

# MISSISSIPPI

January 2010

## Headlines

### HFMA PRESIDENT’S MESSAGE

#### Upcoming HFMA Meetings

##### 2010 MS HFMA Annual Institute

April 26-28, 2010

Beau Rivage Casino

Biloxi, Mississippi

##### MS HFMA Meeting

June 11, 2010

Hilton Hotel

Jackson, Mississippi

##### 2010 MS HFMA Summer Institute

TBA

Philadelphia, Mississippi



**HAPPY NEW YEAR!**

It’s hard to believe it is 2010. I know everyone has made their New Year’s resolutions and are going to stick to them this coming year.

As your chapter prepares for the upcoming year, we will be offering educational meetings to cover such areas as RAC (Recovery Audit Contract), MIC (Medicaid Integrity Contractors) and the Healthcare Reform Bill, just to name a few. In April, your new officers and board will be installed. Now is the time if you would like to serve on any of the committees or become active in any way with your chapter to do so. Please let myself or Sandy Riley know if you would like to serve.

We had close to 500 attendees at the Region 9 meeting held in New Orleans November 15-17, 2009. Region 9 consists of Arkansas, Louisiana, Mississippi, Oklahoma and Texas. The speakers were very informative. If you did not attend, please make plans to attend this year. Everyone had a good time.

The Tri-State meeting was held January

20-22, 2010 in Tunica at Gold Strike Casino. The theme this year was “The Wind of Change”.

Our annual meeting will be April 27<sup>th</sup> and 28<sup>th</sup> in Biloxi at the Beau Rivage Casino. Margie has already started working on the speakers and has several lined up. Our Region 9 Executive, Lloyd Haggard, will install the upcoming officers and board.

Have you considered HFMA’s certification programs? They prepare you for increasingly responsible positions in the industry. Certification demonstrates your understanding of healthcare financial management. HFMA offers two levels of certification: Certified Healthcare Financial Professional (CHFP) and Fellow of the Healthcare Financial Management Association (FHFMA). Please see David Williams, certification chairman, for any questions or to set up taking the exam.

In closing, I want to thank all the dedicated members who have, over the years, assumed responsibilities for positions in our chapter and the sponsors who have supported our chapter. They have allowed our chapter to provide more opportunities for members and non-members.

*Jerry Knighton, FHFMA*

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**Brett Bateman,**  
**HORNE LLP**

*Brett is a supervisor in health care services at HORNE LLP. He works on hospitals and other healthcare facilities on issues such as preparation of Medicare/Medicaid cost reports, support for Medicare and Medicaid audits, and low volume adjustment requests. He also has experience on a variety of reimbursement consulting engagements such as interim financial reviews, implementation of IME/GME programs and evaluation of clinic designation to maximize reimbursement.*

This article is designed to give the reader a brief understanding of the 340B Drug Pricing Program (the program). It will give benefits of the program, some of the current qualification criteria, recent changes, and proposed changes as outlined in Senate Bill H.R. 3590. This article will focus mainly on the rules and benefits as it relates to hospitals.

The 340B Drug Pricing program offers reduced costs on covered outpatient drugs to qualified disproportionate share hospitals. The program was introduced by Public Law 102-585, the Veterans Health Care Act of 1992. It is administered through the Office of Pharmacy Affairs (OPA), a department of the Health Resources and Services Administration (HRSA). This Office is responsible for processing applications of new enrollees and monitoring of current qualified entities, to ensure they remain qualified to participate in the program.

In order to qualify as an eligible hospital, four criteria must be met, as outlined in the SSA sub section 1886(d)(1)(B). These four criteria are:

1. Must be a subsection (d) hospital. This qualification limits participation to Acute Inpatient Prospective Payment (IPPS) hospitals. This excludes rehabilitation hospitals, psychiatric hospitals, cancer centers, and long-term care hospitals.
2. The hospital is owned or operated by a unit of the State or local government, is a public or private non-profit entity which has been granted governmental powers, or is a private non-profit hospital which has a contract with the State or local government to provide health care services to low income individuals who are not entitled to bene-

fits under title XVIII of the Social Security Act or eligible for assistance under the State plan under this title.

3. The qualifying hospital must have an allowable disproportionate share adjustment (DSH) percentage of at least 11.75% as reported on the most recent cost report.
4. The hospital cannot be a part of a group purchasing organization or part of a group purchasing arrangement for outpatient drugs.

