Chargemaster 101: Pharmacy, Charge Capture and Q & A

Presented by Sandy Sage RN, HomeTown Health, LLC
April 12, 2018
Hospital Transformation Consortium

WEBINAR ETIQUETTE

• All attendees are in “Listen Only” mode
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  - Open “Questions” pane in dashboard.
  - Type in comments or questions.
  - Comments will be monitored throughout webinar.
  - Questions will be addressed at end of the webinar.
Hospital Transformation Consortium

WEBINAR RESOURCES

- This webinar will be recorded and emailed to you to share with others on your team.

- Handouts are available for download in the Handouts pane and will be emailed out to attendees after the webinar.
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- Pass online quiz with 80% or better.
- Complete webinar evaluation.

Following this webinar, all attendees who have viewed the recording in its entirety will receive an email with a link to the quiz and evaluation.

Anyone that misses the webinar can view the recording online, posted on the program Dashboard, for CEUs.
Are you on this webinar with a group?

If so, please enter: first/last names and email addresses of those in attendance with you in the Questions Pane.
<table>
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<tr>
<th>AGENDA</th>
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| **Welcome & Introductions** | Jennie Price  
|                        | HomeTown Health, LLC |
| **Q & A, Pharmacy, Charge Capture and injections & Infusions** | Sandy Sage RN,  
|                        | HomeTown Health, LLC |
| **Upcoming Events & Resources** | Jennie Price  
|                        | HomeTown Health, LLC |
Time’s Up!

We have added one more webinar to this series to be held May 17th at 2 pm Eastern/1 pm Central: “Becoming Transparent: Bringing it all Together.”

If you have questions or certain parts of the CDM you need to hear more about, please let us know!
Speaker Bio

- Sandy Sage, RN is a Revenue Cycle Trainer for HomeTown Health University
- Hospital Liaison for HomeTown Health
- Project Leader for the SHIP grant programs
- She has been a Registered Nurse since 1990
- She has been a Nurse Manager in the ED & Medical-Surgical floor, Case Manager, clinical liaison between medical and accounting, Revenue Analyst, Quality Coordinator, and BO staff trainer
Chargemaster 101: Pharmacy, Charge Capture and Q & A

Presented by Sandy Sage RN, HomeTown Health, LLC

Learning Outcome Standard: Based upon CMS and AMA guidelines.
**Program Goals**

“The goal of the Hospital Transformation Consortium is to build a group of hospitals and other stakeholders that work together to support hospital collaboration and a community of shared best practices in transforming areas of Quality & Data Reporting, Financial Processes, & Technology in order to improve the value for the patient.”

The Objective of the “Price Transparency/Chargemaster” includes:

- 1 Helping hospitals develop the foundation for pricing transparency
- 2 Allow hospitals to do a self-assessment of their own chargemaster
- 3 Encourage department manager involvement in the chargemaster
Disclosure of Proprietary Interest

HomeTown Health does not have any proprietary interest in any product, instrument, device, service, or material discussed during this learning event.

The education offered by HomeTown Health in this program is compensated by the HRSA Small Hospital Improvement Program (SHIP) grant.
Learning Outcomes

- Identify the revenue code to be billed for self-administered drugs (SAD)
- Define an NDC code
- Describe why it is important to bill the correct units in the correct amount in pharmacy
- List the hierarchy order for injections and infusions
Q and A
Q and A

Q: Can we bill for a wound vac for negative pressure wound therapy?
A: Wound v (wound vacuum) are considered DME. There is no separate payment for hospitals. If the patient is going to a SNF or Home Health, consider having the DME provider apply the wound vac at discharge.

Q: Our RN performs wound care in the hospital, can we bill for that care?
A: Services must be provided under the “incident to” rules. This means that services must be provided in a clinic or office setting. The doctor must be in the office or clinic when the RN performs the service. If done on an inpatient it is not separately billable. CPT codes 97957 and 97958 are used only for MD services not for RN services.

Q and A

Q: Is there a new code for screening colonoscopy?

A: Yes, Use 76706.

The co-insurance and deductible are waived for Medicare patients.

