



healthcare financial management association

Kentucky Chapter financial scene

December, 2004

Upcoming Events

Winter Institute

Friday, January 21 2005
Louisville Marriott East

Spring HFMA Meeting

Thursday, March 31 2005
Friday, April 1, 2005
Embassy Suites Lexington
Vendors (potentially)

Summer Institute

Thursday, July 28 2005
Friday, July 29, 2005
Marriott Downtown
Louisville

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A Message From Our Regional Executive

By Katie Black, CHFP, Region IV Executive



It is my honor and pleasure to serve as the 2004-05 Regional Executive (RE) for Region

chapter and making them feel welcome. Introduce them to everyone and include them in your networking activities. We all like to feel "in on things."

...enjoy the personal satisfaction of the achievement.

IV which includes North Carolina, Maryland, Virginia, Washington Metro, West Virginia and my home chapter, Kentucky. For a year and a half, I was an RE-in-Training, learning the responsibilities of the position and getting to know the leaders from all six chapters. It has been a great experience and a model for succession planning.

The RE's role (formerly Chapter Liaison Representative) has expanded significantly over the past two years taking on the new responsibility of volunteer and policy link between the chapters of the region and the National Board of Directors. Our Regional Executive-Elect is Christopher Johnson from the North Carolina chapter. Chris and I are working closely together to ensure that the Region's Presidents and Presidents-Elect have a strong voice in shaping the future of HFMA.

Two important national initiatives for this year are Member Retention and Certification. You, as members, can **play a very important role in member retention** by seeking out new members in our

You all know that Certification is a passion with me. **The value of Certification** in your career is proven. It is a fact that certified members really do earn higher incomes (if that is of interest to you). This is a commitment to professional excellence but you will also enjoy the personal satisfaction of the achievement.

A personification of commitment to certification in our chapter is Chris Ellington, Vice President of Finance at Appalachian Regional Healthcare. Chris, a newly certified member himself about a eighteen months ago, is making certification a reality in his organization by requiring his senior finance leadership to study and sit for the certification exams which becomes part of their annual evaluations. Chris has pledged ARH support for these leaders in the form of study guides, exam fees, study time on the job and his personal ongoing encouragement.

Those of you who may have been thinking about becoming certified, take the plunge and become part of the elite. You will be glad you did.

HFMA National's On-line Membership Directory

Have you visited HFMA National's On-line Membership Directory lately? Here's the link: http://www.hfma.org/dual_login.cfm. When you select "HFMA Directory" not only can you search for members of our chapter, you can also search for all of your HFMA colleagues by name, company, and location — regardless of chapter! You may also view your current contact information and make edits to your profile, as well as view any products you have ordered, events you have registered for, your CPE credits, your Founders points, and more!

It is vital that HFMA has your correct information, so please take a moment to view your record now. By doing so, you will ensure that HFMA continues to provide you with valuable information and insights that further your success.



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Editorial Mission

Financial Scene supports the mission of the Kentucky Chapter by serving as a key resource for individuals involved or interested in the financial management of health care.

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.

Publication Objective

Financial Scene 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

Financial Scene 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. HFMA Founder Points are granted for any articles published in *Financial Scene*.

Deadline for Articles:

January 2, 2005
April 1, 2005

beyond the numbers

PRESIDENT'S MESSAGE *David Kottak*



....Corey's coach was thinking "Beyond the Numbers," this year's National slogan.

Dear HFMA Member:

Basketball season is rapidly approaching and as a lifelong resident of Kentucky I can't help but get excited. Last night I attended my fifteen year old son Corey's initial game of the 2004/2005 season. In the eyes of an unbiased parent (I am talking about me here) he performed well. His "box score" for the game showed positive contributions in just about every category: points, rebounds, assists and steals.

As we went through our usual father / son post game debriefing, which I certainly take more pleasure in than he does, I asked what his coach had to say after the game. Interestingly enough his coach did not focus on the "box score" categories. Instead he spoke to Corey about the need for leadership and the importance of teamwork. In today's "microwave" environment I couldn't help but find this attitude refreshing.

It struck me that Corey's coach was thinking "Beyond the Numbers," this year's National slogan. He was less concerned about the results of one game than he was about creating the fundamentals and culture for long term success. While it remains to be seen what kind of year the Ballard High School Junior Varsity Basketball team will have, I certainly believe that Coach Huff is on the right track.

