

# FINANCIAL SCENE



**hfma**

Healthcare Financial Management Association

## The Final Provider Based Regulations

*Rene Remek Savarise  
Hall, Render, Killian Heath and  
Lyman, PSC*

*This article summarizes the presentation made by Ms. Savarise at the Summer Institute. It is provided as a service to our members that could not attend the educational session.*

meets all of the provider-based criteria — rather it need only satisfy certain “core” criteria. Conversely, a more stringent standard is applied to hospitals seeking provider-based status for off-campus services. If the service is off-campus, then the hospital must show that all of the provider-based criteria set forth in the regulation are met. CMS makes it clear in this final regulation that it does not intend to make provider-based determination about components or units within a provider that do not furnish the types of services for which separate payment could be claimed under Medicare or Medicaid. Such services include for example, housekeeping, laundry, medical records and security.

The final rule no longer contains an explicit requirement that an application be filed and approval obtained from CMS prior to an entity being treated as provider-based for billing and cost-reporting purposes. Rather, it establishes an attestation process. Following this process, the main provider attests in writing to CMS that its on- or off-campus entity meets the pertinent criteria enumerated in the regulation. The main provider can treat its entity as provider-based for billing and cost-reporting prior to receiving a decision from CMS. The amount of information that the main provider must submit using the attestation process will differ depending on the location of the entity. For on-campus entities, the provider will only need to attest that it meets the “core criteria” as described below. Moreover, the main provider is not required to submit documentation to CMS supporting its attestation, rather it must maintain the documentation on-site and make it available upon CMS’s request. In contrast, a main provider seeking to treat an off-campus entity as provider-based is required to attest in writing that its off-campus entity meets all of the core criteria plus all of the additional criteria outlined in the regulation. The main provider must also submit to CMS, with its written attestation, all documentation supporting its

*Continued on page 3*

### Program Schedule

**MEMBERS NEW TO  
HEALTHCARE MEETING  
AND FALL INSTITUTE**

October 28–29, 2002  
Marriott-East  
Louisville, KY

**WINTER INSTITUTE**

January 17, 2003  
Embassy Suites  
Lexington, KY

**AR FOCUS WORKSHOP**

March 14, 2003  
St. Office Park Meeting Center  
Lexington, KY

**SPRING INSTITUTE**

March 27–28, 2003  
Holiday Inn–University Plaza  
Bowling Green, KY

### In This Issue

The Final Provider Based Regulations .....	1–4
President’s Message.....	2
KHA Update .....	5
New Members.....	6
The OPSS Corner .....	7
Guidelines for Incentive Compensation .....	8

**For more news see the chapter website — [www.hfmaky.org](http://www.hfmaky.org)**

On August 1, 2002, the Centers for Medicare and Medicaid Services (“CMS”) published the final regulations regarding provider-based requirements. These regulations are included among CMS’s regulations pertaining to the hospital in-patient Prospective Payment System and FY 2003 rates. The effective date of these final provider-based regulations is October 1, 2002. These final regulations modify in several key ways the current regulations, which are found at 42 C.F.R. 413.65. The final regulations relax the application process, they also relax the rules for an on-campus entity to qualify as provider-based. The management contract and joint-venture rules for on-campus entities are also modified. The compliance period for the “grandfathered” entities is extended and the list of entities that are excluded from the purview of the regulation is expanded.

The final regulation is predicated on a threshold question and a key concept. That is, whether separate payment for a service can be claimed under Medicare/Medicaid. If the answer to this question is yes, then in order for an entity providing out-patient services to be considered provider-based it must be deemed to be integral to and a subordinate part of the hospital (“main provider”) with which it is affiliated. The regulation identifies a list of criteria, all or some of which must be satisfied in order for the entity to be deemed provider-based. Whether all of the criteria must be satisfied, or only a portion of them, depends on where the entity is located. A hospital seeking provider-based status for an entity located on its campus does not have to demonstrate to CMS that its provider entity



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### *Financial Scene*

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Opinions expressed in articles or features are those of the author and do not necessarily reflect the view of the Kentucky Chapter, the Healthcare Financial Management Association, or the Editor. The Editor reserves the right to edit material and accept or reject contributions whether solicited or not. All correspondence is assumed to be a release for publication unless otherwise indicated.

