advolife

Advomas Quarterly Newsletter | 4th Quarter | Volume 76

MEDICAID WORK REQUIREMENTS

How Will You and Your Patients Be Impacted?

ASSIGNMENT OF BENEFITS & AUTO CASES

Assignment AFTER not BEFORE SERVICE = PAYMENT

2019 MICHIGAN PROPOSED POLICIES

Potential Changes for Your Reimbursement

advomas®
Healthcare Eligibility Advocates

That's a Wrap!

Advomas is committed to resolving all uninsured and underinsured complex payer claims for providers and health plans.

2018 proved to be one of our most successful years in company history. How did we do it?

Our people. Our compassion. Our innovation. Our effectiveness.

Our role requires not just patience and persistence, but an alertness and understanding of federal and state healthcare rules and regulations. Our advocates spend time not just in your hospitals or at your patient's homes, they spend it in the classroom.

One of our distinctive trademarks is "commitment to quality" and this all starts with focused education. We know that sending an experienced and knowledgeable patient advocate to work on your behalf is critical to improved results.

As we enter 2019 we learn from our mistakes and continue to stay informed of proposed and published policies that impact our clients' bottom lines.

Thank you for providing us with another year to make a difference in our community. We are forever grateful for each and every client and the trust you have in Advomas to help your patients.

We hope you find this issue helpful for understanding the opportunities and challenges of securing the highest payer for your uninsured patients.

Happy, Healthy New Year!

Jennifer K. Rakolta
President

Medicaid Work Requirements:
Where Are We Headed?

Michigan Legislature is working on a bill that requires all Medicaid recipients to work. Currently, it has passed a bill that asks the federal government for a waiver to let it, as of Jan. 1, 2020, require able-bodied adult Medicaid recipients under the Healthy Michigan Plan to work, look for work, volunteer or be in training or school for 80 hours each month unless otherwise exempt, or risk losing their benefits.

Governor Snyder had concerns with the details of the bill and signed legislation that is much different from the original one in June, which could still impact a large population of the adult Medicaid recipients under HMP. Some of the changes from the original bill include the following: applies strictly to HMP enrollees, hours to comply reduced from 29 to 20 hours per week and exemptions were added such as a 3-month grace period which can be satisfied by volunteer work, and no lifetime limits on HMP enrollees but enrollees will have to contribute 5% of their annual income after 48 months in order to continue receiving the benefit. Although there is no guarantee CMS will grant permission allowing this, the Trump administration has previously indicated it would be more open to some form of work requirements for particular Medicaid enrollees.

Currently, four states have been granted waivers as "demonstration projects" to see how the requirements may work, with Michigan's unlikely to even be submitted until fall.

What is the potential effect?

In one recent report, early estimates in Michigan say that as many as half of the 670,000 people on HMP may fall under the requirements, but after adding in exemptions and those that are already working, it leaves only an estimated 6% of the Medicaid population that could be targeted. Conversely, the same report also notes that even those who potentially meet the requirements, may have issues retaining coverage due to the inability to report work hours or exemptions due to lack of access to a computer or email as well as an overall lack of understanding of the requirements they need to report that could lead to mistakes that could take significant time to rectify, as well as those who are seasonal or part-time workers with hours that fluctuate throughout the year.

At this time, it appears too early to tell what level the overall impact these requirements will have on the HMP enrollees themselves as well as their providers and their self-pay populations.

Stay tuned …

Jon Mills, Advomas
VP of Field Operations

Making Sure Providers Get Paid for Services on Auto Accident Cases

Assignment AFTER not BEFORE Service EQUALS Payment

On May 25, 2017, the Michigan Supreme Court issued its long-awaited opinion in *Covenant Medical Center, Inc v State Farm Mut Auto Ins Co*, 500 Mich 191 (2017). The main issue presented was whether healthcare providers have an independent cause of action against no-fault insurers under the Michigan No Fault Act. The Court in *Covenant* held that medical/healthcare providers do not have an independent cause of action to pursue claims directly against a no-fault insurer. The *Covenant* Court did not discuss or issue a ruling on the validity of assignments by the patient.

