



A NEWSLETTER FOR THE MEMBERS OF THE
OHIO MEDICAL GROUP MANAGERS ASSOCIATION

MedMANAGEMENT Matters

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SPRING 2010

Message from the *President*



**Ohio MGMA President
Cheryl J. Hanlon,
RN, CMPE**

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Dear Ohio MGMA Members:

Thank you for choosing Ohio MGMA as your professional organization. With the uncertain economic atmosphere, we realize that many medical groups are cutting back on discretionary expenses, and educational funding may be limited. Ohio MGMA is committed to providing value for your membership.

2010 has brought many changes to our organization that will enhance member benefits. If you haven't visited our website lately, check us out at www.ohiomgma.com. I would also encourage you to check back with our website often as we post new content frequently as a tool to help you stay informed. Our website offers the ability to pay and renew your membership online, register and pay online for meetings, and preview future events. Other new features include current industry news, announcements and legislative updates pertinent to medical group management. Soon-to-be available on our website is the Ohio MGMA Job Board. Our members will be able post their open positions for free, giving you a place on the web to advertise to our entire membership of medical practice executives as well as those who browse by our website.

The OMGMA board has grown with two additional Member-at-Large positions and

we welcome Steven Davies, VP Southeast Ohio Physician Services – OhioHealth and Iris Darst, Practice Manager - The Franklin Clinic. Steven and Iris will assist with developing mentoring opportunities with local college and university health administration programs, and relationships with the Ohio Local MGMA chapters.

In addition to the annual scholarships available through Ohio MGMA, we are offering paid registration to the 2010 MGMA meeting for any Ohio MGMA member who attains fellowship in the ACMPE this year. We encourage you to get the most out of your membership. Picture yourself on the stage in New Orleans!

Of course, some of my favorite benefits of being an Ohio MGMA member are the networking opportunities and the relationships that I have developed over the past 14 years. I am excited about our planned meetings for 2010. Please take advantage of the benefits of membership; consider volunteering for a committee or project, and strengthen your leadership skills. I look forward to seeing you at our first meeting of the year on Friday, March 5th at The Conference Center at NorthPointe.

See You Soon!

Cheryl J. Hanlon, RN, CMPE
Ohio MGMA President

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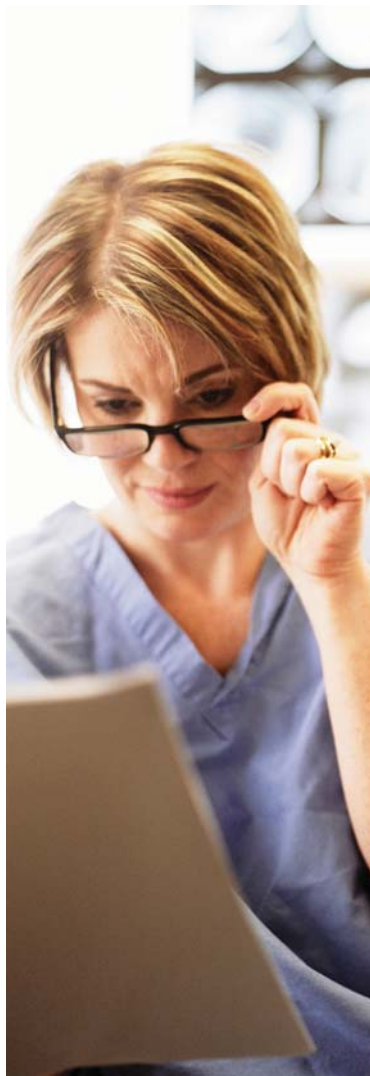
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MedMANAGEMENT *Matters*



MedManagement Matters

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Advertising space is available for industry suppliers. For rates, ad specs and deadline dates for future issues please contact the Ohio MGMA office at (330) 621-4353 or by email at main@ohiomgma.com

A Call to Authors

Ohio MGMA welcomes the submission of articles and other information from our members for publication. To submit a potential article/information for the next issue please contact the Ohio MGMA office at (330) 621-4353 or by email at main@ohiomgma.com

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OHIO MGMA

Purpose & Objective

- To promote a program of mutual education in the field of medical group practice administration.
- To disseminate information of mutual interest.
- To improve administration in medical groups in order to serve the members of the Association, the medical groups they represent and medical group practice.
- To cooperate with other organizations having similar aims and objectives.



