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On January 21, 2011, the Kentucky Chapter - HFMA celebrated its 45th Anniversary. As many of you know because you attended, this was the date of the 2011 annual Winter Institute at the Crown Plaza Hotel in Louisville. In the midst of much illness as well as the day after the state received bad weather, the Winter Institute still had over 130 people attend. This number was actually higher but I assume the weather had an impact on the others not attending. I believe this turnout says a lot about 1.) the quality of members who are part of the Kentucky Chapter and 2.) the high quality educational programs the Kentucky Chapter is committed to providing.

In these tough economic times, I understand how difficult it is to get people involved in professional societies such as HFMA. At the same time, it does get expensive to try to send 3 or 4 people to the national ANI which can be on the other side of the country.

I had a conversation with Brad Wilkie, President of the Indiana Chapter, about HFMA and what it really means to be a member. The way he described it was like being part of a fraternity or sorority. This is a great way to get involved, receive outstanding education, especially within the state, and develop a great network of healthcare financial peers that you can call upon at any time. I will be honest; at times I am guilty of not picking up my telephone when I do not recognize the number. I will let the call go to either my voice mail or our Administrative Assistant will answer. I will say this, if she comes back and says it is Mr./Mrs. Smith from HFMA, I will typically drop what I am doing to take the call. I am not saying that I am right, but HFMA does have some privileges.

Consider this, for around $300 per year; show your staff you are committed to seeing them grow professionally by signing them up to be HFMA members. We would all like bigger raises but that just might not be possible. An HFMA membership shows your employees that you are committed to their continued success and growth as a healthcare finance professional. They will receive a copy of the monthly HFM Magazine and have access to all of the on-line resources. They will also be able to attend the four annual educational institutes put on by the chapter. Who knows, they might even consider sitting and passing the HFMA Certification Exam.

With all of this said, I would first like to thank everyone for their continued support of the Kentucky Chapter. I believe the chapter is doing many positive things and heading in the right direction. We just received the results from our annual Member Satisfaction Survey and we have achieved one of the best scores ever. This means we are far from perfect and we recognize we have opportunities for improvement. This sentence seems to contradict the improvement. I can assure you, the Kentucky Chapter is committed to providing an outstanding, value-driven service for our members. My challenge to you is to Step Up and make a commitment to you and your employees and be members of HFMA. I will also challenge you to attend one more event in 2011 than you did in 2010.

I have really enjoyed being part of HFMA and I know the benefits I have received, far outweigh the minimal cost I pay each year for my membership. I think 2011 is off to a nice start for the Kentucky Chapter. Whether you are a provider, a payor or vendor, I hope 2011 is a great year for you and I hope to see you at one of our upcoming events.

Andy Strausbaugh, President
Kentucky Chapter - HFMA
2010 - 2011
Happy 45th Anniversary
Kentucky Chapter
HFMA
LETTER FROM THE EDITOR

A call for volunteers!

There are several exciting upcoming HFMA educational events and we are in need of your help!

We need folks to take pictures or write up a blurb of upcoming events. If you find a class or speaker particularly interesting at either the Road Show or ANI to please take the time to write a couple of paragraphs down and send to us. We’ll also gladly accept and print any pictures that you take. Just let us know (if you do) who the pictures are of.

Sincerely,

Jeff Presser
Dean Dorton Allen Ford, PLLC
jpresser@ddafhealthcare.com

The Financial Diagnosis

EDITORIAL POLICY

Opinions expressed in articles or features are those of the author and do not necessarily reflect the view of the Kentucky Chapter, the Healthcare Financial Management Association, or the Editor. The Editor reserves the right to edit material and accept or reject contributions whether solicited or not. All correspondence is assumed to be a release for publication unless otherwise indicated.

EDITORIAL MISSION

The Financial Diagnosis supports the mission of the Kentucky Chapter by serving as a key source for individuals involving in or interested in the financial management of healthcare.

PUBLICATION OBJECTIVE

The Financial Diagnosis is the official publication of the Kentucky Chapter HFMA and is written and edited principally to provide members with information regarding Chapter and national activities, current and useful news of both national and local significance, information about seminars and conferences and networking with colleagues, and to serve as a forum for the exchange of ideas and information.

ARTICLE SUBMISSION

The Financial Diagnosis encourages submission of material for publication. Articles should be typewritten and submitted electronically to the Editor by the deadlines listed below. The Editor reserves the right to edit, accept or reject materials whether solicited or not.
The 800: CMS Audits of Outpatient Quality Indicator Reporting for 2011

By: Sally Hardgrove and Stephanie Hershberger

Section 1833(t)(17)(A) of the Social Security Act requires hospitals failing to submit outpatient quality indicators incur a 2 percent reduction to their outpatient prospective payment system (OPPS) market basket update for the year at issue. The act requires the Centers for Medicare & Medicaid Services (CMS) to conduct validation audits of the submitted data to ensure participating hospitals are submitting accurate data, and 800 hospitals will be randomly chosen to help with the validation process.

Although participation in the Hospital Outpatient Quality Data Reporting Program (HOP QDRP) is voluntary for Critical Access Hospitals (CAHs), those that choose to participate are not subject to the validation audit requirement.

In the fiscal year 2011 OPPS Final Rule, published in the November 24, 2010, Federal Register, CMS outlined the new validation audit procedures applicable to the update for federal FY2012. The audit methodology is similar to that in place for the FY2011 update, with some modifications intended to ease administrative burden. For example, hospitals with fewer than five cases in a quarter for a particular quality indicator are not required to report patient level data for that indicator. Hospitals with volumes exceeding a certain threshold for an indicator are permitted to sample cases and submit data for the sample rather than all applicable cases. The hospital is required to follow the sampling methodology and submission requirements as published in the Hospital Out Patient Department Specifications Manual at least three months in advance of the quarterly deadline.

In FY2011, the HOP QDRP permits CMS to randomly select 800 hospitals (approximately 20 percent of all participating PPS hospitals) for validation audits to confirm the data reported to OPPS Clinical Warehouse is accurate and reliable. (Visit www.bkd.com/docs/pdf/OPPS_PrvdrsSelctd2010Q2_112210.pdf to download list.)