On September 1, 2009, 74 FR 45206 implemented section 6004 of the Deficit Reduction Act (DRA) of 2005. This provision added Children's hospitals as a qualified entity. This new development is great news for Children's hospitals, and will allow a considerable savings on outpatient drugs as a participant of the program. These hospitals will be required to meet the four qualifications of participation. The qualification related to the DSH percentage could present a problem for these facilities. Because Children's hospitals do not participate in the Medicare program, there is no

***“The 340B Drug Pricing Program is one simple tool that Hospitals can use to fight the ever increasing cost of drugs.”***

SSI percentage. Therefore, the DSH percentage criteria must be met based solely on Medicaid utilization. This would require the hospital to have a substantial Medicaid utilization to reach the minimum DSH qualification standard of 11.75%. Children's hospitals can apply for retroactive discounts on qualified drugs purchased on or after February 8, 2006. All qualification

criteria must be met for each year that retroactive discounts are applied for.

Currently under the Senate version of the Health Care Reform Bill, The Patient Protection and Affordable Care Act (H.R. 3590), there are provisions related to the 340B Drug Pricing Program. This Senate version would expand the program to include inpatient drugs, lower the qualifying DSH percentage to 8% for Sole Community Hospitals, and allow participation of other types of hospitals.

In today's economy, hospitals are being asked to do more with less. Hospitals are on a constant mission to find ways to reduce cost. The 340B Drug Pricing Program is one simple tool that Hospitals can use to fight the ever increasing cost of drugs.



**Kimberly L. Cappleman,**  
Phelps Dunbar LLP

*Kim is an associate in the Tupelo office practicing health law. Her practice includes assisting clients in the preparation and negotiation of contractual arrangements between hospitals and physicians, advising clients regarding issues arising from the HIPAA privacy rule, assisting clients in structuring business arrangements in compliance with Medicare and Medicaid billing rules and assisting clients in developing and implementing corporate compliance programs regarding Medicare and Medicaid billing issues, HIPAA compliance, and Anti-Kickback and Stark issues.*

The American Recovery and Reinvestment Act of 2009 (“ARRA”) included a number of changes to the privacy and security requirements established by the Department of Health and Human Services (“DHHS”) under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). One of the most significant changes to the HIPAA privacy and security rules is ARRA’s requirement that covered entities notify an individual and, in some cases, DHHS and the media, when the individual’s unsecured protected health information is “breached.” On August 24, 2009, DHHS published regulations governing this notification process. The regulations were effective on September 23, 2009.

### **When is protected health information “unsecured?”**

ARRA defines “unsecured protected health information” as “protected health information that is not secured through the use of a technology or methodology specified by the Secretary [of DHHS] in guidance,” and requires DHHS to issue guidance describing technologies and methodologies that render protected health information secure by making it “unusable, unreadable or indecipherable to unauthorized individuals.” On April 17, 2009, DHHS issued guidance listing encryption and destruction as the two technologies and methodologies that would meet this standard. Protected health information that is neither encrypted nor destroyed in accordance with this guidance will be considered “unsecured” for purposes of determining whether the covered entity is required to follow the notification procedures below. The August 24 regulations further clarify that de-identified information is not protected health information and therefore is not subject to the notification requirements.

Interestingly, encryption is treated as an “addressable” implementation specification under the HIPAA security rule, meaning that a covered entity that determines that encryption is not practicable may use another methodology designed to secure its protected health information if certain documentation requirements are met. Thus, a covered entity that fails to encrypt certain electronic protected health information may not be in violation of the HIPAA security rule. Nevertheless, the information will be considered “unsecured” for purposes of determining the covered entity’s notification obligations.

### **When is protected health information “breached?”**

The regulations define “breach” as “the acquisition, access, use or disclosure of protected health information in a manner not permitted under [the HIPAA privacy rules] which compromises the security or privacy of the protected health information.”

In the preamble to the August 24 regulations, DHHS clarifies that not all violations of the HIPAA privacy rule will be considered breaches subject to the notification requirements, and that a violation of the HIPAA security rule alone does not constitute a breach subject to the notification requirements. However, a violation of the security rule may lead to a use or disclosure of unsecured protected health information that is

***ARRA requires that covered entities notify an individual and, in some cases, DHHS and the media, when the individual’s unsecured protected health information is “breached.”***

not permitted by the HIPAA privacy rule, in which case the security rule violation may result in notification obligations. DHHS also states that uses or disclosures that involve more than the minimum necessary information, in violation of the HIPAA privacy rule, may qualify as breaches subject to the notification obligation.

In addition to violating the HIPAA privacy rule, the statutory language requires that the impermissible use or disclosure must also “compromise the security or privacy of the protected health information” in order to be subject to the notification obligation. DHHS has interpreted this language as requiring that the use or disclosure “pose a significant risk of financial, reputational or other harm to the individual.” Covered entities must therefore conduct a risk assessment in order to determine whether use or disclosure of unsecured protected health information in violation of the HIPAA privacy rule creates a significant risk of harm to the individual.