Although it was anticipated that this would be a huge victory for insurers and significantly limit litigation, it only increased litigation in the No-Fault arena. Since *Covenant*, healthcare providers have filed suits based on executed assignments by the patient. In support of these suits, providers are arguing that an assignee stands in the position of the assignor and possesses the same rights and is subject to the same defenses. *Burkhardt*, 260 Mich App at 652-653. Attached to their complaints is the patient's executed assignment to the provider that assigns over the patient's right to performance by the insurance company for payment of the medical expenses they incurred with that provider.

Insurance companies have fired back with motions to dismiss these provider suits, arguing that Plaintiff cannot rely upon an assignment because their insurance policy contains a valid and enforceable contract provision that prohibits assignments. They have also attacked the language in the assignments and have argued that they are illusory, specifically that the assignment does not clearly manifest any intent to transfer anything. Finally, insurance companies have argued that providers are generally not parties to the insurance contract, and are not third-party beneficiaries of that contract. *Shay v Aldrich*, 487 Mich 648, 662; 790 NW2d 629 (2010). As there is no binding case law which requires insurers to enter into contracts for the benefit of the potential future medical providers who may possibly provide treatment to the insured at some point.

With so many different rulings throughout the trial courts as to the validity of assignments, it was only a matter of time that a trial judge would issue a universal ruling. Soon after, Judge Kevin Burke of the 15th Judicial District Court in the City of Ann Arbor, Michigan issued a universal ruling holding that assignment clauses in insurance policies are unenforceable. Most judges have followed Burke's lead and have honored assignments. Motions for Summary Disposition based upon *Covenant* and the insurance company's anti-assignment clause have since become futile.

Realizing that suits based upon assignments are not going away any time soon, insurance companies are now defending these cases based on the dates these assignments are executed. M.C.L. § 500.3143, provides in full: "An agreement for assignment of a right to benefits payable in the future is void." Courts have repeatedly held this statute to be clear and unambiguous ("We believe that this statutory language is 'clear and unambiguous'.") *USAA Ins. Co. v. Houston General Ins. Co.*, 220 Mich. App. 386; 559 N.W.2d 98 (1996); *Prof'l Rehab. Assocs. v. State Farm Mut. Auto. Ins. Co.*, 228 Mich. App. 167; 577 N.W.2d 909 (1998). Accordingly, if the only purported assignment of rights letter relative to the patient's claim is for a date **before** the patient received medical treatment, pursuant to MCL 500.3143, that provider will not have the right to recover from the insurance company and the insurance company will have a basis to dismiss the case.

It is very important that all providers ensure that all assignments are executed after service is performed to ensure payment from the carriers. Even if the date or service and signed assignment fall on the same date, it is important to ensure the assignment is executed on the way out of the office and not on the way in. The reality is that if there is an ongoing provider suit, there is a first party suit filed by the patient in another Court. If provided an opportunity to depose the patient, the insurance defense will without a doubt ask the patient if they signed the provider's assignment before or after treatment. Give the insurance companies one less defense and, going forward, implement as a new practice to always have assignments completed after service.

*Should you have more questions regarding the Assignment of Benefits process please call our inhouse legal counsel at **248-989-4200**.*

Proposed Policies for 2019

1830-MEDICARE-P

This proposal will be highly beneficial for providers in that they could now bill Medicaid for services rendered to patients over the age of 65 who are "eligible for but not enrolled" in Medicare. This will allow patients to be able to receive needed medical services without being rejected for not having secured Medicare coverage. Providers currently hold up and/or write off millions of dollars for services rendered to patients over the age of 65 who do not have coverage because they either haven't enrolled or can't afford to pay the premiums. These cases will now be processed as any other potential third party liability issue, claims will be paid and taken back once Medicare coverage for the dates of service would be secured, and the provider will then have 6 months to pursue payment from Medicare.

