



AUGUST 2010



MISSISSIPPI

Headlines

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The 2010 MS HFMA Summer Workshop is quickly approaching. Have you registered yet?

Don't miss out on this great opportunity to learn, engage with speakers, industry leaders, HFMA leadership and your peers from around the state, and enjoy a fun golf outing at the beautiful Dancing Rabbit Resort. For additional information, see page 6. To register today, follow the link below.

August 19 - 20, 2010

Silver Star Hotel & Casino

Choctaw, Mississippi

http://www.mshfma.org/site/epage/59697_331.htm

Mississippi HFMA...Your Educational Resource...

MS Chapter of HFMA · August 2010



Sandy Riley, CME
MS HFMA Chapter President

Healthcare Financial Management's National Theme for 2010-2011 is "Step Up." The Mississippi Chapter of HFMA provides the forum for us to share our experiences as we "step up" to meet our ever-changing challenges.

In May, the Mississippi Chapter of HFMA ended an extremely successful year, meeting every goal set by National HFMA. At the Annual National Institute in Las Vegas June 20-24, 2010, Jerry Knighton, 2009-2010 MS Chapter President, received the Chapter's Gold Awards for every category - Education, Membership, and Certification and the Yerger award for the Tri-State meeting!

Our membership's enthusiasm is contagious and we invite you to join us as we continue to grow and succeed.

The 2010-2011 Leadership Team plans to continue to build on the successes of our past leaders. If ever there has been a need for a professional organization such as HFMA, now is certainly the time. On March 23, 2011, HFMA's President and CEO Dick Clarke remarked on healthcare reform, *"This is a tipping point for our industry. It will change the fundamentals of how we perform our jobs as financial leaders. HFMA is ready to help members deal with the complexities, unintended consequences, and challenges this legislation will create."*

Healthcare Reform, as well as the many other challenges we face in the healthcare industry, will be our focus for the upcoming year. We commit to provide the most timely, relevant information possible and provide networking opportunities that will enable us all to survive in this most challenging time.

We would encourage you, if you have not achieved certification in your field, to become certified through HFMA's certification program – this not only enhances your status in the industry but also assures that your healthcare finance knowledge is current.

Don't miss the opportunity to take advantage of educational opportunities that are available not only through your Mississippi HFMA Chapter but also through National HFMA! HFMA is your educational resource. Let's all support each other and take this journey through healthcare reform together. I look forward to working with each and every one of you.

Sandy Riley, CME

NEWS to NOTE

HFMA's 2010 ANI THE HEALTHCARE FINANCE CONFERENCE

The MSHFMA chapter received Gold Awards for every category—Education, Membership and Certification and the Yerger Award for the Tri-State meeting! The National HFMA's Awards and Recognition Program is designed to provide incentives and recognition of chapter activities to achieve results as defined by the Davis Chapter Management System (DCMS) policy. It is intended to focus chapters on important activities that add value for members or the Association while simultaneously encouraging innovation and improvement. Six award groups are identified:

- The Robert M. Shelton Award for Sustained Chapter Excellence
- The Helen M. Yerger Special Recognition Award
- The C. Henry Hottum Award for Educational Performance Improvement
- Awards of Excellence for Education, including:
 - The Sister Mary Gerald Bronze Award of Excellence for Education
 - The John M. Stag Silver Award of Excellence for Education
 - The Charles F. Mehler Gold Award of Excellence for Education

- Awards of Excellence for Certification: Bronze, Silver and Gold Levels
- Awards of Excellence for Membership Growth and Retention: Bronze, Silver and Gold Levels



Jerry Knighton

2009-2010 MS HFMA Chapter President



Mike Ernst

Memorial Hospital at Gulfport

Newly elected to the Mississippi Chapter of HFMA Board of Directors this year, this spotlight is on Mike Ernst.

He has been the Director of Business office Services at Memorial Hospital Gulfport, MS since December 1999. He has over 27 years of experience in the Healthcare field. His undergraduate degree is a Bachelor of Science in

Business Administration degree with a major in marketing and a minor in management from the University of Southern Mississippi in Hattiesburg, Mississippi. Mike earned a Masters of Business Administration degree from William Carey College (Gulf Coast branch) in May of 2005.