Welcome our New Ohio MGMA *Members*

We welcome our new members! Please encourage your colleagues to join our organization. We find strength in numbers. Membership applications

can be found on our website - www.ohiomgma.com or you can call the Ohio MGMA office at (330) 621-4353.

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20 Ways for Medical Practices to Reduce Risk & Occupancy Cost as tenants in 2010!



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This information is provided compliments of The Schenk Company, Inc Greg Schenk SIOR 614-496-2715 www.irephtenant.com and Schenkseminars.com Greg@irephtenant.com Helping Medical Clients Improve their bottom line thru there real estate facilities for 23 years!

**Footnote
 The Urban Land Institute stated in Jan 5th NY Times that the real estate industry will have worst year since the 1991-92 real estate depression. Integra Realty Resources 2009 guide states many office markets will be in a hyper supply and recession stage for many markets. Marcus & Millichap Office vacancy report 1/19/09*

Record high office space vacancies* means medical practices have more leverage over landlords than ever before. Whether renewing a lease or relocating many lease items are overlooked and thousands of dollars left on the negotiating table. Practices should pay close attention to these ideas to insure they will profit greatly in 2010. From our 24 years experience here are the most important items to review with your trusted advisers.

1. Eliminate Personal Guaranty - *The Landlord can look only to the Lessee entity in case of default.*
2. Limit Personal Guaranty to a fixed time period - *The guaranty expires after said period.*
3. Limit Personal Guaranty to a fixed dollar amount - *This creates a maximum cap for which the guarantor is liable.*
4. Obtain a "kick-out" clause at any time if a penalty payment is made by Tenant. - *Tenant can pay a penalty to Landlord and break the Lease, rather than be responsible for the full term.*
5. Strike the Non-ASSIGNABILITY. - *Make assigning the Lease to a partner or purchaser a possibility.*
6. Get as many options as possible with the longest terms possible. - *Gives Tenant control over the space, protects against increasing rents.*
7. Cap Common Area Maintenance, Taxes and Insurance increases. - *Same as above.*
8. Eliminate Space Substitution (relocation) Clause. - *Transfers more control from Landlord to Tenant, prevents Landlord from relocating Tenant without Tenant's consent and compensation.*
9. Eliminate management fees from CAM. - *Reduces CAM and protects Tenant from overcharges by Landlord.*
10. Obtain the right to audit CAM charges. - *Protects Tenant against Landlord overcharges.*
11. Define what is included in CAM very precisely (No advertising, no management over ride, etc.).
12. Increase Grace Period for late rents. - *Gives Tenant additional time prior to penalties.*
13. Decrease Late Penalty. - *Lowers Tenant's potential costs.*
14. Increase time allowed to cure defaults. - *Gives Tenant more flexibility in their remedies.*

15. Limit Landlords ability to lease adjacent spaces to parking intensive neighbors. - *Prevents Tenant from facing a parking problem.*
16. Retain rights to interior furniture, fixtures and equipment. - *Allows tenant to retain more of its assets.*
17. Obtain right to rebuild yourself. - *Gives Tenant the option to do its own repairs if Landlord is too slow.*
18. Obtain right of first refusal on adjacent space. - *Allows Tenant to expand into adjacent space.*
19. Obtain option to buy. - *More relevant to smaller properties, this gives Tenant the option to purchase the property.*
20. Have Landlord guarantee HVAC, electrical, plumbing, etc. for a time period. - *May reduce Tenant's expense.*

Most practices are so busy working in their business they forget to take a step back and work on their business. The ones that do will improve there bottom line significantly as next to employees salaries lease payments or mortgage payments represent the second highest out of pocket expense.

