Top 10 Things Hospitals Need to Know About Health Reform—But Were Afraid to Ask

By Susan DeVore

Healthcare reform ushers in a decade of transformations. Yet there continues to be a knowledge gap about what the law means.

At a Glance

The top 10 critical areas of reform that are of concern to hospitals include:

• Understand financial implications
• Do more with less
• Optimize revenue cycle, labor productivity, and supply chain
• Move patients from self-pay to coverage
• Make quality job No. 1
• Prepare for transparency
• Deal with infections
• Implement physician alignment
• Move from volume to value: accountable care organizations
• Obtain HITECH funding

Based on in-depth analyses of healthcare reform legislation, the following are the top 10 reforms that require immediate attention from hospital executives and providers.

1. Understand Financial Implications

A thorough understanding of reform's financial implications from now until 2020 is crucial. Because many provisions are variable based on performance, hospitals need to model each provision using real-world data to calculate impact to the bottom line. Hospitals should take steps now to either build impact calculators themselves or work with a consultant to do so. Although changes will occur throughout the implementation of the law, an ongoing ability to project the impact is essential.

2. Do More with Less

Although payment increasingly will be tied to performance, all hospitals have to absorb cuts. These include $147 billion in market basket cuts, including an adjustment for “productivity improvements,” as well as disproportionate share payment reductions over 10 years and a coding adjustment (sometimes called the “behavioral offset” under the inpatient prospective payment system). Taken together, analysis indicates hospitals need to cut Medicare expenses by 10 percent just to preserve today's margins. Although the coverage expansion will help offset this somewhat, these gains are much more challenging to quantify.

3. Optimize Revenue Cycle, Labor Productivity, and Supply Chain

With so many cuts coming, cost reductions will come from staff, supplies, and the hospitals’ management of revenue. For the revenue cycle, cuts in Medicare and Medicaid can be offset by proper coding and ensuring charges are captured, billed appropriately, and collected in a timely manner per the new filing rules. Regarding labor, hospitals need to invest in automation and process improvements to ensure that employees are performing to the “top” of their licensure and operating efficiently. In supply chain, hospitals need to drive down prices through group purchasing and take a critical look at supply utilization.

4. Move Patients from Self-Pay to Covered

Reform will provide insurance to an estimated 32 million more Americans. But for those who don’t opt into the insurance pools, hospitals will need to ensure they are made aware of their coverage options in order to avoid continued uncompensated care. This means training staff to understand the variety of public and private options and helping patients enroll as soon as they are eligible and certainly before services are provided, if possible.

(continued on page 4)
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A Message from the Chapter President…..

Hope everyone has had a good summer. As I get older summer seems to go by faster. This year is no exception. We have had one of the hottest summers in years past. It has been a great summer so far, with the University of South Carolina winning the NCAA Baseball Championship. “Sorry Bob, had to say it.”

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.

The 2010-2011 National HFMA Chairwoman is Debi Kuchka-Craig. STEP Up is the theme she has chosen for this year. As healthcare professionals, one of our core qualities is our drive to STEP Up by applying our business leadership skills to the service of delivering the best possible care to the communities we serve.

You have to have the passion needed to meet challenges.
You have to engage and empower stakeholders.
We have to create a sense of urgency.
We have to accept accountability.

It was great to see everyone at our Annual Institute, held June 1-4, 2010, in Myrtle Beach, SC. I want to thank Woody Turner with Lexington Medical Center and Jude Crowell with Washington and West for putting together a great institute. Thank you for STEPPING Up.

At the National Annual Institute, held June 20-23, 2010, in Las Vegas, NV our chapter received several honors and awards for our past performance under the leadership of Ray High. I want to thank Ray for a successful year and for allowing me to STEP Up.

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.

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. Thanks for allowing me to STEP Up.

Ken
5. Make Quality Job No. 1

Under reform, many readmissions, infections, and instances of harm that are deemed “preventable” will result in reduced payment, making quality a top priority. In readmissions, the penalties are particularly severe, as hospitals won’t just be penalized for the excess costs of their readmissions; instead, the penalty will be levied against all diagnosis-related groups, driving the dollar amount significantly higher. Because payment cuts for events like hospital-acquired conditions are levied against those in the bottom performance quartiles, hospitals need a clinical comparative database to assess how they measure up. They may also need solutions that enhance quality and safety, such as electronic infection surveillance or quality measures reporting tools. Although payments based on performance are two to four years away from implementation, the baselines and measurement periods will begin well before the effective dates, so developing a plan for success and initiating change under these new pay-for-performance systems will be essential.

6. Prepare for Transparency

Under reform, hospital charges by condition and sanctions data will be publicly reported. You can count on the media, regulators, and lawmakers to pay close attention to the numbers and results. Hospitals need to start measuring themselves to ensure that public reports indicate high quality and cost-effectiveness. Hospitals should also prepare for transparency provisions such as comparative effectiveness research, which will better inform purchasing and treatments that are proven to enhance quality and reduce costs.

7. Deal with Infections

Hospitals soon may be penalized three times for the same infection: through the current Centers for Medicare & Medicaid Services policy, through value-based purchasing, and through a standalone infection policy. For these infections, hospitals need to get rates as close to zero as possible. Hospitals may be assisted in this effort using an electronic infection surveillance system and training clinicians on the use of evidence-based care as well as correct documentation and identification of conditions that are present on admission, among other considerations.

8. Implement Physician Alignment

Physicians provide treatment and recommend admission and discharge. As such, hospitals and physicians need to be on the same page before embarking on clinical quality or process changes. Moreover, hospitals need to develop alignment structures to prepare for bundled payments and accountable care organizations (ACOs) that reward improved quality, satisfaction, and cost-effectiveness.

9. Move from Volume to Value: ACOs

ACOs could transform today’s payment system from micromanaged, yearly fee-for-service cuts to one that allows providers to better coordinate care. That said, ACOs represent a sea change, and work must begin now to develop care networks, payer partnerships, and other capabilities necessary to evolve from volume to value.