For anesthesia report CPT code 00812

Use 00811 if screening is changed to diagnostic with a modifier PT. Only deductible will be waived.
Q and A

Q: We have charged for CPT 80053, 85025, and 84443. We are getting a claim edit that states we need to bill the panel code of 80050 in lieu of individual codes. Per our Lab Manager, we don’t have a panel built for these, so what are our next steps?

A: For 80050, Medicare does not accept that code so the components have to be billed separately. For some payers they have to be billed as a panel.

Some systems will set edits for specific payers in the billing system. The billers may have to combine them into a panel or separate them at the time of billing. Check and see how it can be set up in your billing system. Maybe it can be set as an explosion code, then it can explode only for certain payers like Medicare.
Q: We were denied from Medicare on CPT 84295 stating it was part of a panel, but this was done outside of the panel. We added a 59 modifier, but it still didn’t pay. Should we have added a 91 instead?

A: Yes use 91 as the test is being repeated on the same date of service.
Q: Another denial I’m seeing frequently for a panel code is on CPT 80076. We have not added a modifier to that one, but the other code it was billed with were CPT 80069

A:

80069 Albumin, Calcium, Chloride, Creatinine, Glucose, Phosphate, Potassium, Sodium

80076 Albumin, Bilirubin total, bilirubin direct, Phosphatase, Protein, ALT, AST

Instead of these two the doctor should order the CMP - 80053 The only test missing and that would need to be billed separately is Bili direct.

80053 Albumin, Calcium, Chloride, Creatinine, Glucose, Phosphate, Phosphatate, Potassium, Sodium, Bilirubin total, bicarb, Glucose, BUN, protein, ALT, AST
Q: Can we bill for specialty mattresses that we rent for the patient if they are at risk for bed sores?
A: No, rental equipment should be captured via rental cost in your Cost Report. Make sure there is a process in place to keep track of rentals for the CFO.

Q: How do we charge patients for convenience items?
A: Put chargeable convenience items in revenue code 990
Q: What are the most common late charges that affect billing?

A: Pathology charges.

Charges are not entered until pathology specimens have been read. Many specimens are sent out for reading. Ask your lab to notify the coders that charges are still pending. This will allow them to hold the claim in HIM until the charges are entered.
Pharmacy
Revenue Codes

- 250 - General Pharmacy
- 253 - Take Home Drugs
- 255 - Drugs incident to Radiology
- 258 - IV solutions
- 259 - Other Pharmacy

- 634 - EPO < 10,000 units
- 635 - EPO > 10,000 units
- 636 - Drugs requiring HCPCS codes
- 637 - self administered drugs
Medicare Payment Rules

- Inpatient drugs for SNFs and PPS hospitals are included in the PPS rates and are not paid separately.
- Inpatient drugs for CAHs are paid based on 101% cost.
- Drugs that are granted “pass-through” status are paid separately to PPS hospitals.
- Outpatient pass-through drugs must be billed with the appropriate HCPCS code, revenue code, and with the administration code.
NDC Codes

- National Drug Code assigned to each product.
- 11 digit, 3 segment number
- Universal product identifier for prescription and OTC drugs
- 1st segment identifies the labeler or company that manufactures or distributes the drug
- 2nd segment identifies the product specific strength, dosage and formulation of the drug.
- 3rd segment identifies the package size and type
Medicaid NDC Billing

- To comply with the Federal Deficit Reduction Act of 2005 Medicaid providers must submit the NDC code for each HCPCS coded drug.

- States must collect the data for submitting and collecting Medicaid drug rebates and federal payment.

- Each state may have different recommendations for billing.
Report the 11 digit number on the drug’s box or vial, they may be displayed as a 10 digit number on the box.

Use the N4 qualifier before the NDC number (on an EDI claim it will automatically put the N4)

Add zeros if the NDC is not in 5-4-2 format
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Units for Billing

- Revenue code 636 requires HCPCS code for billing.
- When you add a HCPCS code to the Chargemaster for a drug, check the description for the amount for billing.
- Example:
  - J2405 - Ondansetron or Zofran per 1 mg
  - Zofran is given in 2 or 4 mg doses
  - Vial is 4mg/2ml
  - When it is charged the units must reflect the descriptor
  - Nurse charges one vial for a 4 mg dose, the bill must not reflect the charge of one vial but should have 4 units to reflect the milligrams.
Units for Billing

- Most hospital EHRs are able to do an “explosion” code.
- When one dose of Zofran is charged the system automatically puts 4 units on the claim.

