It is official, the Affordable Care Act is here, the government has shut down, and Peyton Manning just rushed for a touchdown. These are all things that I did not think would happen in 2013 but here we are. With so much transformation happening in such a short period of time, my question to you is what can HFMA do to help? I encourage you to send me an email to let me know how we can be of assistance at president@hfmaky.org. Heck, feel free to send me a message to let me know you are reading this article or what you think of the new newsletter. Your feedback is always welcomed.

When it comes to the degree of change we are facing in healthcare, I can’t help but think about the advice of Clark Kellogg which is to simply focus on “controlling the controllable.” During the Tri-State meeting in September at the Bellterra Casino and Resort, our keynote speaker Friday morning was Clark Kellogg, former NBA lottery pick, CBS NCAA basketball analyst and announcer, and VP of Player Development for the Indiana Pacers. I thought I would take this opportunity to share with you some the highlights of my interaction with Mr. Kellogg.

Mr. Kellogg arrived the evening before his presentation and against his better judgment, he agreed to have dinner with the four chapter presidents. Let’s just say after a meal and three hours of conversation, he is the one who initiated bringing our meeting to a close. To say that I have a short attention span would be an understatement. I have never been so engaged in a conversation. Mr. Kellogg was very insightful and we did not have a lack of questions to ask him about his career, past, present, and future.

As the current VP of Player Development for the Indiana Pacers, Mr. Kellogg provides an infinite amount of expert life coaching that I feel applies to us as healthcare professionals. His role with the organization is to mentor NBA players both on and off the court. With so much pressure, responsibility, and power thrown at these young men so early in their careers, it takes a special person to provide them with the guidance needed. Where most people have the luxury to grow and mature over the span of forty plus years for their career development, professional athletes do not have that luxury. With a career that is lucky to last more than ten years, they must deal with everything we deal with in a condensed timeframe. Complicate that further with millions of dollars; it can be a bit overwhelming for these young athletes.

Mr. Kellogg was kind enough to discuss some of his philosophies that he shares with the players in addition to his three children who have all went on to receive Division I athletic scholarships. First, fair does not always mean equal. He often told his children they are all different with different strengths and weaknesses and he will always treat them fairly but because of their differences it may not always equate to being equal. I think we all struggle with this perception, whether it is with our children or managing people in the workplace; it is a tough reality but we can always strive to be fair.

Next, he talked about controlling the controllable. So many times we focus on things that can’t be changed, but if we exert that energy on the things that we can, we will not only maintain a more positive outlook but we can often times achieve our goal much quicker.

Finally, I asked Mr. Kellogg if there was a single bit of advice he would share with us, what would that be? In addition to having a strong faith, which he has accredited much of his success, he said always cherish and love your family and don’t be afraid to show it. He has always felt it is important to be a good role model for his children and being a faithful loving spouse plays a key element to that. The continuous display of love for his wife and children have been essential to his own personal development as a husband and father which are the backbone of his achievements.

As the night came to a close, we focused a little more on the subject matter near and dear to many of Kentucky’s hearts - basketball. I asked what has been his most memorable game he has watched or announced. After bypassing his own children’s games, he said it is the 2000 Michigan State national championship game in which they beat Florida (I know this will make many Kentucky fans happy). Seeing the leadership displayed by the senior Mecum Cleaves to increasingly inspire his time right down to the final minute of the championship game by returning from an injury was something magical he will never forget.

Finally, I had to ask Mr. Kellogg the burning question that everyone in the state of Kentucky wants to know. What is the best college rivalry in basketball? Whether he said it because of his present company or because I look a lot more intimidating sitting down versus standing, it meant a lot coming from someone who lives, eats, and sleeps college basketball. Of course his answer was Kentucky and Louisville, but we could not get him to predict who is going all the way in the 2013-14 season.
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“IT IS OUR OBJECTIVE OVER THE NEXT YEAR TO TAKE KY HFMA TO A WHOLE NEW LEVEL BY DOING WHATEVER IT TAKES.”

HFMA Kentucky SUMMER 2013 • page 2
Reducing Hospital Prices While Increasing Net Revenues

By MARK JEZIORSKI

Hospital prices have been in the press recently. Newspapers around the country have been publishing stories highlighting the wide disparities in prices for common medical procedures and tests among hospitals in close proximity to each other. Concerned about its prices being high, one hospital undertook an initiative to reduce its prices. This hospital was able to dramatically decrease prices, improve its median ratio of prices to wage adjusted APC payments and increase net revenues.

OBJECTIVES
The management of this hospital undertook a major initiative to review and lower its hospital’s prices. Specifically, management’s objectives were to 1) decrease prices 2) have the new prices set at a reasonable percentile relative to comparable hospitals’ prices and 3) decrease the ratio of prices to wage adjusted APC payments. In addition, management 1) wanted no change in gross revenues, 2) did not want a decrease in net revenues, 3) did not want prices to be below payment rates (e.g. wage adjusted APC payments) and 4) wanted prices to be based on a methodology that was reasonable and easy to understand. As part of this initiative, management also wanted to stop charging for general pharmacy and supply items since these items are generally not separately reimbursed by its third party payors.

APPROACH
The approach taken to achieve the objectives for this initiative was to construct models that calculate the changes in gross and net revenues resulting from pricing changes. Management provided its ideal price point relative to the comparable hospitals’ prices and ideal ratio of prices to wage adjusted APC payments. Prices were developed based on the ideal price point and ratio of prices to wage adjusted APC payments. The changes in gross and net revenues were calculated using these prices. Management then reviewed the gross and net revenue changes and revised the price point and ratio of prices to wage adjusted APC payments. New prices were developed and the gross and net revenues were re-calculated. This process continued until an outcome was achieved that met all of the objectives for this initiative.

In the end, the prices were set at or below the 60th percentile of the comparable hospitals prices with a median ratio of prices to wage adjusted APC payments of 2.5. There were a few prices (approximately 3%) that ended up being above the 60th percentile. The majority of these prices were above the 60th percentile so that the prices would be above the wage adjusted APC payments.