10. Obtain HITECH Funding and Qualify for Grants and Pilots

Although not a part of reform, funding for health IT will enable hospitals to achieve quality, safety, and cost goals. But “wiring” health care requires interconnected systems supporting free-flowing information. To qualify for funding, hospitals need implementation plans that fit within the government’s overarching vision, while addressing the business relationships, processes, and technology platforms that work best for unique local networks. Moreover the law also sets aside money for grants and pilots through the Center for Medicare and Medicaid Innovation, and hospitals should carefully review these criteria and take advantage of those that most closely align with their strategic vision.

Susan DeVore is president and CEO, Premier healthcare alliance, Charlotte, N.C., and a member of HFMA’s North Carolina Chapter

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Editor’s note: Health Reform continues to dominate the healthcare finance landscape and that includes discussions of the topic in the Palmetto State News. In the Summer 2010 issue, we are running two articles on reform written by two qualified authors from two mainstream healthcare finance related organizations. While similar in nature, the articles are unique enough and the Palmetto State News felt both would be beneficial to chapter members.
On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA), which amended the timely filing requirements to reduce the maximum time period for submission of all Medicare FFS claims to one calendar year after the date of service.

Under the new law, claims for services furnished on or after January 1, 2010, must be filed within one calendar year after the date of service*. In addition, Section 6404 mandates that claims for services furnished before January 1, 2010, must be filed no later than December 31, 2010.

The change in the timely filing regulations means that, this year, providers will now have to submit an additional three (3) months worth of claims by the December 31, 2010 deadline.

Solution

PricewaterhouseCoopers’ Virtual Business Office (PwC’s VBO) assists hospital business offices meet Medicare’s timely filing guidelines and generate additional cash flow, without re-aligning resources or requiring additional space. We work as a collector on your patient accounting system, thereby preserving it as the system of record from a compliance standpoint.

To stay ahead of the new timely filing regulations, we recommend the following strategy:

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<th>PwC VBO’s Recommended Timely Filing Strategy</th>
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<td><strong>Claim’s Beginning Date of Service</strong></td>
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Is CAH Still the Right Answer?

Why Critical Access Hospitals need to take a fresh look at their situation in light of HIT incentives and healthcare reform

by Tommy Barnhart, member, and David Hall, senior manager, Dixon Hughes PLLC

Most critical access hospital leaders shudder at the thought of operating their facility without the benefits of CAH status. However, it’s possible that provisions included in the pending HIT incentive program and recently enacted healthcare reform could ultimately result in increased Medicare and Medicaid reimbursement for hospitals that cancel their CAH designation. CAH leaders must reassess their position in light of these imminent changes to identify what opportunities might be available.

HIT Incentives

As part of the American Recovery and Reinvestment Act of 2009, over $20 billion of funding will be available to hospitals and physicians that meet certain standards for implementing health information technology beginning in 2011. Although many program details remain to be finalized, it is clear that under the current legislation the incentives offered to critical access hospitals are far less appealing than what is available to PPS facilities. One obvious difference is that PPS hospitals are eligible to receive incentive payments from both Medicare and Medicaid, while a CAH can only receive payments from Medicare. Additionally, the provisions for calculating the Medicare incentive payments generally result in larger amounts for a PPS hospital than a CAH, all other factors being equal. In some scenarios the projected difference is millions of dollars over the life of the incentive program. CAH advocates continue their efforts to encourage both Congress and CMS to revise the program to make CAH incentives more equitable. Unfortunately these efforts have not yet been successful. Critical access hospitals should continue to monitor the incentive program as details continue to be finalized and perhaps revised.

Healthcare Reform

Although CMS is still in the process of interpreting many of the requirements of healthcare reform, it is obvious there will be significant effects on future reimbursement for all hospitals. It appears at least one provision could provide a short-term benefit to a CAH converting back to PPS status. Section 3125 of the Patient Protection and Affordable Care Act provides temporary improvements to the inpatient payment adjustment for low-volume hospitals. These improvements are effective for only 2011 and 2012, but could mitigate a reduction in inpatient reimbursement resulting from losing CAH status during a time period the hospital is benefitting from the HIT incentive provisions available to PPS facilities. The low-volume adjustment for these two years is expected to offer additional reimbursement for any PPS hospital located at least 15 miles away from another hospital and with less than 1,600 Medicare discharges. The payment adjustment is scaled based on the number of discharges, and is as much as a 25% add-on for qualifying hospitals with 200 or fewer Medicare discharges. CMS has not yet finalized its regulations related to this provision, so it remains to be seen if there will be any stipulations relevant to a hospital converting from CAH status. As with the numerous other healthcare reform provisions that have not been fully addressed, hospitals should continue to monitor the additional regulations and guidance published by CMS.

Other Opportunities for PPS Providers

It’s possible that a CAH could qualify for certain beneficial designations if it converted back to PPS. Sole Community Hospital, Medicare Dependant Hospital and Rural Referral Center status all have various requirements for qualifying, and provide different benefits that can result in significant additional reimbursement. Many of these provisions have been enhanced in recent years. It is important to note that status would not automatically be reinstated for a hospital that had previously received a particular designation prior to conversion to CAH. And since some requirements have recently changed a hospital cannot assume that it could qualify now just because it had previously qualified prior to CAH status.

Long-Term Implications

Critical access hospitals need to not only assess the immediate reimbursement impact that could result from converting back to PPS status, they must also fully understand the long-term ramifications after the HIT incentive payment program has concluded. For a CAH that originally qualified under the necessary provider provisions, hospitals leadership must understand that regaining CAH status might not ever be an option in the future. Hospitals that believe they could re-qualify for CAH status must ensure they fully understand all the requirements of current regulations. They must also be willing to accept the reality that these requirements may be revised in the future by Congress or CMS, or that future circumstances could change, such as a new hospital or even a new road being built nearby, that could impact the CAH qualification process.
The Assessment Process

The process of understanding the potential ramifications of forfeiture CAH status involves many detailed steps. Understanding the HIT incentive program includes not only projecting payment calculations but also assessing the ability and timing of meeting critical requirements including “meaningful user” status. Understanding reimbursement impact must include a complete analysis of CAH and PPS provisions for the entire facility, including projecting the future effects of healthcare reform. Hospitals will need to wait until the HIT incentive payment regulations are finalized, which will most likely happen this summer, before they can complete their assessment. Many significant questions have been raised in response to the rules proposed in January 2010, so it is possible that substantial changes could result that would impact projections.

