The final rule for changes to the Hospital Outpatient Prospective Payment System (OPPS) for Calendar Year (CY) 2014 was released by the Centers for Medicare & Medicaid Services (CMS) on November 27, 2013. The effective date for this release is January 1, 2014, with the exception of the following which are effective January 26, 2014: certain provisions pertaining to Value-Based Purchasing (VBP) appeals, organ procurement organizations (OPOs), Quality Improvement Organizations (QIOs) and the Electronic Health Record (EHR) incentive program.

OPPS Payment Update

The CY 2014 market basket update is 1.7 percent. This is comprised of the Fiscal Year 2014 Inpatient Prospective Payment System (IPPS) market basket increase of 2.5 percent reduced by 0.5 percent for the productivity adjustment and 0.3 percent reduction for the CY 2014 OPPS market basket. CMS has estimated that for CY 2014 total payments will be approximately $50.4 billion to the approximately 4,100 facilities that are paid under OPPS. This amount also represents an estimated increase of $4.372 billion when compared to CY 2013 payments without consideration of changes in enrollment, utilization and case mix. CMS will also continue to apply the statutory 2.0 percent reduction in payments for hospitals that fail to meet the hospital outpatient quality reporting requirements.

Article continues on page 4
Mark your calendars

Heart of America Programming

The topics listed are subject to change and will be more clearly defined as the program year progresses:

**FEBRUARY 20, 2014**

*Benchmarking—Using Evidence Based $45*

Strategies to Improve Revenue Cycle Operations

Light Breakfast 7:30 AM – 11:30 AM

**MARCH 20, 2014**

*Healthcare 101 Back by popular demand!* Lunch 7:30 AM – 4:30 PM - $45

**APRIL 24, 2014**

*Leadership/Organizational Skills & Awards Banquet*

Lunch 12:00 PM – 4:30 PM - $65

National Webinars

Learn about timely healthcare finance topics and earn CPEs. Most live webinars are free for HFMA members and $99 for non-members, unless otherwise noted.

- **January 21** Reducing Denials by Engaging Physicians Through a Clinical Documentation Chain
- **January 22** Optimizing Patient Statement Design to Improve Clarity and Reduce Billing Inquiries
- **January 29** Making the Transition to Outcome-Based Quality Payments
- **February 11** Beyond ICD-10: Are You Ready for What’s Next?
- **February 12** HFMA’s e2 Learning: Educate Staff to Elevate Performance
- **February 20** How to Develop and Maintain Supply Chain Transparency and Control
- **March 4** A Vendor Guide to HFMA’s e2 Learning: Generate Results for Your Clients

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View all upcoming live webinars

HFMA provides webinars available one calendar year following the live webinar date and year. Most on-demand webinars are free for HFMA members and $99 for non-members, unless otherwise noted.

- **Available until May 30, 2014** Reimbursement Model Transition Planning: From Fee-for-Volume to Fee-for-Value
- **Available until June 6, 2014** Challenges with Transitioning to Accountable Care
- **Available until Sep 24, 2014** Understanding the Impact of Consumable Costs that Exceed their Capital Investments
Happy New Year!

It seems very odd for me to say this as I am writing this article a week before Christmas. I am still in the thick of shopping and planning for the upcoming Christmas holiday as I am sure many of you were at that time. 2013 has been a very joyous year for my family and we get to experience Christmas for the first time through our little girl’s eyes. It certainly puts a whole new perspective on the holidays and makes me realize what the season is truly about. My hope is that every member of the Heart of America chapter had a wonderful holiday season with family and friends.

It is a common tradition to set resolutions or goals at the beginning of a new year. My challenge to you is to find ways to get involved in our chapter. One of the easiest ways to get involved is to attend our local educational programs. The program committee is working very hard to schedule outstanding speakers to discuss current and relevant happenings in healthcare.