CURRENT (PRE-INITIATIVE) PRICES AND RATES
The following table presents what the hospital’s current prices/rates were in three categories that represent the majority of the non supply/implant and pharmacy/pharmaceutical prices. The table shows the percentage of prices relative to the percentiles of the comparable hospitals’ prices/rates. For example, two percent (2%) of the hospital’s current room and board rates were higher than all of the comparable hospitals’ rates, fifty-nine percent (59%) were greater than the 75th percentile of the comparable hospitals’ rates and sixty-one percent (61%) were greater than the 60th percentile of the comparable hospitals’ rates.

<table>
<thead>
<tr>
<th>Category</th>
<th>Current Prices Relative to the Comparable Hospitals’ Prices/Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&gt;100th</td>
</tr>
<tr>
<td>Room &amp; Board</td>
<td>2%</td>
</tr>
<tr>
<td>Non-Cost Based Items with CPT/MCPCS Codes(^1)</td>
<td>20%</td>
</tr>
<tr>
<td>Operating Room Time</td>
<td>25%</td>
</tr>
<tr>
<td>Overall for Above Categories</td>
<td>20%</td>
</tr>
</tbody>
</table>

\(^1\)Cost-based items include pharmacy, pharmaceuticals, supplies, implants, etc.

The ratios of the currents prices to the wage adjusted APC payments varied from 0.2 to 27.7. The median ratio of prices to wage adjusted APC payments was 3.0
NEW PRICES AND RATES

Forty-four percent (44%) of the hospital’s prices were decreased, forty-two percent (42%) of the prices remained the same and thirteen percent (13%) of the prices were increased. Ninety-seven percent (97%) of the room and board, non-cost based items with CPT/HCPCS codes and operating room time charges were set at or below the 60th percentile of the comparable hospitals’ prices.

<table>
<thead>
<tr>
<th>Category</th>
<th>New Prices Relative to the Comparable Hospitals’ Prices/Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&gt;100th</td>
</tr>
<tr>
<td>Room &amp; Board</td>
<td>0%</td>
</tr>
<tr>
<td>Non-Cost Based Items with CPT/HCPCS Codes†</td>
<td>1%</td>
</tr>
<tr>
<td>Operating Room Time</td>
<td>0%</td>
</tr>
<tr>
<td>Overall for Above Categories</td>
<td>1%</td>
</tr>
</tbody>
</table>

Comparing the new prices to the current prices, it can be seen that the profile of prices relative to the comparable hospitals’ prices changed significantly. The percentage of prices that are the highest relative to the comparable hospitals’ prices was reduced from twenty percent (20%) to one percent (1%) and the percentage of prices that are above the 60th percentile of the comparable hospitals’ prices was reduced from thirty-nine percent (39%) to three percent (3%).

The median ratio of prices to wage adjusted APC payment was decreased from 3.0 to 2.5. The new ratio of 2.5 is twenty-two percent (22%) below the lowest ratio for the comparable hospitals. Also, the hospital stopped charging for general pharmacy and supply items which is essentially having a zero price for these items.

GROSS AND NET REVENUE IMPACTS

Gross revenues are projected to increase by 0.4% as a result of the pricing changes. The change in net revenues related to all contracted commercial payment terms except the “lesser of” provisions and before the impact of the pricing changes on outlier payments is projected to be $1,300,000. The pricing changes are projected to result in a net revenue decrease of $400,000 because of the “lesser of” contract provisions. Outlier payments are projected to decrease by $400,000 as a result of the pricing changes. Overall, net revenues are projected to increase by $700,000.

<table>
<thead>
<tr>
<th>Category</th>
<th>1st Yr Change in Net Revenues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net Impact Before Outlier Payments and “Lesser of” Provisions</td>
<td>$1,500,000</td>
</tr>
<tr>
<td>Impact of “Lesser of ” Contract Provisions</td>
<td>-$400,000</td>
</tr>
<tr>
<td>Impact on Outlier Payments</td>
<td>-$400,000</td>
</tr>
<tr>
<td>Total Change In Net Revenues in First Year</td>
<td>$700,000</td>
</tr>
</tbody>
</table>

KEY TO ACHIEVING OUTCOME

In the case of this hospital, the key to increasing net revenues while decreasing 44% of the prices and not changing 42% of the prices was accurately modeling all reimbursements impacted by price changes and modeling all contract provisions that would impact net revenues from changes in prices. Only by modeling all reimbursements and all contract provisions that would impact net revenues from pricing changes could net revenues be optimized for a given change (or no change) in gross revenues and the change in net revenues be accurately projected.

Reimbursements impacted by price changes include, but are not limited to, items paid a percentage of charges unless they are included in a case rate, items paid a percentage of charges up to a cap, claims paid a percentage of charges, claims paid a percentage of charges up to a cap, inpatient outliers, outpatient outliers, etc. Accurately modeling some of these reimbursements impacted by price changes was a significant undertaking. One of the reasons for the undertaking being significant was that claims data had to be utilized to model some managed care payors’ payments because the payments were a percentage of charges up to cap for charges on the claim excluding select carve-outs for implants and pharmaceuticals.

Also critical to achieving the desired outcome was the modeling of all contract provisions that impact net revenues when prices were changed. Two of the more significant contract provisions in the case of this hospital included “lesser of”
provisions and caps on charge increases. If these contract provisions were not modeled, the hospital would have projected significantly more net revenues than what was achievable and would have ended up with less net revenues than if the provisions were modeled. The hospital would have ended up with less net revenues because modeling these provisions allowed the hospital to mitigate the impact that the contract provisions were having by appropriately adjusting prices.

SUMMARY
Hospital prices are in the spotlight once again. This situation may prompt some hospitals to consider lowering their prices. These hospitals can take heart in the fact that one hospital was able to reduce a significant number of prices while increasing net revenues. The key to achieving this outcome was accurately modeling all reimbursements impacted by price changes and modeling all contract provisions that impact net revenues from pricing changes.

