When the officials at the tourism department adopted the phrase Smiling Faces, Beautiful Faces to describe South Carolina, Main Street in downtown Greenville had to be a determining factor. Even with the cold temperatures, the snow and then the dreaded ice, the SC HFMA Winter Institute remained warm and the attendees remained smiling.

Planning for the January event began in the heat of the previous summer. The conference committee, led by Ronnie Hyatt, CFO of Bon Secours Saint Francis Health System, met on a regular basis, each member working to ensure valuable programming and exceptional networking.


Braving the elements, attendees later walked from Main Street to Washington to take a walk on the wild side at Wild Wing Café. Hospital finance folks packed out the second floor of this legendary Greenville hot spot. The temperature outside was not enough to discourage friends from enjoying good food, good times and great camaraderie.

Thursday delivered a welcomed wake up call when those at the Hyatt realized the hotel hadn’t lost power.
Palmetto State News

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Please contact with any updates to data contained within this publication.

Palmetto State News is the official publication of the South Carolina Chapter of the Healthcare Financial Management Association.

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

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A Message from the Chapter President…..

Recently, I received an email from a gentleman named Gerald Fuller. He is a past HFMA National Chairman from 1980-1981. He was searching for H. Ray Everett (Yes, THE H. Ray Everett). They had worked together for years in HFMA and had become close friends. Mr. Fuller stated in his email that they had lost touch recently and he was trying to contact him. Since Mr. Everett was from SC he thought we may be able to assist him. I put out my “feelers” and we were able to track Mr. Everett in Mount Pleasant. Jerry Morton was able to provide this information. Mr. Fuller was grateful for the assistance but had actually already located him by the time I responded to him the next day. He mentioned to me that HFMA was like a group of family members to him rather than business associates. After my conversation with Mr. Fuller, it dawned on me how important these two men were to each other and that HFMA had played such a large role in developing this relationship. I mention this to you to remind you of one of the benefits of an HFMA membership that you do not pay for…..Life Long Friendships!

Four months remain in this current chapter year. During the Winter Institute, I provided an update on the Chapter’s health. Here are a couple of notables:
Our goal for education this year was to provide 16 hours of education per member. YTD, we have provided 14.51 hours.
Member retention goal was 87%. We have retained 86.2% of our members. We have 50 Financial Executives in our chapter.
Our goal is 51 for the year. 68.8% of our officers and board members are providers. Our goal is 60% for the year.
Membership is 488 strong! Financially the chapter is doing well.

Based on these results, I see no reason why we will not exceed all of our CBSC goals for the chapter year. Thanks for your hard work!

Soon you will receive a ballot with a slate of officers and board members for the upcoming year. This is the proposed leadership for the next year. Please respond accordingly and have your voice heard.

Our Winter Meeting was held January 16-18 in Greenville, SC. Ronnie Hyatt and his planning committee put together an incredible meeting. We had 137 total registrants. 35% of attendees were providers. Education sessions were timely and relevant. The Annual Awards Meeting was moved from dinner to lunch this year and many chapter members and sponsors received well deserved awards for their volunteerism and dedication in the support of our Palmetto Chapter. The food was great and the entertainment was provided by the Southern Wesleyan University Jazz Ensemble. I believe this to be the best attended Winter Institute in years, if not ever. Thanks Ronnie for you and your committee’s hard work!

On January 25th, we graduated the second class of 53 CRCA graduates at the SCHA conference center. The event was well attended, food was wonderful and Tommy Cockrell gave an inspiring speech. I had the distinct pleasure of handing out graduate certificates with Annette Drachman our Region V Executive. Kay Coons is busy gathering her new committee together for the next cycle of examinees. If you are interested in participating, please contact Kay. On behalf of the SCHF-MA, “Congratulations Graduates!”

As this year winds down, I am “blown away” by the efforts of our volunteer members. It amazes me how generous our members are of their time and energy in making our chapter one of the best. Thanks for your support this year. It has truly been an honor to serve you as Chapter President.

Roger Sipe
How healthy is your medical credit score?

System being designed to help hospitals figure out whether they’ll get paid

By JASON ROBERSON / The Dallas Morning News / jroberson@dallasnews.com

Mortgage lenders aren’t the only ones showing more interest in your credit score these days – the health industry is creating its own score to judge your ability to pay.

The new medFICO score, being designed with the help of credit industry giant Fair Isaac Corp., could debut as early as this summer in some hospitals.

Healthcare Analytics, a Waltham, Mass., health technology firm, is developing the score. It is backed by funding from Fair Isaac, of Minneapolis; Dallas-based Tenet Healthcare Corp.; and venture capital firm North Bridge Venture Partners, also based in Waltham. Each kicked in $10 million for the project.

