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SAVE THE DATE!
January 21, 2011
Winter Education Institute
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### 2010 - 2011

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<th>Contact Information</th>
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<tbody>
<tr>
<td>Certification/Career Advancement Chair</td>
<td>Cindy Sharp</td>
<td><a href="mailto:csharp@fmhhs.com">csharp@fmhhs.com</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(812) 949-5690</td>
</tr>
<tr>
<td>Corporate Sponsorship Chair</td>
<td>Tony Sudduth</td>
<td><a href="mailto:tsudduth@tjsamson.org">tsudduth@tjsamson.org</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(270) 651-4114</td>
</tr>
<tr>
<td>Entertainment Chair</td>
<td>Meg Edwards</td>
<td><a href="mailto:megedwards@credit-bureau.com">megedwards@credit-bureau.com</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(859) 252-0011 ext 239</td>
</tr>
<tr>
<td>Information Systems Chair</td>
<td>Chris Graff</td>
<td><a href="mailto:cgraaff@bkd.com">cgraaff@bkd.com</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(502) 581-0435</td>
</tr>
<tr>
<td>Membership Directory Chair</td>
<td>Don Frank</td>
<td><a href="mailto:dfrank@onlinebls.com">dfrank@onlinebls.com</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(859) 578-6858</td>
</tr>
<tr>
<td>Newsletter Chair</td>
<td>Jeff Presser</td>
<td><a href="mailto:jpresser@ddfky.com">jpresser@ddfky.com</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(502) 244-6440</td>
</tr>
<tr>
<td>Outreach &amp; PR Chair</td>
<td>Tony Miranda</td>
<td><a href="mailto:tmiranda@seniorcare-corp.com">tmiranda@seniorcare-corp.com</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(502) 753-6034</td>
</tr>
<tr>
<td>Rural Healthcare &amp; Reimbursement Chair</td>
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<td><a href="mailto:drnce@blueandco.com">drnce@blueandco.com</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(502) 992-3500</td>
</tr>
<tr>
<td>Student Membership Chair</td>
<td>Matt Fulton</td>
<td><a href="mailto:mcfulton@healthcarestrategygroup.com">mcfulton@healthcarestrategygroup.com</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(502) 814-1191</td>
</tr>
<tr>
<td>Yerger Awards Chair</td>
<td>Katie Black</td>
<td><a href="mailto:katie.black@na.firstsource.com">katie.black@na.firstsource.com</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(502) 499-0855 ext 3117</td>
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A Rewarding Experience

In September of this year, Chris Woosley and I had the opportunity to represent the Kentucky Chapter at the Region IV Fall President’s meeting for HFMA held in Austin, Texas. Although this was a fantastic event, the Rewarding Experience happened to me on the way home.

On my return flight, I had a two-hour layover in Atlanta and calculated by the time we take off, land in Louisville, retrieve my baggage and car; I should be home around 10:30 pm.

I boarded the plane, found my seat, and settled in for takeoff. About 5 minutes had passed when I overheard a conversation between a man and woman about her daughter who was ill and was admitted to a hospital. She was very upset because the only information she had was to get to Louisville as quickly as possible because her daughter did not have much time. I went about my business but could not help overhearing their discussion. It sounded like she was talking about the hospital where I work.

After several minutes, I approached the lady, introduced myself, and told her where I worked. I asked, “Are you trying to get to this hospital?” She said yes, introduced herself, and said she was supposed to get to Louisville ASAP because her daughter was gravely ill, but that was all she knew. Before our plane took off, I contacted the hospital and was able to get an update on her daughter’s condition, which had improved.

Once we landed in Louisville, I waited for her and we walked to the baggage claim area together. She spoke with great pride about her daughter, grandchildren and other family members. She also shared her experience growing up as a child in England and living in South Africa. She was a very interesting woman who had clearly done a lot in life and had many stories to share. As we approached baggage claim, she told me to go on and she would get her bag and take a taxi. I was very persistent that I would not leave her and I let her know I had to get my bag as well. As bags started coming out, she said, “There is my bag.” Believe it or not, my bag was next in line. We both smiled and said it must be our destiny to meet.

We walked out to my car and I drove her to the hospital. By this time, it was somewhere around 11:00 pm. When we arrived at the hospital, I carried her bag in and took her straight to her daughter’s room in the ICU where we were greeted by her other daughter. I helped her get settled in and met some of her family members. I ended up leaving the hospital about midnight and was very happy to get home to my wife and kids.

The next day and every day after that, I made rounds and checked on her and her daughter. The good news is the daughter is doing fine. Since her discharge, I continue to get e-mails from various family members, including those who live in New York and Oregon. In particular, I still receive e-mails from my fellow passenger, who lives in Sarasota, Florida. As I stated earlier, she is a wonderful and very interesting person.

As we all know, the healthcare industry is changing rapidly. The only certainty we have is that tomorrow will look different than today. Whether we are consultants, vendors, or providers, we never get a second chance to make a first impression. I have always lived my life by trying to do the little things better each day. I am a long way from being perfect, but what seems to allow people or organizations to go from good to great, is doing the little things a little better than the next guy.

I wanted to share this story with you because it has been a very rewarding experience. I would not have had this opportunity if it were not for HFMA and the Fall President’s meeting. I often joke with people that I am just over achieving in life. In reality, I am. I am not the smartest guy in the world, but I do realize that if you help others, treat them with respect, and do the little things, anything is possible.

Since this will be the last newsletter before the holidays, I would like to wish everyone a Happy Holiday Season and I hope 2011 brings good health and prosperity to you and your family.

Sincerely,

Andy Strausbaugh, President
Kentucky Chapter – HFMA
2010 - 2011
I hope everyone is well and getting excited about the Holiday Season. It’s right around the corner.

I would like to ask you to consider volunteering for the newsletter. We could use some additional help. It could be in the form of finding articles, proofreading, interviewing, taking pictures at events and seminars, and etc. If you are interested, please contact me. We’d love to have you on the team!

In this edition, we present to you some articles we found to be very interesting. Many of the articles are from the HFMA website and other partner websites. HFMA’s website is very informative and has a lot of good information on it. I encourage you to check it out.

Due to tense holiday schedules of everyone involved, we will continue with our CFO interviews in our next issue.

I hope you have a wonderful Holiday Season with your loved ones.

Sincerely,

Jeff Presser
Editor
jpresser@ddfky.com
The highly anticipated final “meaningful use” regulations for certified electronic health record (EHR) technology were published on July 28 by the Department of Health and Human Services and the Office of the National Coordinator for Health Information Technology (ONC), creating quite a buzz in the healthcare provider community. After more than 2,000 public comments were taken into consideration, the final regulations are more relaxed than the original proposed rules.

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Among the major changes reflected in the new regulations is a reduction in the number of meaningful use objectives. For example, hospitals must now achieve 14 core meaningful use measures and physicians need to meet 15, compared with the previous 23 and 25 measures, respectively. Additionally, hospitals and physicians have the flexibility to choose up to an additional five measures from a set of 10 measures, and can defer reporting on them until Stage II.