He has 11 years of experience as a consultant of healthcare business services and accounting with HCA, HealthTrust, FIT and Epic Healthcare. Mike has consulted to healthcare Managers, Directors and CFOs in over 100 hospitals in more than 30 states. He has experience at managing operations for multi hospital centralized business offices (CBOs) as well as independent public facilities. As an HCA Business Office Consultant, Mike authored the first written book of business services operations policy and procedures (inclusive of the data systems usage then in place with HCA) and assisted with its deployment through out the companies 104 hospitals. He served on both the HCA and HealthTrust Acquisition teams in the internal audit groups of the respective companies.

While there has been extensive travel in his career to date, Mike advises he has enjoyed the opportunity to live and work for the past 10 years on the Mississippi Gulf Coast. He is a Director for Mississippi Deep Sea Fishing Rodeo in Gulfport, Ms. The world's largest fishing tournament, sometimes there are as many as 700 fishermen entering the Rodeo and 30,000 spectators attending the 4 day events on the 4th of July weekends. He currently serves as both sponsor and program Chairman for the event that he uses 2 weeks of vacation to attend and work at each year. He is also a member of the Krewe of Orange Grove Mardi Gras in Gulfport Missis-

sippi and served as the 2008 Mardi Gras King for the Krewe. Favorite event at Mardi Gras is riding the floats in parades.

Other activities he participates in outside of work are USM alumni chapter activities, Chamber of Commerce Ambassador; William Carey Leadership class mentor, Kids softball coach (seasonally) or umpire, and occasionally gets to go fishing.

He has never been married (yet) , but also enjoys the time he gets to spend with his sisters' families and all of the nieces and nephews and 8 grand nieces and grand nephews.

In closing Mike truly believes his success in life is mainly due to hard work, and the many positive and great relationships that he has had with the all the people he has and does work with. "Without them, I would have never been able to accomplish all that I have on my own. They have brought joy and happiness to my life and work. They have supported me, taught me, and inspired me."

Save the Date!

CALENDAR OF EVENTS

[MS HFMA 2010 Summer Workshop](#)
Thursday August 19 - August 20, 2010
Silver Star Hotel & Casino
Choctaw, MS

[Region 9 Meeting](#)
Sunday November 14 - November 16, 2010
New Orleans, LA

[TriState Meeting](#)
Wednesday January 19 - January 21, 2011
Golden Strike Casino
Tunica, MS

MORE HOSPITALS TO BECOME ELIGIBLE TO REFINANCE DEBT THROUGH HUD



Ken Gould

Lancaster Pollard

Ken Gould is a vice president with Lancaster Pollard, a financial services firm based in Columbus, Ohio that specializes in providing capital funding and financial advisory services to the senior living, health care, affordable housing and private education sectors. In addition to underwriting tax-exempt bond offerings, Lancaster Pollard provides organizations a complete range of funding options through its FHA/GNMA/USDA-approved mortgage lender subsidiary. Ken is the client's primary point of contact and is responsible for all of the details involved in the underwriting and closing processes.

Since joining the firm in 2004, Ken has focused his efforts on long-term care, health care and senior living analysis, providing support on a range of bond transactions and mortgage loans for rehabilitations, new constructions and refinance projects totaling more than \$300 million. He has thorough understanding of the various financing structures available through conventional financing, FHA programs and the USDA Community Facilities.

Reprinted with permission from Lancaster Pollard's "The Capital Issue" at www.lancasterpollard.com.

The first public option to refinance hospital debt will be made viable for more hospitals if proposed changes are codified later this spring. The new eligibility standards for HUD mortgage insurance, announced in late January, would enable more hospitals, including those below investment grade, to reduce interest rates, exit troubled banking relationships, extend debt amortizations or otherwise alter existing hospital debt structures.

In the Proposed Rule currently published in the Federal Register, HUD emphasizes that its financing is designed for necessary community hospitals that are strong enough to qualify under its relatively conservative underwriting guidelines, but that do not have access to other funding sources. Comments on HUD's revised threshold requirements are being accepted through March 30, and advocates already are developing responses to further refine the criteria.

The Evolution of Refinancing Through HUD

Mortgage insurance can be used by hospitals of all sizes to finance construction and renovation at some of the lowest rates and best terms available. Prior to July 1, 2009, a hospital could refinance debt using HUD mortgage insurance, known as the FHA/HUD Section 242 program, only if 20% of its transaction was made up of money for new projects. The 20% new money requirement was not viable for most hospitals, as taking on additional leverage or the burden of a project was not tenable.