Proposed Policy Draft

Michigan Department of Health and Human Services
Medical Services Administration

Distribution: All Providers

Issued: December 1, 2018 (Proposed)

Subject: Claims for Medicaid Beneficiaries Eligible for Medicare

Effective: January 1, 2019 (Proposed)

Programs Affected: Medicaid, Healthy Michigan Plan, Children's Special Health Care Services, Maternity Outpatient Medical Services

To assist in maintaining access to care and continuity of services, providers rendering services to Medicaid beneficiaries in fee-for-service and managed care plans who are eligible for, but not enrolled in, Medicare will have claims paid by Medicaid for Medicaid-covered services effective for dates of service on and after January 1, 2019. In compliance with federal third party liability statute and regulations that require all liable sources of third party payers be identified, affected claims where Medicare coverage was later obtained will be voided in accordance with policy described in the Coordination of Benefits Chapter of the Medicaid Provider Manual. The provider must bill Medicare for covered services once the beneficiary obtains Medicare coverage. Current Medicaid liability policy still applies.

The Michigan Department of Health and Human Services (MDHHS) urges beneficiaries to enroll in Medicare as soon as they become eligible to take advantage of Medicaid assistance with Medicare out-of-pocket costs. Providers should refer beneficiaries who need to enroll in Medicare to their nearest Social Security office or suggest that they contact the Michigan Medicare/Medicaid Assistance Program (MMAP) at 1-800-803-7174.

As a reminder, balance billing a Qualified Medicare Beneficiary (QMB) is prohibited by federal law. All payments made by Medicare and Medicaid are considered payment in full. QMBs have no legal obligation for additional payment to the provider.

1844- MEDICAID ELIGIBILITY ASSET POLICY

Proposed Policy Draft

Michigan Department of Health and Human Services
Medical Services Administration

Distribution: Bridges Eligibility Manual (BEM) Holders

Issued: January 1, 2019 (Proposed)

Subject: Medicaid Eligibility Asset Policy

Effective: February 1, 2019 (Proposed)

Programs Affected: Supplemental Security Income (SSI)-Related Medicaid Categories

Medicaid provides medical assistance to individuals and families who meet the Medicaid financial and nonfinancial eligibility factors. The goal of the program is to ensure essential health care services are available to those who otherwise would not have the financial resources to purchase them. The United States Department of Health and Human Services (HHS) develops and issues federal regulations that set the requirements and guidelines for the State of Michigan to follow in determining Medicaid eligibility.

Section 1613 of the Social Security Act allows for a three-month exclusion of the proceeds from the sale of an individual's homestead when there is the intent to purchase a new domicile which will meet the definition of a homestead. Current Michigan Department of Health and Human Services (MDHHS) policy allows for a greater period for the exclusion than allowed under the federal regulation. Effective February 1, 2019, the period of exclusion will be three months to align with federal policy. This change also requires an update to MDHHS policy regarding the definition of a homestead to exclude income-producing property located on the homestead property.

1845- ERP- MEDICAID ESTATE RECOVERY PROGRAM; EXCESS PATIENT PAY AMOUNTS

Proposed Policy Draft

Michigan Department of Health and Human Services
Medical Services Administration

Distribution: All Providers

Issued: January 1, 2019 (Proposed)

Subject: Medicaid Estate Recovery Program; Excess Patient Pay Amounts

Effective: As Indicated (Proposed)

Programs Affected: Medicaid, Healthy Michigan Plan, Children's Special Health Care Services, Children's Waiver, MI Health Link, Program of All-Inclusive Care for the Elderly

Pursuant to 42 USC § 1396p, the federal government requires state Medicaid programs to seek recovery from the estates of certain deceased beneficiaries who received benefits from a state Medicaid program. This is referred to as the Estate Recovery Program. Under some circumstances, the state may choose not to seek or may defer recovery from the estate.

Estate recovery applies only to Medicaid beneficiaries who:

- are 55 years of age or older; and
- received long-term care services anytime on or after September 30, 2007.

The Estate Recovery Program can only recover from assets flowing through the probate process.

Excess Patient Funds Subject to Estate Recovery

When a provider has a balance in a patient trust account after the death of a beneficiary, any balance in the account should be refunded to the family to open a probate estate with those funds. Once an estate is opened in probate court, the Michigan Department of Health and Human Services (MDHHS) will file a claim.