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Upcoming *Events*

March 5, 2010

Ohio MGMA Winter Educational Conference
"Driving Your Personnel to Peak Performance"

Featuring Keynote Speakers

- **Scott Warrick, JD, MLHR, SPHR**
"Adopting Legal and Effective Hiring Practices"
- **Kendall Stewart, MD, MBA, DFAPA**
"Managing Average Employees"
"Managing Net-Negative Employee"

May 7, 2010

Annual Spring Payer Meeting -
Co-hosted Ohio MGMA & Ohio State Medical Association

Make plans to attend the Annual Spring Payer meeting which will be held at the Conference Center at NorthPointe - Lewis Center. This is an all-day conference with the major payers of Ohio. Payers will present expected changes for the coming year, give feedback on how to get claims paid in a timely manner, and answer your questions about claims processing and reimbursement. Please plan to join us on May 7, 2010 and bring your billing/coding staff!

Save the Date

September 17, 2010

Ohio MGMA Fall Educational Conference

For Information on these events: download agendas and brochures as they become available and to register for these events visit our website, www.ohiomgma.com

Local Chapter Event Spotlight

May 13, 2010
Cincinnati MGMA
Spring Seminar

Cincinnati MGMA is pleased to announce our 2010 Spring Seminar, "Technology in Healthcare". We will be featuring one General Session and four Breakout Sessions (attendees may select 2 breakout sessions to attend). For more information contact Kateri Haskett by email khaskett@pediatricassociatesnky.com

You Ask, You Respond

Q What is your team doing to reduce practice expenses?

A Our office has changed phone plans reducing monthly expenses by approximately 50%, negotiated decreased rent rate/terms and abatement's (for building improvements) with Landlord, used credit cards with rebates to pay majority of bills and minimized Yellow Pages advertising dollars to opt for more affordable Internet exposure (aligning us with our client base who is more technologically advanced and serving as a more affordable means of communication with our patients/families).

Gaynel Sheldon
Practice Manager
Associated Pediatrics

We would encourage Ohio MGMA members to submit your question for the next publication of MedManagement Matters! To submit your question: send via email to the Ohio MGMA office at main@ohiomgma.com with the subject line: Peer to Peer Question. Once we have selected a question we will poll our membership for a response to be published in the next issue.

Meaningful EHR Use and the Physician Practice

Adele Allison

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February 4, 2010

Now that EHR has become legislated through the American Recovery and Reinvestment Act of 2009 (ARRA), EHR adoption is imminent. EHS, Inc., a leader in certified physician software, has noticed a collective pause among physicians as relates to EHR solutions. Confusion abounds with questions, such as how do I qualify for ARRA EHR incentives? How will I receive these incentives? What happens if I do not adopt EHR technology?

ARRA/HITECH

ARRA was signed into law on February 17, 2009. Title IV of ARRA is known as the Health Information Technology for Economic and Clinical Health Act or HITECH and sets forth the carrots and sticks physicians face for EHR adoption through Medicare/Medicaid programs. Providers that meet the meaningful EHR use requirements will be eligible to receive up to \$44,000-\$63,750 in incentive payments; non-adopters being subject to Medicare reimbursement penalties beginning in 2015.

The goals of HITECH are simple. Push provider EHR adoption of certified EHR technology. Have those providers capture structured clinical data, move that data interoperability, and report data to CMS and States.

How do I qualify?

Building on HITECH, the definition of "meaningful use" is one of the most critical decision points of the Obama administration's healthcare IT efforts. Meaningful use will ultimately drive the types of products physicians will implement and the standards required for health information exchange.