Mark Jeziorski is president of Sophical Solutions, LLC. He may be reached at markj@sophicalsolutions.com.
A new facility cannot provide the best clinical care.
It can’t implement national quality standards
for the best patient outcomes.
It cannot hold the hand of those being cared for.
But what it can do –
Is be a place where those gifted in providing compassion...
those committed to quality...can do all of those things.
Enacted March 23, 2010, the Patient Protection and Affordable Care Act, Pub. L. 111-148 (“PPACA”), added new requirements under Section 501(r) of the Internal Revenue Code that charitable hospital organizations must meet in order to maintain 501(c)(3) status on a facility by facility basis. Although final regulations are pending, hospital organizations are urged to review the interim guidance, including IRS Notice 2011-52 and 78 Fed. Reg. 20523 (April 5, 2013) and 77 Fed. Reg. 38148 (June 26, 2012) for information on the new requirements. This article provides an overview of the new 501(r) requirements and related implications concerning community health needs assessments and financial assistance and other policies.

FINANCIAL ASSISTANCE AND OTHER POLICIES

Section 501(r) requires that a Section 501(c)(3) hospital adopt a written financial assistance policy (“FAP”) that contains certain required elements. Section 501(r) also requires that the hospital’s policies include certain statements related to the provision of emergency medical care and certain restrictions on collections of amounts owed by patients. The statute enumerates the requirements but provides little detail for hospitals to utilize in drafting and implementing their policies. In partial relief, the Internal Revenue Service (“IRS”) issued several guidance documents, the most recent of which is proposed regulations, setting forth more detail regarding the requirements of a FAP, emergency care policies, and collections policies. See 77 Fed. Reg. 38148 (June 22, 2012). Under Section 501(c) (3) hospital’s FAP (or a separate written collections policy or emergency care policy, in certain cases) must contain the following elements: (a) Eligibility criteria for financial assistance and whether the assistance includes free or discounted care; (b) The basis for calculating amounts charged to individuals eligible for financial assistance; (c) Limitation on amounts charged to those eligible for financial assistance to amounts generally billed (“AGB”) to individuals who have insurance covering emergency or other medically necessary care; (d) A method for calculating AGB; (e) A description of the process for the patient to apply for financial assistance; (f) Actions that may be taken in the event of non-payment by a patient (these actions may be included in a separate written collections policy); (g) A list of actions the hospital organization will take to widely publicize the FAP; (h) A requirement that the hospital provide, without discrimination, care for emergency medical conditions to individuals, regardless of whether the individuals are eligible for financial assistance under the hospital’s FAP (this statement may be included in a separate emergency care policy); and (i) A prohibition from engaging in extraordinary collections actions prior to making reasonable efforts to determine whether an individual is eligible for financial assistance.

The proposed regulations provide guidance to hospitals on each of the above-listed elements, and although hospital organizations have benefited from this additional information, the proposed regulations continue to present challenges due to their limited flexibility and strict requirements related to the organizations’ policies.

For example, the proposed regulations require that the hospital must limit the amount charged to a person eligible for financial assistance under a FAP as follows: (a) in the case of emergency or other medically necessary care, to not more than AGB, and (b) for all other medical care, less than gross charges for the care. Further, the regulations set forth two alternative methods for calculating AGB, one of which must be adopted by the hospital in its FAP. The two methods are the “look-back” method and the “prospective” method. Under the “look-back” method, the hospital determines AGB by multiplying gross charges by one or more percentages of gross charges, called “AGB percentages.” The hospital determines such AGB percentages by dividing Medicare payments or Medicare payments plus private health insurance payments by gross charges. The AGB percentages may be applied universally or may vary based upon the category of service. Under the “prospective” method, a hospital may determine AGB for any emergency or medically necessary care by using the same billing and coding process the hospital would use if the person was a Medicare fee-for-service beneficiary. AGB is set at an amount Medicare and the beneficiary together would be expected to pay for the care. The proposed regulations do not specify whether a hospital may alter its methodology if, for example, its patient population changes over time. On issuance of the proposed regulations the IRS...
requested comments on whether a hospital may change its approach, and if so, when it may do so.

The proposed regulations also contain specific requirements regarding methods that the hospital organization must use to widely publicize its FAP. These include measures to: (a) make paper copies of the FAP, the FAP application form, and a plain language summary of the FAP available upon request and without charge, both for distribution within the hospital and by mail; (b) conspicuously display the FAP (or information about the FAP) to notify visitors to the hospital about the FAP; (c) inform and notify members of the community about the FAP in a manner reasonably calculated to reach those most likely to need financial assistance; and (d) make a copy of the FAP, the FAP application form, and a plain language summary of the FAP available on the hospital’s website.

Information regarding the FAP must also be made available in the primary language of any populations with limited proficiency in English that constitute more than 10 percent of the residents of the community served by the hospital facility.

In this requirement and others, the proposed regulations emphasize the importance to the IRS of tailoring the methods of publicizing the FAP to the specific community served by the hospital. The hospital organization will need to report on its Form 990 the specific methods that it uses to publicize the policy within the community served by the hospital facility.

Thus, each hospital organization must ensure that it meets the publication criteria under 501(r) and the implementing regulations for each of its hospital facilities.

COMMUNITY HEALTH NEEDS ASSESSMENTS ("CHNA")

New Section 501(r)(3) requires hospital organizations to conduct a CHNA at least once every three years and to adopt a corresponding implementation strategy to meet the needs identified through the assessment. For purposes of this section, a hospital organization is “an organization that operates a facility required by a State to be licensed, registered or similarly recognized as a hospital and any other organization that the Secretary determines has the provision of hospital care as its principal function or purpose, constituting the basis of its exemption under section 501(c) (3).” I.R.C. 501(r)(2)(A). Further, hospital organizations operating more than one facility must separately meet the 501(r) CHNA requirements. Failure to meet these new requirements carries significant penalty, including a $50,000 excise tax for each facility failing to meet the requirements per taxable year and potential revocation of 501(c)(3) status. The CHNA requirements are effective for taxable years beginning after March 23, 2012, which means hospital organizations should have already met these requirements or for Calendar Year Fiscal years, be honing in on meeting these new requirements now.