 Especially Important for high dollar drugs!!

- If you are being reimbursed $100/mg for a drug and only report one unit or mg, when you should be reporting 4 units, you are only being paid 1/4\(^{th}\) of what you should be reimbursed.
Units for Billing

- If a full dosage provided is less than the HCPCS code descriptor specifying the minimum dosage, report one unit of the HCPCS code for the minimum dosage amount.
- If the drug given is not a multiple of the descriptor, round to the next highest unit.
- It is important to continue to bill packaged drugs to help CMS determine cost for future rates.
Self Administered Drugs

- Medicare Part B does not generally cover drugs that can be self-administered such as pills or self-injectables.
- **Exceptions**: blood clotting factors, immunosuppressive therapy, erythropoietin for ESRD patients, some osteoporosis drugs for homebound patients, and certain oral cancer drugs.
- Medicare Part B will cover drugs that are considered “incident to” a physician’s service provided they are not drugs the patient currently self-administers.
- The provision is “not *usually* self-administered”
Self Administered Drugs

- Per CMS the term “administered” refers to the physical process by which the drug enters the body. It doesn’t refer to whether or not there is medical supervision of the drug administration.
- Injectable drugs can usually be eligible for the “incident to” benefit and are not considered self-administered.
- In addition to oral medications, suppositories and topical medications are usually considered self-administered.
- It is up to each individual MAC to decide what is considered self-administered.
POLL QUESTION

Have you reviewed your chargemaster for self-administered drugs and put them in revenue code 637?
Self Administered Drugs

**Drugs that are considered supplies**

- Medicare pays for drugs that are considered supplies because they are integral to a procedure. Patients cannot be billed for these types of drugs.

**Examples:**

- Sedatives administered for a pre-op procedure
- Eye drops given prior to an ophthalmic procedure
- Barium for diagnostic imaging
- Antibiotic ointments applied to a surgical incision at the end of a procedure
Drugs that are not considered supplies

Examples:

- A laxative for constipation while a patient is awaiting an x-ray
- Daily routine insulin given prior to a surgical procedure
- A fentanyl patch or oral pain medication for a patient presenting to the ER with pain
- Oral pain medication given to a patient who complains of headache during chemotherapy
340B Drugs

- Hospitals that are eligible for the 340B program receive discounts on eligible outpatient drugs.
- If you use 340B drugs for Medicaid patients you must make sure that you are not receiving additional rebates through the Medicaid rebate program.
- Some states require modifier usage for 340B drugs.
- Recertification must be done annually to participate in the program.
For FFS Medicare patients you must bill the 340B drugs with a modifier JG if they are status indicator “K”.

CAHs do not have to use the JG modifier.

Off-campus hospital departments that use 340B drugs must report them with the modifier JG then the modifier PO second.

Pharmacists must communicate with the Business Office to ensure these are being reported correctly.
POLL QUESTION

Does your hospital participate in the 340B program?
Discarded Drugs

- If you must discard the unused portion of a single-use vial or other single-use package after administering a dose, Medicare provides payment for the entire portion of drug or biological indicated on the vial or package label.

- Covered wastage must be billed on a separate detail line with HCPCS modifier JW.

- It must be documented in the medical record with date, time and amount wasted.

- On review, if this is not documented, the drug will be denied.
Modifier JW

Appropriate Usage

Submit this code when a single use vial/package is opened and the entire dose/quantity is not administered and the remainder is discarded.

Inappropriate Usage

When the actual dose of the drug administered is less than the billing units established by HCPCS description.

How to bill

A single use vial that is labeled to contain 100 units of a drug has 95 units administered to the patient and 5 units discarded. The 95 unit dose is billed on one line, while the discarded 5 units may be billed on another line with the JW modifier.
**Modifier JW**

**Billing Example Without Use of JW Modifier**

- “One billing unit for a drug is equal to 10mg of the drug in a single use vial. A 7mg dose is administered to a patient while 3mg of the remaining drug is discarded. The 7mg dose is billed using one billing unit that represents 10mg on a single line item. The single line item of 1 unit would be processed for payment of the total 10mg of drug administered and discarded.

