers of a health system to negotiate independently with payers—will likely keep Massachusetts hospitals focused on the task at hand.

The implications for health systems are evident. If excess cost growth imperils coverage expansion and/or threatens to bust the federal budget, it is not a question of whether Congress will intervene to mute cost growth, but how strongly it will do so. Healthcare delivery systems have a limited window of opportunity to collaborate with patients, employers, and other providers within their community to reduce cost growth or risk significant federal intervention.

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Getting the Most Out of Evernote
Author: Bryan Sherwood, Dean Dorton Allen Ford Technology, bsherwood@ddaftech.com

What is Evernote? Simply put, Evernote helps you remember everything. Think of it as a digital filing cabinet. You can store photos, audio files, receipts and all sorts of documents for easy recall. Since it syncs your notes “in the cloud,” you’ll be able to access your notes virtually anywhere.

How Can You Use Evernote?

Use Evernote as a document repository. Do you want to go paperless, or are there times you need to access documents when you are away from home or the office? Evernote is not only a great place to store all kinds of information but it makes that information accessible on almost any device whether it’s your smartphone, computer, or tablet.

Use Evernote to track projects. With Evernote, you can keep all of the information you need for a project right at your fingertips. Save documents, emails, photos, and audio recordings all in one central location. Save that information in a virtual “notebook” or tag it with the project name to make finding all project-related information a snap.

Use Evernote for notetaking. Evernote is a powerful tool for notetaking. Create a new note and begin typing right away. Evernote provides basic text formatting, checkboxes, tables and bullets--everything you need for notetaking!

Use Evernote for travel planning. Wouldn’t it be great to have every bit of information you needed for your next trip in one place? Evernote makes that possible. Save your passport, travel itineraries, reservation information, maps, or business documents – anything you may need or use during the trip. Use Note Links to link all related travel documents to a single note for a seamless presentation of your travel information.

Tips and Tricks

Tag notes. As mentioned above, you can quickly “tag” notes and later search for saved items by their tags. Tags are a great way to organize a large number of related notes.

Organize your notes in notebooks. Evernote allows you to create virtual “notebooks” to organize your notes by subject. You can create notebooks for all kinds of things: receipts, projects, medications, and business cards, to give a few examples.

Share your notes. Evernote can share your notes with friends, family, or co-workers with just a few clicks. Premium users can view and edit notes for real time collaboration.

Use the web clipping tool. With the Evernote web clipping tool, you can save a web page, a selection of a web page or a url into Evernote.

Evernote is a feature-rich tool that can make you more productive and better organized. Learn more about Evernote on their website at www.evernote.com.

For help with Evernote or any other professional app, contact Dean Dorton Allen Ford Technology by emailing Bryan Sherwood (bsherwood@ddaftech.com) or Jason Miller (jmiller@ddaftech.com) or by calling 859-425-7700.

Please note that it is important to consider your office information security policies and any applicable regulatory compliance concerns before deciding to store information with a third-party, cloud-based service like Evernote.

Indian Summer Camp for Kids with Cancer Update

HFMA is proud to announce we’ve exceeded our fundraising goal for Indian Summer Camp for Kids with Cancer. At the Winter Institute, a goal of $1500 was set to provide the camp with new audio-visual equipment to be used in camp activities. Collections ended after the Spring Institute, and resulted in a total donation of $1755. Thanks to everyone who participated in helping us achieve this great goal.
The intent of the BCA was to rein in long-term federal spending and raise the debt ceiling. To those ends, it enacted $917 billion in cuts to discretionary spending (excluding Medicare) over 10 years and raised the debt ceiling by $900 billion. In addition, the BCA created a 12-member joint committee of Congress (also known as the “Super Committee”) to produce proposed legislation that would reduce the deficit by at least $1.5 trillion over 10 years.

The act mandated a sequestration process (or sequester) that would be triggered if the joint committee was unable to agree on a proposal for at least $1.2 trillion in spending cuts. To no one’s great surprise, the joint committee failed to reach an agreement, and the sequestration process was triggered. Under the provisions of the sequester, the president can request a debt limit increase of up to $1.2 trillion, and across-the-board cuts equal to the debt limit increase would apply to both mandatory and discretionary programs, with total reductions split equally between defense and nondefense functions. The cuts would be carried out from FY13 through FY21, a period of nine years. Medicare cuts would be capped at 2 percent and limited to cuts to provider payments.

