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SAVE THE DATE!

2010 Fall Education Institute
October 14-15
Embassy Suites
Lexington, KY

2010 Revenue Integrity Workshop
November 5
Embassy Suites
Lexington, KY

www.hfmaky.org
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### 2010 - 2011
#### Officers and Directors

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<td>Andy Strausbaugh</td>
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<td>Regional Executive</td>
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Kentucky HFMA has a New Chapter President

Meet Andy Strausbaugh

**Professional:** Currently Andy is the Vice President of Finance and Operations for Norton Brownsboro Hospital in Louisville, KY. Prior to this he was the System Director of Reimbursement for Norton Healthcare; as well, he was Manager of Reimbursement, Budget and Decision Support for Deaconess Health System in Evansville, IN.

**Personal:** Andy was born and raised in Lafayette, IN. He graduated from Hanover College with a BA in Business Administration in 1992 and received his Master’s in Health Administration in 1995 from Indiana University.

**Family:** Andy has been married to wife Kathy for 15 years. They have 3 boys, Alex (9), Ben (7) and Nate (3) and a new 6 month old puppy named Sadie.

**Hobbies:** Andy enjoys spending time with family, playing golf, exercising and working in the yard.

**Favorite Musical Group:** AC/DC.

**Favorite Movie:** “A Few Good Men”

**3 Things You May Not know about Andy:**

1. Lived in Hawaii for 2 years
2. Ran the 2002 Chicago Marathon
3. Played several satellite professional tennis tournaments after college

**Goal as President of HFMA:** My goal as President of the Kentucky Chapter – HFMA for 2010-2011 is to build on the momentum of the chapter as established by all of those who have lead the chapter before me.

In these tough economic times, I want to ensure we provide the highest quality of educational sessions to our membership by being a good steward of our financial and human resources. In addition to the typical educational institutes, I want to offer additional educational opportunities such as webinars and other half day educational institutes in locations other than Louisville and Lexington.
Greetings! It is hard to believe I am writing this message as President of the Kentucky Chapter – HFMA. First, I want to say how honored I am to serve in this role and volunteer with so many outstanding people. I also want to thank all of those who have served the chapter before me, paving the way and creating such a wonderful organization.

If you would have told me 10 years ago I would be president of a state-wide professional organization I would have laughed first and then said, “You are crazy!” I used to consider myself very shy. Standing and talking in front of people, especially a group with well over 100 people, was not in my personality.

One day I was asked to get involved and assist the chapter. I was very reluctant but agreed to get involved. Early on in this process I realized this was actually a lot of fun and I was learning a lot. Furthermore, we have a lot of great leaders involved in our chapter so this was another way to better build my skills by observing these leadership styles. I served two years as the Corporate Sponsorship Chair. Once again I thought “you want a quiet and shy guy to not only get involved but ask corporations to donate money to the chapter?” I was amazed with what is possible if you just ask. As you all know, we have a lot of great sponsors who support our chapter. Without their kindness and support, we would not be able to do the things we do. Furthermore, this was yet another opportunity to meet and interact with a lot of really great people. Finally, from an overall chapter operations perspective, our sponsors and vendors provide a lot of valuable input as well.

As I moved through the Vice President Chairs and became President-Elect, I found myself thinking about how this process of volunteering with our chapter has made me a stronger and more confident person both professionally and personally. In addition, I have made many lasting friendships with people from all over Kentucky and other chapters as well.

I know volunteering for any organization adds time and additional commitments to the ever growing “Plate” we all have. I can honestly say giving time back to any community organization is very rewarding and worth the effort. This year’s HFMA theme established by the new National Chair, Debbie Kuchka-Craig is “Step UP.” Whether it is with HFMA, a community board or your child’s school, I challenge all of you to “Step UP” and get involved. During these tough economic times, many organizations need the creative minds of good volunteers. Healthcare Financial Leaders have always proven they could “Step UP” and meet any challenge head on.

I look forward to the upcoming year and serving as the President of the Kentucky Chapter – HFMA. This truly has been a great experience for me, one that I will always cherish and which has made me a more confident person. I will once again challenge each of you to get involved and give back to an organization. If you are interested in the Kentucky Chapter – HFMA, please see our new Volunteer Form on our website. I guarantee you will learn a lot, meet many outstanding leaders and have FUN !!!!!!

Thanks again for the opportunity to serve our chapter and I look forward to seeing all of you at one of our educational sessions.

Sincerely,

Andy Strausbaugh, President
Kentucky Chapter – HFMA
2010 - 2011

See Andy Strausbaugh “State of the Chapter” address on the website, www.hfmaky.org
Greetings Kentucky HFMA members! I hope my message finds you well both personally and professionally.

My name is Jeff Presser and I am your new newsletter chairman. I have worked in health care since 1993 and currently for Dean Dorton Ford, PSC as a Manager of Business Consulting. Previously I worked for Jewish Hospital and St. Mary’s Health Care as a Reimbursement Manager.

I have been married for 13 years and have a soon to be 4-year-old daughter. I enjoy spending time with my family, reading, watching movies, listening to music and working in our yard.

I must say that I was a bit nervous when I volunteered for this position. I didn’t know a thing about how to put a newsletter together. Well, little did I know that Dean Dorton Ford has a secret weapon when it comes to this kind of thing. Her name is Monica Wesolowski and she is a talented writer and editor who is discovering hidden gifts in newsletter design and layout. Needless to say, Monica has been the answer to all of my newsletter insecurities. Together we’ve talked, brainstormed, researched and talked some more, developing a vision of what the Kentucky Chapter HFMA newsletter could be. I certainly hope that you will be pleased with the result.

In April of this year I attended the HFMA Leadership program in Phoenix, Arizona. While there I decided to create a regular segment in our newsletter spotlighting CFO’s from Healthcare Organizations across our state. In this initial, introductory segment we have interviewed four; Ron Sowell of CHC, Mike Gough of Norton, Joe Grossman of ARH and Gary Emers of St. Joseph. Because of the wealth of information from these four gentlemen (and space limitations) I’ve included their full interviews in a separate, supplemental issue. In this issue you will find an article that summarizes key points from all four interviews. We’re narrowing down our choices for the next (2) CFOs that will be in our next issue, so stay tuned! If you have any suggestions for articles or have questions or feedback on our new look, please don’t hesitate to contact me.

I look forward to bringing to your attention lots of helpful articles and information in the upcoming newsletters.

Sincerely,
Jeff Presser
Dean Dorton Ford
jpresser@ddfky.com
Kentucky Hospitals Pursue Medicaid Rate Appeals

By: Steve Price, Carole Christian, John Woodard of Wyatt, Tarrant & Combs, LLP

In 1995 a federal district judge decided in a lawsuit brought by Kentucky Hospitals that Medicaid inpatient reimbursements that covered 93% to 96% of hospital, Medicaid recognized costs were within the permissible, federal “zone of reasonableness”. The Court recognized, however, that while the State should be permitted to experiment with its reimbursements, recent changes to the methodology could result in the rates becoming unreasonable and inadequate. While upholding the methodology as a whole, the Court concluded that individual inequities in hospital rates should be corrected through the administrative appeals process. After that decision the State continued to restrict hospital reimbursements further. By 2001 hospitals were receiving approximately 69% to 72% of their Medicaid recognized costs for inpatient acute care services.