Other significant changes include a reduction in percentage thresholds for certain measures, such as ePrescribing, which has been reduced from 75 percent to 40 percent of permissible prescriptions. The reduction takes into account the fact that some pharmacies may not be able to accept electronic prescriptions and some patients may prefer a paper prescription over an electronic copy. Additionally, quality measures for hospitals have been significantly reduced, from 41 to 15 for the reporting period of 2011 and 2012. Physicians will now be required to report on three core or three alternate quality metrics plus three additional quality metrics that are not specialty-specific. If the physician is unable to report on any of the six core/alternate core metrics, then the physician must select six quality measures from the original set of metrics in the proposed rule.

Despite the final rule’s increased flexibility, many are asking if it will be enough to help make the goal of achieving meaningful use to qualify for Medicare and Medicaid incentive payments more realistic. Although some providers and industry associations are pleased with the new regulations, others have expressed concern that the requirements may still be too difficult. There is no question that, for many, the road ahead will be paved with a variety of challenges. Although some organizations have already invested in moving forward with EHR certification, others have been waiting for further regulatory clarity. However, regardless of where their organization is in its EHR implementation process, healthcare providers can no longer afford to delay their detailed meaningful use planning.

Meaningful Use Implementation Timeline

As providers work to determine their implementation approach, they should closely review the timelines for each of the three stages defined by Centers for Medicare & Medicaid Services (CMS) for meeting meaningful use requirements.
Meaningful Use Update (Continued from page 6)

during the five-year implementation period. Each stage has its own deadlines, associated incentives, and unique set of criteria. The requirements for each stage build on the requirements of previous stages until 2015, when all eligible professionals and hospitals are subject to the commencement of Medicare penalties for failure to achieve meaningful use. Furthermore, there is nothing that prevents future stages of meaningful use from being enacted after 2015. Providers should try to adopt meaningful use requirements as early as possible because as the requirements increase in specificity over time, incentive payments decrease until the noncompliance penalties begin in 2015.

Significant changes reflected in the final meaningful use regulations include a delay in the timing for meeting Stage I, II, and III requirements. The final rules cover only Stage I; subsequent regulations will be published by the end of 2011 for Stage II and the end of 2013 for Stage III. Note that CMS has delayed requirements for Stage III, which are still to be determined. In addition, CMS is also prolonging the time frame required to transition from Stage I to Stage II. Nevertheless, it is still important for healthcare providers to move forward promptly with an implementation strategy.

What Is Your Meaningful Use Strategy?

Despite some lingering uncertainty regarding the details around Stages II and III, providers cannot afford to delay their meaningful use planning. First and foremost, providers should decide whether their strategy is to secure incentive funds, to avoid getting penalized, or, ideally, both. Considerations include prioritizing the timing and extent of capital expenditures, and selecting the approach for clinical adoption and the methods to fulfill the specific requirements for meaningful use. The stakes are high for the loss of capital recoupment; there are also significant penalties for not demonstrating meaningful use by 2015 in the form of an adjustment to the market basket update to the Medicare inpatient prospective payment system payment rate for eligible hospitals. That adjustment is one-fourth for FY15, one-half for FY16, and three-fourths for FY17 and thereafter. In addition, hospitals would remain subject to a separate reduction for failure to report quality data under the Reporting Hospital Quality for Annual Payment Update.

Providers also should remember that being designated a “meaningful user” requires that they do more than merely implement an EHR system and provide patients with electronic access to health information in a timely fashion. Organizations may need to invest in business analytics and business intelligence capabilities to help them measure and report the results of their efforts.

In addition, many clinicians may need to significantly change their work flow and patient care processes to more fully utilize an EHR in their daily patient care activities. Furthermore, meaningful use requirements are intended to ramp up in later stages, as the government expects that the resulting new processes from implementing Stage I will deliver better clinical outcomes, increased efficiency, and an enhanced patient experience. Meaningful use has loftier goals than historic EHR use. Even those organizations already advanced in their EHR implementations will need to work diligently to optimize their use to meet the new requirements.

One of the goals of the government’s Health Information Technology Economic and Clinical Health Act (HITECH) program is the exchange of data across and between the providers in a “community,” which highlights the need for the establishment of Health Insurance Exchanges (HIEs). As part of their meaningful use planning process, providers need to determine which, if any, plans their organization, community, and/or state has for an HIE.

(Continued on page 8)
Building a HITECH Road Map

Meeting meaningful use requirements should be a priority for a provider organization’s senior leaders. An internal team of clinicians, health IT (HIT), and finance department staff should establish a clear HITECH road map that addresses important questions such as: What competencies do we have? What capacity do we have? What external resources will we need? Experience has shown that the time to build the right team and access the best resources is before a deadline is looming.

A meaningful use road map should include not only goals and expected outcomes, but also timelines, staffing requirements, and a projection of expected capital and operating costs. It is also important to factor in potential risks and the necessary controls. Remember, by applying for reimbursement from the federal government, you are attesting that you have implemented technology that fulfills the requirements of meaningful use and achieves certain metrics. It’s much like receiving a grant; considerable reporting and compliance are involved - including the requirement to maintain evidence of qualification to receive incentive payments for 10 years.

Key Considerations for Providers

Despite still-evolving definitions, standards, and requirements, many hospitals and physicians find themselves compelled to move ahead with incomplete information to meet the aggressive timelines established by the HITECH Act. As a result, healthcare providers may feel like they are being asked to hit a moving target as they work to demonstrate meaningful use of certified EHRs to qualify for HITECH Act Medicare and Medicaid incentive payments.

Critical questions in the provider planning process should include:

- Have we determined the estimated HITECH incentives and penalties (including Medicaid and physician estimates)?
- Does our current timeline align with the HITECH incentives and penalties timeline?
- Do we need to reevaluate our current EHR vendor to ensure it can meet the new requirements and certification criteria?
- Do we have plans to accelerate implementation?
- What about process redesign and clinician adoption? Do we have plans to deal with these common barriers?
- Do we have a full understanding of the security and privacy requirements of the HITECH Act?

To receive meaningful use reimbursement, eligible hospitals and professionals will be voluntarily putting themselves into a more regulated environment. However, providers that proactively plan for meaningful use implementation and execute effectively should find their efforts to be worth the investment.

John T. Bigalke, FHFA, CPA, is vice chairman and U.S. Industry Leader, Health Sciences & Government, Deloitte LLP, Orlando, Fla., and a member of HFMA’s Florida Chapter (jbigalke@deloitte.com).

Mitchell Morris, MD, is principal and national leader for health IT, Health Sciences & Government, Deloitte Consulting LLP, Costa Mesa, Ariz. (mitchmorris@deloitte.com).

Reprinted with Permission from HFMA Magazine. Original Print date: November 1, 2010
HFMA –Kentucky Chapter Annual Fall Educational Institute took place on October 14 – 15 at the Embassy Suites in Lexington Kentucky. The keynote speaker was Dr. Kenneth Wilson. Dr. Wilson is the System Associate Vice President of Clinical Affairs at Norton Healthcare, and he shared information and insight into the Accountable Care Organization Pilot Project.

Sean Dieterle, Senior VP and Senior PIMCO Portfolio Specialist for Allianz Global Investors Distributors, LLC spoke about The Journey to a New Normal, sharing insights on how the changes in the global economy and markets and the financial drama in Europe is transforming the world.

