Letter from the President

Happy New Year!! Well...maybe it's not quite time for Dick Clark’s New Year’s Rockin’ Eve, but June 1st did mark a new fiscal year for HFMA. My name is Chris Woosley and I am honored to be your president for the 2011-2012 fiscal year. Before I mention the exciting things to come this year, I want to say a special thanks to Andy Strausbaugh. The Kentucky Chapter is coming off a stellar year, meeting or exceeding all the goals set forth by National HFMA. The Kentucky Chapter received five awards at this year’s Presidents’ dinner at ANI: a Gold award for certification, a Bronze award for education, a Gold award for membership growth and retention, and two special recognition awards known as Yerger awards. Our success this past year can be largely attributed to Andy’s outstanding leadership, passion and commitment to HFMA and its members. Please join me in congratulating Andy when you see him. One thing is apparent...I certainly have big shoes to fill.

This year’s National Chairman is Greg Adams, Senior Vice President and Partner for Panacea Healthcare Solutions in Wesley Chapel, Florida. Each year, the Chairman chooses a theme for his or her term in office. Greg’s theme is “Believe to Achieve.” In short, his message to us as healthcare finance leaders is simple...if we believe in each other and the teams we have assembled, we can be successful. Greg’s choice of themes could not be more appropriate for today’s turbulent healthcare environment. I truly believe in the leadership team we have assembled for Kentucky HFMA. I know that together, through everyone’s efforts, we will have another successful year.

Now for more on the year to come. The leadership team has already spent countless hours planning for the new year. We have a number of exciting events coming up over the next twelve months. We will continue to host our regular Summer, Spring and Winter Institutes. We will also be collaborating with the Indiana Pressler Memorial, Southwest Ohio, and Central Ohio Chapters to bring you the second ever “Tri-State Institute.” This year’s Tri-State Institute will be held at Belterra Resort and Casino on September 14th - 16th. We are anticipating around 350-400 attendees, so reserve your rooms today. You can learn more about this exciting event by visiting http://www.hfmaconference.com. In addition to our regular institutes, we are holding a new and improved Patient Financial Services Workshop, two additional “Road Shows” to cater to our rural members, and Healthcare 101 is back by popular demand. Don’t forget to take advantage of the webinars that National HFMA provides. Not only is it a way to get free education, but we get credit as a Chapter.

SAVE THE DATE

HFMA 2011 Multi-Chapter Conference
September 14-16, 2011
Belterra Casino & Golf Resort
Florence, Indiana

For registration information, please visit http://www.hfmaconference.com
Preparing for Shifts in Medicaid Coverage

Healthcare Financial Management, February 1, 2011

The Affordable Care Act has made it possible for roughly half of the country’s uninsured patients to become eligible for healthcare coverage under state Medicaid programs. That could mean as many as 23 million people will be added to Medicaid rolls.

The explosive growth in the Medicaid population may have a positive benefit on hospitals as they stand to receive at least some payment for services instead of absorbing the costs of bad debt and charity care for the indigent.

There is the danger, however, that the rising numbers of Medicaid patients will threaten margins.

Although subsidies from the federal government will ease the transition to Medicaid coverage in the first few years of reform, at some point states will have to assume full financial responsibility for Medicaid beneficiaries, and it is not clear how state governments will be able to do so. State budgets most likely will not increase, so while treating the increasing numbers of Medicaid patients will raise costs for hospitals, the costs may not be balanced by increases in payment.

Hospitals therefore may have to make do with lower per-procedure or per-patient Medicaid payments.

Most of the money to reimburse hospitals for treating Medicaid patients may end up coming from other sources of payment that are already slated for hospitals. As a result, safety net and teaching hospitals may face reductions in disproportionate share and graduate medical education funding.

The growth of the Medicaid population also may negatively affect the revenue cycle. Medicaid programs characteristically are slow to pay, and in most states they follow a complicated, manual, and elongated application procedure that can interrupt the revenue stream.

