Scary State of Healthcare
SCHFMA Fall Institute
October 22-24, 2014

Topics to include:

Charity Care...Connecting the Dots—Becky Brugler, Roper St. Francis Healthcare
Database Essentials and Getting the Data You Need from your IT—Brad Adams, Vanderbilt University Medical Center
MAP APP: Best Practices from Sisters Of Charity Providence Hospital—Jho Outlaw, Providence Hospital
The Doctor in In(tegrated) - Josh Halverson, ECG, and Frank Panzerella, Bassett Healthcare Network
And many more!

Bring your costume for the Costume Party on October 23rd!

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Our Vision: The South Carolina Chapter of the Healthcare Financial Management Association will continue to be the leading professional resource for individuals seeking excellence in the area of financial management of integrated health systems and other healthcare organizations.

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Palmetto State News
Editor: Jasper Powell
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Please contact Jasper with any updates to data contained within this publication.

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Opinions expressed here are those of the author and do not reflect the views of the HFMA or the South Carolina Chapter.

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The 2014-2015 HFMA South Carolina Chapter Corporate Sponsorship Applications are now open!
The chapter truly appreciates the generous support from all of our corporate sponsors. Contact Julianne Dreon at julianne.dreon@anmedhealth.org for more information on becoming an SCHFMA Corporate Sponsor

Updated 08-06-2014
A Message from the Chapter President...

Well, the new HFMA year has started out very busy. The many past presidents in our chapter told me that it would happen that way. They also said my year as president would be over quickly so I am going to try to take the advice of one very wise past president who told me to too be sure to slow down enough to enjoy leading this great chapter. I am honored and humbled to serve as your president, so I am going to do my best to take that great advice (thanks Ken Scheller).

Before I go any further, I want to once again thank and congratulate the one and only Jude Crowell and his leadership team for a great 2013-14 chapter year. Jude’s passion for the success of our chapter, for people, and community service will benefit our chapter for years to come and I look forward to working with Jude on taking our chapter to the next level in serving our communities. I am also going to take this opportunity to thank one of our unsung heroes, and there are many, in this chapter and that is Debra Wolfe. Debra has willingly and graciously handled running the registration desks at all our institutes for many years now. Thank you Debra!

As you will see about midway through this newsletter, we have a lot of great education planned this year. I would encourage you to go ahead and mark your calendars to attend these great events. We will open registration on the events happening between now and the end of the calendar year very soon. Be sure to like/follow the chapter on Facebook, Twitter and LinkedIn to stay up-to-date on chapter happenings.

In closing, I like quotes so if you have any favorites, please send them to me. I will share one that is fitting for what most of us are going through each day “If everything's under control, you're going too slow” Mario Andretti, American race car driver. This quote is also fitting when thinking about this year’s HFMA theme which is “leading the change”. The great thing about change, even though chaotic at times, is opportunity. The opportunity to learn and improve our healthcare industry to the benefit of those we serve.
Denials could double under ICD-10. Cut them in half now.

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PricewaterhouseCoopers' new Virtual Business Office, located in Columbia, SC manages third party accounts receivable and provides detailed analysis and recommendations to enhance cash recovery.

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Get Acquainted with Region 5

Greetings from your Region 5, Regional Executive! I am so excited to serve our region over the next year. Region 5 is an outstanding region with extremely successful chapters. Our region includes the states of Alabama, Florida, Georgia, South Carolina, and Tennessee.

Region 5 leadership consists of the Presidents and President-Elects of the five chapters, in addition to a Regional Executive and a Regional Executive Elect. As the current Regional Executive (RE), my role is to:

- Serve as the primary volunteer and policy link between the chapters and the Association
- Assist chapter leaders in serving members
- Promote and lead change efforts to drive HFMA’s strategies
- Foster dialogue and communication at all levels of HFMA
- Represent the needs and interests of chapter leaders to the HFMA Board and staff
- Work to create a seamless system of service for HFMA’s members
- Encourage chapters to collaborate and help other chapters

In short, the RE position serves as link between the chapters and the national office of HFMA. An RE takes concerns, comments, and ideas, from the regional board meetings, and conveys them to National. These comments, concerns and recommendations are shared with the National HFMA Board. So, what this means is “chapters actually have a voice on how HFMA operates at all levels.”