#### Publication Objective

The *Financial Scene* is the official publication of the Kentucky Chapter Healthcare Financial Management Association. Our objective is to provide members with information regarding Chapter and national activities, with current and useful news of both national and local significance to serve as a forum for the exchange of ideas and information.

*Financial Scene* strongly encourages submission of material for publication. Articles should be typewritten and submitted electronically to Editor by the deadlines listed below. The Editor reserves the right to edit materials and accept or reject contributions whether solicited or not. HFMA Founder Points are granted for any articles published in *Financial Scene*.

#### Deadline for articles:

Dec/Jan	12/1/2002
Feb/Mar	2/1/2003
April/May	4/1/2003

## President's Message



*Christopher Roszman*

On September 13th and 14th the Kentucky Chapter hosted the annual HFMA Region 4 (Mid-Atlantic Region) Fall Presidents Meeting at the Seelbach Hotel. This is an important Regional planning meeting that establishes the direction for the fiscal year 2004.

This meeting included the President and President-Elects for The Mid-Atlantic Region: Kentucky, Maryland, West Virginia, Virginia, North Carolina and Metropolitan Washington D.C. Chapters. Also in attendance to conduct the meeting were Bunnie Overby, the Region 4 Regional Executive (formerly called Chapter liaison Representative), Mark Higdon, Regional Executive-Elect, and Amelia Bryant, our National Board Member. I was quite pleased that Richard Clarke, President and CEO of HFMA attended and participated in the meeting.

Two agenda items in particular were discussed and acted on that will affect the Kentucky Chapter. First, I am proud to announce that Katie Black (Kentucky Chapter President 1997-98) was elected to become Region 4's Regional Executive for fiscal year 2005. It is my observation that Katie has been one of the most, (if not the most), active members over the last ten years. I say ten years because that is about how long I have been a member of the Kentucky Chapter and I recall Katie being as active and helpful then as she is now. We all know Katie will do a wonderful job in the Regional Executive role!

It was also agreed that the Mid-Atlantic Conference would be held in Asheville, North Carolina in November of 2003. Due to potential conflicts with HFMA Annual National Institute and other local chapter meetings, the Regional meeting scheduled was changed to every 18-months from once a year. Therefore the Regional meeting scheduled to be hosted by Kentucky in 2004 has been moved to Spring of 2005. It will be hosted by West Virginia, rather than Kentucky, in order to keep the location more geographically centered within Region 4.

Finally, please plan on attending one of our upcoming concurrent programs, the Fall Institute, or Healthcare 101, on October 28th and 29th at the Marriott East in Louisville. See you there!



*Fall Presidents' Meeting in Louisville at the Seelbach Hotel. Left to right: Dick Clarke, HFMA National President and CEO; Amelia Bryant, National Board Member; Bunnie Overby, Regional Executive; Mary McKinley, Kentucky Chapter President-Elect; and Chris Roszman, Kentucky Chapter President.*

## The Final Provider Based Regulations

...Continued from page 1

claim that the off-campus entity meets the provider-based requirements.

The core criteria that both on- and off-campus facilities must meet are: common licensure (except in states like Kentucky requiring site specific licenses); integrated clinical and financial services; public awareness that the provider-based entity is integrated with and subordinate to the main provider; and such other obligations as are identified in the existing regulation found at 42 C.F.R. 413.65(g). Those other obligations include showing that the entity complies with the requirements of the Emergency Medical Treatment And Active Labor Act, that it is utilizing correct site of service indicators, and that it is complying with certain beneficiary notice and anti-discrimination provisions found in other relevant statutes and regulations. In addition to meeting the core criteria, off-campus entities must also demonstrate that they are: operated under the ownership and control of the main provider; that their supervision and administration is fully integrated with that of the main provider; and that the provider-based entity is located within the immediate vicinity of the main provider.

Certain restrictions regarding management contracts have been eased by the final regulation as well. Facilities or organizations operating under a management contract will be considered provider-based if the main provider (or organization employing the staff of the main provider) employs all members of the provider-based entity staff who are directly involved in the delivery of patient care. This is a change from the existing rule, which precluded main providers from effectually utilizing management contracts of any sort for their provider-based entities. The final rule also provides an exception for employees who are paid under a fee schedule, such as physicians, therapists and other similarly situated professionals, and management staff who are not directly involved in patient care; under this exception, these individuals need not be directly employed by the main provider. However, if a main provider elects to use a management contract arrangement with its provider-based entity, it must retain significant control over the operations or services provided via the management contract. No distinction is drawn between

on and off-campus entities for purposes of applying the management contract rules. In addition, regardless of where the provider-based entity is located, the main provider must be the contracting party, and not its parent, or any other corporate entity associated with it.