The new-money requirement was eliminated with the Federal Housing Administration's announcement of the FHA Section 242/223 (f) refinancing program last July. But vague and restrictive eligibility requirements thwarted hospitals that sought to use the eagerly-awaited option. The required debt service coverage and operating margin ratios for refinancing, for example, were 1.8x and 0.33, contrasted with 1.25x and 0.0 for new construction. An additional requirement that the hospital either have experienced a 1% interest rate increase or be facing an "imminent" increase in its interest rate left doubt as to whether fixed-rate debt could be refinanced at all.

Hospital advocates nationwide pushed for revisions to the eligibility. The changes were announced Jan. 29 in a Proposed Rule published in the Federal Register for public comment prior to its codification.

How Has Eligibility Changed?

Changes to the refinancing criteria include:

- The required three-year average Operating Margin ratio has been reduced to 0.0% from 0.33%.
- The required three-year average Debt Service Coverage ratio has been reduced to 1.4x from 1.8x.
- The requirement that a hospital have experienced an interest rate increase of at least 1% or face an "imminent" interest rate hike has been replaced with a more flexible and defined standard. Hospitals must now meet three of the following seven criteria to be eligible to refinance:

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- Refinancing would reduce total operating expenses by at least 0.25%.
- The new interest rate would be at least 0.50% lower than the current rate.
- The current interest rate has increased at least 1 percentage point since Jan. 1, 2008, or likely will increase that much within one year.
- Annual total debt service is over 3.4% of total operating revenues.
- Credit enhancement on current financing has been or will be withdrawn or expired, or the enhancement provider has been or will be downgraded.
- The current financing has overly restrictive bond covenants.
- Other circumstances demonstrate that the hospital's financial health depends on refinancing.

The hospital must also demonstrate that it provides an essential service to its community and that there are few affordable refinancing options. HUD is also focusing on market need, although this determination can vary in different scenarios. For example, a state-designated Critical Access Hospital will most assuredly receive more scrutiny than a federally-designated Critical Access Hospital, as will a hospital seeking to use a high percentage of its loan for expansion in a competitive market area. A market need study will usually be required, but can be waived at HUD's discretion.

Hospitals that meet the above criteria would do well to include FHA in their refinancing considerations because interest rates are lower via HUD financing than via unrated, unenhanced fixed-rate bonds, and HUD's cash collateral requirements are lower than those of many banks.

The traditional 242 program for new construction continues to be an option for independent hospitals, as well as for hospital systems that seek to isolate the credit risk of a single asset (perhaps a smaller hospital in a multi-hospital system). For public-owned hospitals, the 242 program can be utilized in conjunction with Build America Bonds, resulting in a significantly reduced cost of capital.

HUD estimates that it could complete about 40 hospital refinances in calendar year 2010, assuming processing of 60 days for each application. While this timing estimate appears reasonable given the assumed workload, as of early February no hospital refinance has yet been completed to provide an actual comparison. HUD's timing also assumes an even distribution of applications during a calendar year, an assumption that in future years will likely be reasonable.

With the revisions to its FHA Section 242/223(f) mortgage insurance program, HUD has introduced a viable public sector refinance option where none existed before. While certainly not a panacea, the addition of a non-private-sector refinancing choice provides relief to mid-level community hospitals at a time when they need it, and will continue to be worth including in any comparisons of refinancing options even when the market stabilizes.

Real-life FHA Refinances

A West Virginia hospital has just submitted to refinance its short-term debt structures into a long-term FHA-insured loan under the new eligibility criteria. Debt service is currently high, and the hospital, with \$180 million net patient revenue, is strapped for cash. Refinancing into a 25-year FHA amortization would reduce annual debt service from \$6.5 million to \$2.6 million.

An Illinois hospital, with experience using multiple financing options, is exploring FHA Section 242/223(f) to refinance out of a variable-rate structure enhanced by a letter of credit. The letter of credit fee has increased by 2 percentage points, and it will not be renewed when it expires this year because the provider is no longer interested in smaller hospital credits. Rates on FHA financing, however, are fixed rate, and the mortgage insurance premium will not vary from 0.5%.

In Indiana, a county-run hospital's letter of credit provider was downgraded, and its bonds are now trading at a premium, if at all, causing higher costs even though the hospital's own credit profile was not a factor. The hospital is exploring refinancing with FHA Section 242/223(f).

