Is the Cabinet Time-Barred From Recouping Those Funds?

by Steve Price, Esq.

It is not unusual for providers in Kentucky to receive a letter from the Cabinet for Health and Family Services (Cabinet) stating that recent audit adjustments have been made to a cost report filed a decade or more earlier. Now the provider is suddenly informed that it owes the Medicaid Program a substantial amount of money. Records may not have been retained. Personnel have left. Regulations have changed. Yet the provider must still defend itself or acquiesce to these adjustments to ancient cost reports. The Cabinet has long taken the position that it is never time-barred from auditing cost reports or recouping money from providers. Indeed, the Cabinet rarely pays attention to time-frames contained in its regulations except to say “Gotcha” when a provider misses one. In a recent decision, Commonwealth of Kentucky, Cabinet for Health and Family Services v. EPI Corporation, Inc., the Kentucky Supreme Court ruled, however, that the Cabinet had not been timely in its efforts and, therefore, was barred from recouping alleged overpayments resulting from audit adjustments.

The EPI case involved a long-running dispute between a nursing home provider and the Cabinet over audit adjustments affecting Medicaid rates paid for long-term care. The adjustments were made to cost reports filed with the Cabinet from 1988 to 1996. Audits and administrative proceedings were not completed until 2004. When EPI finally received an administrative hearing and raised a statute of limitations defense, the Hearing Officer held the fifteen years statute of limitations for contract actions applied. EPI appealed that decision to the Circuit Court which granted EPI summary judgment, finding that the five-year statute of limitations for statutory actions applied to bar recoupment. The Cabinet appealed that ruling to the Court of Appeals. EPI argued there that for the 1988 through 1995 cost years the Cabinet was time-barred from a provision in its own regulation requiring that recoupments be completed within twenty-one months from the end of the provider’s cost reporting period. The Court of Appeals affirmed the Circuit Court’s decision on the basis of this twenty-one month limitation on recoupments in the regulation.

The regulation was amended in 1996 and the twenty-one month time limitation on recoupment was deleted. Since the regulation no longer contained a statute of limitations applicable to recoupments the Court of Appeals decided the five year statute of limitations for liabilities created by statute found in KRS 413.120(2) was applicable to recoupments for the 1996 cost year. This five-year statute of limitations began to run when the provider submitted its cost report to the Cabinet since the agency could then determine the amount of any Medicaid overpayments, if any. The Court of Appeals specifically noted that “the Cabinet controls if and when an audit of a cost year will occur. Their delay in commencing with an audit should
President’s Message  by Dale Skaggs, FACHE, CPA

Dear HFMA Member:

As I began to draft my message this month I realized that my tenure as President is quickly coming to an end. While several thoughts come to mind, first and foremost, it was an honor and privilege to serve as chapter president. Please accept my sincere gratitude for everyone’s participation and involvement making 2008/2009 another successful year for our Chapter.

Speaking of success, the Spring Institute was absolutely phenomenal! The Chapter education committee continued the trend of bringing in national speakers and partnered with KHA on a rural issues track which brought our attendance to a record setting 180 people. The speaker presentations were informative and interactive, and the recent survey feedback suggests that this was one of our best meetings. Thank you to all of our sponsors, members and volunteers that made it all possible. If you were unable to attend, please visit our website at www.hfmaky.org to view presentations.

During the Spring Institute we also inducted the new officers for 2009/2010. Please join me in welcoming our new President – Bill Jones and the other officers elected. I would again like to encourage all of you to get involved in the Chapter. There are still plenty of areas that you can help with. Time is of the essence, so please contact any of the chapter officers to become involved.

In closing, I want to reiterate my message from the last issue regarding the current economic constraints that many of you are facing. Cost-cutting is a very real issue to all of us. Many organizations are suspending out-of-state and overnight travel for educational events. If there is a topic, webinar or presenter that you would like for the Chapter to consider please contact us. We continually strive to put on relevant topics that, with the help of our corporate sponsors, can be offered at very affordable rates. Your suggestions and comments are greatly appreciated.

Best Wishes and Thanks Again,
Dale

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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Financial Scene

**Is the Cabinet Time-Barred From Recouping Those Funds**

not extend their ability to collect overpayments.” This meant the Cabinet had five years from the time the cost report was filed to recoup. If the Cabinet acted in a timely fashion in accordance with its own regulations all audits and adjustments could have been easily completed within five years.