Listed below are our upcoming program events:
- February 20, 2014: Benchmarking in the Time of Change (A focus on ICD-10 and Revenue Cycle System Transitions)
- March 20, 2014: Healthcare 101
- April 24, 2014: Leadership & Organizational Skills and Annual Award Banquet

Another way to get involved with the chapter is to volunteer to serve on a committee. This is a great way to continue to network with other members and serve the chapter by helping with new members, planning a program or helping with the chapter newsletter, website or social activities. Jim Mozena, our President-Elect, is already starting to actively recruit members to assist in the upcoming fiscal year. If you would like to serve on a committee, please contact Jim via email jmochen@nueterra.com.

Thank you to the Heart of America members that participated in the Member Satisfaction Survey that was sent to members in October. This survey is released annually by National and is a very helpful tool that is used by the officers and board members as we strategically plan the future chapter years. Your feedback is invaluable as the leaders of the chapter strive to make our members very satisfied. In the upcoming months we will be closely reviewing the results and implementing new ideas for the coming years.

If there is anything that I can do for you please feel free to contact me at amlindsay@saint-lukes.org or 816-932-2496. I look forward to hearing from you soon. As always, it is a pleasure to serve the Heart of America Chapter.

Warm Regards, Andrea Lindsay, HOA Chapter President
Rural Adjustment & Cancer Hospital Payment Adjustment

CMS will continue the 7.1 percent adjustment on OPPS payments made to certain rural sole community hospitals (SCHs), including essential access community hospitals (EACHs). CMS will also continue to provide additional payments to cancer hospitals if their outpatient costs are determined to be greater than the costs of other hospitals paid under OPPS.

Comprehensive APCs

While CMS has finalized their policy to establish 29 comprehensive Ambulatory Payment Classifications (APCs) to pay prospectively on the most costly hospital outpatient device-dependent services, the decision was also made by CMS to delay implementation of this policy until CY 2015. Once implemented, this policy will result in a single prospective payment to hospitals for a service, including a high-cost device, based on the cost of all the individually reported codes on the claim. CMS has also modified the methodology currently used to make larger payments for complex and costly multiple device procedures. As a result of bundling these services as one payment, it is anticipated that beneficiary copayments will be reduced. Due to the delay in implementation, CMS is inviting comments on this portion of the rule.

Hospital Outpatient Therapeutic Services Supervision

CMS initially specified in the CY 2009 rules that direct supervision is required for hospital outpatient therapeutic services, including services provided by CAHs. In response to concerns raised by CAHs and small rural hospitals with 100 or fewer beds about the difficulty in meeting this standard, CMS decided that this rule would not be enforced at CAHs and small rural hospitals with 100 or fewer beds. This nonenforcement continues through the CY 2013 rules but will expire December 31, 2013. Therefore, beginning January 1, 2014, outpatient therapeutic services will require a minimum of direct supervision at all hospitals unless one of the exceptions is met.

Outlier Payments

For CY 2014, CMS will continue to make outlier payments that are equal to 50 percent of the amount by which the cost of furnishing the service is in excess of 1.75 times the APC payment amount. In order for this payment to be made, both the 1.75 multiple threshold and the fixed-dollar threshold of $2,900 must be met. This fixed-dollar threshold is up from $2,025 in CY 2013.

Medicare Fee-for-Service Electronic Health Records (EHR) Incentive Program

CMS finalized regulations which provide a special method for making hospital-based determinations for 2014 in cases where eligible professionals (EP) have reassigned their benefits to Method II CAHs. This was previously not possible due to system limitations. As a result of adopting these regulations for 2014, CMS will begin to make payments based on CAH II claims one year earlier than originally anticipated. CMS did clarify that in situations where no 12-month cost reporting period begins on or after the beginning of a payment year, CMS will use the most recent 12-month cost reporting period available at the time of final settlement.

Flat Payment Rates

CMS proposed two flat payment rates for the technical component of hospital evaluation and management (E/M) services. They proposed a flat amount for both hospital-based clinic and emergency department visits, regardless of the Current Procedural Terminology (CPT) level selected. The emergency department E/M rate change was deferred, with CMS citing a need for further study of the impact of any rate flattening on the provider community.