As hospitals take steps to ensure that they identify and qualify as many patients as possible for Medicaid coverage or financial assistance, they are also streamlining administrative, revenue cycle, and operational processes to mitigate the
adverse effects that the influx of Medicaid patients may exert on margin and cash flow.

In particular, many providers are identifying and readying for potential effects on eligibility screening processes, financial assistance counseling and enrollment, and near-term financial strategy.

Eligibility Screening
When it comes to reviewing registration processes most likely to be affected by shifts in coverage, hospital leaders are focusing on enhancing ways to identify third-party payer sources, paying particular attention to the emergency department (ED) and opportunities to incorporate workflow tools.

Accelerating third-party payer identification. Halifax Health, the largest healthcare provider in east central Florida, is preparing for the expansion in Medicaid by strengthening its registration methods, particularly screening for third-party payment eligibility.

A member of Florida’s Safety Net Hospital Alliance, Halifax Health is one of about 20 hospitals that care for nearly 60 percent of the state’s Medicaid enrollees. The system has a tertiary and community hospital with 944 beds and more than 500 physicians on its medical staff. It also provides psychiatric services and has four designated cancer treatment centers as well as centers of excellence in cardiology, orthopedics, and the neurosciences.

“We already have a very active program for identifying any patients who would have any type of third-party coverage, whether through a local charity or victim’s compensation fund, Social Security, disability, or Medicaid,” says Arvin Lewis, Chief Revenue Officer for Halifax Health. Now, the health system is focused on building this program, which in 2008 shifted $34 million in charges from self-pay to Medicaid and in 2009 raised that number to $46 million.

“Many patients, even those who qualify for Medicaid, do not sign up for all of the third-party payment programs that are available to them,” says Lewis. “So we are continuing to try to assist in identifying these opportunities. It’s good for patients, it’s good for the hospital, and it’s good for the community. After all, whatever programs we can identify that people are qualified to receive will ultimately improve payment. And payment is necessary for the hospital to continue to support its mission of care.”

Halifax Health is combining internal and external resources to strengthen third-party payment eligibility screening. Its revenue cycle team works side by side with clinical staff, social services professionals, and government program specialists to uncover new and existing eligibility, complete and submit applications, and track cases from inception to resolution. “We have to balance the ledger, so we plan to aggressively enroll patients in third-party payer programs as well as Medicaid,” Lewis says.

Halifax Health also is accelerating eligibility decisions. The health system partnered with an outside vendor about three years ago to speed its processes.

“By the end of the first inpatient day, we want to have a clear view of the patient from a financial standpoint: Does the patient have coverage? If not, what are the programs the patient may qualify for, and how can we assist in securing qualification? The patient may not be able to participate in this process on day one, but we are doing the background, working with the family, and getting forms completed to be able to move forward,” he says.

Focusing on the emergency department. New Hanover Health Network is expanding the role of its outside Medicaid eligibility vendor partner.

The past few months, says Ed Ollie, CFO, our vendor and internal staff have begun to focus on our outpatient areas and ED. “We’re taking a hard look at what we need to do to put in procedures, people, and processes for Medicaid eligibility,” he says. “How well we get paid will depend on how well we obtain Medicaid coverage for those who are eligible. That will make a big difference for us in the next three to four years.”

The health system is exploring how it can add staff to screen for and assist with Medicaid eligibility at the point of care in the ED. “We believe that under the proposed healthcare reform, we will need more people and training for staffing customer service on the front side, because there will be a large group of people who will not know if they qualify for Medicaid,” he says. “We don’t know how many there will be because the program has not been rolled out to the degree needed to understand yet, but staff on the front end will nevertheless have to be more skilled and have more information.”

A renovated ED at New Hanover Regional Medical Center will accommodate more patients, increase patient throughput, and improve onsite registration efficiency and effectiveness, says Ollie. The ED experience has been broken down into components to help hospital leaders better understand the time it takes to complete the individual components; for example, how long it takes to complete the registration process, how long patients wait before being seen by a physician, how much time is spent in the ED before the physician orders or treatment are completed, and how long before the patient
is in the inpatient bed or discharged.