Once the assessment process is complete it is possible that many critical access hospitals will conclude they are right where they need to be. However, with all the changes from the past 18 months and all the uncertainty hospitals are facing going forward, CAH leadership cannot assume that status quo is still the right answer.

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Certified Revenue Cycle Associate Program Update

The 2010 Certified Revenue Cycle Associate (CRCA) Program is in full swing. Registration opened on June 1st and to date we have had just over 60 people register for the program. CDs of the updated manual have been distributed to those who have registered. Registration is open until August 1st, but most likely will be extended until August 15th. Staff can register for the program at http://www.schfma.org/education.asp Registration for the program is $65.00 and includes a CD of the manual as well as a video on CD along with the PowerPoint from the review session held on June 18th.

The manual has been updated with the latest payer updates and collection laws. Practice questions and answers have also been included in the manual this year for the first time. This year's manual introduces a new chapter on Coding and Reimbursement. The Chapter gives a very light review of coding principles and reimbursement methodologies. The Chapters are as follows:

1. Patient Access
2. Customer Service
3. UB/1500
4. Medicare
5. Medicaid
6. Tricare
7. The Blues
8. Other Programs
9. COBRA
10. HIPPA
11. Compliance
12. Collections
13. Coding and Reimbursement.

A review of the manual was held on June 18th at the Palmetto Baptist Auditorium. Representatives from payers and other HFMA experts presented all of the Chapters. A video was taken which will be distributed along with the Power Points to all of those who register for the CRCA program. Exam dates and locations will be finalized at the committee meeting to be held July 30th at the Embassy Suites in Columbia.

The exam will be given the third week of October, with a re-take in November. The exam is in two sections and will have 130 questions. A passing grade is 80%. If the participant only passes one part of the exam, they only need to re-take the part they did not pass. The first section of the exam will cover Medicare, Medicaid, and Tricare. Section 2 will cover all of the other chapters. The cost of the exam will be $100.00 and the re-take, if necessary, will be $50.00 (for one or both sections.)

Brian Walker, CRCA
CRCA Committee Chair
A/R Manager, Patient Accounts
Palmetto Health
Is your department and/or organization full of energy? Do you know? Start with yourself. Where is your energy level when you think of the work you do and where you do it?

Our energy is what influences the quality of everything around us. Physical, mental, emotional, and spiritual energy impacts us in profound ways - the quality of our work, the quality of our relationships, the quality of our life outside of work – everything. It stands to reason then that how our places of work function is in large part due to the collective energy of ourselves and those around us.

While this article will focus on the energy in our workplaces, OUR energy is a function of how we care for ourselves - mentally, physically, emotionally, spiritually. In my coaching practice I find many individuals not doing a good job in one or more of these areas. It shows in the quality of what is occurring in their lives. My encouragement is that you take an inventory of yourself. Where you have opportunities commit to improving your balance in those areas. I think you will find some remarkable changes. Remember, it is more important to manage your energy than your time.

Often our focus at work is on the tactical, strategic, and technology we use to run our businesses. Less frequently, we focus on what is going on our culture and whether our behaviors and practices bring energy or take energy.

Surveys over the past several years in the areas of employee engagement, productivity, effectiveness, ability to change, and performance all draw the same conclusion: our organization’s outcomes (financial, customer loyalty, employee performance and retention) are tied to how engaged our people are – or, what their energy is like.

Our ability to influence their engagement is tied to five major areas (reference Juice, Inc’s whitepaper, The 5 Drivers of Engagement)
1. How well a person fits in their job, department, organization.
2. How clear they are about what their job is, what is expected of them, and how they are being measured.
3. How well they are supported.
4. How valued they are.
5. Their perception of doing meaningful or inspiring work.

The key to these areas is that they touch the five key needs we all have (love and belonging, security, freedom (choice), power and recognition (significance), and purpose. All of the behaviors of engagement focus on creating a positive emotional response in the person because we feel first and think second. While some find this notion counter intuitive to their own experience, it is the science of the brain (the prefrontal cortex (rational, logical center) filters first through the Amygdala – the emotion center). That is why what is most important to an employee initially is how they feel about where they work, their job, the people around them, and their organization.

Profound improvement in culture, and as a result, performance, is tied to these questions.
1. Do we hire for fit and exhibit behaviors that help support people in their new job, new department/organization, etc.?
2. Is there clarity at all levels with job/behavioral expectations, goals, measures, and how people are performing?
3. Do our people have all the resources they need, including freedom and authority to do their job? Does everyone receive timely feedback concerning their behavior and performance? Do our people have a chance to grow and develop?
4. Do people feel heard? Are they recognized for their contributions on a timely basis? Do we connect a person’s performance/results with how it contributes to the team/organization?
5. Do we connect work to the overall mission of the organization? Do we emphasize strengths and match people’s strengths to our needs? Does our environment promote taking risk in order to improve?

The next time you have 60 minutes of unstructured time to make yourself 10% more productive, consider spending 10 minutes with six people who work with you making them more productive.
Certification Update:

The 2009/2010 Chapter year was one of the best periods of time on record that our Chapter experienced for Certification. During that period of time, twelve (12) exams were passed, which earned us a gold medal at the HFMA Awards Ceremony in Las Vegas! Congratulations to all members who passed each of these exams.

The challenge now lies ahead. As we begin the 2010/2011 Chapter year, be on the lookout for the following activities:

- September - Certification Information Teleconference
- October - Kick-off of our annual Certification Incentive Program (earn your chance at winning cash for passing an exam)!
- January - New Certification manuals arrive for the 2011/2012 year
- February - Certification Coaching Course

Our Chapter Board of Directors has graciously purchased a library of study guides to help you study/pass exams; so please contact me if you’d like to check one out. They also have agreed to reimburse you exam fees in full when you pass. No excuses left - now is the time to advance your career! Please feel free to contact me for more information regarding HFMA National Certification!