Excess Patient Pay Amounts

If the provider has an excess patient pay amount and has been billing Medicaid, the provider must return any overpayments made by MDHHS. This must be done using a replacement claim or void/cancel claim. The provider may then use the remaining funds for beneficiary private pay. This is a separate process unrelated to the Estate Recovery Program.

POLICY UPDATE FROM MDHHS MSA- 1850

Great news for the healthcare community of Michigan! Hospitals and other medical providers for years have been writing off millions of dollars in charges for patients over the age of 65 that have good Medicaid coverage but do not have one or both parts of Medicare. The MDHHS has just formally released a new Medicaid policy that now allows providers to bill Medicaid fee for service and managed care plans for services rendered to patients over the age of 65 that in the past would have been rejected due to being "eligible for but not enrolled" in Medicare. The new policy will be effective for dates of service on or after January 1, 2019 and will provide the following benefits:

- **Maintain access and continuity of care for patients over the age of 65**
- **Less bad debt to hospitals and other medical providers**
- **Reduced days in AR**
- **Increased revenue**

Providers are encouraged to advise their patients to apply for Medicare coverage but do not have to wait for the outcome of that to bill Medicaid for services rendered. And, as with other Third Party Liability situations, should the patient secure Medicare that results in coverage back to their dates of service, a Medicaid takeback will occur and the provider will be able to bill Medicare for the services rendered instead at that time.

For further details of this policy change, we have referenced the link here for you - **MSA 18-50.pdf**. Please let us know if you should have any questions or need anything further regarding this matter.

Please contact Cheryl Korpela, CAO at **248-989-4200** ext. **226** for questions pertaining to Medicaid and Medicare policy changes.

Data, Data, Data

Stacey Milio, Advomas Business Intelligence Manager, weighs in on Advomas eligibility reporting

The reporting we provide serves a multitude of purposes. Foremost, it shows the numbers. It provides measurements on the outcome of our work. It can also indicate trends and highlight historical outliers. It offers insights that can lead to forecasts and aid in decision-making. Despite being able do all these things, what our reports cannot do is quantify our impact on the lives of the individuals we have helped. They cannot provide an assessment of the value patients place on our assistance or heir interactions with our representatives. In other words, they do not tell the rest of the story. Statistical reports generally lack this kind of qualitative data.

What exactly is qualitative data? It is defined as a measurement of quality rather than quantity. In scientific research this type of data is usually obtained through careful observation of the subjects being studied, or by in-depth interviews with participants involved in the topic of interest. It is subjective in nature and not as easily verifiable or analyzed as quantitative, or statistical, data because its basis lies in the contextual reasons informing how and why people feel about or perceive something. It takes the form of words. Because of this, qualitative information possesses a holistic value that can present insights which would otherwise be overlooked by focusing solely on the statistical data. For example, insights into what we are doing that sets us apart from our competitors.

Typically, we do not have much access to this type of data in order to share it with our clients through formal reporting. This is primarily because it relies on the patient's participation, and the sensitive nature of our assistance does not readily lend itself to public testimonial. When we do receive feedback directly from patients, it may not be possible to share it through a report in order to protect their privacy. Therefore, we rely on conversations to convey what patients have volunteered regarding the impact our company has had on their lives and the quality of the assistance our representatives provided. These conversations, whether through email or verbal means, might not always reach a wide audience or can be buried amongst the large amounts of information we sift through each day. Unlike a report, they may not be as easily referred to at a later date. This additional evidence of the value of our work gets lost. It becomes the phantom data hiding in the numbers.

DON'T FORGET!

No more MSA-2565 for all cases other than newborns.

Advomas Hosts MDHHS Community Partners

Beginning in January of 2018, Advomas began holding MI Bridges training sessions for Community Partner Navigators at our corporate office in Troy. MI Bridges is a partnership between the general public and the State of Michigan that aims to connect greater numbers of individuals and families in Michigan to a range of state and local resources, as well as MDHHS benefit programs, to promote household stability. Navigation Partners are community-based organizations that have agreed to provide this one-on-one assistance to MI Bridges users by assisting them with completing a needs survey, finding local resources or applying online for an MDHHS benefit program. Navigators support MI Bridges users by teaching them to use the system so that that in time, they are able to use it on their own. Providing training to these agencies has increased the number of Michigan citizens with access to healthcare and continues to strengthen the partnership between providers, payers and patients in route to a healthier community.