Breakout sessions included topics for the investor, CFO’s, accountants & auditors, and coding and compliance specialists with such topics as Peeling Back the Onion on Investment Expenses, Emerging Trends: Provider Based Clinics (for PPS & Critical Access Hospitals), Accounting & Auditing Updates, Project Management: Key to ICD-10/5010 Success, and Evolving Capital Finance Options for Hospitals.

General Sessions and Roundtables were lively with “What Keeps These CFOs Awake at Night?”, where the CFO panel shared their thoughts of current issues and their impact on their organizations. Other topics included claims denials and prevention, capital finance options for hospitals, managing retirement plans and ethics and integrity. This Fall Educational Institute was a perfect forum for the wealth of information on the healthcare and investment industries.

Total attendance at the Institute was 146. Those attending enjoyed a social gathering for dinner and the Comedy Club.
With President Obama’s recent healthcare reform many in the healthcare industry are left scrutinizing the specifics and wondering what the legislation will mean for the industry. But what will these details mean for hospital CFOs and how can they best start preparing their organizations for these upcoming changes and potential challenges?

The Long and the Short of It

With the healthcare reform legislation so complex yet still in its infancy, CFOs are just beginning to explore the long- and short-term initiatives and consequences. For the long-term, hospital and health system CFOs will need to prepare an operating environment heavily impacted by payment reform initiatives. Greg Scarbrough, CFO/VP Finance Oconee Memorial Hospital believes this to be the calm before the storm. “Health care reform and models will be affected both in the short term and long term: short term because of the unknowns, and in the long term because of how the short term rulemaking will affect us. Our jobs have just become increasingly more difficult, and to prepare for them in terms of cost and budgets, we’re going to have rising costs. Budgets will become much more difficult. Bottom lines will be harder to come by. We are in for challenging times over the next few years as the models evolve,” he anticipates.

Year over year increases in both commercial and Medicare payment rates will also become highly regulated and constrained. “Beginning in roughly 2012, and accelerating throughout the decade, CFO’s will have to navigate the many carrots and sticks associated with a wide-range of payment reform initiatives. These initiatives will initially relate to very specific clinical metrics and gradually expand to include broader populations of patients and annual payments,” says Sg2’s VP Strategic Planning Bill Woodson.

With Medicare reimbursement rates being adjusted in terms of reductions to their market basket updates, the main concern for CFOs is how will they be able to make up for Medicare revenue? However, they see both an advantage, but also a risk to payment reform aspects related to accountable care organizations, bundled payments and value-based purchasing.

Greg DeBor, client partner of CSC Health Delivery, explains, “The upside they see is that hospitals and health systems that can figure out how to operate in the new payment environment are likely to prosper. The risks they see are that making the transition potentially forces cannibalizing their existing fee-for-service business by foregoing volume and revenue; that there may not be uniformity in such programs across Medicare, Medicare and private payers; and that if the payment reform experiment turns out like the last time they participated in capitation in the ‘90s, hospitals could lose their shirts.”

However, in the short-term, with most commercial payers negotiating much more aggressively on year over year contract increases, most CFOs are going to have to start preparing by running payment scenarios that show the impact of more commercially insured and Medicaid patients, decreased bad debt post 2014 and decreased DSH payments.

Depending on the size of operations, some smaller organizations may need to look to bigger partners due to declining reimbursement, cost efficiencies, inability to obtain capital and lack of other necessary resources. In regards to the immediate impacts of the reform on EMR/EHR and technology, providers will need to get onboard now or be a victim of reimbursement cuts in the future.

Jeffrey Rooney, CFO Saint Agnes Medical Center, suggests that hospitals are going to have to achieve a more improved cost structure model in order to prepare for healthcare reform changes. “You need to know where you’re making money and where you’re losing money. There are a lot of hospitals out there that don’t know that, and it’s really up to finance, the CFO and the staff in finance, to put that information out there and provide it to the decision makers. We’re taking about a level of accuracy and quality that needs to improve. I think having information such as ‘well we’re losing money in this area and we’re making money in this area,’ you have to be fairly confident in that information so that you can say, ‘okay, maybe we’re not going to have this program anymore’. Those are the kinds of tough decisions that people have avoided for a long time, because they don’t want to give up something,” he explains.

The Potentials and Answering to Your CEO & the Board

The healthcare reform holds the promise of reducing charity care and the bad debt normally reserved for both considering more Americans will likely have some form of health insurance. Payment reform also holds the promise of larger population-based contracting over time producing a more predictable revenue model. However, the (Continued on page 11)
benefits and challenges will vary depending on payer mix and the wealth of the commercial, Medicare and Medicaid payments. There is a potential for standardization of insurance benefits and contracting/reimbursement across the government and private payers once insurance gateways and payment reform pilots begin to take shape.

Scarbrough also sees potential benefits in the quality and focused improvement models of hospitals and organizations. “The benefits come in the quality side, and in the focus and improvements in quality in all organizations that will be the cornerstone of some of these models, and I think that’s a pure, solid benefit for our patients, certainly, but our payers as well,” he explains.

Over the next few years CFOs will be very busy figuring out changing volumes and payment mechanisms and explaining these health reform variables to their CEOs and hospital boards. According to DeBor, CFOs will have to address questions such as how much Medicaid expansion will actually take place and what will that mean? Will private payers follow the federal and state lead in payment reform and accountable care, etc., or will they take their own approaches and further confuse reimbursement? How will hospitals acquire the tools to operate in and understand how they are performing in the post-reform world? Will they have the right services mix and the right staff? Will they have enough staff to match increased demand? What new partnerships will they need to forge and what will the hospital’s role be in a bundled or accountable care model?

“Complicating all this is that hospital CFOs are still trying to figure out what the Medicare and Medicaid incentives introduced for implementing Meaningful Use with electronic health records introduced in ARRA mean to their organizations. Now they’ll need to figure out how the health reform changes relate to those, too,” he says.

CFOs will most likely need to acquire additional capital or operating funds to set up new management organizations, potentially to obtain practices or new treatment capabilities and acquire more integrated information systems and business intelligence capabilities for managing performance of the new ACO. These are necessary steps in order to project how costs and revenues are changing and analyze their bottom lines.

However, this may lead to M&A discussions and potentially alternative staffing models with capacity and throughput being large considerations. A lean, but fully functioning personnel model will need to be established in order to handle the volume of increased care as well as an aging population.

Cost, Budgets, Bottom Lines: 10 Tips on How to Prepare

Christopher E. Rivard, Partner and Healthcare Group Chair at Moss Adams LLP, offers some tips on how CFOs can best prepare:

1. CFOs should be running a model for their facility assuming payment at 100% Medicare rates. This is a “stress” test for the facility that will indicate ability to survive the coming changes and will highlight areas where improvements or cost reductions must be made.

2. All entities must commit to a renewed focus on cost containment and efficiency. Decreases in revenue are surely coming and, regardless of quality improvements, will require a reduction in costs. This is important not only to improve the bottom line of the facility but also to make it an attractive partner to other organizations.

3. All organizations should begin or expand processes to analyze opportunities for collaboration with other partners and/or integration strategies. The concepts of bundled charges and accountable care are real and planning needs to begin now.

