

Palmetto State News



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Fall 2010



HFMA Healthcare Financial Management Association

Former SC HFMA President Passes Away

Wayne Douglas McPherson

By Lynda Keisler, Past President SCHFMA

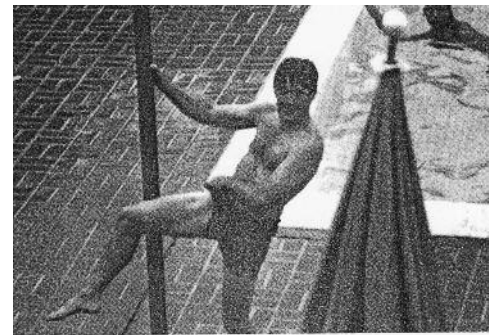
On October 3, 2010, we said good-bye to one of our outstanding HFMA members. Wayne McPherson was born April 26, 1949 in Frankfurt, Germany to Emma Lee Morton and the late Sgt. Maj. Frank H. McPherson, Jr. (U. S. Army Ret.). Wayne leaves many wonderful memories behind that will be cherished by his beloved wife and best friend Susan Vaughan McPherson, his daughter Lara McPherson Anderson and her husband Karl, his mom, brothers, sisters, other family members and close friends. Wayne held a BS in Business Management and a MS in Business Administration from the University of South Carolina, and completed the Executive Graduate Program in Health Care Financial Management at USC.

Wayne was one of a kind. The kind you loved to be around, because no matter what you were doing, you knew Wayne would make it fun. He had a quick wit, to-the-point personality, and a generous heart. Some even called him a “financial wizard”. Wayne began his financial career at Richland Memorial Hospital, where he worked for almost 20 years and served as Vice President of Finance. When Wayne started at Richland Memorial, he debated over making finance a career, or becoming a full time life guard. After he got to know some of the staff at Richland Memorial, he knew he could make a difference and have fun doing it.

Wayne joined HFMA and found not only new friends, but a challenge to make SCHFMA one of the leading chapters in the nation. As Tommy Cockrell says, “Wayne’s year as president put SC on the map”. In 1982-1983 Wayne was elected chapter president, after having been president-elect and treasurer. For the first time, SC won the coveted GLD award of excellence that continued for six years. SC also won Best Project/ Public relations, Best Newsletter,

and Best Membership Plan. In 1983-1984, SC won the Shelton Award for sustained Chapter Excellence.

In 1984-1985, Wayne was elected CLR for our region. He received the Follmer, Reeves, and Muncie merit awards. He went on to represent SC at national HFMA and continued to be a frequent speaker on Patient Accounting nation-wide. Soon, everyone was talking about the guy from SC. In 1986 Wayne decided to change careers. He went to work with Deloitte Consulting, and it did not take him long to make Partner. Always knowing the answers after a quick numbers review, Wayne’s team members respectfully used the phrase, “Go stupid early” to avoid the “wizard’s” scrutiny. Wayne retired from Deloitte Consulting in 2002. While all of his cherished friends and co-workers will miss him more than words can say, he will always be with us in our hearts and in the wonderful memories we will treasure throughout our lives. The memories will keep us smiling as the stories are retold through the years.



Our chapter made a donation in Wayne’s memory to the Walter N. Pro Animal Shelter.

Palmetto State News

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A Message from the Chapter President.....



Ken Scheller

Hope everyone is enjoying the fall season. I cannot believe that Thanksgiving and Christmas are right around the corner. Where has the time gone?

It was great to see everyone at our Fall Institute, held at the Francis Marion Hotel in Charleston, SC. I want to thank everyone for the exceptional attendance. We had 103 attendees, of which 44% were from the provider community. Thank you to our Sponsors and Attendees for making this Institute successful. Greg Taylor, with Dixon Hughes PLLC, Alice Childs, with Dixon Hughes PLLC, and the rest of the committee did a great job of creating an agenda with excellent education sessions and networking opportunities for the attendees. Thank you for **STEPPING Up**.

Even though we are already five months into the new chapter year, we still have plenty of work in progress.

Currently, Ronnie Hyatt and his committee are putting the final touches on the Membership Directory. Please make sure that your information is correct on the National HFMA Web Site.

Most members have or will receive a survey from National HFMA regarding chapter satisfaction. I would like to encourage you to take the time to complete this survey so that your feedback can be used to improve our chapter operations. National has decided to have a yearly survey instead of every two years. This gives the Officers, Board Members and I relevant and timely feedback.

If you have feedback that you would like to share anytime before or after the survey, please do not hesitate to contact myself or any Chapter Officer or Board Member. **We welcome your ideas and feedback!**

The Education Committee, lead by Greg Taylor, is preparing the next one day education session “Medicare 201 – Advanced Reimbursement Issues” to be held at the Embassy Suites in Columbia on November 16th.

Our last one day education session, “SC HFMA Revenue Cycle Boot Camp”, had a great turn out, with 96% of those attending coming from the provider community.

The CRCA Committee, under the leadership of Brian Walker, is preparing for the final exam opportunity and the celebration luncheon on January 14th, which will include the South Carolina HFMA yearly awards.

I want to remind everyone that National is hosting its 2nd Virtual Healthcare Finance Conference (December 1st and 2nd). I encourage everyone to attend this conference and learn about critical content on reform, cost, quality and more – all from the convenience of your home or office. The registration is free for all HFMA Members.

I also want to thank the Sponsors, without your support we would not be able to provide the high level of education to our members. Thank you for **STEPPING Up**.

I want to, again, thank you for the opportunity to serve as your President this chapter year. I want all of you to know that I do not accept this responsibility lightly. I promise you that I will do the best job I can as your President.