Best Regards,
Steve

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Health reform: Prospering in a post-reform world

Background

While it might be overly dramatic to say that everything has changed with the passage of health reform, it can certainly be said that the health system of tomorrow will not be the same as today’s. Much of the “patchwork quilt” that paid for the uninsured will largely be replaced by public or private insurance coverage. A stronger focus will be placed on paying hospitals and physicians for quality. Insurers will be highly regulated but have access to new customers through health exchanges. Pharmaceutical companies will see increased pricing pressures through discounts and fees even as they see new customers. Individuals and businesses will face the choice of providing and paying for health coverage or paying penalties. In short, health reform is big and comprehensive, and it will affect nearly all parts of the health system.

Under the new law, health reform is achieved through three primary mechanisms: new coverage, new funding, and new regulators. These mechanisms acting together create a profoundly different world for the health industry and its customers, a world in which current business practices, markets, and silos may no longer be relevant.

To prosper in the post-reform world, health executives will need to reassess current strategies and find ways to work together.

To prosper in the post-reform world, health executives will need to reassess current strategies and find ways to work together. This excerpt illustrates the mega trends that the provider sector will face as a result of health reform, the provisions in the law that are driving them, and recommendations on how organizations can turn these challenges into new opportunities. It concludes with a new vision for organizational strategy development that is based on cross-sector collaboration rather than siloed competition.

Key Findings

Providers

- New reimbursement models favor hospital and physician alignment, including physician employment, over the traditional private practice model. Bundled payments, accountable care organizations (ACOs), medical homes, reduced readmissions, and quality-based reimbursement require hospitals and physicians to become partners in payment.

- Beginning in 2015, a 300-bed hospital with poor quality metrics could be penalized by more than $1.3 million per year. Even more important, these hospitals could suffer reputational damage as these metrics are published online, which is now the most popular place for consumers to seek health information. In addition, some quality metrics will be measured on a relative basis resulting in increased pressure for hospitals to improve quality.

- The number of Medicaid recipients will increase by more than 40% from 2010 to 2019, so hospitals must learn to operate on Medicaid rates. Traditionally, Medicaid rates haven’t covered all costs so hospitals will need to quickly address fixed costs.

Each sector will feel direct impacts from the new law, and during the months following the signing of the legislation, many people may ask, "What does this mean to me?"
### What the new law does to drive this

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<th><strong>Think of physicians as partners in payment, not customers or competitors</strong></th>
<th><strong>Quality metrics matter; stay out of the bottom quartile</strong></th>
<th><strong>Immediate considerations for hospital systems</strong></th>
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<td><strong>Injects bundled rates.</strong> Medicare will begin a bundled payment pilot program no later than 2013 for episodes of care through 30 days post-discharge; state Medicaid programs may begin bundled payment demonstration projects around episodes of care.</td>
<td><strong>Penalizes hospitals for readmissions.</strong> Beginning in October 2012, hospitals will be financially penalized for “excess” readmissions when compared to “expected” risk adjusted levels of readmissions based on the 30-day readmission measures for acute myocardial infarction, heart failure, and pneumonia that are currently part of the Medicare pay-for-reporting program.</td>
<td><strong>Expands Medicaid eligibility.</strong> The Medicaid population will grow by more than 40% by 2019 as eligibility is expanded to more adults. An estimated 16 million more individuals will be enrolled in Medicaid.</td>
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<td><strong>Opens the market for ACOs.</strong> ACOs are organized groups of providers accountable for the overall care for a group of Medicare beneficiaries. If ACOs achieve cost savings through the coordination of care, the organization is eligible to keep a portion of the savings to be defined by the Secretary of HHS.</td>
<td><strong>Bases part of hospital payment on value-based purchasing (VBP).</strong> Starting in 2013, hospitals will be paid according to a VBP program schedule, whereby the payments are made based on hospitals’ quality measure outcomes. Outcomes will be collected beginning October 2012.</td>
<td><strong>Reduces disproportionate share (DSH) payments.</strong> Hospitals that care for disproportionately high numbers of uninsured and Medicaid patients currently receive extra funding from Medicare and Medicaid. But in 2014, Medicare DSH will be reduced 75%, the same year that the insurance exchanges and individual and employer mandates become effective.</td>
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<td><strong>Increases primary care reimbursement rate.</strong> Medicare will now pay a 10% bonus on fees to primary care physicians from 2011 through 2015. Hospitals may see the increase in primary care reimbursement as an incentive to purchase primary care practices as they look for further alignment options.</td>
<td><strong>Penalizes hospitals for hospital-acquired conditions (HACs).</strong> Beginning in 2015, the law subtracts 1% of payments from hospitals with the highest rates of HACs, resulting in nationwide reductions of $1.5 billion over 10 years.</td>
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<td><strong>Enables Medicaid medical homes.</strong> Under this program, a designated provider or team of health professionals provide comprehensive care management, referrals, patient and family support, and the use of health information technology. Participating providers will receive a medical assistance payment and participating states will receive a 90% federal medical assistance percentage (FMAP) payment for two years.</td>
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**What this means to providers**
**Immediate considerations for hospitals**

Hospitals that do not have good relationships with their physicians could struggle with new alignment opportunities. The range of physician alignment models is wide and includes options from physician management to physician employment. Each organization should determine the best options for their situation.

**Quality metrics matter; stay out of the bottom quartile**

Don't get stuck in the bottom quartile, and work towards continuous quality improvement. Beginning in 2013, high-scoring hospitals will receive a higher payment of 1%, which rises to 2% in 2017 and beyond. In addition to the direct financial impact, the law requires an organization's quality metrics to be publicly available and accessible. Hospital quality information will move beyond the organization and government websites to health websites, consumer advocacy sites as well as become a norm on health plan sites.