In the final rule, CMS allows entities located on a main provider's campus to be operated under a joint-venture as long as all other applicable provider-based requirements are met. This is a significant turn-about, as the existing rule precludes joint-ventures of any sort to qualify for provider-based status. CMS identifies several additional criteria that must be met by an on-campus entity operated via a joint-venture. First, the on-campus entity must be partially owned by at least one provider member of the joint-venture. The amount of ownership interest that the provider member has in the joint-venture is irrelevant. The entity owned by the joint-venture must be located on the campus of the provider that is a partial owner of the joint-venture, and it must be provider-based to that provider. That is, it must satisfy the applicable provider-based criteria without regard to the joint-venture arrangement. CMS has not relaxed the joint-venture rule as it applies to off-campus entities. No off-campus entity will qualify as a provider-based entity if it is operated through a joint-venture.

Under the final rule, CMS makes it clear that whether the entity is on- or off-campus, if all or a number of services are provided "under arrangement" that entity will not qualify for provider-based status. However, limited, specific patient services may be provided "under arrangement." In making its determination, CMS will evaluate the entity as a whole and not according to an individual service. This is a departure from the previous rule where it was commonly thought that if a service was provided "under arrangement" it could disqualify an entity from its provider-based status.

The final rule also expands the types of facilities that are exempt from complying with the regulation. The types added are: independent diagnostic testing facilities that furnish only services paid under a fee schedule; facilities that only screen mammography services; departments of providers that do not furnish types of

Continued on page 4

## HIGHLIGHTS from the SUMMER EDUCATION INSTITUTE



Chris Roszman (right) presents Mary McKinley with her certificate for attaining the status of Fellow of the Healthcare Financial Management Association at the Summer Institute in Louisville.



Dorothy Zimmerman, Ronda Beck, and John Burgett at the Summer Institute in Louisville.



John Baker, a Six Sigma Master Blackbelt with Commonwealth Health Corporation spoke on the subject during the Summer Institute.

## The Final Provider Based Regulations...continued from page 3

health care services for which separate payment could be claimed under Medicare or Medicaid; ambulance services; and facilities (except for those operating as parts of CAH's) furnishing only physical therapy, occupational therapy or speech therapy to ambulatory patients as long as the \$1500 cap is in effect. Services currently included in the regulation include ASC's, CORF's, HHA's, SNF's, hospices and ESRD facilities; and excluded in-patient hospital rehabilitation units.

The final rule delays the effective date of the provider-based rules for certain entities. Those entities that were "treated" as provider-based on or before October 1, 2001 will continue to be treated as provider-based until the start of the hospital's cost-reporting period beginning on or after July 1, 2003. An entity is considered to be treated as provider-based if it has a written determination from CMS issued prior to October 1, 2000 that it is provider-based or if it has been billing and being paid as a provider-based entity on or before October 1, 2001. Entities that are treated as provider-based will not be subject to the provider-based criteria until the start of the hospital's first cost-reporting period beginning on or after July 1, 2003. For those provider-based entities which were not "treated" as provider-based on or before October 1, 2000 or for those entities that have not requested provider-based status before October 1, 2002, they will be required to comply with all the provider-based requirements (the core requirements and the additional requirements) effective October 1, 2002. If a facility has requested provider-based status on or after October 1, 2000 or before October 1, 2002, then that entity will be treated as provider-based for any period before CMS makes a final determination.

Under the final rule, CMS has stated that no adjustments in payments to the provider will be made until after CMS determines that the facility does not meet or intend to meet the provider-based requirements. A facility will have 30 days to respond to an adverse determination by CMS regarding its entity's provider-based status. If a hospital has treated an entity as provider-based but has not requested an advance determination of such status, then upon an adverse determination, CMS may recoup the difference between the amount that was actually paid to the provider and what it should have been paid had it been

treated appropriately as a free-standing entity. Continued payments to the provider will be made only if the provider indicates to CMS that it intends to seek provider-based determination and that it will comply with the provider-based requirements.