This issue of the *Financial Scene* contains a number of articles which should be of interest to you as Healthcare Financial Managers. Some of the major challenges impacting Kentucky Hospitals at both the Federal and State level are discussed in detail. While it remains to be seen what impact the recent elections will have on healthcare funding these articles will provide valuable insight.

I give a special thanks to Larry Vaughn of Commonwealth Health Corporation. Larry has graciously volunteered his time and talents to assist Bob Brandenburg and the Newsletter Committee. Larry has made a number of tremendous improvements to the layout and appearance of the *Financial Scene*. Thanks for your time and efforts!

Very truly yours,

David C. Kottak
President

Why Become A Certified Healthcare Financial Professional (CHFP)?

By Carl Biber, CPA, CFE, carlbiber@catholichalth.net

When I first started with CHAN Healthcare Auditors, a company focused exclusively on providing internal audit services to the healthcare industry, I knew my limited healthcare experience would make delivering value-added services to our clients a challenge. That thought not only troubled me, but motivated me. I decided to pursue two major initiatives to help get me to where I needed to be:

1. Pursue graduate work that concentrated in health care, and
2. Pursue the CHFP credential offered by the HFMA.

This was important to me because I wanted to fulfill my company's mission "to provide high quality, cost effective internal audit services that exceed the expectations of our owners and clients" and the mission of our clients. I believed that in order for me to be trusted, respected, and relied upon as an independent, yet effective team member, I had to learn as much as I could and turn it into value.

I didn't know much about the HFMA at first, or about the credential, but it didn't take long for me to learn that a lot of people in the industry, including those in our own company, looked to HFMA as a valuable resource that's reliable and timely.

What was my approach?

- I scheduled my time to take the Core and Specialty exams when it wasn't so hectic. For me, this was during the summer, which provided me more focused time to study without the burden of simultaneous graduate classes.
- I attended a Coaching Course sponsored by the Kentucky Chapter in January 2004. Not only were the speakers knowledgeable, but their candid approach provided an attendee the tools to study in an effective and efficient manner. After the session, I did not feel overwhelmed. Matter of fact, I felt confident that with a little elbow grease, I could take the exams and obtain passable scores.

- For both the Core and Specialty exams, I obtained the respective study guides from the Kentucky Chapter and read both completely four times. I realize this sounds like a lot, so adjust your goals accordingly. I would read for about 30 minutes every weekday, regardless of the number of chapters I covered.
- I took each of the chapter quizzes, completed the End-Of-Course exam 3

times and went to the HFMA website a couple of times and looked over the 10 or so sample questions they had posted to make sure I didn't miss anything important.

- I took the Core exam first and followed with the Accounting/Finance Specialty exam about 6 weeks later.

I'm sharing this story to let each and every reader know that studying and

Continued on page 4

Meet The New Members Added From June 2004 to September 2004

Gail Hurt

Staff Accountant
Clinton County Hospital

Lisa McRoberts

Accounting Manager
Fleming County Hospital

Michael Lawton

Vice President Managed Care
Norton Healthcare

John W. Artis

Partner

Gordon Hippe

Manager
Dean, Dorton & Ford, PSC

Lori L. Gondry

Supervisor Of Internal Audit
Kindred Healthcare

Paul B. Gray

Audit Manager
Chan Healthcare Auditors

Heather E. Combs

Senior Network Account
Manager
Unitedhealthcare

Lindsey New

Payables Clerk

Michael Pendleton

Enterprise Vice President
Mckesson

Michael D. Thomas

Student

Michael L. Lynch

President

Autumn McFann

Director Of Internal Audit
King's Daughters Medical
Center

Jeff J. Blau, MD

Reviewer
Health Alliance

Candice Duncan

Student

Shawn Adams

Ernest & Young, LLP

Jeff D. Kingery

Director Pt Financial Services
Flaget Memorial Hospital

T. Scott Taylor

Member
Taylor and Associates, PLLC

Richard Carrico

VP Finance
Norton Healthcare

Tina M. Blakeman

Accounting Supervisor
Jane Todd Crawford Mem
Hosp

LaDonna Dozer

Manager Patient Billing
Hardin Memorial Hospital

Christopher M. Wilson

Systems Support Manager
Norton Healthcare

Scott Reed

Staff Accountant
Blue & Co. LLC

Robert C. Besten

Nurses Registry & Home
Health

Rhonda Potts

Accounting Manager
Mary Chiles Hospital

Susan Starling

President/CEO
Marcum & Wallace Mem
Hospital

Wade R. Stone, CHE

Administrator
The Medical Center At
Scottsville

Susan Strehle

Executive Administrator
Kingsbrook Lifecare Center

Debi S. Rissover

Patient Financial Services
Mgr.
OhioHealth

Adam L. Hanauer

Assistant Regional Director
Aim Healthcare Services, Inc.