All hospitals that have elected to participate in the 2012 payment update are eligible for review. Per the rule, 800 hospitals will be randomly selected for the validation audit. In the past, the audit consisted of five cases per hospital in the OPPS Clinical Warehouse. CMS believes that a larger sample from only a percentage of hospitals would provide a representative sample of every type of hospital and increase the reliability of data, while reducing the burden of compliance for hospitals overall. This would improve CMS' ability to project the finding across the entire provider base.

For each randomly selected hospital, CMS will randomly select 12 cases per quarter. CMS chose 48 cases as it is close to 50, the sample size considered adequate for a probe sample used to identify trending relationships. CMS believes this specified number of cases will provide increased reliability in estimating the validity of data submitted by the hospital. With each of these 48 cases, CMS will re-abstract the quality measure data elements and compare the results to information submitted by the hospital. The hospital must achieve a correlation of at least 75 percent for its data to be considered reliable and to receive the full 2012 OPPS payment update. If the hospital fails to meet the 75 percent threshold, it will be as though the hospital failed to report. Dates of service under review to validate the 2012 update are April 1, 2010, to March 31, 2011.

CMS’ interest is whether the information submitted by the hospitals is accurate and reliable in reflecting patient care given and documented in medical records. The agency is not interested in accuracy by measure or topic area, so the sample will not be stratified by indicator.

Once the data is requested by CMS, the hospital has 45 calendar days to submit the requested information. If the hospital fails to do so within the allotted time, it will receive a 2 percent reduction in its 2012 payment update factor. Note that this reduction will only affect the payment year audited.

There is a reconsideration process available to hospitals where audit results indicate failure to provide accurate and reliable data. Under this process, the hospital must submit a Reconsideration Request form (available at www.qualitynet.org/dcs/ContentServer?c=Page&pgename=QnetPublic%2FPage2FQnetTier4&cid=1228694343534) to CMS by February 3, 2012. If the hospital is not satisfied with the result of the reconsideration decision, there also is an appeal process available.

If you are one of the 800 hospitals randomly selected and CMS requests data for a validation audit, it is in your best interest to comply. The extra effort required for the audit is well worth the opportunity to receive the full 2012 payment update.

If you have questions about this new reporting requirement, please contact your BKD advisor or Sally Hardgrove at shardgrove@bkd.com.


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Biography Info:

Sally Hardgrove, RHIA, is a Senior Managing Consultant with BKD’s National Health Care Team. Sally is a health information management (HIM) professional, and specializes in mid-revenue cycle consulting.

Stephanie Hershberger is a staff accountant with the Indianapolis office of BKD, and assists the East Region health care teams in performing financial audits and preparing cost reports.
Enactment of the Affordable Care Act (ACA) was a historic event. Along with the Recovery Act, the ACA will usher in the most extensive changes in the U.S. health care system since the creation of Medicare and Medicaid. Under this law, the next few years will be a period of what economists call "creative destruction": our fragmented, fee-for-service health care delivery system will be transformed into a higher-quality, higher-productivity system with strong incentives for efficient, coordinated care.1 Consequently, the actions of physicians and hospitals during this period will determine the structure of the delivery system for many years. The implications will be profound for hospitals' dominant role in the health care system and for physicians' income, autonomy, and work environments.

The ACA aims to simultaneously improve the quality of care and reduce costs. Doing so will require focused efforts to improve care for the 10% of patients who account for 64% of all U.S. health care costs.2 Much of this cost derives from high rates of unnecessary hospitalizations and potentially avoidable complications,3 and these, in turn, are partially driven by fee-for-service incentives that fail to adequately reward coordinated care that effectively prevents illness. The ACA includes numerous provisions designed to catalyze transformation of the delivery system, moving it away from fee for service and toward coordinated care (see table).

These provisions will result in incentives for the development of information systems and infrastructure necessary for better and more efficient management of chronic conditions. Such outpatient changes will be reinforced by hospital readmissions policies that improve handoffs and by initiatives to reduce the occurrence of hospital-acquired infections and "never events."The desired consequence of these changes is enhanced tertiary prevention, leading to substantial reductions in unnecessarily expensive specialty referrals and tests and avoidable complications. And the ultimate consequences should be significant improvements in health and fewer exacerbations of chronic illnesses.

Achievement of this level of care coordination will require the development of larger integrated delivery organizations — preferably, accountable care organizations (ACOs) that incorporate primary care practices structured as patient-centered medical homes and that can support new investments in information systems and coordination of care. These ACOs may include one or more hospitals, though they may instead contract with hospitals for specific services chosen on the basis of their cost and quality. Larger ACOs are likely to be contracted directly by payers to manage the continuum of care. They are also likely to bear financial risk, receiving greater payments for the care of chronically ill patients and accepting at least partial responsibility for the costs of specialists' visits, tests, emergency room visits, and hospitalizations. Memories of the inflexible managed-care gatekeepers of the 1990s could lead to theoretically permissive, if practically narrow, networks of providers, although these organizations will need to work closely with a small group of efficient specialists and facilities to achieve their quality and efficiency goals.

A crucial question is who will control these ACOs. We can envision two
Physicians vs. Hospitals...continued from page 8)

possible futures: one of physician-controlled ACOs, with physicians affiliating and contracting with hospitals, controlling the flow of funds through the marketplace; and one of hospital-controlled ACOs that will employ physicians. Whoever controls the ACOs will capture the largest share of any savings.

For physicians to control ACOs, they would have to overcome several hurdles. The first is collaboration: ACOs will require clinical, administrative, and fiscal cooperation, and physicians have seldom demonstrated the ability to effectively organize themselves into groups, agree on clinical guidelines, and devise ways to equitably distribute money. Nearly three quarters of office-based physicians, representing nearly 95% of all U.S. practices, work in groups of five or fewer physicians. Since much of the savings from coordinating care will come from successfully avoiding tests, procedures, and hospitalizations, the question of how to divide profits among primary care physicians and specialists will be contentious. Proceduralists who would end up losing income are likely to resist key structural changes.

In addition, ACOs will require sophisticated information technology (IT) systems and skilled managers in order to hold clinicians accountable. Historically, doctors have not shown the willingness to assume more capital risk or to invest in overhead. Finally, memories of the failed capitation models of the 1990s may make some physicians hesitant to participate.

If hospitals are to control ACOs, they, too, will need to overcome barriers. First, they will need to trade near-term revenue for long-term savings. Hospitals are typically at the center of current health care markets, and by focusing on procedures and severely ill patients, most have been fairly profitable. Building an ACO will require hospitals to shift to a more outpatient-focused, coordinated care model and forgo some profits from procedures and admissions. Hospitals' decisions will be further complicated if payers do not change their payment models similarly and simultaneously.