“We take that whole service continuum, measure it in terms of time against best practices, and decide how to improve performance,” he says. “We want to get patients into care areas and taken care of in shorter time frames, so we are watching these things carefully.”

Leveraging workflow tools. Oakwood Healthcare System plans to replace its current eligibility checking system with a more robust one that builds in workflow tools to help segment and batch insurer groups on the basis of such factors as the probability that a patient will pay a portion of the healthcare bill and the likelihood that the patient will qualify for third-party payer programs.

“Based on data elements—such as age and income—and other factors, such as zip code, the system we’re looking at can help staff set priorities,” says Lynn Flynn, corporate director of revenue cycle operations of the four-hospital, 1,267-bed health system in southeastern Michigan.

The enhanced system will check workflow of pended case automatically, which is a task currently being performed by staff manually.

There is no plan to hire more staff going forward. “Our plan is to implement workflow tools so the staff can be more productive and effective,” says Flynn.

Financial assistance counseling and enrollment. Also key is examining financial assistance processes. Areas to review include improving content and timing of financial counseling services, staffing for effectiveness, and identifying opportunities to enhance enrollment efficiency.

Improving counseling communications. Oakwood Healthcare System has a financial clearance center that functions not only to stanch the flow of bad debt dollars, but also to connect with patients before elective procedures to make sure they understand their financial responsibilities.

Financial clearance staff provide “financial informed consent” patterned after standard presurgical informed consent, that seeks to educate each patient about coverage benefits, the estimated cost of care, the likelihood of eligibility for financial assistance, and the amount the patient would pay.

During the preregistration process, the financial clearance staff determine whether a patient has insurance and whether the insurance plan will cover all the costs of care. For those who do not have insurance or who have insufficient coverage, financial advisers screen for other coverages, such as COBRA for the recently unemployed, auto accident victim or liability coverage, Medicaid or some other government program, and charity care.

The clearance staff also arrange for discounts and payment plans. “We make sure we communicate financial process to patients up front so they understand when they have a liability, and we work out a payment plan before the service is provided,” Flynn says.

Financial clearance staff work hand-in-glove with many of the health system’s physicians. The financial counselors provide updated patient insurance information for physicians who make referrals for elective treatment, and they help complete financial assistance or charity care applications for the patients who are referred by members of the medical staff.

The health system works with a vendor to automate the review of cases that may be covered by charity care. Credit scores, assets, and residence zip codes are analyzed electronically, which eliminates the need for patients to complete lengthy applications and allows financial counselors to more easily differentiate between bad debt and charity, Flynn says.

Staffing for effectiveness. Park Nicolett Health Services is piloting several programs that may help the Minnesota-based 426-bed hospital and 25-clinic health system adapt to an influx of Medicaid-eligible patients.

Shireen Stone, Senior Director of Patient Financial Services for Park Nicolett, explains that the health system has a long-standing method of verifying insurance coverage before service, but in the past year has been working more closely with its clinics and outpatient departments to help patients apply for Medicaid coverage.

“The difficult economy has made it harder and more stressful for our patients to get the health care they need, and we are striving to make the system friendlier for them. We are seeing more situations where patients want to understand their eligibility for financial assistance before they receive care or service,” Stone says. “Our financial assistance program is intended to address emergent, episodic needs—not to substitute for insurance coverage. For nonemergent services, we now work with patients on site to screen for Medicaid eligibility and explain their financial obligations and the types of payment
Kentucky Chapter HFMA
2011 – 2012 Officers and Directors

On March 17th, Bob Barbier (Past President and former Regional Executive) inducted the following individuals in as officers of the Kentucky HFMA for 2011-2012:

- **President**
  Chris Woosley

- **President Elect**
  Theresa Scholl

- **Immediate Past President**
  Andy Strausbaugh

- **VP Education**
  Scott Reed

- **VP Communications**
  Tony Sudduth

- **VP Member Services**
  Don Frank

- **Secretary**
  Jeanene Whittaker

- **Treasurer**
  Kourtney Nett

- **Director**
  Shawn Adams

- **Director**
  Joe Ruark

- **Director**
  Nick Motta

- **Director**
  Russ Ranallo

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One only sees trouble, another see opportunity.