The Cabinet petitioned the Kentucky Supreme Court which reviewed the case and affirmed the Court of Appeals’ decision. The Supreme Court held in an unpublished opinion, that an agency was bound by the clear and literal language of its own regulations. In this case the plain reading of the regulation was to place a twenty-one month time limit on the Cabinet’s ability to recoup overpayments.

What this means is that a provider who receives notice of an audit adjustment to a cost report filed prior to 1996 should, at a minimum, timely request a Dispute Resolution Meeting and raise the twenty-one month statute of limitations contained in the old regulation as a ban to recoupment now. For cost reports filed after 1995 and more than five years ago the provider should raise the five-year statute of limitations in KRS 413.120(2). There may also be some other statutes of limitations (e.g. from Medicare) providers could raise depending on the circumstances. Changes to regulations in later years not at issue in the EPI case need to be taken into consideration. The bottom-line though is that the Kentucky courts have, for the first time, said there needs to be some finality to the Cabinet’s auditing and recoupment processes.

Steve Price is a partner in the Louisville office of Wyatt, Tarrant & Combs, LLP and litigated the EPI case along with his partners, Frank Chuppe and Virginia Snell. The opinions in this article are intended to be general in nature. You should consult with counsel for legal advice relating to your own situation. If you would like a copy of the Supreme Court’s EPI decision, e-mail your request to sprice@wyattfirm.com or contact Steve Price at 502-562-7305 for more information.

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Using a Frontline Offense to Mitigate Your Financial Risk
In Today’s Sick Economy

By Bruce Nelson, Vice President, SearchAmerica, a part of Experian

It is a usual day at a hospital. A new patient enters an Emergency Room needing care for a broken arm. The treatment process begins… the registrar admits the patient, a nurse preps the receiving room, an X-ray technician readiness the equipment, and the financial director sighs as he sees the hospital’s finances plunge. Why? In today’s economy, every patient entering their facility is more and more likely to be discharged feeling better, but leave the hospital in a weaker financial state than when they entered.

An ever growing number of today’s patients are responsible to pay for a portion of their care. Many need financial assistance, charity, or a payment plan, or they may simply default on their financial obligation. The number of uninsured patients is rising rapidly to an estimated 25 million adults in the United States, an increase of 60 percent since 2003 according to a recent study by PriceWaterhouseCoopers. The result is a rise in self-pay patient population, who may simply default on their financial obligation. These individuals are often unable or unwilling to pay the high deductibles associated with their treatment now requires the hospital knowing its financial risk in serving this individual and then mitigating this risk as much as possible.

Step Two: Deliver a Personalized Financial Treatment

The hospital’s frontline should have a suite of payment options available that protect the hospital from accumulating bad debt. These may include pre-payment at registration (cash, credit card, or a medical care credit card plan issued by a third party), hospital approved payment plans, charity programs, and government assistance programs, among others. Especially for self-pay patients, appropriate options should be made available to ensure payment using one or multiple options.

Teaming with medical staff, frontend personnel should be able to offer patients approximate costs of proposed treatments, especially those that can be delayed or are elective. This information can change the necessary financial relationship and options available. It also empowers the patient to make educated choices on elective or optional components of their care.

Step Three: Act Quickly

Aging of accounts will worsen in recessions. Collection policies and procedures should be directed at carefully segmented patient populations defined according to a patient’s ability to pay their bill and its balance. In addition to frontline collections, some suggestions have included offering incentives for pre-paying or early payment of medical bills to maximize cash balances in the short term. Often the first medical bill to reach a patient may be the first one paid, hospitals should see this as a race and beat other providers to the finish line.

There is no magic to surviving in today’s economy, avoiding layoffs and the other cost cutting measures. However the hospitals frontline can minimize risk and improve cash balances if used properly. It is time to equip frontend staff with the technology and processes to identify patients quickly, assess their financial capabilities, and trigger a financial plan made to fit each unique patient.

If a hospital falls into poor financial health, its mission cannot be fulfilled. It is important to the community it serves to be diligent in protecting its financial health.

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Red Flag Rules Compliance Now Standard Part of Revenue Cycle Operations By Bruce Nelson, Vice President, Sales and Marketing, SearchAmerica, A part of Experian

Hospitals are working diligently on their programs to comply with the new Identity Theft Red Flags and Notices of Address Discrepancy from the Federal Trade Commission (FTC) to combat identity theft at their facilities. However, as the details of their programs are being evaluated many questions arise:

- Will our proposed program create too many false positives or “red flags” that we cannot manage appropriately?
- How should the collection of patient demographic information alter our program?
- Should a red flag account be identified at patient registration or during the billing and collections processes following services?