A. Conducting the CHNA

A hospital facility (“facility”) must perform five steps in conducting its CHNA in order to be in compliance: (a) define the community it serves; (b) assess the health needs of its community; (c) obtain and take into account input from “persons who represent the broad interests of the community,” including those with public health expertise; (d) document the CHNA in a written report that is adopted by the facility’s governing body; and (e) make the CHNA report “widely available to the public.” Only upon the date that each of these five steps is complete is the facility considered to have “conducted” its CHNA.

The rules do not prescribe a particular method for defining a given community, but rather permit the facility to consider all of the relevant facts and circumstances, including consideration of its target populations, its principal functions (such as particular service lines or targeted diseases) or its geographic area. Facilities are cautioned against excluding low income, minority or medically underserved persons who should be included in the community based upon living in the geographical limits or who are part of its targeted populations, affected by the facility’s principal functions, or otherwise be included under the methodology chosen by the facility in defining its community.

Next, a facility must identify the significant health needs of its community, prioritize those health needs and identify potential resources and programs available to address those needs. Here again, the rules permit a facility to determine which identified health needs are significant after a review of all of the relevant facts and circumstances. Examples of processes that might be utilized include an evaluation of the level of urgency to be applied in addressing a given health need, the feasibility and effectiveness of potential interventions, the burden or scope of the health need, disparities associated with the need, and the level of importance placed on the need by the community.

Seeking input from local experts representing the broad interests of the community is vitally important to the CHNA process. Although a facility may seek input from others, at minimum, it must seek input from at least one member of the state, local, regional or tribal health department; and from members of the medically underserved (including those experiencing health disparities or otherwise at risk for receiving inadequate medical care due to language, financial, geographic or other barriers), low income or minority populations (or organizations or representatives serving the interests of such persons). In addition, it must consider written comments received by the facility as a result of its most recently conducted CHNA and adopted implementation strategy.
B. The CHNA Written Report

Documentation of the CHNA in a written report for each separate facility is equally important. This is so even where the exercise is performed in collaboration with other organizations or facilities. The written report must include the facility’s definition of its community, including a determination of how it was made. In addition, the dates and sources of data that formed the basis of the assessment, the analytical methods used to perform the assessment, and a description of the gaps, if any, in the facility’s ability to assess its community’s needs, must be provided. The identities of any third parties contracted by the facility to complete the assessment must also be included in this section of the report.

Next, a description of how the facility obtained input from persons representing the broad interests of the community must be documented. A facility satisfies this requirement if the written report (a) summarizes, in general terms, the input received from such persons and how (such as by focus groups, surveys, written comments, etc.) and over what time period the input was received; (b) provides the names of any organizations providing input, along with a summary of the nature or scope of such organization’s input; and (c) describes the low income, minority or medically underserved populations who provided input (or the organizations or individuals providing input on their behalf). A prioritized description of the community’s significant health needs, including a description of the criteria and process used to identify a health need as significant and determine its priority status is required. Finally, though not required to be exhaustive, the written report must provide a description of the potential resources and measures identified through the CHNA that may address each of the significant health needs.

C. Making the Report Widely Available to the Public

The CHNA requirements are not met unless the written report is made widely available to the public. A facility will satisfy this requirement only if it (a) makes the complete CHNA report available on its website and leaves the report on the website until the two subsequent reports are made available on the website; and (b) makes a paper copy of the CHNA report available for public inspection at the facility, free of charge, and keeps that copy available for public inspection until the facility has made its subsequent two CHNA reports available for public inspection.

Notice 2011-52 details additional website requirements. First, the CHNA report must be conspicuously posted on the website so that it can be easily located. It must clearly inform the reader that the document is available, provide instructions for downloading the document and ensure that the document is posted in a format that exactly reproduces the image of the report when it is accessed, downloaded, viewed and printed in hardcopy. If the facility has its report on a website maintained by another organization, the facility’s website must provide a link on its website where it is posted with clear instructions on how to access it. Further, the facility must provide any individual who requests an on-line copy of the report with the URL or website address where it can be accessed. In addition, no special computer hardware or software must be required in order for an individual with internet access to download, view or print the document, the individual must not be required to create an account or otherwise provide personal information in order to access the report, nor be required to pay a fee in order to access the report.

D. CHNA Implementation Strategy

In addition to conducting the CHNA, a facility must also adopt an implementation strategy to meet the identified health needs, with such adoption date considered to be the date it is approved by the facility’s authorized governing body. This must occur in the same taxable year in which the CHNA is conducted. For each identified significant health need, the written implementation strategy must either (a) describe how the facility intends to address the significant health need, including the potential impact of its actions, a plan for evaluating the impact of its actions, and identification of the resources the facility intends to commit to addressing the particular health need; or (b) identify the particular health need as one that the facility is not intending to address, along with an explanation of the reasons it does not intend to address it, such as inadequate resource availability, a relative lack of expertise to address the health need or an assignment of a low priority in relation to other prioritized health need.

The facility’s most recent implementation strategy must either be attached to the facility’s annual Form 990, or alternatively the URL(s) to the website where the implementation strategy is posted and must be made publicly available must be documented on Form 990. As with the CHNA, each facility must separately document its implementation strategy, regardless of whether it was jointly completed with another organization (permitted by the proposed regulations).

E. Excise Tax and Reporting Requirements

Failure to satisfy each of the CHNA requirements may have serious implications for hospital organizations. Section 4959 of the I.R.C., through PPACA, imposes a $50,000 excise tax on a hospital organization that fails to meet any of the CHNA requirements with respect to any taxable year. Any excise tax imposed is in addition to any other tax imposed on a hospital organization for a low priority in relation to other prioritized health need.

In addition, the healthcare team at Dean Dorton consists of accounting, tax, and consulting professionals trained to meet the unique needs of the healthcare industry.
comply with these new requirements. In addition to the requirement of attaching the most recent implementation strategy on Form 990 (or URL), a facility must annually provide a description on its Form 990, any actions taken during the taxable year to address the significant health needs, or the reasons why no actions were taken. In requiring such an annual update, the expectation appears clear that facilities must use the implementation strategy as a working document, continuously implementing and evaluating CHNA activities.