WELCOME NEW AND REINSTATED MEMBERS

Jackie S. McKenzie

Director of Operations/Diagnostic Svcs
Beacham Memorial Hospital

William V. Williams, III

VP Operations Finance—MS Division
Health Management Associates

Russ Lyle

Director
OCH Regional Medical Center

William L. Eubank

Member of the Firm
Eubank & Betts, Inc

D. James (Jim) Blackwood, Jr.

Attorney
Copeland, Cook, Taylor & Bush, P.A.

Jeremy S. Scott

Controller
Health Management Associates

Brandon J. Raff

Strategic Planning & Project Analyst
Memorial Hospital of Gulfport

Ashley L. Verrette

Audit Associate
KPMG

Chanda Roberts

Accounting Manager
Magee General Hospital

Mandy L. Alford

Controller
Tri-Lakes Medical Center

Eugenia Stark Thomas

Balch & Bingham, LLP

Wendy T. Fisher

Senior Accountant
Rush Health Systems

Ben R. Hester

Senior Associate
HORNE LLP

James M. Nester

Director of Business Services
Rush Health System, Inc.

Penny Wood

Senior Manager
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UPCOMING MS HFMA SUMMER WORKSHOP - AUGUST 19 - 20, 2010

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Contact:

**Warren Ladner, Membership
Committee Chair**

warren.ladner@hma.com

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KEYNOTE ADDRESS BY AARON BEAM



"I think others can learn from my story," Beam says. "From how I started a major company, how I got involved in the fraud while serving as Chief Financial Officer, and more importantly, the human story, the pain of going through a trial and going to prison."

A keynote address by Aaron Beam, founder and former CFO of HealthSouth, will complement our excellent educational sessions planned for the Summer Workshop with a gripping, real-life story of his costly brush with corporate fraud. Beam's story is the untold story of HealthSouth, one of America's most successful health care companies and consequently, the perpetrator of one of its biggest frauds in history.

You won't want to miss this! Register today at www.mshfma.org

WHAT'S HIDING IN YOUR VENDOR INVENTORIES?



Steve Levin, CEO

Connance

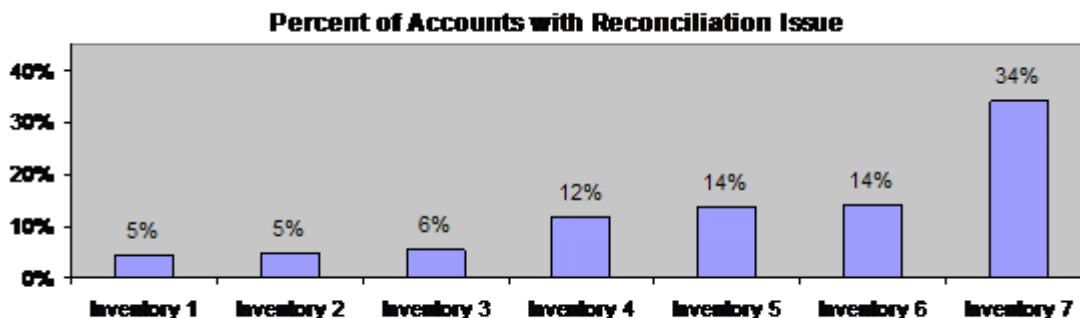
Steve co-founded Connance, a leading provider of back-office, self-pay collection and scoring solutions, following a nearly two-decade career as a management consultant with Monitor Group, an international management consulting firm. At Monitor, he was a Senior Partner and worked extensively in healthcare. His experience included senior advisor to leading healthcare networks in revenue cycle restructuring. Steve holds a B.A. in Engineering Sciences from Dartmouth College and an MBA from Harvard Business School.

Today, most hospital business offices rely on third party vendors, such as collection agencies, extended business office partners and eligibility firms, to augment their internal collection efforts. Every day, accounts and financial updates flow back and forth between a hospital and its vendors. Despite everyone's best intentions, the current operating routines and processes often result in inconsistencies between the inventory records of a hospital and its vendors.

Always thought to be a relatively minor issue, recent research suggests the inventory reconciliation problem is significant, pervasive and critical. Reconciliation issues between providers and their vendors can lead simply to lost cash and high operating costs or go so far as to create regulatory issues and major public relations problems.

The Magnitude of Inventory Reconciliation Issues Can Be Significant

Based on findings from inventory reconciliation initiatives at multiple providers around the United States, between 5% and 34% of inventory held at vendors had reconciliation issues with the providers' records.