**Immediate considerations for hospital systems**

Though the increase in the insured population is positive, the increase in the Medicaid population creates extra challenges in working within the available funds. (According to the American Hospital Association, hospitals received 89 cents for every dollar spent on caring for Medicaid patients in 2008.) Hospitals should be prepared for a shift in their payer mix given the expansion of Medicaid and the insurance mandate. Additionally, organizations may choose to aggressively market to the newly insured and grow their market share to take advantage of new federal funding. Hospitals need to strategize ways to control their costs and take advantage of opportunities to gain market share when it financially makes sense.

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**Conclusion:** Reform has opened the door for the industries to work together to achieve change. Each sector will feel direct impacts from the new law, and during the months following the signing of the legislation, many people may ask, “What does this mean to me?” Organizations across all sectors face three main themes:

- There will be significant changes in the way federal funds flow.
- There will be increased regulation and accountabilities.
- We are all entering a decade of regulation and reform.

Prospering in this decade of regulation and reform is possible. It will require organizations to think outside the box and cross the line to partner with those who have sometimes been deemed the enemy. Health reform legislation provides the framework for sectors to work together on long-overdue changes to the cost, quality, and outcomes of care. It is now up to the sectors to combine their strengths to prosper in a post-reform world.

To read "Health reform: Prospering in a post-reform world" in its entirety, please visit www.pwc.com/healthreform.
By now, you have probably realized that America has gone mad over social media (SM). It’s hard to ignore. According to a recent report from Forrester Research, more than 80% of Americans use social media monthly, and more than half of adults’ ages 35 to 44 are in some type of social network.

What exactly is SM and what are so many people using it for? Ed Bennett, director of web strategy management at the University of Maryland Medical System, describes social media as a tool, conversation, and “a bunch of websites with silly names.” In more conventional terms, the technological phenomenon is based on websites that enable users to immediately interact with others by sharing content, pictures, videos, blog entries, etc. One popular social network, for example, is Twitter, a way of sending short messages (140 characters or less) and building on the “tweets” of others. As of April 20, 2010, 507 U.S. hospitals had accounts on Twitter. The biggest kid on the SM block is Facebook, with more than 400 million active users—who spend more than 500 billion minutes per month on the privately held website. In addition, yes, they do it between 8 and 5.

SM has found a place in the healthcare industry as well. Bennett reports that as of April 2010, 660 U.S. hospitals were using YouTube channels, Linked-In, Facebook, Twitter, and other blogs. SM can help with marketing, employee recruitment, information technology, customer service, education, and crisis communications. Essentially, they work best when it generates interaction between your employees and you or with you and your patients. “It’s about community and relationship building and engaging in conversations,” says Amber Naslund, a consultant with Radian6, a SM-monitoring software company. “The most important thing to remember is the public views social media as ‘all about me.”

Even if you do not use SM for external purposes, consider establishing policies to ensure these sites are used properly in your offices. Providing guidelines will help employees know what you consider inappropriate or what could violate someone’s privacy. Each employee mingling between digital social circles is a representative of your hospital, and their posts are public—or, a Pete Cashmore of the blog reviewer Mashable said, “Privacy is dead, and social media hold the smoking gun.” Make sure your policy statement is structured to minimize lost productivity and outlines your hospital’s expectations.

To Learn More
To view Bennett’s slideshow, see www.slideshare.net/edbennett/hospitals-social-media. For a list of social media policies, SM resources for healthcare professionals, and Bennett’s blog, visit http://ebennett.org
Member Spotlight Article

By Brian Shannon

Personal:
Name: J. Larry Pope
Title: Chief Financial Officer
Hospital name & website: Baptist Easley Hospital; www.baptisteasley.org
Colleges attended & degrees:
  Central Wesleyan College, undergraduate degree &
  Webster University, Masters in Business and Computer Resources & Information Mgmt
Current member of HFMA? Yes

About Your Hospital:
What is new and exciting at your hospital?
Baptist Easley Hospital made a transition October 1, 2009 to a free standing 501c3 acute care hospital. Previously the hospital was owned by Palmetto Health and operated under the umbrella of a three hospital system. As of October 1, 2009 a joint venture was created between Palmetto Health and Greenville Hospital System sharing ownership (50/50) of Baptist Easley Hospital. This new joint venture required that a new freestanding organization be established.

What is it like to work for your hospital?
Baptist Easley is a great place to work. I have been here since 1981 and have seen many changes, many people come and go, and it is still the caring, family oriented hospital that is was in 1981. Our CEO, Roddey Gettys has three rules:
1. Have fun at work, 2. Treat others like you want to be treated, 3. 10-5 rule (when you approach someone, at 10 feet – make eye contact, then at 5 feet – greet them). These three rules truly make a difference in the culture of the organization and public perception. We get comments all the time regarding how friendly this hospital is.

What are some of your department and organizational goals this year?
Becoming a freestanding hospital has changed the way that we do business from several different angles. Certainly managing cash and accounts receivable has always been very important to me, but knowing that payroll is coming out of your own account rather than a corporate account changes the perspective a little. I have the standard A/R days goal, a cash goal, and a net operating income goal. These are all financial goals. I have a people goal as well - to maintain employee satisfaction in the top decile as compared to all hospitals in the Press Gainey database. I also have a service goal and a growth goal.

About Your Career:
What are some of your personal priorities for your hospital this year?
To lead our financial areas to a level of success that our clinical areas have already experienced. Our clinical departments have raised the bar and achieved success in the area of quality and satisfaction that is second to none. I commend their leadership for these accomplishments. HFMA’s theme for next year is “Step Up” and this is exactly what my plans are for our financial areas. We do a great job already, but there is always opportunity for improvement. We will STEP UP.

What is your business philosophy?
Always tell the truth, be fair and ethical.

What is the best way to keep a competitive edge?
Never stop learning. There is an educational opportunity every day. It is up to us to take advantage of the opportunities that come our way.

How do you measure success?
Financial performance is the most obvious to me. Our organization has been financially successful in recent years and it has been because we have made great progress in other areas. Baptist Easley has had tremendous success in patient, employee and physician satisfaction for some time. These outcomes have helped us grow volumes, maintain a very stable workforce and recruit physicians that provide quality care.