During these turbulent times, let our healthcare team work with you to anticipate changes and identify new opportunities to help you successfully navigate to your goals.
Preparing for Shifts in Medicaid Coverage, Continued from page 4

plans we offer. Park Nicollet has account specialists at the hospital and at two of its clinic sites, and anticipates adding specialists more broadly after it replaces its current manual, somewhat cumbersome process for screening patients.

“In the future,” she continues, “we want to deal with these situations in a more proactive way that is less stressful for the patient and also better for the organization. One way is to have account specialists work onsite with certain groups of uninsured patients, such as those who have chronic conditions and are likely to return periodically for care, such as oncology patients. We want to work with our providers and those patients to help them understand what to expect financially and when they are eligible, get them enrolled for Medicaid. We recently became a certified agent for the state of Minnesota to assist patients with Medicaid application. Instead of working with outside agencies to do that, we can now prepare one of the applications on site.”

Moving toward greater automation. Park Nicolett plans to take advantage of some of the tools within its practice management system to help reduce manual efforts in administering financial assistance applications. In addition, a document management system is being installed to automate charity care and financial assistance screening.

The health system’s website features a financial assistance calculator that helps patients determine whether they might qualify for financial assistance based on their state of residence, household size, and household income. The website also provides answers to the most frequently asked questions about financial assistance, including how a patient may qualify, how the program works, how long the approval process takes, and whether a patient may be eligible for assistance even if he or she has insurance or receives some type of government aid.

The current process is unwieldy, however, because the existing system does not handle scanned documents and does not have workflow capabilities. “We have seen a huge increase in the number of financial assistance applications in the past two years. We’re looking for greater efficiencies with the new system,” Stone says.

Financial strategy. Of course, managing shifts in Medicaid coverage requires greater preparation than simply revamping processes around registration. The likelihood of higher populations of Medicaid patients is prompting health system leaders to examine the entire financial strategy for how to function and still be profitable. The issue is particularly challenging for safety net hospitals. “We will be expanding a patient base where we not only don’t make money, but—in most cases—can’t even break even. Meanwhile, we are going to be losing money that we have been receiving in other areas, such as disproportionate share or graduate medical education,” Lewis explains.

If, as Ollie anticipates, states eventually reduce what they pay for Medicaid services, hospitals may have margin issues. “The product we provide is a healthcare service,” he says. “If we’re producing it at the same cost level and serving increased numbers of people because they now have access to healthcare coverage, we are going to be incurring more total costs while receiving, we are projecting decreased payments over the next several years. The impact on charity care is suggested to go down, but it appears it will be difficult to have sufficient margin to reinvest in our facility and equipment.”

To protect their financial health going forward, many hospitals are examining their overall strategy for improving payment and protecting cash flow in relation to Medicaid. In particular, efforts include educating Medicaid recipients on coverage for extended services, focusing collection efforts on payment ability and propensity to pay, and seeking greater efficiencies from Medicaid state administrators.

Enhancing consumer education on Medicaid processes and coverage. New Hanover Health has several communication initiatives designed not only to help patients understand what they need to know about Medicaid eligibility, but also to encourage receipt of appropriate follow-up care. “When someone is eligible for Medicaid, it is not just the stay in a hospital that is covered. Prescriptions and other healthcare services also are covered,” notes Ollie. So when a patient leaves the hospital with a prescription for an antibiotic, for example, the hospital focuses on ensuring the patient recognizes resources are available to get the prescription filled.

“Without the information, the patient is much more likely to end up not complying with the treatment, creating greater likelihood that the patient will end up in the ED with a need for readmission,” he says. Such a result negatively impacts both the quality and cost of care delivery. Payment efforts around decreasing readmissions make initiatives such as these even more important to the hospital’s bottom line.