Numerous administrative appeals were filed by Kentucky hospitals between 1996 and 2003. The hospitals demonstrated in these appeals that the per diem methodology actually penalized hospitals for increased efficiency. Every court that considered the issue during those years found that the Medicaid rates paid hospitals were inadequate and did not otherwise comply with the law. Almost without exception hospital appeals resulted in judgments favorable to the hospital and/or a favorable settlement. Nonetheless, the State designed its new DRG methodology to include a budget neutrality factor based upon the prior, inadequate and antiquated per diem methodology’s payments.

All hospital appeals of the new DRG rates for 2004 through 2006 were settled in a “Global Settlement” that was effective in June 2009. During settlement negotiations the hospitals repeatedly told the State that if the, as of then unpublished DRG rates, effective October 15, 2007, did not at least approach the federal court’s “zone of reasonableness”, then more appeals would follow.

The new DRG weights and hospital base rates were finally published in 2009. The resulting rates, which the State prefers to call the “Lewin” rates, have not approached the zone of reasonableness for most hospitals. Indeed by the State’s own predictions, the new DRG rates were expected to produce rates that covered, on average, only 78% of Medicaid costs. Not surprisingly, most hospitals filed administrative appeals.

Most of those appeals have been through “Dispute Resolution Meetings” (DRM) which are the first stage of the administrative appeals process. Dispute Resolution decisions are not expected until next Fall, however, as the State has noticed its intent to take 180 days to issue decisions. All the data is not in, but so far the new rates appear to have produced some unexpected and, as of yet, unexplained anomalies. The bottom line remains, however, that no methodology can produce adequate rates when it is artificially restricted by a budget neutrality pool that is based on the demonstrated inadequacies and deficiencies of the old, per diem methodology. In effect, the budget neutrality pool adopted by the State limits hospital payments to 1991 costs. Yet nobody wants 1991 medicine or technology when they go to the hospital. Since Medicaid patients are such a large percentage of Kentucky hospitals’ patient load (on average 20%), then this massive shortfall in Medicaid reimbursements affects the cost and availability of health care for everyone in the State. This dilemma will only be intensified if the federal government adds more people to the Medicaid roles at the current inadequate rates.

Steve Price, Carole Christian and John Woodard are partners at Wyatt, Tarrant & Combs, LLP and are frequently involved in hospital reimbursement issues. They may be reached through the attorney listing at www.wyattfirm.com.
ANI - A Success Despite Relocation

By Chris Woosley
Corporate Controller, Baptist Healthcare System, Inc., President-Elect KYHFMA

HFMA’s Annual National Institute (ANI) took place on June 20 – 22 at the Venetian Hotel in Las Vegas, Nevada. The conference, originally scheduled to be held in Nashville until a flood forced the closure of The Gaylord Opryland Hotel, was a great success despite the last minute venue change. Whether you were looking for great technical education, a motivational message or a chance to network with peers, this year’s ANI did not disappoint. The lineup of keynote and breakout speakers was truly outstanding and proved that HFMA remains an indispensable resource for education in healthcare finance.

Ian Morrison, healthcare author and futurist provided insight related to the future of the healthcare market place. Pulitzer Prize winning political columnist, George Will, addressed issues surrounding the current landscape of healthcare politics and what to expect in future policy. Former Senate Majority Leader, Bill Frist, gave his perspective on healthcare reform and discussed how we can maximize value in healthcare delivery. And finally, Christopher Gardiner, author of and main character in The Pursuit of Happiness, provided inspiration with how he persevered through overwhelming obstacles to overcome homelessness and become a self-made millionaire.

Breakout sessions included a wide variety of topics geared towards everyone from CFOs to coding and compliance professionals to front line managers. All the topics were very relevant to the current healthcare environment and provided valuable education that could be taken back to attendees’ individual organizations and put into action.

Total attendance at the event was approximately 4,500. The Kentucky Chapter was well represented with 74 members in attendance. At the Chapter Presidents dinner, Bill Jones, Immediate Past President, accepted four awards on behalf of the Kentucky Chapter for his outstanding effort during the 2010 fiscal year.

The vendor hall included 378 of the best healthcare consultants, advisors and technology firms in the industry. The booths were much more elaborate than the booths we are accustomed to at Kentucky events. Many provided games, product demonstrations and giveaways for those who stopped by to chat. One booth even brought in a bright orange Lamborghini. Unfortunately, they not give it away or allow for test drives.

For those Kentucky members who were unable to attend ANI, rest assured that your Chapter leadership will continue to strive to bring ANI-caliber speakers right here to Kentucky. Thank you for continuing to support the activities of the Kentucky Chapter. Be sure to visit the National HFMA website (hfma.org) for more information regarding ANI or the Kentucky Chapter website (hfmaky.org) for the latest on upcoming events.

Debora Kuchka-Craig, HFMA National Chair, KY Chapter HFMA Past-President Bill Jones, and Catherine Jacobson, CPA, Past HFMA National Chair
Christopher Gardner, Bestselling author of “The Pursuit of Happiness”
On March 23, 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act, followed shortly thereafter by the Health Care and Education Reconciliation Act of 2010 on Wednesday March 31, 2010. Combined, these laws are what we commonly refer to as “Healthcare Reform” and they are intended to expand health insurance coverage and improve the ways in which healthcare is delivered. The scheduled changes in our healthcare delivery system will surely affect our entire population to some extent. However, out of any group of people, physicians will most likely face the most changes under Healthcare Reform. While intent of these new laws is to improve medical care while cutting costs, the pending side-effects for physicians will include an increased dependency on hospital-physician alignment strategies and a movement away from the private practice model.

**Expanded Coverage = More Covered Patients**

At a fundamental level, the intent of Healthcare Reform seems to benefit both those who seek medical care and those that provide it. Estimates are that approximately 32 million uninsured people will have health insurance under the new laws. Logically, this would mean that more people would be able to seek medical attention and that charity care and bad debt would decrease.

It is estimated however that approximately 16 million of these newly insured will fall under the Medicaid program, which generally reimburses physicians far less than other payers causing many offices to decline to accept Medicaid patients.

Then again, under another Healthcare Reform provision, Medicaid reimbursements will be set to Medicare payment rates for general internists, family physicians and pediatricians starting in 2013 and 2014. These groups have been long considered under-compensated in comparison to other more specialized areas of medicine such as cardiology, orthopedics or oncology.

Add to this the fact that primary care will also receive a 10% increase in reimbursement from 2011 to 2015 with an additional 10% for primary care physicians and general surgeons in underserved areas and it would seem that 16 million new patients could equate to a measurable amount of revenue for private practices.

Although Medicare rates today are often far better than Medicaid rates, this provision does not benefit those physicians outside of primary care. Also, despite the fact that under the proposed “American Jobs and Closing Tax Loopholes Act” (May 22, 2010) the scheduled 21.3% Medicare pay cut has been potentially replaced by modest increases of 1.3% in 2010, another increase of 1% in 2011 and possibly additional increases through 2013, physicians will still be faced with a reversion to the sustained growth formula (SGR) in 2014 (and possibly another 20%+ reduction in reimbursement) which may offset some or all of the benefit from moving Medicaid payments to Medicare rates.