In closing, I encourage all of you to get to know your chapter officers — Ronnie Hyatt, Diane Story and Jude Crowell — the board members and the committee chairs. I challenge everyone to be an “Active” member and **STEP Up**. If there is anything that I can do for you, please let me know. Thanks for allowing me to **STEP Up**.

Ken

HFMA REGION V FALL PRESIDENTS' MEETING

August 22-29, 2010

(Article Authored by Ronnie Hyatt, President-Elect, HFMA – SC Chapter)



Royal Caribbean's "Serenade of the Seas"

An HFMA meeting on a cruise ship? Yes, it IS true, and it's been a custom and practice for many years with HFMA Region V (FL, AL, GA, TN and SC) Presidents and Presidents-Elect. This year's "Fall Presidents' Meeting" and cruise took place on Royal Caribbean's "Serenade of the Seas", August 22nd – 29th, 2010. The itinerary started in San Juan, PR, and took the group to Aruba, Curacao, Dominica, St. Thomas and two days at sea interspersed, before returning to San Juan.

HFMA–SC Chapter was well represented by Ken Scheller, President and Ronnie Hyatt, President-Elect. Each of the other states represented had of course their corresponding President and President-Elect, as well. Additional participants from Region V and/or National HFMA were Lee Ann Burney, Regional Executive; Dwight Tillman, Regional Executive-Elect; Eileen Crow, HFMA Director-Chapter Relations; and, Christine Sarrico, Board Member, National HFMA.

The week provided ample time for each person to share ideas, offer "best practice" processes, and to hear from National and Region V as to current events, policy changes or clarifications, and other important matters. Of course, there was some fun time allotted, too, and zip lines, snorkel excursions, rainforest hikes and waterfalls, and "jewelry shopping" were just some of the island opportunities to take advantage of and learn about some of the local cultures in each destination.



While of course this event was both business and fun, it is in a way recognition of those attending for the many hours and hard work put in on behalf of the SC Chapter, Region V and National HFMA, as well. This should be an encouragement for both long-standing and new members of any Chapter to "get involved" and participate in the future direction of their HFMA Chapter, Region V, as well as the continued success of National HFMA!



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CMA Designation Can Improve Marketability Within the Healthcare Field

by Kyle Herbert, MBA, CMA, FHFMA, FACHE

Over the last three years virtually every healthcare professional has somehow been affected by the worst economic recession since the Great Depression. Several healthcare organizations have either reduced their workforce or in some cases terminated operations. During this financial meltdown employees must take the responsibility to safeguard themselves against threats such as layoffs and closings. The traditional solution to not only job protection but also career advancement is to further one's education. This method has proven to be successful regardless of the field; however, the process requires a substantial amount of time, money and effort. Despite these hardships, a healthcare professional can enhance their marketability whether it be attaining a graduate degree or achieving a high level certification.

Regardless of the industry, practically everyone who has a financial background is aware of the CPA designation. Historically, healthcare accountants have viewed the CPA (Certified Public Accountant) designation as the premier standard for all accounting and financial practices. The CPA exam tests not only financial accounting/reporting but also taxation and auditing. This rigorous examination has evolved through out the years partly due to candidates repeatedly failing the exam. An alternative certification that I believe is equal in stature; however, not as well publicized is the CMA (Certified Management Accountant) designation. This examination covers a broad scope of financial and non financial issues and it does not entail the strenuous requirements that the CPA demands. The CMA designation does not require an undergraduate accounting degree and the financial benefits of attaining the certification can be very rewarding.

A significant difference between the CMA and the CPA are the education and experience requirements. To sit for the CMA a candidate only needs a bachelor degree from an accredited university or college regardless of the major

where as the CPA exam requires a substantial amount of undergraduate accounting courses. The experience prerequisite for the CMA only requires that the professional have at least two years experience in management accounting or financial management. In comparison, the CPA exam requires that the candidate must work at least one full year under the direct supervision of a current CPA.

Healthcare managers are constantly looking for personnel who can analyze and dissect financial data. The CMA exam specializes in educating those highly motivated people who desire increased responsibility and higher compensation. Topics such as management by exception and contribution margin are emphasized throughout the exam's curriculum. Candidates are also thoroughly tested on budgeting techniques and cost allocation methods. This subject matter becomes even more relevant due to the federal government's mandate on health care reform. The unpredictability of healthcare accounting demands that a financial professional be diligent enough to cope with the volatility of Medicare and Medicaid regulations.

Within the last five years I have passed both the CMA and CPA exams and each designation has been vital to my career advancement. However, I utilize the concepts and ideas tested within the CMA much more than I do the taxation/regulation issues I learned while studying for the CPA. Passing the CMA exam has not only provided me with financial security but it has also been the motivating catalyst to me advancing my education in all other areas. I strongly suggest that each prospective member of HFMA research the feasibility of obtaining the CMA designation. This process is not easy but the rewards significantly outweigh the costs.

[Kyle Herbert is a Senior Reimbursement Analyst at Palmetto Health in Columbia, SC. He can be reached at \[kyle.herbert@palmettohealth.org\]\(mailto:kyle.herbert@palmettohealth.org\).](#)

Healthcare Finance as a Career Choice

by Kyle Herbert, MBA, CMA, FHFMA, FACHE

Those who have chosen a career path in accounting have typically been classified as either audit or tax professionals. Historically this segregation has been accurate since most accountants have pursued CPA licensure within these fields. However, the growth of certain industries such as health care has provided financial professionals the opportunity to pursue careers outside of the audit/tax realm. A driving factor to this expansion is the Federal government's enactment of health care reform in an attempt to extend health coverage as well as decrease costs. Another contributing factor is that new advancements in medical technology and pharmaceutical research are altering the means to how health care is administered. People are beginning to live longer as cures are discovered, vaccines are created and therapies are developed. As this progression continues there is a correlating increase in demand for those who have financial expertise.