On January 13, 2010, CMS published its notice of proposed rulemaking, outlining the initial stage 1 criterion. Two additional stages will be added through future CMS rulemaking. Everyone must be at a stage 3 level of meaningful use by 2015. The Medicare/Medicaid incentive programs are mutually exclusive. The following is a guide to becoming an eligible professional:

	Medicare	Medicaid
Eligible Provider Types	MD, DO, DDS, DMD, DPM, Optometrists, DC	Physicians, Pediatricians, Dentists, Midwives, Nurse Practitioners, Physician Assistants leading a FQHC/RHC
EHR Reporting Periods	Year 1: any continuous 90-day period within the calendar year; Years 2-4: the entire calendar year	Year 1: any continuous 90-day period within the calendar year; Years 2-4: the entire calendar year
Meaningful Use Criteria	Stage 1: 25 objectives/measures (17 measures require a numerator/denominator; 8 require "Yes/No" with 5 as structured data)	Not required the first year. Thereafter, the Medicare criterion apply and States may add additional criteria (E.g. participation in the state health information exchange)
Volume Threshold Requirement	None required, but payment is capped at 75% of Medicare allowable received during the EHR Reporting Period	Medicaid encounters must represent 20% for pediatricians; 30% for FQHC/RHCs; and, 30% for all others

How do I get paid?

A common misunderstanding within the physician community, the incentive dollars are not for purchasing EHR technology, but for the meaningful use of such technology. The following outlines information related to payment:

	Medicare	Medicaid
Payment Year	Calendar year (CY) beginning January 1, 2011	Beginning 2010 for adoption, implementation, or upgrading of EHR. Meaningful Use beginning CY2011
Reporting Requirements	CY2011 – no electronic submission, results reported through attestation CY2012 – electronic submission to CMS required	TBD by each State
Incentive Opportunity	Up to \$44,000 per provider by NPI; Incentives end after 2014	Up to \$63,750 per provider by NPI; Incentives end after 2016
Penalty for Non-Adoption	Medicare payment adjustment decrease to 99% of allowable in 2015; 98% of allowable in 2016; 97% of allowable in 2017	No penalty for non-adoption
Incentive Payment Administration	Through Medicare Administrative Contractors to the TIN	Through States to the TIN

Where do I begin?

Optimal outcome requires a well thought-out transition plan, appropriate expectation setting, managing people and managing the process. Remember, higher quality is often less costly and quality improvement is critical. Make sure your technology partner is certified and can help you through the transition because the devil is most certainly in the details.



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When you were in eighth grade, did you ever consider not going into 9th grade? Besides being required by State law, it was an automatic assumption that you would attend the next level of education. However, as you moved into 12th grade, it was no longer a given that you would go into a four year college. While many of us did, others chose to pursue a technical trade, joined the military, or started full time employment. The basic premise of our education is that it is a choice. A choice towards how much education, where to become educated on, what kind of education, who will provide it, and for what purpose will it achieve? Education is a resource tool that sharpens our skills and prepares us better to handle every day situations. Education is the glue that binds us to quality outcomes. Education gives us the learning needed to address new projects and improve existing ones. We never stop learning and our pursuit of education, whether formal or informal, helps us in the performance of our chosen profession. Now that you are an adult learner, I want to encourage you to join the American College of Medical Practices Executives (ACMPE) and become board certified. It's an education worth pursuing.

ACMPE is the certification body of the Medical Group Management Association (MGMA). By joining ACMPE, one receives board certification in medical practice management. This process earns the respect of one's colleagues and peers and a member is able to use the designation of "Certified Medical Practice Executive (CMPE)" as a member or "Fellow (FACMPE)". According to studies, ACMPE members earn more income in their profession than non-certified professionals. Also, when seeking employment, an ACMPE member has a distinct advantage over non-

certified professionals. Some organizations make ACMPE certification as a minimum requirement to be considered for a position. Colleagues, peers, and employers value these credentials.