**Payments Shift from Fee for Service to Coordinated Care**

Some of the more “reform” oriented portions of Healthcare Reform (Continued on page 12)
In September of 2010, National Patient Account Services (NPAS), a wholly-owned subsidiary of the world’s largest provider of healthcare services, Hospital Corporation of America (HCA), will celebrate its 30th anniversary. It was in 1980 that some forward-thinking hospital executives came to two conclusions that they wanted to take action on: 1. Self Pay patients deserve to be treated with the same dignity and respect that Insured patients receive, and 2. Self Pay patients, and the hospital, are better served by speaking with them openly and honestly about their obligation so the patient can truly understand their options.

One problem, though: to speak with patients is the most expensive way to follow up patient accounts, so how do you effectively work the low-return self pay accounts by using the most expensive method to collect? The paradox was solved by rethinking the entire collection process in terms of People, Process and Technology so that the proper balance of Collections, Customer service, Costs and Compliance (the Four C’s) could be successfully achieved.

Today, NPAS successfully demonstrates the sustained balance of the Four C’s through the “scientific” blend of high production, high-tech call center strategies and latest technologies, and the high-touch management of over 700 people in Louisville (the division headquarters) and Bedford, TX. The dedication to speaking with patients instead of just sending letters means that NPAS has to effectively manage phone calls to more than 25,000 patients every single day! And every one of them is recorded.

Today, NPAS still focuses solely on helping hospitals lower costs and increase cash from the most difficult part of the revenue cycle, the self pay patients. With 22,000+ new patient accounts EVERYDAY from more than 250 facilities in 30 states, NPAS has managed, just over the last 10 years, about $50 BILLION in early out collections from about 45 Million patient accounts. NPAS records almost as many compliments from patients about our service as they do valid patient complaints, demonstrating the continuous commitment to patient satisfaction and quality.

HCA makes this service available to ANY hospital, tax-exempt or for-profit, and it’s free to get started.

Upcoming Spotlights:
New KYHFMA Platinum Sponsors:
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Now Tracking Your Cash is Easier.
Reform addresses controlling the costs and improving the quality of the healthcare delivery system. Perhaps the most significant change that this will bring about is centered on a shift from payments for individual procedures, evaluations, consultations, etc., in an à la carte manner to a grouped payment for all of the services provided to each patient.

Currently, Medicare is scheduled to begin a demonstration period by 2013 for "bundled rates". Under bundled rates, hospitals, pediatric Accountable Care Organizations (ACOs) and other certain healthcare entities will receive a single payment for each "episode of care". An episode of care will include all healthcare services provided for a hospitalization for a period up to 30 days post-discharge. This would include all physician services, diagnostic services, laboratory tests, facility fees and many other services related to the original diagnosis.

A bundled payment in effect places a ceiling on how much will be reimbursed in total for a patient’s care, thereby creating a control on total costs. Since the healthcare entity receiving payment would be at risk for ensuring the most cost efficient care for the patient, it is in the entity’s interest to include only those physicians, specialists, diagnostic services, etc. that are most necessary during the episode of care. It will also be important the patient receives the appropriate and most effective treatment since each episode of care will extend to include the 30 days post-discharge.

Any number of individual providers can be involved in a patient’s episode of care. Since a single payment will be issued for each of these episodes, just who receives this payment will be of special interest to physicians and specialists. In our current healthcare delivery model, it is generally understood and fairly well defined who gets paid for what. However, if one entity is commissioned to receive this lump sum payment, an interesting question will be raised as to how it is split between each of the individual providers.

This change in the payment system will likely drive primary care physicians, specialists, diagnostic services, hospitals, and other healthcare providers from operating as individual entities into a single team of sorts. In order to determine in advance what portion of the bundled payment a provider receives, there will need to be some defined understanding between the provider and the healthcare entity that is receiving payment.

Increased Hospital-Physician Integration

Partnerships between hospitals and physicians are certainly not new, but physicians have been in increasing numbers seeking the relative security of hospital employment, professional service agreements, management contracts and other arrangements with hospitals and health networks in response to uncertainties in the healthcare industry and the economy.

Even before Healthcare Reform had become a reality, physicians have faced certain challenges specific to private practice. Some of these issues include:

- Lack of negotiating power.
- Private practices lack the leverage necessary to negotiate favorable reimbursement rates from insurance companies. Typically, if a practice is unhappy with the payments offered by a payer, the only option that they have is to drop the carrier. As a result, many practices have not been able to garner commercial payer contracts that have kept pace with rising operating expenses.
- Employment issues.
  - Hiring and retaining staff can be difficult for any small employer. Often times, private practices must offer higher wages in order to attract qualified staff.
  - Related to the issue of buying power, health benefits, retirement plans and other fringe benefits can be significantly more expensive for a small employer. In order to offset the lack of such benefits, many practices are forced to offer an increased wage.
  - Staff management can also be a daunting task for some practices where the practice administrator or physician owner(s) must wear many hats, including that of human resources manager in addition to that of both the administrative and clinical staff manager.
- Practice growth and continuity.
  - It is becoming more and more common for recent medical school graduates to opt for hospital employment over private practice. Generational differences in entrepreneurial spirit, an increased value in “quality of life” and a desire for job security have made it more difficult for private practices to recruit new physicians. Add to this the fact that new physicians typically have $150,000 plus in student loan debt, and it becomes understandable why the relative security of hospital employment might seem to be a reasonable option for recent graduates.

The combination of these issues can lead to the following (and commonly found) scenarios:

- Year-to-year net revenue per case, and possibly overall net revenues, does not grow at a pace
necessary for practice growth (or does not grow at all) due to unfavorable payer contracts.

- Operating costs have increased as a result of rising salaries, benefit plan costs and increases in supply expense.
- As a result of slow (or no) revenue growth and increased expenses, net income to the practice suffers.

Add to this the downward pressure that Healthcare Reform presents to physicians (bundled payments, reduced Medicare rates and an expanded Medicaid population), and it becomes clear that any remaining financial incentives to operate a private practice have been measurably diminished.

For these reasons, it is important in the near-term for physicians to establish relationships with healthcare entities that can provide some certainty as to the level of income that can be expected for specific services. These hospital-physician relationships can vary in their level of integration of the physician into the hospital or health network. Some of these include but are not limited to (listed from least to most integrated):

- Medical directorships, service agreements, on-call agreements, etc.
  - Physicians enter into an agreement to supplement or improve hospital services, administration, operations, etc.
- Facilities/equipment leasing.
  - Facilities or equipment leasing agreements are fairly commonplace and simple in nature. These agreements generally are very similar to any other arm's length medical space or equipment lease agreement between two separate parties.
- Hospital - physician joint ventures.
  - Joint ventures in service lines such as imaging, surgery centers and specialty hospitals split risk between the hospital and physicians.
  - Ideally, these joint ventures give the appearance of a single entity despite the fact that the physicians remain independent of the hospital outside of the joint venture.
- Co-management of a hospital department or service line.
  - In a co-management model, the physicians offer various support services to the hospital in a certain department or service line.
  - The hospital typically pays the physicians an annual fee for these management services.
  - Other services can be provided by the physicians as part of the co-management agreement, resulting in an additional revenue stream for the physicians.
- Physician employment.
  - The physician becomes an employee of the hospital or its physician group.
  - Terms of employment can include incentive payments for production, quality, cost savings or other criteria aimed at improving overall medical care.

