hfma great lakes chapter
healthcare financial management association

HFMA SVSU Panel Discussion – A Panel of (5) Great Lakes HFMA members will be answering industry questions for an SVSU classroom of students in Master's degree program with Health Care focus

When: Tuesday, March 22, 2016 from 4 p.m. to 6 p.m.

Where: SVSU Campus, Health and Human Services Building

Sample Questions provided by SVSU Students ahead of time:

(1) Limitations on access to care due to high deductibles and co-payments with individual plans purchased on the Federal healthcare exchange. What impact is this having upon your communities and potential patients? How are your organizations responding? Do you support the AHA's position (per the December 18, 2015 letter to Andrew Slavitt, Acting Administrator, CMS) in response to Proposed Rule: CMS-9937-P/RIN 0938-AS57)urging CMS to "act now and in the final rule require QHPs to accept third party premium and cost-sharing payments from hospitals, hospital-affiliated foundations and other charitable organizations, just as they are required to accept these payments from the Ryan White"? How would this impact your organization's ability to expand access to care? How would your organization respond if DHHS agreed to this request?

(2) Now that HCAHPS Scores are tied to reimbursement, how involved is finance with the patient care experience?

(3) Has your organization implemented point of service collections? Have those efforts been successful? If patients decline care as a result, what percentage of patients decline due to high deductibles and/or co-payment requirements of their health plans? How does your organization respond in such circumstances?

(4) Do you see a different payment model emerging in long term care with cost/quality based health delivery model?

(5) What is the financial impact of acute care and / or skilled nursing facility regulations on the bottom line?

(6) Do you think the not-for-profit status of hospitals is in jeopardy?

(7) in 2009, tax-exempt hospitals varied markedly in the level of community benefits provided, with most of their benefit-related expenditures allocated to patient care services (on average 85%). Almost half these expenditures went to subsidizing the cost of care for patients covered by means-tested government insurance programs, mostly medicaid. Only 5.3% went to community health improvement. What efforts has your organization made to increase the overall percent of community benefits from community health improvement activities (compared to charity care)?

(8) Has your organization integrated price and quality information in a price transparency tool? If so, how did you market the tool? How have consumers responded? Have you experienced an increase or decrease patient volume as a result?

(9) How did your organization revise its financial assistance policy? How did you "widely publicize" your FAP?

(10) What are your organization's population health strategies?

(11) What advice do you have for students trying to enter the job market in healthcare administration and leadership if they do not possess a clinical degree?