Chris McClurg

Controller
Consolidated Health Systems

Monica J. Guenin

Senior Provider Auditor
Anthem Blue Cross

Mark Bates

Executive Vp Operations
Healthcare Recoveries

Certified Healthcare Financial Professional, continued

passing these exams is not a complex mound of spaghetti in search of a non-existent meatball. It's a simple, straightforward process that with a little energy, can reward you with a respectable credential that acknowledges dedication and commitment to the health care profession. The knowledge that I obtained in preparing for the exams equipped me

with a knowledge base that not only helps me to fulfill the mission of CHAN Healthcare Auditors and our clients, but it provides me with a positive foundation that enables me to add value to the clients we serve.

I realize this may seem overwhelming – I understand. I have a family with two young girls, a full-time job, attending two graduate classes, and all the events of an average Kentuckian. But the time I spent on the material was no more than 30 minutes a day. This worked well for me

and allowed me to pass both exams this summer on the first try. Set up your own routine, and find whatever it takes that works for you.

The proctor I worked with (Katie Black) was angelic, considerate, patient and kind in everyway. I'm grateful Katie created a relaxed and appropriate environment for taking the exam.

Are You Considering Implementing Sarbanes-Oxley Act Section 404?

By David Richard, Shareholder, Dean Dorton Ford, PSC

Management and auditor reporting on internal controls required by Section 404 of Sarbanes-Oxley might give a company's (organization's) board great comfort and peace of mind knowing that its company's (organization's) management was going "that extra mile" to assure them that the effectiveness of the company's (organization's) internal control structure and procedures over financial reporting is being diligently addressed. Such a commitment to oversight might very well make sense to larger tax-exempt organizations – especially those with large regional or national constituencies or those regularly rated by independent charity evaluators like charitynavigator.org.

So what does complying with Sarbanes-Oxley *Section 404* mean? *Section 404: Management Assessment of Internal Controls* requires each annual report of an issuer (publicly traded company) to contain an "internal control report," which shall: (1) state the responsibility of management for establishing and maintaining an adequate internal control structure and procedures for financial reporting; and (2) contain an assessment, as of the end of the issuer's fiscal year, of the effectiveness of the internal control structure and procedures of the issuer for financial reporting.

Each issuer's auditor shall attest to, and report on, the assessment made by

the management of the issuer. An attestation made under this section shall be in accordance with standards for attestation engagements issued or adopted by the Public Company Accounting Oversight Board (PCAOB). The attestation engagement shall not be the subject of a separate engagement.

According to a Financial Executives International (FEI) survey (www.fei.org/news/404_survey.cfm), the cost of compliance with section 404 revealed a 38% increase on average in audit fees. The survey found companies are expecting to document processes

are hiring third parties (generally accounting firms other than their auditors) to assist them in their internal assessment. Per the AICPA's *Internal Control Reporting, Implementing Sarbanes-Oxley Act Section 404*: "Entities that lack sufficient resources or expertise may look to third parties for assistance. Completely outsourcing the entire project to a third party normally would be inappropriate for management to do – ultimately, management should remain responsible for evaluating and reporting on the effectiveness of the entity's internal control. However, third

"....compliance with section 404 revealed a 38% increase on average in audit fees."

that cover roughly 92 percent of their total revenues. They expect their auditors to test between 42 and 57% of those documented processes.

Most management assessments are likely to be conducted in accordance with the Committee of Sponsoring Organizations of the Treadway Commission (COSO)'s *Internal Control – Integrated Framework*. This document, which was originally published in 1992, established a framework for internal control and provided evaluation tools that business and other entities could use to evaluate their control systems. A copy of the report can be obtained by calling the American Institute of CPAs (AICPA) at (888) 777-7077. Many issuers

parties may be engaged to participate as part of the project team or to provide other services such as training."