Second, hospitals, which have generally struggled to operate outpatient practices effectively, may have difficulty designing ACOs. Acquiring practices and hiring physicians as employees typically reduce the physicians' incentive to work long hours and, therefore, reduce their productivity.

It is unlikely that one of these ACO models will dominate throughout the country; local market conditions will influence which one prevails in each community. In geographic areas where the physician base is fragmented and physicians are unlikely to collaborate or where there are already well-established hospital-based health systems, hospitals are likely to dominate. In areas that have well-functioning physician groups, with working IT systems and effective management systems, physician dominance seems more likely. In many other markets, the future is open. In these places, hospitals have the advantage, since they traditionally have more management talent, accounting capability, IT systems, and cheaper access to capital than do physician groups.

Holding off on creating ACOs is likely to be a bad long-term strategy for physicians. First, health care reform has passed, bringing extensive changes, and it would be very difficult to repeal or modify the ACA so as to delay reforms. Congress’s pay-as-you-go rules would require lawmakers to find equivalent savings if they discarded ACA provisions that were expected to save health care dollars — especially at a time when there is tremendous pressure to use any available savings to reduce the deficit. Moreover, policies pursued by the new Independent Payment Advisory Board will probably increase the pressure on providers to coordinate care and form ACOs. Finally, private health plans are facing even more pressure from employers and state insurance commissioners to control premiums.

Established institutional relationships tend to persist because of “path dependence”: decisions about the future are constrained by decisions made in the past, even though circumstances may change. Although it is unequivocally inefficient, inequitable, and otherwise problematic to finance health care with a combination of employer-based coverage, Medicare, and Medicaid, it has proved impossible to change this structure. Similarly, once the new payment system and other changes included in the ACA transform the relationship between hospitals and physicians, the new order will become entrenched and persist until the next period of creative destruction.

If physicians come to dominate, hospitals' census will decline, and their revenue will fall, with little compensatory growth in outpatient services, since physicians are likely to self-refer. This decline will, in turn, lower hospitals’ bond ratings, making it harder for them to borrow money and expand. As hospitals’ financial activity and employment decline, their influence in their local communities will also wane. And it will be hard for them to recover from this diminished role.

Conversely, if hospitals come to dominate ACOs, they will accrue more of the savings from the new delivery system, and physicians' incomes and status as independent professionals will decline. Once relegated to the position of employees and contractors, physicians will have difficulty regaining income, status, the ability to raise capital, and the influence necessary to control health care institutions.

Therefore, the actor who moves first effectively is likely to assume the momentum and dominate the local market. A wait-and-see approach could succeed if the first mover executes poorly, failing to coordinate care and manage risk. But rather than controlling destiny, cautious actors will be hanging their fate on the mistakes of others.

In the early 20th century, the health care system changed dramatically with the introduction of antiseptics and the increasing safety and success of surgery: hospitals gained (Continued on page 10)
power as they became associated with hope and health rather than fear and death. Now, after decades of hospital hegemony, we stand at another crossroads; physicians may be able to gain market leadership if they move first. How the development of ACOs plays out over the next few years is likely to have lasting implications for the practice of medicine, patients’ experience of health care, and health care costs in the United States. The next decade will be critical for developing an effective model and making historic changes in the structure of our health care system.

This article (10.1056/NEJMp1011712) was published on November 10, 2010, at NEJM.org.

Source Information

References

Maryland hospitals and regulators are teaming up in an experimental payment plan to reduce unnecessary admissions while improving patient care.

One of six patients hospitalized in Maryland in the past year ended up back in the same facility within a month, a risky situation for them and a costly one for bill payers.

To keep that from happening so often, more than a dozen hospitals may join an experiment: Upend the traditional way they are paid and set in motion changes that could both boost patient care and reduce preventable admissions.

“We think we can turn that trend a bit,” said Stuart Erdman, finance director for the Johns Hopkins Health System.

The voluntary effort, which includes hospitals such as Suburban, Howard County General and the University of Maryland Medical Center, would essentially cap payments for in-patient care at about this year’s levels for three years. During that time, hospitals could reap substantial savings if they reduce re-admissions -- and lose money if they go up. Smaller hospitals in more rural areas are being offered a slightly different program with a broader goal.

The initiative could provide a national example of how to reduce unnecessary or repeat hospital admissions, which drive up the nation’s health care tab and put patients at risk. In some ways, the state is uniquely positioned to make such a move, as it is the only one where regulators set hospital rates - and all insurers agree to pay those rates.

To reduce unnecessary admissions, Maryland hospitals would have to work with doctors and other providers in the community to ensure that patients get the care they need - preferably in lower cost settings. Patients leaving the hospital, for example, might be connected with care managers or nurses to ensure they take their medications and get prescribed follow-up treatment.

“We’re trying to push the idea that health care doesn’t stop at the walls of the institution: You’re trying to treat the community,” said the effort’s main driver, Robert Murray, executive director of the Maryland Health Services Cost Review Commission.

Murray’s agency will meet Dec. 8 to discuss the proposals, with final approval possible early next year for the urban hospitals. Meanwhile, the state is negotiating contracts for a similar type of payment change with smaller, more rural hospitals that are the sole providers in their regions.

Instead of capping payments for re-admissions, the program for smaller hospitals sets a target budget for all care, inpatient and outpatient. The target is set slightly above their current total expenditures and only rises based on inflation and population growth in the coming years. If hospitals reduce admission rates or appropriately shift some patients to lower cost care in outpatient clinics or doctors’ offices, they will come out ahead. If their admission rates increase, they could lose money.

The move changes hospitals’ incentives from doing more things that now generate revenue -- admissions, tests and procedures -- to focusing on “how to provide better care more efficiently,” says James Xinis, chief executive at Calvert Memorial in Prince Frederick.

Two rural hospitals - Garrett County Memorial in Oakland and McCready Memorial in Crisfield -- have already signed such contracts for three years and at least seven more, including Calvert, are in line to do so, says Murray.

The initiatives are the broadest nationally to use financial incentives to reduce unnecessary hospitalizations, experts say. But they also caution that it must be done right - with proper safeguards for patients.