Pat Pokorzynski
Advomas Director of Education

Advomas Launching New Website in 2019!

Providing better real time reporting and an improved patient experience!

Policy Highlights of 2018

Policies & Performance - A look back at the highlights of 2018

Medicaid:

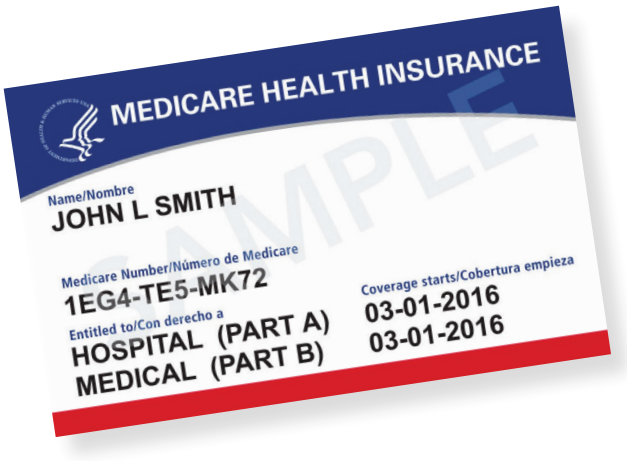
Universal Caseloads - Rolled out in more than half of the counties in the State of MI. This task-based initiative means that clients will no longer have one caseworker, but instead be supported by a team of caseworkers who focus on processing parts of a client's case. In an effort to ease the burden on their staff the State of MI has introduced this system to improve workload balance and collaboration between offices and staff.

RSDI policy change in MAGI Medicaid eligibility determinations – Effective October 1, 2018 - The State of MI updated their policy on income received from Retirement, Survivors and Disability Insurance under guidance from the federal government. Under the change all RSDI income is countable to tax filers and adults (including spouses) not claimed as dependents.

New MI Bridges - As a part of MDHHS's Integrated Service Delivery effort, MI Bridges and the Assistance Application have undergone transformative changes. These changes have been made in close collaboration with clients, community partners, and MDHHS caseworkers who have provided input and feedback throughout the process. The new MI Bridges has enabled residents to identify their needs and connect to community resources that meet those needs to improve stability over time. These resources include community programs and organizations through a partnership with Michigan 2-1-1. Advomas has hosted monthly training sessions for MDHHS Navigation Partners as they continue to educate community-based organizations on how to better connect and assist their clients. As a part of the role out, our Director of Education Patrick Pokorzynski became a MI Bridges Community Partner trainer and now assists MDHHS in the training of Navigation Partners.

Medicare:

Medicare Beneficiary Identifier - The Centers for Medicare & Medicaid Services (CMS) is required to remove Social Security Numbers (SSNs) from all Medicare cards by April 2019. A new, unique Medicare Beneficiary Identifier (MBI) Number is replacing the SSN-based Health Insurance Claim Number (HICN) on each new Medicare card. CMS began mailing new Medicare cards to people on 10/1/2018 and providers may have already begun to see the MBI in CHAMPS member eligibility screens.



Company Kudos!

Advomas - Leading with Results for more than 30 years

Advomas provides more than **100 million dollars** each year in direct reimbursement to hospitals and health plans.

Advomas Announcements!

Meet new Director of Client Services, Stacy Gilbert

Gilbert joined Advomas in 2006 in an entry level clerical position. Following several advancements, she served as the Support Services Director for 7 years. During this time, Gilbert gained experience with numerous hospital systems such as EPIC, Meditech & Paragon. Gilbert is excited to take on her new role as the Director of Client Relations, where she will work to strengthen the relationship with Advomas clients and ensure that the clients and patients we serve receive excellent customer service and results.

Advomas Quality Team

Here at Advomas, we hold the quality of our production to the highest standard to ensure success and continuing achievements in the health care industry at every step.

A unique upfront, middle and backend review process has been created and implemented throughout each department to continue to provide a quality measurement of excellence.