It will be difficult to follow in the footsteps of Cathy Dougherty, our outgoing RE; I want to thank her for her mentoring and friendship that will have a lasting effect on our region. HFMA’s Annual National Institute just finished up in Las Vegas. Region 5 showed out with multiple awards for our individual chapters and the region as a whole! The following chapters were recognized:

Alabama – The Henry Hottum Award for Education Performance Improvement (highest honor), The Platinum Award of Excellence for Education, the Award of Excellence for Certification-Bronze, and 2 Helen M. Yerger Awards.

Florida – The John M. Stagl Silver Award for Excellence for Education, Gold Award for Membership Growth and Retention, Award of Excellence for Certification-Bronze, and 3 Helen M. Yerger Awards.

Georgia – The Charles Mehler Gold Award of Excellence for Education, Award of Excellence for Membership Growth and Retention-Bronze and 3 Helen M. Yerger Awards

South Carolina – The Sister Mary Gerald Bronze Award of Excellence for Education,

Tennessee – The John M. Stagl Silver Award for Excellence for Education

As a Region, Region 5 won 3 Yergers in total: 2014 Region 5 Dixie Institute, Region 5 Webinars, and Region 5 Multi-State Certification Practicum Webinars.

A successful year, indeed for our Region! Congratulations!! I am looking forward to continuing the tradition of leadership in healthcare for HFMA Region 5.

As a HFMA member, if you know of projects or initiatives that would make sense for our region, please contact me by email at Kimberly.shrewsbury@shhpens.org. Look for additional regional updates throughout the year in the chapters’ newsletter. I look forward to communicating with you throughout the year.
How Hospitals are Shifting Resources Post-ACA
Susan Harrison and Steve Kennedy
Lancaster Pollard

Health care reform has caused a seismic shift in the U.S. health care landscape. The aftershocks continue to be far reaching—toppling long-standing paradigms and causing hospitals to reevaluate how they currently operate.

With the implementation of the Affordable Care Act in 2010 (“ACA”), the existing methods of revenue generation for hospitals were directly impacted due to reduced reimbursement levels on Medicaid and Medicare payors going forward. Concurrently, the ACA assigned incentives and corresponding penalties to health care providers to drive higher quality care and cost savings, which directly affects existing providers.

ACA Impacts
The intent of the law is to better align patient care with a holistic approach to treatment, ultimately resulting in lower overall health care costs; a significant component of this is preventative medicine. With the introduction of the ACA, a fee-for-value model will eventually replace the fee-for-service model. Physicians will no longer be incentivized to perform more procedures to generate revenue. Instead, the fee-for-value model will compensate based on outcomes, thereby incentivizing a greater effort on using preventative and holistic therapies. It also will promote the real-time exchange of information through the use of electronic health records to lower health care costs and improve clinical decision making.

According to a study published by a health information network in May 2013, “82% of health plans surveyed consider the ACA a “major priority.” Nearly 60% of respondents forecast that more than half of their business will be supported by value-based payment models in the next five years. And, of those, 60% are at least midway through implementation.

Traditionally, hospitals have charged for extended stays and testing, been reasonably reimbursed, then spread that revenue over high fixed costs attributed to their equipment and infrastructure. As the health care industry adapts to the new requirements, providers are assessing their current operations and profit margins, and adjusting their services accordingly. As a result, hospitals are accelerating the change from an inpatient to an outpatient model.

Transition from Inpatient to Outpatient Services
Driven by decreased levels of reimbursement and smaller profitability margins for health care providers, hospital boards will be providing greater scrutiny over capital projects going forward. Advanced technology will continue to be an investment for most hospitals as well as the reuse of space previously allocated for lower acuity patients in the hospital. This repurposing is targeting increased outpatient service offerings where the majority of revenue is currently being generated.