“This offers an opportunity for a win-win, promising to reduce cost and waste and at the same time making patients feel better,” says Stephen Jencks, a medical doctor and Baltimore-based health consultant who has spent years studying hospital readmissions.

But he warns there could be problems - hospitals directing patients to rival facilities to keep down readmissions, for example. “The first step should not be on the patient’s toes,” Jencks says.

(Continued on page 12)
In an outline of the plans, Murray acknowledges that they potentially could lead hospitals to “provide insufficient care” or could even raise costs if hospitals simply hold returning patients in emergency departments - thus avoiding an admission.

Hospitals would still receive payments for returning patients who are seen in emergency departments or held for “observation” but not admitted.

Murray says his agency will closely monitor hospitals’ practices.

The Maryland Hospital Association says it supports efforts to reduce readmissions, but cautions that not every hospital would be able to accept the types of voluntary arrangements Murray is suggesting. The association says it also wants a statewide effort - funded by an increase in hospital rates.

Much is riding on finding a solution: Nearly 17 percent of patients in Maryland in the last fiscal year were readmitted to the same hospital within a month, care that accounted for more than $1.2 billion of the approximately $9 billion spent on hospital care, according Murray's report.

Reducing same-hospital admissions would save money and could also have a spillover effect in reducing emergency department visits, he says, allowing the state to approve smaller hospital rate increases in the future.

Maryland’s average 30-day re-admission rate for patients in the Medicare program for seniors and the disabled - 22 percent – is the second highest in the country, a study of 2003-2004 discharges by Jencks published last year in the New England Journal of Medicine found.

To reap savings, hospitals will need to make changes, such as hiring case managers or nurses to more closely track patients who are discharged or offering longer hours at urgent care clinics. “There would be a post-discharge clinic that would ensure that a patient sees their physician or other care provider within 48 hours of discharge to see if everything is OK," says Thomas Mullen, president and CEO of Mercy Health Services in Baltimore.

The payment proposal comes well ahead of requirements in the new health law that will reduce Medicare payments to hospitals in fiscal 2013 that have above-average re-admission rates for heart attack, heart failure and pneumonia. The Maryland effort is also broader, seeking to reduce admissions across the board.

Raymond Grahe, chief financial officer at Washington County Hospital in Hagerstown, says his hospital is interested and is in talks with Murray’s office over a budget contract. “This is what was missing from the health care reform package: It was basically about insurance reform, when what it truly needed was care reform," says Grahe.
Muhammad Yunus, a Bangladeshi economist Professor, was awarded the Nobel Peace Prize in 2006 for his work that has focused the attention of the world on the microcredit idea he pioneered. In micro-financing, the social cohesion of everyone in a group is responsible for everyone else’s loans. It has become immensely popular in the poorer countries of Africa and India where the majority of potential borrowers are below most lender break-even points and few have assets valuable enough to be held as collateral. According to Grameen Bank, the community development bank founded by Yunus in 1976, these very small loans (typically less than $100) are made to the rural poor in developing countries who normally do not qualify for traditional banking credit. It is often the only way they can establish a business and lift themselves out of poverty.

In the African country of Mali, the Mali Health Organizing Project (MHOP) provides healthcare to some of the poorest people of Mali. One of MHOP’s social innovation projects is the Action for Health initiative, a program that provides in-home health care and health education for women and children using specially designed cell phones to text data back to a central server to create electronic medical records and support doctors in effectively treating patients. However, instead of charging user fees, which deter the poorest from seeking care, MHOP charges “action-fees” (ranging from community trash clean up to tree planting campaigns or health awareness training events) that help create economic, social, and political capital without demanding cash from people who cannot afford to pay.

Although a relatively new concept in the United States, the idea of social innovation has begun to become a powerful alternative to traditionally prescriptive methods of solving social issues. Armed with innovative ideas, social entrepreneurs conceive a concept that easily resolves the problems. With both public and private access to grants, loans, and/or bonds, the social entrepreneur can put concepts into action. President Obama recently created the Office of Social Innovation and Civic Participation within the White House to catalyze new and innovative ways of encouraging government to do business. According to the White House Press Secretary, the Social Innovation Fund (SIF) is a new way of doing business for the federal government that stands to yield greater impact on urgent national challenges. The SIF will target millions in public-private funds to expand effective solutions to social challenges in the areas of economic opportunity, healthy futures, youth development, and school support. It will partner with foundations, philanthropists, and corporations that will commit matching resources, funding, and technical assistance. As State and Federal governments grapple with the reality of shrinking budgets and large deficits, the new Office will identify the most promising, results-oriented programs, provide growth capital for these programs, expand their reach throughout the country, and improve the use of data and evaluation on what programs the government funds.

In July 2010, the Corporation for National and Community Service (CNCS) announced its inaugural SIF grants across more than 20 states and consisting of 11 organizations selected through a process involving 60 external experts. The portfolio includes $74 million in secured private match funds, which is beyond the statutory requirement of $50 million; a 3:1 private-public match. When combined with federal resources, this will result in $123 million being targeted toward promising organizations that train the unemployed, increase access to health services for the underserved and prepare youth for academic and economic success. Selectees range from the ‘Mayor’s Fund to Advance New York City’ used to change the way governments reduce poverty in America to the ‘Foundation for a Healthy Kentucky’ that will match and re-grant the SIF funds to improve access to needed health services.
and promote health equity in low-income communities in Kentucky. In this case, sub-grantees will match funds received, and provide strategies to increase nutritional health and fitness, integrate mental health and medical services, and increase access to health services in underserved (rural, low-income, and uninsured) communities. Projects include the utilization of health IT to connect with other sites, expanding existing navigation programs, and establishing primary care and satellite clinics using telemedicine technology to collaborate with physicians at a central location. They are all part of a family of new financing devices forming to provide funding to social innovations that improve healthcare for the underserved.

The Healthcare Reform Act calls for a great deal of innovation in order to meet the technological needs of the expansion of Medicaid and the creation of Health Insurance Exchanges. Since hospitals will have more uninsured people eligible for programs and potential reimbursement to the hospital, they will need an efficient enrollment program that will quickly screen and fill out all the paperwork to get their patients applications completed. Hospitals are on the front lines of health care reform: many patients may be eligible under the new program guidelines but not enrolled or aware of the programs until they have entered the hospital. Brining automation to the screening process vastly improves the efficiency crucial to meeting the government deadlines and maintaining a database of screenings. Automation in the assistance of the uninsured and underinsured is a necessary step to accomplish the goals of healthcare reform.