There are very few industries or businesses that are truly recession proof; however, the health care field has proven to be the exception. Regardless of war, economic depression or weather driven catastrophe the presence of a health care delivery system will always exist. As some point in all our lives we will acquire some type of illness or medical issue that compels us to consult a physician, possibly require surgery or in rare cases an extended stay in a hospital. No matter what the extent of the illness or timeframe of injury there will always be a need for someone to maintain fiscal responsibility. Financial personnel are needed to bill the third party, post revenue, collect cash, determine uncollectibility, process invoices, formulate a budget and do all this within guidelines created by the State and Federal government. Billing methodologies must be adapted and collection techniques must be altered to meet the demand of new technology. Due to these advancements the job security within the health care accounting field is relatively secure. There may be times when late hours are

worked and certain job duties may seem routine but overall the financial health care industry is attractive to those who desire stability.

Historically, accountants have been perceived as boring, reclusive people who sit at a desk all day and have no personality. I admit I have worked with a few colleagues who were extremely introverted and the majority of an accountant's day is spent behind a desk; however, the job duties are far from boring or mundane. Those who pursue a field in accounting are extremely analytical and highly motivated. Understanding double entry accounting is like learning a new language and comprehending the trickle effect of each ledger entry takes time to truly master. The technical aspects of the accounting field have been compared to similar industries such as manufacturing or engineering. In other words, accounting is financial engineering. It is not data entry and it is not easy. The health care accountant's career is challenging and it is constantly evolving. The primary reason why many people discontinue a career in accounting is not because they are not good with numbers but because they simply lack the necessary discipline and work ethic.

Over the last ten years many colleges and universities have begun offering undergraduate health care accounting courses in response to the increased demand for the profession. The industry is even becoming more significant with the Federal government's attempt to reform the American health care system. There has never been a time where it would *not benefit* an aspiring financial professional to enter the health care field. I strongly suggest that each member of HFMA encourage friends and/or family to pursue a career within the financial health care realm.

Kyle Herbert is a Senior Reimbursement Analyst at Palmetto Health in Columbia, SC. He can be reached at kyle.herbert@palmettohealth.org.

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Value-Based Purchasing: The New Reimbursement Challenges

By Dr. Nick Sear, Chief Medical Officer, MedAssets

When “The Patient Protection and Affordable Care Act” became law, the structure for the business of patient care received another dose of change. As providers react to provisions in this law, one core concept will be at the forefront – value-based purchasing. This program has significant qualitative and operational implications, and providers must prepare and reengineer their organizations for reimbursement challenges and opportunities that lie ahead.

The Origins of Value-Based Purchasing

The initial program components for value-based purchasing were included in the Deficit Reduction Act of 2005, which through the Inpatient Prospective Payment System, outlined measures to transition to outcomes-based reimbursement. The IPPS was the vehicle to develop and select measures of quality; report, collect and validate quality data; determine the structure, size and source of value-based payment adjustments; and disclose information on provider performance.

Moving Forward: Tips for Providers

Below are key tips to prepare for value-based purchasing:

Understand the Performance Assessment Model

- A key element of this initiative is creating a Total Performance Score, which determines the levels of incentive payments providers receive. Under this scenario, performance payments are based on criteria published annually on measurements that apply to providers’ individual patient populations and service mix. Measures are grouped into domains, and each domain is scored. From this benchmark data, each provider receives a performance score upon which incentive payments are based.
- The scoring model considers two facets – the increase in levels of quality improvement year over year and maintenance of already-high performance achievement. This approach rewards the stronger result of these two measures that fits each provider’s circumstances, recognizing both substantial progress toward quality goals and the hard work required to keep quality achievement at high levels.

Take Measures

- The core of the value-based purchasing concept is in measures that rate clinical quality and ultimately affect reimbursement – DRG clinical practice guidelines, clinical outcomes centered on 30-day mortality rates, patient satisfaction survey performance and the transition of focus from Never Events to healthcare-acquired conditions.

Providers that capture data electronically are on track to meet the larger goal of having universal electronic medical records, which in turn will help evaluate hospital performance and fuel the value-based purchasing process. The bottom line: from dispensing aspirin to giving discharge instructions, providers will have to document it electronically to get paid for it. To incent providers to make the switch, Congress authorized \$27 billion over five years as part of the 2009 Stimulus package. Hospitals can qualify for up to \$44,000 by meeting certain “meaningful use” criteria. The time to begin the transition is now.

Act Now – The Future is Here

- Providers that move quickly to embrace comprehensive electronic medical records will position themselves to meet mandated milestones, receive incentive payments and avoid future penalties for non-compliance.

The importance of the new quality component to the reimbursement process underscores the need for chief financial officers and chief medical officers to work closely on issues related to the performance-score process – and fully understand the parameters for measurement as they are rolled-out. Now rooted in law and regulation, value-based purchasing is here to stay, and providers that work diligently to meet its requirements will reap the rewards.



WHY?