What are your biggest accomplishments in the last 24 months?
I would have to say making the transition to a free standing hospital. I was only on the fringe of what occurred, but the complex nature of this transaction was more than can be imagined. New ID’s, new databases, credentialing with payors, banking relationships, service agreements with members, establishing of a Board of Trustee’s, regulatory approval, and the list could go on and on. Accomplishing the transition was done by a team that performed like clockwork. Job well done.

What goal have you set, but not yet achieved?
To break even with our physician practices.

What has been your biggest business lesson learned?
Learning to trust, but verify.

What is your career advice?
Surround yourself with great people. You cannot do it alone. A trait of a good leader is someone who is willing to delegate tasks and share the credit when accomplishments have been made.

What do you like least about your job?
There really is not any one thing that I dislike about my job. I guess it could boil down to the perception that finance people...
might not be as caring as others. Sometimes hard decisions have to be made and they may fall on the shoulders of finance. This does not always make us the most popular people in the organization. This is not always pleasant.

**What do you like most about your job?**
I work for an organization that provides such purpose. Not everyone can say that. My mother was always so proud of me and the fact that I worked for a hospital. I am always very proud to represent our organization in the community that I live in.

**When you were a kid, you thought you would grow up to be a race car driver!**

**More About You:**

**What is your pet peeve?**
Talking with someone who is not a good listener.

**What are you greatest passions in life?**
Doing the very best that I can in all that I do. Earning trust and respect is very important to me. Walking the talk is what I strive for.

**What is your favorite quote?**
Do unto others as you would have them do unto you. If you do this, life is much easier.

**What is your favorite book?**
The Richest Man In Town by V.J. Smith is the book I read most recently. It is the story of a Wal-Mart employee that is loved by everyone because of the caring and kind way he treats people when they come thru his register. It is a heartwarming book that shares life’s lesson in a very simplistic way.

**What is your favorite movie?**
Raiders of the Lost Ark ranks up there with me as one of the most memorable action movies. My first love in movies are comedies though. As one of my good friends says….“the type where you check your brain at the door.”

**What is your favorite way to spend your free time?**
My wife and I enjoy movies. We have been known to do a marathon Saturday, taking in three movies in one day. I also enjoy time with our three daughters and now five grandchildren. Music is the hobby that I can get lost in. I have had the love of music as far back as I can remember. I am in a beach music and oldies band called The Flashbacks, playing bass guitar and also have a part time recording studio. I was recently interviewed for an article and told the reporter that “my music allows me to revisit my youth in a harmless way.” I truly believe that.

**If you could meet anyone, who would it be?**
I think it would have been interesting to have visited with former President Ronald Reagan. He had such career transitions during his life and was a great communicator. It would have been fascinating to spend a little time discussing his life experiences and getting to know him.

**If you could change one thing about yourself, what would it be?**
I would like to be a little taller. That is about the only thing that I do not have control over. I think if I were 6’5” a lot of things would be different. Everything else I can change if I really choose to.

**About HFMA:**

**What do you like most about HFMA?**
The friendships that have come out of HFMA membership. I would have never connected with such great people had I not been a part of HFMA.

**What is your favorite HFMA event or memory?**
Region V Fall Presidents Meeting (August 1995). This meeting was on board a Royal Caribbean cruise ship. It was a perfect week - colleagues, friends and family. Food and entertainment second to none. It was great!!!

**What can HFMA do to make itself better?**
Keep providing quality education and be there to help us turn on a dime when the time comes.
Hello. Hello. Remember me?

I twisted Jay's arm and was able to get one last article into the newsletter before I fade away into the Past President's land of obscurity.

Do you remember being eight years old and thinking a year seemed like a lifetime? From birthday to birthday, the beginning of school until summer vacation, or the long wait for Christmas! All of which took for........ever.

Well, I have now experienced the complete opposite of that. My year as President of the chapter seemed over before I knew it. Maybe it is akin to watching our children grow up. Many HFMA colleagues have asked how my year went, and if I was glad it was over. My answer has remained consistent, in that, I am honored to have served as the chapter's President, am very proud of the things we accomplished, and am happy to enter into the Past President's club.

As I reflect on my 13 years as a member of the chapter, one thing I like the most about HFMA is our continuous work to improve the way we do things. As noted on the HFMA website, the Helen M. Yerger Award recognizes this hard work to improve chapter performance in the categories of Collaboration, Education, Improvement, Innovation, Member Communications, Member Service, and Membership Recruitment and Retention. As is customary for our chapter's president, I encouraged our board and committee chairs to identify opportunities for improvement. Though I believe we had many ideas and implemented several changes, we were honored to have received four Helen M. Yerger awards. Two were single chapter awards, one in Member Communications for Efficiencies in Chapter Newsletter Delivery, lead by Jay Rickman, and one in Member Service for The Crisis Ministries service project, lead by Jude Crowell. Our other two “Yergers” were multi-chapter awards, one in Collaboration for Giving Back to the troops, lead by Ken Scheller, and one in Education, for the Dixie Institute, lead by Tommy Cockrell and Camie Patterson, and authored by Debbie Hunt.

Having mentioned the Helen M. Yerger Awards won by our chapter this year, I would be remiss were I not to also mention the C. Henry Hottum Award for Educational Performance Improvement, the John M. Stagl Silver Award of Excellence for Education, the Gold Award of Excellence for Certification, and the Bronze Award for Membership Growth and Retention.

What an awesome year! I am honored to have served! Congratulations and Thank you to all who served with me. I look forward to seeing everyone at the next event.

Best,
Ray High
Past President

In Memoriam

Please join others in the South Carolina chapter of HFMA in mourning the loss of one of its former members, Lanny Day. Lanny passed away August 1, 2010 at the age of 60.

Lanny was a chapter member from 1991 to 2001 and was retired from Deloitte Consulting and had many, many friends in the healthcare finance field.

Memorials may be made to SCOA, (South Carolina Oncology Associates), Attn: Meredith Anderson, PO Box 2046, West Columbia, SC 29171.
Meet your 2010 HFMA Region V Regional Executive - Lee Ann Burney

Lee Ann Burney, CPA, FHFMA has been in healthcare for 25 years. An active member of HFMA, she has served as Treasurer, Vice-President, President-elect, President, Parliamentarian and Chairman of the Board for the Tennessee Chapter, and has received the Follmer Bronze, Reeves Silver, Muncie Gold Merit Awards, and the Medal of Honor. She currently is the Regional Executive for Region V, which includes the Alabama, Florida, Georgia, South Carolina and Tennessee Chapters.