Although social innovation is in its infancy in the United States, it seems uncontested that it is a good way to capitalize social value, and provide better incentives for public agencies to make preventative investments that address the health care needs of their state and specifically the underserved. Both public and private oversight allows companies to improve programs by keeping them goal-oriented and contingent on effective progress while serving the public good. It seems to be the best way for the government and private sector to collaborate, help the uninsured, and manage the costs of programs. As social innovation enhances and expands outdated systems and processes into the digital age, automation and technology will allow private hospitals and public programs to communicate with one another more efficiently and better serve the uninsured in their communities.
1st Education Road Show
A Must Attend Event for
Healthcare Financial Professionals

As requested by our members
KY HFMA is taking education on the road
to Owensboro, KY

February 18, 2011

Special Thanks to the Program Sponsors
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KY HFMA Road Show | Earn 4 CPE | February 18, 2011
Since 1994, Kentucky, like most other states, has imposed a state-specific tax on hospitals and other healthcare providers in the state, the proceeds of which are used to fund various aspects of Kentucky’s Medicaid program. The tax, assessed pursuant to KRS 142.303, is 2.5% of a hospital’s gross revenues. In the past, the tax has been mutually beneficial to both the Commonwealth as a whole and Kentucky hospitals individually because the Commonwealth uses the tax proceeds to increase its Medicaid funding for hospitals, which in turn increases the federal matching funds for the state. Of course, such a scheme is vulnerable to abuse so Congress, in compromise legislation enacted in 1991, expressly allowed the states’ continued use of healthcare provider taxes for enhancing matching federal Medicaid funding as long as the tax satisfied certain restrictions. The Kentucky provider tax conforms to all the restrictions imposed by Congress, and thus receives matching federal funds for the tax revenue it produces.

The provider tax has been especially beneficial to critical access hospitals, which are rural hospitals with 25 acute-care beds or less. Critical access hospitals are different from all other hospitals in that Medicare pays 101% of the hospitals’ actual costs in providing services to Medicare patients. Since Kentucky enacted its provider tax in 1994, Kentucky critical access hospitals have reported the amount of provider tax they pay in their annual Medicare cost reports, and the Centers for Medicare and Medicaid Services (CMS) has always reimbursed the hospitals for the amount of tax allocable to Medicare patients. But in an abrupt about-face, CMS published its Fiscal Year 2011 Hospital Inpatient Prospective Payments System Final Rule on August 16, 2010 that greatly reduced the amount of reimbursement that the critical access hospitals will receive for their provider tax payments. The result in Kentucky is that fiscal intermediaries have been offsetting the amount of provider tax claimed by critical access hospitals by the amount of Disproportionate Share Hospital (DSH) payments each hospital receives. DSH payments are payments to hospitals that provide a large portion of healthcare services to indigent patients who do not qualify for Medicare or Medicaid. CMS claims that these DSH payments are associated with the provider tax assessment because the Commonwealth deposits the provider tax revenues into a fund that, in part, funds the DSH program.

Although CMS referred to its final rule as a “clarification” of its regulations, in reality it is a major change in CMS’s policy that will result in less reimbursement for critical access hospitals in Kentucky. The Kentucky Hospital Association (KHA) and the twenty-nine critical access hospitals in Kentucky believe CMS’s new interpretation to be invalid and unenforceable because it is contrary to the intent of Congress as well as governing Medicare statutes and regulations. The principal arguments against the validity of the CMS final rule are outlined below.

**DSH Payments are not Associated with the Provider Tax**

CMS essentially argues that because the provider tax proceeds go into a fund that, in part, makes DSH payments to critical access hospitals, the hospitals are not actually incurring the cost of the provider tax. This argument is flawed because the amount of provider tax each critical access hospital pays is based on revenue and the amount of DSH funding each receives is based solely on the amount of indigent care it provides. Thus, paying the provider tax, which is required by law, is no guarantee that any hospital will see a dime of DSH funding. DSH is supposed to compensate for the cost of providing healthcare services to indigent patients, but DSH funding in reality only covers about 40% of the actual cost of care for DSH-eligible patients. It does not, and is not intended to, compensate critical access hospitals for the provider tax they pay.

**CMS’s New Policy Impermissibly Shifts Medicare Costs to Non-Medicare Patients**

Medicare law requires that the cost of providing services to Medicare individuals is not borne by those not covered by Medicare. In other words, Medicare should pay for the cost of providing care to its own patients, no more and no less. The new final rule violates this statutory provision by refusing to reimburse hospitals for the provider tax assessment allocable to Medicare beneficiaries. If Medicare will not pay for the full amount of the provider tax for Medicare patients then the hospitals must compensate by shifting that cost to non-Medicare patients—they cannot simply avoid pay-
Today, most hospital business offices rely on third party vendors, such as collection agencies, extended business office partners and eligibility firms, to augment their internal collection efforts. Every day, accounts and financial updates flow back and forth between a hospital and its vendors. Despite everyone’s best intentions, the current operating routines and processes often result in inconsistencies between the inventory records of a hospital and its vendors.

Always thought to be a relatively minor issue, recent research suggests the inventory reconciliation problem is significant, pervasive and critical. Reconciliation issues between providers and their vendors can lead simply to lost cash and high operating costs or go so far as to create regulatory issues and major public relations problems.

**The Magnitude of Inventory Reconciliation Issues Can Be Significant**

Based on findings from inventory reconciliation initiatives at multiple providers around the United States, between 5% and 34% of inventory held at vendors had reconciliation issues with the providers’ records.

The average reconciliation error rate across this sample of providers was 13%. However, even in situations where the provider had only a single vendor, the reconciliation error rate was high.

Reconciliation issues broke down into five categories:
The result of CMS’s new policy is that someone else will have to pay the provider tax associated with providing services to Medicare patients.