- The process provides a learning experience and contributes to your professional growth
- Enhance professional credibility within the industry and differentiate your level of experience
- Prepare for opportunities as a leader and someone who may influence the future of health care

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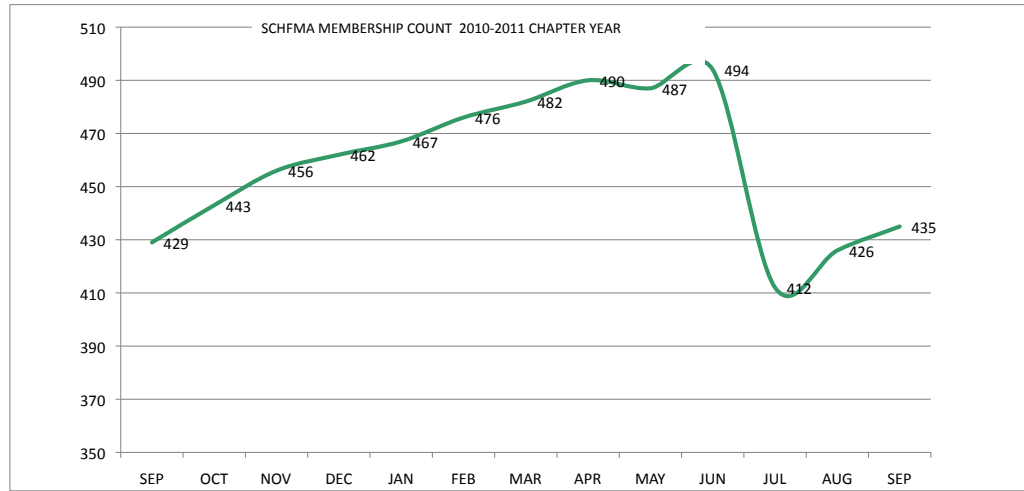
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SC HFMA Membership Chart for Chapter Year June 10-May 11

BEGIN	520
MAY 08	531
JUN	540
JUL	431
AUG	448
SEP	455
OCT	461
NOV	466
DEC	469
JAN	471
FEB	479
MAR	485
APR	497
MAY	504
JUN	510
JUL	399
AUG	410
SEP	429
OCT	443
NOV	456
DEC	462
JAN	467
FEB	476
MAR	482
APR	490
MAY	487
JUN	494
JUL	412
AUG	426
SEP	435



SURVEY ANYONE!

Please take a moment to share your experience with the South Carolina Chapter of HFMA so that we can continue to provide services that meet your needs. We value your input and take it very seriously. Whether you have little experience with the chapter or a lot, please offer your feedback so that we will know how to provide you with the best possible membership experience.

<http://vovici.com/1.dll/JGsA5D9E8D9E8lePD9U493692J.htm>

We appreciate your feedback very much.

Kenneth M. Scheller
President
South Carolina Chapter

NEW!!

Certified Healthcare Financial Professional (CHFP) Information

If you are currently a CHFP candidate, please read below!

NEW: Effective January 2011

The CHFP (Certified Healthcare Financial Professional) certification is designed for mid-level healthcare finance professionals who aspire to the executive level or desire confirmation of financial management expertise.

Candidates should have a minimum of 3-5 years healthcare finance management experience.

What Members Told Us

Our members told us our certification program was difficult to access—the study guides were cumbersome and expensive. They needed easy, flexible access to the educational material so they could fit their continuing education into their often tightly scheduled day. Our members told us that they needed broad cross-functional knowledge of business operations in their jobs. Healthcare finance executives told us they need finance managers with broad, cross-functional knowledge for successful business operations.

And then there was access to the testing sites. Hospital firewalls are notoriously finicky about the programs they let through—and rightly so. But it made lots of problems for candidates who were scheduled to take tests, but had difficulty gaining access from their testing site.

It was clearly time to look into ways to improve our certification process so it would better serve our members while maintaining the high standards that make HFMA certification attractive to employers. Under the guidance of the HFMA Board of Examiners, the Certified Healthcare Financial Professional certification program has been restructured and changes will go into effect in January 2011.

These changes affect only the CHFP designation; the current FHFMA requirements will stay the same.

Our Solution

Under the new model:

- Candidates are required to successfully complete one comprehensive certification exam rather than a core exam and a specialty exam. The exam assesses healthcare financial management practice knowledge in six domains: revenue cycle, disbursements, budgeting-forecasting, internal controls, financial reporting, and contract management.
- Candidates must hold a current and active regular HFMA membership; the two-year membership requirement has been dropped.
- Preparation materials will be available online and will be available for pre-order in the fall of 2010 (watch the Certification website for more information)
- Testing will be administered in testing centers located throughout the country; most sites will be located in community colleges and universities and every state has at least one site.

The Advisory Committee

A key component of the restructuring was establishing a Chapter Certification Advisory Committee (CCAC) to provide feedback on the program changes as they are implemented. The CCAC is composed of a representative from each region. Each Regional Executive invited a member from his or her region to serve on the committee. HFMA has reached out to current certification candidates via a direct mail letter to explain the changes and offer guidance during the transition period and plans to follow up with e-mail and phone communications.

For more information regarding these changes, please contact Steve Lutfy, FHFMA, Certification Chair (stephen.g.lutfy@us.pwc.com), or call National HFMA at (800) 252-4362, ext. 311, or e-mail certification@hfma.org.

Revenue Cycle

Moving Forward One Electronic Claim Attachment at a Time

In order to adapt and thrive in this new age of healthcare reform, it is imperative that providers and health plans alike maximize efficiencies. The time to act is now. Technology is available that will enable both health plans and providers to adjudicate claims not only quicker but also without manual intervention. Specifically, the ASC X12 275 transaction makes it possible for a provider to respond to a health plan's request for additional information to properly adjudicate a claim. Moreover, using standardized code sets will speed up the flow of information leading to claims being paid and finalized faster than ever before.

The process begins when a health plan requests additional information in the form of an ASC X12 277 transaction and then adjudicates the claim based upon the response received. It is vital that the information received is explicit and consistent so matching logic can be used to automatically attach the required documentation. Ideally, this will be best utilized through a medical imaging system that is dynamic enough to locate the requested information and extract it to an image format. The image would then be attached and sent back to the health plan in the form of an X12 275 transaction. Upon receiving the required data the health plan would then finalize the claim and pay the provider.