CONCLUSION

“A hospital organization...shall not be treated as described in subsection (c)(3) unless the organization” meets the community health needs assessment requirements, the financial assistance policy requirements, the requirements on charges, and the billing and collections requirements. In general, the IRS and Treasury Department has stated that it will take a facts and circumstances approach in making the determination to revoke a hospital organization’s 501(c)(3) status, revoking such status only where there is a finding of willful or egregious behavior, and only with regard to the particular facility(ies) failing to meet the requirements. The interim guidance provides that minor or inadvertent errors or omissions, due to reasonable cause and subsequently promptly corrected by the facility, will not be considered a failure to meet the 501(r) requirements requiring revocation and that future guidance that establishes a process for excusing other errors or omissions, once corrected and disclosed, will be forthcoming. The stakes of noncompliance are high. Hospital organizations are urged to review the guidance received to date and take steps to ensure compliance with each of the 501(r) requirements.

1 The proposed regulations have created some uproar and received their share of criticism. It is expected that the IRS will make certain changes when it issues final regulations.2 Note that these rules are highly prescriptive and apply to written policies. The fact that a hospital has a separate charity care program may not be enough if their written policies are defective.

2 Note that these rules are highly prescriptive and apply to written policies. The fact that a hospital has a separate charity care program may not be enough if their written policies are defective.
The Kentucky Chapter HFMA is committed to supporting a Healthier You! These FREE APPS can help you achieve and maintain your personal fitness goals! Remember, whatever it takes!

**Sleep Studio** - Custom sleep guides, breathing exercises and music to prepare you for deep, restful sleep. Wake up to soothing sounds or music from your own library.

**Interval Timer-Second by Runloop** - Templates for HIIT, tabata and circuit training. Assign your music to intervals or timers.

**Instant Heart Rate by Azumio** - Use your iPhone camera to detect the pulse from your fingertip. Track your heart rate over time.

**7 Minute Workout** - 12 high intensity bodyweight exercises, voice prompted so you can complete the entire workout without looking at a timer.

**Look for a HFMA affiliated race soon!**

If interested in helping, contact:
Kyle Monroe
kmonroe@humana.com

**UPCOMING RUNNING EVENTS**

**Cold weather running!**

**2013 RUNNING EVENTS**

BECCA’S MEMORIAL TURKEY TROT
Elizabethtown | November 23

EKU COLONEL COLOR RUN
Richmond | November 23

GREAT TURKEY 5K
Bowling Green | November 28

HOLIDAY HUSTLE 5K
Owensboro | December 7

POLAR BEAR GRAND PRIX – REINDEER ROMP 4K
Louisville | December 14

JINGLE BELL RUN/WALK
Covington | December 14

**2014 RUNNING EVENTS**

POLAR BEAR GRAND PRIX – FROSTBITE 5K
Louisville | January 11

TOPO TRAIL RUN SERIES
Taylor Mill | January 25

POLAR BEAR GRAND PRIX – SNOWMAN SHUFFLE 4 Miler
Louisville | February 8

ANTHEM 5K FITNESS CLASSIC
Louisville | February 22

- **CHECK OUT THESE HELPFUL LINKS TO SUPPORT A HEALTHY LIFESTYLE** -

runningintheusa.com
roadracerunner.com/races/running-calendar.aspx?state=ky
swagssportshoes.com/runningracecalendar.htm

parks.ky.gov
louisville.gov/healthyhometown
eatingwell.com, fastfoodnutrition.org

tristateconference
the Kentucky Chapter hfma is committed to supporting a healthier You! these free apps can help you achieve and maintain your personal fitness goals! remember, whatever it takes!

- sleep studio - Custom sleep guides, breathing exercises and music to prepare you for deep, restful sleep. Wake up to soothing sounds or music from your own library.
- interval timer - second by runloop - templates for hiit, tabata and circuit training. Assign your music to intervals or timers.
- instant heart rate by azumio - Use your iphone camera to detect the pulse from your fingertip. Track your heart rate over time.
- 7 minute workout - 12 high intensity bodyweight exercises, voice prompted so you can complete the entire workout without looking at a timer.

look for a hfma affiliated race soon!

if interested in helping, contact:
Kyle monroe
kmonroe@humana.com

Upcoming Running Events
Cold weather running!

2013 Running Events
- Becca's Memorial Turkey Trot - Elizabethtown l November 23
- EKU Colonel Color Run - Richmond l November 23
- Great Turkey 5K - Bowling Green l November 28
- Holiday Hustle 5K - Owensboro l December 7
- Polar Bear Grand Prix – Reindeer Romp 4K - Louisville l December 14
- Jingle Bell Run/Walk - Covington l December 14

2014 Running Events
- Polar Bear Grand Prix – Frostbite 5K - Louisville l January 11
- Topo Trail Run Series - Taylor Mill l January 25
- Polar Bear Grand Prix – Snowman Shuffle 4 Miler - Louisville l February 8
- Anthem 5K Fitness Classic - Louisville l February 22

- Check out these helpful links to support a healthy lifestyle -
- runningintheusa.com
- roadracerunner.com/races/running calendar.aspx?state=ky
- swagssportshoes.com/runningracecalendar.htm
- parks.ky.gov
- louisvilleky.gov/healthyhometown
- eatingwell.com; fastfoodnutrition.org

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Are You Prepared for the New TCPA Rules Effective October 16, 2013?

By REnea Remes havArse, ESQ & LeA Lockhart, ESQ, OF HALL, REnder, KiLlIAN, HEATH & LYMAN PSC

On October 16, 2013, new regulations went into effect that narrow two key safeguards that currently exist for businesses under the Telephone Consumer Protection Act ("TCPA").

The TCPA was enacted principally to bolster consumer privacy by prohibiting the use of auto-dialers to make certain calls (or text messages) to cellular phones, and pre-recorded telemarketing calls to cellular and residential phones. See 47 U.S.C. §227 et seq.