The type of strategy to pursue is highly dependent on the specific facts and circumstances around the needs of the physician practice, the hospital and the community that they serve. Hospital-physician alignment has typically been a balancing act between weighing the benefits of hospital integration against preserving autonomy from the hospital.

However, the risks and challenges of private practice appear to be quickly outweighing the need for autonomy. Physicians will continue to be faced with the various demands of practice management even while practice income will decline as the expansion of healthcare coverage results in a rising population of Medicare/Medicaid and other governmental beneficiaries.

It is for these reasons that private practices will likely seek hospital-physician alignment strategies that are more and more integrated as the various components of Healthcare Reform become effective. As physicians seek to secure future revenue streams through a remodeled healthcare delivery system, private practices will likely fall by the wayside.
Ron Sowell  Commonwealth Health Corporation (CHC)

**Family:**  Debbie, wife of 32 years; met in high school. Two children:  Kellie, CPA in Bowling Green; Brad, second year law student

**College:**  BA from Western KY University in 1977; double major in Government & Economics. Masters in Public Administration from UK in 1978

**Favorite Music:**  Rolling Stones, Elton John, Chicago, Rod Stewart, Billy Joel, Andrew Lloyd Weber musicals including “Phantom of the Opera” and “Aida”.

**Currently reading:**  “The Snowball: Warren Buffett and the Business of Life” by Alice Schroeder.

**Sports favorites:**  High school and college sports, most especially when his nephews and niece are playing. Also Western Kentucky University events.

**Favorite Vacation spot:**  Destin, Florida and Cancun Mexico

Michael W. Gough  Norton Healthcare

**Family:**  Judy, wife of 26 years. Two children:  Jill & Jeff


**Favorite Music:**  Mostly country. George Jones, Hank Williams, Sr. Some classic rock; Journey and other 80’s music.

**Favorite Author:**  John Grisham.

**Sports favorites:**  University of Louisville Cardinals (27 year season ticket holder)

**Favorite Vacation spot:**  Palm Beach Florida

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**CHC**

Formed in 1984 as a not-for-profit holding company for The Medical Center at Bowling Green, Franklin and Scottsville, and Commonwealth Regional Specialty Hospital, CHC has grown to be an expansive healthcare corporation in South-central Kentucky and beyond employing over 2,500 people in four hospitals and other health related businesses. Its Urgent Care sees over 60,000 patients annually and CHC operates the only ambulance service in Warren County.¹

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**Norton**

In combining resources with the Methodist Hospital Commission and the Evangelical Hospital Association in 1960 the foundation for the Norton Healthcare Pavilion was begun. Other locally owned facilities and organizations have joined the Norton family that now includes five large hospitals, eleven Immediate Care Centers and more than 90 physician practice locations making Norton Healthcare Louisville’s leading health care provider.²

¹ Information obtained from http://www.chc.net

² Information obtained from http://www.nortonhealthcare.com
Joe Grossman
Appalachian Regional Healthcare
(ARH)

Family: Lee, wife of 27 years. Four children, ages 26, 23, 19; youngest is a sophomore at Henry Clay High School.

College: BA from Purdue University in 1983; in Industrial Management with emphasis in accounting, and a computer science minor.


Favorite Authors: Greshem, Clancy, James Patterson.

Sports favorites: Cincinnati Reds Baseball, Cincinnati Bengals. College: “You can’t help but love the Cats”. Purdue Boilermakers

Favorite Vacation spot: South Bend, where the fishing is good and the relaxing is at a maximum.

Gary Emers
Saint Joseph Health System

Family: Barbara, wife of 24 years. Son; 17 years old, junior in high school.

College: BA in accounting from University of Wisconsin, Eau Claire. MBA in Finance from DePaul University in Chicago.

Favorite Music: The Ramones, Clapton, Springsteen, Lynyrd Skynyrd.

Currently Reading: “Rework” by 37signals

Sports favorites: College and Pro sport. University of Kentucky, Milwaukee Brewers.

Favorite Vacation spot: The Grand Strand Beaches in South Carolina as well as Myrtle Beach. Hiking in the Grand Canyon in Arizona. Sedona, Flagstaff. “As a family we enjoy vacations and outings that are outdoors with activities like hiking.”

ARH

ARH operates exclusively for a charitable purpose, their services being available to all members of their communities. Began in 1956 as the Miners Memorial Hospital Association, it was made up of 10 hospitals across Kentucky, West Virginia and Virginia.

The ARH System has been selected as the 2010 Outstanding Rural Health Organization by the NRHA for its outreach programs, preventive health and education, quality and efficiency of care and community support and involvement. 3

Saint Joseph

Saint Joseph Health System has recently introduced Kentucky’s first ‘No Wait’ Emergency rooms at their Saint Joseph Hospital, Saint Joseph East and Saint Joseph - Jessamine, where emergency care begins within 5 minutes of a patient’s arrival providing a better care experience.

On May 8, 2010, during the Eleventh annual Maternity Fair, Saint Joseph East celebrated the grand opening of their Women’s Hospital at Saint Joseph East. 4

3 Information obtained from http://www.arh.org

4 Information obtained from http://www.saintjosephhealthsystem.org
Healthcare Reform from the CFO’s Chair

By Mark Carter, Jeff Presser, and Monica Wesolowski, Dean Dorton Ford, PSC

It’s has been one of the hottest political and financial topics on the minds of many this year. President Obama’s healthcare reform. Even though the full effects of the new laws won’t be felt for many years, CFO’s of provider organizations and facilities are already taking steps for what the future will bring.

In May 2010, as the new chairman of the Kentucky Chapter HFMA newsletter, Jeff Presser had the idea to interview a few of these CFO’s across the region and get their viewpoint on healthcare reform and what they’re doing to prepare for it. In this introductory piece to a new regular segment of the Financial Diagnosis, Mr. Presser was able to garner the time of four of these financial authorities; Ron Sowell, Executive VP and CFO of Commonwealth Heath Corporation (CHC), Michael Gough, senior VP and CFO of Norton Healthcare, Joe Grossman, VP of Operations & CFO of Appalachian Regional Healthcare (ARH), and Gary Ermers, CFO of Saint Joseph Health System.

Top of the List

When asked what the top issues (in general) are facing their organizations today, the nearly unanimous reply was:

2. Tighter competition for capital.
3. Cost reduction.
4. Physician Integration.

Reform and Changing Reimbursements

One of Gary Emers’ (Saint Joseph Healthcare System) major concerns is the reductions to reimbursements, most specifically the eventual elimination of Disproportionate Share Hospital payments (DSH), along with the reductions in both Medicare and Medicaid. “At this point all you really know is that the federal funding portion of it is going down.” Emers spoke in regards to the reductions of payments from Medicaid in 2014. “Kentucky is not exactly a wealthy state, so how much can the state take on some of that?” He went on to say, “We are trying to position ourselves...where we’re going to succeed, no matter what ultimate final form healthcare reform [takes].”