The management assessment is a substantial undertaking requiring specific skills. For non-publicly traded entities, the company (organization) could choose to bypass the management assessment and hire its auditors or another CPA firm to conduct an examination and attest to the state of the company's (organization's) internal controls in accordance with the COSO standards or with attestation standards established by the AICPA.

Issues Facing Kentucky Hospitals

By Carol Blevins Ormay, Vice President/Membership Services, Kentucky Hospital Association

Despite the payment “fixes” in the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), Kentucky hospitals continue to struggle to obtain adequate reimbursement for Medicaid and Medicare patients.

In state fiscal year (SFY) 2004, Kentucky hospitals received \$197 million in Medicaid DSH payments approximately \$171 million was paid in October 2003, and a supplemental DSH payment of \$26 million was paid in June 2004 as a result of Congressional passage of the MMA which increased federal DSH funding for Kentucky by 16 percent beginning in SFY 2004.

In SFY 2005, Kentucky hospitals are slated to receive \$171 million of the federally allotted \$197 million in DSH funds. The decrease is due to the state not appropriating adequate monies to draw down the available funds from the federal government (which would cost the state an additional \$8 million) – even though the cost of providing indigent care has increased. Because indigent care costs are escalating, it is critical that hospitals receive 100 percent of all federal DSH funding available.

The legislature must appropriate a total of \$37 million in state matching funds to draw all federal DSH dollars available for private acute care and mental hospital DSH. State law directs use of the hospital provider tax to fund state DSH match. Funds to support the full DSH match are available because hospitals pay \$150 million in taxes annually, and more than the \$37 million needed to fund DSH was collected prior to the annual October DSH payment.

Unlike other businesses that are taxed based on net income, hospitals are taxed 2½ percent of gross revenues (collections) for inpatient and outpatient services. Kentucky’s hospital tax is out of step with the rest of the country – 44 other states either do not tax hospitals (38) or return 80 percent to 100 percent of the funding raised by a tax to hospitals for indigent care and to cover their Medicaid shortfall.

Taxes paid by hospitals have doubled from \$74 million in 1994 to nearly \$150

million in 2004, which generated \$500 million for the Medicaid program in 2004. In 2003 only 17 percent of the funding generated by the hospital tax was returned to hospitals. Overall Medicaid inpatient cost coverage is currently at approximately 69 percent (compared to 95 percent in 1994 when the tax was enacted). This is well below the *zone of reasonableness* defined by a federal judge and recognized by the state in individual hospital rate settlements this year.

Hospitals are the second largest private employer in the Commonwealth and are often the largest private employer in their county. Kentucky’s hospitals cannot continue to pay an ever increasing tax, provide increasing amounts of indigent care and continue to provide quality patient care with Medicaid payments covering only 69 percent of costs.

On the federal side, Congress will return to Washington the week of November 15 and will either pass a comprehensive (omnibus) spending bill, rolling the remaining appropriations bills into one, or pass another continuing resolution to keep the government up and running until the 109th Congress convenes in January.

Two key hospital issues could be addressed during the lame duck session, including:

The 75% Rule — The House-approved Labor, Health and Human Services spending bill includes a moratorium on enforcement of the 75% Rule (prospective payment for inpatient rehabilitation facilities) until 60 days after the Government Accountability Office completes its study, assessing the impact the current rule has on access to rehabilitation services. The Senate Appropriations Committee approved a bill that includes a one-year moratorium on enforcement of the 75% Rule, but instead asks the Institute of Medicine to conduct the impact analysis. The measure still needs to be approved by the full Senate.

J-1 Visa Waiver Program — The House passed legislation which would renew the J-1 visa waiver program for two years, and help staff medically underserved communities with foreign physicians. The Senate Judiciary Committee passed a slightly different version, but the Senate adjourned before voting on the measure. Kentucky regularly fills its allotment of J-1 visa physicians and this program needs to be renewed. If this bill does not pass, the only J-1 visa physicians available to Kentucky would come through the Appalachian Regional Commission. *Currently, the only member of the Kentucky Congressional Delegation supporting this legislation is Fifth District Congressman Hal Rogers.*

Two other hospital issues, including the extension of the enhanced federal matching rate (FMAP) and the cost-based payment for reference lab services for critical access hospitals (CAH), remain in committee. **The FMAP legislation has no Kentucky sponsors**, although the expiration of the extension cost Kentucky \$140 million on June 30, 2004. The CAH lab legislation has two Kentucky sponsors: Fifth District Congressman **Hal Rogers** and Sixth District Congressman **Ben Chandler**. It is unlikely that these bills will move in the lame duck session unless they are rolled into an omnibus budget bill.