“We are providing educational outreach so patients understand that when they qualify for Medicaid, they have access to extended services,” Ollie says.

Focusing on financial obligation prior to service and propensity to pay. As hospital resources are strained, collecting
payment in the most efficient fashion becomes increasingly important.

Many hospitals are strengthening efforts to better identify patient payment ability early on in the revenue cycle. In the past 36 months, New Hanover has moved staff from the back office to the front end of the registration process to aid in determining patient payment responsibility prior to service. “We are talking to patients early in the process so they know what to expect regarding any financial obligation and the payment arrangements available, and hopefully we can remove some of their anxiety about coming to the hospital or about the new Medicaid program,” Ollie says.

New Hanover also is looking at patients’ propensity to pay. Determining payment ability helps hospitals target collection resources appropriately and provide optimal customer service. “If we can understand the differences in the patients’ ability to pay, we can appropriately collect monies from those who are able to pay,” Ollie says. It should be noted that some patients who qualify for Medicaid may still be able to pay a portion of their healthcare bill.

Seeking state processing efficiencies. Anticipating a cash flow slowdown with the rise of the Medicaid population, Oakwood Health is joining other hospitals to work with the state of Michigan on the development of an electronic application process. “We have communicated to the Michigan Department of Human Services staff that an electronic application and an electronic signature instead of the paper application would facilitate eligibility decisions and claims processing,” Flynn says.

Also, Oakwood Health is paying state workers to process patient applications onsite. “State workers are able to process them a little faster when they are dedicated on location instead of working out of district offices,” she says.

Additionally, the health system’s new eligibility system will allow financial counselors to keep better tabs on the status of the Medicaid applications. “Currently, we evaluate self-pay patients to see if they meet Medicaid eligibility criteria. We then place those cases in a pending status as we work through the application,” says Flynn. “That means someone has to go back periodically and check on the pending cases. It’s really not staff value-added time if they are constantly having to track the status of these cases. A tool from the new eligibility system will allow us to do more frequent checks against the state and the Medicaid database and use automation rather than manual intervention to see when a pending case is approved.”

Top priorities going forward. The goal of healthcare reform is to move uninsured individuals onto the rolls of the insured, largely through Medicaid. The effect of such monumental change on hospital revenue cycles remains to be seen. Regardless, some issues need to be top priorities for hospital leadership. The first is to consider the patient, says Ollie: “How will we deal with all the people who may qualify for Medicaid quickly and efficiently?” The other is to consider the organization at large: “How would a rise in Medicaid coverage affect the way we conduct the business of health care?”

Read more: http://www.faqs.org/periodicals/201102/2273326501.html#ixzz1RXppfrNq
The HFMA Peer Review process is a rigorous product and service evaluation program that significantly reduces risk and expands your purchasing options. Here are five reasons you should start your next purchasing process with HFMA Peer Reviewed products and services:

1) Reviewers whose opinions matter

HFMA Peer Review process is based on evaluations conducted by your fellow CFOs - healthcare professionals whose needs and concerns are similar to your own. No one is more qualified to cut through inflated marketing claims. The HFMA Peer Reviewed designation is your assurance that a product or service has proven its quality, value and ROI in healthcare environments like yours.

2) The due diligence you'd conduct if you had the time

HFMA conducts a far more rigorous due diligence process than your time and resources allow. A thorough, 11-step screening process evaluates products and services against HFMA’s high standards for effectiveness, quality, price, value and customer support. The process includes extensive surveys of current customers, as well as organizations that considered but ultimately decided not to purchase the product or service. The Peer Review team leaves no stone unturned during the evaluation process.

3) An impartial review process

No matter how thorough your own due diligence process, it's difficult to get an impartial review of products or services you're considering. Vendor websites, literature and references are obviously biased to emphasize the positives, and discussions with your network of colleagues might not uncover product limitations, drawbacks or service problems. The HFMA Peer Review process challenges those claims. If a product or service doesn’t deliver, it won’t earn HFMA Peer Reviewed designation.