Exempt from the cuts were Medicaid, welfare programs such as food stamps, and other low-income subsidies, as well as Social Security, veterans’ benefits, civilian and military retirement, and net interest payments.

Splitting the annual reduction of the sequester evenly between defense and nondefense functions would result in a $54.7 billion reduction for each function.

**The Impact of the Original Sequester on Medicare**

According to a September 2012 report from the Office of Management and Budget (OMB), the sequester would pare Medicare by $11.8 billion in FY13, with the cuts distributed among Part A ($5.8 billion), Part B ($5.2 billion), and Part D ($0.6 billion). Other cuts of $0.2 billion would affect affordable insurance exchange grants, program management, state grants and demonstrations, and fraud and abuse control, among other programs.

In early January, Congress averted the so-called fiscal cliff by passing the American Taxpayer Relief Act of 2012 (Public Law 112-240), which postponed the implementation of the sequester until March 1, 2013, reducing the total cut for FY13 by $24 billion, or 22 percent, to $85.3 billion.

The Revised Sequester: Impact on Health Care

President Obama and congressional leaders were unable to reach an agreement to avert the automatic spending cuts of the revised sequester, which took effect on March 1.

According to the Congressional Budget Office (CBO), the total cut of $85.3 billion for FY13 includes $42.7 billion in cuts to defense, $9.9 billion in cuts to Medicare, and $32.8 billion in cuts to other nondefense programs. Medicare accounts for 12 percent of the total cut and 23 percent of the nondefense portion.

How might the $9.9 billion in cuts to Medicare be allocated? In the absence of further guidance from the OMB, a reasonable approach would be to apply the same proportions as did the OMB in its September 2012 report. This step would yield the allocation reflected in the chart at the left below, with Medicare Parts A and B sustaining the lion’s share of the cuts. Medicare Part A could be cut by $4.9 billion, which could include an estimated $3.1 billion cut to hospital inpatient payments. That would translate into an estimated $0.9 million reduction in Medicare payment for the average hospital, which could in turn lead to layoffs of approximately 20 employees per hospital, in the absence of other cost-saving measures and based on the general relationship between hospital revenue reduction and direct employment cuts established by Pittsburgh-based consulting firm Tripp Umbach in a report published in September 2012.

Medicare Part B could be cut by $4.4 billion, which could include an estimated $1.7 billion cut to physician payments and a $0.7 billion cut to hospital outpatient payments.

According to the rule for sequestration, reductions in Medicare will begin in April, the month after the sequestration order is issued, thereby delaying some of the effect on outlays until the ensuing fiscal year. Thus, for the federal government’s FY13, which ends Sept. 30, the actual cuts could be $1.55 billion to hospital inpatient payments, $0.85 billion to physician payments, and $0.35 billion to hospital outpatient payments.

**Long-Term Implications for Hospitals**

Unless it is repealed by Congress, the BCA—with its annual $109.3 billion sequester cuts—will require the federal government to take some rather bad-tasting medicine for each of the next eight years. For healthcare providers, there will be the specter of 2 percent funding reductions each year, as reimbursement rates are held captive to the broader philosophical and fiscal debate between the two political parties on the best way to reduce the deficit and spur economic growth.
The winner of the chocolate bunny & gift certificate was Thomas Hales, FHFMA, LFACHE, CFO, Crittenden Health Systems. Exhibitor - Shirley Mason from Berlin-Wheeler Receivables Management.
Hospital facilities operated by 501(c)(3) organizations were provided some much needed clarification on April 3, 2013 via the issue of proposed regulations for Internal Revenue Code 501(r)(3) relating to the community health needs assessment (CHNA), reports of which generally need to be completed in 2013.

These proposed regulations supersede the interim guidance provided in IRS Notice 2011-52, which was released in July 2011. However, for transition purposes, Notice 2011-52 may be relied upon only for a CHNA made widely available to the public, and an implementation strategy adopted, on or before Oct. 5, 2013.