4. Providers should consider approaching insurers and proactively renewing contracts in order to prevent tough negotiations in the next year or two. Possibly offer reductions in pricing now to preempt larger cuts in the future. This might also result in more volume directed to the hospital.

5. If an entity is tax-exempt, CFOs should begin establishing a methodology to meet the new reporting requirements which begin in 2010 and 2012 including a community health needs assessment. They should also plan for much tougher justification of tax exempt status.

6. Be very frugal with spending and make sure the Board is clear regarding any revenue return for new capital investments.

7. Management should assume their facility is over-bedded and that services will continue to be pushed to an outpatient setting. Plan for greater acuity in existing beds but possibly lower census.

8. Develop a plan to create or maintain an image that draws others to your organization for integration opportunities.
CMS Is Tying FY13 Payments to Quality Reporting Program

Hospitals that have intensive care units (ICUs) and participate in the Centers for Medicare & Medicaid Services’ (CMS’s) Hospital Inpatient Quality Reporting Program will soon need to begin submitting quarterly data about central line-associated bloodstream infections to the National Healthcare Safety Network (NHSN) of the Centers for Disease Control and Prevention.

To receive FY13 Medicare payments, hospitals with adult, pediatric, and neonatal ICUs must begin submitting the infection data on or after January 1, 2011—whether or not they have central line days. Hospitals that do not have ICU beds do not have to submit data; however, they need to submit a notification form, according to a recent notice from CMS.

The Tattered Medicaid Long-Term Care Safety Net

By Howard Gleckman,
Senior Research Associate at the Urban Institute

ORIGINAL PUB DATE: NOV. 29, 2010
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Medicaid, the state-federal health program that also pays for nearly half of all long-term care services for the frail elderly and younger people with disabilities, is in big trouble. A deep ongoing budget crisis in most states as well as the likely end of the federal economic stimulus payments could lead to both long-term care service cuts and reduced payments to the nursing homes and home health agencies that provide this assistance.

And this squeeze may only be just beginning. Faced with an historic deficit, the federal government could opt to reduce its future Medicaid payments, forcing states to choose between cuts in acute care for young families or long-term care. This tenuous future is why the U.S. must begin to consider broad-based insurance to finance long-term care.

The Medicaid long-term care benefit is a critical safety net for the frail elderly and others with disabilities. Many recipients are once middle-class people who went broke paying for their own medical and personal care. Now, without financial resources, they must turn to Medicaid.

For those who cannot afford the nearly $80,000-a-year price tag for nursing facility care or the $20 an hour tab for home health aides, Medicaid is often the only option. Currently Medicaid spends more than $100 billion, or one-third of its total budget, on long-term care services. It is by far the biggest payer of long-term nursing facility and home health services. By contrast, private long-term care insurance pays less than 10 percent of these expenses. Medicare only pays for nursing care for a limited period after a patient has been discharged from the hospital.

But the Medicaid safety net is fraying. Facing their own massive budget shortfalls, states have already begun trimming benefits, many occurring in Medicaid’s home and community based programs. That’s because states are required to provide assistance in a nursing facility, but not at home. Thus, states cut where they can, even though beneficiaries prefer home care and some research suggests the states themselves can save money by helping Medicaid long-term care recipients stay in the community.

Until now, those benefit cuts have been relatively modest. The Kaiser Family Foundation estimates that 18 states reduced long-term care benefits in 2010 and another 10 plan to do so this year while more than 30 expanded their programs. The main reason: The huge 2009 economic stimulus included $87 billion in additional federal Medicaid payments to states through December 2010. In August, Congress reluctantly added another $16 billion and extended the additional payments through June 2011. (KHN is a program of the foundation.)

But that money is about to dry up. With Republicans winning control of the House and picking up seats in the Senate, and with worries about the federal deficit growing, there is little chance Congress will provide any additional Medicaid dollars.

The long-run future is even dicier. To start, the new health law will add an estimated 16 million more acute care patients to the Medicaid rolls starting in 2014. Congress promised to pick up most of the cost of those added beneficiaries, though the federal payment will slowly decline. If states pay more for those acute care patients, the extra dollars must come from somewhere. And one possibility is Medicaid funding for long-term care.

The real risk to states, however, is that Washington will fail to keep its commitment. Given the growing fiscal crunch, I’d worry about that promise if I were a governor.

Some conservative law-makers in Texas and elsewhere have floated the idea of pulling out of Medicaid entirely. But since a state can’t withdraw from only part of Medicaid, this decision would leave long-term care beneficiaries with no safety net at all.

While states can’t change the rules, Congress can. Already, influential deficit hawks are suggesting how that might happen.

For instance, the co-chairs of President Obama’s fiscal commission, former Clinton Administration chief of staff Erskine Bowles and former Sen. Alan Simpson, R-Wyo., have proposed capping the federal share of Medicaid long-term care costs—a step that could reduce federal payments by nearly $90 billion over 10 years.

A second deficit commission would go much further. The privately-funded Bipartisan Policy Center’s panel suggested major changes in Medicaid long-term care assistance. The most far-reaching suggests states and Congress fundamentally renegotiate their Medicaid responsibilities.

For instance, one level of government could take full responsibility for all long-term care while the other handles acute care.

These proposals won’t become law anytime soon. But they are evidence that Medicaid could be on the fiscal chopping block. In that environment, it makes sense to get the program out of the long-term care business. And a way to do that would be to replace it with a broad-based insurance system. The Community Living Assistance Services and Support Act, which was created by the health overhaul, will create a voluntary national long-term care insurance program. Program participants would begin contributing in 2012, but wouldn’t be eligible for benefits for at least five years. But there are real doubts about whether CLASS insurance will attract enough middle-class buyers to reduce the burden on Medicaid. If it can’t, Congress should begin to think about what insurance design can, and do so before the Medicaid safety net for long-term care is in tatters.
In Emergency Rooms, It's Getting Tougher To Say 'No' To CT Scans

By Amita Parashar
KHN Staff Writer

Anyone who has made a recent trip to the emergency room knows the visit is likely to set off a round of routine diagnostic tests: blood work, electrocardiogram, urine sample. And a routine CT scan? A new study shows that the emergency department use of these scans -- also known as computerized tomography -- has increased nearly six-fold since 1995 and shows no sign of tapering off.

Is it too much?

CT, a pricey technology that once took nine days to complete, was used in 2007 to diagnose 16.2 million headaches, stomach aches, back pain, chest pain and the like -- a huge increase from 1995's figure of 2.7 million, according to the new study published online in the journal Radiology. Other studies have also sparked concerns about the technology’s possible overuse -- including radiation exposure or the significant costs.

Dr. David Larson, author of the study, says it's getting more difficult for doctors to decide when to do a CT scan. "Because it's so widely available, because the images are so exquisite, there's the temptation to use it for anything." The findings suggest, he adds, that "we may be heading toward overutilization or inappropriate utilization."

But Dr. Jeff Goldsmith, co-author of the book “The Sorcerer's Apprentice: How Medical Imaging Is Changing Health Care,” says it's different when you’re the one lying on the table with a stabbing pain in your gut. He has twice had CT scans for abdominal pain and says he was “grateful” the scan could diagnose his problem and lead to quick treatment.