The score is already raising questions from consumer advocacy groups that fear it will be checked before patients are treated. People with low medical credit scores could receive lower-quality care than those with a healthy medFICO, they argue.

"How much assurance do I have that they’re not going to look at this medFICO first, before they decide whether to treat or not?" asked Linda Foley, founder of the Identity Theft Resource Center in San Diego.

Post-discharge checking

That will not happen, says Stephen Farber, chairman and chief executive of Healthcare Analytics. Hospitals will check the score, which will be based on the patient’s medical bill payment history, only after the patient is discharged, he said.

"We only come into play once the patient has been treated and discharged, and the bill already exists," said Mr. Farber, who has visited hospital executives nationwide over the last six months to sell the concept. "We just help figure out what sort of relief a hospital should grant the patient."

Hospitals and other caregivers already can tap into regular credit scores – even without the patient’s permission – but those are not necessarily a good indication of whether a patient will pay a medical bill, Mr. Farber says. Such credit scores are based on voluntary purchases, such as a car. Health care debt is largely involuntary.

Under the Fair Credit Reporting Act, hospitals and doctors are allowed to report health care debts to credit reporting agencies, but they cannot indicate what they were for.

"They have to do it in a way that there will be no way a person looking at the information would be able to guess what they were treated for," said Frank Dorman, spokesman for the U.S. Fair Trade Commission.
Two recent court decisions addressing the allowability of bad debts have once again focused the spotlight on Medicare bad debts. Both of these decisions raise questions as to what providers should be doing to protect themselves from having their bad debts disallowed if they were claimed on the cost report while the accounts were still at an outside collection agency (“OCA”).

On August 8, 2007, the District Court for the Eastern District of California ruled in Dameron Hospital Association v. Leavitt, Medicare & Medicaid (CCH) Guide ¶ 302,169 (Aug. 8, 2007) that the bad debt moratorium barred CMS from disallowing Dameron Hospital’s bad debts that were at an OCA when claimed on the cost report. Unfortunately, the next week, the Sixth Circuit’s decision in Battle Creek Health System v. Leavitt, Medicare & Medicaid (CCH) Guide ¶ 302,172, (6th Cir. Aug. 14, 2007) upheld CMS’ position that bad debts may not be claimed as allowable until they are returned from the OCA.

Dameron Hospital Association v. Leavitt: The Application of the Bad Debt Moratorium

In Dameron, the district court’s decision was based entirely upon the bad debt moratorium. It ruled that based upon Dameron’s specific facts, the bad debt moratorium barred CMS from disallowing the provider’s bad debts. The bad debt moratorium essentially provides that a provider cannot be required to change its bad debt policy if a provider can show that: (1) its bad debt policy was in accordance with the rules in effect in August of 1987; (2) it has not changed its policy since August 1, 1987; and (3) an intermediary had accepted this policy the court applied a very practical standard for the application of the bad debt moratorium. In applying the bad debt moratorium, the court applied a very practical standard for the application of the bad debt moratorium.

In Dameron, there was no dispute that the provider’s bad debt policy to claim its bad debts on its cost report while still at an OCA was in "accordance with the rules then in effect.” CMS agreed that it was. The only issue in dispute was whether the intermediary had accepted Dameron’s bad debt write off policy prior to August 1, 1987. Frequently, the documentation required by the intermediary to prove “acceptance” can be difficult to produce. In Dameron, the intermediary maintained that the only documentation that was adequate to show acceptance was Dameron’s audit work papers from 1987. Dameron no longer had these papers. The Court, however, took a practical view, rejected the Intermediary’s demand and applied a reasonable documentation standard.

The court not only rejected the intermediary’s documentation requirement outright, it accepted the unrefuted testimony of Dameron’s staff, emphasizing that the Intermediary did not dispute any of this evidence. The Court also addressed what qualifies as the Intermediary’s “acceptance” of a provider’s bad debt policy. It found that an intermediary’s acceptance of reimbursement for a provider’s “bad debt following an investigation and audit constitutes ‘acceptance’ for purposes of triggering the moratorium.” Thus, the Court adopted a reasonable evidentiary documentation standard to prove that an intermediary has accepted a provider’s pre-August 1987 bad debt policy. Moreover, it concluded that if the intermediary paid a provider year in and year out for its bad debts – it accepted its bad debt policy.

Does This Impact My Hospital?

This decision is not binding outside of the Eastern District of California, but it provides a well reasoned analysis of the type of documentation that should be accepted to show that the bad debt moratorium applies. Intermediaries are disallowing bad debts in spite of the fact that providers have historically collected on their bad debts for 120 days, sent them to an OCA at the same time the accounts were written off on their cost reports, and intermediaries have consistently allowed them. The decision in Dameron may help providers sustain the position that they should be protected by the bad debt moratorium. Where appropriate, providers should demand that the bad debt moratorium be applied.