**CMS is Trying to Circumvent Congressional Approval of Provider Taxes**

With this final rule, CMS is essentially giving with one hand and taking away with the other. On the one hand, CMS is allowing states to impose provider taxes for the purpose of enhancing their federal matching funds. Congress explicitly endorsed the use of provider taxes in 1991 by passing a federal statute to allow provider tax revenue to be eligible for Medicaid federal matching funding. But on the other hand, without congressional approval, CMS is trying to claw back a portion of that federal money through Medicare by reducing the amount of money that CMS will reimburse the hospitals for their provider tax assessments. This action undermines the compromise legislation that Congress passed in 1991 by making provider taxes much less beneficial to critical access hospitals. In addition, the new policy’s disproportionate effect on critical access hospitals is contrary to congressional intent to ensure the survival of critical access hospitals, which serve some of the most financially vulnerable populations.

The KHA and the critical access hospitals will be challenging CMS’s interpretation in administrative and judicial actions in the upcoming months. The final outcome of these challenges could have long-term consequences for critical access hospitals and ultimately could affect the survival of the Kentucky provider tax.

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**What’s Hiding in Your Vendor Inventories … Continued from page 17**

Vendors also appear to demonstrate different performance on account and inventory reconciliation activities. As the research indicated, some vendors seemed to systematically operate at lower than 90% accuracy while others were close to 98% accurate.

**How do Inventory Reconciliation Problems Happen?**

For each account, countless financial events such as payments, adjustments, reversals, etc. occur every day both in the hospital business office and in vendor operations. All these events need to be dutifully credited, debited and noted in both provider and vendor inventory records in exactly the same way.

For instance, an event as simple as a patient going to the hospital to pay a past-due bill previously sent to a collection agency creates a string of follow-on events in the hospital’s patient accounting system that need to be connected to and mirrored in the collection agency’s inventory records. That same check, subsequently failing to clear at the patient’s bank, will lead to another series of reversal transactions that need to be mirrored yet again. If
the reversal occurs in the next month, it means that all the unwinding activity will be part of a different monthly close effort. As these examples demonstrate, there are multiple opportunities for reconciliation issues to percolate in even the simplest, most common events.

<table>
<thead>
<tr>
<th>Reconciliation Issue</th>
<th>Possible Ramifications</th>
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| Account open at hospital, but not at agency               | • No work is being done on the account so no money is being collected.  
• Patient may incorrectly be told that their financial obligations are complete. |
| Hospital and vendor have different balance due           | • Vendor is either pursuing too much or too little money, both of which are problematic. Too much exposes the hospital to legal and public relations issues. Too little leaks cash.  
• Unexplained changes to the balance due undermine patient confidence in the accuracy of the bill now and in the future. This breakdown delays patient payment as the patient is expecting the billed amount to change.  
• Creates unproductive administrative costs at both the vendor and provider when the gap is identified and needs to be explained. |
| Account closed at hospital, but open at vendor           | • Vendor is requesting payment on an account that has been resolved or otherwise closed.  
• In the event that the account has been written off to charity or taken as bad debt on a cost report, significant legal and compliance issues are created.  
• Patient goodwill and community relations put at risk.  
• Vendor is incurring costs to collect. |
| Account at wrong vendor                                  | • Collection efforts may be inappropriate for the type of account. Different agencies are often contracted to operate under different policies, processes, and commission rates.  
• Patient satisfaction risked by exposure to more aggressive collection tactics than warranted. |
| Account at two vendors                                   | • Patient is pursued by more than one vendor, creating frustration with the provider and potentially excess payment.  
• Hospital potentially paying commissions to both vendors.  
• Extra collection costs incurred by vendors. |

By having the ability to access and benchmark thousands of account placements and recalls every day between providers and vendors around the United States, some trends have emerged. These include:

1. Accounts are closed in the patient accounting system, but not recalled from the vendor;
2. Accounts are closed by the vendor, but not updated as such in the patient accounting system;
3. Accounts on payment plan appear at the vendor, but are not documented as such in the provider’s records;
4. Vendor is continuing collection efforts on accounts on hold for review at the provider; and,
5. ‘Missing transactions’ or transactions that are recorded in the patient accounting system, but are not sent to the vendor, and vice versa.
Over time, the small numbers of account problems compound and mature into the 5% to 34% inventory reconciliation issues noted earlier.

Possible Negative Outcomes from Reconciliation Issues

Not only are the number of accounts involved significant, but these reconciliation problems lead directly to problematic outcomes. Some of the more concerning problems include:

In almost every situation, reconciliation issues are elevating operating costs, distracting management attention and reducing cash recovery. It also creates the opportunity to undermine patient satisfaction, generate negative PR in the local community, and put the provider at risk with regulators, CMS and other oversight organizations.

What Can a Provider Do to Address Inventory Reconciliation Issues?

Many hospital business offices only perform spot checks or "rough reconciliations" due to the volume of activity, inaccessible account data and limitations with patient accounting system. Many hospitals also use time consuming, manually intensive account matching, thinking they can solve their reconciliation problems with human intervention. While better than doing nothing, they are insufficient. The scale and scope of the previously mentioned research plus the trend to use more outsourcers in business office processes suggest providers and their vendors need to enhance key routines:

1. Check placement files for misplaced accounts and identify root causes of problems. Despite their best efforts, hospitals do occasionally send a handful of accounts to a vendor that either should not have been sent to a vendor or were already sent to a vendor. When this happens, it is critical that the accounts are identified, inventory records are corrected, and the underlying reasons for the account being incorrectly placed are identified and corrected.

2. Reconcile balances for all accounts in placement and recall files. It is not sufficient to simply confirm receipt of the placement file and total number of accounts. Individual account balances need to be verified as well, preferably by cross checking account-level financial transactions.

3. Reconcile full inventory at each vendor, at least monthly. Given the compounding effect of problems over time, full reconciliation at least monthly is necessary. In many situations, weekly reconciliation of the entire inventory may be appropriate.

4. Update policies and procedures and monitor adherence. A number of inventory issues are created as a result of inadvertent customer service activity, such as incorrectly moving or closing an account or applying an incorrect transaction code. A good practice is to review policies and procedures at least once per year to check that they are up to date, cover all reasonable situations and are understood by employees in the business office and at vendors. The provider also needs to monitor adherence to these policies and procedures.

5. Ensure comprehensive and common reporting. Numerous hospitals unknowingly rely on incomplete information or reports generated using different variable definitions. Having accurate reports that are common across vendors to track inventory reconciliation is central to having clean, accurate account inventories.

Long term, cost effective approaches generally are technology enabled, automating the exception identification process.

Ultimately, whenever a provider corrects existing inventory reconciliation issues and prevents new ones from occurring, they are improving the patient experience, reducing operating costs and compliance risks, and enabling their vendors to be more effective. It is a true win-win experience.