“ARH... serves the second poorest area in the country. As such, we are very dependent on governmental payers,” says Joe Grossman of Appalachian Regional Healthcare. The loss of DSH and cuts to Medicare and Medicaid "will have a big negative impact on us also."

Competition for Capital

Through initiatives to improve quality and decrease costs to consumers assist in the provision of the maximum amount of capital for re-investment, needs for more capital sometimes can seem endless. Ron Sowell of CHC said, “Our challenge is to find that proper balance that enables us to continue to be at the forefront in medical technology, facilities and human resources while keeping our bond insurers, our bond holders and our rating agencies comfortable with an improving balance sheet.”

Reducing costs and physician integration

All four of the interviewed CFO’s were in agreement in these two important issues. “The kind of radical changes that are [going to be] necessary to make you, as a provider, successful with the amounts of cuts we’re having, is going to have to be a whole transformation of the way care is delivered,” said Mike Gough of Norton Healthcare. “We need to be..."
CMS “Rules” on Disproportionate Share Hospital (DSH) Appeal Issues

One of the most highly contested areas of Medicare reimbursement is the Medicare Disproportionate Share Hospital (DSH) formula. The Centers for Medicare & Medicaid Services (CMS) released CMS-1498-R on April 28, 2010, taking a firm position on three commonly appealed issues affecting DSH payments and remanding countless appeals back to the Medicare contractors. Each hospital should evaluate this ruling’s impact on its existing DSH appeals and consider how it could affect the DSH amount claimed on the next Medicare cost report.

This ruling affects any open Medicare cost reports and cost reports with a properly pending appeal on the following issues:

- Supplemental Security Income (SSI) Matching Process
- Exhausted Part A Days
- Labor/Delivery Room Days

**SSI Matching Process**

CMS has conceded through this ruling (and reaffirmed in the proposed inpatient prospective payment system rule released on May 4, 2010) it has not used the “best available data” to calculate the numerator of the SSI fraction. CMS is careful to state, however, the underlying matching process has been “lawful.”

The numerator of the SSI fraction is the number of inpatient days for individuals entitled to both Medicare Part A and SSI. This number has historically been identified by comparing a unique number in the SSI records (Title II numbers) to the Medicare Provider Analysis and Review (MedPAR) file using the Health Insurance Claim Account Numbers (HICANS).

This ruling and the proposed inpatient prospective payment system (PPS) rule adopt the revised matching process implemented in the Baystate Medical Center v. Leavitt case. Effective October 1, 2010, the identification of SSI days will include updated and refined SSI eligibility data and Medicare records and include matching by Social Security numbers in addition to HICANS and Title II numbers. CMS expects many public comments in response to the proposed rule and intends to make changes to the matching process if changes are deemed appropriate. Approved changes will be included in the final inpatient PPS rule.

**Exhausted Part A Days**

Under CMS’ original policy, patients only were included in the numerator of the SSI fraction if the inpatient stay was “covered” under Medicare Part A and entitled to SSI benefits. Effective October 1, 2004, CMS changed its policy to include an inpatient stay in the numerator of the SSI fraction if the patient was “entitled” to Medicare Part A and entitled to SSI benefits, thereby also including patients whose Part A hospital benefits were exhausted. This opened the door for numerous appeals.

Various arguments related to this issue have been raised. Some hospitals have appealed to have exhausted Part A days added back to the SSI fraction prior to October 1, 2004, while others argue the days should be included in the Medicaid fraction. This ruling confirms CMS’ position that exhausted Part A days should be included in the numerator of the SSI fraction and not in the Medicaid fraction.

**Labor/Delivery Room Days**

Prior to 2009, CMS would include Labor and Delivery Room (LDR) in the total and Medicaid days used in the DSH calculation only if the patients occupied a routine bed prior to occupying an ancillary LDR bed before the census-taking hour. Effective October 1, 2009, (per the FY2010 Final Rule), CMS revised its policy to include the LDR days in the total and Medicaid days regardless of whether the patient had occupied a routine bed prior to occupying an ancillary LDR bed. Hospitals have appealed this issue for many years; some of those appeals have already been resolved.

**CMS Proposed Resolution of Appeals**

The positions taken by CMS on the above issues will be applied to all properly pending DSH appeals and all open cost reports that have not been finalized through an initial notice of program reimbursement (NPR). For the exhausted Part A days issue, this would only apply to cost reports with discharges prior to October 1, 2004. CMS further states—because the DSH appeals will be resolved and remanded back to the Medicare contractors to recalculate the DSH percentages—existing appeals related to these issues can no longer continue. Any future appeals, such as arguing exhausted Part A days are more appropriate in the Medicaid fraction, could be initiated only after the issuance of initial/revised NPRs, which could delay further DSH appeals for years.

(Continued on page 18)
DSH Appeals ... (Continued from page 17)

Action Steps for Hospitals
Hospitals should verify their appeal rights have been appropriately preserved on each of these issues and the appeals have followed applicable jurisdictional and procedural requirements. Hospitals then have two options:

1. Patiently wait for the tribunal to approve each qualifying appeal to be remanded to the Medicare contractor
2. Submit a written request to expedite the disposition of appeals to the appropriate appeals tribunal and provide a copy of the written remand to the appropriate Medicare contractor, who will then determine if the appeal is subject to the ruling

While the second option should expedite the processing of the appeal, the hospital will be required to produce the supporting documentation to the Medicare contractor.

Finally, hospitals should consider filing cost reports in accordance with this CMS ruling, proactively including the LDR days in the total and Medicaid days of the Medicaid fraction. Hospitals also could include an estimate of changes to the SSI ratio resulting from the revised matching process and inclusion of exhausted Part A days as a protested item on the cost report to preserve appeal rights moving forward. The inclusion of any of these items should be disclosed in a transmittal letter (with a reference to this CMS ruling) accompanying the Medicare cost report submission to the Medicare contractors.

For more information, contact your BKD advisor.

CFO’s Chair (Continued from page 16)

aligned with our physicians.” Working together, Gough went on to say, gives everyone the same goals on lowering costs.

“Physician integration,” Joe Grossman of ARH said, “alleviates some of the administrative tasks from the physicians, allowing them to concentrate more time on their patients.” He believes that it will be one of the main strategies that will address cost productivity.

Implications of Healthcare Reform
At the top of the list of implications of healthcare reform, the large influx of newly insured consumers into the healthcare system that were not covered by any level of insurance previously sits firmly in the number two spot. These folks, who previously may have neglected their healthcare due to lack of insurance will now be flooding the system that is already suffering from a physician shortage across the state. While providing healthcare for all, as many as 35 million newly insured is a staggering number.

The cost of treating patients who have no insurance is in the billions nationwide. “If those patients are now covered, then that’s going to be a big help.” Gough said in regards to offsetting the elimination of DSH as well as Medicaid cuts by the government. It’s a sentiment that many agree on. But while something is better than nothing, will it be enough?