Her professional career has exposed her to a wide range of healthcare financial situations. She has worked in both a not-for-profit government owned indigent hospital, a not-for-profit private teaching hospital, a CPA firm, a consulting firm and currently works in the corporate office of a national for-profit hospital chain. Her hospitals have included acute, rehab, specialty, teaching, psych, transplant, and dialysis units, doing everything from preparing budgets, financials, tax returns, certificate of needs, bond issues, cost report preparation, audit, appeals, and re-openings. She currently works mainly with Cost Report Reimbursement.

In her spare time, Lee Ann enjoys spending time with her husband and two almost grown sons. She loves travelling and adventure, and feels blessed to have been able to experience rafting on the Colorado, dog sledding in Alaska, biking across the Golden Gate Bridge and snorkeling in the Caribbean. She and her family spend as much time as they can on the water and when the season changes, they love to tailgate and cheer on the TN Titans or her nephew’s football games.

Rickman named Regional Executive Elect

By Ray High

Having been nominated by the HFMA South Carolina Chapter board at its June 1st meeting, Jay Rickman was elected by the HFMA Region 5 Board at its June 20th meeting during the Annual National Institute, held in Las Vegas, NV. The HFMA South Carolina Chapter nominates a candidate once every five years for this prestigious position, and reserves the nominations for only chapter past-presidents who have demonstrated their commitment and spirit of volunteerism to the chapter. Jay served as the HFMA South Carolina Chapter President during the 2004-2005 chapter year, having successfully served through the officer rotation as a board member, Secretary, and Vice President. Jay has worked for AMCOL SYSTEMS for 30 years, currently serving as Vice President, and has been a member of HFMA for twenty five years.

The Regional Executive represents Region 5 (Alabama, Florida, Georgia, Tennessee, and South Carolina) as the primary volunteer and policy link between the chapters and the national association. As a member of the National Regional Executive Council, one of Jay’s key responsibilities will be to set policy and goals related to the Chapter Balanced Score Card, Davis Chapter Management System, and Founders Merit Award Program. Attending the Annual National Institute, the Fall Presidents Meeting, the Regional Executive Council Meeting, the Leadership Training Conference, and multiple Region 5 chapter institutes will demand a rigorous travel schedule, but will enable Jay to understand and support the strategies set by the National Board, and to communicate with the Regional Executive Council the opportunities and challenges in executing those strategies at the chapter level. Members are encouraged to aspire to hire levels of HFMA involvement at the chapter and national level.

Jay will serve one year as Regional Executive Elect, and one year as Regional Executive, beginning June 1, 2011 and serving through May 31, 2013.

Please join me in Congratulating Jay for this honor.
## SC HFMA Education

### Calendar of Events

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Assembling a Revenue Cycle Team
By Julie Waddell

For hospitals, developing and maintaining an effective revenue cycle process is critical for success in today’s ever-changing healthcare environment. While policies and procedures must be implemented in order to achieve optimal reimbursement, the importance of creating a well-functioning team to follow and maintain those policies and procedures cannot be taken for granted.

Presbyterian Hospital of Denton, TX has adopted such a philosophy that has lead to significant improvements as well as enhanced employee morale.

Key Functions & Structure

When assembling a revenue cycle team, hospital executives must first identify the key functions of everyone involved in the business office—scheduling, pre-registration, registration, financial counseling, billing, collections, underpayments and denials. In addition, it is important to consider other responsibilities, such as revenue integrity, coding, transcription, case management, training, reporting and analysis.

The organizational structure of a successful revenue cycle team is relatively simple. The revenue cycle director should oversee four distinct areas: admitting and patient access, billing and collections, training, and revenue integrity and CDM. Within the admitting and patient access area, there are three subsets: insurance verification, scheduling and financial counseling.

Presbyterian Hospital of Denton, is structured just this way. According to PFS Director Tammy Stone (CHAM), this reporting structure ensures standardization, maximum efficiency and cooperation throughout the revenue cycle. As part of the orientation and training process, revenue cycle staff is immersed in understanding the reliance in these four distinct areas and how they contribute to the success of the entire organization.

Stone employs the “birth to grave” concept from a billing and collections standpoint vs. specialization. This ensures that each account is handled efficiently through the billing and collections process and prompts complete accountability from the team. Leaders should begin by looking within their own organization and then branching out via the Internet, colleges and trade schools, as well as soliciting referrals from other employees. Next, job postings must contain the appropriate key words and phrases with clearly defined requirements regarding skill sets and experience.

Thorough telephone screenings should be conducted, followed by personal and panel interviews. In addition, many hospitals have begun implementing targeted behavioral assessments during the interview process.

Behavioral Assessments & Interviewing

Behavioral assessments help executives determine exactly what they are looking for in an employee through carefully developed scenarios. Because past behavior is the best indicator of future behavior, these scenarios require a candidate to analyze a situation from his or her past which is related to the job being sought, and then describe how he or she responded in that situation. Desirable responses to these scenarios are identified prior to the interviews, so that individuals responding appropriately can progress to the next screening stage.

Stone is a proponent of behavioral interviewing. She uses real-life scenarios to evaluate how a person might respond under pressure. “I believe you can train anyone to do anything, but you cannot teach attitude,” says Stone. She reminds her team that no matter what kind of day they may be having, it could not be as bad as the person in front of them that may be dealing with illness, fear or economic challenges.

When adopting the behavioral interviewing approach, it is important to remember that proper preparation is key to success. First, competencies and behaviors for each position must be analyzed, and then skills must be identified for each competency. Next, questions must be developed that relate to those competencies. Finally, resumes must be reviewed to identify key areas that pertain to the list of competencies, and interviewers must take good notes during interviews so that the responses can be properly evaluated. Only then can the behavioral interview process be a successful one.