Source: Connance Benchmark Research

The average reconciliation error rate across this sample of providers was 13%. However, even in situations where the provider had only a single vendor, the reconciliation error rate was high.

Vendors also appear to demonstrate different performance on account and inventory reconciliation activities. As the research indicated, some vendors seemed to systematically operate at lower than 90% accuracy while others were close to 98% accurate.

How do Inventory Reconciliation Problems Happen?

For each account, countless financial events such as payments, adjustments, reversals, etc. occur every day both in the hospital business office and in vendor operations. All these events need to be dutifully credited, debited and noted in both provider and vendor inventory records in exactly the same way.

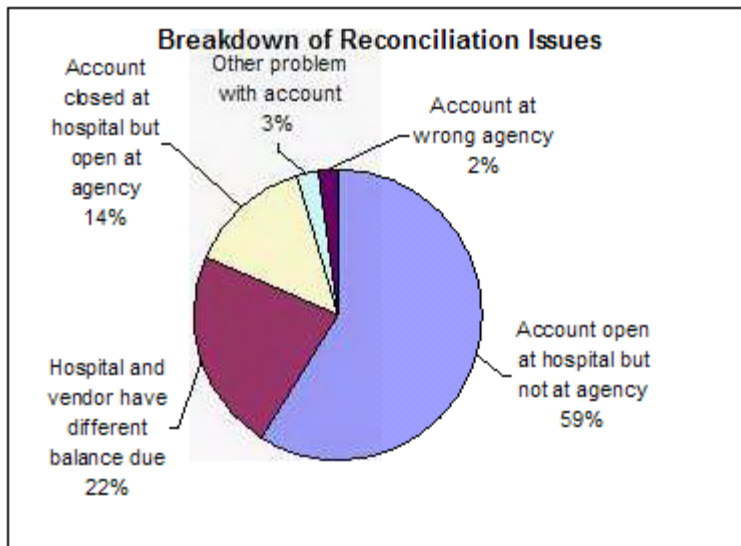
For instance, an event as simple as a patient going to the hospital to pay a past-due bill previously sent to a collection agency creates a string of follow-on events in the hospital's patient accounting system that need to be connected to and mirrored in the collection agency's inventory records.

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WHAT'S HIDING IN YOUR VENDOR INVENTORIES? - CONT.

Reconciliation issues broken down into five categories



Source: Connance Benchmark Research

That same check, subsequently failing to clear at the patient's bank, will lead to another series of reversal transactions that need to be mirrored yet again. If the reversal occurs in the next month, it means that all the unwinding activity will be part of a different monthly close effort. As these examples demonstrate, there are multiple opportunities for reconciliation issues to percolate in even the simplest, most common events.

By having the ability to access and benchmark thousands of account placements and recalls every day between providers and vendors around the United States, some trends have emerged. These include:

1. Accounts are closed in the patient accounting system, but not recalled from the vendor;
2. Accounts are closed by the vendor, but not updated as such in the patient accounting system;
3. Accounts on payment plan appear at the vendor, but are not documented as such in the provider's records;
4. Vendor is continuing collection efforts on accounts on hold for review at the provider; and,
5. 'Missing transactions' or transactions that are recorded in the patient accounting system, but are not sent to the vendor, and vice versa.

Over time, the small numbers of account problems compound and mature into the 5% to 34% inventory reconciliation issues noted earlier.

(continued on page 10)

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WHAT'S HIDING IN YOUR VENDOR INVENTORIES?

Possible Negative Outcomes from Reconciliation Issues

Not only are the number of accounts involved significant, but these reconciliation problems lead directly to problematic outcomes. Some of the more concerning problems include:

Reconciliation Issue	Possible Ramifications
Account open at hospital, but not at agency	<ul style="list-style-type: none"> ▪ No work is being done on the account so no money is being collected. ▪ Patient may incorrectly be told that their financial obligations are complete.
Hospital and vendor have different balance due	<ul style="list-style-type: none"> ▪ Vendor is either pursuing too much or too little money, both of which are problematic. Too much exposes the hospital to legal and public relations issues. Too little leaks cash. ▪ Unexplained changes to the balance due undermine patient confidence in the accuracy of the bill now and in the future. This breakdown delays patient payment as the patient is expecting the billed amount to change. ▪ Creates unproductive administrative costs at both the vendor and provider when the gap is identified and needs to be explained.
Account closed at hospital, but open at vendor	<ul style="list-style-type: none"> ▪ Vendor is requesting payment on an account that has been resolved or otherwise closed. ▪ In the event that the account has been written off to charity or taken as bad debt on a cost report, significant legal and compliance issues are created. ▪ Patient goodwill and community relations put at risk. ▪ Vendor is incurring costs to collect.
Account at wrong vendor	<ul style="list-style-type: none"> ▪ Collection efforts may be inappropriate for the type of account. Different agencies are often contracted to operate under different policies, processes, and commission rates. ▪ Patient satisfaction risked by exposure to more aggressive collection tactics than warranted.
Account at two vendors	<ul style="list-style-type: none"> ▪ Patient is pursued by more than one vendor, creating frustration with the provider and potentially excess payment. ▪ Hospital potentially paying commissions to both vendors. ▪ Extra collection costs incurred by vendors.

