Medicaid Shortchanges Hospitals On Outpatient Reimbursements by Steve Price, Esq.

Before the Kentucky Medicaid Program went to Diagnosis Related Groups (DRGs) for inpatient hospital reimbursements, outpatient reimbursements were much simpler too. Prior to 2003 Medicaid paid for outpatient services on an interim basis at sixty-five percent of the hospital’s usual and customary charges with a year-end settlement to the lower of cost or charges. Following the advent of DRGs for inpatient services, Medicaid also began tinkering with outpatient reimbursements. This article addresses reimbursements for outpatient services rendered outside the emergency room.

What The Regulation Says. The Outpatient Reimbursement Regulation, 907 KAR 1:015, provides that non-emergency room services will be reimbursed as follows: The following six procedures are paid for at a flat rate: Cardiac Cath - $1,478 (unilateral) or $1,770 (bilateral); CAT Scan - $478; Lithotripsy - $3,737; MRI - $593; Observation room - $458; and Ultrasound - $177. Surgeries are also paid for at flat rates if they fall in one of the eight, 1996 Medicare ASC groupings. Otherwise surgeries are paid according to the facility specific, outpatient cost-to-charge ratio. If multiple surgeries are provided on the same day, only the highest paid surgery is reimbursed.

Most remaining services and supplies (hereinafter “2 (1)(g) services”) are paid at the facility specific cost-to-charge ratio and settled to cost at year end. Lab services are paid flat rates according to the Medicare Technical Component; or otherwise according to the hospital specific cost-to-charge ratio. Thus, the payment scheme for non-emergency room services outlined in the regulation can be simplified, as follows:

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<tr>
<th>Type of Service</th>
<th>Payment Methodology</th>
<th>Quantity Payable</th>
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<tbody>
<tr>
<td>Six Specific Services</td>
<td>Flat Rates</td>
<td>All That Apply</td>
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<tr>
<td>Surgery</td>
<td>ASC Flat Rates or Cost-to-Charge Ratio</td>
<td>Highest One Only</td>
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<tr>
<td>All Other – 2 (1)(g) Services and Supplies</td>
<td>Cost-to-Charge Ratio Settled to Costs Year End</td>
<td>All That Apply</td>
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<tr>
<td>Lab</td>
<td>Medicare Technical Component or Cost-to-Charge Ratio</td>
<td>All That Apply</td>
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What Medicaid Does. Here is the rub, which is not in the regulation: If a Medicaid patient receives any flat rate service, then Medicaid has been bundling any cost-settled 2 (1)(g) service that appears as a line item on the same invoice into the flat rate payment. This has bizarre results.
It's a New Year!

I would be willing to bet most of you are not as happy as me to see the start of a New Year. As we look back and reflect on 2007, we realize many of us have jumped over many hurdles this past year: both professional and personal. The start of 2008 brings many of us hope. Hope for a healthier and happier year and another chance to step up and Make a Difference.

While the calendar year has ended, our work as your Kentucky HFMA Officers is now just barely more than ½ over. We have successfully completed our Summer, Fall and Fall A/R Institutes. While we didn’t quite reach our goal of 200 attendees to the Fall Institute in Lexington, our survey results were excellent. Our commitment to education and high quality speakers remains as strong as ever. Please make sure to mark your calendars for the Winter Institute being held on January 25 in Louisville at The Galt House and the Annual Spring Institute will be held on March 20 and 21 in Lexington.

Another of the “behind the scenes” events that will occur in connection with the Winter Institute is the recommendation of next year’s Slate of Officers for the Kentucky HFMA. If you have an interest in getting more involved with the HFMA, you need to go ahead and speak up. The final Board approved slate of officers will be distributed to the membership next year for a vote of approval. If you’re not in line to serve as an officer, there are still plenty of opportunities to get involved in a less time intensive role. Now is the time to get in touch with an HFMA officer.

If you need any extra encouragement to get involved this year, perhaps this will help: In the coming months Leadership Training Conference will be held April 13-15 in San Antonio, Texas. And if that isn’t enough, I am certain a trip to Las Vegas could be the deciding factor as the Annual National Institute (ANI) will be held June 22-26 out in Las Vegas.