- Billing another unit on a separate line item with the JW modifier for the discarded 3 mg of drug is not permitted because it would result in overpayment. Therefore, when the billing unit is equal to or greater than the total actual dose and the amount discarded, the use of the JW modifier is not permitted.”
Common Drugs

2 commonly used drugs that the JW modifier may be used on:

- **RC 636 Iron Dextran**
  - 100mg/2ml  
  - J1750

- **RC 636 Alteplase (TPA)**
  - 100 mg/inj.
  - J2997
Modifier JW - Steps to Take

1. Identify all single use vials you currently use.
2. Determine which are G or K status indicator drugs. (addendum B)
3. Determine how discarded drugs are documented in the medical record and by whom (nurses, pharmacists)
4. Are drugs charged as dispensed or as supplied?
5. Check your system, does it allow charging separately for discarded drugs?
6. Work together with all involved to identify process or documentation and charging changes required for compliance.
Pharmacy Tips

- Revenue Code 258 is for IV fluids and does NOT require a HCPCS code.
- Vaccines are in revenue 636 with a CPT code.
- Billing patients for self-administered drugs is a hospital decision. They must be billed to Medicare either way.
- Don’t forget to put LOCM and HOCM in the Chargemaster for Radiology.
Pharmacy Managers

- **Identify**: Identify any codes that are in your CDM that are no longer active (Not in the code book)
- **Remove**: Remove or delete any inactive codes
- **Add**: Add HCPCS codes to all revenue code 636 charges or change 636 to 250
- **Check**: Check to make sure that all drugs have NDC codes correctly entered.
Pharmacy Managers

Make
Make sure that you are charging for Radiology contrasts correctly

Review
Review the MAC’s SAD list and put all SAD drugs in revenue code 637

Educate
Educate staff on charging for the correct amounts of drugs that require detail coding.
The Charging Process
Consistency is Key

- Charging needs to be consistent to avoid:
  - Missing charges
  - Late charges
  - Incorrect charges
  - Duplicate charges
Evaluate the Process

- Look at each charging process closely.
- **Scanning:** Once an item has been scanned, what needs to happen to allow it to cross to the billing side?
- **Manual Entry:** Do you have back-up data entry staff? Are charges entered every day or do you have different deadlines, i.e. 3 days to enter charges?
- **Order Entry:** Have your systems been audited to ensure that charges are crossing correctly?
Each department manager should review the charges for their departments daily.

Charges should be compared against orders and patient list to make sure everything was charged and charged correctly.

Accountability is important. Monitor this area for compliance.
POLL QUESTION

Does each manager in your hospital do a daily charge reconciliation?
NCCI Edits

- National Correct Coding Initiative
- CMS developed the NCCI edits to promote proper coding and to control inappropriate payments of Part B claims.
NCCI Edits

- Two types of edits
  - PTP Procedure to Procedure edits
    - Prevents inappropriate payment of services that should not be reported together
  - MUEs Medically Unlikely Edits
    - Prevents payments for inappropriate numbers of units of the same service on the same day
Finding PTP Edits

Go to CMS.gov

Related Links

Hospital PTP Edits v24.0 effective January 1, 2018 (492,215 records) 0001M/80050 - 27894/G0471

Hospital PTP Edits v24.0 effective January 1, 2018 (491,890 records) 28001/0213T - 49999/49570

Hospital PTP Edits v24.0 effective January 1, 2018 (365,778 records) 50010/0213T - 79999/36000

Hospital PTP Edits v24.0 effective January 1, 2018 (140,660 records) 80003/80002 - R0075/R0070
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PTP Edits

If you see a “0” by a pair of codes, that means they should *never be reported* on the same day for the same patient.

If they are reported together, the column one code will be paid the column 2 denied.
PTP Edits

Just because there is a “1” meaning modifier allowed, does not mean you should use one.

The “9” means there is no longer an edit in place.