About the Author

Steven Levin is CEO and co-founder of Connance, a leading provider of back-office, self-pay collection and scoring solutions. Contact him at slevin@connance.com or visit www.connance.com
On November 2, 2010, the Centers for Medicare and Medicaid Services (CMS) issued the final rule on the 2011 update for the Medicare Home Health Prospective Payment System (PPS) rates—yet another document issued in 2010 to send ripples through the home health provider community. This rule, combined with the Patient Protection and Affordable Care Act of 2010 (PPACA), has created the furthest-reaching changes facing home health agencies since the implementation of the original home health PPS in 2000.

The home health industry has been thrust into the government spotlight with repeated reports from the Medicare Payment Advisory Commission (MedPAC) about excessive profit margins and accusations of questionable business practices. With this negative attention, home health took its fair share of the hit as our government looked to reform health care with the passing of PPACA in March. CMS also has taken matters into its own hands with payment reductions and implementation of additional compliance requirements for home health.

The 2011 home health payment rule was used as a vehicle to implement some of the home health provisions within PPACA. Therefore, a refresher on those provisions will help provide the groundwork to better understand the rule’s changes.

**Home Health Provisions in PPACA**

PPACA included specific rules for updating home health payment rates, new Medicare coverage requirements for home health services and directives for the Department of Health and Human Services (HHS) and MedPAC to perform studies on home health payment methodologies. Items affecting home health payment rates include:

- A 3 percent rural add-on effective for Medicare episodes ending on or after April 1, 2010, and before January 1, 2016
- Indefinite continuance of the agency-specific 10 percent outlier payment cap
- A 2.5 percent 2011 reduction to the Medicare home health PPS base rates due to realigning outlier budget of 5 percent versus outlier spending target of 2.5 percent
- A 1 percent reduction in the annual Medicare home health market basket update for the years 2011 through 2013
- Rebasing of payment rates to better approximate costs over a four-year phase-in beginning with 2014, with a maximum reduction of 3.5 percent per year
- Reduction of the annual Medicare home health market basket update by a productivity adjustment, beginning in 2015

Wage index changes can vastly change the ultimate effect on a specific geographic area’s payment rates. Some areas are receiving wage index decreases that double the decrease in their payment rates, while other areas are receiving wage index increases that virtually wipe out the base rate decrease.

(Continued on page 22)
The non-routine supply (NRS) payment and low utilization payment adjustment (LUPA) payment rates were both decreased by 1.5 percent, as they are not impacted by the case mix creep adjustment. The outlier payment provisions are unchanged, and the agency-specific 10 percent outlier payment cap is retained as required by PPACA.

Rural payment rates receive a 3 percent rural add-on as specified in PPACA. This add-on is included in the rural base rates as well as the NRS and LUPA rural payment rates.

As mentioned above, the 2011 payment rule not only provided the update for the Medicare home health PPS payment rates, it also addressed several non-rate issues. These non-rate issues address compliance concerns and implement PPACA requirements.

**Physician Face-to-Face Encounters**

For Medicare home health admissions on or after January 1, 2011, the certifying physician must have a face-to-face encounter with the patient either within 90 days prior to or 30 days after admission. The encounter must be performed by a qualified certifying physician or other qualified non-physician practitioner and must be related to the primary reason the patient is being admitted to home health. Appropriate documentation must be in place as a condition of payment.

**Therapy Standards**

The payment rule addressed therapy standards in home health, as therapy utilization continues to be a focus of concern of CMS and others. According to clarification within the requirements, therapy documentation should focus on functional, measurable and objective goals and progress being made towards these goals. New standards require qualified therapists, excluding assistants, to assess, measure and document progress toward goals at least every 30 days, or prior to the 13th and 19th total therapy visits. Additional guidance also is provided on the coverage of maintenance therapy. These heightened therapy standards are not effective until April 1, 2011.

**Additional HCPCS Codes**

Effective January 1, 2011, new Healthcare Common Procedure Coding System (HCPCS) codes are to be used on Medicare claims. These new HCPCS codes include new “G” codes to be used for maintenance therapy visits as well as for visits performed by therapy assistants. New “G” codes also will be required for nursing visits for management and evaluation, observation and assessment and training and education. The intent of these new codes is to help provide CMS with a better understanding of the home health services being provided.

**Capitalization**

To protect patient care of new-start agencies, additional capitalization requirements were set forth in the payment rule. New-start agencies now must prove that three months’ operating capital is in place at three points: upon application, at the time of survey and when enrolling in Medicare. CMS will require cost report data of comparable agencies as a basis to determine the necessary capitalization.

**36-Month Rule**

The 36-month rule was actually put in place under the 2010 payment rule, but the 2011 payment rule provides further guidance on the application of the rule after a year of confusion. The 36-month rule prohibits the conveyance of the home health provider agreement to a buyer if the selling agency started within 36 months or a prior change of ownership took place in the last 36 months. Under these circumstances, the buyer must enroll in Medicare as a new, or initial, agency. The 2011 payment rule confirms it does apply to both asset and stock transactions. However, it will only be applied to changes in “majority” ownership, and several exceptions to the rule are provided, including death of an owner, indirect ownership changes and changes in entity structure.

**Take Action Now**

Agencies must move quickly to prepare for these far-reaching changes. Preparation should include education, assessment of opportunities to improve operational efficiencies and implementation of policies and procedures to ensure compliance. Contact your BKD advisor for further information.
Every day, healthcare professionals improve lives. As healthcare finance professionals, we may not be able to provide direct patient care to relieve pain and improve health, but we can ensure that the organizations we serve have the resources they need to carry out the mission of improving lives. And key to providing those resources is the cash produced by a high-performing revenue cycle.

Until recently, healthcare finance professionals have lacked the process-improvement tools they need to achieve a high-performing revenue cycle. There have been no generally agreed upon measures of excellence, and no way to compare performance with others. More challenging, there has been no consensus about the successful practices that produce measurably high performance.

A new HFMA initiative called MAP puts reliable performance improvement of the revenue cycle in your grasp.

MAP stands for Measure, Apply, and Perform—the core components of performance improvement.