Hospitals across the country have experienced declines in inpatient admissions since 2009, driven by the slow U.S. economic rebound, continued rise of high-deductible insurances plans, less use of beds overall, advances in technology and medicine, birth rate decline and the implementation of the ACA. Most industry experts, including analysts at Standard and Poor’s and Moody’s Investor Services, predict a continuing falling off of inpatient volumes. Health
care consulting firm Sg2 in its 2013 outlook predicted a 3% decline in inpatient admissions over the next five years and a 17% increase in outpatient services, where hospitals currently generate more than half of their revenue.

This shift to outpatient services has been most evident across rural hospitals as shown in the chart. The higher outpatient revenue for rural hospitals is driven by the fact that many act as the sole site for patient care in the community and market demand dictates the need to offer those additional services.

Hospitals are beginning to assess how to best use their respective facility’s space as a result of changing market and regulatory demands. As technology has advanced and more equipment has come into the market along with electronic medical records and corresponding need for computer access, some of this space is being used to accommodate that technology. With the implementation of the ACA, patient satisfaction also has become an indicator of provider performance and an important aspect of value-based health care. As patients begin to have more of a say about their care provider, hospitals will continue to adapt. An example of how this feedback plays out is an increased demand for observation units in hospitals affiliated with emergency room traffic; these units accommodate a 23-hour stay. Within the inpatient space, shared rooms are being renovated into private rooms to meet patient preferences.

Outsourcing is trending as acute care hospitals seek ways to align with physicians to achieve cost-effective and quality care delivery, which accountable care organizations are already set up to do. Areas where outsourcing has increased substantially include information technology and clinical services like anesthesia, emergency department staffing, dialysis services, diagnostic imaging and hospitalist staffing.

"Each of these services extends the ability of the hospital to provide full service without having to attract [or] retain a full complement of specialty physicians in a particular community," said Augustus Crocker, executive vice president and general manager of The Greeley Company, in Becker’s Hospital Review. This allows hospitals to be less reliant on a long-term physician-patient relationship.

**Current Capital Project Trends**

In response to the current marketplace, hospitals are expected to direct lower-cost care through increased outpatient services. According to Charles Michelson of Saltz Michelson Architects, from the South Florida Hospital News and Healthcare Report, “We’re seeing more outpatient types of facilities doing a variety of testing and treatment to keep expenses down; the cost to the consumer is not as high as doing the same work inside a hospital. More health care providers are planning to create facilities outside the hospital now that patient care is moving back into the community where space is less expensive. Hospitals will serve as places for very serious medical treatments only, saving money for the medical system and the patients receiving treatment.”

In order to maintain competitiveness and revenue generation, hospitals are continuing to be cognizant of the aging demographic as well and tackling capital projects that tailor to that demographic, such as orthopedics, oncology and mental health for dementia. Hospitals also are focusing on the implementation of the latest technology in order to have greater patient data
access and the ability to share information for educational purposes and holistic treatment. According to a report by MarketsandMarkets, the U.S. health care IT outsourcing market is expected to grow by 42.8% in the next five years.

All of these features align with the improvement of a holistic treatment approach for patient care. According to the aforementioned health information study, “90% of health plans agree that automating the exchange of ‘new’ information required under value-based payments is critical to success, with 85% saying the highest value will come from real-time exchange, though less than half have real-time capabilities.”

**A Midwest Hospital Builds For Better Patient Experience**

Sauk Prairie Healthcare is a 36-bed community hospital in Prairie du Sac, Wis. Hospital leadership decided to replace its aging facility, originally built in 1956, on a new site that would include more space for outpatient services and be flexible to accommodate changing demographics and future growth. Enhancing patient experience and focusing on holistic care both influenced the project design.

After input from stakeholders, including physicians, staff, volunteers and the community, the newly opened hospital still has the same number of beds, but with larger patient rooms, operating rooms, and labor and delivery rooms. To further enhance the patient experience, it was designed with emphasis on patient privacy and dignity. Examples of this are separate public and patient corridors in the surgical services area as well as labor and delivery being located in a secluded and secure area of the new hospital.