Whether you are an experienced medical practice executive or just joining the profession, I strongly encourage you to consider membership in ACMPE. This effort will help you to achieve your personal and professional goals towards board certification.

To get started, go to the web site <http://www.mgma.com/acmpe/index.cfm> and explore the information available to you including:

- Getting Started
- Board Certification
- Resources
- Fellowship
- Awards
- Transcripts
- Frequently Asked Questions

This web site will get you started for an important part of your professional career.

If I can help in any way to answer your questions or support you in pursuit of ACMPE membership, please let me know.





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CMS Informally Announces PCOS Enrollment Delay till 2011

CMS is extending until Jan. 3, 2011, the deadline to enroll in the Medicare Provider Enrollment Chain and Ownership Supply (PECOS) system, the agency's director of enrollment James Bossenmeyer indicated yesterday. One reason he cited for the extension beyond the current April 5 deadline: the number of Medicare Part B providers who still are not in the electronic PECOS system. CMS indicates that it will send a reminder to all physicians to enroll in the new PECOS system if they enrolled in Medicare more than six years ago. [More details about PECOS is on the CMS Web site.](#) New information includes a database of all physicians currently enrolled in PECOS and instructions on how to access and use the information.

Interested in Getting Involved in Politics?

The AMA's AMPAC will conduct its annual campaign school April 21 to 25. The program, being held in Pentagon City (located just minutes from downtown Washington, D.C.) is for AMA members who wish to get involved in the political process as advocates and volunteers for medicine-friendly candidates. Organized around a simulated congressional campaign, the school has physicians participate as campaign staff, receiving instruction in campaign strategy, media advertising and political fundraising. If you are interested in participating, contact Jim Wilson, AMA political education programs manager, at 202.789.7465 or jim.wilson@ama-assn.org.

Reminder - Deadline to Change Medicare Participation Status Set for March 17

Congress provided a temporary (60-day) reprieve from the 21.2% Medicare physician payment cut, originally scheduled for January 1, 2010. The cut will now go into effect on March 1, 2010, if Congress doesn't act. Congressional leaders say that prior to the new deadline, they want to enact legislation that would stop the cut, however there is no guarantee now that this will occur prior to March 1. As a result of this uncertainty and to allow more time for Congress to complete its

work and give physicians a clearer picture of what Medicare reimbursement will be in 2010, the Centers for Medicare and Medicaid Services (CMS) has extended the period for providers to make changes to their Medicare participation status through **March 17**. This means that physicians who have not already changed their status still can do so, and those who made a change can retract it. Because the decision is retroactive, however, those who switch from non-par to par would have to refund any balance billing collected from their patients between January 1 and their new decision date.

As of press time, CMS has not made a decision whether or not any additional extensions will be provided if Congress does not act prior to March 1, or if another short-term delay of the cuts goes into effect. **Therefore, those who wish to change their status may not be able to do so after March 17th.** As a reminder, participation decisions are effective January 1 and are binding for the entire year.

MedLearn Matters Article Issued on Payment for ASC Services Furnished to Medicare Beneficiaries During a Part A Skilled Nursing Facility (SNF) Stay

CMS issued a MedLearn Matters article to explain a new edit that CMS will put in place to "prevent separate payment for facility costs billed by ASCs for Medicare beneficiaries in Part A SNF stays." Essentially, if a Medicare beneficiary is in a Part A SNF stay, the professional services they require during that stay, and now the ASC services they require, must be paid for by the SNF directly – not Medicare. This is what known as SNF consolidated billing (CB). SNF CB was mandated under the Balanced Budget Act (BBA) of 1997.

According to CMS, "Effective for claims with dates of service on or after January 1, 2008, Medicare will deny claims from an ASC that is enrolled as a provider specialty type 49, where the service has a Type of Service of F, and the patient is in a Part A SNF CB stay. Also, where Medicare receives a SNF claim for a patient in a Part A SNF CB stay and has previously paid an ASC claim incorrectly due to SNF CB, Medicare will follow current processes to recoup any overpayment from the ASC." The change will be implemented on July 6, 2010.