The number one implication of healthcare reform? Payment. Providers are currently being paid ‘per
procedure’, but that is going to change under bundled payments from governmental agencies like Medicare, under which many of the newly insured from the reform legislation will fall. One payment will be made for a single episode of care. This circles back to our topic on physician integration. Without it, how is the decision made as to who gets what?

“Under the Reform Act, we will have to … manage through a long period of mixed payment models. Eventually, we will transition from the DRG system and discount charge contracts to models that are going to reward patient care management over the full continuum of care.” - Ron Sowell, CHC.

The Next Five Years?

In the next five years Norton, Saint Joseph, ARH and CHC will be working on and further implementing measures to ready them for the final results of healthcare reform. With a growing need for heavier IT support, facilities are likely to spend more resources on information technologies than ever before. “Information is going to be powerful in managing people’s care better,” says Mike Gough.

Even with the stress that is going to be placed on an already stressed system by a large influx of newly insured these are still opportunities. Such an influx will force efficiency improvements to ensure that care is seamless to the consumer. Providers will have the challenges and opportunities to meet the needs of greater numbers of patients.

“I embrace change!” said Gary Emers of Saint Joseph. “[We will] be meeting the needs of a greater number of patients. [We will have] health equity regardless of socio-economic, racial, or rural situations. We want the highest quality in all of those unmet markets through our dispersed integrated network.”

“It will be years before many of the regulations are promulgated by what appears to be a dozen or more federal departments and agencies that are going to play a role in healthcare reform,” says Ron Sowell. “While the resources will be required to monitor developments and to implement appropriate responses to the reform legislation, I think it’s imperative that we keep all this in a proper balance with what remains as the other challenges that we already face on a day-to-day basis. Those who panic and seem consumed by the perceived threats of healthcare reform should probably be reminded that many in our industry thought that the introduction of DRG’s in the early 1980’s would be the end of the financial viability of hospitals, and we all seemed to survive that turbulent period intact.”

Ron’s observation is important. Provocations of “socialized medicine” and much of the hyperbole voiced by the talking heads during the debate are surely overblown. Certainly, there will be winners and losers, as is always the case with dramatic change. The winners will be organizations that focus strategic energy on succeeding in the new environment, embracing change, instead of wasting vital resources in a futile attempt to maintain the status quo. What will you do to insure your organization wins?

Gary Emers, Ron Sowell, Joe Grossman and Mike Gough had more to say on these issues. Please see our supplemental publication for their full interviews.
Over the past couple of months there have been several presentations and seminars on the Patient Protection and Affordable Care Act (PPACA), or more commonly referred to as the Healthcare Reform Act. Presentations have included discussions on the tax implications, Justice Department enforcement, and the Insurance industry impact. At these presentations there have been several expert panels comprised of executives from providers and insurers discussing the impact on their organizations and for some, their personal views on the subject.

One of the themes observed from these panelists has been, with a few exceptions, a prevailing attitude of, “How am I going to fit the new requirements of the Healthcare Reform Act into my existing system?” Before that question is answered, we need to be sure it is even the right question to ask.

Clayton Christensen coined the term Disruptive Innovation, which “describes a process by which a product or service takes root initially in simple applications in the bottom of a market then relentlessly moves ‘up market’ eventually disrupting established competitors.” He uses several examples of this concept applied to Healthcare in his book “The Innovator’s Prescription”. While not disruptive innovation, the Healthcare Reform Act presents to us, in essence, Disruptive Regulation.

The regulation does not direct Healthcare organizations (providers, insurers, etc.) how to change their business practices, the way they are organized, or their business models. It does, however, lay out new means of reimbursement, coverage requirements, and tax implications, which will become very disruptive to organizations that continue to operate the way they always have.

To meet the needs of this new “Disruptive Regulation” will require all involved in healthcare to become very innovative in their approach to delivering and providing care for patients. What these innovations are and what they look like remains to be determined. Ideas like Accountable Care Organizations (ACOs) as mentioned in the Healthcare Reform Act represent a model of healthcare service and reimbursement focused on providing a continuum of care for the patient. Again, while no one is sure what these ACOs will look like, especially since, according to one attorney who spoke at a recent seminar, the ACO model as outlined “breaks at least five existing federal laws,” What is sure is that a new line of thinking will be required to deliver healthcare efficiently and effectively.

So, instead of taking the “woe is me” attitude and trying to figure out how to fit the new regulations into existing systems, a more appropriate question to ask might be, “how am I going to change my business model and processes to meet the new requirements?” Organizations that seize this as an opportunity to develop innovative new processes, organizational structures, and business models stand to benefit a great deal.

The Ever-Changing Role of the Hospital CFO

By Monica Wesolowski, Dean Dorton Ford, PSC

History has taught us that change, whether good or bad, is inevitable. So too has the role of CFO changed over time. Ron Sowell of Commonwealth Heath Corporation says, “The breadth of issues that I and the entire finance and accounting team deal with today has grown...in proportion to the general growth of our corporation.” As CFO he’s worked in public relations, marketing initiatives and many community affairs.

“Gone are the days of Here’s the income statement.” Says Michael Gough of Norton Healthcare. What hospitals used to want in their CFO’s “was a very good accountant, someone who kept the books and kept track of what was being made or lost and where.”

“It used to be financing, general ledger and revenue cycle. While Revenue cycle has remained a big piece of it, as well as financing, there are a lot more operational [tasks],” said Joe Grossman Appalachian Regional Healthcare.

In a hospital setting, the chief financial officer must have a very solid understanding of operations. They interact with the clinical leadership and teams daily, so they need to know and understand what is needed to support their teams. “The CFO is key in working...on the strategic and tactical level[s] for operations, arm in arm with [their] teammates. You’re part of that decision making and accountability from the beginning. In the CFO role, you have to continue to learn and develop new tools and skill sets to keep growing with the role. But it also makes the role far more rewarding and far more connected to the organization’s success,” stated Gary Emers, of Saint Joseph Health System.

One can’t help but wonder what the future might bring.
Implementing and Communicating Process Changes

By Marquita Bell
Client Support Manager, National Patient Account Services

In today’s changing economy it is very important for an organization to continuously evaluate their processes. Often, a process change originates from customer feedback or a specialized request. Before making a change, the company needs to assess and make sure they maintain alignment with their financial and organizational goals. Successful organizations place customer needs as the forefront to their success, but many forward thinking companies also use strategic planning and establish measures to improve their services, calculate the financial impact and avoid unintended consequences.

Developing a Process Improvement Request Tracking (PIRT) system enables an organization to evaluate and implement those exceptions with the best chances to enhance the organization’s mission. Some key aspects of a PIRT system are to:

- Introduce a need for change
- Review the current process
- Recommend a solution and list expected benefits
- Create an open forum for feedback
- Obtain final approval of the process change
- Communicate the implementation plan and assign tasks
- Document the approved change and process

A PIRT is led internally by a sponsor and owner (usually a department head) who are responsible for managing the process change from introduction to implementation and internally assure that it meets some suggested business criteria. For example, a revenue cycle organization may use the “4-C’s”: Collections, Cost, Customer Service and Compliance.