4) A better list of candidates

In today’s rapidly changing marketplace, it’s challenging and time consuming to keep up with all the product and service options available. Moreover, you may be understandably reluctant to consider an unknown vendor, especially for a critical purchase. You may go back to the same vendors over and over simply because you're unaware of better alternatives or don’t have time to check them out. Because HFMA's Peer Reviewed products and services have been so thoroughly vetted, you can consider new sources with confidence and widen your purchasing horizons safely.

5) Assurance of continued service and support

HFMA Peer Reviewed status is not a once-and-you’re-done designation. HFMA conducts an annual re-evaluation of Peer Reviewed products and services to ensure that they continue to meet the rigorous standards that secured initial approval. This is additional assurance of the vendor’s long-term commitment to quality, effectiveness and customer support.

The Bottom Line

HFMA's Peer Review designation helps ensure that a product or service will do what it claims to do and will provide a solid ROI. It also documents that the vendor has demonstrated expertise in the healthcare industry and a strong reputation for integrity. For Gregg Beeg, CFO of Central Michigan Hospital in Mount Pleasant, Michigan, and HFMA Fellow, the HFMA Peer Reviewed credential carries tremendous weight in vendor comparisons. “It is exceptional the quality of the organizations that are granted and approved through the Peer Review process,” he says. He calls the HFMA Peer Reviewed designation “a gold star benchmark that all of us in the healthcare industry can use.”
Don’t Be Afraid To Fail
Author: Greg Adams, FHFMA

No one hits a home run every time—not even the late, great Babe Ruth. In fact, home-run hitters tend to strike out often.

Babe Ruth hit 714 homers, but he also went down swinging 1,330 times. If he was afraid to fail, he didn’t let it get in his way. Sometimes, in health care today, it feels like we have to swing for the fences, given what’s at stake with new payment models, accountable care organizations (ACOs), and other value-based payment structures.

And while we can’t let the fear of failure get in our way, that doesn’t mean we should swing wildly at every pitch that comes our way. It’s important to pick the right pitch to swing at. As Max Reynolds advises in his article about ACOs in this issue of hfm, “Look before you leap.”

In HFMA’s Value Project report, which was released in June, five potential value strategies were identified, based, in part, on a provider’s choice of how much responsibility for risk to assume and when to assume that risk. Of course, every choice carries some risk. At one end of the continuum, providers that seek to keep the price/volume-driven status quo may reduce their risk in the short run, but risk the eventual loss of organizational independence if they are unable to maintain this strategy. And at the other end of the risk continuum—population health management—providers that choose to accept responsibility for the health of a defined population are taking on risks of a different scope and magnitude. Those that attempted this strategy years ago under the guise of capitation will not soon forget the costs of failure. Understandably, they are not eager to take those risks again.

Each organization should weigh the potential risks and benefits of various value strategies in the context of its own unique strengths, weaknesses, opportunities, and threats. Within that context, HFMA’s Value Project offers a way forward. It starts with assessing your organization’s current and desired future state on the value continuum, based on your degree of integration and your willingness and ability to accept risk. HFMA is developing a web-based tool that includes a self-assessment questionnaire and in-depth resources on the skills organizations need to develop to succeed as value providers. In the coming months, HFMA will also produce a series of reports describing how to bridge the gap between current practices and a value-based future. Through the use of these tools, HFMA can help our members choose the right pitches to swing at and help improve chances of success.

Of course, no matter how well-prepared you are, there’s no guarantee you’re going to hit one out of the ballpark. But as any good coach will tell you, as long as you’re well-prepared, don’t worry so much about the risk of failure. Worry about the chances you miss when you don’t even try.
At present, 26 states are involved in Florida et al v. United States Department of Health and Human Services, which challenges the Patient Protection and Affordable Care Act (PPACA) on the grounds that the act constitutes a federal mandate forcing individuals to purchase health insurance in violation of the Commerce Clause of Article I of the Constitution. On February 7, 2011, 21 Governors sent a letter to Health and Human Services (HHS) Secretary Kathleen Sebelius requesting complete flexibility and control over the structure and operation of the exchanges to determine what best benefits their citizens. Secretary Sebelius and the HHS responded claiming the PPACA already offers what the Governors were requesting. The legislation also makes it difficult for Governors to avoid their exchange-related responsibilities. If states fail to create an exchange accepted by HHS in time, the federal government will intervene to establish and operate an exchange of its own as outlined by the PPACA.