With the federal and state government being the primary payer for patient care, it is critically important that hospital executives and other senior managers talk to lawmakers about reimbursement issues. *Numbers count in the legislative process!* Lawmakers need to hear how their decisions affect their area hospitals. For more information about KHA’s state and federal legislative priorities, visit the Advocacy section of the KHA Website at www.kyha.com.

Want to plan ahead?

ANI 2005

June 26–30, 2005 • Las Vegas, NV

Medicare Modernization Act: CMS Finalizes Regulations

In what has apparently been a busy summer at CMS, the federal agency is putting the Medicare Modernization Act of 2003 (MMA) into action by finalizing previously proposed regulations.

CMS has finalized a spate of regulations first proposed in the May 18, 2004 Federal Register. These final regulations implement payment and policy changes for acute care hospitals required by parts of the MMA and were published into final regulations on August 11, 2004 Federal Register and generally become effective on October 1, 2004.

These new and far-reaching final regulations cover a broad range of areas. Highlights include:

- Increased payments to acute care hospitals for inpatient services in fiscal year 2005;
- Significant impact on “hospitals-within-hospitals”; and
- Creation of a link between quality services to Medicare beneficiaries and payment for those services.

Payment Increases. CMS projects that the combined impact of the inflation update and other changes will yield an average 5.7 percent increase in payments for urban hospitals in fiscal year 2005, while rural hospitals will see an average increase of 6.2 percent. In FY 2005, Medicare payments to approximately 3,900 acute care hospitals under the inpatient prospective payment system (IPPS) are projected to be \$105 billion, up from a projected \$100 billion in fiscal year 2004.

Hospitals-Within-Hospitals. The regulations modify several policies affecting arrangements in which a long-term care hospital (LTCH) is located within another hospital. Changes to the hospital-within-hospital concepts include revisions to certain referral and expenditure limitations from the host hospital.

Quality Reporting. As required by the MMA, hospitals reporting specified quality data will receive an inflation update equal to the hospital market basket percentage increase of 3.3 percent. Hospitals that do not report this information will receive the market basket percentage increase less 0.4 percentage points, or a 2.9 percent increase. The market basket percentage increase refers to the projected rate of inflation for goods and services used by hospitals in caring for Medicare beneficiaries. This is the first time that hospital payment rate increases have been related to performance, in this case by providing incentives for making quality of care information available to patients and health professionals. According to CMS, the overwhelming majority of acute care hospitals will be eligible to get the full update for 2005.

Metropolitan Statistical Areas. The final regulations also address the impact of the new Metropolitan Statistical Area (MSA) definitions on hospital geographic classification. The MSAs, which were developed by the Office of Management and Budget on the basis of 2000 Census data, will replace the currently used Metropolitan Statistical Areas and New England County Metropolitan Areas, which reflect 1990 data. As a result of these changes, a number of hospitals currently located in

rural areas will benefit from being classified into areas with higher payment rates.

For hospitals that will experience a decrease in their wage indices, CMS has decided to provide for a phase-in of the new MSAs over a two-year period. Hospitals that will experience an increase as a result of the new MSAs will receive the full benefit of the new labor markets in FY 2005. In addition, hospitals that had been reclassified by the Medicare Geographic Classification Review Board will continue to be paid according to their reclassification. Those hospitals that had applied for reclassification in 2005 will be permitted to withdraw their applications if reclassification will no longer be to their advantage. Hospitals that had previously been reclassified to an adjoining MSA that has been split under the new MSA definitions will be reclassified to the new MSA nearest them.

For hospitals in areas that have been redesignated from urban to rural as a result of the labor market area changes, CMS is providing a three-year period during which those hospitals will continue to be paid as urban hospitals.

The MSA changes also have an impact on hospitals that are entitled to automatic geographic reclassification because they are located in rural counties whose workforces tend to commute to adjacent urban areas. The number of such counties is increasing from 28 to 97 under the final regulations.