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**James Milam,**  
**Phelps Dunbar LLP**

*Jimmy is a partner in the business practice group in the Tupelo office. He practices in the areas of secured lending transactions, commercial real estate and bankruptcy and creditor's rights. He is an agent for various title insurance companies and is experienced in the negotiation and issuance of all types of Mississippi title policies for owners, leasehold interests and lenders. In addition, for nearly thirty years, Jimmy has handled an array of real estate related matters including site acquisition, construction, development and financing of casino projects, acquisition and leasing of industrial development sites, various joint venture and hospital transactions including a recent large-scale secured hospital transaction and refinancing loan backed by a section 242 HUD/FHA guarantee.*

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**Contact:**

**Joyce Turnage,  
Membership Committee  
Chair**

**joyce.turnage@horne-llp.com**

On July 1, 2009, in Notice H 09-05, the Department of Housing and Urban Development ("HUD") announced changes to its Section 242 hospital mortgage insurance program. Designed to provide credit support for various hospital-related construction and renovation projects by providing mortgage insurance for low-interest loans made by HUD's qualified Federal Housing Authority ("FHA") lenders, the Section 242 program has been around for decades and has been successfully employed in hundreds of financings, although some evidence suggests a slowing of demand over the past ten (10) years or so. The historical eligibility requirements for Section 242 projects are currently being amended to allow for inclusion in the program of certain qualifying refinancing of existing hospital debt and for new hospital purchases. Designed to provide alternative access to credit in an ever-tightening private financial market, the anticipated revisions to the Section 242 program should have a salutary effect in this corner of the marketplace, although various matters of concern with the proposed revisions, primarily proposed financial ratio requirements, appear currently to be under review by HUD.

As of the time of composition of this article, these revisions are proposals only. While HUD has announced its intention to publish a rule for public notice and comment which will provide the formal language and changes by which these proposals are sought by HUD to be instituted with the force of law, the rule does not yet appear to have been released. Once released by HUD and published in the Federal Register, the rule will be subject to notice and comment by the public for a standard period of sixty (60) days; HUD will thereafter consider all comments received and presumably a final rule will be adopted in due course to implement the changes in the Section 242 mortgage guarantee insurance program, which will serve as the final word. Since we do not at present have access to the final terms or language of the revisions in the form of an officially published rule from HUD, the comments in this article are necessarily predictive, and are based on the statements and language contained in HUD's Notice H 09-05 only. Of course, the final rules which will emerge later from HUD could be similar or different from the terms of the Notice.

### **Brief History of Section 242**

Administered by the FHA, the Section 242 program began in 1968, and since that time has provided government loan insurance for

between three hundred and four hundred (300-400) loans totaling nearly 13 billion dollars (\$13,000,000,000) across at least forty-one (41) states. Borrowers have included nonprofit, proprietary and public hospitals, hospital-related facilities where acute care services account for the majority of revenues and adjusted patient days, as well as critical access hospitals and major tertiary care facilities. In addition, many borrowers have in the past been able to issue only non-rated credits. By stepping into the perceived credit-quality breach, the federal government, through the Section 242 program, provides the ultimate security for repayment of the qualifying loan by guaranteeing, with its full faith and credit, the borrower hospital's reimbursement obligation, which in turn allows for an enhanced bond credit rating with its consequent attendant benefits to the hospital borrower.

The allowed target market for Section 242 loans has historically been hospital construction and renovation projects, including ancillary facilities such as garages and medical office buildings. Major capital projects frequently financed with Section 242 guarantees have included construction, expansion, rehabilitation, remodeling and equipment purchases. In such cases, however, existing debt refinancing has been limited to eighty percent (80%) of the insured loan, with the balance being committed to, in broad terms, new construction or renovation. Purchases of new hospitals and one hundred percent (100%) take-out loans for refinancing of existing debt have not been historically covered by the Section 242 program.

Section 242 loans are unlimited as to maximum loan amount, though subject to a loan-to-value ratio cap of ninety percent (90%). The credit obligation is non-recourse to the hospital and must be secured by a first mortgage covering the entire hospital, rather than simply the "project portion," for the term of the construction period plus an additional self-amortizing term of twenty-five (25) years.

The nitty gritty of the financial requirements for historical Section 242 guaranteed loans requires an average operating margin over the past three (3) years preceding the date of application of greater than, or equal to, 0.0%, and an average debt service coverage ratio of greater than, or equal to, 1.25x, though exceptions to this last requirement may be requested. As discussed below, these requirements are being amended and are the subject of some controversy which may result in future revisions when the rule is published.