Orientation, Education & Training

Once the employees that comprise the revenue cycle team are identified and hired, then the real work begins. Each employee must participate in a proper orientation program, complete with all necessary training needed to get started in their jobs with minimal delay and maximum results.

Even after the orientation process, employees must participate in an ongoing evaluation of their skills and take part in training programs. Employees at all levels should be aware of their career paths within the organization and a mentoring program should be established to encourage growth. Employees should also be encouraged to participate in professional organizations related to their job functions. At Presbyterian Hospital of Denton, each patient access associate is strongly encouraged to obtain CHAA (Certified Healthcare Access Associate) status from NAHAM. A $500 one-time bonus is offered to those who sit for and pass the exam. The exam
consists of 115 multiple choice questions related to patient access services. As of June 2010, 97% of Tammy’s staff have been certified.

As part of the ongoing education and training at Presbyterian Hospital of Denton, staff members rotate throughout the revenue cycle positions to gain a better understanding of how their performance affects the others. For example, patient access staff is trained on back-end billing and collections to gain a better understanding of their accuracy and effectiveness on the front-end processes. Each month access staff is required to spend four hours following up on accounts in which patient balances are due but have yet to be collected in the pre-service area.

Policies, Procedures, Processes, & Compassion

With a strong focus on finding the right people to join a revenue cycle team, hospital executives can also look at their processes to make sure they are setting their staff up for success. Customer satisfaction should have the highest expectations and the highest standards. Nothing less than optimal customer satisfaction should be accepted. One example includes Presbyterian Hospital of Denton’s adoption of the “Red Coat Program.” Representatives from the Admissions Department can be seen around the hospital wearing a red scarf, tie or pocket scarf as they “sweep” through the area outside of Admissions to see how they can assist patients. From finding a magazine to providing directions, grabbing a cup of coffee or even taking the extra time to sit with a nervous patient, the Red Coats can be seen meeting patients’ needs in simple and heart-felt ways.

"By personally reaching out to the patients and families, we are showing them that we are aware of their circumstances," states Kenna Karmel, admitting manager. "We see them. They are not forgotten, and we genuinely care about their comfort."

Technology & Workflow Tools

Next, stakeholders should evaluate their hospital’s technological needs, both for the present and the future. Workflow tools can align users operationally, emotionally and strategically to the vision of the revenue cycle team by distributing accountability and focusing on personal results. In addition, they identify gaps and collection opportunities that could improve the bottom line.

Perhaps most importantly, workflow tools can provide users with personal worklists and reminders that can deliver quantifiable results. For example, users can view a segmented personal accounts receivable analysis which clearly identifies accounts that require follow-up. This type of regular, daily feedback encourages users to focus on activities that produce results.

Presbyterian Hospital of Denton has experienced improvements in patient satisfaction, collections, and a reduction in denials due to accuracy. In 2009, the hospital exceeded their upfront cash target by $836,000 while increasing patient satisfaction particularly in the ER and outpatient services areas. Additionally, employee morale is at its highest historical levels, with the hospital experiencing a 91% retention rate and a 15% increase in employee satisfaction, compared to 2008.

For hospitals wishing to enhance their revenue cycle efforts, they must clearly define the behaviors and skills of each position, evaluate skill sets of current employees to identify gaps, and seek out talent to fill any gaps that may exist. With the appropriate individuals in place, executives must implement performance criteria, monitor and measure performance, encourage mentoring and establish career paths. Next, they must identify technology that can assist their employees and implement the necessary training associated with any new technology. By monitoring customer satisfaction – both internal and external – revenue cycle leaders will quickly learn what works and what does not. And through incentive programs and celebrations, as well as clear communication at all levels, healthcare providers will reap the benefits of these arduous but important steps.

Julie Waddell, Vice President, Revenue Cycle Solutions Strategy, MedAssets, jwaddell@medassets.com

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Your Vote Can Make a Difference

Pepsi is awarding grants of all sizes as part of the Pepsi Refresh Project. The goal is to recognize and reward people, businesses, and non-profits with ideas to make a positive impact on their communities and beyond. Your supporting vote during the month of August will be most appreciated!

Click to read about the contest and vote: www.refresheverything.com/sthc3737
Medicare 201 - Advanced Reimbursement Issues

Understanding the Critical Components of Hospital Reimbursement

November 16, 2010
Embassy Suites Columbia
200 Stoneridge Drive
Columbia, SC 29210

8:30 AM - 9:00 AM  Registration and Continental Breakfast
9:00 AM – 3:30 PM  Educational Program
12:00 Noon  Networking Lunch Provided

Who Should Attend
Chief Financial Officers
Controllers
Reimbursement Directors and Managers
Accounting and Finance Staff

Objectives: By attending this event participants will be able to:
• Understand the critical components of hospital reimbursement, including Medicare DSH, Medicare Bad Debts, wage index, 340B and Medicare special designations
• Determine how Medicare calculates hospital reimbursement payments
• Learn what specific factors drive reimbursement amounts
• Analyze potential opportunities for hospitals to increase Medicare reimbursement
• Discuss recent and significant changes due to healthcare reform
• Discover the latest trends in Contractor audits
• Consider the latest changes to the 340B program

Course Instructors
Hal Guthrie, CPA, Senior Manager, Dixon Hughes PLLC
Kevin Callaway, CPA, Senior Manager, Dixon Hughes PLLC
Kathe Hoots, CPA, Senior Manager, Dixon Hughes PLLC

Course Description
This course will provide an overview of Medicare hospital reimbursement policies and calculations, and also summarize the impact of changes due to health reform. Specific examples will be provided of various calculations and the related impact on reimbursement.

Course pending CPE approval of up to 6 credit hours

Registration fee of $60 per attendee required.

For more information and to register please visit www.schfma.org. For information only contact Greg Taylor, gtaylor@dixon-hughes.com
The 2010-2011 South Carolina HFMA Corporate Sponsorship
Applications are now open!

The chapter truly appreciates the generous support from all of our corporate sponsors.

Contact Jennifer Winchester at jpwinchester@lexhealth.org for more information on becoming a SC HFMA Corporate Sponsor