If a provider does not request a provider-based determination for an entity by October 1, 2002, but it is grandfathered, CMS will not recoup payments for any period before the provider's cost-reporting period beginning on or after July 1, 2003. CMS also does not intend to recoup payments for any period before the hospital's cost-reporting period on or after January 10, 2001, if the facility meets the "good faith" exception. The criteria a facility must meet under the good faith exception are: licensure, public awareness that the services were performed and billed as if they were furnished by a department of the hospital, and that those services were billed with the correct site of service indicator.

The new regulation requires a facility to report any material changes in its provider-based relationships. This is an ongoing obligation and failure to report

such changes can result in possible recoupment of payments and reduction or denial of future payments.

In sum, there are a number of benefits that can accrue to a hospital if it obtains a determination from CMS that its entity is provider-based. Among them, is that it possibly limits the amount of recoupment that would otherwise be demanded if a provider-based determination had not been obtained. It also limits possible exposure under other laws including the False Claims Act and the Anti-kickback Law should CMS decide that a hospital had an ulterior motive in seeking reimbursement as a provider-based entity. Hospitals should take this time to evaluate their out-patient services and whether to seek a provider-based determination for any of those services.

*Renee Savarise is a shareholder with Hall Render, practicing in the areas of Federal and State Healthcare Regulatory Law, Business Transactions and Compliance, including Reimbursement, Fraud, Abuse, False Claims, Stark and Anti-Kickback Law.*

## Annual Presidents' Banquet



*Attending HFMA's annual Presidents' Banquet this past June in Seattle, WA were (left to right) Katie Black, Dorothy Zimmerman, Tony Miranda, and Chris Roszman. During the banquet the Kentucky Chapter received the National awards as follows: A Gold award of excellence in membership growth, a Silver award of excellence for certification and a Bronze award of excellence for education. Kentucky also received Helen M. Yerger Special Recognition Awards in the areas of Member Services, Education and Process Improvements.*

## KHA UPDATE

## Medicaid Managed Care Oversight Committee Meets

(As reported in KHA CEO Briefing, September 30, 2002 Issue)

The Medicaid Managed Care Oversight Committee met on September 24, in Frankfort. **Marcia Morgan**, Secretary of the Cabinet for Health Services, and **Kathy Kustra**, the Governor's Special Advisor on Medicaid, testified regarding the current status of the Medicaid program.

Kustra stated that the fee-based payment with a bundled rate for hospital emergency room services, implemented September 1, will save \$18-\$20 million for the Medicaid Program. A state rate has been implemented for Medicare Part A Services for dual eligibles. This rate will be paid instead of paying the full deductible and co-insurance, saving Medicaid \$35-\$40 million a year. Kustra testified that 117 hospitals in Kentucky have been reimbursed \$197.4 million for

their indigent care costs through the Medicaid DSH program in FY 2002 and if Congress does not act and funding reverts back to the BBA amount, the FY 2003 amount will be \$170 million.

Kustra stated that the Department held a conference on August 29 on plans for contracting with an administrative services organization (ASO) for Medicaid for the rest of the state outside of Region 3 and plans to procure the contract for the ASO in Spring 2003. Kustra testified that the intergovernmental transfer (IGT) in FY '02 offset the Medicaid shortfall by \$161 million.

Kustra reported the budgeted amount for Medicaid for 2002 was \$3.3 million, but the year-end amount exceeded \$3.7 million. As of August 2002, the Medicaid program is at an all-time high for eligibles with 595,192 Medicaid recipients plus another 51,000 K-CHIP eligibles.

## Students and Faculty Feed Future Growth

(Abstracted from Notes from National)

HFMA is committed to increasing awareness of its membership opportunities to faculty members and students in healthcare administration and finance. Realizing the important role these individuals play in the future of the industry and the Association, HFMA continues its efforts to establish and expand relation-

ships with faculty members who provide a direct link to students.