**Measure:** MAP provides industry-standard indicators for consistent measurement and reliable comparisons with peers.

**Apply:** MAP provides demonstrated best practices linked to the performance indicators.

**Perform:** MAP helps you achieve revenue cycle excellence and recognizes high performance.

Created by and for healthcare leaders, HFMA’s MAP will provide industry-driven measures of revenue cycle excellence, tools to apply those measures across the industry, and successful practices that drive high performance. The components of the MAP are:

- **MAP Keys:** Indicators of revenue cycle excellence
- **MAP App:** The essential tool to track performance and recommend improvement
- **MAP Award:** A recognition of high-performing hospitals
- **MAP Event:** A live exchange of demonstrated successful practices

**MAP Keys** are indicators of revenue cycle excellence. Developed by industry leaders led by HFMA, MAP Keys define the essentials of revenue cycle performance in clear, unbiased terms and set the standards for the healthcare industry. MAP Keys eliminate the confusion of varying metrics and dubious comparisons. They ensure consistent revenue cycle reporting across institutions and allow peer-to-peer comparisons that make sense.

Using MAP Keys, healthcare finance professionals can improve business intelligence, strengthen revenue cycle management, and decide where to focus for improvement. To date, HFMA has released 19 MAP Keys, and we will produce new ones to reflect the changing industry and the continuing need for standards for revenue cycle excellence. More information is available at www.hfma.org/mapkeys.

**MAP App**

The next feature of HFMA’s MAP is a customized web-based tool to track performance and recommend improvements. This tool is called the MAP App.

The MAP App will track a hospital’s performance throughout the revenue cycle and compare that performance with the performance of other organizations. You will be able to compare performance against the industry as a whole and against a customized peer group. The MAP App also will offer successful practices and includes a community discussion forum for airing common concerns and sharing ideas and strategies. A pilot of this tool was unveiled at this year’s ANI. We plan to roll out the tool for general use within several months. Look for more information at www.hfma.org/mapapp.

**MAP Award**

Being able to measure revenue cycle performance means that we can recognize high performers. To honor hospitals that achieve revenue cycle excellence, we have created the MAP Award for High Performance in Revenue Cycle. MAP Award winners excel in meeting the benchmarks established in the MAP Keys and PATIENT FRIENDLY BILLING® practices. The MAP Award is sponsored by 3M Health Information Systems.

The award was established in 2009, and the 2010 winners were announced in June at ANI. Their successful practices will be shared in the MAP App, HFMA publications, and live education, including the MAP Event. Additional information about the award and this year’s winners is at www.hfma.org/mapaward.

**MAP Event**

At the MAP Event, high-performing organizations share their cutting-edge strategies. The MAP Event brings together the best ideas in today’s healthcare industry for improving revenue cycle performance, strengthening cash position, and ultimately generating the resources to support the mission of care.

This year’s MAP Event takes place November 7-9 in San Diego at the Coronado Island Marriott Resort & Spa. The MAP Award-winning organizations who will present are Baylor Health System, Danbury Hospital, Princeton Baptist Medical Center, Carolinas HealthCare System, Hospital of the University of Pennsylvania, Touchette Regional Hospital, and Sharp Grossmont.

At the MAP Event, you’ll learn these organizations’ methods to:
Identify efficiency improvements to decrease Net Days in A/R
Reduce denials and ultimately decrease Aged A/R
Educate consumers on payment expectations to increase POS Cash Collections
Develop a comprehensive financial counseling process to identify payment sources and reduce Bad Debt
Improve operational performance and reduce Cost to Collect
Use technology to increase Front-End Efficiencies, including Insurance Verification and Pre-Authorization
Simplify charity care policies to ensure consistent application and compliance

And you’ll learn how your organization can win a MAP Award next year.
A keynote address by Quint Studer provides you with the motivation and the tools for “Straight-A Leadership: Alignment, Action and Accountability.”
Be part of the community of high-performers. To register for the MAP Event, call 800-252-4362, ext. 2, or visit hfma.org/mapevent.

NEW MEMBERS

Gary Brodarick  Consultant  Quorum Health Resources
Stephanie Hall  Consultant  Phillips Consulting, Inc.
Margaret Enlow  Regional Director, MC  Saint Joseph Health System
Michelle Bowling  Acct Manager  Saint Joseph Health System
Chris Hall  Vice President  Marsh
Sara Michener  Dir. Of Compliance  Jennie Stuart Medical Center
Bryan Vaughn  Director, Sales Support  Firstsource Solutions USA
Matt Shropshire  Decision Support Analysis  Catholic Health Initiatives
Sandra Deubel  Bus. Office Manager  Rockcastle Regional Hospital

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

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

<table>
<thead>
<tr>
<th>Level</th>
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<td>Bronze</td>
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<tr>
<td>Silver</td>
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<tr>
<td>Gold</td>
<td>$3,000</td>
</tr>
<tr>
<td>Platinum</td>
<td>$4,000</td>
</tr>
</tbody>
</table>

#### Bronze - $1,000
1. One (1) free registration to a conference
2. Signage recognizing level of sponsorship at every event
3. Listing of sponsor’s name and/or logo on meeting announcements
4. Sponsor will receive a Kentucky HFMA shirt showing level of sponsorship
5. Recognition during welcome and closing remarks at every meeting
6. List of registrants after each event (if requested)
7. Acknowledgement in the Chapter’s newsletter, membership directory and on website

#### Silver - $2,000
1. One (1) free exhibit space **one** KY Chapter Institute ($600 value)
2. Two (2) free registrations to one of the conferences
3. Signage recognizing level of sponsorship at every event
4. Listing of sponsor’s name and/or logo on meeting announcements
5. Recognition during welcome and closing remarks at every meeting
6. Sponsor will receive a Kentucky HFMA shirt showing level of sponsorship
7. List of registrants after each event (if requested)
8. Acknowledgement in the Chapter’s newsletter, membership directory and on website

#### Gold - $3,000
1. One (1) free exhibit space **two** KY Chapter Institutes ($1200 value)
2. One (1) free membership to the Kentucky Chapter of HFMA (cannot be used towards current membership)
3. Two (2) free registrations to one of the conferences
4. Signage recognizing level of sponsorship at every event
5. Listing of sponsor’s name and/or logo on meeting announcements
6. Recognition during welcome and closing remarks at every meeting
7. Sponsor will receive a Kentucky HFMA shirt showing level of sponsorship
8. List of registrants after each event (if requested)
9. Acknowledgement in the Chapter’s newsletter, membership directory and on website

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