Even if the majority of states were not fighting the PPACA, they may have to refrain from making any significant progress on the exchanges until state officials address their looming budget deficits. According to the Center on Budget and Policy Priorities, “the upcoming fiscal year is shaping up as one of states’ most difficult budget years on record. Thus far, some 44 states and the District of Columbia are projecting budget shortfalls totaling $112 billion for Fiscal Year 2012”. With budget constraints being a major hurdle to the creation and implementation of health insurance exchanges (HIE), Secretary Sebelius recently stated that the federal government plans to give grants to states and the District of Columbia to help establish them. On the other hand, some states have put the wheels in motion to remove the Federal money from their budgets.

However, states will have many options in creating the exchanges, or can choose not to create them at all. According to the National Academy of Social Insurance, states will have five avenues in which to structure the exchanges: creating or using a government agency; a not-for-profit entity created by the state; a multi-state exchange; a sub-state exchange serving geographical areas; or allow the federal government to setup and run the exchange. While it might be difficult to imagine the insurance exchanges being built with legal and budget battles occurring nationwide, the multiple options indicate that, unless the bill is overturned, the insurance exchanges are likely to be formed.

The Medicaid piece may be the most complicated program to automate, and the insurance exchanges will need to coordinate with the Medicaid program to achieve the goals of the PPACA. In order to be as valuable to the citizens as possible and give them the most effective way to find the medical coverage they need, the health insurance exchanges should be overly inclusive giving people the highest possible number of administrator and program options. If the HIE is not a “one-stop-shop” for citizens to search for insurance and public programs they are eligible to enroll in, then it will not have achieved its purpose. A single selection tool must also be capable of combining the insurance exchanges with Medicaid eligibility and enrollment screening. This tool could include state and local government programs, as well as charity care programs, for those eligible for insurance but may still need assistance on past medical bills. Perhaps the biggest question related to health insurance exchanges is whether the states will be able to handle the outreach necessary to get newly eligible people enrolled and meet the goals of the PPACA.

With Medicaid expanding to cover virtually all individuals under 65 with income levels up to 133% of the Federal Poverty Line (FPL), the Congressional Budget Office (CBO) estimates that by 2019 the PPACA will enroll 16 million additional currently uninsured people in the Medicaid program . . .

The current outreach that is necessary to maximize enrollment has clearly been insufficient. The Medicaid population is not static: someone who is not eligible today may be eligible tomorrow. This makes constant outreach and education necessary to assist those eligible with the enrollment process. Considering the budget woes of states, it is hard to imagine an effective outreach program being developed to assist not only newly eligible people, but the current people who are eligible that never enrolled. By 2014, states will have to implement an effective automated HIE that will incorporate both
public assistance programs and various insurance options. However, uninsured patients will continue to enter hospitals as current outreach efforts fall short and future outreach efforts are at the mercy of state budgets. Those hospitals that become more proficient at Medicaid screening and have the ability to assist and educate patients in the enrollment processes of available programs will be in the best position to provide assistance to the uninsured and to ensure the services they provide will be reimbursed.

Christopher Thunder is a policy analyst and writer for R&B Solutions, a Medicaid Advocacy company headquartered in Waukegan, Illinois.

Ryan Brebner is Manager of Business Development for R&B Solutions, and is responsible for leading the company’s sales and marketing. Ryan is an active member of HFMA, AAHAM, and NAHAM. For further information, Ryan Brebner can be reached at 847-887-8514.