The scope and magnitude of the proposed change will determine which track a PIRT will follow. A fast track change may have a shorter approval list, and therefore shorter time frame. However a fast track PIRT should only be utilized if the cost of the change is under a predetermined limit and only impacts one operational unit. Ideally a fast track is used for changes within the department that the process change originated from.

Changes that impact more than one operational unit and/or exceed a pre-determined cost follow the standard track approval process. With the assistance of a web-based application, the PIRT change request is moved along the pre-determined approval distribution list, which consists of department heads across the organization. By including each department head, most unintended consequences can be avoided.

Each distribution list should have a set number of days to approve or deny the change. The application sends a daily reminder to those who have not approved the change and also to the individual who sponsored the change. If no response is received, the sponsor and owner can personally remind the member to review for acceptance/denial or they can consult with the executive staff to keep the PIRT moving. Members of the distribution lists can also log an issue or ask a question of the sponsor via the change request tool which is logged for record. Executive management determines final approval of all change requests given the feedback of the approval group and if the process change continues to meet the organization’s goals (i.e. 4 C’s).

Once final approval of a process change has been granted; tasks are assigned to implement the change, notification goes out to the impacted areas, staff members are trained and clients are notified if applicable. The new process is then listed within an On-line Reference Manual that offers employees quick direction on both standardized and special processes.

The desired result is that the client’s needs are continuously met and the organization has improved its organizational goals, such as increased collections, lowered costs and strengthened customer service while maintaining compliance.
The 2010 Kentucky Chapter HFMA Annual Summer Educational Institute was held at the Hyatt Regency in downtown Louisville this year, July 29 and 30. Almost a dozen speakers were onsite to share their knowledge and insight across many issues that Healthcare finance is facing every day. Topics ranged from personal perspectives, to revenue, marketing to client feedback, giving a wide variety of educational opportunities that centered broadly around Healthcare reform.

The first day opened with new Chapter President Andy Strausbaugh giving opening remarks and a welcome to all. Daniel Simons, keynote speaker and author, shared how our intuitions can sometimes be misleading and showed an example of how even a gorilla wandering through a room can sometimes be missed if our focus is intently elsewhere. He explained how people are often far less aware of their visual surroundings than what they think.

Walt Bearden of TRACE, and Steven Hovan of University of Tennessee Medical Center, addressed protecting revenue. John Fiumano, CEO of Kadent, discussed using analytical and strategic models to manage receivables. Larry Scinto, of PA Consulting, shared his views on setting goals and using benchmarking in setting performance targets. Dr. Craig Schneider from the Massachusetts Health Data Consortium shared how the state of Massachusetts has become the leader in implementing health information technology systems and enabling health information exchange. Nancy Porte, of Vovici, talked about customer satisfaction and leveraging feedback. Dr. Rick Thomas was there to focus on Marketing and the major implications healthcare reform has had on the industry. That night, some of the attendees of the Summer Educational Institute attended a Louisville Bats game at Slugger Field. They had great seats for the game and enjoyed baseball park food and drinks. It was a great time had by all who attended the game.

Day two, after opening remarks and welcome, Jamie Cleverly of Cleverly & Associates discussed cost reduction and identifying opportunities. Nessy Shems, of Piper Jaffray & Co., spoke about the impact of Healthcare Reform and Implications to Borrowers. Charole Christian, an attorney at Wyatt, Tarrant & Combs discussed new compliance for providers under the PPAC act.

This year attendance climbed to 157 from the 2009 total of 126 (an unconfirmed attendance record). Many thanks go out to the Board of Kentucky HFMA for making this Summer Institute so successful. Special applause goes to Theresa Scholl, VP of Education. Theresa would like to thank her team members for all their hard work in preparing an outstanding Institute and bringing in high caliber speakers:

- Shawn Adams, Chair
- Chris Graff, Co-Chair
- Scott Reed
- Shelley Gast
- George Hopkins
- Aaron Judzewitsch
- Heather Haynes
- Jeff Presser, Dean Dorton Ford, PSC
- Newsletter Chair

Andy Strausbaugh
Kentucky Chapter President
Abby Vibbert & Clint Brill
New Chapter Members

Charlie Schuhmann & Mike Weeks

Daniel Simons
Keynote Speaker & Author

Bob Steltenpohl & Jim Morris

Michael Thomas, Meg Edwards, Glenn Grigsby & Jeff Presser
A meeting of the Medicaid Cost Containment Task Force and Medicaid Oversight and Advisory Committee was held on Tuesday, July 20 in Frankfort, Ky. This is a joint Senate-House task force charged with advising the legislative chambers and the administration on approaches to reduce the growth in Medicaid spending.

Elizabeth Johnson and Neville Wise, Commissioner and Deputy Commissioner of Kentucky Medicaid, made a lengthy presentation to Senate and House members of the Task Force and Committee. The Task Force and Advisory Committee included a number of lawmakers that included Senate President David Williams and House Speaker Greg Stumbo, both aspiring governors.

The presentation by Commissioner Johnson and Deputy Commissioner Wise covered such issues as:

- An Overview of the Medicaid Program
- Medicaid Cost Drivers
- Medicaid Cost Containment Measures
- Medicaid Pharmacy Benefit

Medicaid provides coverage to approximately 800,000 of Kentucky’s most vulnerable citizens, including 60,000 children. Medicaid paid for 21,000 births in Kentucky in 2009, approximately 37% of all Kentucky births for that year. That’s a startling percentage given that Medicaid is intended to cover our poorest citizens.

Kentucky’s Medicaid program has seen unprecedented growth in the number of new enrollees over the past year due to a weakening economy. During 2009, over 3,000 new recipients were added each month compared to 930 per month in 2008. Most of the new recipients were children.

According to Commissioner Johnson, Medicaid is the primary payer of healthcare in Kentucky. Medicaid has approximately 40,000 enrolled hospitals, physicians and other providers.

Commissioner Johnson identified the following cost drivers during 2009:

- Extraordinary Events
  - Hospital Inpatient Medicaid Settlements
  - American Recovery and Reinvestment Act Payment Acceleration (stimulus funds provided to shore up state shortfalls)
- “Unprecedented” Eligibility Growth related to the poor economy
- Cost and Utilization Growth
  - More physician offices converting to Primary Care Centers and Rural Health Clinics (with enhanced payment rates from Medicaid)
  - New services
  - Physician payment increase

The Medicaid cost containment measures taken, or to be taken by Medicaid include the following:

- Post payment pharmacy audits
- Prior authorization of certain drugs
- Changing time when recipients can refill a prescription
- Fill prescriptions from Medicaid Providers only
- Modify coverage of OTC medications
- Enhanced Lock-In Program
- Quit paying for hospital acquired conditions and never events

Efficiencies achieved by Medicaid outlined by Commissioner Johnson are as follows:

- Diabetic supplies to be purchased through pharmacy instead of DME
- New Program Integrity Support Vendor
- Implement recoupment from providers billing in excess of coverage limits
- Revenue Intercepts
- Health Insurance Premium Payments

The following is a list of Medicaid benefit expenditures for selected categories of service in 2009:

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient and Outpatient Hospital</td>
<td>$1.05 billion</td>
</tr>
<tr>
<td>PCC and RHC</td>
<td>$149 million</td>
</tr>
<tr>
<td>Community Living Waiver</td>
<td>$241 million</td>
</tr>
<tr>
<td>Physicians</td>
<td>$339 million</td>
</tr>
</tbody>
</table>

(Continued on page 25)
Medicaid Update continued from page 24

Total expenditures for these selected programs in 2009 were $1.78 billion (total Medicaid spending, when including other services such as nursing home care were about $5.5 billion). Commissioner Johnson outlined a total savings of $65 million or 3.6% of the selected services (around 1% of total spending) from the above cost containment measures and efficiencies. Some of those measures have not been implemented as yet.