Providers Have Assumed More Responsibility

The Red Flag Rules require healthcare organizations to properly identify patients in order to protect their identity. The FTC assures the healthcare community that the Red Flag Rules should not prevent any organization from providing medical services to a patient. Instead, they have placed another layer of responsibility onto providers.

Some in our industry have referred to this new regulation as an “unfunded mandate” which obligates hospitals and clinics to proactively identify ID theft triggers based on FTC criteria. This new criteria may cause unnecessary triggers due to routine patient interaction. For example: a patient calls and states “I have never been to your facility.” This fairly routine event according to the FTC is a Red Flag rule trigger. In this situation, after researching, the patient had a specimen taken at their doctor’s office which was later ran at the hospital’s lab thus creating a false positive Red Flag trigger.

Most Medical ID Theft Risk is Internal

Medical ID theft most often results from internal misuse of patient or guarantor information. This shouldn’t be surprising. Retailers have known for decades that most of their shoplifting incidences occur not from its shoppers, but its employees. Hospitals are not immune to this phenomenon.

The Red Flag Rules do require internal controls over staff and preventive steps to reduce the number of Red Flag alerts and identity theft cases for a hospital before they occur.

Storing photocopies of government IDs such as driver’s licenses and Social Security cards within patient files is currently commonplace. These files can be accessible by all individuals participating in the care of the patient, including lab technicians, nursing staff, physicians, physical therapists, pharmacists and pharmacy technicians, among others. However these can be the information sources needed by identity thieves to perpetuate their crimes. This process requires review to ensure appropriate controls are in place to eliminate the temptation by internal staff.

A recommended solution to prevent internal misuse of patient information would be to automate the demographic validation process. This involves utilizing state of the art identity verification workflow and storage solutions. Access would be controlled by user security and passwords.

Red Flags Will Be Numerous Under Current Processes

Creating too many false positives is a justifiable concern by all healthcare providers. Many every day billing questions and occurrences could be used alone to identify a Red Flag account, but would create dozens or hundreds of red flag accounts each day – the vast majority of these would not be true instances of identity theft.

For example, if a patient arrives at the Emergency Department (ED) without documentation, should this be considered a red flag account?

The answer is not a simple yes or no, but an assessment of the demographics and what is considered normal for each facility. For example, if a facility serves a large immigrant population it will not be uncommon to encounter patients in the admissions process without documentation. In this case, this alone shouldn’t constitute a Red Flag as it would create too many false positives and become burdensome for the hospitals and its patients. Instead, Ms. Lefkovitz recommends adding other criteria that would identify a Red Flag, such as billings returned to the provider by the post office as undeliverable.

The FTC is advising each provider to assess its patient populations and identify potential red flag criteria that are too commonplace to be considered an anomaly. Instead the FTC is advising providers to develop multiple criteria that must be encountered before identifying it as a red flag.

A few examples of common billing questions that may prove to be a false positive red flag are:

- Billing Inquiries:
  - Patient claims to have never been at the hospital
  - Patient claims to have never received the medical service on the bill
  - Dispute of a bill based on claim of identity theft
  - Mail sent to patient repeatedly returned as undeliverable despite ongoing transactions on active account

- Clinical Identifiers:
  - Medical services are inconsistent with a diagnosis
  - Allergies listed on chart are disputed by patient

- Admissions Alerts:
  - Patient provided insurance number but provides no insurance cards
  - Lack of correlation between Social Security number range and date of birth
  - Repetitive address or phone number supplied by multiple patients on financial assistance applications
  - Personal information inconsistent with information already on file

Steps to Improve Compliance

Until the Identity Theft Red Flags and Notices of Address Discrepancy, most hospitals discovered identity theft cases after medical services were rendered and the patient released. This unfortunate discovery resulted in unrecoverable expenses. Now not only will there be a loss in rev-

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Red Flag Rules Compliance  continued from page 5

enue, but potential government fines if processes are not in place and used consistently. The following are recommended steps that hospitals can use to mitigate their risk and improve their compliance with recent regulations:

**Step One: Be Proactive**

The FTC has mandated providers to become both proactive and reactive in their approaches. Historically, this has not been the case, and hospitals have followed-up on accounts only when their traditional billing and collection efforts failed.