Additionally, natural light and access to nature was a design feature carried throughout the building to create a healing environment, including a meditation room and walking trails on the campus.

**Maintaining Focus on ACA Changes**

As evidenced, it is essential for hospitals to remain competitive in the marketplace and to maintain and improve profitability by adapting to the changing health care landscape driven, in part, by the implementation of the Affordable Care Act. A hospital’s decision to align itself with the intended goals of the ACA and purpose its facilities accordingly, if needed, will give it a head start on competitors in the marketplace and better position it for the road ahead.

Susan Harrison is an associate with Lancaster Pollard in Columbus, Ohio, with a focused interest in health care. Her experience spans small- and mid-sized, privately held companies, health care, financial services and insurance. She has a Master of Business Administration degree from The University of North Carolina. She may be reached at sharrison@lancasterpollard.com.

Steve Kennedy is a managing director and member of the executive committee at Lancaster Pollard. He is the regional manager for the firm’s Western Great Lakes and South Central regions and is the lead health care banker in Illinois as well as West and Central Texas. He is based out of the firm’s headquarters in Columbus, Ohio. He may be reached at skennedy@lancasterpollard.com.

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It has already been an exciting start to our 2014 CRCA program! We began with our free education session in Columbia, SC on June 13th. This was an all-day event in which participants heard speakers on each chapter contained in the CRCA manual. Topics included Medicare, Medicaid, BCBS, Coding, Reimbursement, Compliance and many others. A special thank you to all of our presenters this year...Steve Lutfy, Lawrence Laddaga, Donna McGowan, Kevin Bonds, Contessa Struckman, Evonne Glenn, Miranda Watkins and Tara Gibson. We had approximately 35 in attendance.

Program Registration opened on June 23rd and to date we have 68 people registered. Registration will continue through August 31st and the cost is $65 per person. That fee includes the study material for the exam. One exiting addition to this year’s program are our social media links. Thanks to Jasper Powell our presentations from the education session have been uploaded to our YouTube account with links to the PowerPoint presentations. You can also search for our “CRCA Question of the Day” on Twitter using #2014CRCA. These will also be added to the website weekly so that no one misses anything!

We are in the process of finalizing test dates and sites so please check in to the SCHFMA website for updates. Test registration will open on September 1st with test dates the second week of October.

Please make sure that everyone in your organization from Revenue Cycle to Patient Access and more are aware of the program. If you have questions regarding the program please contact Tara Gibson, CRCA Chair, at tara_gibson@bshsi.org or call 864-605-3943.
Jude Crowell accepts the Sister Mary Gerald Bronze Award for Education from Kari Conicelli and Steven Rose at the Annual National Institute in Las Vegas on June 23, 2014.

Congratulations to Candi Powers on planning a great year of education!

HFMA’s Annual Institute, June 22-24, in Las Vegas, Nevada was a BIG success thanks in part the generous gift of time and talent of this year’s 35 volunteer course coordinators and floor managers. Volunteer course coordinators greeted attendees as they arrived at their respective sessions, scanned badges, introduced speakers, and distributed and collected session evaluations – not to mention daily gatherings at their 6 a.m. breakfast meetings. Pete Sabal, Nevada Chapter, lead this year’s energetic volunteers who represented more than 15 chapters including two e-students. Our own Frank Grella was part of the 2014 team.

Remember to mark your calendar now for next year’s ANI, June 22-25, 2015 in Orlando, Florida (note the Monday-Thursday pattern in deference to Father’s Day!).
Shay Eskew, VP of Client Services with Enablecomp, his wife, and their children welcomed a new addition to the family. Stella Maris Eskew was born on June 3rd, shortly after our Annual Institute. Mom and Baby are doing great. Shay is excited to say that he now has the Fab 5, pictured right. Congratulations to the Eskews!