The new regulations will:

1. Eliminate the “established business relationship” exception.
A business can no longer avoid TCPA liability for otherwise prohibited telemarketing calls to residential landlines if the business has an “established business relationship” with the plaintiff. See 47 C.F.R. § 64.1200(a)(2)(ii) (2008).

2. Amend the “prior express consent” exception to require a written agreement.
A business will only qualify for the “prior express consent” exception if the consumer has physically or electronically signed a written consent that is clear and unambiguous. The consumer must specifically agree to receive future auto-dialed or pre-recorded telemarketing calls on a designated cellular or residential line, and such consent must not be conditioned on a purchase. See 47 C.F.R. § 64.1200(f)(8). To the extent that the call is not advertising or telemarketing, no “prior express consent” would be required for pre-recorded calls made to a residential line; however, oral or written “prior express consent” would still be required for all pre-recorded or auto-dialed calls made to a cellular phone—no matter the purpose of the call.

In the case of auto-dialed or pre-recorded debt collection calls to a cellular phone, the “prior express consent” need not be in writing, unless such calls include any type of advertisement. Though the courts are split over whether auto-dialed or pre-recorded debt collection calls require such consent to be granted specifically to a third-party debt collector, the burden of demonstrating “prior express consent” rests with the party defending a TCPA claim. See Mais v. Gulf Coast Collection Bureau, Inc., 11-61936-CIV, 2013 WL 1899616 (S.D. Fla. 2013) (holding that the provision of a patient’s cellular phone number on hospital admission forms did not constitute “prior express consent” to a third-party debt collector, but provider was not held vicariously liable for debt collector’s TCPA violations).

GUIDANCE FOR PROVIDERS
Harmed persons or entities may bring forth actions for TCPA violations. The Act imposes statutory damages of $500 per violation and of up to $1,500 per knowing or willful violation. See 47 U.S.C. §227(b)(3). As TCPA lawsuits grow at an alarming rate, hospitals and healthcare providers must be aware of the severe consequences that are risked by not obtaining proper patient consent as required under the TCPA.

To avoid litigation, a provider should consider adopting elements of the new FCC rule prior to its effective date of October 16, 2013, with regard to both telemarketing and debt collection.
Telemarketing and advertisements via pre-recorded voice or auto-dialer technology:

- Providers must obtain a written agreement including the signature of the consumer, the telephone number to which the consumer authorizes calls to be made, and a “clear and conspicuous disclosure” informing the consumer signing that:
  - The agreement authorizes the receipt of future calls containing auto-dialed or pre-recorded telemarketing messages on behalf of a specific advertiser; and
  - That consent is not a condition of purchase. See 47 C.F.R. § 64.1200(f)(6).
- Providers should maintain evidence of each consumer’s written consent for at least four (4) years, which is the federal statute of limitations for TCPA actions.

Debt collection:

- Hospital admission forms should be amended to acknowledge that the patient is providing “prior express consent” for the hospital, its providers, and agents, including debt collectors, to place calls to the patient’s designated cellular or residential phones using any type of auto-dialed or pre-recorded message for any permissible purpose.

- That consent is not a condition of purchase. See 47 U.S.C. § 227(c).
- The agreement authorizes the receipt of future calls containing auto-dialed or pre-recorded telemarketing messages on behalf of a specific advertiser; and
- That consent is not a condition of purchase. See 47 U.S.C. § 227(c).

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Name: Jerry Smith
Hometown: Erlanger, KY
Title: Account Executive
Company/Organization: CBCS
College/University attended and degree:
Northern Kentucky University; Radio/TV/Film
Career History:
Media writer/producer, where I sold, wrote and directed commercials and videos for 12 years, sales exclusively for the last 10 years.

What are the greatest challenges of your job?
Standing out from the crowd

What is the most fulfilling aspect of your job?
Success

Professional Memberships and Associations:
HFMA, AAHAM, MGMA

Community involvement activities or associations:
My church, service at Fairhaven Men’s Shelter

What was your first job?
Mail Santa Claus. I was fifteen.

What are your top three passions?
Reading, history, politics

CATS or CARDS? Like I would take sides.

Favorite Restaurant: Cheesecake Factory
Favorite Vacation destination: Florida or NYC

What is one interesting fact about you that most people don’t know?
I’ve met the Soup Nazi from Seinfeld

What are your hobbies or favorite activities?
Writing, collecting comic books and art, trying to spend time with my daughter now that she’s a college student.

What would your fantasy job be—whether you’re qualified for it or not?
Trapeze artist

Do you use social networking: Facebook, Twitter, etc?
I check in with Facebook occasionally but not addicted. Too busy for Twitter.

Do you have any shopping weaknesses?
I’m not really a shopper, but it’s hard to leave any bookstore without a purchase.

What do you do for stress relief?
Read, write or catch a movie. I love old black & white noir films.

Favorite TV Show: Breaking Bad—I’m so sad it’s gone!
What do you listen to in the car?
Books on CD or Celtic music

When you were a kid, what did you say you wanted to be when you grew up?
A fireman of course!
In today's contentious political climate, when hardly anyone agrees on anything, here's a rare subject of consensus: Health spending is slowing, and almost everyone thinks that's a good thing. Aside from relieving pressures on federal and state budgets, it could help reverse stagnant wages by moderating the cost of employer-paid insurance. Compensation would shift from insurance to wages. What the experts don't agree on is who (or what) caused the slowdown and whether it will continue.

First, the basic figures. In each of 2009, 2010 and 2011, U.S. health spending increased a modest 3.9 percent, virtually identical with the slow growth of the economy (gross domestic product, or GDP). So health spending remained steady at 17.9 percent of GDP after years of increases. Almost no one predicted this.

Not surprisingly, the Obama administration suggests that the Affordable Care Act ("Obamacare") is a main cause. "As ACA Implementation Continues, Consumer Health Care Cost Growth Has Slowed" is the headline of a recent White House blog post by Alan Krueger, head of the Council of Economic Advisers. Many statistical sources, he notes, confirm the slowdown.