About R&B Solutions: (www.randbsolutions.net)
R&B Solutions is a leading Medicaid Advocacy corporation that both uninsured patients and medical providers alike have come to trust to solve many of the problems facing uninsured patients and the medical facilities from which they seek help. R&B Solutions offers a wide variety of solutions for medical providers to assist their patients. The company uses highly trained patient advocates efficient in State Human Services processes, internally developed software, and years of legal experience to identify and assist the uninsured. R&B Solutions offers expertise in the field of Medicaid Advocacy (inpatient solution), Solutions for Uninsured Patients (SUP), outpatient solutions, and RAMP (Rapid Application for Medical Programs), proprietary software that screens for Medicaid and charity eligibility. Founded in 1986, R&B assists health care providers and their uninsured patients across the United States.
2011 Kentucky Chapter HFMA Annual Summer Educational Institute
Author: Dale Skaggs, Blue and Company

The 2011 Kentucky Chapter HFMA Annual Summer Educational Institute was held at the Hyatt Regency in downtown Louisville this year on July 28 and 29. This year’s attendance climbed to a record breaking 182, up from the 2010 total of 157. Many thanks go out to Scott Reed, VP of Education and all who helped plan the meeting. The agenda for this meeting included the following topics: Where is Healthcare Going?, The Medicare Cost Report is Changing! Be Prepared for the 2552-10, Managing Financial Results of a Hospital Owned Physician Practice, ICD-10 – 800 Days and Counting!, Meaningful Use of HIT & the Affordable Care Act, No-Go on the ACO (What You Should Be Thinking About Now). The handouts for the sessions will soon be posted on the Chapter’s website at http://www.hfmaky.org/.

The first day began with Lisa Disselkamp, who discussed Using Time and Labor to Increase Profitability and Productivity. The highlight for day one was the Managed Care Organization panel. Carrie Banahan from the department of Medicaid was the moderator and each of the new managed care companies sent a representative to give general information about each of their companies, their past success in other states and their specific approach to implementing managed care in Kentucky. That night, several of the attendees went to a Louisville Bats game at Slugger Field. They had great seats for the game and enjoyed baseball park food and drinks.

Day two began with a presentation by John Sena which covered Emerging Trends in Healthcare: Preparing for Tomorrow, Today. The Summer Institute was a great success and continues to build upon the Chapters commitment to bring high quality, national speakers and timely topics to the membership.

The next education institute will be the Tri-State Fall Institute and Vendor Show meeting at Belterra Casino on September 14-16. A link for registration has been provided, http://www.hfmaconference.com/program_registration.html. Please mark your calendars now and plan to attend.

Job Opportunities

**Director, Business Office**

Ephraim McDowell Health is seeking a full-time Director, Business Office, who will lead revenue cycle initiatives including the integration of patient registration, patient scheduling and patient accounts to ensure timely billing and collection activities. Maintains efficient work flow by continuously analyzing and evaluating productivity, staffing levels, scope of service and Associate and patient satisfaction concerns. Bachelor’s required; Masters preferred. 7-10 years billing and revenue cycle experience. Applicants may apply online at www.emhealth.org.

Ephraim McDowell Health
217 South Third Street
Danville, KY  40422
EOE

**Business Analyst**

Manages the EMH Business Analysis/Decision Support to include system-wide budgeting, forecasting, bench-marking, cost-accounting, productivity and service line analysis, cost reporting, and other types of patient demographic and fiscal analysis. Supports the EMH System CFOs and Leadership team with fiscal and reimbursement monitoring, modeling, trending, and reporting. Works directly with Patient Care areas/directors on financial/reimbursement issues as well as patient demographic reporting. Directs the EMH Chargemaster to include annual rate-setting, analysis, and continual updating and monitoring. Provides statistical analysis and reports to all departments and outside customers through various software applications. Exhibits the values of F.I.R.S.T. (Friendliness, Innovation, Respect, Service, and Trust).

Ephraim McDowell Health
217 South Third Street
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The Financial Diagnosis supports the mission of the Kentucky Chapter by serving as a key source for individuals involved in or interested in the financial management of healthcare.

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

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