Go to the following links to review the MedLearn Matters article <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6702.pdf>, or the official CMS instruction <http://www.cms.hhs.gov/Transmittals/downloads/R1911CP.pdf> to its carriers.

CMS Annual Report on National Health Spending

The Centers for Medicare and Medicaid (CMS) released its annual report (http://www.cms.hhs.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopOfPage) on national health spending. According to the CMS press release, 2008 had the “the slowest rate of growth since [CMS] started officially tracking expenditures in 1960.” The rate slowed to 4.4 percent down from 6.0 percent in 2007.

However, despite the decelerated growth, health spending’s share of the gross domestic product increased from 15.9 percent in 2007 to 16.2 percent in 2008.

CMS also reports the following statistics:

- Hospital spending in 2008 grew 4.5 percent to \$718.4 billion, compared to 5.9 percent in 2007, the slowest rate of increase since 1998.
- Physician and clinical services’ spending increased 5.0 percent in 2008, a deceleration from 5.8 percent in 2007.
- Retail prescription drug spending growth also decelerated to 3.2 percent in 2008 as per capita use of prescription medications declined slightly, mainly due to impacts of the recession, a low number of new product introductions, and safety and efficacy concerns.
- Spending growth for both nursing home and home health services decelerated in 2008. For nursing homes, spending grew 4.6 percent in 2008 compared to 5.8 percent in 2007.
- Total health care spending by public programs, such as Medicare and Medicaid, grew 6.5 percent in 2008, the same rate as in 2007.
- Health care spending by private sources of funds grew only 2.6 percent in 2008 compared to 5.6 percent in 2007.
- Private health insurance premiums grew 3.1 percent in 2008, a deceleration from 4.4 percent in 2007.

Single-Payer Bill Re-Introduced in Ohio House in 2009

For each new session of the General Assembly, bills introduced in previous sessions which have not been acted upon must be reintroduced if action by the new Assembly is desired. Accordingly, on **April 29, 2009** State Representatives Michael Skindell and Robert Hagan jointly reintroduced the Health Care For All Ohioans Act (HCFAOA) in the House of Representatives (**H.B. 159**). **Co-sponsors of H.B. 159 are:** Barbara Boyd, Edna Brown,



Michael DeBose, John Domenick, Mike Foley, Marian Harris, Sandra Stabile Harwood, Joseph Koziura, Tom Letson, Clayton Luckie, Dale Mallory, Peter Ujvagi, W. Carlton Weddington, Sandra Williams, and Kenny Yuko.

Ohio’s Medicaid program.

At a time when our state budget faces painful cuts, Ohio policymakers will continue to look at Medicaid reform recommendations. Medicaid is the most expensive single item in the state budget and it is extremely important to measure the progress made toward the cost-saving recommendations provided in the 2006 and 2008 Medicaid performance audit study.

Only about 15 of the original 109 recommendations for Medicaid reform have been implemented. Another 40 recommendations show only partial progress. Medicaid has an enormous impact on the state’s budget, but the program is necessary to protect the health and well-being of approximately 2 million of Ohio’s most vulnerable citizens: low-income families, children, pregnant women, the elderly and people with disabilities. This adds up to almost 16 percent of the state’s population.

Since it started in 1968, Ohio’s Medicaid program has grown into a mammoth bureaucracy, costing taxpayers more than \$13 billion last year. These costs consume 37 percent — nearly two fifths — of Ohio’s General Revenue Fund (GRF) budget. What’s more, Medicaid’s annual costs keep growing at a rate much faster than state revenues. This creates pressure that keeps taxes higher than they otherwise might be and crowds out the state’s ability to fund other important services.

The 2008 Follow-up Medicaid Performance Audit, as well as the 2006 Medicaid Performance Audit on which it is based, are available at www.auditor.state.oh.us.



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