In almost every situation, reconciliation issues are elevating operating costs, distracting management attention and reducing cash recovery. It also creates the opportunity to undermine patient satisfaction, generate negative PR in the local community, and put the provider at risk with regulators, CMS and other oversight organizations.

What Can a Provider Do to Address Inventory Reconciliation Issues?

Many hospital business offices only perform spot checks or “rough reconciliations” due to the volume of activity, inaccessible account data and limitations with patient accounting system. Many hospitals also use time consuming, manually intensive account matching, thinking they can solve their reconciliation problems with human intervention. While better than doing nothing, they are insufficient.

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WHAT'S HIDING IN YOUR VENDOR INVENTORIES?

The scale and scope of the previously mentioned research plus the trend to use more outsourcers in business office processes suggest providers and their vendors need to enhance key routines:

1. **Check placement files for misplaced accounts and identify root causes of problems.** Despite their best efforts, hospitals do occasionally send a handful of accounts to a vendor that either should not have been sent to a vendor or were already sent to a vendor. When this happens, it is critical that the accounts are identified, inventory records are corrected, and the underlying reasons for the account being incorrectly placed are identified and corrected.
2. **Reconcile balances for all accounts in placement and recall files.** It is not sufficient to simply confirm receipt of the placement file and total number of accounts. Individual account balances need to be verified as well, preferably by cross checking account-level financial transactions.
3. **Reconcile full inventory at each vendor, at least monthly.** Given the compounding effect of problems over time, full reconciliation at least monthly is necessary. In many situations, weekly reconciliation of the entire inventory may be appropriate.
4. **Update policies and procedures and monitor adherence.** A number of inventory issues are created as a result of inadvertent customer service activity, such as incorrectly moving or closing an account or applying an incorrect transaction code. A good practice is to review policies and procedures at least once per year to check that they are up to date, cover all reasonable situations and are understood by employees in the business office and at vendors. The provider also needs to monitor adherence to these policies and procedures.
5. **Ensure comprehensive and common reporting.** Numerous hospitals unknowingly rely on incomplete information or reports generated using different variable definitions. Having accurate reports that are common across vendors to track inventory reconciliation is central to having clean, accurate account inventories.

Long term, cost effective approaches generally are technology enabled, automating the exception identification process.

Ultimately, whenever a provider corrects existing inventory reconciliation issues and prevents new ones from occurring, they are improving the patient experience, reducing operating costs and compliance risks, and enabling their vendors to be more effective. It is a true win-win-win experience.

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SUMMARY OF COVERAGE UNDER HEALTHCARE REFORM



Beth McGown

Chamberlin Edmonds

Elizabeth A. McGown (Beth) joined Chamberlin Edmonds in February of 2004 as Senior Vice President and General Counsel. Prior to joining Chamberlin Edmonds, Beth served for six years as Vice President and General Counsel of a privately held home delivered healthcare services company based in the Midwest that provided oxygen, clinical respiratory services and home medical equipment. Beth has significant experience with healthcare regulatory and reimbursement

issues, contracting, mergers and acquisitions, and corporate governance. In addition to two years as V.P. and General Counsel for a certified homecare and private duty nursing company, her experience includes 11 years as a Division Director and Assistant Commissioner with the Georgia Medicaid program. Beth managed the legal, contractual and regulatory aspects of Medicaid administration including eligibility policy, surveillance and utilization review, third party liability, fraud and abuse and provider enrollment. Her 33 years of private and governmental healthcare experience and her general practice experience provide Chamberlin Edmonds with healthcare and general corporate expertise.

Beth received her Bachelor of Arts degree in History from the University of Rochester, and received her J.D. from Boston College Law School.