However, CMS finalized the rule requiring hospitals to bill HCPCS code G0463 for a hospital-based clinic visit. PPS payment will be the same for any clinic visit, regardless of location (on- or off-campus) or level of service provided. This payment change applies only to the hospital technical component of clinic visits; physician professional component payment will not be affected by the rule. Physicians will continue to bill their level based on the CMS documentation guidelines for E/M assignment. Ancillary services will continue to be paid separately in most situations. The national nonwage-adjusted payment rates for 2014 and 2013 are in the table below:

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<td>99201</td>
<td>$56.77</td>
<td>G0463</td>
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<tr>
<td>99202</td>
<td>$73.68</td>
<td>G0463</td>
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<td>$96.96</td>
<td>G0463</td>
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</table>
The actual effects of the clinic payment change will vary based on the volume and distribution of the individual clinic’s Medicare visits. Those clinics whose visits have historically tended to fall in E/M levels 1 and 2 (99201, 99211, 99202, 99212) likely will see an increase in total payments from Medicare. Those clinics where the visits historically were coded using levels 3, 4 and 5 (99203, 99213, 99204, 99214, 99205, 99215) will see a reduction in Medicare outpatient reimbursement. The closer the historical distribution is to a true bell curve, the greater the payment reduction. In its June 2013 report to Congress, the Medicare Payment Advisory Commission (MedPAC) addressed the Medicare payment differences across different ambulatory settings. The report cited a need to address these payment differences, because many services are shifting from physicians’ offices to hospital-based clinics, increasing both Medicare expenditures and beneficiary coinsurance responsibilities. In the final rule, CMS discussed the cost differences in providing similar services in a clinic physically situated on the hospital campus compared to a clinic in an off-campus, provider-based clinic. CMS did not attempt to rectify the payment differences in 2014. Instead, CMS intends to develop a mechanism to identify services provided in off-campus, provider-based clinics and study the issue further.

For the near future, CMS will continue to pay clinic visits provided in the hospital at a higher rate than those provided in a freestanding physician office. Provider-based status remains, for now, a more favorably reimbursed regulatory status, regardless of visit code distribution.

**Packaging Services**

Another area of significant impact for hospital clinics paid under OPPS is the expansion of categories of packaged items and services where payment is considered included in payment for the procedure. From its inception, OPPS has packaged services such as supplies, anesthesia and recovery time. CMS has gradually packaged payment for more and more services that it considers “integral” to the primary procedure. The intent has been to move OPPS from a fee schedule, “per click” payment methodology to a prospective payment system that more closely resembles Medicare DRGs.

Of the seven additional categories of services originally proposed by CMS, only five were added in the final rules:
- Drugs, biological and radiopharmaceuticals that function as supplies when used in a diagnostic test or procedure (such as contrast media and nuclear medicine isotopes)
- Drugs and biologicals that function as supplies in a surgical procedure, including skin substitutes
- Certain clinical laboratory tests
- Device removal procedures that are billed with other surgical procedures involving repair or replacement of the device
- Certain procedures described by “add-on” codes. This list of packaged “add-on” codes is selective and does not include the range of drug administration “add-on” procedures; had CMS elected to package the drug administration codes, significant revenue losses would have resulted for services provided in the Emergency Department, Infusion Clinics and Observation status.

CMS also elected not to package ancillary services with status indicator “X,” which includes most imaging procedures and cardiac diagnostic tests. The only exception is the decision to conditionally package payment for CPT 93017, Cardiovascular Stress Test by Exercise or Pharmacological Stress. The code will be packaged when billed in combination with myocardial perfusion imaging, billed with CPT 78452.

CMS finalized the proposal to package clinical laboratory tests in the OPPS when they are “integral, ancillary, supportive, dependent or adjunctive” to a primary service or procedure. Molecular pathology, evaluation of surgical specimens and other select CPT codes are exceptions to the packaging rule. Medicare will continue to pay separately for an otherwise packaged test in either of the following situations:
- The lab test is the only service provided to the beneficiary on that day of service.
- The lab test is ordered for a different purpose and by a different physician than the primary service.