As of May, actual health-care prices (hospital admissions, doctors' visits, drugs) had risen just 1.1 percent over the previous year, "the slowest rate of increase in nearly 50 years," Krueger reports. Meanwhile, the Bureau of Labor Statistics survey of business compensation finds that "real" (inflation-adjusted) health insurance costs rose 1.8 percent annually from the end of 2009 to the end of 2012, down from 2.2 percent from 2006 to 2009.

But is Obamacare responsible? Be skeptical.

To be fair, Krueger never actually makes that claim. The blog post is something of a sleight of hand. It simply says that the spending slowdown and the ACA's implementation have coincided. There's no explicit language linking the two, though unsuspecting readers would surely take away that message. The post is both politically self-serving and intellectually defensible.

Among the skeptics is economist Timothy Taylor, whose "Conversable Economist" blog is consistently nonpartisan. In a post, Taylor notes that the ACA "is mostly not yet implemented," casting doubt on its impact. He also cites several studies indicating that the slowdown has complex origins.

One study comes from the Organization for Economic Cooperation and Development (OECD), a group of 34 mostly rich nations. Growth in health spending has collapsed in most of its member countries, says the OECD. A global slowdown calls into question Obamacare's role.

In some countries, says the OECD, acute economic crises have forced steep cuts in government health spending. In both 2010 and 2011, Greece's real health spending dropped 11 percent. Elsewhere, slowdowns seem to accompany weak economies. In Canada, real health spending increased an average of 4.6 percent annually from 2000 to 2009 but fell to 3 percent in 2010 and 0.8 percent in 2011. Both government and private health spending subsided in many countries, says the OECD.

The recession may explain the U.S. slowdown. Even the insured may have postponed some care to save out-of-pocket costs. As the number of uninsured rose, some care may have been foregone altogether. Or people may have moved from private insurance to Medicaid, a federal-state program for the poor. This would dampen spending, because reimbursement rates are lower for Medicaid than for private insurance.

A second study was done by Charles Roehrig and colleagues at the Center for Sustainable Health Spending in Ann Arbor, Mich. In a 2012 article for the New England Journal of Medicine, they argued that the slowdown began in 2005, well before President Obama's election. That, too, would seem to limit Obamacare's influence. The study attributed the slowdown to "structural" changes, including use of less-expensive generic drugs, higher patient co-payments and deductibles, which discouraged some care; and lower administrative costs in doctors' offices and hospitals.

But Roehrig doesn't completely dismiss Obamacare's effect. It may have inspired a general cautiousness. "The industry is looking around and saying, 'We've got to cut costs,'" he said in an interview.

Will the spending slowdown continue? At least three forces favor a slowdown: the start in 2014 of most of Obamacare — as more people get insurance, they use more medical care; an increasingly older population — average health costs for those 65 and over are more than triple those for people ages 25 to 44; and the economic recovery, which may extend employer-paid coverage to more workers.

A slowdown that overcomes these pressures would suggest major "structural" changes and not just temporary savings from the recession.
How Providers Should Prepare For Health Insurance Exchanges

By MATT WEEKLEY, Plante Moran

1. SELECT A STRATEGIC DIRECTION: EITHER ACTIVELY PURSUE INSURANCE EXCHANGE PARTICIPANTS OR BE PASSIVE

This will be determined by the provider’s estimation of how aggressive it needs to be in order to optimize its payer mix. Early indicators are that the exchange plans will contract with providers at a 10 to 20 percent discount from current commercial rates. It’s important to realize that the exchanges will not only attract those currently without health insurance. It is likely that some employers plan to transition to the exchanges, principally through a Defined Contribution Plan. That means providers may lose revenue as a result. There also is risk that provider bad debts will increase. For example, if 65 percent of all new exchange members participate at the bronze level, roughly 40 percent of the approved charges will be paid out of pocket, and now will be required to be collected from the insured. (Note: The annual limit is $6,350 for individuals and $12,700 for families.) At the same time, there are scheduled reductions in disproportionate share payments, with a national target of $500 million in reductions in 2014, increasing to $600 million in 2015.

TAKEAWAYS:
- Providers should conduct an analysis to identify the potential financial impact of this new payer mix and adjust their expenses accordingly.
- Providers should create a tracking mechanism, a separate insurance plan, plus a separate financial class code, so that the exchange activity is not rolled up into the commercial financial class category, in order to monitor and trend volumes, revenue, and collections accordingly.

2. PREPARE COMMUNICATION SYSTEMS FOR NEWLY INSURED PATIENTS

Although it’s a given that providers will be experiencing a surge in newly insured patients, it’s not clear where they will access the healthcare system. Primary care practices are already experiencing capacity issues. The Massachusetts model tells us to expect significant volume increases in hospital emergency departments.

TAKEAWAYS:
- Providers should develop an internal communication plan regarding how their emergency departments will refer these patients after the immediate episode of care. What primary care physicians in the system have the capacity to serve them? Are there wellness programs available to prevent more expensive hospital services in the future?
- Providers should train their staff to assist uninsured patients in selecting a health insurance program from the exchange (required to disclose any conflicts) or to direct patients to the appropriate healthcare navigators at the state level.
- Providers that decide to pursue health insurance exchange plan participants should consider implementing a marketing program to explain the programs they participate in, thus directing patients to plans that allow the provider to care for them while maintaining a positive margin.

3. HOW SHOULD PROVIDERS PLAN TO WORK WITH HEALTH INSURANCE EXCHANGE QUALIFIED PLANS?

There will be opportunities. For example, providers can work with health plans to identify chronic patients, including those with diabetes, chronic heart failure, and behavioral health issues, and design plans and marketing programs specifically for these patient populations to keep them as healthy as possible. Providers can also work with health plans to ensure their offerings on the exchanges include the appropriate quality indicators that can be tracked and reported. Providers can
also create risk-sharing arrangements with health plans for narrow networks and share in cost savings if quality and cost objectives are met.