*Emphasis needs to be on the prevention of Red Flag instances.*

To do so, providers need to establish new controls. First, they need to dramatically limit access to SSN and other patient identification information to internal and third party (e.g., collection agencies) to prevent internally generated cases. Minimizing the internal theft of medical IDs will have the most significant impact on reducing both red flag instances and losses from identity theft.

Secondly, patient folders need to be stripped of all mentions and photocopies of government IDs. This includes folders for new patients, recurring patients, and former patients.

**Step Two: Involve Other Departments**

Securing patient information cannot be achieved by finance and administration alone, executives are required to monitor the Red Flag Program periodically. However, other departments need to become actively involved in the process. The following are just a few examples:

*Human Resources.* For hiring, payroll, credential validations, and other activities performed by this group, human resources staff have access to the identification (SSN, driver’s license number, etc.) needed by identity thieves. Hospitals need to be sure this information is secure and accessed only by those that need it.

Likewise, as they hire, they should pay attention to any background checks that include identity theft citations or convictions. These individuals need to have very strict controls on their access to patient information, or no access at all, and have their activities monitored frequently.

Human Resources is usually vital in setting up permissions and access to a providers facility and systems. Administration should team with this department to create access controls that are consistently and appropriately maintained, at hiring and throughout a staff member’s employment.

Lastly, as hospital personnel are oriented to the provider’s policies in training sessions, they need to become aware of the Red Flag Rules and, if appropriate, their role in compliance. This will specifically impact registration and billing staff, but all hospital staff should be aware of the need for strict controls over patient identification information.

*Healthcare Information Management (HIM)/Medical Records.* This department is critical for proactive reduction in identity theft and compliance with the Red Flag Rules. Its staff must work with finance and administration to identify new user permissions and controls to protect the electronic storage of government IDs in patient folders (until removed) and the secure database where they will reside. They should also review their current procedures used to detect misuse of passwords that have access to identification information.

In addition, patient folders contain identification information that will need to be removed. Medical Records is critical to performing this task as they are knowledgeable in where this information resides within the folders for current patients and in historical records that may be accessible to staff. This department is instrumental in developing the plan that will govern the information in new patient folders as well as how to ‘clean’ existing and former patient documentation.

**Step Three: Develop Industry Best Practice**

Virtually all hospitals must comply with the Identity Theft Red Flags and Notices of Address Discrepancy. Providers should team together to share their programs and aid one another in developing best practices for those serving similar patient demographics.

Your Red Flag Policy should reflect a strong due diligence process with a goal to decrease premature filings. The following are some examples of industry best
Red Flag Rules Compliance
continued from page 6

practices that hospitals are considering and/or including in their Red Flag Rules programs:

Red Flag Policy Triggers:
- **Differing Information.** Management will be immediately notified when personal information provided by the patient is inconsistent with current patient information residing in its systems.
- **Altered Documents.** Management will be immediately notified if a patient’s identification documents appear to have been altered.
- **Unauthorized Charges.** Management will be immediately notified when the hospital is advised of unauthorized charges applied to bank or credit/debit card accounts from their organization.
- **Fraud Alert.** If a fraud alert is associated with a patient account, the information must be verified with the guarantor or disregarded if unable to validate.

Proactive Protection of Patient Accounts:
- **Website.** All patient websites or portals containing patient information must be password protected.
- **Phone Inquiries.** Date of birth or a SSN of the account guarantor will be verified on all inbound phone calls requesting account information.
- **Statements.** Requests for medical documents and/or patient statements will only be sent to the address on record for the guarantor.
- **Physician/Health Provider Requests.** These offices will be provided an identification code that will be required when requesting account information.
- **Name and Address Changes.** A photo ID (for in-person requests) or the patient’s date of birth and/or SSN (for phone requests) is required to change the name and/or address on a patient’s account.

Payment/Refund Controls:
- **Credit Card Payments.** All payments given via phone will require the 3–4 digit identification number located on the backside of the credit card.
- **Refunds.** All patient refunds will be mailed to the address of the guarantor or refunded to the original credit/debit card used for payment.

Policy Changes:
- **Updates to the Red Flag Program.** Management will periodically update its Red Flag Rules program based on its experience with identity theft, new methods of identity theft are discovered, and the availability of new solutions to detect, prevent, and mitigate identity theft.