Further instructions on billing unrelated lab procedures on a bill type 14X will be issued to the contractors. A packaged code list, separated by subcategory, was released as Addendum P to the final rule.

CMS stated in the final rule that many of these changes are intended to reduce administrative burden on the providers. However, Medicaid, Tricare and commercial insurers still require detailed coding of clinic visits and separate billing of services packaged by Medicare.

In addition to the changes noted above, the CY 2014 OPPS rules also contain regulations regarding:
- Ambulatory Surgical Center Payment Updates
- Hospital Outpatient Quality Reporting (QDR) Programs
- Ambulatory Surgical Center Quality Reporting (ASCQR) Programs
- Changes to Organ Procurement Organization (OPO) regulations
- Revisions to the Quality Improvement Organizations Regulations

Details of these regulations and a copy of the full CY 2014 OPPS Final Rule can be found on The Office of the Federal Register website.

Becky Grupe, rgrupe@bkd.com
Sally Hardgrove, shardgrove@bkd.com
Sincere appreciation is extended to our corporate sponsors for 2013. Your support of our Chapter significantly improves our ability to offer quality programs to our members. Please consider joining our fantastic group of sponsoring organizations.

if you are a service provider, please contact:
Mea Austin  785-842-0726
Mary Knollmeyer  913-791-3500 x 4018
Where Has The Year Gone?

It is this time every year when I ask myself that question. Recently, during a three hour car ride by myself, I had several follow-up questions. What have I accomplished this year? Was it a good year or a bad year? What will next year be like? Should I drive through McDonalds or eat a salad when I get home? Just to clarify, these questions are really thoughts. Even though I spend a lot of time in my car going to board meetings this time of year, I have not yet started talking to myself.

These questions/thoughts led me to the question – What has Region 8 accomplished this year? There have been many great accomplishments. Here are just a few:

National Awards
For the 2012-2013 HFMA year, Region 8 received 34 awards. These awards included five Hottum Awards for Educational Excellence, eleven Chapter Yerger Awards, two Multi-Chapter Yergers, and two Platinum Awards for Education (this was the first year this level was awarded, and Nebraska and Sunflower Chapters were two out of only six Platinum Awards in the country!)

HFMA Region 8 MidAmerica Summer Institute
This first year event organized by numerous chapter leaders was spectacular! We could not have imagined a better outcome to all the time and commitment that went into the event. Don’t miss the next HFMA Region 8 MidAmerica Summer Institute being held in St. Louis August 18 – 20, 2014.

Education! Education! Education!
Through chapter events and Region 8 webinars, members of the Region 8 chapters had access to the highest quality education in the country.

Leadership
The Region has once again been blessed with great leaders. Each year the volunteers that serve at the chapter level amaze me with their hard work and dedication. Additionally, Region 8 has two representatives on the National HFMA Board of Directors. Carol Friesen and Mike Allen (he may have transferred to another Region, but we will still claim him) have done a great job representing our Region.

Members
The members of the chapters in Region 8 are the reason for these accomplishments. It’s your support of the chapter leaders, attendance at education events and commitment to the profession that make our Region the best Region in HFMA!

This list could go on and on and on. I look forward to the continued success of Region 8 this coming year!

My telephone number is 402-330-2660 and my email address is rhoffman@seimjohnson.com. I welcome your questions and comments at any time!

HFMA’s Virtual Conference

Mark your calendar for this live event—free to HFMA members. HFMA’s Virtual Conference provides you with unique and cutting edge programming—all from the convenience of your home or office.
Analysis of the viability of hospital and healthcare system business units and service lines must address total value of the entities to the strategic and financial goals of the organization. A business/service line analysis framework provides insights for business leaders on using resources wisely while serving community needs.