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**NEW REGULATIONS REQUIRING PATIENT NOTIFICATION OF BREACH OF PROTECTED HEALTH INFORMATION-CONT.**

The preamble lists the following factors that may be considered in such an assessment, although this list is non-exclusive:

- **Who impermissibly used the information or to whom was the information impermissibly disclosed?** DHHS recognizes that, for example, an impermissible disclosure of protected health information to another entity governed by the HIPAA security and privacy rules may create a lower degree of risk than disclosure to a person or entity not covered by these rules.
- **Did the covered entity immediately take steps to mitigate the use or disclosure?** For example, if protected health information is inadvertently faxed to the wrong entity, but the covered entity recovers the information and requests a written agreement from the recipient that the information will not be further used or disclosed, such actions may be taken as evidence that the information has not been compromised.
- **Was the impermissibly disclosed protected health information returned prior to being accessed for an improper purpose?** DHHS gives the example of a laptop containing protected health information being lost or stolen but recovered before the information is accessed, altered, transferred otherwise compromised as a situation in which there may be no significant risk of harm to the individual.
- **What is the nature of the protected health information?** DHHS states:

For example, if a covered entity improperly discloses protected health information that merely included the name of an individual and the fact that he received services from a hospital, then this would constitute a violation of the Privacy Rule, but it may not constitute a significant risk of financial or reputational harm to the individual. In contrast, if the information indicates the type of services that the individual received (such as oncology services), that the individual received services from a specialized facility (such as a substance abuse treatment program), or if the protected health information includes information that increases the risk of identity theft (such as a social security number, account number, or mother’s maiden name), then there is a higher likelihood that the impermissible use or disclosure compromised the security and privacy of the information. The risk assessment should be fact specific, and the covered entity or business associate should keep in mind that many forms of health information, not just information about sexually transmitted diseases or mental health, should be considered sensitive for purposes of the risk of reputational harm – especially in light of fears about employment discrimination.

DHHS created a narrow explicit exception to the breach definition for uses and disclosures of information that excludes individuals’ dates of birth, zip codes and the 16 identifiers listed

in 45 C.F.R. § 164.512(e)(2) that must be excluded in order to create a limited data set. If the information falls into this category, it is not subject to the notification requirements and no risk assessment is required. Additionally, the following circumstances are excepted from the breach definition:

- Unintentional acquisition, access or use of protected health information by a workforce member or individual acting under the authority of a covered entity or business associate where the recipient does not further use or disclose the information in a manner not permitted by the HIPAA privacy rule;
- Inadvertent disclosure of protected health information from one person authorized to access protected health information at a covered entity or business associate to another person authorized to access protected health information at the same covered entity, business associate, or organized health care arrangement in which the covered entity participates, if the information is not further used or disclosed in a manner not permitted by the HIPAA privacy rule; and
- Unauthorized disclosures in which the covered entity has a good faith belief that the unauthorized person to whom protected health information was disclosed would not reasonably have been able to retain the information.

**If unsecured protected health information is “breached,” what steps must the covered entity take?**

1. **Individual Notification.** Covered entities must provide written notice to individuals whose unsecured protected health information is breached by first-class mail to the individual’s last known address. The covered entity may use the individual’s email address if the individual has consented to receive information from the covered entity by email. If the individual is deceased, the information must be sent to his or her personal representative or next of kin.

If the covered entity does not have sufficient contact information for some or all of the affected individuals or if some notices are returned as undeliverable, the covered entity must provide substitute notice for these individuals in a form reasonably calculated to reach the individuals for whom it is being provided. If the covered entity is providing alternative notice to fewer than 10 individuals, the notice may be by telephone, email or other means. If providing substitute notice to more than 10 individuals, the covered entity must provide the notice through either a conspicuous posting for a period of 90 days on the covered entity’s web site or in major print or broadcast media in geographic areas where the individuals likely reside.

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**HUD SECTION 242 HOSPITAL MORTGAGE INSURANCE PROGRAM TO BE EXPANDED—CONT.**

Finally, Section 242 guaranteed mortgage loans typically require that the hospital borrower commission an external financial feasibility report documenting the necessity of the project and provide financial tables required by HUD to compare the borrower’s performance against industry and peer group standards. Typical fees are 0.15% of loan amount for FHA application fee, 0.15% of loan amount for FHA commitment fee, 0.50% for FHA inspection fee, 0.50% of outstanding loan amount annually for FHA mortgage insurance premium, and negotiable financing and placement fees to the borrower’s financial advisors. Furthermore, as a part of the loan package, escrows are customarily required for a mortgage reserve fund, real estate tax and insurance liabilities, working capital and to cover any initial anticipated operating deficit. The typical process, from initial review by an experienced advisor through closing, can take up to ten (10) months, or longer, depending on circumstances and the ready availability of needed information.