For information from the FTC on the Red Flag Rules, visit [www.ftc.gov](http://www.ftc.gov), call (202) 326-3058, or email your questions to redflags@ftc.gov.
Stepping Back: How has Access to Capital Changed?  
By Tanya K. Hahn

Day to day, minute to minute focus on the capital markets can make it harder to see where we are compared to where we were only a few months ago at the height of (one hopes) the market fallout. The markets have obviously not stabilized. Yet there has been some improvement since a low point in October, when investors were playing hot potato with variable-rate bonds, and some banks turned away depositors and borrowers and closed their doors — permanently.

Borrowers with outstanding debt or who plan to issue bonds or notes in the near future are in slightly improved positions in February 2009 compared to fall 2008 (though they may look wistfully back at 2007). The overall landscape of both variable-rate bonds/notes and fixed-rate debt changed considerably in the past few months. Much of this can be understood through changes in the banking world over this short period of time.

Banking on change

Many banks had quite a wake-up call last fall when variable-rate bonds failed to find buyers, and banks had to extend cash and credit in connection with draws on letters of credit that were enhancing billions of dollars in floating-rate debt. Never in the history of this financing structure had there been such widespread draws on letters of credit. Already reeling from the fallout and negative impact to their financial positions from sub-prime mortgages, many banks realized too late how vulnerable they had left themselves by lending more than they could safely support in both capital and liquidity. Many banks have since had their credit ratings downgraded by rating agencies as a result of declining financial performance.

This situation is part of a spiraling chain reaction. As part of this complex spiral, a bank’s strength impacts the decisions of investors (primarily money market funds) that purchase bonds/notes backed by letters of credit. Many of these funds are legally forbidden from holding more than a certain amount of bonds from lower-rated banks. If a bank is, or might be, downgraded, investors may be less likely to buy debt backed by that bank, or they may require a higher interest rate to offset perceived risk.

Therefore some banks, often mid-size regional banks, are trying to reestablish their capital and liquidity positions and attempting to shore up the market’s perception of their credit risk by removing what they see as riskier assets from their balance sheets. In some cases, this has resulted in banks asking borrowers to pay loans back, sometimes on technical violations of debt agreements that normally would prompt a warning rather than loan termination.

Current Impact on Letters of Credit and Variable-Rate Debt

In February, variable-rate bonds are again finding buyers. The letter of credit (LOC) structure functioned exactly as intended as a stopgap for borrowers, but the fall 2008 invocation of banks’ responsibility to take on these bonds has left banks looking at borrowers through a new lens. Increased scrutiny of borrowers has tightened the credit markets and limited access to necessary capital for renovation and improvement projects. Reflective of this, the borrowers getting their deals done with bank LOCs are typically very strong or may have standalone investment-grade ratings. Investors who buy these bonds and notes are also looking not just at the rating of the bank involved in the transaction, but also at the borrower’s liquidity and credit strength in relation to the transaction size. Bigger and stronger, right now, is not just better, it is almost all that is getting done. Big banks are doing big deals with highly-rated borrowers.

Local community banks should not be forgotten, however. Many of these escaped the fallout of the sub-prime mortgage crisis and were not as leveraged as their regional bank counterparts. They are often still strong and willing to participate in financings.

Borrowers with existing LOCs and variable-rate debt are overall in decent shape. In the fall, variable rates spiked to at least 8% at the height of the liquidity crisis. Now, variable-rate, tax-exempt bonds are generally being remarketed at less than 3% depending on the LOC bank and region of the country. The difference between the high and the low ends of the remarketing range, however, is dramatic. Large national banks’ bonds are resetting at 0.25 to 0.50%, while regional banks are resetting in the 2 to 3% range. An individual bank’s LOC interest rates can vary widely depending on different investors’ perceptions of that bank’s credit risk.

Stronger borrowers paying higher-than-market interest rates may have opportunities to replace their LOCs with ones from a higher-rated bank, potentially lowering interest cost. However, many borrowers will be better off staying with their current LOC provider and working with the bank to ensure the LOC stays in place and is renewed, even if it means paying a higher annual bank fee. Rates on existing LOC-enhanced, variable-rate debt are low compared to fixed-rate transactions, but few new deals are getting done due to banks’ judicious allocation of capital and liquidity. Some banks
are charging more for the risk they are taking, setting higher covenants and requiring the movement of substantial banking business to them in return for use of their capital.