**Analysis Framework Considerations**

The framework should consider mission, nature of operations, market environment/competitive position, financial performance, and compatibility with new-era needs and competencies.

<table>
<thead>
<tr>
<th>Framework for Business/Service Analysis</th>
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<tr>
<td><strong>Mission</strong></td>
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<td><strong>Nature of Operations</strong></td>
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<td><strong>Market Environment/Competitive Position</strong></td>
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<td><strong>Financial Performance</strong></td>
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<td><strong>New-Era Compatibility</strong></td>
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The following are full descriptions of each framework element.

**Mission.** Considerations include:
- Benefit provided to and support provided by the community
- Whether a void would be created if the business/services were not provided
- Whether other organizations would appropriately fill that void

**Nature of operations.** Considerations include:
- Whether patients/customers flow across the businesses and services or whether the operations are detached and separate
- The extent to which the business/service functions as a stand-alone operation (i.e., systems, management, funding of operations, utilization of shared services)
- The alignment of associated strategic requirements and financial incentives with the core operations of the organization
- The downstream or upstream implications of eliminating this business/service

**Market environment and competitive position.** Considerations include:
- The attractiveness and demand for this business/service
- The key industry drivers and requirements for success of this business/service
- The intensity of competition and the organization’s ability to differentiate from others
- Whether the organization has a competitive position that is relevant and sustainable in its market

**Financial performance.** Considerations include:
- The historical financial performance of the business/service
- The level of financial performance generally achieved within the industry for this type of business/service
- Future capital requirements and the level of performance that can be expected
- The estimated valuation of the business/service
- The impact divestiture would have on the overall credit profile and the financial position of the organization
- The impact development of a new business/service or acquisition would have on the credit profile/financial position of the organization

**New-era compatibility.** Considerations include:
- Whether the business/service supports longitudinal patient management across the continuum of care
- The business/service’s impact on the organization’s brand and image
- Whether this business/service has a material cost structure advantage or disadvantage relative to competitors
- Whether the organization can be an essential provider of this business/service with sufficient scale of operation to succeed

**Categories Define Analysis Approach**

Ultimately, discussions related to an organization’s businesses and services must openly address total value of the business to determine if it is the best use of scarce resources available to meet community needs.

*Article continues on next page*
The following figure provides an appropriate evaluation matrix, with four categories of businesses and services. Tough decisions will need to be made and implemented by hospital and health system boards and executive teams.

Medical Center Decides to Divest Two Businesses

Given the significant capital investment requirements of its new business model, one academic medical center evaluated its options in the changing landscape. The evaluations started with the development of a financially oriented business plan for each service line and business unit currently owned and operated by the organization. The medical center owned a home health business and a reference laboratory business, among other entities.

Each business plan was supported by fact-based assumptions about volume, revenue, expense, and associated capital costs going forward. Sensitivity and scenario analyses were completed for the key drivers to understand the range of possible outcomes. Each plan was integrated into the organization’s long-term strategic financial plan in order to understand the impact of the businesses on the organization’s strategic and financial success going forward.

Home health business. The academic medical center needed access to high-quality, post-acute care in order to manage patients’ health following discharge, thereby minimizing readmissions. But the economics of its home health business were difficult. Competition was intense in its market. The business was not profitable, and its losses were expected to increase. The medical center was concerned about its ability to sustain the business in the long run and provide the necessary capital and resources to maintain ongoing quality services. It decided to divest the home health business to one of the major players in the market, which could continue providing quality services more effectively and efficiently in the community. The divestiture would mitigate the medical center’s losses and enable the organization to redirect capital capacity to initiatives in its core competency and mission-driven areas.

Reference laboratory business. The academic medical center’s reference laboratory business, on the other hand, was very profitable, having been significantly capitalized over the years. But the business did not meet leadership’s criteria for core services. Two large laboratory companies, which already provided services in the community, proposed to purchase the medical center’s business to increase their market penetration. The medical center decided to divest its reference lab business and use the proceeds to build its balance sheet in support of core strategic initiatives.