**Proposed Changes**

Although not yet “proposed” in the official sense by publication of a rule in the Federal Register, changes in the Section 242 program appear clearly to be on the way. For purposes of this discussion, we will refer to the changes described in Notice H 09-05 as having been proposed, while recognizing that the formal legal process for implementing change remains in its embryonic stages at present. To the extent requirements and customary practices discussed above as part of the historical fabric of Section 242 loans are not specifically discussed below, our working assumption is that those items, requirements and considerations will, in the main, remain in place. The discussion below is designed to highlight what appears to be the most prominent of the coming changes; there may, however, be others in the future and some of the fine details of the existing, proposed changes may not be covered specifically below. This review is intended to be more broad-based than highly specific and all-inclusive. If questions arise involving specific issues, we will be glad on request to consider those inquiries and respond on a case-by-case basis.

The gravamen of the proposed changes is to expand the types of projects that qualify for Section 242 mortgage guarantee insurance by adding two general types of transactions to the eligible list. Of interest is the fact that no statutory amendments have been made by Congress, nor are any apparently needed, to authorize this expansion. HUD interprets Section 223(f), the relevant lending provision in the National Housing Act, of which Section 242 is also a part, to have extended the power to FHA long ago to utilize the mortgage guarantee program for the purposes now proposed. FHA had simply never done so in the past because of HUD’s belief that the private capital markets provided sufficient resources on acceptable terms to the hospital community without the need for the en-

hancement of federal guarantees. Believing that time has come and gone, HUD has determined the time is now ripe for inclusion in the Section 242 federally guaranteed mortgage program of (a) loans providing for hospital refinancings equal to one hundred percent (100%) of take-out debt, as well as (b) credit facilities designed to provide acquisition capital for hospital purchases. These are significant changes. Following on their heels are suggested changes to the financial requirements for acceptable ratios, which may prove to be a stumbling block, and appear to be under continued discussion at present.

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**MS HFMA WELCOMES NEW AND REINSTATED MEMBERS**

***Angela M Carter***

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Interim CEO  
Natchez Regional Medical Center

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## HUD SECTION 242 HOSPITAL MORTGAGE INSURANCE PROGRAM-CONT.

The maximum mortgage amount permitted will under the changes be inclusive of the cost of refinancing existing debt, including the payoff, reasonable and customary legal, organizational, title and recording fees and expenses, plus costs of any repairs amounting to less than twenty percent (20%) of the new mortgage amount, plus lender fees, loan, professional and inspection fees. There will be, however, no continued eligibility mandate for new construction or renovation, historically referred to in HUD parlance as “hard” costs, though if hard costs are included, they may not reach or exceed a threshold of twenty percent (20%) of the loan amount. The coming changes also anticipate that the costs of acquiring a hospital will qualify for lending and insurance purposes under Sections 223(f) and 242. In such case, in addition to the above requirements, although there is no theoretical ceiling, the maximum mortgage amount is limited to the lesser of the actual purchase price of the land and improvements or HUD’s estimate of the fair market value thereof.

Proclaiming that one of its overriding goals in making these changes is “to lower the monthly debt service costs ... of ...[hospitals],” HUD also curiously proposed to amend certain financial eligibility items, the result of which may be to inhibit the effectiveness of the revised program. For example, to qualify, an applicant must under the changes have maintained an aggregate operating margin of at least 0.33% (formerly 0.00%), an average debt service coverage ratio of at least 1.8x (formerly 1.25x) for the last three (3) years, *and* must have experienced an actual or imminent increase in its relevant interest rate of at least 1% since January 1, 2008 as a result of the credit crisis.

These higher coverage ratios could well present a disqualifying barrier for many hospitals, and the interest rate increase test appears to exclude the refinancing of fixed-rate debt, and per-

haps of some variable rate demand bonds as well. Concerns about these issues were set out last summer in correspondence addressed to the FHA Commissioner and joined by the American Hospital Association, among others including the National Rural Health Association. Those concerns are believed to have been well received in the halls of government, and guidelines that are more “workable” from the borrower’s standpoint may be in the offing. Related legislative proposals are also in the mix at present, including suggested legislation that would allow FHA to “pick up” hospital construction projects that lost their financing “mid-stream,” and that would extend possible FHA financing to stand-alone hospital-related projects, such as medical office buildings, without the requirement of a supporting collateral mortgage on the entire underlying hospital facility.

### Conclusion

Whatever the final contours of the coming changes in the Section 242 mortgage insurance program currently being driven by the relatively barren private lending markets, it seems evident that the former landscape is being remodeled to accommodate the growing need, and public expectation, in this country for enhanced access to high quality health care services on a geographically widespread basis. HUD is to be commended for its seemingly quick and market-based reaction to the recent “drying up” of private credit. While accurate soothsaying is beyond the capacity of all, the signals coming from HUD and FHA seem highly suggestive that the final rule implementing these changes will be driven by the empirical needs of the marketplace and will indeed serve the important purpose of the Section 242 program, as expressed by HUD, “to lower the monthly debt service costs ... of ...[hospitals].”