The recently passed Healthcare Reform statutes (also known as the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010) seek to provide healthcare payment coverage for most US citizens. The statutory approach is to base eligibility for healthcare benefits assistance on a sliding income scale. The foundation of this scale is an expansion of public programs, specifically Medicaid. Building on that foundation is a combination of an individual mandate accompanied by the creation of Health Benefit Exchanges through which individuals/families may qualify for subsidies to assist with purchase of private health

insurance. Individuals who purchase insurance through an employer plan may continue to do so. Employers are encouraged to offer insurance through both subsidies for small employers and penalties for larger employers who fail to offer health insurance. The law also makes changes to the private insurance marketplace to standardize coverage programs and make the purchase of individual policies more understandable to the public. Let's dive a little deeper into each of these categories.

Medicaid Expansion:

Medicaid will be expanded to all individuals under age 65 with incomes up to 133% of the Federal Poverty Level (FPL) [today = \$14,404 for an individual and \$29,327 for a family of four]. The measure of income will be based on the IRS definition of modified adjusted gross income. This expansion will create a uniform minimum Medicaid income eligibility threshold across all states. The focus on income as a primary criterion ends the historic connection to old welfare rules that excluded most adults without dependent children. As with current Medicaid law, undocumented immigrants will not be eligible for participation in the regular Medicaid program, but hospitals providing emergency services to the undocumented will still be able to seek reimbursement under the emergency medical assistance program. To benefit from the enhanced funding under the new law, States are required to maintain their current levels of cover-

The legislative effort is not air tight by any means but it is estimated to reduce the number of uninsured by 32 million by 2019

age for children under the Children's Health Insurance Program. To assist financially strapped states with provision of Medicaid benefits to more people, the federal government will provide 100% federal funding for the newly eligible Medicaid recipients for years 2014 – 2016, 95% federal funding for 2017, 94% federal funding for 2018, 93% federal funding for 2019 and 90% federal funding for 2020 and

future years. [For 2009, the average federal funding rate for Mississippi Medicaid is 83.62%.] The State Medicaid program and the primary care network in Mississippi will be further benefited by the requirement that payments to primary care doctors for primary care services will be increased to 100% of the Medicare payment rates in 2013 and 2014 with 100% federal financing.

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SUMMARY OF COVERAGE UNDER HEALTHCARE REFORM – CONT.

Individual Mandate and State Health Benefit Exchanges:

Beginning in 2014, all individuals will be required to have health insurance (with some exceptions for financial hardship or religious objections). If someone fails to obtain coverage there is a penalty of the greater of \$695 per person per year (max. per family of \$2,085), or 2.5% of household income. This mandate and penalty is phased in between 2014 and 2016. States will create Health Benefit Exchanges where individuals can purchase insurance and apply for premium subsidies based on income. Subsidies will be available on a sliding scale based on income and will limit the cost of the basic premium to between 2% of income for those with up to 133% of the poverty level and up to 9.5% of income for those between 300-400% of the FPL. Cost-sharing subsidies will also be available to people with incomes between 133 – 400% of FPL to limit out-of-pocket spending for the individual (and uncompensated care provided by hospitals). Plans in the Exchanges will offer certain standardized minimum benefit packages. Insurers will offer four levels of coverage plus a catastrophic coverage plan. The benefits packages must meet the minimum set of standards and may add extra coverage.

The Exchanges will clearly outline the coverage and the various premiums and out-of-pocket costs for each level of coverage. Only US citizens and legal immigrants may purchase coverage through the Exchanges. While initially the exchanges are only available to individuals/families who wish to purchase insurance, eventually the Exchanges will open to small businesses and larger businesses.

Employer Requirements and Credits

The new law does not provide a direct employer mandate, but it does assess a fee on employers who do not offer health coverage if even one of their employees receives a premium subsidy by buying insurance off the Exchange. An employer with more than 50 employees will be assessed a fee of \$2,000 per full-time employee (in excess of 30 employees). Employers that do offer coverage but have at least one employee who receives a premium credit through an exchange must pay the lesser of \$3,000 for each employee who receives a premium subsidy or \$2,000 for each full-time employee. Employers that offer health insurance must provide a voucher to employees with incomes below 400% FPL if the employee's share of the premium is between 8 and 9.8% of income. Employers that offer this free choice voucher will not have to pay the employer penalties. Small employers (no greater than 25 employees with average annual wage of less than \$50,000) will receive a tax credit of up to 35% of the employer's contribution toward the employee's health insurance premium for tax years 2010 – 2013 if the employer contributes at least 50% of the total premium cost. The tax credit is greater for very small firms and phases out for larger employers. Once small businesses can buy off the Exchange in 2014, these businesses are eligible for a tax credit of up to 50% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the premium. This tax credit is available for tax years 2014 and 2015. Large employers who offer health insurance plans will be required to automatically enroll employees unless the employee affirmatively opts out of coverage.