Critical Access Hospitals. The final regulations also implement a number of provisions in the MMA designed to help critical access hospitals (CAHs) as they serve rural beneficiaries. For example, these hospitals can now designate up to 25 beds as either acute care beds or beds that may be used for either acute or post-acute care (called swing beds). Now CAHs can also set aside units of up to ten beds each to be used exclusively for inpatient rehabilitation and psychiatric services. These units, which would not count toward the CAH's 25-bed maximum, will be paid as if they were distinct parts of acute care hospitals, and will have to meet the same standards as units in acute care hospitals. In addition, payment for both inpatient and outpatient services rendered by critical access hospitals has been increased from 100 percent to 101 percent of reasonable costs. Finally, CAHs that are in a county that is now classified as urban will be permitted to retain their CAH status for two years and will be able to elect rural status.

New Technologies. The final regulations approve two technologies for add-on payments. One is an implantable neurostimulator for deep brain stimulation, which is used to treat patients with essential tremor and Parkinson's disease. The other is a device that provides cardiac resynchronization therapy with defibrillation. It provides significant benefits in treating congestive heart failure and ventricular arrhythmias that could result in sudden death. In addition, the final regulations continue new technology payments in FY 2005 for a technology which, when placed at a spinal fusion site, promotes bone growth, offering a less invasive alternative to a traditional bone graft. This technology was first

approved for new technology payments for FY 2004, reports CMS.

DRG Changes. Through the new final regulations, CMS is also adopting several changes to the diagnosis related groups (DRGs) that serve as the basis for payment under the IPPS. The rule creates a new DRG for certain craniotomy procedures that involve the implantation of a chemotherapeutic agent. This DRG also includes cases in which the principal diagnosis is an acute complex central nervous system diagnosis.

Based on a review of claims data, CMS is increasing payment to hospitals for treating burn patients who have respiratory failure and require the long-term use of mechanical ventilation. In addition, CMS is reassigning heart assist devices, including left ventricular assist devices or LVADs, to the DRG for heart transplants, which will increase the payment for these devices. These devices were originally approved only as a “bridge” therapy to keep a patient alive while awaiting a heart transplant, but are now approved as a “destination” therapy for patients requiring permanent mechanical cardiac support, but for whom a transplant is not anticipated. This DRG will now be called “Heart Transplant or Implant of Heart Assist System.” This will have the effect of increasing payment for the heart assist system, but is not expected to reduce payments for transplants.

Additional changes to the DRGs include splitting the DRG for tracheostomy into two new DRGs, to allow for a higher payment when an additional surgical procedure is performed with the tracheostomy, and removing a spinal fusion procedure requiring only a single incision from the DRG for spinal fusions requiring two incisions, resulting in a higher payment for the latter procedures.

Graduate Medical Education. The final regulations adopt two changes affecting hospitals that receive graduate medical education payments. First, it implements section 422 of the MMA, which redistributes unused residency slots among teaching hospitals to better reflect changes in the location of residency training. Hospitals located in rural areas are given first priority. Second, it allows a hospital to receive full payment for up to four years of specialty training when a resident matches simultaneously to a generalized, preliminary year of training and a subsequent specialty training program. The final rule also modifies the requirement that a hospital have a written agreement with a non-hospital site if the hospital wants to count the time a resident spends in the non-hospital site in its indirect medical education and graduate medical education full time equivalent count by permitting the hospital to satisfy this requirement by paying the costs associated with the training program in the non-hospital setting by the end of the third month following a month in which the training in the non-hospital setting occurred.

This article is intended to be a general summary of very complex regulations. Contributions to this article are from the Ernst & Young LLP Health Sciences Bulletin © 2003 Ernst & Young LLP. Specific questions about reimbursement related matters should be directed to a qualified reimbursement professional.

Ephraim McDowell Health — A Provider Profile

By Mary R. Begley and Maleena Streeval

Ephraim McDowell Health in Danville, Kentucky, is the umbrella organization for a healthcare system that includes three hospitals, six family medical centers, an independent and assisted living facility, a wellness center, a home medical equipment store, an outpatient diagnostics center, a children's learning and development center and an outpatient rehabilitation facility . . . 15 entities in total.

Ephraim McDowell Health was created in October 1997 with Ephraim McDowell Regional Medical Center (hospital) at its core. The healthcare system was established as the hospital began expanding the services it provided into neighboring communities. The system's offices and the hospital, which is accredited by the



Joint Commission on Accreditation of Healthcare Organizations, are located in Danville, named one of the 100 best small towns in America by *TIME* magazine.