- 1) Health plan sends a request for the additional information that is required to adjudicate the claim (X12 277)
- 2) Provider responds with an electronic claim attachment with the information the payer requested (X12 275)
- 3) Health plan adjudicates the claim based on the information received (X12 835)

Building electronic claim attachments into today's workflow will benefit both payers and providers. With little to no human interaction claims will flow faster, cheaper, and more efficiently. Electronic transactions process much faster than paper and are not sent by certified mail so the overhead associated with shipping and handling confidential documentation will be eliminated. The responses should also be solicited so every request for additional information will have a corresponding response with the required claim data in the attachment so there is a one-to-one ratio. Operating on a claim by claim basis allows for more precise tracking and also provides the benefit of easier claim status maintenance by health plans.

Despite all the benefits that submitting claim attachments electronically hold there are still drawbacks. The initial cost can be a detriment since extensive testing

and development will be needed in addition to the hardware and software costs. Spending is under more scrutiny than ever before and depending on how the medical loss ratios are defined important health plan activities could be put on hold or cut from the budget entirely. Very few health plans are using this technology today and the more payers that embrace this technology the more economies of scale will negate the costs for providers. While this process has the potential of being void of human interference, the fact remains that a large portion of healthcare documents are still on paper. All required documents will have to be scanned, stored, and indexed in a manner that the system can automatically access these records and attach them to the electronic claim. Not only will the system have to be intelligent enough to accurately process electronic requests it will also have to collect the right amount of data for the intended purpose. This might seem overwhelming at first but, the same arguments and obstacles apply to almost every new implementation involving sensitive material and automated transactions.

The ASC X12 275 transaction is here to stay and will become more widely used throughout health care. Companies that are getting by today with out-of-date technology will not survive in the dynamic future. Defining and qualifying medical expenses will weed out and shape the landscape in many health care markets. Meanwhile, policymakers are pushing to provide incentives for companies to develop new health care technologies aimed at improving efficiency and expanding the marketplace. As more uninsured patients receive coverage the more vital electronic transactions become because staffing and administrative costs will grow in relation to the increased volume of paper claims. However, in a stable production environment that fully utilizes all electronic transactions an increase in volume would have a negligible impact on overhead expenses. Health plans and providers will be able to shift manually intensive work to more specialized projects that might have been overlooked in the past. Furthermore, providers and payers should embrace electronic claim attachments and form an even tighter symbiotic relationship as we move forward together into the future.

About the Author

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Debt Compliance: Know Your Role

By Matt Barr, CPA, Audit Manager
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With the economic downturn over the past couple of years, there has been a renewed focus on compliance with debt covenants, both financial and non-financial. Diminishing investment returns, shifts in payor mix, and increasing charity care are just some of the challenges faced by hospitals in trying to maintain compliance with financial covenants. Additionally, a hospital may be required to adhere to covenants not only in the loan agreement, but in the master trust indenture or letter of credit agreement. The costs of obtaining a waiver for non-compliance can be significant, but the ramifications of being in default can be even worse. At a time when a debt covenant violation could have a significant impact on a hospital, it is important to monitor this information on an on-going basis. Equally important is to understand the definitions affecting these financial covenants.

Changes and updates to accounting standards the past couple years have a direct impact on certain financial covenants, the most notable of which relates to other-than-temporary impairment of investments (OTTI). OTTI is a non-cash loss resulting from a management determination that an investment in a loss position is impaired and likely to not recover its initial cost. The effect of this determination on a hospital's statement of operations is that this non-cash OTTI loss is reported within the performance indicator, as opposed to outside of the performance indicator similar to unrealized gains and losses on investments. Depending on the definition, for example, of what parameters are to be used in determining the long-term debt service coverage ratio, an OTTI loss could negatively affect that calculation, even though it is a non-cash loss. Additionally, when an OTTI adjustment is taken, the cost basis of that investment for accounting purposes is now the value of the investment at the point OTTI was taken, not the original cost. Therefore, going forward, any unrealized or realized gain or loss as reported on the statement of operations is not based on the original cost, but the adjusted OTTI cost. It is important to determine what basis, either historical cost or OTTI adjusted, should be used in determining the hospital's long-term debt service coverage ratio for covenant purposes. For those documents that do not address non-cash gains or losses outside of depreciation and amortization, it may be necessary to involve legal counsel to determine the appropriate method to calculate.

It is also important for management and the board to be familiar with all covenants, both financial and non-financial, included in each of the debt documents. Insurance requirements, restrictions on incurring additional debt, and capital purchase requirement are just a few that management needs to adhere to.

When a hospital is not in compliance with a covenant, it could trigger an event of default. Should an event of default occur, the hospital will almost certainly need to obtain a waiver for non-compliance from the bank. Should a waiver not be obtained, or if the bank is unwilling to provide this, generally, the outstanding debt will become due and payable on demand. In this instance, from an audit prospective, the outstanding debt would then need to be classified as a current liability on the hospital's balance sheet. Furthermore, a going concern opinion on the financial statements would need to be considered factoring in the hospital's ability to repay this obligation. Management is encouraged to begin discussing with the appropriate parties sooner rather than later any known non-compliance.

Debt documents generally require some form of reporting from your independent auditor regarding compliance with certain covenants. Both the auditor and the hospital should be aware of the reporting requirements in the debt documents. There may be instances in which the debt documents require certification on covenants from the auditor that are not within the scope of the audit, and thereby precluding the auditors from being able to report on those covenants without conducting a separate engagement, or performing additional procedures. For new bond issues, agreed-upon procedures are now required to address compliance with more covenants in these bond documents. These procedures for testing compliance are generally outside the scope of the financial statement audit. For the hospital, these agreed-upon procedures will result in additional fees.

In summary, management and the board should be familiar with the covenants outlined in the debt documents as well as the definitions, particularly for financial covenants, pertaining to calculations required under the debt documents. Waivers are becoming more difficult to obtain and are becoming more costly. Ongoing communication with the bank and the hospital's auditors are key to avoiding surprises of non-compliance at the last minute.