**TAKEAWAYS:**
- Work with payers in the development of patient registries, the design of predictive analytic programs, and increased sharing of data.
- Ensure that internal staff training is occurring on the required capturing of quality indicators for payers and any impact those may have on incentive payments to the health system.
- Model potential narrow network relationships to identify the enrollment required for a financial break-even point.

It’s becoming more obvious that we’re moving away from a wholesale strategy to a retail strategy in insurance. Employment-based insurance is giving way to defined contributions, where a relationship is now being constructed between the individual and the insurance company, as opposed to the individual and the employer for those benefits. Private exchanges will grow more rapidly than the public exchanges, and ultimately encompass a greater number of beneficiaries. So providers will have to continue to focus on efficiency in care delivery, with an emphasis on the labor force — representing 50 percent of the total cost to providers. Reduced contract rates will require re-engineering of healthcare delivery — a different way to perform the same services — and new ways to be competitive on price.

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**We Welcome Our New Members!**

**Missy Freeman**  
Compliance Manager  
Baptist Health Paducah

**Kim McDonald**  
Operations Manager  
Lexington Clinic

**Tressa Saum**  
Administrator, Associated Physician Services  
Lexington Clinic

**Jennifer Cress**  
Product Manager  
Zirmed

**Harold C Warman, Jr.**  
Chief Executive Officer  
Highlands Health System

**Jennifer Conrey**  
Sr. Accountant and Tax Liaison  
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**Heather Jackson**  
Senior Staff Accountant  
Prestige Healthcare
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The following information was taken from http://www.hfma.org/fhfma:

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**PLEASE JOIN US IN CONGRATULATING OUR CHAPTER’S NEWLY CERTIFIED MEMBER:**

**JON CHASTAIN, CHFP!**
wage adjusted APC payments was 3.0

The ratios of the currents prices to the wage adjusted APC payments varied from 0.2 to 27.7. The median ratio of prices to comparable hospitals’ rates.

75th percentile of the comparable hospitals’ rates and sixty-one percent (61%) were greater than the 60th percentile of the percentiles of the comparable hospitals’ prices/rates. For example, two percent (2%) of the hospital’s current room of the non supply/implant and pharmacy/pharmaceutical prices. The table shows the percentage of prices relative to the hospital’s current prices/rates in three categories that represent the majority adjusted APC payments.

CUrrent (pre-initiatiVe) priCes and rates

60th percentile. The majority of these prices were above the 60th percentile so that the prices would be above the wage

In the end, the prices were set at or below the 60th percentile of the comparable hospitals prices with a median ratio of these prices. Management then reviewed the gross and net revenue changes and revised the price point and ratio of prices to wage adjusted APC payments. The changes in gross and net revenues were calculated using these prices. Management provided its ideal price point relative to the comparable hospitals’ prices and ideal ratio of prices to wage adjusted APC payments. Prices were developed based on the ideal price point and ratio of prices to wage adjusted APC payments.

The approach taken to achieve the objectives for this initiative was to construct models that calculate the changes in gross

supply items since these items are generally not separately reimbursed by its third party payors.

management’s objectives were to 1) decrease prices 2) have the new prices set at a reasonable percentile relative to payments (e.g. wage adjusted APC payments) and 4) wanted prices to be based on a methodology that was reasonable and easy to understand. As part of this initiative, management also wanted to stop charging for general pharmacy and board rates were higher than all of the comparable hospitals’ rates, fifty-nine percent (59%) were greater than the 60th percentile of the comparable hospitals’ rates.

Hospital prices have been in the press recently. Newspapers around the country have been publishing stories highlighting the wide disparities in prices for common medical procedures and tests among hospitals in close proximity to each other. Concerned about its prices being high, one hospital undertook an initiative to reduce its prices. This hospital was able to reduce prices while increasing net revenues.

Reducing Hospital Prices While Increasing Net Revenues

By MARK JezIoRSKI

WHAT ARE THE ODDS YOU CAN IMPROVE YOUR MARGIN BY 1.5 TO 5%?

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WHAT ARE THE ODDS YOU CAN IMPROVE YOUR MARGIN BY 1.5 TO 5%?
HFMA of Kentucky thanks the following sponsors who have made this year’s newsletter possible:

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who have all went on to receive Division I athletic scholarships.

Mr. Kellogg was kind enough to discuss some of his philosophies on mentoring and leadership. Where most people have the luxury to grow in their careers, it takes a special person to provide them with the guidance needed. Where most people grow in their careers, it takes a special person to provide them with the guidance needed. Where most people grow in their careers, it takes a special person to provide them with the guidance needed.

His role with the organization is to mentor NBA players both past, present, and future. The Pacers, Mr. Kellogg provides an infinite amount of expert life interaction with Mr. Kellogg. He was very insightful and we did not rush for a touchdown.

I thought I would take the meeting to a close. To say that I have a short attention span but here we are. With so much government has shut down, it takes a special person to provide them with the guidance needed.

When it comes to the degree of change we are facing in the new newsletter. Your feedback is always welcomed.

Finally, I had to ask Mr. Kellogg the burning question that everyone in the state of Kentucky wants to know. What is the best college rivalry in basketball? Whether he said it because of his answer was Kentucky and Louisville, but we could always cherish and love your family and don’t be afraid of their differences it may not always equate to being equal. I said always cherish and love your family and don’t be afraid. But here we are.

In my conversation with Mr. Kellogg which is to simply focus on "controlling the present," I asked what has much quicker. Against his better judgment, he agreed to have dinner with the HFMA do to help? I encourage you. Pinpoint, in a conversation. Mr. Kellogg was very insightful and we did not rush for a touchdown.

Seeing the leadership displayed by the senior Mateen Cleaves of Florida (I know this will make many Kentucky fans happy). We can often times achieve our goal much quicker.

times we focus on things that can't be changed, but if we exert that energy on the things that we can, we will not only maintain a more positive outlook but we can often times achieve our goal much quicker.

It takes a special person to provide them with the guidance needed. Where most people grow in their careers, it takes a special person to provide them with the guidance needed.