HFMA's web site now includes specific sections highlighting faculty and student resources available through HFMA. Visit:

<http://www.hfma.org/facultyresources> and

<http://www.hfma.org/studentresources>



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### REVIEW YOUR FOUNDER MERIT POINTS

HFMA depends on volunteers. The Founders Merit Award Series was created to recognize individual members' contributions. The Founder Merit Points for the Chapter Year 2001-2002 may now be viewed on the national website, [www.hfma.org](http://www.hfma.org). Proceed to member login, select membership area, and next click onto membership directory button. You will see on the left side of the screen a button called Profile with your name. If you click on that, it will display your demographics, including founder points awarded by last three chapter years. If you feel the number is incorrect, please contact Sheri Gould at [sheri.gould@1pnt.net](mailto:sheri.gould@1pnt.net).

## New Member Spotlight

Jessica Delker is a senior associate at PriceWaterhouseCoopers. Her duties include leading staff on various engagements with her primary responsibility being testing and preparation of financial statements. Jessica is an avid runner, having completed two marathons and a handful of mini-marathons. She also enjoys cooking, reading, gardening and volunteering.

Jessica began work at PWC, and one major client she worked on was Humana. Two years later, she is still on the Humana engagement and has only begun to scratch the surface of everything there is to know! She joined HFMA because her manager suggested joining would give her a greater understanding of the healthcare function. Jessica says, "I think it's a great net-

working tool. I am constantly learning new things working on a handful of things at the same time, and trying to do the best I can. It is difficult to keep up-to-date with the ever-changing environment in healthcare and accounting overall." Welcome, Jessica.

## Welcome to the Following New Members

*Please be sure to welcome our newest members at our next meeting.*

Carrie Austin  
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This month's MYSTERY MEMBER:  
Cindy Shea, Reimbursement Analyst  
Methodist Hospital  
Henderson, KY  
Call Ronda Beck at 859-323-5702 ext  
192 by 11/1 for your prize!

## HFMA Examines Impact on Banking Relationships

*(Abstracted from Notes from National)*

HFMA has published a report to help healthcare providers and payers evaluate how the Health Insurance Portability and Accountability Act (HIPAA) of 1996 may affect their relationships with banks.

HFMA President and CEO Richard L. Clarke, FHFMA, says, "The role that HIPAA plays in the relationships between banks and healthcare entities largely has been overlooked as the healthcare community prepares to implement HIPAA. However, healthcare providers and payers are held responsible not only for their own actions to comply with regulations, but

also the actions of their business partners. Therefore, providers must take an active role in ensuring that the banks they do business with fully comply with HIPAA's requirements."

Banks are subject to HIPAA's privacy and security requirements when they perform functions that involve the processing of explanation-of-benefits data or other protected patient information on behalf of payers and providers. Consumer-initiated transactions, such as cashing patients' checks and processing patients' credit care payments, are exempt from HIPAA.

HFMA's report suggests HIPAA is not receiving attention in the banking

community for several reasons. Most banks currently are preoccupied with the new privacy aspects of the Gramm Leach Bliley Act (Pub. Law 106-102) to make HIPAA a priority. Also, banks may overestimate the protective aspects of the financial services exemption in HIPAA's privacy law and regulation.

Members can download a free copy of the report at:

[http://www.hfma.org/resource/focus\\_areas/HIPAA@Work/articles/7\\_26\\_2002.htm](http://www.hfma.org/resource/focus_areas/HIPAA@Work/articles/7_26_2002.htm)

# The OPPS Corner

By Gretchen Evans,  
Arden Health Services

## Intravenous therapy

What code do we use to report when a patient receives an IV infusion of antibiotics while in the Emergency Department? Can we also add points to our ED facility level for this service?

**Question 1:** For Medicare patients, the correct code is Q0081 for APC 120 with National Payment rate of \$157.80. Don't forget the antibiotic needs to be charged through the pharmacy order entry system.

**Question 2:** Review your ED encounter point system form. Any service that can be assigned a code should not be included in your point system as this is viewed as "double-dipping" the system. Reimbursement for each code includes the components required to provide the service to the patient regardless of who and where the service is provided, and should not be broken-out or unbundled. With this information, your encounter form should not refer to the number of IV bottles provided with points added for each bottle provided or that the patient had 3 laboratory tests and 1 x-ray performed for a total of XX points.