Battle Creek Health Systems v. Leavitt: Bad Debts at OCA When Claimed

The providers in Battle Creek also claimed bad debts on their cost reports while the accounts were still at an OCA. Unlike Dameron, however, this decision was not favorable to providers. Rather, the Sixth Circuit affirmed CMS’ position that if a bad debt is at an OCA, it may not be claimed on the cost report until it is returned from the OCA.

The Sixth Circuit did not plow any new ground. It found that since the accounts were at the OCA, they did not meet the regulatory requirements for bad debts; they were neither uncollectible nor worthless. Specifically, the court said the “very fact
fact that a collection agency was still attempting to collect the bad debts at issue indicates that these debts had not yet been determined to be ‘actually uncollectible when claimed as worthless’ and certainly contraindicates that ‘[s]ound business judgment established that there was no likelihood of recovery at any time in the future.’” The Court adopted CMS’ presumption of collectability—if the account is at an OCA, it is collectable.

The Court also adopted CMS’ assertion that the 120 day rule is discretionary on the part of the provider—e.g. the provider “may” write the bad debt off after 120 days, but it did not release the provider from meeting the general regulatory criteria prior to writing off the bad debt. Lastly, the Court also rejected the Provider’s argument that PRM § 316 evidenced that the CMS expected providers to continue collection efforts after the bad debt is written off. To the contrary, the Court found that “this common-sense provision merely recognized that if a provider recovers amounts previously included in allowable bad debts, it must reduce reimbursable costs in the period during which the debt was recovered by the same amount.”

The decision in Battle Creek unequivocally rejected the key arguments that the provider community has made to contest CMS’ requirement that a bad debt must be returned from the OCA before it is written off on the cost report.

Does this Affect My Hospital?

This decision is only binding in the Sixth Circuit and since all providers are free to appeal to the District of Columbia, even hospitals located in the Sixth Circuit can avoid the negative consequences of this decision. Moreover, there is nothing about the Sixth Circuit’s analysis that would necessarily compel another court to follow it. Other appeal courts may be willing to look at the weak points in the Sixth Circuit’s analysis and they may not show as much deference to CMS as did the Sixth Circuit. Providers should consider appealing all denials of their bad debts that were based upon the accounts active status at an OCA.

Joanne B. Erde, PA is a partner in the law firm of Duane Morris LLP. She can be reached at 305-960-2218 or jerde@duanemorris.com.

OBRA 1989, § 6023, amending OBRA 1987, § 4008(c)

The Sixth Circuit includes Kentucky, Michigan, Ohio, and Tennessee.
By custom, hospitals generally do not report delinquent accounts, but they do turn them over to collection agencies, said Norm Magnuson, vice president of public affairs for the Consumer Data Industry Association, a Washington D.C. trade group for companies that provide credit reports.

In such cases, only the medical provider’s name and the amount owed would be listed. But even that cannot be included if the name gives away too much information, as in the Betty Ford Clinic, widely known as an alcohol and drug rehabilitation facility.

The proposed medFICO score would be legal as long as it only includes billing data. And unlike a standard report, which only lists late medical bills, the medFICO score would reflect a history of on-time payments.

To develop its scoring system, Healthcare Analytics is collecting patient billing data from hospital systems with a combined $100 billion in annual net revenue.

Tenet executives say the scoring system could help them decide whether a given patient can pay his or her bill or if they should just write it off as uncollectible, or a "bad debt" in industry lingo.

Without a way to gauge the likelihood that patients will pay their bills, hospitals cannot comfortably invest in new projects or accurately balance expenses against revenue.

Adding up debts

Tenet, the nation's third largest hospital system, with 63 hospitals and medical centers, had $433 million in bad debt through this year's third quarter. Seventy-five percent of that bad debt was from uninsured patients and 25 percent from those with deductibles they couldn't, or wouldn't, pay, according to Steve Mooney, Tenet's senior vice president of patient financial services.

To figure out how to collect from patients, Tenet now divides them into categories based on whether they are married or single, whether they came through the emergency room or had a scheduled procedure, and whether their regular credit score is high or low.

"But the problem with the credit score is that not everybody has one," Mr. Mooney said. "We have about 40 percent of our self-pay patients who we do not get a credit score on."

Meanwhile, consumer advocates argue that given the problems arising from the current Fair Isaac credit score – such as identity theft and inaccurate scoring data – it should not become the basis for a medical version.

In an analysis of more than 500,000 individuals' credit scores, the Consumer Federation of America says it found that 29 percent were 50 points lower than they should have been.

"What if there's a mis-scoring – whether it's due to some clerical error, or due to an identity theft issue, where you have two William S. Joneses, who have similar numbers?" asked Ms. Foley. "This is the same problem we've seen in the credit industry."