David Williams,  
HORNE LLP

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**The process for application, testing and certification can be found on the HFMA.org website of or further information contact David Williams, certification chair @ 601-326-1320 or david.williams@horne-llp.com**

**NEW REGULATIONS REQUIRING PATIENT NOTIFICATION OF BREACH OF PROTECTED HEALTH INFORMATION-CONT.**

Notice by telephone or other means may be made in addition to written notice in cases deemed by the covered entity to require urgency because of possible imminent misuse of the unsecured protected health information.

- 2. Media Notification.** Notice must be provided to prominent media outlets serving a state or jurisdiction following discovery of a breach if the unsecured protected health information of more than 500 residents of that state or jurisdiction is breached. This notice is in addition to the notice to individuals, not in lieu of such notice.
- 3. DHHS Notification.** In addition to notifying individuals and the media, a covered entity is required to notify DHHS of breaches of unsecured protected health information. For breaches involving 500 or more individuals, this notification must be made concurrently with the individual and media notices. For breaches involving fewer than 500 individuals, the covered entity must maintain a log or other documentation and must submit the information annually no later than 60 days after the end of each calendar year for breaches occurring during the preceding year. For 2009, covered entities are required to submit information only for breaches occurring after September 23, 2009.
- 4. Content of Notification.** Covered entities providing notifications to individuals or to the media must include the following information:
  - A brief description of what happened, including the date of the breach and the date of discovery of the breach, if known;
  - A description of the types of unsecured protected health information involved in the breach;
  - Any steps the individual should take to protect himself or herself from potential harm resulting from the breach;
  - A brief description of steps the covered entity is taking to investigate the breach, mitigate harm to individuals and protect against future breaches; and
  - Contact procedures for individuals to ask questions or receive information from the covered entity, which must include a toll-free telephone number, e-mail address, Web site or postal address.
- 5. Timeliness Requirements.** Notification to the individual and, if required, to the media must be made “without unreasonable delay and in no case later than 60 calendar days” after the date the covered entity discovers the breach or by exercising reasonable diligence should have discovered the breach, subject to an exception for situations in which law enforcement has requested a delay in notification. The covered entity is deemed to have knowledge of a breach if the breach is known (or should

have been known) to any workforce member or agent of the covered entity other than the person committing the breach. The preamble makes it clear that certain business associates may be treated as agents of the covered entity, such that the 60-day time period begins to run for the covered entity when the business associate discovers the breach.

DHHS makes clear that 60 days is the maximum amount of time that may be taken to investigate the alleged breach and fulfill the covered entity’s notification obligations, stating:

[Some] commenters suggested that suspected but unconfirmed breaches should not be treated as discovered until all the facts of the breach could be confirmed. Others suggested that 60 days was an insufficient amount of time to conduct a complete investigation and send the required notifications. We disagree. Waiting longer than 60 days to notify individuals of breaches of their unsecured protected health information could substantially increase the risk of harm to individuals as a result of the breach and decrease the ability of the individuals to effectively protect themselves from such harm. . . .

Further, the duration of an investigation is limited by the statute and interim final rule’s requirement that any delay be reasonable – the investigation cannot take an unreasonable amount of time. Thus, if a covered entity learns of an impermissible use or disclosure but unreasonably allows the investigation to lag for 30 days, this would constitute an unreasonable delay. Further, the 60 days is an outer limit and therefore, in some cases, it may be an “unreasonable delay” to wait until the 60<sup>th</sup> day to provide notification.

**How do these requirements apply to business associates?**

If a business associate discovers a breach of protected health information, the business associate is required to notify the covered entity of the breach, providing the same information to the covered entity that the covered entity must provide to the individual, media and DHHS. This requirement, as well as DHHS’s statements indicating that a covered entity may be deemed to have discovered a breach on the date that a business associate knows or by exercising reasonable diligence should know of the breach, make it imperative that covered entities and business associates establish a procedure for communications concerning breaches of unsecured protected health information.

ARRA requires that its changes to the HIPAA privacy and security rules be incorporated into business associate agreements. As covered entities and business associates prepare their revised agreements, the following issues should be taken into consideration:

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**NEW REGULATIONS REQUIRING PATIENT NOTIFICATION OF BREACH OF PROTECTED HEALTH INFORMATION-CONT.**

- How long will the business associate have to report potential breaches of protected health information to the covered entity?
- To whom will the business associate be required to report such potential breaches?
- Who will be responsible for preparing, sending, and bearing the cost of notifications to individuals and the media if the breach is determined to be the result of the business associate’s actions? Who will make this determination?
- If the covered entity prepares and sends the notifications to individuals and/or the media, will the business associate have input into the wording of the notification document, and vice versa?