Our quality team is comprised of some of the most experienced staff members in their field, who can conduct detailed analyses to identify any issues and/or provide any ongoing educational opportunities.

With ever-growing changes in Federal, State, and Health Plan policies, it's essential that we strive to meet the needs of our clients with the utmost accuracy when processing cases.

In one such case, our Eligibility Specialist onsite assessed a patient as not Medicaid eligible due to the patient having excess income. When our quality department reviewed the case they discovered that the patient was caring for their grandchild, which added additional program eligibility for the patient as a caretaker/relative of a minor child. Due to the thorough review of our quality department, the patient was approved for Medicaid coverage and their hospital bill was covered. Without this added measure of quality assurance, we may have missed the eligibility for this patient.

Steve Hosmer - *Quality Assurance Specialist*

Steve began with Advomas in December 2004 prior to which he was an EMT member. Steve has served in leadership positions with specific focuses in Medicaid field work, and as an eligibility specialist, appeals specialist and most recently as a member of the Quality Assurance Team. As a member of the Quality Team, Steve enjoys the opportunity to apply years of training and skills to resolve complicated cases. Knowing that if even the smallest detail is overlooked, we could potentially be presenting an incomplete product to the clients and patients we represent. This is what keeps Steve motivated.

Advomas Employee Spotlight

Meet Samuel Hill - Eligibility Specialist

I was born & raised in Detroit, MI and graduated high school & college (Henry Ford Community College) in the metro area.

I joined Advomas for the opportunity to help people with their health needs in this community. It has been a most wonderful experience.

Outside of work I am a husband, father, and an Elder/preacher at my church. I am a passionate fan of U of M football and basketball. Go Blue!!

When it comes to helping the community, I am grateful to help with food drives as well as working with inner city youth (especially those from single parent homes) to help them find a path to college or higher education.

Being at Advomas has opened my eyes even more to how much we need to help one another in this world. I will always be thankful for this experience!

Michigan Revenue Cycle Association (MRCA) Meeting Dates:

January 11, 2019

March 15, 2019

May 17, 2019

HFMA Western Chapter Spring Conference

May 22, 2019 – May 24, 2019

HFMA Eastern Chapter Fall Conference

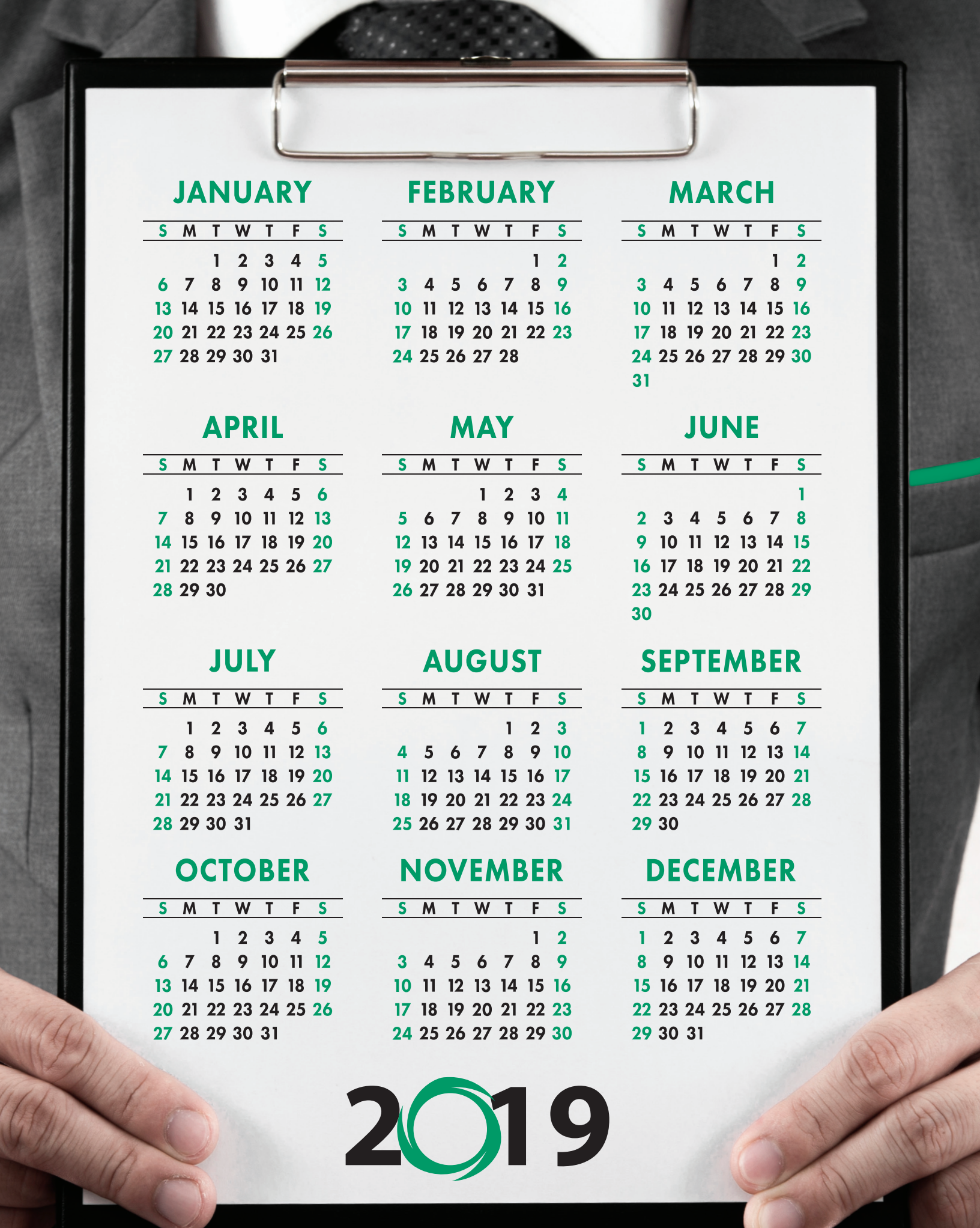
October 28, 2019 – October 29, 2019

MHA Meeting Dates:

MHA Legislative Policy Panel Meeting
March 14, 2019 | MHA Capitol Advocacy Center, Lansing

MHA Legislative Policy Panel Meeting
May 23, 2019 | MHA Capitol Advocacy Center, Lansing

MHA Annual Membership Meeting
June 26, 2019 | Grand Hotel, Mackinac Island



JANUARY

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

FEBRUARY

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28		

MARCH

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

APRIL

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

MAY

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

JUNE

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

JULY

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

AUGUST

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

SEPTEMBER

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

OCTOBER

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

NOVEMBER

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

DECEMBER

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

2019

The PINK FUND® Honors its First Donor at its Annual Dancing with the Stars Event

"While fighting for their lives, women and men in treatment for breast cancer often lose their livelihoods."

- Molly MacDonald, Founder

In October I received an award for being the first person to make a donation to "Pink Fund." I am delighted and honored but, of all the things I have done in my life which bordered on notable, I would never have believed an award would be forthcoming from this … a donation to a new charity in its embryonic stage.

So … why?

It certainly wasn't because they hadn't yet qualified for 501c3 status. I wrote it off anyway. It wasn't because Molly was one terrific salesman. It wasn't because it was a great cause. It wasn't because I had three of my staff develop breast cancer and I personally knew the economic hardship they would have if I had not continued their wages.

So, it appears to have come down to one thing: My son played hockey and I saw many coaches, but there was one who stood out head and shoulders above all others. His kids all developed to their maximum. The coach (and one heck of a hockey player) was Al Lafrate, and his coaching came down to one simple philosophy.

When discussing developing players, he once casually said, "All these kids really need is someone to believe in them."

So, I just received an award for believing in Molly and her cause.

If you have met Molly or considered the Pink Fund's mission, believing in both is the easiest thing in the world to do.

So, what I did was easy and I'm not quite sure it was worthy of an award, but I will keep it in a prominent place on my desk.

Anyway, yay Pink Fund and yay Molly!
Ten years later, you have verified my belief.

W. Bruce Knight

W. Bruce Knight
Founder & CEO

1607 East Big Beaver
Suite 350
Troy, MI 48083

p: 248.989.4200
f: 248.989.4201

advomas.com