It is important to keep in mind that these proposed regulations will not be effective until they are published as final or temporary regulations; this means that the provisions apply to returns filed on or after the date the final or temporary regulations are issued. Although not yet effective, these proposed regulations show us what the IRS and Treasury expect the regulations to look like when finalized.

This article will focus on the significant changes and clarifications presented in the proposed regulations compared to Notice 2011-52 guidance issued earlier.

**Background**

Under §501(r)(3), hospitals must conduct community health needs assessments at least once every three years and adopt an implementation strategy to meet the needs identified in the assessments. These assessments must take into account input from persons representing a cross section of the community served by the hospital, including those with specialized knowledge or expertise in public health, and must be made widely available to the public.

The CHNA requirement is effective for tax years beginning after March 23, 2012, which is generally the fiscal year ending in 2013. For example, hospitals with a June year end must complete the assessment by June 30, 2013, and calendar year end hospitals must complete the CHNA by Dec. 31, 2013.

Failure to satisfy this requirement may result in the imposition of a $50,000 excise tax on the hospital facility and potential loss of tax-exempt status. If a hospital organization operates more than one hospital facility, then the CHNA requirements apply separately with respect to each facility. Also note, since the CHNA requirements apply separately to each facility, each facility is exposed to the excise tax and risk of loss of tax-exemption, meaning for a hospital group the excise tax can well exceed $50,000 if multiple facilities do not comply.

**Notable Guidance**

**Some relief if inadvertent failure to satisfy all CHNA requirements**

The effect of the failure to meet all of the §501(r) criteria has been a top question in the minds of hospitals and those who work with them. Questions and concerns such as those listed below have caused some nervousness among hospitals.

- For a hospital organization that operates multiple hospital facilities, what happens if just one of the facilities fails to satisfy the requirements?
- For a hospital with tax-exempt bonds, how is the exempt status of the bonds impacted by not meeting §501(r) requirements?
- If a facility falls short on satisfying the rules, is its income taxable?

The proposed rules do provide some answers, and some relief, to hospital facilities.

In certain situations, an omission or error that is minor, inadvertent, and due to reasonable cause, and which the hospital facility corrects as promptly after discovery as is reasonable, will not be considered a failure to meet the §501(r) requirement. Guidance will be issued in the future which will provide that a facility’s failure to meet one or more of the requirements described in the regulations that is neither willful nor egregious will be excused if the hospital facility corrects and provides disclosure in accordance with the rules set forth in such guidance.

- The proposed rules also provide that the relative size, scope, nature and significance of any failures to meet the §501(r) requirements will be considered when deciding whether to revoke a hospital organization’s exempt status. All the facts and circumstances will be considered in this determination.
- Regarding the question of a multiple-facility hospital that operates a facility that does not meet the requirements, the proposed rules provide that the noncompliant facility will cease to be exempt from tax, while the hospital organization will continue to be exempt under §501(c)(3). The income related to the noncompliant facility will be subject to tax, and may not offset the other unrelated business income of the hospital. [Note: This treatment does not apply in the event of minor and inadvertent omissions or errors described above.]
- The proposed rules provide that failure to comply...
with §501(r) will not in and of itself result in the interest from qualified tax-exempt bond issues becoming taxable.

**Conducting and documenting the CHNA**

In conducting a CHNA, a hospital facility must define the community it serves and assess the health needs of that community. The CHNA is considered “conducted” on the date the hospital has completed these steps:

- Take into account input from persons who represent the broad interest of the community, including those with special knowledge of or expertise in public health;
- Document the CHNA in a written report that is adopted by an authorized body of the hospital facility; and
- Make the CHNA report widely available to the public.

An important change in these proposed rules is that the CHNA need only identify and prioritize significant health needs – this replaces the earlier guidance that required that each identified need be listed and prioritized. Whether a health need is determined to be significant is determined based on all the facts and circumstances present in its community.

The proposed rules also provide that a CHNA report that is marked “DRAFT” may be posted for public comment without triggering its next three-year CHNA cycle.

The CHNA report must include the following five elements:

1. A definition of the community served and description of how the community was determined;
2. A description of the process and methods used to conduct the CHNA;
3. A description of how the hospital facility took into account input from persons who represent the broad interests of the community;
4. A prioritized description of the significant health needs identified through the CHNA; and
5. A description of the potential measures and resources identified through the CHNA to address the significant health needs.