We would like to welcome the following new members to HFMA South Carolina Chapter:

- Nalini Agarwal, Lexington Medical Center
- Melissa Bass, Virginia College
- Thomas DiLiegro, Roper St. Francis Healthcare
- Julie Dunn, Resource One Health Management Services
- Paige Horn, Greenville Health Systems
- Gordon Reese, Healthcare Application Consulting Solutions, Inc
- Staci Sansone, General Credit Services, Inc.
- Sandy Scott, Abbott Immunology
- Laura Varn, Medical University Hospital Authority
- Andrew Warren, McKesson Technology Solutions
- Jim Zupon, UCI Medical Affiliates

Do you have news that you would like to spread on the Kudzu vine? Just email Jasper and we’ll be glad to share! jpowell@selfregional.org
Upcoming SCHFMA Events

Fundamentals of Healthcare Reform — August 22 — Columbia
Revenue Cycle Forum — September 9 — Columbia
Fall Institute — October 22-24 — Charleston
Finance and Reimbursement Forum — November 18 — Columbia
Chapter Awards and CRCA Graduation — January 9 — Columbia
Region 5 DIXIE Institute — February 17-20 — Charleston
Payer Summit — March 20 — Columbia
Annual Institute — May 26-29 — Myrtle Beach

For more information on events, visit our webpage at
www.schfma.org/events.htm
The South Carolina Chapter would like to congratulate the below list of Certified Members* and also celebrate our accomplishment of being ranked #7 in the United States, when comparing Certified Members to total membership!

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Lynnwood H Young, FHFMA

To get your name “on the list” and learn more about HFMA Certification, please contact:

Steve Lutfy, FHFMA
SCHFMA Certification Chair
stephen.g.lutfy@us.pwc.com
(803) 753 5209

Did you know that the South Carolina Chapter will purchase a license key to unlock the National HFMA On-Line Study Guide for you at no cost, in exchange for your commitment to sit for the exam within 6 months of receipt (a $195 value)! Additionally, the Chapter will reimburse your exam fees in full when you pass the exam (a $395 value!)

Step-up to the plate and advance your professional career with HFMA Certification!

*As of July 2014
Charleston Ghost Stories
Gathered by Jacklyn Carter, Roper St. Francis

The Francis Marion Hotel is no stranger to ghosts. In 1929, a guest named Ned Cohen was staying in a room on the tenth floor when he fell to his death. It was a gruesome sight on the street and to this day, no one knows what compelled him to jump — perhaps a Southern belle he had recently met. Today, guests on the tenth floor report seeing Ned in his dinner jacket wandering the halls or have been startled when their window suddenly opens up and a cold breeze fills the room. "We have had guests say that they don't believe in ghosts," says the concierge, "but they'll swear that they've seen or felt something in their rooms with them." If you dare, stay in room 1010, and say hello to Ned while you're there.

If you get a chance to visit The Battery (White Point Garden) you may sense the spirits of pirates that were hanged here long ago. Rumor has it the ghosts walk through the park looking for their executioners.

Finally, if you like a side of supernatural with your shrimp and grits you will want to plan a lunch or dinner at Poogan’s Porch at 72 Queen St. Zoe St. Amand used to room in the house when she was a spinster schoolteacher living with her sister, Elizabeth. When Elizabeth died in 1945, Zoe became lonely, depressed and was often seen calling out her sister’s name. Neighbors finally took her to St. Francis Hospital to live out the remainder of her life. Zoe’s spirit apparently returned to this home. Diners frequently report feeling like someone has brushed up against them even though nobody's there. On the extreme side of things, there have been reports of place settings rotating on tables and customers feeling a sensation that someone uninvited has joined them for dinner. Some have even seen Zoe herself.

SCHFMA Fall Institute
The Frightening State of Healthcare
Save the Date...if you dare...

When: October 22-24, 2014
Where: Francis Marion Hotel in Charleston, South Carolina
Book your room using this group code: SCHFMA2014
Room Rate: $172 per night
www.francismarionhotel.com
(877) 756-2121
Keep checking our website for the most up to date information
www.schfma.org/events.htm

#schfmafi14
The Centers for Medicare and Medicaid Services (CMS) pays for Medicare inpatient hospital care on the basis of Diagnosis Related Groups (DRGs). Certain DRGs (known as Transfer DRGs) are paid under the Medicare Post Acute Care Transfer Rule (Transfer Rule), which reduces payments for hospitals that transfer patients to other providers to continue treatment.