Hope for a Homer

This Major Leaguer had little chance of hitting a home run...until he visited some kids who gave him hope.

By Brett Gardner, New York, New York

As appeared in **Guideposts**.

I'm an outfielder for the New York Yankees, and I can do a lot of things to help my team win a ball game.

I'm blessed with great speed—I leg out bunts, steal bases and stretch singles into doubles. I've learned to be a disciplined hitter—I draw walks and I get on base. I'm pretty good with the glove too—I get to a lot of balls because of my speed.

What I definitely am not blessed with is power. I'm no slugger. One look at me and you'll know why.

The official Yankees' guide lists me as 5' 10," 185 pounds, but that's generous. When I walked to the plate the night of May 15, 2009, I had one career home run to my credit. And I didn't have much of a prayer of hitting another.

Then again, prayer had already been a big part of my day. That morning I'd visited kids at New York-Presbyterian Morgan Stanley Children's Hospital, not that far from Yankee Stadium. I have to admit, when I walked into the hospital reading room, I didn't know much about the boys and girls I'd be seeing—how sick they were, what they were going through.

Project Sunshine, an organization that provides free educational, arts and social programs to kids with medical challenges, had put the visit together. I was there with Linda Ruth Tosetti, one of Babe Ruth's granddaughters. She told the story of how the Babe had once promised a sick child that he'd hit a home run for him, and how, later that day, he had done exactly that.

Then Linda introduced me. I explained that I almost never hit home runs. I told some baseball stories—about how I made the Yankees, about my better-known teammates, like Derek Jeter.

Afterward, one girl came up to me in her wheelchair. She was on the small side, but flashed a huge smile. She introduced herself: Alyssa Esposito, 18, of Long Island, New York. She told me she was waiting for a heart transplant. "I've been here since January," she said.

Oh, man, I thought. To me, a bad day was going 0 for 4 at the plate. And here was this girl, just a teenager, fighting for her life.

Alyssa tapped me on the arm. I figured she wanted an autograph. Instead, she said, "I have something I want to give you." She unhooked a bracelet from around her wrist. It was simple, a yellow cord with a small silver charm. She had gotten it that morning from Project Sunshine. "This will make you hit a home run tonight," Alyssa said. "I prayed about it."

"Thank you," I said, slipping the bracelet on, praying that by some miracle I'd slug a ball out of the park. More important, I prayed she'd get the transplant she'd been waiting for.

"I'll be watching the game," she said.

When I got to Yankee Stadium in the afternoon, I checked the lineup card for our game that night against the Minnesota Twins. I wasn't scheduled to play. *So much for answered prayers*, I thought. I hoped Alyssa wouldn't be disappointed. I took off her bracelet and tucked it safely in my locker. Then I pulled on my uniform and turned my focus to baseball.

The game began. I sat on the bench, watching our left fielder Johnny Damon roam the outfield, tracking down fly balls. Then the craziest thing happened. In the third inning, Johnny—generally a mellow guy—got into it with the home plate umpire over a called third strike. The ump tossed him out of the game.

Joe Girardi, our manager, pointed to me. "Gardy," he said, "you're playing left."

My first time up, I singled. My next at-bat came in the seventh inning. We were trailing the Twins, 4-1. With two out, I stepped to the plate. I have to be honest, I wasn't thinking about Alyssa. I was thinking about doing my job: getting on base, then maybe stealing second to get into scoring position so we could get back in the game.

Strike one. *Focus*, I told myself.

Strike two. I stepped out of the batter's box and gathered myself. Took a deep breath.

I was ready for the third pitch. I lined a shot that sliced toward the left field foul line. Single, I figured, running to

first base. Our first base coach waved his arm—the signal to head for second. Turning, I saw the ball get past the Twins left fielder and roll to the wall. Double, I thought. But as I neared second, I saw the ball take a crazy carom away from the left fielder. Triple, I decided and raced for third.

That's when our third-base coach began windmilling his arm. I went into an all-out sprint for home. I knew it would be a close play. Ten feet from the plate, I dove headfirst. Safe! An inside-the-park home run!

In the dugout, the guys were all over me. Inside-the-park homers are pretty exciting, and very rare. We'd cut the lead to 4-2 and were back in the game.

I took a seat on the bench and tried to catch my breath. That's when it occurred to me: It happened just like Alyssa said it would!

I told my teammates about Alyssa and the bracelet. I think she inspired us, because we rallied in the ninth inning to win the game, 5-4.

Alyssa's prayer for me had been answered. But what about my prayer for her? *Take care of her, Lord*, I pleaded.

The next day, one of the Yankees publicists pulled me aside. "Did you hear about Alyssa?" he asked. "They found a donor. She had a successful heart transplant last night."

I saw Alyssa that summer, when she was well enough to visit Yankee Stadium. She flashed a huge grin and tapped her chest, where her new heart was. "You had a big heart to begin with," I said.

"Do you still have the bracelet?" she asked.

"I keep it in my locker," I said. It's a reminder of the power of prayers—and of the One who answers them.

Brett Gardner is the nephew of Conway Hospital business office employee Joanne Gardner. Brett is from Holly Hill, SC and played college baseball at the College of Charleston and now plays Major League Baseball with the New York Yankees in 2005.

Inside the Audit and RAC Preparation Process at Norton Healthcare

By Janice Redden and Kate Banks
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One health system addressed challenges with the Recovery Audit Contractor (RAC) program by having a RAC audit response plan in place.