"It could be viewed as an emerging standard of care rather than something we should be 'concerned' about," he says. He even suggests that increased CT scanning might eventually lower health care costs by preventing unnecessary, even higher-cost, exploratory surgery. A typical CT scan of the heart can cost $500 to $1500.

Meanwhile, because the most recent available data lags a few years behind the times, it’s hard to know what the current utilization rates are. If the trends observed in the study have held true, then "by now probably about 20 percent of patient visits are affiliated with a CT scan," Dr. Larson says. He adds a note of caution about making such predictions, but preliminary data from 2008, which was not included in the study, seems to follow the trend.

Nonetheless physicians, including Dr. Larson and Dr. Goldsmith, see the need for more research into when CT scans might not be an appropriate tool so they can be sure they're not missing an important diagnosis.

"The value that a CT provides, even if it's negative, is reassurance. It's hard to provide a dollar value on reassurance," Dr. Larson says.

This is one of KHN's "Short Takes" - brief items in the news. For the latest from KHN, check out our News section.
(http://www.kaiserhealthnews.org/Headlines.aspx)
Wide Variation in Private Insurer Payment Rates Evidence of Hospital Market Power

In Extreme Cases, Some Hospitals Command Almost Five Times What Medicare Pays for Inpatient Care

WASHINGTON, DC—Wide variation in private insurer payment rates to hospitals across and within local markets suggests that some hospitals have significant market power to negotiate higher-than-competitive prices, according to a study released today by the Center for Studying Health System Change (HSC) commissioned by Catalyst for Payment Reform.

Looking across eight health care markets—Cleveland; Indianapolis; Los Angeles; Miami; Milwaukee; Richmond, Va.; San Francisco; and rural Wisconsin—average inpatient hospital payment rates of four large national insurers ranged from 147 percent of Medicare in Miami to 210 percent in San Francisco, according to the study. In extreme cases, some hospitals command almost five times what Medicare pays for inpatient services and more than seven times what Medicare pays for outpatient care.

“The variation in hospital prices found in this study is inconsistent with highly competitive markets—at least for markets outside of health care,” said HSC President Paul B. Ginsburg, Ph.D., an economist and author of the study. “Indeed, observers of markets outside of health care would find the degree of price variation stunning.”

“The study confirms that many hospitals use their market power to get exorbitantly high private payment rates. Employers are very concerned about how this situation contributes to the unsustainable rise in health care costs and are looking into payment reforms that can improve the quality and cost-effectiveness of care,” said Suzanne Delbanco, executive director of Catalyst for Payment Reform (CPR), an independent, nonprofit group that works on behalf of large employers.

The study analyzed data on private insurer payment rates to hospitals and physician practices, focusing on variation across and within markets. Four major insurers—Aetna, Anthem Blue Cross Blue Shield, CIGNA and UnitedHealth Group—provided blinded hospital and physician payment rate data in the eight markets, reporting their contracted payment rates for commercial insurance as percentages of Medicare payment rates. The study’s findings are detailed in a new HSC Research Brief—Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power.

Price variation within markets was even more dramatic than variation across markets. For example, the hospital with prices at the 25th percentile of Los Angeles hospitals received 84 percent of Medicare rates for inpatient care, while the hospital with prices at the 75th percentile received 184 percent of Medicare rates. The highest-priced Los Angeles hospital with substantial inpatient claims volume received 418 percent of Medicare.

While not as pronounced, significant variation in physician payment rates also exists across and within markets and by specialty, the study found. Standard physician rates—those not subject to negotiation—across the eight markets were within 20 percent of Medicare rates in most of the geographic areas. Miami had the lowest standard physician rates at 82 percent of Medicare, while Milwaukee and rural Wisconsin stood out at the high end at 166 percent and 176 percent of Medicare, respectively.

Many factors likely play a role in the substantial variation of hospital payment rates, including the overall degree of hospital concentration in particular markets. But even in markets without high overall concentration, single hospital systems sometimes dominate geographic submarkets, according to the study. Hospital reputation also plays an important role. Some hospitals are so highly regarded that consumers perceive any health plan network as undesirable that excludes these hospitals.

The Center for Studying Health System Change is a nonpartisan policy research organization committed to providing objective and timely research on the nation’s changing health system to help inform policy makers and contribute to better health care policy. HSC, based in Washington, D.C., is funded in part by the Robert Wood Johnson Foundation and is affiliated with Mathematica Policy Research.

On behalf of large employers, the independent, nonprofit Catalyst for Payment Reform (CPR) works to identify and coordinate workable reforms, track the nation’s progress, and promote alignment between the public and private sectors. For more information, go to www.catalyzepaymentreform.org.
so-called must-have hospitals. Some markets have such marquee hospitals, but others do not.

Within a hospital system, a highly regarded flagship hospital can lead to higher rates for the system’s other hospitals, since hospital systems often have the clout to negotiate rates as a single entity. Those who believe that cost shifting—the concept that health care providers do not fully exercise their market power to maximize profits so that they are in a position to raise rates to private payers in response to cuts in public payer rates—is an important point in relatively low Medicaid payment rates in some areas leading to higher payment rates for private insurers.

Hospitals often acknowledge that private insurance rates are rising more rapidly than their costs but attribute the spread to increasingly constrained Medicare and Medicaid payment rates—a cost-shifting argument. However, the Medicare Payment Advisory Commission (MedPAC) has found that hospitals with substantial negotiating leverage can allow unit costs to rise because they can obtain higher private insurance rates to offset negative Medicare margins that result from their high costs.

The study points out that purchasers and public policy makers can address provider market power and the role it plays in rapidly rising health care costs, through two distinct approaches—using market approaches to strengthen competitive forces or constraining payment rates through regulation.

“Neither market nor regulatory approaches to constraining provider market power and constraining health care spending growth will be politically popular,” the study concludes. “Hard choices and trade-offs will be needed. But the failure to act to constrain spending growth will result in declining access to high-quality care for many Americans over the longer run and undermine the nation’s fiscal health.”

(Hospital Market Power ... Continued from page 15)
States Cutting Medicaid Benefits As They Stagger Under Economic Downturn

By PHIL GALEWITZ
KHN Staff Writer

ORIGINAL PUB DATE: SEP 30, 2010
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In Arizona, about 640,000 adult Medicaid recipients will lose coverage tomorrow for podiatry care, insulin pumps and most dental services. In Washington, D.C., in November, doctors who treat 250,000 Medicaid patients are scheduled to see their fees cut 20 percent.

These are some of the newest cutbacks in Medicaid as states grapple with surging enrollment -- and spending -- in the government health insurance program for the poor that covers nearly 49 million Americans.

Driven by the economic downturn, enrollment in the state-federal program rose by 8.5 percent in fiscal year 2010, which for most states ended in June, according to study released today by the Kaiser Family Foundation’s Commission on Medicaid and the Uninsured. State spending on Medicaid jumped an average of 8.8 percent in 2010, the biggest increase in eight years and the second biggest jump in two decades, the study found. The growing costs for Medicaid come as the faltering economy has stripped state tax revenues.

The 2009 economic stimulus, which provided an additional $87 billion in federal funding for Medicaid, prohibited states from tightening eligibility requirements. To save money, many states trimmed or eliminated so-called "optional" benefits -- such as vision and dental services -- and reduced reimbursements for doctors, hospitals and other medical providers.