**Conclusion**

ARRA’s notification requirements could potentially result in significant expenditures of time and capital for covered entities and business associates. When combined with ARRA’s increased civil penalties and potential enforcement actions by state attorneys general, the notification requirements also create the potential for increased liability for these entities. Covered entities and business associates should carefully consider drafting and/or amending policies, procedures and business associate agreements with these factors in mind.

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**Recovery Audit Contractors are here – are you ready?** As many providers know, The Centers for Medicare & Medicaid Services have instituted Recovery Audit Contractors (“RAC”), a new program to detect and correct past improper payments (over- or under-payments) made on claims of health care services provided to Medicare beneficiaries. Connolly Consulting Associates, Inc. (“Connolly”), the RAC for Mississippi, has conducted provider outreach sessions in Mississippi and may begin audits at any time.

CMS tested RAC through a 3-year demonstration period in four states, which ended on March 27, 2008. From March 2005 to March 2008, CMS estimated the demonstration RACs collected \$1.03 billion in overpayments. The demonstration program established that most of these improper payments occur when payments are made for services not medically necessary or incorrectly coded, or when providers fail to submit sufficient documentation to support a claim. Connolly participated in the RAC Demonstration Program. It identified \$270.4 million in improper payments – \$266.1 million in overpayments and \$4.3 million in underpayments. Of Connolly’s determinations that were appealed, approximately 54.1% were resolved in the provider’s favor.

The RAC Program became permanent in all 50 states effective January 1, 2010. There are four permanent RACs, each responsible for approximately one-fourth of the country. Mississippi is located in Region C, the region assigned to Connolly. Connolly is paid a 9% contingency fee derived from any improper payments they collect from providers, so there is strong incentive to actually find error.

**Who will RAC affect?** Any physician, health care provider or supplier that bills the Medicare fee-for-service program is subject to RAC review, including hospitals, physician practices, nursing homes, home health agencies, hospice, durable medical equipment suppliers and all other providers or suppliers that bill Medicare Parts A and B.

**Why is CMS implementing RAC?** Of all the federal agencies that reported to the Office of Management and Budget in 2007, Medicare had the third highest error rate, with approximately \$10.8 billion in improper payments. RAC is another means of oversight implemented by CMS in an effort to reduce this Medicare error rate.

**How does RAC work?** RACs review provider claims on a post-payment basis. There are two types of review: automated and complex. The automated reviews generally allow for a decision to be made without the RAC requesting medical records. RACs may use automated review where there is certainty that the claim contains an overpayment. With complex reviews, typically the RAC will first contact the provider with notice of a possible overpayment and a medical records request. The RAC will then review the medical records provided and make a decision about a suspected improper payment. If the RAC concludes from their audit of these records that there has been an overpayment, it will send claims information to the provider’s carrier, Fiscal Intermediary (“FI”), or Medicare Ad-

ministrative Contractor (“MAC”) for adjustment. The carrier, FI, or MAC will then issue the provider a remittance advice notice, and the RAC will issue the provider a notice of determination/demand letter.

CMS initially established mandatory uniform limits on the number of records a RAC can request in a 45-day period. On December 2, 2009, CMS eroded these limits when it announced increased medical records request limits for DRG validation issues. Based on this increase in medical records request limits for one issue, we feel that expanded medical records request limits for all issues may be on the horizon for all providers.

The maximum length of the “look-back period” in which the RAC can review records is 3 years, with a maximum look-back date of October 1, 2007. In addition, each RAC is required to: (1) employ a full-time RAC medical director, Medicare coding experts, and a staff of nurses and/or therapists; (2) provide on request the credentials of its reviewers; (3) maintain an external validation process with a RAC validation contractor, who will provide a public annual accuracy score; and (4) maintain frequent vulnerability reporting. RACs may review claims in the current fiscal year; and there will be a RAC claim status web page established in January 2010.

**The race is on.** Connolly has been the first of the RACs to identify and post new issues to its website. As of January 4, 2010, Connolly has identified 76 issues, the majority of which concern DRG validation for hospitals, for automated and complex review. Thirty-nine of those issues are currently approved for reviews of claims submitted by providers in Mississippi.

At least one other RAC was not to be outdone. HealthDataInsights, the Region D RAC, posted 530 new issues for review on January 7, 2010. We recommend that Mississippi providers pay close attention not only to Connolly’s approved issues webpage, but also to the other RACs’ approved issues pages, as the RACs are sure to communicate with one another and “borrow” identified issues.