An interesting point made by Senate President Williams was that Kentucky has many people in low wage jobs that have employer sponsored insurance. These people would most likely qualify for Medicaid. In 2014, when coverage mandates begin with Health Care Reform, he speculated that some employers will drop their health insurance and pay the penalty tax. If this happens, many of these people will likely become Medicaid recipients.

There was much discussion about the Lock-In program proposed by Medicaid. This is a program where recipients, who have certain utilization characteristics (inarticulately referred to as “frequent fliers” in the industry), will be “locked-in” to a primary care provider, pharmacy, and hospital for non-emergent care. Commissioner Johnson estimated the savings for Medicaid would be approximately $5 million. If a recipient goes to the ER for non-life threatening services, the Hospital is to discharge the recipient to their primary care physician (PCP) and will be paid an assessment fee only.

President Williams discussed Medicaid’s “Wrap Around” program. This is where a Medicaid recipient is covered by an employee sponsored health insurance plan. Medicaid would pay the recipients premium and be a secondary payer. The discussion centered on whether the Kentucky Medicaid program was actually saving money with such a program. Commissioner Johnson wanted to determine if more recipients are eligible for this program. Senate President Williams wanted the Commissioner to quantify the savings the “Wrap Around” program brought to Medicaid.

Finally, Speaker Stumbo wondered aloud if savings could be achieved by scaling back “optional” programs. For example, pharmacy, dental and home care services are provided at the option of the state. There was some discussion, led by Representative Jimmie Lee of Elizabeth town, around the “unintended consequence of eliminating one of the so-called optional services”. For example, eliminating pharmacy coverage might result in diabetics not getting needed medicines and ending up in the hospital, thereby increasing costs in excess of the savings from cutting the drug benefit.

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Have kudo’s or congratulations you would like to pass out?
Have something great happen in your life?
Getting married? New addition to the family?

Send it to us! We’d love to share your news with the rest of our readers. Forward your news along with contact information to Monica Wesolowski, assistant to the Newsletter Chairman, at lvillereception@ddfky.com. Do you have a picture to go with your news? Send it along too!

Please limit pictures to one. Submitted correspondence and pictures constitute permission to print. Editor reserves the right to accept or reject submissions.

NEW MEMBERS

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Company/Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jeff Presser</td>
<td>Manager of Business Consulting Services</td>
<td>Dean Dorton Ford, PSC</td>
</tr>
<tr>
<td>Clinton A. Brill</td>
<td>Managed Care Analyst</td>
<td>Bottom Line Systems, Inc.</td>
</tr>
<tr>
<td>Diane M. Riley</td>
<td>Area Controller</td>
<td>Healthsouth Deaconess Rehabilitation Hospital</td>
</tr>
<tr>
<td>Amy Vibbert</td>
<td>Supervisor</td>
<td>Bottom Line Systems</td>
</tr>
<tr>
<td>Marty A. Lautner</td>
<td>VP/CFO</td>
<td>Cardinal Hill Rehabilitation Hospital</td>
</tr>
<tr>
<td>Mendy Evans</td>
<td>VP Finance</td>
<td>Saint Joseph Hospital East</td>
</tr>
<tr>
<td>Tiffaney N. Reynolds</td>
<td>Hospital Billing Manager</td>
<td>Trover Clinic</td>
</tr>
<tr>
<td>Delandual L. Conwell</td>
<td>Decision Support Analyst</td>
<td>Catholic Health Initiatives</td>
</tr>
</tbody>
</table>

Please look for these new faces at upcoming chapter events and help make them feel welcome!

HFMA is the nation’s leading personal membership organization for healthcare financial management professionals. HFMA members participate in 70 local chapters and include nearly 32,000 healthcare financial management professionals employed by hospitals, integrated delivery systems, managed care organizations, ambulatory and long-term care facilities, physician practices, accounting and consulting firms, and insurance companies.
# Kentucky Chapter of HFMA
## Corporate Sponsorship Levels and Benefits
### 2010-2011

<table>
<thead>
<tr>
<th>Level</th>
<th>Amount</th>
<th>Benefits</th>
</tr>
</thead>
</table>
| **Bronze** - $1,000 | | 1. One (1) free registration to a conference  
2. Signage recognizing level of sponsorship at every event  
3. Listing of sponsor's name and/or logo on meeting announcements  
4. Sponsor will receive a Kentucky HFMA shirt showing level of sponsorship  
5. Recognition during welcome and closing remarks at every meeting  
6. List of registrants after each event (if requested)  
7. Acknowledgement in the Chapter's newsletter, membership directory and on website |
| **Silver** - $2,000 | | 1. One (1) free exhibit space **one** KY Chapter Institute ($600 value)  
2. Two (2) free registrations to one of the conferences  
3. Signage recognizing level of sponsorship at every event  
4. Listing of sponsor's name and/or logo on meeting announcements  
5. Recognition during welcome and closing remarks at every meeting  
6. Sponsor will receive a Kentucky HFMA shirt showing level of sponsorship  
7. List of registrants after each event (if requested)  
8. Acknowledgement in the Chapter's newsletter, membership directory and on website |
| **Gold** - $3,000 | | 1. One (1) free exhibit space **two** KY Chapter Institutes ($1200 value)  
2. One (1) free membership to the Kentucky Chapter of HFMA (cannot be used towards current membership)  
3. Two (2) free registrations to one of the conferences  
4. Signage recognizing level of sponsorship at every event  
5. Listing of sponsor's name and/or logo on meeting announcements  
6. Recognition during welcome and closing remarks at every meeting  
7. Sponsor will receive a Kentucky HFMA shirt showing level of sponsorship  
8. List of registrants after each event (if requested)  
9. Acknowledgement in the Chapter's newsletter, membership directory and on website |
| **Platinum** - $4,000 | | 1. One (1) free exhibit space **two** KY Chapter Institutes ($1200 value)  
2. Two (2) free membership to the Kentucky Chapter of HFMA (cannot be used towards current membership)  
3. Two (2) free registrations to two (2) of the conferences  
4. Signage recognizing level of sponsorship at every event  
5. Listing of sponsor's name and/or logo on mtg. announcements  
6. Recognition during welcome and closing remarks at every meeting  
7. Sponsor will receive a Kentucky HFMA shirt showing level of sponsorship  
8. List of registrants after each event (if requested)  
9. Acknowledgement in the Chapter's newsletter, membership directory and on website  
10. ¼ page ad in each newsletter  
11. ½ page article in one newsletter introducing company |