The study, based on a survey of Medicaid officials in all 50 states, found 20 states reduced or restricted benefits in 2010. That’s twice the number of states as in 2009 and the highest number since the survey started in 2001. Thirty-nine states cut or froze reimbursements for doctors and hospitals, up from 33 states in 2009. The efforts are continuing; 14 states have plans to cut benefits and 37 to restrict fees in 2011. Yet despite the fiscal concerns, this year, 41 states made it easier to enroll or stay enrolled in Medicaid and a few states, such as Colorado and Wisconsin, are expanding eligibility.

"The report shows the continued depth of the struggle to provide care during the deep recession," said Diane Rowland, executive vice president of the Kaiser Family Foundation and executive director of the Kaiser Commission on Medicaid and the Uninsured. (KHN is a program of the foundation.)

Peter Cunningham, a senior fellow at the Center for Studying Health System Change, a Washington think tank, said the cutbacks are driving down doctor participation. "There is no doubt that lowering rates to providers is going to affect the percent of doctors who accept Medicaid patients," he said. He added, however, providers’ decisions about accepting Medicaid is also based on other factors, including whether they are paid in a timely manner and how much paperwork the program requires.

Rowland said that losing providers now will make it more difficult to attract doctors to care for the estimated 16 million additional beneficiaries that will be added when the program is expanded in 2014 under the health overhaul law. "Any erosion in Medicaid coverage now makes the hill steeper to climb in 2014," she said.

"Penny Wise And Pound Foolish"

Advocates for Medicaid recipients say they understand why states are cutting spending, but they argue that the moves eventually will lead to higher costs because people won’t get preventive care or be able to avoid health complications.

"It’s penny wise and pound foolish," Eddie Sissons, executive director of the Arizona Foundation for Behavioral Health, said of the state’s plan to eliminate numerous benefits for adults on Medicaid. She said Arizona’s decision to stop paying for diabetics to get their feet checked by a podiatrist or be eligible for an insulin pump could cause patients to suffer...
needlessly from complications.

Officials in Arizona, one of the hardest hit states in the economic downturn, say they had no choice as they addressed a more than $2 billion shortfall in the state budget. "Arizona has been facing an unprecedented fiscal crisis for the past couple of years," said Jennifer Carusetta, chief legislative liaison for the Arizona Medicaid program, which cut $20 million of its budget. "This has placed the state in a position where there are only these types of difficult choices to be made."

Nationally, Medicaid pays about 25 percent less to doctors than Medicare does, according to a 2008 study in Health Affairs.

Washington, D.C., and 10 states pay Medicaid providers the same fees they get from Medicare. But faced with a budget shortfall, the District has asked the federal government to approve its plan to lower fees. They expect to begin the new fee schedule Nov. 1.

"When we drop rates, we always worry that we lose providers," said Julie Hudman, director of the D.C. Department of Health Care Finance, which oversees the Medicaid program.

Doctors say that's just what will happen.

"I think it's a terrible idea," Dr. Peter Lavine, president of the D.C. Medical Society, said of the rate cuts. Lavine, an orthopedic surgeon, predicts the cuts could trigger many doctors to stop treating Medicaid patients and that hospitals serving large numbers of low income patients will suffer. "The premise of saving money or balancing the budget by sacrificing health care does not make much sense and is very short sighted."

The District's broad Medicaid eligibility rules -- it covers anyone earning below 200 percent of the federal poverty level ($44,100 for a family of four) -- is a key reason that just 6 percent of the District's residents are uninsured, the second lowest percentage in the nation.

Hudman said she resisted cutting any optional benefits because it would not have produced substantial savings.

'It's Just Mind Boggling'

In Louisiana, officials have cut hospital Medicaid fees by nearly 20 percent in the past 18 months.

"It's just mind boggling," said John Matissino, president and CEO of the Louisiana Hospital Association. He noted rates are now at 1994 levels. He said the rate cuts are causing hospitals to reduce services and staff. With predictions that 42 percent of state residents will be eligible for Medicaid after 2014, the hospital industry is worried how it will handle the influx. "It will be a horrible situation," Matissino said.

While the trims this year to Medicaid recipients and providers are not new, they become more difficult because they come on top of earlier cutbacks, said January Angeles, a policy analyst for the Center on Budget and Policy Priorities, a Washington

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**STATES** | **SERVICES ELIMINATED: Fiscal Year 2010**
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Arizona | Denture coverage and specified dental services
California | Multiple optional services for non-pregnant, non-institutionalized adults including acupuncture, dental (with exceptions), audiology, speech, optometry, podiatry, psychology services and chiropractic services and incontinence creams and washes
Connecticut | Over-the-counter drugs (OTCs) except insulin, insulin syringes, and nutritional for tube fed individuals
Hawaii | Dental coverage (except emergency services)
New Hampshire | Chiropractic care benefits
New Mexico | Bariatric surgery. (The state also limited routine adult vision services and appliances)
Oregon | Non-medical vision services. (The state also reduced dental services and denture coverage)
Virginia | Disease management program. (The state also expanded mental health and dental prior authorizations requirements)

**STATES** | **SERVICES ELIMINATED: FY 2011**
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Arizona | Most dental care, podiatry services, insulin pumps, percussive vests, bone-anchored hearing aids, cochlear implants, specified transplants, well exams, certain microprocessor-controlled prosthetics, all orthotics, and non-emergency transportation for childless adults. (The state is also limiting outpatient physical therapy visits to 15 visits per contract year)
Kansas | Attendant care provided in the local education agency setting. (The state is also limiting hospice services to 210 days)
Massachusetts | Restorative dental services and dentures. (The state is also limiting coverage for most acute inpatient hospital stays to only the first 20 days)
North Carolina | Obesity surgery, panniculectomy procedures, and maternal outreach worker program services. (The state is also imposing new coverage restrictions on breast surgery and personal care services and increasing its medical necessity standard)

(Continued on page 19)
research organization that researches policy and programs affecting low and moderate income people. She said the lower payment levels will make it harder for states to increase numbers of providers for the 2014 expansion.

To find cost savings and improve care, state Medicaid programs continue to turn to managed care companies, HMOs. In 2010, 13 states expanded managed care or mandated enrollment. In 2011, 20 states plan to take such steps.

But managed care has not been a panacea for Medicaid’s financial woes. Tennessee, which was one of the first states to move to Medicaid managed care in the 1990s, was only able to avert major cuts by passing a hospital provider tax this year.

Unless the economy drastically improves, state Medicaid officials see more tough times ahead. “Unfortunately, these tough choices are not over,” said Caruseta of Arizona. The state will need to identify an additional $1 billion in funding for the 2012 fiscal year in order to replace the loss of enhanced federal matching funds that are set to expire next June.

Volunteer

If you’re a long-time member or a new member to the Kentucky Chapter, we have many opportunities to become involved. You can write an article for the newsletter or even Chair a Committee. We will certainly keep you as busy as you want! Please visit the Kentucky Chapter website at www.hfmaky.org. On the Chapter Information page, click the Volunteer—Get Involved button. There is a link to fill out an easy form.

Sign up today!

OOPS...We Goofed....