Ephraim McDowell Regional Medical Center is a 187-bed licensed acute care facility that has an additional 25 nursing facility beds. The medical staff currently is comprised of nearly 100 physicians who offer 26 different medical specialties.

The history of Ephraim McDowell Regional Medical Center begins with the story and medical accomplishments of the physician whose name it bears. Dr. Ephraim McDowell is commonly credited with performing the first abdominal surgery west of the Appalachian Mountains — an ovariectomy on 47-year-old Jane Todd Crawford. Mrs. Crawford rode on horseback 50 miles from Greensburg to Danville for the surgery, which was performed on Christmas Day in 1809. The courage and heroism of both Dr. McDowell and Mrs. Crawford are evident in the fact that surgery of any kind often proved fatal at that time, and there were no antiseptics or anesthesia for Dr. McDowell to use in removing

the 20-pound ovarian tumor from Mrs. Crawford. She not only survived the surgery, but also returned home after 25 days and lived another 32 years.

Following Dr. McDowell's successful surgery on Mrs. Crawford, Danville became home to a number of physicians. This growing medical community led to the formation of a community hospital, which was established in 1887 on West Main Street. Through the years, the hospital expanded often to serve its community.

The hospital began its second century in 1987 with a name change to Ephraim McDowell Regional Medical Center, reflecting its ever-growing service area in a broad region in central Kentucky. As of 2004, the Medical Center's primary service area included Boyle and five contiguous counties — Casey, Garrard, Lincoln, Mercer and Washington — with a total population of more than 113,000 residents.

Continuing in Dr. McDowell's tradition of innovation and excellence, the hospital was the first facility in central Kentucky to have available a computer-aided detection (CAD) system for detecting breast cancer. The newest piece of technology added at the Medical Center is a 1.5 Tesla MRI (Magnetic Resonance Imaging), which is the top of the line in terms of magnet strength for a community hospital. It offers increased diagnostic capabilities, including more in-depth studies of the abdomen, the gallbladder and bile ducts as well as the blood vessels. Other advanced technology available at the Medical Center are a CT scanner, cardiac catheterization/angiography, positron emission tomography (PET), transesophageal echocardiogram equipment (TEE), stereotactic breast biopsy service and sentinel node biopsy service. In July, 2004, the system opened a new Open MRI located in its separate diagnostic center. A new 16-slice CT scanner is anticipated to be operational there in January 2005, offering the capabilities to detect the tiniest abnormalities or tumors.

Most of the nursing staff have completed training in Advanced Cardiac Life Support (ACLS) while nurses who provide care to pediatric patients are also

certified in Pediatric Advanced Life Support (PALS). In addition, nearly 40 nurses are certified in their specialty — whether it be psychiatry nursing or oncology nursing or obstetrics nursing or critical care nursing.

The community's trust in the hospital is reflected annually in the more than 9,300 inpatient admissions, 30,000 ER visits, 900 deliveries, 9,000 surgical procedures, 370,000 laboratory and pathology procedures, and over 72,000 advanced diagnostic technology procedures.

While Ephraim McDowell Regional Medical Center is the core of Ephraim McDowell Health, the system also includes two other hospitals. Russell County Hospital in Russell Springs is a 45-bed hospital accredited by JCAHO, and Fort Logan Hospital in neighboring Stanford is a 25-bed critical access hospital with an additional 30 extended care beds.

Providing quality care close to home is the goal of the six family medical centers that Ephraim McDowell Health has in Boyle and five surrounding counties — Danville Family Physicians in Boyle County, Liberty Family Medical Center in Casey County, North Garrard Family Medical Center in Lincoln County, Harrodsburg Family Medical Center in Mercer County and Homestead Family Medicine in Washington County. Each offers family medical care for all ages, provided by physicians, nurse practitioners and/or physician assistants, as well as on-site laboratory and X-ray.

Ephraim McDowell Health truly provides a continuum of care, from one age group to the next. A Children's Place is a children's learning and development center that serves children ages 6 weeks to 10 years. McDowell Place of Danville is an independent and assisted living community that offers 98 residential units. Other levels of care available at this facility are personal care and respite care.



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who have made this year's meeting possible:*

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