Analysis Framework Aids in Decision Making

When deciding the fate of a business line or service, paying attention to a single consideration could result in faulty decision making. A business/service line analysis framework that includes many considerations and a service evaluation matrix assists hospital and health system leaders in taking a holistic approach to determining the value of a business/service and making judicious decisions.
The federal government has enacted a two year budget agreement and is discussing a fix to the physician sustainable growth rate formula. The U.S. House of Representatives and U.S. Senate passed a budget agreement that provides a budget compromise for fiscal years 2014 and 2015. The agreement extended the Medicare dependent and low-volume payment programs, retroactively through March 31, and extends the sequestration cuts to hospitals to 2022 and 2023. The effect on Missouri’s hospitals for the Medicare dependent and low-volume payment extensions will result in an additional $4.3 million. The effect of extending the sequestration into 2022 and 2023 will result in a reduction of Medicare payments amounting to $208 million.

In addition to the revisions to certain Medicare payment programs, the budget agreement also restores the Affordable Care Act’s Medicaid disproportionate share cuts in fiscal year 2014 while delaying fiscal year 2015 cuts for one year and extending the cuts an additional year to 2023. The effect for 2014 will be a reduction to the estimated cuts in payments of $27.3 million and pushes 2015’s cuts amounting to more than $31.3 million into fiscal year 2016. This creates a Medicaid DSH payment reduction cliff in 2016, increasing the cut from $30.8 million to $62.1 million.

The budget agreement also contains a short-term physician payment fix, which averts the 20 percent payment reduction through March 31. Averting the SGR rate cut and extending the current level of payments to physicians for 90 days allows additional time for Congress to focus on a permanent fix. The SGR fix has bicameral and bipartisan support, which includes very little legislative differences. However, funding for the SGR fix has yet to be determined.

The Missouri Hospital Association will continue to work diligently with community leaders and state officials to decrease Missouri’s uninsured rate. Medicaid transformation will be the cornerstone of MHA’s advocacy efforts during the 2014 state legislative sessions. Throughout the past year, support has been increasing from hospital boards, local and state Chamber of Commerces and other coalitions. Once again, MHA will be calling on these organizations and hospital leaders throughout the state to provide support in this effort.
Name: Todd Goforth 
Employer: North Kansas City Hospital 
Title: Patient Accounts Supervisor

Why did you join HOA-HFMA? 
I joined HFMA for education opportunities and, as I’m fairly new to Healthcare, to meet other people in this field.

Marital status? Children? 
I have been married for 26 years to my wife, Christine. We have two sons, Collin and Alex, who both attend college.

How long and why do you work in healthcare? 
I've worked in healthcare for 2 ½ years. Even though I don’t have a clinical background, I wanted to be in a field where I could help people.

What is your personal or professional motto 
“You only fail when you stop trying.” – Albert Einstein

What do you like most about your job? 
I really like the people that I work with here at NKCH and that I get the opportunity to help patients. Being a patient can be stressful both physically and financially, and it's rewarding to be able to make their experience here a positive one.

Please describe some of your favorite accomplishments or biggest challenges met: 
After taking a 20 year break, I went back to college and recently graduated with my B.S in Business Management.

What advice would you give to someone entering the healthcare field? 
Healthcare is challenging and is always changing. The next few years will include major changes in the Healthcare landscape. If you like a career that is financially and emotionally rewarding, this is the place to be.
Welcome New Members!

Jill C. Anderson  
Revenue Cycle Executive  
Cerner Corporation  
Work Phone: (816) 448-1691  
jill.c.anderson@cerner.com

Todd Goforth  
Supervisor, Patient Financial Services  
North Kansas City Hospital  
Work Phone: (816) 691-5269  
todd.goforth@nkch.org

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**Come Join Us!**
HFMA volunteers receive opportunities for professional development, information, networking, and advocacy and earn Founders points when they participate in a chapter committee.