The proposed rules no longer require the CHNA report to contain the names or titles of the individuals contacted within the organizations consulted during the process. A complete copy of the CHNA report is to be conspicuously posted on a website, and remain on that website until two subsequent CHNA reports have been posted so that information on trends will be available to the public.

**Collaboration with others**

Under certain circumstances, the proposed rules ease up on the general requirement that each hospital facility issue a separate written CHNA report when it conducts its CHNA in collaboration with other organizations. A significant exception to the separate report requirement is available when a hospital facility collaborates with other hospital facilities in conducting its CHNA: All of the collaborating hospital facilities may produce a joint CHNA report as long as all of the facilities define their community to be the same and conduct a joint CHNA process. This joint report must clearly identify each hospital facility to which it applies and an authorized body of each collaborating facility must adopt the joint CHNA report.

Like the CHNA report, a separate implementation strategy is generally required, but the proposed rules provide an exception: A facility that collaborates on and issues a joint CHNA report may adopt a joint implementation strategy if it meets the following requirements:

1. The joint implementation strategy must be clearly identified as applying to the facility;
2. It must clearly identify the facility’s particular role and responsibilities in taking the actions described in the implementation strategy and the programs and resources the facility plans to commit in taking the actions; and
3. It must include a summary that helps the reader easily locate those portions of the joint implementation strategy that relate to the hospital facility.

**More implementation strategy rules**

Consistent with previous guidance, for each significant health need identified, the hospital facility must describe how it intends to address the need, or alternatively, explain why the hospital does not intend to address the need. These proposed rules add the additional requirement that the implementation strategy must include:

- A description of the anticipated impact of these actions and the plan to evaluate such impact;
- The programs and resources the hospital facility plans to commit to address the health need; and
- Any planned collaboration between the facility and other facilities or organizations in addressing the health need.

The facility must also establish a feedback mechanism in its CHNA process to take into account written comments received on its most recently adopted implementation strategy.

Under the proposed rules it is no longer necessary that the facility’s implementation strategy be attached to the hospital’s Form 990 (Return of Organization Exempt from Income Tax) if, as an alternative, the hospital discloses on its Form 990 the URL(s) of subsequent CHNA reports.
the web page(s) on which the document is posted. Added in the proposed rules is the requirement that a description be provided on each year’s Form 990 of the actions taken during that tax year to address the significant health needs identified through its most recent CHNA.

TRANSITION RULES
Generally, the implementation strategy is required to be adopted in the same year the CHNA is conducted. The proposed rules provide some transition relief with respect to the first implementation strategy adopted under the CHNA requirements. The transition rules for adopting the implementation strategy depend on the tax year in which a hospital facility conducts its first CHNA:

(1) CHNA conducted in a tax year beginning BEFORE March 23, 2012:

If a facility conducted its first CHNA in its tax year beginning before March 23, 2012, and it adopted its implementation strategy on or before the 15th day of the fifth calendar month following the close of its first taxable year beginning after March 23, 2012, then the CHNA is considered conducted in the tax year the CHNA process was completed, notwithstanding the fact that the implementation strategy was not adopted by the end of that tax year.

Example provided in the preamble to the proposed regulations:

A hospital facility reporting on a calendar-year basis that conducts a CHNA in 2012 and adopts an implementation strategy for that CHNA on or before May 15, 2014 does not need to meet the CHNA requirements again until 2015.

(2) CHNA conducted in a tax year beginning AFTER March 23, 2012:

If a facility conducted its first CHNA in its tax year beginning after March 23, 2012, and it adopted its implementation strategy on or before the 15th day of the fifth calendar month following the close of its first taxable year beginning after March 23, 2012, then the CHNA is considered conducted in the tax year the CHNA process was completed (tax year beginning after March 23, 2012).

The complete proposed regulations may be found on the IRS’s website at irs.gov. Plante Moran staff is available to assist organizations with understanding CHNA requirements. Sue Miencier can be reached at sue.miencier@plantemoran.com or 248.223.3682.
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2012 - 2013
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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.

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