In a significant number of cases, patients are not treated as planned after being transferred, or an inaccurate discharge status code is assigned to the claim. These factors result in an unwarranted reduction in the transferring hospital’s Medicare payment. The impact to US hospitals is in the hundreds of millions of dollars per year.

**The impact to US hospitals is in the hundreds of millions of dollars per year.**

Properly reviewing the post-transfer care that patients receive and identifying underpayment situations can provide hospitals with a significant revenue boost. However, it’s important to identify and address these situations in a manner that is compliant.

**Why do Underpayments Occur?**

An important factor in the Transfer Rule and Medicare’s calculation of hospital reimbursement is the discharge status code.

The discharge status code is assigned by the hospital based on the expected treatment, if any, planned after the patient leaves the care of the hospital. The proper discharge status code is determined after consultation with the patient and the patient’s family, their physician, and hospital personnel. It can indicate, among other scenarios, that a patient will be discharged to:

- Home
- A nursing home
- Home health care
- A rehabilitation facility
- A psychiatric facility, or
- Another acute care hospital

Only certain discharge status codes are impacted by the Transfer Rule.

Unfortunately, reality dictates that not everything that is planned after discharge actually occurs. In some of the cases impacted by the Transfer Rule, the care the patient receives after discharge from the original acute care hospital doesn’t correlate with the discharge status that was assigned, and the hospital may be underpaid as a result.

There are several significant causes of Transfer DRG underpayments.

When assigning the discharge status code to the patient’s bill, the hospital does not always have enough information available to make the proper assignment. The discharge plan may lack the level of care specificity that is needed in order for the proper assignment to occur. In this situation, assumptions may be made based on the name of the post-discharge care provider.

Many post-acute providers furnish multiple disciplines of care. Without accurate documentation, the wrong discharge status code
may be selected, leading to an underpayment. Sometimes, home health care is planned post-discharge, but the patient or family makes other arrangements or delays care.

For example, instead of home health care by a licensed home health agency, the patient’s family may cancel the care plan and decide to take care of the patient at home themselves. The hospital is unaware that the plan of care has changed, is reimbursed at a lower level, and an underpayment has occurred.

Finally, some discharge status codes are used infrequently, and occasionally a hospital billing system is missing a particular code. In this case, the “next best” code will likely be assigned, and this code may inappropriately trigger the Transfer Rule when CMS determines the hospital’s reimbursement for that claim.

Addressing the Issue

Even though the causes of Transfer DRG underpayments are fairly well understood, that doesn’t mean the underpayments are easy to identify.

A good process requires sometimes tedious research, and a detailed understanding of the financial and clinical factors that drive Medicare Transfer DRG billing. Identifying claims impacted by the rule and using Medicare eligibility systems are essential steps; however, they are not the only steps required to confirm an account is an underpayment.

For example, many Medicare patients are transferred to a nursing home after a hospital stay. The appropriate discharge status code assignment depends upon whether the nursing home is certified by Medicare, the levels of care provided by the nursing home, the level of care actually received and required by the patient at the nursing home, whether the patient’s permanent residence is at the nursing home and other factors.

In fact, it can be quite easy to adjust a Medicare bill in a non-compliant manner when attempting to recover Transfer DRG underpayments, resulting in the submission of a potential false claim. A less experienced researcher may assume from the presence or absence of certain information in Medicare eligibility and billing databases that a Transfer DRG underpayment exists, when in fact it does not.

In certain situations, some post-acute care providers don’t submit timely bills to Medicare. This means that follow up with post acute care providers and Medicare contractors is required to confirm that all relevant information is available when making a final determination of an underpayment.

The follow up work can truly be significant if it’s done correctly. After the proper data analysis to identify potential underpayments, which can involve re-pricing the claims as non-transfers, eligibility and billing information in CMS databases must be reviewed. This is followed by phone calls to Medicare contractors, nursing homes, home health agencies, etc. Finally, claims must be adjusted and a proper audit trail maintained for all activity.