This legislative effort to put in place mechanisms to tighten the safety net and assist low and moderate income families with the purchase of private health insurance is not air tight by any means but it is estimated to reduce the number of uninsured by 32 million nationwide by 2019. Stay tuned.

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Your Assistance Needed

CPAR Initiative & Development Committee

We are pleased to announce that the Mississippi Chapter of HFMA is considering implementing and offering the Certified Patient Account Representative (CPAR) Program. Our mission is to provide educational resources to enhance the knowledge, personal growth and development to Account Representatives in all healthcare professions. The purpose of the program is to educate as well as recognize those who have demonstrated fulfillment and proficiency in the revenue cycle field.

The Certified Patient Account Representative (CPAR) Program is an ideal training and certification program for:

- Patient Access Staff
- Patient Financial Staff
- Customer Service Staff
- Other Healthcare Professionals

We are also pleased to announce that Johnathan Bedell has taken the lead to assist us in the possibility of implementing this program within the Mississippi Chapter of HFMA. Johnathan worked extensively with this program as a member of the Alabama HFMA Chapter and has recently moved to Mississippi. His knowledge and expertise will be an invaluable asset as we move forward.

Currently Alabama, Georgia, Tennessee, Florida, and South Carolina all have this successful program in place. The CPAR Program can lead to offering other certification programs for the Revenue Cycle Staff. As we continue to strengthen our chapter with this endeavor we are seeking individuals who would be interested in taking part in developing this program.

If you would like to become a part of this initiative and Johnathan's CPAR Committee, contact him at

Johnathan.Bedell@na.firstsource.com



David Williams

HORNE LLP

NOW IS THE TIME

If you've ever thought about becoming a certified member there is no better time than the present. With all of discussions of health care reform and its impact on the financial aspects healthcare, set your career apart with the additional designation as a certified healthcare professional.

The exam is currently structured with a CORE exam which tests the baseline knowledge of healthcare finance and a specialty portion in one of the following areas:

- (1) Accounting and Finance
- (2) Physician Practice Management
- (3) Managed Care and
- (4) Patient Financial Services.

The Chapter has purchased study guides in its library to be provided to members upon request for each exam and the Chapter also hosts coaching courses throughout the year at our educational meetings.

The process for application, testing and certification can be found on the HFMA.org website or for further information contact David Williams, certification chair @ 601-326-1320 or david.williams@horne-llp.com

CONGRATULATIONS TO RECENTLY CERTIFIED MEMBERS!

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The mission of our chapter is to provide healthcare financial professionals in our state education and information to assist them with better job performance and career enhancement. We believe our organization is in the best position to provide this education and information and we intend to do that.

Our intent is to offer healthcare professionals a quality product and a value for their money. We intend to enhance the value of our meetings in several ways including making sure our programming is relevant, filling up our agendas with more hours and speakers, consistent communication, and by partnering with other groups to leverage our resources for better speakers, etc.

So how does this impact you? In order to keep our educational sessions at the highest level and also at an affordable price; we need your sponsorship commitment to subsidize those meetings. Your corporate sponsorship is important in insuring our success in meeting the educational needs for healthcare professionals in our state. The Corporate Sponsorship Program details the program, including costs and the various benefits you will receive as a corporate sponsor.

Your corporate sponsorship is key to the continued success of our chapter. Thank you for getting involved with our chapter and becoming a part of an organization with a strong tradition of excellence and service.

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Robin Long
Newsletter Editor

Thank you all for taking the time to read our first newsletter for the 2010-2011 year. The format is different, so please give us feedback on what you do and don't like about it. We hope everyone enjoyed their summer and look forward to a great year under President Sandy Riley and a hard working board. A very special thanks to Irena Zaneva, Horne LLP, for her hard work and expertise in preparing this newsletter and making it possible. Take care and we'll see you in Philadelphia at the Summer Workshop!

Robin J. Long



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Headlines

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MISSISSIPPI HEADLINES

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