Ms. Foley said a recent personal experience heightened her sensitivity to the possible dangers.

The day before she was interviewed, she said she spent more than six hours in an emergency room with her husband, who was believed to be suffering a heart attack.

"We have an HMO, but what if we didn't have health coverage?" Ms. Foley asked. "If he had a low score, would he have gotten the same type of care that he got last night?"

Mr. Mooney, of Tenet Healthcare, says the hospital business has changed over the past 30 years to take on characteristics of the retail industry. With patients expected to pay a larger share and do more comparison shopping, they soon will be able to purchase health care much like an automobile, he said.

Pamela Dixon, executive director of the World Privacy Forum, a consumer advocacy group, isn't impressed. "I don't like it; I don't like it at all. These are people's lives we're talking about. This isn't some car."
What is HFMA Certification and Why Should I Become Certified?

SC is 9th out of 68 chapters with 10.54% of members being certified

That answer is simple. Survey results have shown a strong relationship between certification and career advancement. In fact, Certified members of HFMA:

- Tend to earn a higher annual salary
- Are more likely to be hired for upper-level positions in healthcare finance
- Are respected members of the healthcare leadership team.

Ok, so what are the requirements of becoming a Certified Member of HFMA, or a CHFP (Certified Healthcare Financial Professional)?

Two years total as a regular HFMA member*

Two years of professional experience in the healthcare finance industry

60 semester hours of college coursework from accredited institution or 60 professional development contact hours

Successful completion of the HFMA Core certification exam*

Successful completion of one HFMA specialty certification exam*

References from a current elected chapter officer and your CEO or supervisor

Submit conforming application with one-time fee within 24 months of successfully completing the first exam

*Note: Exams may be taken at any time after you become an HFMA member. Specialty exams include Accounting and Finance, Financial Management of Physician Practices, Managed Care, and Patient Financial Services

Great, so what are my next steps?

I. Registering for the exam:

If you are an HFMA member, you are eligible to take the exam. HFMA National must receive exam applications and payment at least 10 business days prior to the scheduled exam date. Exams applications are available he HFMA website at:

http://www.hfma.org/login/index.cfm?script_name=/site/certification/exam_application.cfm

Candidates and approved proctors are issued passwords in an e-mail about two business days prior to the scheduled exam.

II. Preparing for the exam:

People learn differently and should employ the techniques that are most effective for them and conducive to their preferred learning style.

Complete the HFMA self-study course and all of the review activities, or check out a study guide from our Chapter library. Our Chapter Board of Directors has approved purchase of a variety of study guides to assist you with studying. Please contact Steve Lutfy, FHFMA, to check-out a study guide "mailto:(stephen.g.lutfy@us.pwc.com"

All certification exam questions are based on content covered in the current version of the course. On the average, the course takes about 12 to 15 hours to complete. Draw upon your professional experiences as you complete the course and prepare for the exam. The course assumes you are beginning with some baseline knowledge.

Attend a coaching course/review session relatively close to the time you plan to take the exam.

If you have already completed the corresponding self-study course, the coaching course can serve as a review of the course content.

If you have not yet completed the self-study course, the coaching course can serve as an introduction and an overview of the materials covered.

Once you complete the coaching course, review the materials within the next few days. The closer the review is completed to the course, the more likely you are to commit some of the materials to long-term memory.

Find a comfortable place to study with good lighting and few distractions. Stay focused on the task at hand. Complete your review of the content as close to the time you plan to complete the exam as possible to ensure the materials are “fresh in your mind.”

Budget your time and make sure you have enough time to study and be well-prepared. Allow adequate time in advance to the scheduled exam date to review the materials multiple times and avoid “cramming” for the exam. Exam candidates tell us they typically spend 20 additional hours reviewing the content.

Pace your studying. You are likely to retain more of the information if you spend time studying some of the materials over a period of time versus trying to study all of the materials in a day or two. By studying everyday, you are more likely to commit the information to your long-term memory. If you study at the last minute and attempt to “cram” for the exam, you are less likely to remember the information.

Continued on page 18
Nursing Home Charity Event
By: Maria Hallman

February is Jerry Walker Nursing Home Volunteer Month!!!

Please join us by volunteering a few hours to a nursing home in your community. **In memory of Jerry Walker, Medical Data Systems will reward the individual with the most volunteer hours with a prize of $200.00.**

**What:**
HFMA members (and others they recruit) volunteer a few hours to the nursing home of their choice during a day in February. The volunteer activity and time can be anything that the volunteer and the nursing home agree to. Many activities will involve interacting with and entertaining residents.

*This year let's make this Valentine month special and bring hearts, stuffed bears and cards!!!*

Last year, volunteers played bingo, assisted with crafts, served refreshments, delivered care packages and flower arrangements, transported residents, made prayer blankets, and entertained residents with their musical talents.