How many more reasons do you need to get more involved in the HFMA. It’s a New Year. Step up and Make a Difference by getting involved.
For example, if a Medicaid patient has a pacemaker implanted followed by a stay in an observation bed, Medicaid has been paying $458 for the observation room and nothing for the pacemaker, which costs thousands of dollars. Medicaid has also been bundling supplies, x-rays and even the labs into flat rate payments. Thus, Medicaid has not been following its own regulation.

**The Problem Is Hidden.** The shortages caused by Medicaid’s misapplication of the regulation do not show up, however, at the year-end settlement of 2 (1)(g) claims to costs provided for in the regulation. All 2 (1)(g) claims that Medicaid bundled into fixed rate payments are included in Medicaid’s Outpatient Hospital Fixed Rate Summary. Those claims are not included in Medicaid’s Outpatient Hospital Summary, which is used to settle claims paid on an interim basis (at the hospital’s cost to charge ratio) to costs at year end. Consequently, the attendant costs of the claims improperly bundled into the fixed rate claims (and which, therefore receive no interim payment) are not being taken into consideration in the year-end settlement either. If a hospital tries to include those costs when submitting its cost report, Medicaid kicks them back out.

The problem is also masked some by the fact that Medicaid’s Outpatient Fixed Rate Summary also includes Emergency Room claims. Section 4 of the regulation dealing with Emergency Room reimbursements does, in effect, bundle all 2 (1)(g) services and supplies provided in the Emergency Room into the ER fixed payments. In addition, it appears that Medicaid’s claims processing sometimes fails to recognize some commonly used CPT or HCPCS codes, adding further to the confusion.

**Medicaid Is Wrong.** Nothing in the Outpatient Reimbursement Regulation gives Medicaid the authority to bundle 2 (1)(g) settled to cost services into 2 (1)(a) flat rate payments in this manner for non-ER services and supplies. The Provider Billing Instructions For Hospital Services Provider Type-01 Manual states: “If there is a flat rate procedure and a cost of [sic] charge procedure done on the same day, reimbursement is only for the flat rate procedure. Example: MRI and lab.” However, the Provider Billing Instructions Manual has not been incorporated into the regulation. It cannot be used as controlling authority on this point to contradict the regulation.

In July, Medicaid filed an emergency regulation to give itself authority for this bundling practice. That emergency regulation provided that if any 2 (1)(g) service appeared on a claim with a line item reimbursed with a flat rate, then reimbursement for the 2 (1)(g) service “1. Shall not be cost settled; and 2. Shall be included in the flat rate.” After one hospital filed suit to enjoin Medicaid from using this emergency regulation to bundle payments, Medicaid partially relented. It withdrew the ordinary regulation it was promulgating to replace the E-reg, causing the emergency regulation to be withdrawn too. Therefore, the old regulation, which does not authorize bundling by Medicaid, remains in effect for the present time. Medicaid has not admitted, however, that it has been improperly bundling payments for the past three years and, apparently, it has not fixed its system to correct the problem.

**Protect Your Hospital.** Hospitals that receive outpatient settlement letters from Medicaid for fiscal years 2003 and beyond should examine their outpatient reimbursements closely to see whether they have been shortchanged and, if so, file appeals within thirty days. Hospitals should spot check some Remittance Advices, particularly for those claims with low reimbursements relative to total invoice charges to see if they have a claim against Medicaid. The bundling, once one becomes attuned to it, is easy to spot. Even the bundling of relatively small dollar items such as supplies or x-rays into flat rate payments can add up to significant sums over time.

It remains to be seen what Medicaid will do next with outpatient reimbursements. Watch closely.