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**January Sponsor Spotlight: McGladrey LLP**

The rapid evolution of the health care field presents a variety of tough challenges. Improving patient care and safety while coping with ever-rising costs is difficult enough. But today’s health care leaders must also deal with complicated and fast-changing reimbursement systems, cumbersome tax codes and unpredictable revenue cycles — all while managing disparate risks and pursuing capital for investments in everything from information technology to advanced medical equipment. What's more, industry executives must adapt to an array of complex changes mandated by recent health care reform legislation.

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The 60th Anniversary Gala was held on October 10, 2013, at the Arrowhead Stadium. Former Chiefs Player Kevin Lockett provided the keynote address and several past presidents shared favorite memories.

The following were presented with awards* during the event: Newest Members – Haley Bonney and Nate Gifford; Served as President (twice) – Mary Knollmeyer; and Most Membership Years – Gordon Glass. Each attendee received an engraved, commemorative glass mug, and the day ended with a tour of the stadium. *Awards were based on those registered for the meeting.
1 L to R: Kerrie Pence, Andrea Lindsay, Kevin Lockett, Mary Jonscher, and Natalie Lee

2 Mary Knollmeyer, past HOA President, “Reporting live from Arrowhead Stadium.”

3 Michael Scholtes – “I emphatically deny the rumor that I will be coaching for the Oakland Raiders next year!”

4 L to R: Cindy Smith and Nate Gifford. “Go Chiefs!”

5 L to R: Jeff Morgan and Jim Mozena talk game plays.

6 L to R: Frank Tokic, Jerry Plagge, Sue Brammer, and Gordon Glass

7 Arrowhead Stadium – Impressive view from the press box
The 17th Annual Joint Fall Conference was back in Kansas City this year, held at the Adams Pointe Conference Center in Blue Springs, October 23rd through the 25th. The conference had close to 100 attendees, including 25 from the Heart of America Chapter.

The conference kicked off on Wednesday afternoon with opening remarks from our own HOA President, Andrea Lindsay. Those who attended the first session were treated to a presentation by Jerry Teplitz, J.D., PhD, “Increasing Your Professional Power While Managing the Stress of Change”, which provided strategies for enhancing communication in the workplace, as well as some unconventional techniques for managing stress. Other speakers included Bowen F. White, M.D., Leigh Patterson from Cox Health and Branson and Betsy Smith of Arvest, who focused on “New Lock Box Functions”. Shauna Woody-Coussens of BKD, shared her expertise and experience in detecting fraud in the workplace, and Katherine Murphy of Passport Health discussed the ongoing issue of hospital readmissions. Other speakers on Thursday included Allie Alvarez of Nueterra and Marcia McCoy of Saint Luke’s, Mike Nichols of McGladrey, and Sandy Soerries with Medical Revenue Solutions. The final day of the conference included a presentation by Andrew Wheeler, MHA, who provided up-to-date information on the Affordable Care Act and its impact on Missouri hospitals.

Friday also included a presentation by Michael Bohon, Healthcare Solutions Bureau, and Rebecca Bool, PhD, who discussed the risks and benefits of Value-Based Care models.

The conference also provided multiple opportunities for networking and entertainment. A reception and trade show were held on the first day of the conference, and Thursday evening included dinner and a magic show with professional magician, Magic Scott.

We would like to thank all of the speakers and conference attendees who made this year’s Joint Fall Conference a success! Please make plans to join us again next year.

L to R: Jim Mozena (with Dr. Bowen White): “Healthcare really is a juggling act.”

Shauna Woody-Coussens, BKD, shares her expertise in fraud detection.
Allie Alvarez, Nueterra, discusses the Nueterra Global Alliance.

Katherine Murphy, Passport Health, presents “Hospital Readmissions: The Rendezvous is Over”.

Speaker Michael Bohon of Healthcare Solutions Bureau.

Nate Gifford proudly displays the vendor prize he won, one of several giveaways provided by the event sponsorship.

Becca Bool, PhD, discussed value-based care models.
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