The Centers for Medicare & Medicaid Services (CMS) RAC program rollout is expected to create increased scrutiny of Medicare reimbursement for hospital inpatient and outpatient services, skilled nursing facilities, physician practices, ambulance services, laboratory services, and durable medical equipment providers. The RAC program also is expected to result in a significant loss of revenue and additional operational costs for healthcare providers. Audited hospitals will be required to return all challenged Medicare payments immediately, and earn them back only after completing a complicated appeals process. Meanwhile, hospitals are already facing complex reviews in some regions as well as audits by federal, state, and even commercial payers. Complex reviews occur when RACs or other auditors have identified a likely improper payment and are requesting that the provider furnish the medical records attached to the claim to conduct a more in-depth review.

Now more than ever, it is critical for hospitals to expand upon and leverage the lessons learned by their organizations and others during the RAC pilot. Healthcare providers should look both outside and inside their organizations to prepare for the RAC challenges that lie ahead. By looking outside, they can leverage the lessons learned by other organizations that have already put RAC systems and teams into place. Norton Healthcare, a not-for-profit organization serving the Louisville, Ky., region, has taken this approach—and has positioned itself to more efficiently respond to RAC audit requests.

It Takes a Village—or in This Case, the Right Team

Healthcare providers that participated in the RAC pilots agree that assigning a team to focus on RAC audit responses is critical to ensuring that an organization will be able to respond in a timely manner with the proper documentation. Choosing the right team for the job is a key to success. Deciding to establish a RAC audit response team is the easy part. Determining who should be on that

team and how the team will operate is more challenging. Team members should be focused and dedicated to the process. The team should include members of the revenue cycle department in addition to representatives from health information management (HIM), compliance, and case management.

RAC audit response teams should be developed using existing teams. For example, Norton Healthcare includes five hospitals, 11 immediate care centers, and more than 90 physician practice locations. Putting together a team in a large health system is a complex undertaking, so Norton decided to build its RAC audit response preparation around an existing process that had already achieved a high level of success. A billing and documentation committee that reviews all billing, coding, and compliance issues has been in place at Norton for several years. Members of that committee—which includes representation from the health system's revenue integrity, HIM, care management, compliance, patient access, reimbursement, and business office functions—were chosen to handle the RAC audits as well. The organization benefits from being able to leverage the skills and experience of the cross-functional team members for the RAC audit responses. The team meets semimonthly, with the vice president of compliance serving as committee chair. The health system's legal and patient access departments also are involved in the process. Norton also has a billing and documentation team that works specifically with physician practices; this team also will be instrumental in the organization's RAC audit response. This multidisciplinary group meets every two months. Establishing clear, distinct communication channels for the RAC team is important. The team uses e-mail and conference calls to stay up-to-date on activities between meetings, and ensures that some type of communication occurs daily.

To further streamline the process and avoid confusion around responsibilities, Norton established a central post office (P.O.) box for RAC correspondence. Whether a RAC letter is addressed to one of Norton's hospitals or one of its physician practices, the letter is delivered to one P.O. box that is controlled by the revenue integrity department. That department is responsible for routing the letter to the appropriate hospital or practice group.

Preparation Is Paramount to Success

Other keys to developing a RAC audit response strategy revolve around preparation. In addition to identifying a RAC audit response team, Norton identified four key action steps to undertake early in the process.

Mine data continually to identify potential risks. By evaluating past claims, organizations can identify potentially vulnerable areas and make corrections before an audit begins. The RAC demonstration showed that correct coding is essential to ensuring that claims are not flagged for either “clearly containing errors” or being “likely to contain errors.” Identifying areas of noncompliance and implementing a process improvement program to remedy identified deficiencies will help organizations minimize the financial impact of recoupment. Organizations also should analyze processes used in departments that contribute to Medicare compliance issues, such as patient access, case management, physician practice patterns, and finance. Norton began conducting proactive chart audits in June 2008 and found some instances where the organization had inadvertently filed incorrect claims. Recently, Norton received correspondence from the Office of Inspector General (OIG) regarding billing errors that Norton already had identified as issues and had attempted to refile with National Government Services (NGS). Because the claims were refiled past the point of timely filing, NGS returned them to Norton. Norton contacted the OIG, which ultimately determined the claims were acceptable for processing. The lesson learned is that hospitals need to follow up to ensure that rebilled claims are processed correctly with the payer. This proactive approach has helped Norton as it faces NGS, Medicaid integrity contractors, and commercial payer audits for Current Procedural Terminology and Healthcare Common Procedure Coding System coding.

Incorporate automated components into the process. The RAC process can be cumbersome, and facilities in the pilot program found that manual processes were not sufficient for addressing RAC needs. Those that processed claims manually missed some deadlines and lost revenue. Establishing an automated RAC tracking solution is paramount to navigating the process. Facilities should use software that ensures that only valid claims are audited, provides a mechanism for escalating reminders as deadlines are approached or missed, develops tracking mechanisms, facilitates departmental communication, identifies systemic trends and weaknesses, manages appeals, and allows for capturing and monitoring data that can be shared with healthcare industry organizations, such as the American Hospital Association.

In September 2009, Norton implemented web-based software that streamlines and automates cumbersome RAC processes. The new tool audits historical claims and uses an interactive workflow and customized reporting to appeal RAC audit findings in a timely and efficient manner. The tool also links to a coding and reference research tool to quickly search for new rules and regulations and helps identify areas for improvement, such as compliance and reimbursement issues. With no limits on the number of automated requests (which do not require medical records) that can be sent to a provider, Norton anticipates this strategy as being important to its response. However, there will be a maximum number of medical records that can be requested per 45-day period per hospital campus.