Our most sincere apologies to:

Amy Vibbert, whom was listed as Abby Vibbert in the “2010 Summer Institute” Article of our last issue.
The Financial Diagnosis

As Hospital System Expands, Patient Advocates Worry

By JORDAN RAU
KHN Staff Writer

ORIgINAL PUB DATE: NOV 29, 2010
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This story was produced in collaboration with XQED and npr

BURLINGAME, Calif. - Sutter Health’s gleaming $618 million Mills-Peninsula Medical Center, scheduled to open here in February, is filled with doctor- and patient-friendly features.

Every patient room is private, unlike in the older hospital that sits next door waiting to be razed. The new operating rooms are almost a third larger. The building’s filtration systems expel air instead of recycling it through the building, reducing the transmission of infectious diseases. There are three open-air gardens within the building and one on a roof where patients can relax.

“Healing the body is more than good medicine — it’s good environment,” says Larry Kollerer, the project manager overseeing the construction.

Through new construction and expanding its doctors’ groups, Sutter Health is enhancing its position as one of the most dominant hospital systems in California. In addition, Sutter is further ahead of many competitors in fashioning itself into a so-called accountable care organization, responsible for coordinating care between hospitals, specialists and primary doctors.

Although Sutter executives say these developments will improve patient care, some analysts and patient advocates worry about the growing leverage the non-profit hospital system has in negotiating rates paid by insurers, employers and patients. Sutter already is the priciest health system in California.

Nurses and doctors crowd around a station at California Pacific Medical Center’s Pacific Campus, a Sutter Health Facility. "The days where it was one doctor and one nurse providing care are over," says Dr. Lory Wiviott, California Pacific Medical Center’s chief of medicine.

"As Sutter gets bigger," says Anthony Wright, executive director of Health Access California, a nonprofit advocacy group based in Sacramento, "it can dictate higher prices and is less accountable for ensuring good quality because it has a lock on certain markets."

Laying Groundwork

Sutter officials say they have already invested heavily in advancements such as electronic health records that are encouraged by the federal health overhaul law passed this year. Federal health officials hope the changes encouraged by the law will lead to more efficient care for patients in Medicare, the federal program for seniors and the disabled, and that better practices ultimately will filter down to the privately insured.

"Sutter is positioned to respond well to the will of Congress," says Patrick E. Fry, Sutter’s president and CEO.

Sutter hospitals in the Bay Area last year received more than 1 million outpatient visits from patients who were covered by insurance or paid out of pocket. That was 35 percent of the region’s total and more than any other hospital system, state data show. Sutter’s hospitals had 40,181 inpatient admissions, meaning that more than one out of every four hospitalizations in the Bay Area took place at a Sutter facility. Only Kaiser Permanente admitted more patients. (Kaiser Health News is not affiliated with the insurer.)

Sutter is expanding on several fronts. In September, Brown & Toland, one of San Francisco’s largest physician groups with 800 doctors, joined the network of doctors affiliated with nonprofit foundations Sutter established. More than 330,000 patients see Brown & Toland physicians, who are more likely to refer them to Sutter hospitals when they need treatments.

At the new Mills-Peninsula hospital, many Sutter-affiliated doctors will work in a building connected to the hospital. Jeff Gerard, a Sutter executive who oversees the region, predicts a change for the better: "People actually see each other at lunch and it’s a wonderful way to share information and build relationships, and it just doesn’t happen in today’s environment."

(Continued on page 21)
In San Francisco, Sutter is also planning to consolidate its inpatient services now provided at two of its city campuses into a new 556-bed, 17-story hospital. Dr. Lory Wiviott, chief of medicine at Sutter's California Pacific Medical Center, says the existing facilities are becoming obsolete.

"Medicine has changed since this facility was built," he says during an interview at the campus on Buchanan. "The days where it was one doctor and one nurse providing care are over. It becomes a competitive sport just to have enough room."

'Let's Gentrify Our Patient Base'

That may be the case, but Alain Enthoven, a Stanford health economist, says many of the expensive construction elements at new hospitals don't improve patient care. "In some cases," he says, "our hospitals are rather more beautiful than we really need, if we're trying to get health care out to all Americans."

Sutter's proposed placement of the new hospital in an upscale neighborhood has been greeted skeptically, especially given Sutter's reputation for strategically locating its facilities to bolster its market clout and attract the best paying patients. "A big piece of this is 'let's gentrify our patient base, and we'll have a better bottom line.' And there's a piece of 'let's create these places where we'll have a more upscale experience,"' says Ken Jacobs, a professor at the University of California, Berkeley's Labor Center. "They're trying to get away from a place where you have people who are uninsured or on Medi-Cal, the state's low-paying insurance coverage for the poor.

The prices Sutter gets for privately insured patients have risen to the point that in 2009, the average price of a day of care at its hospitals was 37 percent above the state average. That helps explain why hospital care in the West Bay counties of Marin, San Francisco and San Mateo is on average more expensive than anywhere else in California, according to the state data.

A Federal Trade Commission analysis in 2008 determined Sutter's merger of Summit Medical Center in Oakland and Alta Bates Medical Center in Berkeley in 1999 "may have been anticompetitive" and led to big price increases of as much as 72 percent for one insurer.

Impact Of 'Accountable Care'

Some insurers are starting to balk at Sutter's high prices. When the University of California and its insurer, Health Net, this year designed a new health maintenance organization network for university employees, it excluded several Sutter medical groups and hospitals because they were more expensive than other providers, according to Brad Kieffer, a Health Net spokesman.

Stephen Shortell, dean of the UC Berkeley School of Public Health, says Sutter already has so much market leverage in northern California that he doubts simply becoming an accountable care organization would give it more influence than it has now. "To say they're going to be able to increase their negotiating clout to set prices would mean to expand significantly and acquire more hospital physicians and hospitals," he says.

Yet that is what Sutter CEO Fry envisions. "We have an opportunity to grow our medical foundations," Fry says. "We have opportunities to build new hospitals in different areas because our medical groups are large enough to support a new facility."
The People Behind The Entitlement Debate

Well before we have any clarity on the impact of the election on health reform, the pundits are handicapping the prospects of efforts to make a serious dent in the national debt and deficit. Three national commissions are hammering out recommendations for reducing the debt and reining in entitlement spending, putting two giant health programs that serve the elderly, disabled and low-income Americans, Medicaid and Medicare, as well as Social Security, in the crosshairs of a new policy debate.

Just yesterday, the Administration’s National Commission on Fiscal Responsibility and Reform, chaired by Erskine Bowles and Alan Simpson, released draft recommendations, with final recommendations due before the end of the year. Also yesterday, the Peterson-Pew Commission on Budget Reform issued a report recommending changes in budget process rules to help drive down the national debt. And next week, the Bipartisan Policy Center’s Debt Reduction Task Force, chaired by Pete Domenici and Alice Rivlin, is expected to issue their recommendations.

All three groups are tackling very real challenges. The national debt has climbed to $13.7 trillion and the federal deficit has reached nearly $1.4 trillion. Spending on Social Security and mandatory health programs (Medicare, Medicaid and CHIP) account for about 40 percent of the federal budget, and according to CBO, will grow from roughly 10 percent of GDP today to 16 percent in twenty five years, due to the aging of the population and the rising costs of health care. With projections like these few openly support doing nothing, even though how much can actually get through the legislative process remains unclear.