A borrower should seek advice from its financial adviser or investment banker if the borrower’s LOC will expire within two years, or if the bank’s willingness to work with the borrower has changed. Most LOC borrowers, however, should be in a good place, with rates as low as they are.

**Current Impact on Fixed-Rate Debt**

Many borrowers that issued fixed-rate debt in recent years should have locked in very low rates and be in a good position to weather this market.

Few new fixed-rate health care and housing deals have closed since the fall, and fixed-rate debt issuance has not heated up to the levels anticipated at the close of 2008. Long-term investors in tax-exempt bonds and taxable loans have experienced reduced liquidity and hence a limited ability to purchase new debt issues. Wiling investors are demanding a higher rate of return (interest rate) for perceived higher-risk borrowers, like health care and housing entities, in comparison to governmental borrowers who can rely on tax revenue for debt repayment and are perceived as lower risks.

Borrowers looking to use fixed-rate debt for a current project often have a 10-year prepayment penalty period. In the current environment, they may have the ability and desire to negotiate a shorter prepayment penalty period in return for paying a higher interest rate to investors. This serves to attract potentially more investors to the transaction and also provides future financing flexibility to refinance when the markets have settled down.

**What Now, and What Next?**

Several financing strategies are still viable for new debt issuances, or for refinancing troubled debt. The Federal Home Loan Bank can wrap LOCs for its member banks, many of which are small and lack their own credit ratings. This lets borrowers turn to their local banks for a cost of capital similar to that usually available only to larger, rated organizations. Government enhancement programs, such as the FHA Sections 242, 232 and 221 mortgage insurance programs, also remain strong options for hospitals, senior living, and affordable housing projects. Health care and housing providers also may consider doing a straight term loan with a bank, building in plans to refinance later down the road. Finally, organizations that are strong within their sector could consider paying to get an independent credit rating from a rating agency, possibly enticing investors by setting their transaction apart from a non-rated deal.

Many borrowers who issued debt recently are in a good position. Those who need to issue debt in the near future will have to look to new, alternative and creative ways to access capital. Working with an investment bank or financial adviser who understands and monitors how banks and enhancement options are viewed by investors, and what new options are coming available, will provide the borrower the best access to capital.

Tanya K. Hahn is a managing director with Lancaster Pollard. She can be reached at thahn@lancasterpollard.com or (614) 224–8800. Reprinted with permission from “The Capital Issue” at www.lancasterpollard.com.

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**Member Spotlight:**

**Autumn McFann**  
**Controller, King’s Daughters Medical Center**

Autumn has been a member of HFMA since 2004. She received her undergraduate degree in accounting from Marshall University and is currently working on her MBA at Morehead State University. Autumn started working with Kelley, Galloway & Company, PSC in Ashland, Kentucky in 1999 and became a Certified Public Accountant (CPA) in 2000. She joined the King’s Daughters Medical Center team in 2004 as the Director of Internal Audit. She spent a year as the Financial Operations Director in 2008, and was promoted to Controller in January 2009. Autumn is enjoying the challenges of overseeing the day to day accounting operations as she settles into her new role. She is also active in several other organizations, including the Healthcare Committee of the Kentucky Society of CPAs, the Community Leadership Development Committee of the Ashland Alliance, and she is a board member of the Shelter of Hope. Autumn believes the greatest challenge facing King’s Daughters Medical Center today is the current state of the economy and how it impacts the operations of the organization.
Spring Meeting

On March 19 and 20, the Kentucky Chapter of HFMA held their spring meeting in Lexington, Kentucky at the Embassy Suites. The session included several outstanding speakers including John McMunn (Day 1 keynote) who spoke on motivational leadership and Todd Arwood (Day 2 keynote) who provided an energetic discussion on generational differences and leadership principles. We were also fortunate to have four education tracks over the two days: General Session, Patient Financial Services, Financial Services and Rural Hospital. The Rural Hospital track was co-sponsored by the Kentucky Hospital Association. In addition, we offered an Healthcare 101 concurrent session on the first day, led by Dr. Michael Nowicki. A highlight of the event was the “Capital Markets Roundtable” session with four industry experts updating us on current developments and addressing questions. The meeting was very well attended with our highest attendance in years. Also, many participants joined in the fun on Thursday evening watching the NCAA tournament and playing Texas Hold ‘Em. Stay tuned for upcoming educational sessions. You won’t want to miss out.

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