Steve Price is a partner at Wyatt, Tarrant & Combs, LLP who frequently advises hospitals on reimbursement issues. For more information he can be contacted at 2800 PNC Plaza, 500 West Jefferson Street, Louisville, Kentucky 40202; or 502.562.7303.
On November 15, the Cabinet for Health and Family Services Department for Medicaid Services issued emergency regulations implementing a new DRG system for acute care hospitals, new rates for cost based hospitals, and updated rates for making disproportionate share payments. The Department had issued these regulations October 15, but they contained inadvertent errors which were corrected with the November 15 filings. Because the changes were initially filed as emergency regulations on October 15, this will be the effective date for making payments under the new rates. However, due to MMIS issues, the actual timing of retroactive mass adjustments is currently unknown. The DRG and cost based regulations contain rate enhancements using the $26 million in earmarked provider tax funds made available under KHA’s provider tax legislation, that when matched, will bring $88 million in new funding for hospitals of which $68 million is allocated to acute care hospitals.

The DRG regulation implements the methodology recommended by KHA and the Hospital Technical Advisory Committee developed by the Lewin Group. Under the new method, each hospital will be paid a base rate that reflects the hospital’s specific costs adjusted by a uniform budget neutrality factor (applied to all hospitals). Hospitals can also qualify for a high volume add-on to their rate based on their number of Medicaid paid days or the percent of Medicaid to total patient days. The add-on amount is tiered so that more hospitals can qualify at some level. Hospitals that qualify under both criteria will receive the highest applicable add-on. Hospitals qualifying for an add-on payment will receive the add-on amount based on the statewide length of stay for a patient’s DRG. The system will use new weights that have been calculated based on Medicaid claims instead of the modified Medicare weights that are currently used. Separate neonatal weights have been calculated for Level II and Level III NICUs as mother and baby claims will be paid separately. The new DRG system will distribute the $68 million in two ways — $32 million is provided through the base rates and $36 million is distributed through the high volume add-on. Rates were developed using 2005 cost reports, trended and indexed, and 2006 paid claims data. Hospitals will receive inflationary updates annually between rebasing periods, which are to occur every four years. As a result of this methodology, aggregate cost coverage will increase from approximately 65 percent to 80 percent, and the range of cost coverage — which previously ran from about 46 percent to 96 percent — will now be compressed from a low of 70 percent to a high of 86 percent. Those hospitals at the lowest cost coverage are the providers of the least amount of Medicaid services.

The new cost based regulation also updates per diem rates for freestanding psychiatric, rehabilitation, and long term acute hospitals using trended and indexed 2005 cost reports. Rates are calculated by applying a parity factor (equal to the aggregate DRG cost coverage) to the higher of the hospital’s base cost per day or rate floor, set at 95 percent of the group’s weighted average. Provider tax funds are added to this amount on a prorata basis. No changes were made in the calculation of rates for distinct part units or critical access hospitals.

Changes to the DSH regulation will update the rates used for calculation of inpatient indigent care to incorporate the new cost based rates and will calculate a proxy per diem for DRG paid hospitals. A hospital’s proxy per diem will be calculated by dividing the total of DRG payments for the State fiscal year ending June 30 by the Medicaid paid days for the year. Since these changes were not finalized before DSH payments were made this year, they will apply to future year payments.

For more information contact Steve Miller, V.P. Finance, Kentucky Hospital Association, 2501 Nelson Miller Parkway, Louisville, Kentucky 40223-2221; PH (502) 426-6220 or e-mail: smiller@kyha.com.
Data Breaches And Complaints Lead To OIG HIPAA Audits; HHS Hires Additional Privacy Enforcement Specialists

By Erin Brisbay McMahon, Esq.

We hear it on the news almost every day: a computer was stolen from a health care provider, and the hard drive may have contained social security numbers of patients as well as other identifying information. Perhaps in response to these reports, the Office of Inspector General (OIG), the Centers for Medicare and Medicaid Services (CMS), and the Department of Health and Human Services (HHS) have all sent strong signals recently that enforcement of the HIPAA security and privacy rules will begin to be undertaken in earnest.