Using modifiers to get past the edits is a No-No!
Injections and Infusions
Poll Question

Who does your charging for injections and infusions in the ER and Observation?
Injections and Infusions

- Charge on outpatients, Emergency Room and Observation patients.
- Can be charged by nursing or by HIM coders or other staff.
- It is important to provide education for charging staff.
- Complicated rules for charging.
CPT Codes

- 96365 - Initial hour of medicated infusion
- 96366 - each additional hour of medicated infusion
- 96367 - each additional sequential infusion of a new drug
- 96368 - concurrent infusion (bill once per day)
- 96360 - Initial hour of hydration infusion
- 96361 - each additional hour of hydration
- 96374 - Initial IV push drug
- 96375 - each additional IV push; different drug
- 96376 - each additional IV push; same drug
- 96372 - IM or Sub-q injection
Initial Hierarchy

- Based on type of injection or infusion and not on timing.
- 3 initial codes: 96365, 96374, 96360
- Only use once per day
Rules

- Any medicated infusion 15 minutes or less is an injection.
- Any hydration infusion 30 minutes or less is not charged.
- Only one initial infusion or injection can be charged, all others are each additional charges.
- Check the MUE edits to see how many per day are allowed. If you bill over the amount allowed the claim will deny.

**Important Rules!!!**
Example:

Patient is in the ER and receives the following:
0800 - Normal Saline for hydration  Stop time: 1200
0815 - Demerol IV push
0825 - Rocephin IV infusion Stop time: 0925

What should be billed?
Example:

0800 - Normal Saline for hydration  Stop time: 1200
0815 - Demerol IV push
0825 - Rocephin IV infusion Stop time: 0925

What should be billed?
96365 x 1 Rocephin
96361 x 4 Hydration
96375 x 1 Demerol
Example:

Patient comes into the ER and receives:
IV hydration started at 0900, stop time not documented
IV medicated, Rocephin IVPB started at 0930 no stop time documented
IV Push at 1000 Solumedrol
Example:

Patient comes into the ER and receives:
IV hydration started at 0900, stop time not documented
IV medicated, Rocephin IVPB started at 0930 no stop time
IV Push at 1000 Solumedrol

What should be billed?
IV Push initial 96374
IV subsequent, new drug 96375
Learning Outcomes

- Identify the revenue code to be billed for self-administered drugs (SAD)
- Define an NDC code
- Describe why it is important to bill the correct units in the correct amount in pharmacy
- List the hierarchy order for injections and infusions
References

- https://www.wellcare.com/~media/PDFs/Georgia/.../NDC_Reporting_Guidelines.ashx
Questions?

Contact Sandy Sage at sandy.sage@hometownhealthonline.com or hthtech@hometownhealthonline.com
CONSORTIUM SUPPORT:

WEBSITE DASHBOARD
IOWA
www.hthu.net/iahtc
GA/FL
www.hthu.net/htc17
*Contact HTH for password

PROGRAM CALENDAR
“Cheat Sheet”
SHIP FY18 KICKOFFS

Financial Stability & Population Health: Putting the Pieces Together

**Iowa** SHIP Grant Program
Informational Kickoff FY18
May 30th, 2018
1:30 PM - 2:30 PM Central
https://attendee.gotowebinar.com/register/3846510975840446209

**Georgia** SHIP Grant Program
Informational Kickoff FY18
Fri, Jun 1, 2018 11:00 AM - 12:00 PM Eastern
https://attendee.gotowebinar.com/register/8909368398186930433
Final Pricing Transparency Webinar:

We have added one more webinar to this series to be held May 17th at 2 pm Eastern/1 pm Central: "Becoming Transparent: Bringing it all Together."

If you have questions or certain parts of the CDM you need to hear more about, please let Sandy know!
Resources

Monthly Newsletter
Visit the Dashboard to be added to the mailing list!
Questions?

Questions about these resources or Upcoming Events?

Contact:
Sandy Sage, Financial Program Lead
Sandy.Sage@hometownhealthonline.com

or

Jennie Price, SHIP Program Manager
jennie.price@hometownhealthonline.com
TELL US HOW WE DID!

A survey will launch after this webinar closes: please take a moment to give us your feedback on the training, speaker, content, webinar format, and anything else you can share!

If there’s something we can help your hospital with, please let us know!