## Pain Management

Many facilities have contracted with physicians to provide coverage for this service. Often the staff and equipment are provided by the physicians with the facility charges being billed by the physician's staff for services provided. Here is an example of a hospital not having accurate claims due to a misunderstanding by the physician's staff. The patient is scheduled to the Pain Clinic. The **physician consults with the patient and through the process makes the medical decision to reprogram the pain pump because the current dosage is not adequate to provide pain relief. The physician's staff only submits a charge for the E/M level and does not bill for technical component of the service provided. Therefore, CPT code 62368, electronic analysis of**

**programmable, implanted pump for intrathecal or epidural drug infusion, with re-programming is missed. This is reimbursed under APC 691 for a National payment of \$161.87.**

Another CPT code that is frequently missed is for the refilling of a reservoir with a pain relieving medication. CPT code 96530 is an acceptable Medicare code for billing this service and is reimbursed under APC 125 for a National payment of \$153.22.

## Chemotherapy

**Question:** How does the facility bill for chemotherapy via instillation of medication into the urinary bladder? We have been using the HCPCS Q0084 code, infusion therapy using chemotherapeutic drugs, per visit.

**Answer:** It appears the procedure was for bladder instillation with an anti-neoplastic agent; therefore, the correct code should have been CPT code 51720, bladder instillation of anticarcinogenic agent reimbursed under APC 156 with a National payment rate of \$125.22. Q0084 should only be used for intravenous infusion of chemotherapeutic agents.

## Observation:

**Note:** Program Memorandum Intermediaries, Transmittal A-02-075 dated 8/7/02 relates to the use of the patient's admitting diagnosis to also be taken into consideration when a patient may qualify for Observation under the new APC 0339, HCPCS code G0244 (Letter G with Zero). After January 1, 2003 the admitting diagnosis will be used in addition to the principal and secondary diagnoses codes when determining separate observation payment for services provided on or after April 1, 2002. Prior to April 1, 2002 the admitting diagnosis was not taken into consideration to meet the medical necessity of observation services.

*Gretchen Evans, RN, MBA, CCS, is employed as Manager for Audit Compliance, Arden Health Systems, Nashville, Tennessee.*



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## IRS Information Letter (INFO 2002-0021) Guidelines for Incentive Compensation

By Heather Adkins  
Dean, Dorton and Ford

The purpose of the information letter is to list factors the IRS considers in determining whether incentive arrangements between an exempt organization and an employee violate the no private benefit standard. Organizations cannot be exempt if any of their earnings or assets inure to the benefit of private individuals.

According to the IRS, the following should be included in incentive compensation arrangements:

- Be approved by an independent board of directors or independent compensation committee with a conflict of interest policy
- Result in total compensation that is reasonable (reliable physician compensation survey data for the physician specialty and geographic locale are helpful in establishing reasonableness)
- Be utilized only where there is an arm's length relationship between the employer and employee (the employee should not be impermissibly engaged in the management and control of the employer)
- Have a ceiling on the amount the employee can earn
- Consider data that measures quality service to the employer's constituents, such as quality care and patient satisfaction
- Accomplish a charitable purpose, such as keeping expenses within budgeted amounts if the compensation amount is based on net revenue
- Serve a legitimate business purpose, such as achieving efficiency or economy of operations
- Provide rewards based on services actually performed by the employee rather than rewards based on the employer's performance in an area where the employee performs no significant functions

According to the IRS, the following should not be included in incentive compensation arrangements:

- Have the potential for reducing charitable services provided by the employer
- Transform the employer's principal activity into a joint venture between it and the employee
- Serve as a device to distribute the employer's profits to the persons who control it
- Result in abuse or unwarranted benefits because prices or operating costs don't compare favorably with those of similar organizations

## Region 4 Fall Presidents Meeting



*Dick Clarke, HFMA National President and CEO, at work during September's Region 4 Fall Presidents Meeting held at the Seelbach Hotel in Louisville*



*Mary McKinley and Bunnie Overby at the Region 4 Fall Presidents Meeting.*

# The Kentucky Chapter of HFMA Fall Education Institute & Healthcare 101

## October 28 and 29, 2002

Marriott Louisville East Hotel  
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Fall Institute Registration Fees  
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### *Additional Registrants from the Same Organization*

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*Cancellations must be made four days prior to the meeting date. Fax cancellations to (502) 562-2073.*

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Additional registrants from the same organization: \_\_\_\_\_ Member(s) (\$125.00/person) \_\_\_\_\_ Nonmember(s) \$175.00/person)

Total amount enclosed: \$ \_\_\_\_\_ (Make checks payable to Kentucky Chapter HFMA)

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