**OIG Security Rule Audits**

In March, 2007, Piedmont Hospital in Atlanta, Georgia became the first hospital to be audited by OIG for compliance with the HIPAA security rule. Although information about the audit and its results has been sketchy at best, Computerworld reported in June that it had obtained a list of 42 items of information that the government demanded be produced within 10 days of the start of the audit. Piedmont was apparently asked to provide policies and procedures for:

1. Establishing and terminating users’ access to systems containing electronic patient health information (ePHI).
2. Emergency access to electronic information systems.
3. Inactive computer sessions (periods of inactivity).
4. Recording and examining activity in information systems that contain or use ePHI.
5. Risk assessments and analyses of relevant information systems that house or process ePHI data.
6. A sanctions policy to deal with employee violations of HIPAA or the hospital’s security policies and procedures.
7. Electronically transmitting ePHI.
8. Preventing, detecting, containing and correcting security violations (incident reports).
9. Regularly reviewing records of information system activity, such as audit logs, access reports and security incident tracking reports.
10. Creating, documenting and reviewing exception reports or logs. Please provide a list of examples of security violation logging and monitoring.
11. Monitoring systems and the network, including a listing of all network perimeter devices, i.e. firewalls and routers.
12. Physical access to electronic information systems and the facility in which they are housed.
13. Establishing security access controls; (what types of security access controls are currently implemented or installed in hospitals’ databases that house ePHI data?).
14. Remote access activity, i.e. network infrastructure, platform, access servers, authentication, and encryption software.
15. Internet usage.
16. Wireless security (transmission and usage).
17. Firewalls, routers and switches.
18. Maintenance and repairs of hardware, walls, doors, and locks in sensitive areas.

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Chapter Membership Report  By Theresa Scholl

By now Kentucky Chapter HFMA members should have their new membership directory. Special thanks to Don Frank, Chair of the Membership Directory, for a great job! If you have any suggestions or would like to help us with next year's directory please let me know. The Chapter currently has 516 members. Our retention rate goal is 87%. Currently we’re at 85.9%, so we are close to the goal. Keep up the good work. Listed below are the new members who recently joined our Chapter. Let’s make them feel welcome.

July – Three new members, one transfer.
Kris Schmucker, Student
Evan Long, Central Baptist Hospital – Administrative Resident
Pat Borromero, University of Louisville
James Breen, Mercer Health and Benefits – Consultant; Transfer from Chapter No. 004 Eastern Michigan Chapter

August – Five new members.
Sandra Thacker, Hardin Memorial Hospital – Manager PFS
Richard Whipple, Fifth Third Bank – Vice President
Matthew Biefeld, Humana Military Healthcare Services – Director Claims Administrator
Robert Duley, Central State Operations – Director of Physical Plant Operations
Jennifer Pratt, Commonwealth Health Corp. – Admin. Assistant to the EVP

September – Six new members.
Jonathan York, AHD Corp. – Software Developer
Dominic Adiutori, American Hospital Directory – Director of Customer Service
Gabriela Keemer, Mountjoy & Bressler, LLP – Manager
Jaclyn Dabney, Taylor Regional Hospital – Charge Description Master Specialist
JoAnn Smith, Taylor Regional Hospital – HCIS Code/Team Leader
Adam Shewmaker, Ernst & Young – Senior Consultant

October – One new member.
Todd Oltman, The CSC Group – Senior Account Executive

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19. Terminating an electronic session and encrypting and decrypting ePHI.
20. Transmitting ePHI.
21. Password and server configurations.
22. Antivirus software.
23. Network remote access.