Why doesn’t CMS detect these underpayments?

From the inception of the Transfer Rule, CMS acknowledged that errors can occur with discharge status assignment. They also discussed their plans for edits by the Medicare contractors to identify “overpayment” situations after the receipt of claims from the hospital and post-acute providers. Audits by the Office of Inspector General (OIG) confirmed that hospitals were significantly overpaid and edits were finally implemented.

For example, if a hospital believes a patient is being discharged to home, but the patient’s treatment after discharge in fact includes home health or skilled nursing care, an overpayment
may result. The Medicare contractor will identify this in the claims data and take back the entire original payment, not just the difference between the original payment and the Transfer DRG payment amount. The hospital will then need to submit a claim adjustment to reflect the corrected discharge status.

CMS made it clear from the start that the development of edits would only apply to overpayments; hospitals would have to perform their own validation of proper discharge status code assignment to detect underpayments.

In the past few years, CMS has developed the Recovery Audit Contractor (RAC) program to identify overpayments and underpayments for claims, including those impacted by the Transfer Rule. This is a controversial issue, as ironically the RACs identify underpayments through a computer algorithm and do not validate level of care with post-acute providers. Therefore the RACs are “recovering” Transfer DRG underpayments that are not in compliance with Medicare regulations.

Provider Options for Recovering Underpayments

There are basically three approaches to addressing the issue: an internal process, a consultant/vendor or reliance on the RAC. Each approach has pros and cons, as seen in the chart below, and some providers may use one, two or all of these approaches to identify their Transfer DRG underpayments.

Many providers outsource the recovery effort to an external partner and pay a contingency fee for the recoveries collected. Some organizations such as larger health systems have dedicated resources assigned to special projects that include the identification of Transfer DRG underpayments and following up to make a proper final determination. Handling the work internally may allow a hospital or health system to reduce expenses and maintain full control of the process.

However, it’s not a simple calculation to determine if a claim has been financially impacted by the Transfer Rule, and there can be a lot of

<table>
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<th>Opt on</th>
<th>Pros</th>
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| In-house | • lower pure cost  
• higher level of control | • lack of required expertise  
• absence of adequate resources  
• significant competing priorities |
| Vendor  | • low financial risk (normally contingency-based)  
• generally higher recoveries  
• greater Transfer DRG expertise  
• lower hospital resource requirements | • higher pure cost  
• lower level of process control  
• need for vendor management |
| RAC     | • no hospital resource requirements  
• rate is lower than an external vendor | • automated identification with no validation results in false positives and submission of potential false claims  
• RAC appeal required to contest invalid underpayments  
• not all underpayments are identified |
wasted follow up work unless it’s properly focused on the real opportunities. It can be like looking for a needle in a haystack. The staff required to perform the follow up work often have other critical billing responsibilities. As we’ve already seen, there is a significant potential compliance risk if all of the information is not reviewed and applied correctly.

Finally, some providers, in an effort to keep things simple, rely upon the RAC to identify and recover their underpayments. The cost is far less than a vendor and the provider has limited responsibility. Unfortunately there is significant compliance risk associated with this option and many providers are unaware of the risks involved.

Conclusion

The average hospital loses up to hundreds of thousands of dollars in reimbursement due to Transfer DRG underpayments annually. In the current healthcare reform environment, it’s critical that hospitals capture every dollar of revenue to which they are entitled.

Transfer DRG underpayments typically occur through no fault of the hospital, and the identification of underpayments is not straightforward.

This article was provided by:

For an unedited version of this white paper, please download Transfer DRGs: Approaches to Revenue Recovery
Pictures from our Annual Institute

For More Pictures - Click HERE!
Immediate Past President
Jude Crowell

Immediate Past President, Jude Crowell, pins new president, Greg Taylor

From Right to Left:
Greg Taylor, President
Woody Turner, President-Elect
Estelle Welte, Secretary
Candi Powers, Treasurer

Pictured from Left to Right: Board Members Ray High, Michael Jebaily, Jasper Powell, Julianne Dreon, Janine Ciranni, and Danielle Gori. Not pictured: David Sudduth, Barney Osborne, Adriana Day and Tommy Cockrell (Ex-officio)
Once again we were able to help our good friends at New Directions (Street Reach). We donated almost $1800 and all of the supplies in the picture to the right.