**How:**
First, make a pledge to volunteer by emailing the Coordinator shown below. Then choose a nursing home from the Directory which will be sent to you. Contact the nursing home Administrator or Activity Director to identify an activity and date. Once you have finished your visit, notify the Coordinator so you can get credit. It's that simple.

Don't go alone - bring coworkers, friends, and family. We want as many volunteers as possible! If you don't have a group and want to join up with someone else in your area, just indicate so on your pledge email and we will help you find someone.

**Why:**
For others - give a few hours to bring joy to those who need it most.
For you - feel the satisfaction of knowing that you have made a difference.
For your chapter - Help collaborate with other regional chapters.

**Send an email today to rhigh@medassets.com to sign up!**

Please include in your email:
- Your name and names of other HFMA members in your group
- The number of other volunteers (non-HFMA) you plan to bring
- The nursing home you plan to visit -- or request a Nursing Home Directory to select one
- If you have any questions or comments, contact Ray High at 678-248-8139

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**Top claims against collection agencies for alleged violations**

**From November 1, 2006 - October 31, 2007**

The top reasons for claims based on telephone calls:
1. Harassment or abuse.
2. Falsely threatening legal action.
3. Failure to cease communication.
4. Other.
5. Third party disclosure.

The top reasons for claims based on letters:
1. Falsely representing the character, amount or legal status of the debt.
2. State tort law.
3. Communication after bankruptcy.
4. Failure to provide verification.
5. Communicating with a consumer represented by an attorney.

The top reasons for claims based on credit reporting:
1. Unacceptable information on consumer report.
2. Failure to investigate a disputed debt.
3. Failure to delete or correct an inaccurate report.
4. Information in consumer report exceeds reportable time period.
5. Obtained a consumer report without a permissible purpose.

Source: ACA International
In writing about healthcare information security, I generally try to report, not preach; to analyze, not pontificate. Recent developments led to my temporary insanity, for which your indulgence is begged.

The healthcare industry has had nearly five years to fully implement the HIPAA Security Rule. During that period, more than 35 states have adopted security breach notification and disclosure laws. California, the leader of this movement, expanded its notification and disclosure laws to include personal health information security incidents, with other states to follow. Last year, the FTC identified encryption of data such as ePHI on laptops and other portable media a “best practice.” Why then did the January 2008 announcement from Tony Trinkle, Director of CMS' Office of e-Health Standards and Services, that PricewaterhouseCoopers (PwC) will be conducting covered entity site audits for CMS come as a shock to the healthcare industry?

Should it be shocking that CMS is now implementing an enforcement power under the Security Rule (described in its 2004 public request for proposals to assist it in setting up its Security Rule enforcement processes and procedures)? Personnel were trained and available to conduct site audits of covered entities accused of violating the Security Rule were under contract with CMS by April 2005. Given the many public failures of healthcare organizations to protect ePHI, what is shocking is that CMS took so long to institute Security Rule audits.

Security Rule compliance audits will involve an organization's compliance officer, security director, lead systems security manager and access control manager are long overdue. Why? Because the healthcare industry has been slow to accept of its information security and privacy obligations to patients and the public. What was possibly excusable in January 2006 (when a home health subsidiary of Oregon-based Providence Health experienced the theft, from an employee's car, of unencrypted back up tapes), isn't in 2008. Many organizations fail in three ways – failure to adopt reasonable and appropriate safeguards, workforce failures to follow policies, and failure to implement information security best practices. These failures cannot be justified because justification results covered entities being held to a lesser standard than other industries.

CMS has not named the targeted organizations. However, Trinkle indicates that the 20 initial targets are hospitals with unresolved Security Rule complaints, each with a moderate to high risk to a large volume of records. Good news – if you are a hospital with no unresolved Security Rule complaints, you probably are not going a PwC audit target. Bad news – covered entities and their business associate should expect increased government and private sector scrutiny of their information security, privacy and data protection policies, procedures and processes.

State security breach and notification laws, the FTCs 2007 position on encryption, the federal government’s priority on developing and deploying electronic health records, the ever increasing costs of security incidents to government and private sector organizations, and growing public concern for the privacy of health information make information security and privacy both good healthcare and good business. Yet, recent security incidents involving healthcare organizations highlight that many covered entities are not learning from the mistakes of others, not deploying reasonable and appropriate safeguards and not following recognized best practices. It's not surprising that CMS is beginning to enforce the Security Rule it intended back in 2004.

Recent preventable security incidents support the need for healthcare organizations to wake up. Example: On January 24, 2008, a Massachusetts HMO reported theft of a laptop containing ePHI on 30,000 members. In violation of an expressed corporate policy, the ePHI was not encrypted. Based on recent Ponemon Institute survey data, failure to
Information Security? It’s About Time!