The OIG also had several other requests:
1. Please provide a list of all information systems that house ePHI data, as well as network diagrams, including all hardware and software that are used to collect, store, process or transmit ePHI.
2. Please provide a list of terminated employees.
3. Please provide a list of all new hires.
4. Please provide a list of encryption mechanisms used for ePHI.
5. Please provide a list of authentication methods used to identify users authorized to access ePHI.
6. Please provide a list of outsourced individuals and contractors with access to ePHI data, if applicable. Please include a copy of the contract for these individuals.
7. Please provide a list of transmission methods used to transmit ePHI over an electronic communications network.
8. Please provide organizational charts that include names and titles for the management information system and information system security departments.
9. Please provide entity wide security program plans (e.g., System Security Plan).
10. Please provide a list of all users with access to ePHI data. Please identify each user's access rights and privileges.
11. Please provide a list of systems administrators, backup operators and users.
12. Please include a list of antivirus servers, installed, including their versions.
13. Please provide a list of software used to manage and control access to the Internet.
14. Please provide the antivirus software used for desktop and other devices, including their versions.
15. Please provide a list of users with remote access capabilities.
16. Please provide a list of database security requirements and settings.
17. Please provide a list of all Primary Domain Controllers (PDC) and servers (including Unix, Apple, Linux and Windows). Please identify whether these servers are used for processing, maintaining, updating, and sorting ePHI.
18. Please provide a list of authentication approaches used to verify a person has been authorized for specific access privileges to information and information systems.

Industry analysts have pondered for months why the OIG conducted this audit instead of CMS, which is responsible for enforcement of the HIPAA security rule. However, the OIG’s work plans for FYs 2007 and 2008 do state that OIG will review CMS’s oversight, implementation, and enforcement of the HIPAA security rule. Karen Trudel, Deputy Director of CMS’ Office of Electronic Standards and Services, confirms that CMS has recently contracted with PricewaterhouseCoopers to conduct HIPAA security audits, but OIG plans to conduct at least two more audits, one of which will reportedly occur at Cedars-Sinai Medical Center. CMS noted that audits would be triggered by complaints received by CMS concerning violations of the HIPAA security rule.

HHS Expands Privacy Enforcement Team
On December 7, 2007, HHS’ Office of Civil Rights, which enforces the HIPAA privacy rule, announced that it would be hiring three new health information privacy specialists by sending out an e-mail to its entire privacy listserv with the heading, “HHS is expanding its health information privacy enforcement team.”

Why Civil Money Penalties Should Not Be Your Primary Concern
While neither HHS nor CMS has imposed any civil money penalties for HIPAA violations, both agencies have faced criticism for failing to do so. At HIPAA Summits held to discuss the privacy and security rules, hospital privacy officers complained to the head of OCR that they had no budgets to implement HIPAA, and would not until OCR started handing out CMPs, due to the fact that administrators realized HHS would work with them to correct problems rather than imposing fines.

As a health care lawyer on the front lines of this issue, I caution readers that although the prospect of an OIG audit is scary, it is actually the least of the worries hospitals and other health care providers face in this area. The number one goal should be “getting your house in order,” which means conducting a self-audit at least once a year to see how your organization measures up against HIPAA privacy and security rule requirements and changing technology in your own organization and in the world. Why is this important? Because few organizations can afford the financial and reputational effects of a significant data breach.

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There are over 35 studies that identify listening as the top skill needed to obtain success in business environments. Listening is a very important communication skill. The largest portion of time we spend communicating to others is through listening, which consumes 45% of our day. The remainder consists of 30% talking, 16% reading, and 9% writing. Because everyone has different ways of exposing their communication skills and how they express themselves it creates a barrier for effective listening. Therefore, it is essential that you exercise the traits of a good listener. Good listeners prevent misunderstandings during the communication process by doing the following:

**Face the speaker and maintain eye contact.** This will help you concentrate by minimizing the possibility of being distracted by other thoughts or things going on around you. It also sends a message to the speaker that you are actually paying attention. Beware that other forms of body language will also alert the speaker that you are uninterested or inattentive.

**Show signs of positive reinforcement.** Periodically make short responses such as “uh-huh” or “okay”, and nod to let the speaker know that you are following the conversation. However, if you are not comprehending do not give positive feedback just so they will think that you understand or that you are paying attention. Tell the speaker you are confused so they can help you gain a better understanding.

**Ask questions.** Be sure to ask questions when you don’t understand, but you should also ask questions when you need further clarification. Pose your questions immediately as they arise. If you do not, you will be concerned with trying to understand the previous comment instead of what the speaker is currently saying.

**Don’t interrupt to get your point across.** Focus on what the speaker is saying. Give them the courtesy and time to tell you what they are requesting. Do not talk over the speaker, which is a sure sign that neither of you are listening.