The discussion of these issues is framed almost always in terms of “hard choices” to reduce spending, increase taxes, or both. On the spending side of the ledger, many say the hard choices won’t be made because of political realities, including strong resistance from seniors to any changes to Medicare or Social Security. The mid-term election was just the most recent example illustrating the importance of senior voters. In general, Democrats will resist cuts in these programs and Republicans will resist any new taxes.

But these choices are also hard on legitimate policy grounds, especially when it comes to Medicare. And the most important reason they are hard is that so many seniors and disabled people on Medicare have low incomes and already pay a significant share of those incomes for their health care today. It will be difficult if not impossible to ask the majority of beneficiaries to pay more or make do with less. That has been the missing element in the entitlement/deficit reduction debate: Warren Buffett is not the typical Medicare beneficiary. Instead the prototype is an older woman with multiple chronic illnesses living on an income of less than $25,000 who spends more than 15 percent of her income on health care. It is the people on these programs and the realities of their lives that have been left out of the discussion.

Nearly half (47%) of all elderly and disabled people on Medicare have incomes below twice the federal poverty level (less than $20,800 for an individual and $28,000 for a couple in 2008). Poverty rates are even higher among women, African American and Latino Medicare beneficiaries. And two-thirds of the 8 million disabled people on Medicare who are under age 65 have incomes below twice the poverty rate; beneficiaries with disabilities face more serious access problems than others on the Medicare program.
People on Medicare also already spend a much larger share of their household budgets on health care than the non-elderly do: about 14 percent compared to 4 percent in 2006. And according to our analysis, median out-of-pocket health spending for the elderly and disabled on Medicare as a share of income has been rising, from about 12 percent in 1997 to more than 16 percent in 2006 – with even higher rates for those living below the poverty level (21%) and among those between 100-200 percent of poverty (23%).

Some “hard choices” to be considered may not affect the most vulnerable elderly and disabled, for example proposals that ask higher-income seniors to pay more. The health reform law has already moved further in this direction by increasing the number of higher-income beneficiaries who will pay higher Medicare premiums. Additional efforts to raise costs for higher-income beneficiaries could stir up strong political opposition. Some old ideas may need to be re-evaluated in a post health reform world. For example, proposals to save money by pushing back the retirement age for Medicare to 67 may save money for Medicare, but may not make as significant a dent in federal spending as once envisioned if the 65 and 66 year olds with incomes below 400 percent of poverty become eligible for government tax credits, or for Medicaid, under health reform.

One of the biggest issues likely to emerge is where to draw the line in terms of who should be asked to pay more if policies slow the growth in Medicare by shifting costs to beneficiaries, either directly or indirectly. Who is wealthy enough to pay more? Are adequate protections in place to shield seniors with modest incomes from financial hardship and cost-related access problems? Legislators took one cut at this apple in health reform. The recently enacted health reform law established premium subsidies to limit the financial burden on families with incomes up to 400 percent of the poverty line. The leaders participating in the different debt and deficit reduction commissions and the experts assisting them are certainly aware of these challenges, although they have not really been part of the public discussion to date.

If new policies are proposed to rein in entitlement spending and reduce the deficit, it seems only reasonable to include the following criterion among others for evaluating proposals: do no harm to the financial security or access to care for elderly and disabled beneficiaries living on low and modest incomes. Indeed, given the high out-of-pocket costs these groups have, and the large share of their incomes they already pay for health care, a comprehensive approach might well seek to improve circumstances for these most vulnerable groups, while also advancing “hard choices” for entitlement programs to reduce the deficit.
NEW MEMBERS

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

Pamela D. Howard  Financial Analyst  Owensboro Medical Health System
Patrick Rykwilder  Financial Analyst  Owensboro Medical Health System
Sean M. Buda  Territory Sales Manager  Craneware
Geoff Luber  Chief Financial Officer  Baptist Community Health Services
Robert Wordlow  Sr. Client Support Manager  HCA National Patient Account Services
Carol Thomas, CMPE  Sr. Administrator  University of Louisville, Dept. of Psychiatry
Debra Smith
Stefan W. Hendrickson  CPA  Barr, Anderson, Roberts, PSC
Jennifer Tunget  Assistant Administrator  University Psychiatric Foundation
Jaime L. Sloan  Sr. Manager  CHAN Healthcare Auditors
Seth Blane Hall  VP of Strategy & Reform Program Dev.  University of Kentucky Hospital
Paige Sniger  Associate Director, Managed Care  Bottom Line Systems, Inc.
Rebecca A. Knapp  Denials Manager  ZirMed
Hunter Callahan  Business Development  3M
Peggy A. Rambicure
Jeremy D. Richey  Mgr of Patient Access/Guest Services  Norton Brownsboro/Kosair Children’s Med. Center
Beau V. Fantuzzo  Staff Accountant  Saint Joseph Health System
Susan Bezy  Director Billing & Coding  Norton Healthcare
Ronnie Simpson  Regional Director HIM/CDM  Saint Joseph Berea
Scott Hemmann  Client Advisor  JPMorgan Asset Management
Samuel Riddick  Controller, North America  First Source USA, LLC
Colleen Tomlinson  Internal Audit Manager  FirstSource Solutions USA, LLC
Kimberly Brown Ashby  VP  Trover Health Systems
John Calabrese  Specialist Accounting & Compliance Svc.  Dean Dorton Allen Ford, PSC
Mark Fandiño  Sr. Consultant  BKD, LLP
Jennifer Wagner  Staff Accountant  Methodist Hospital
Matt Davis  Budget Analyst  King’s Daughters Medical Center
Jerald D. Merritt  Chief Medical Officer  ZirMed, Inc.
Debby Comett  Corp. Dir., HIM, Patient Access, Scheduling  Jewish Hospital & St. Mary’s Healthcare
Kara Litteral  Patient Advocacy Supervisor  King’s Daughters Medical Center
Jay P. Swacker  Projects Director  University of Kentucky
Megan M. Haddix  Senior Consultant  BKD, LLP
Colleen D. Winkelman  Managed Care Analyst  Bottom Line Systems, Inc.
LaSandra L. King  Contract Administration Manager  Norton Healthcare, Inc./Managed Care
Gail Fleckstein  Director of Business Office  Ephraim McDowell Regional Medical Center

The Kentucky Chapter also extends a warm welcome to these HFMA members who have recently joined us from other Chapters:

Osman Gruhonjic, CHFP  Chief Financial Officer  Frankfort Regional Medical Center
Liz A. Snodgrass  Chief Financial Officer  Trigg County Hospital
Ben S. Mahaney  Director of Registration/Admitting  University of Kentucky
Thomas G. Spalding
Jason Schmidt  Chief Financial Officer  Logan Memorial Hospital
Aline Lewis  VP  Achieve CCA, Inc.
Jay R. Howell  VP Sales, Alliances & Business Dev.  Anthem Healthcare Intelligence
Luschka M. Montijo
Jonah Michael  Equipment Financing Specialist  First American Healthcare Finance
Robert W. Haralson  Chief Medical Officer  Breckinridge Health
Patrick J. O’Connor  Executive Director, Revenue Cycle  Lake Forest Hospital

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

#### 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 at 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 at 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 at 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