Based on recent Ponemon Institute survey data, failure to enforce its encryption policy may cost the HMO more than $5,000,000. More recently, a New Jersey health plan reported a laptop theft potentially exposing the ePHI of 300,000 members. Although password protected, the laptop’s ePHI was not encrypted. Seems the health plan was “in the midst of installing encryption software” but had not gotten to the laptop in question. Prolonged implementation of its encryption policy could cost the health plan more than $50 million. In each case, the cost of enforcing policies and/or getting encryption software deployed is very small in relation to the resulting damages. Portable media encryption has been viewed as reasonable and appropriate by many in the healthcare industry since at least 2003 and is an accepted “best practice.” No wonder information privacy and security professionals have high blood pressure.

Against this backdrop, the Department of Homeland Security recently reported that foreign hackers are increasingly seeking to steal healthcare records. Add to this foreign hacker threat is the growing problem of medical identity theft. All this occurs at the same time the federal government is placing ever increasing emphasis on and demand for electronic health records – initiatives which may well fail if public concerns over privacy and security protections are not alleviated. In the current environment, no one in the healthcare industry should be surprised that CMS is becoming more aggressive in its Security Rule enforcement.

We see many covered entities and their business associates with extensive written information privacy and security policies and procedures (PnPs). What we don’t always see is the actual deployment and implementation of the written word and actual workforce understanding and acceptance. Our experiences and anecdotal evidence are reflected in Ponemon’s recent survey of nearly 900 IT professionals. This survey, reported out in January 2008, found that companies are not enforcing their data security policies. One example is the finding that 51% of employees copied confidential information onto USB memory sticks, even though 87% of the employees believed their company’s policies forbid such copying. Ponemon Institute stated the case clearly – “Privacy and data protection policies are meaningless if they do not address the full spectrum of threats and if they are not enforced. The development of comprehensive policies, along with training and stringent enforcement of these policies, should be a priority [emphasis added].”

Forget HIPAA; forget government mandates. Ethically and as a matter of good business, every entity that creates, receives, maintains or transmits ePHI has a responsibility to reasonably and appropriately safeguard the ePHI’s confidentiality, integrity and availability. Protect your organization through internal audits and assessments to assure that your information security and privacy PnPs are not just paper; educate your workforce to view ePHI protection as the way your organization conducts business and part of your organization’s culture. Make 2008 and every year thereafter the year of healthcare information security. You will sleep easier and have less to fear from outside auditors sent in by CMS.

Tom Evans is President and Chief Executive Officer of KMK Consulting, McLean, Virginia. For more information on this article, contact Tom at evanst@kmksystems.com or at 703.847.8400. He is also Chair of the American Council for Technology/Industry Advisory Council’s Information Security and Privacy Shared Interest Group (www.actgov.org)
SC HFMA CFO Spotlight Article
By Lisa Goodlett

Personal Information:
Name: Lisa M. Goodlett
Title: Chief Financial Officer (changing to Chief Operating Officer in 2008)
Hospital Name/Location/Website: The Regional Medical Center; Orangeburg, SC www.trmchealth.org
Colleges attended: Undergraduate degree from Clemson and post-graduate degree from U. South Carolina (adjunct professor at USC)
Current member of HFMA? Yes, SC Chapter

Your Hospital's Information:
What is new and exciting at your hospital system?
We are very focused on a variety of quality initiatives at our hospital right now. This includes a big emphasis on the patient and employee experience, but also the culture that we create on a daily basis. And, we are constantly trying to foster an environment where it is fun to work here.
What do you want to share about your hospital system to the other HFMA members?
We are in the process of beginning an exciting revenue cycle consulting engagement. Their work will begin in 2008 and we look forward to the positive outcomes that will certainly come from this partnership.

Your Career Information:
What is your business philosophy?
Always plan for tomorrow. One must always try to implement both short and long term goals and programs. Pay close attention and think about the long term effects of your ideas, when outlining strategies for change.
What is the best way to keep a competitive edge?
Do not be content to stay in your comfort zone or your own world/industry. We must always compare ourselves to other hospitals, but also consider doing the same with other industries. There are lots of great operating and business ideas that come from sectors outside of healthcare.
How do you measure success?
If we can affirmatively say that there was a value add to a patient, to an employee, to an outcome, etc……then it will be considered a success. However, before measuring the success of something, you must establish the baseline to work from. It is difficult to measure value add, if you are not sure where you started.
What are your biggest accomplishments in the last 24 months?
We are thrilled to have received an A rating from both Standard Poor and Fitch!
What goal have you set, but not yet achieved?
We still need a better performance based compensation model-so that our employees can share more in the “win.” After we have measured and determined that a staff member had a successful outcome, they should gain more from it.
What has been your toughest business decision?
I have both a decision and a scenario to share……
Decision: Anytime you impact the labor force in the community. Given our centralized location between Columbia and Charleston, it is necessary for us to keep our work force happily employed.
Scenario: Explaining the complexities of health care.
What has been your biggest business lesson learned?
[With a smile] Expectation management! There needs to be a balance between hearing ideas and making people understand that their wishes may or may not come true.
What is your career advice?
Aim for the fences….do not just go for the bunt in the game of life. Take calculated risks in your life. Also, take time to listen intently to what others have to share.
What do you like least about your job?
Sometimes there is a stereotype about the kind of personality that a CFO has. I find that perception difficult to change in some cases. All CFO’s are unique individuals and offer many interesting sides.
If you were not a CFO, you would be a COO?
In fact, as of January 1st, 2008, I will be serving in that role at our hospital. This will be a good fit for me because I am a process engineer.