**Try not to develop your response mentally.** Do not begin creating your rebuttal before the speaker is finished. If you choose to do so you are not listening but shifting to defense mode. Then you are no longer effectively listening but what is called combative listening. Combative listening is waiting for openings to take the floor or searching for weak points to attack. Hold your fire

Data Breaches And Complaints Lead To OIG HIPAA Audits; HHS Hires Additional Privacy Enforcement Specialists …continued from page 5

Chances are low that anyone from outside your organization will really assess your privacy and security rule compliance until a catastrophic event occurs. In a simple laptop computer theft, tens of thousands of patient records can be compromised. Although the HIPAA privacy and security rules don’t specifically require covered entities to inform affected individuals of such an incident, many states have data breach laws that require companies to inform residents of that state when certain pieces of identifying information have been compromised. These laws require companies to notify affected persons of the breach. When the notifications are received, the media descends and demands to know why affected persons were not informed of the breach sooner. If the data breach involves financial information or social security numbers, the Secret Service and the FBI will be arriving to investigate, in addition to local law enforcement. Consideration must be given as to whether to offer affected persons credit monitoring and other assistance, and for how long. Before a data breach occurs, organizations need to have a response plan in place, including how to respond to telephone calls from patients, reporters, and law enforcement. But a response plan is just one facet of a comprehensive privacy and security compliance plan, which is essential for your organization’s survival.

For more information Erin Brisbay McMahon can be contacted at Wyatt, Tarrant & Combs, LLP, 250 West Main Street, Suite 1600, Lexington, Kentucky 40507-1746, Tel. (859) 288-7452 or e-mail emcmahon@wyattfirm.com.

“Sorry, Can You Repeat That?” by Tanée Brewer, Financial Analyst

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Announcing — a new HFMA resource for those who work in a Small/Rural Provider setting! There is a community available for HFMA members who work in the small or rural provider setting called the Small/Rural Provider Community of Practice (SRCoP). Similar to HFMA’s four specialty Forums, Communities of Practice (CoP) will focus on knowledge and experience sharing on topics and challenges that are unique to different segments of the healthcare finance industry. The Small/Rural Provider CoP is focused on providing business expertise to its members through shared knowledge, resources and expertise. “This community is important because it adds depth to your staff capabilities through resources and best practices shared by community members around the country to strengthen the organizations we serve and ensure that small/rural facilities have quality financial leadership.”

The Small/Rural Provider Community of Practice Design Team

HFMA’s CoPs will provide online interaction tools designed to facilitate discussion and information sharing among our members. Here, members will be able to contribute to discussions, add resources, create new learning, and build community to better the healthcare finance industry. Recent community experiences include shared resources and peer-to-peer discussions on space planning processes, demonstrating community benefit, and IRS compliance.

The Small/Rural Provider CoP was designed by individuals currently in leadership roles in the small/rural setting who started off strong by defining a mission statement: To be a vital resource of knowledge and expertise for small rural healthcare providers. The community has outlined eleven key content areas it wants to focus on:

- Leadership challenges
- Revenue cycle
- Healthcare IT
- Compliance issues for community hospitals
- Meeting community healthcare needs
- Physicians issues
- Jack-of-All Trades role
- Benchmarking
- Core Finance
- New Product Service Lines
- Quality

Upcoming members-only events include a spring event on Benchmarks for Critical Access Hospitals that is in development.

To join the Small/Rural Provider Community of Practice, and to participate in these free members-only events please visit http://www.hfma.org/forums/communities/sr/default.htm or get in touch with a community member by e-mailing your question to communities@hfma.org. Join today (https://www.hfma.org/site/forums/join_cop.cfm) and get $125 in discounts off of HFMA education.

For more information you may also contact Gerald H. Klein, FHFMA, Chief Financial Officer, Lawrence County Memorial, 2200 West State St., Lawrenceville, IL 62439 or phone (618) 943–7202.
HFMA of Kentucky thanks the following sponsors who have made this year’s newsletter possible:

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