Conduct education across the organization, and train key staff. Educating staff organizationwide about the RAC process and putting resources in place to empower staff to address needs is essential for a successful experience. Education of physicians is particularly important because practice patterns can significantly affect compliance and create the potential for the RAC to identify overpayments. The following are steps that organizations can take to educate physicians and staff:

- Train a RAC team ahead of time to handle research and response
- Consider tapping vendors or temporary staff to help with processes such as pulling files from off-site locations
- Appoint internal RAC champions
- Work with physician advisers and administrators on strategy and procedures

Norton's RAC committee members have conducted educational sessions for individual departments and committees, such as its medical executive committee, while carefully explaining what the RACs are looking for, the department's role in the process, and how to handle correspondence and medical record requests. Norton held one training session on how to use its new web-based RAC auditing tool immediately after the tool was implemented and plans to offer additional training opportunities once it begins to receive requests. The HIM department added two release-of-information specialists to work with RAC requests, and those staff members are in place to ensure that charts are readily available to go out the door in the event of a review. Norton's senior leadership team also has designated open positions to fill the role of coding auditors if the facility receives more audits than the existing staff can handle.

Communicate to all stakeholders. Healthcare providers, especially larger institutions, should put a

communications infrastructure in place to ensure proper communication across the organization regarding RAC. Norton posts educational information and RAC updates in central mailrooms and other public areas that all staff members can easily access. For example, Norton created a poster to show all employees what the audit document looks like when mailed through the postal service. The system also directs its communications to physicians. For example, Norton is making efforts to educate and communicate with its physicians and affiliated physician groups about the impact of the RAC audits and includes information on documentation and commercial audits. After all, success largely depends on these groups and their documentation. This education/communication effort has already begun with the orthopedic and neurosurgery departments and has further expanded to the OB-GYN practices affiliated with the organization. When recently anticipating its first RAC communication, the team at Norton began checking the P.O. box regularly. Coincidentally, Norton staff learned that the RAC had mailed a letter to the hospital's main address, even though Norton's change of address form is posted on the RAC website. Norton never did find the RAC letter (which could not be e-mailed). Another letter was sent to an unlikely recipient—one of Norton's human resource executives. Thinking the correspondence was related to a legal matter, that executive involved the organization's legal department before determining that the letter was RAC-related. When the letter, which was sent by the OIG rather than the RAC, was delivered to the revenue integrity department, the HIM department was ready to pull information and documentation.


Looking Ahead

For Norton, the term RAC now stands for Ready, Automated, and Continually improving. Norton is focused on testing and tweaking its improved RAC audit response processes and educating staff and physicians. The organization believes its processes for auditing are in good shape, but also realizes that practice is good before the ballgame, but until you get in the game, you don't really know what to expect. Organizations that have not yet put a RAC audit response plan in place can benefit from Norton's preparation to stay ahead of the audits. Norton and others also can look to healthcare providers that have participated in the pilot program and have identified areas that were problematic during the pilot phase. Thanks to what Norton has learned, other organizations can use these lessons to proactively address issues related to RAC audit requests. Because the number and type of audits will continue to evolve and similar programs to address overpayment issues in other areas such as Medicaid will follow, lessons that are shared regarding how to respond to RAC audit requests will be vital for facilities preparing for the national RAC implementation. Those who heed the advice will have much to gain, both during the RAC process and beyond.

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SC HFMA Education

Calendar of Events



<u>Education Event</u>	<u>Date</u>	<u>Location</u>
Reimbursement Update	November 16, 2010	Columbia
Payor Summit	March 1, 2010	Columbia
Webinar 2:00pm	December 7, 2010	
Winter Awards Luncheon	January 14	Columbia
Webinar 2:00pm	January 18, 2011	
Webinar 2:00pm	April 5, 2011	

ARRA Funds – The Good, the Bad and the Ugly

The American Recovery and Reinvestment Act of 2009 (ARRA) provided \$787 billion in federal tax incentives, expansion of unemployment benefits and other social welfare programs, and domestic spending in education, infrastructure and healthcare. Of the \$787 billion in ARRA funds, approximately \$151 billion was designated for healthcare spending, including funds for capital improvements and financial incentives to promote the use of electronic medical records and other information technology, just to name a couple. With hospitals and healthcare providers beginning to receive unprecedented amounts of federal funding under the ARRA program, it is inevitable that single audits will be triggered. The single audit process will be a key factor in the showing accountability for these funds in that the recipients and uses of all funds are transparent to the public, the public benefits of these funds are clearly, accurately and timely reflected, and so that funds are used for authorized purposes and instances of fraud, waste, error and abuse are mitigated.

In general, a single audit is required when an entity expends \$500,000 or more in federal funding (excluding Medicare and Medicaid funds) in a year. A single audit is in addition to an organization's financial statement audit. The single audit encompasses an award recipient's financial records, financial statements, federal award transactions and expenditures, oversight and management of operations, internal controls and federal assistance received during the period of audit. Financial statements are specifically prepared for the single audit and the award recipient is required to prepare a schedule of expenditures of federal awards.

The infusion of these massive amounts of federal dollars is giving single audits a new meaning these days. In 1984, when the Office of Management and Budget (OMB) Circular A-133 went into effect, the goal of a single audit was to gain consistency in how entities were reporting how federal funds were spent. For the ARRA funds, an equal amount of focus is being placed on reassuring the American taxpayer that their money is being wisely spent.

If your organization has received funds under ARRA, then those administering these funds have seen that they come with a high demand for accountability and transparency, and require reporting enormous amounts of data. In other words, there are strings attached. Even if a hospital or healthcare provider is accustomed to single audits for other types of federal funds, as a recipient of ARRA funds the provider must be prepared for additional rules and regulations accompanied by strict reporting requirements.

Whether your organization has received funds, or will be receiving funds, under ARRA, make certain those in charge of administering these funds read the grant carefully and understand all the compliance requirements. It is important to document policies and procedures in writing and understand all the reporting requirements that come with receipt of these funds. Recipients have inherited a new burden of re-examining, and likely updating, most aspects of operations to accommodate the requirements of this government mandated accountability and transparency.

About the author.....

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