Your Personal Information:
What is your pet peeve?
People who have a lack of accountability. Do not blame others……stand up and own your mistake if it is yours.
What are your greatest passions in life?
Any interaction that leads to authentic moments of thought and connections between human beings. By sharing in authentic moments with others, you can discover experiences

Continued on page 18
Contributor says, “Here is $1 million that you can never spend, Unconditional versus Conditional Promises to Give

The contribution is per

Contributions
Make the Journal Entry for Permanently Restricted Contributions
The contribution is permanently restricted (an endowment). A contributor says, “Here is $1 million that you can never spend, but you can spend the earnings on whatever you want to.”

When the $1 million is received it is a balance sheet entry: Cash 1,000,000(debit)
Permanently restricted net assets 1,000,000(credit)

As investment earnings are generated (let’s say $10,000): Cash 10,000(debit)
Permanently restricted net assets 10,000(credit)

To record the release of the investment earnings: Permanently restricted net assets 10,000(debit)
Net assets released used for operations 10,000(credit)

As you might imagine, the balance of permanently restricted net assets would stay at $1 million forever. Now, if the contributor restricts the earnings for a particular purpose that complicates things. You would need to move the earnings to temporarily restricted net assets and then follow the guidance above related to when and how to release temporarily restricted net assets into revenue (operations) or unrestricted net assets (property and equipment).

Unconditional versus Conditional Promises to Give

A lot of times when someone promises to give you a contribu-
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Finance Director
Medical University Hospital Authority
Columbia Heart

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Patient Accounts Manager
Director of Finance, Regional Physician Network
Director of Legal Affairs Musc Medical Center
VP Consulting & Operations
Manager-HomeCare Finance
Senior Business Analyst
Business Services Manager
Healthcare Consultant
Patient Accounts Manager
Principal
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Senior Accountant
VP/CFO
Director of Patient Accounts
Chief Financial Officer
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VP Finance/CFO
Dir. Patient Financial Services
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Senior Vice President & CFO
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Spartanburg Regional Healthcare System
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MUSC-Hospital Patient Accounting
Loris Healthcare System
AnMed Health
Beaufort Memorial Hospital
Awood Consulting
Roper Saint Francis Healthcare

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realized the hotel hadn’t lost power because of the ice storm. This energized the day beginning with a prayer breakfast led by Beth Templeton from Our Eyes Were Open, a ministry of United Ministries in Greenville that works to end poverty in the Upstate. Other morning sessions included an SCHFMA Update led by Chapter President Roger Sipe, Healthcare Consumerism – Making it Work for Providers and Consumers led by Charles A. Peck, MD, FACP, of LifeMasters, Managing Your Processes to Improve Quality Using Activity Based Methods led by John Ortiz, MSIE, of ExactCost, Inc. and a Healthcare Audit Update led by Larry Hughes, CPA and Greg Taylor, CPA, both Members of Dixon Hughes PLLC. 

Smiles were all around at the Annual Awards Luncheon as cool jazz heated up the ceremony. The Southern Wesleyan University Jazz Ensemble provided the beat as awards were presented. (See box for complete listing of award winners.)

The afternoon sessions kicked off with Severity Based DRGs, presented by Laura Pait of Dixon Hughes PLLC and Physician Alignment Strategies, presented by Mark Halley, of the Halley Group. Following those sessions, Front End Collections and Leveraging Technology, presented by Rob Jacobsen from Bank of America and Donna Finley of CaroMont Health and South Carolina Workers’ Compensation: An Overview of Effectiveness, a presentation given by Gary Thibalt of the SC Workers Compensation Commission and Eric Felker of Park Dansen.

That evening attendees gathered in the exhibit hall for a time of networking. Later, attendees ventured out into the cold to enjoy a lively Main Street, winner of the 2003 Great American Main Street Award. Whether confronting the chill and searching for the Mice On Main, or enjoying a warm Café Latte in cozy Coffee Underground with friends, attendees were able to exchange business cards and share stories in spite of the snow.