You can contact either Kathy Jenkins (pictured left) or Brenda Ryan (on right) if you’d like more information on how you can continue to assist this worthy charity.

(843) 945-4902
www.myndhc.org
1. Lighten Up—keep a relaxed face.

The most important time is the 2 minutes of your introduction—early in your speech folks listen to what they “see” more than what they “hear”. Smile, gesture, and begin the process of eye contact with a few friendly folks.

2. Vary your voice—work at sounding believable and conversational. It is important to speak with energy and enthusiasm.

3. Be glad to be there—the first step to giving a good speech is to be glad to be there. How many speakers actually sound glad? That is your hook.

4. Tell your audience your credentials—make them proud to know you.

5. Talk about the audience—one mark of effective speakers is that they focus less about themselves and more on those who have come to hear them speak.

6. Take up space—powerful people take up physical space.™ Use large gestures and illustrate what the words are saying. Don’t shrink up in the room or you will be overlooked.

7. Speak with power—make sure your voice conveys authority. Women need to be careful about letting their voice rise at the end of a sentence because it sounds like they are asking a question rather than making a statement.

8. Open the floor—after the presentation is finished, open the floor to questions from the audience and answer them.

9. Maintain a calm and even delivery—abrupt changes in behavior can scare your audience. Act cool and in control even if you are panicking inside.

10. If it isn’t funny don’t use it—I am sad to report that everyone is waiting to be offended. Poor word choices can wreck a career. It might be funny with your friends on Friday night but it’s probably not so funny on Monday morning at the office; one slip up and you’ll find yourself in damage-control mode. Remember we’re a sound bite society so you will never get your full say to explain your joke or comment. Be sure to protect yourself.

11. Be word wise

Make your words count. Master the Queen’s English and be careful about using slang. Use proper English and grammar to maintain your professionalism. Drop swear words from your trite words and replace words like: “like”, “whatever”, “you know”, “to be honest”, “to tell the truth”, and “definitely.” You must also drop the corporate speak like: “new tomorrow”, “value-driven”, “feedback”, “visioning”, “stakeholders”, “win-win”, “quality-time”, “synergy”, “strategic”, “networking”, and “programmatic.” Choose your words wisely for your success.

12. Open your talk with an unpredictable personal story—it is best if you can start your speech with something that your audience has not heard from other speakers. If you can tell a personal joke or good line., do so. If you are not a joker, stick to what you do best.

13. Use controlled emotion—if you are just trying to convey information, you could just hand out a report. A speech has some emotion. A good speech might have humor, anger, commitment, and learning.

14. Have a single concept in mind—this is not the time for multiple messages or meandering. Have a clear, concise message with no more than 3 key points and a definitive ending.

15. Be brief and keep your presentations short—studies show that the attention span of today’s audience is about 1,000 seconds, or 16 and one-half minutes.

NOTE: Acknowledge—with graciousness every member of the audience who approaches you after the speech.

Deb Sofield trains women and men nationwide for success in speaking, presentation skills and message development. Sofield is a member of the National Speakers Association.
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Or visit www.hfma.org/webinars

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**Regions 4, 5, and 6 National Certification Webinars**

The dates of the Certification Candidate Practicum webinars are **September 16, 23, 30, October 7, and a review session on November 4, 2014**; all webinars will be from 11:30 a.m. to 1:30 p.m. (ET). The cost to the member will be $30. This is an outstanding price for not only the webinar series but also a 400+ page study guide. The five webinars supplement the on-line study guide available from HFMA and cover the hardest materials tested on the exam. Sessions will be recorded in the event that a registered attendee has to miss a session. You can earn up to 10 hours of CPE for the webinars by attending and responding to the webinar polling questions. No CPE will be awarded for the recorded sessions.

For full details regarding this program, including information regarding CPE and registration please visit http://www.tnhfma.org/chfp-webinars/