We also recommend that providers review the demonstration period findings at [www.cms.hhs.gov/rac](http://www.cms.hhs.gov/rac) to identify patterns of denied claims. RAC permanent findings will be listed on the respective individual RACs’ web sites. You may also check the OIG report at [www.oig.hhs.gov/report.html](http://www.oig.hhs.gov/report.html) and the Comprehensive Error Rate Testing (CERT) report at [www.cms.hhs.gov/cert](http://www.cms.hhs.gov/cert). Once you know where previous improper payments have been found, you can conduct internal audits to assess whether these problems or practices occur within your own practice or facility and then identify corrective actions to implement for compliance.

**You’ve received a demand letter. Now what?** Providers have several options when faced with a RAC audit and demand letter. First, comply with the audit request.

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Be organized and document your response. If an overpayment is identified and a demand letter issued, you may of course pay the demand. CMS allows payment by check, recoupment from future payments, or you may request an extended repayment plan. A second option is the open discussion period. The provider may call the RAC and speak person-to-person with the medical director/etc. to discuss why the audit is wrong and provide any documentation to support that contention. Keep in mind that this discussion neither takes away your right to appeal, nor does it delay the deadline for filing an appeal. Third, you may appeal.

Medicare may begin recoupment on the 41<sup>st</sup> day from the date of the demand letter, unless payment is received in full, an acceptable request for an extension has been received, or a valid request for redetermination (appeal) has been received. Recoupment may be stopped if a valid and timely request for redetermination is received by CMS within 30 days of the date of the demand letter, and again at the second level of appeal if a valid and timely appeal is received by the specified Qualified Independent Contractor (QIC) within 60 days of receipt of the Medicare redetermination notice or revised overpayment notice/demand letter. If a request is received after the stated deadlines, recoupment will stop from that point onward, but any previously recouped funds may not be refunded. After the second level of appeal, recoupment will occur regardless of other appeals.

CMS published figures for appeal outcomes in the target states during the 3-year demonstration period; as of March 27, 2008, only 14% (73,266 of 525,133) of all RAC reviews had been appealed, but approximately 1/3 of those (24,376 of 73,266) were decided in the provider's favor. There are multiple levels of appeal, each with different deadlines, minimum amount in controversy thresholds, and reviewing entities. You must make sure that all appeals are filed timely to preserve your rights and properly stop recoupment. Be sure you have independent counsel to provide assistance and guidance throughout this process.

**Updates from other states.** Connolly began automated review in South Carolina in August 2009. In November 2009, Florida outpatient therapy providers reported receiving demand letters from Connolly, most relating to untimed codes.

The size of the provider does not appear to be a factor in which providers RACs choose to audit. An 88-bed Texas hospital had nine records requested for a DRG issue. The hospital had already performed a defense review of those records. All nine records failed the physician documentation requirements for the DRG that was billed and paid. That hospital is awaiting Connolly's decision but is preparing to remit a refund to Medicare.

An ophthalmologist in Washington saw a patient in an inpatient setting. The physician billed the encounter as an office visit.

A large university hospital in Texas received its first RAC medical records request from Connolly requesting records concerning 39 DRG validation issues.

Medical records requests may sometimes request documentation that is irrelevant or inappropriate. A mid-sized Alabama hospital received a request for inpatient rehabilitation records. Inpatient rehabilitation is not paid under any currently approved issues.

**But wait . . . there's more.** RACs are not the only government contractors searching for improprieties. The health care arena is filled with acronyms, but the most recent additions to that list can spell trouble for providers. In addition to RACs, the federal government has authorized Medicaid Integrity Contractors (MICs), Zone Program Integrity Contractors (ZPICs); and Medicare Administrative Contractors (MACs). CMS hired these organizations to perform a wide range of medical review, data analysis, and evidence-based policy auditing activities. MICs are Medicaid's answer to RACs and will conduct audits similar to RAC audits without some of the restrictions RACs have.

*“RACs are not the only government contractors searching for improprieties.”*

ZPICs deserve particular attention, as their primary purpose is not identifying improper payment but targeting potential fraud through both pre-payment and post-payment audits. Any fraud findings will be referred to the OIG.

On November 18, 2009, the CMS Office of Public Affairs announced tougher new standards in the calculation of 2009 improper payment rates as a part of the administration's focus on eliminating fraud and abuse.

In short, RAC is not the only federal health care auditing initiative that is here. We recommend that providers research these programs and seek the advice of legal counsel to prepare for the upcoming (or already instituted) Medicare and Medicaid auditing initiatives. Are you ready?

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-noun  
1. a person who voluntarily offers himself or herself for

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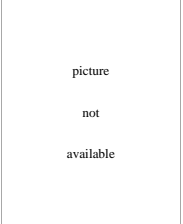
## RAC IS HERE—CONT.



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