Friday morning opened with a motivational speaker John Cook, of Data Image and Recovery and educational sessions on Benchmarking and KPIs in Patient Access, led by Michael Friedberg of Armanti Financial Services and a sponsorship meeting led by Jude Crowell of Advanced Patient Advocacy. The conference closed with an overview of the US/UK Exchange Program through HFMA, presented by program participant Sonya Wyatt of Roper St. Francis Healthcare.

The summer planning paid off, with more than 130 in attendance and sizzling educational programming. Special thanks to Ronnie Hyatt, CFO of Bon Secours St. Francis Health for his committee leadership. Others serving on the committee included, Alice Childs of Dixon Hughes, Jude Crowell of Advanced Patient Advocacy, Maria Hallman of Cymetrix, Rick LaForge of FTI Healthcare, Jacki Meade of Deco Recovery Management, Bill Peters of HRA, Sharon Rosenberry of Park Dansen, and Russell Robinson from Palmetto Baptist.

Mark your calendars now for the South Carolina HFMA Annual Institute, May 27-30, 2008, at the Hilton Myrtle Beach Resort. More information will be forthcoming.
<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
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<tr>
<td>February 19-22, 2008</td>
<td>Region V Dixie Institute</td>
<td>Orlando, FL</td>
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<td>May 27-30, 2008</td>
<td>SCHFMA Annual Institute</td>
<td>Hilton Oceanfront Resort</td>
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<td>Myrtle Beach, SC</td>
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<td>July 23 - 26, 2008</td>
<td>National HFMA ANI at Mandalay Bay Resort &amp; Casino</td>
<td>in Las Vegas, Nevada</td>
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<td>October 22 - 24, 2008</td>
<td>SCHFMA Fall Institute</td>
<td>Francis Marion Hotel</td>
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SC HFMA Chapter Awards

The 2006-2007 Chapter Year Awards were presented during a luncheon on January 17. Congratulations to these well deserving recipients.

**Rex W. Gause Award for Most Active Certified Member**
Bob Minus

**Ruth H. Nicholson Award for Most Active Member**
Roger Sipe, MHA

**Ray Everett Award for Most Outstanding Member**
Deborah Hunt, FHFMA

**Al Turner Past President Award**
Steve Lutfy, FHFMA

**The Follmer Bronze**
Julie Blackwell
Ray High
Michelle Pagel
Diane Story

**The Reeves Silver**
Tom Eckert
Tony Masters

**The Muncie Gold**
Camie Patterson
Roger Sipe

**The Founders Medal of Honor**
Kay Coons
Donnie Durant
Debbie Hunt
Jay Rickman

Left to right, top: Kay Coons receiving Founders Medal of Honor Award, Julie Blackwell receiving the Follmer Bronze Award. Bottom: Donnie Durant receiving the Founders Medal of Honor Award.
**What is HFMA Certification and Why Should I Become Certified?**

*Take short breaks frequently.* Research shows that the information you remember most is what you first and most recently studied. Breaks also allow some time to reflect on what you just studied.

Great, now that I read all that, do you have any "tips" for me?

**Establish ways to “quiz” yourself** on what you just studied. Use the self-assessment activities at the end of each chapter or the test at the end of the self-study course. (None of these questions are on the exam.) If you are in a study group, quiz each other on key concepts.

**Participate in study groups** with your peers. This allows you opportunity to review materials and to establish a support structure. It is also a way to grow your professional network. In fact, our Chapter will be conducting a coaching course in late February or early March to assist!

**Learn the general concepts first** and then focus on the detailed information associated with each of those concepts. Review the content multiple times and in multiple ways. The more you review the materials, the more information you are likely to retain.

**Use the course syllabus as a guideline** for how you will divide your study/review time. The syllabus defines how the number of questions is allocated on the exam by chapter/section.

**Focus more review time** on the areas from which a higher number of questions will be covered.

Remember, all exam questions are based on content covered in the current version of the self study materials.

Still have questions? Contact Steve Lutfy, FHFMA, Chapter Certification Chairman, at (803) 753 - 5209, or stephen.g.lutfy@us.pwc.com for more information!

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**SC HFMA CFO Spotlight Article**

authentic moments with others, you can discover experiences that will forever bond you with them.

**What is your favorite quote?**

“With every right comes responsibility and in every opportunity, an obligation and with every property, a debt.”

-Rockefeller

**What is your favorite book?**

Well the most intriguing book I ever read was “Atlas Shrugged,” by Ayn Rand.

**What is your favorite movie?**

The original Shrek.

**What is your favorite way to spend your free time?**

Anything on the water, but especially boating.

**Your HFMA information:**

What do you like most about the HFMA?

The ability to call fellow peers in the healthcare community to discuss an idea or to work through issues. Some of my best ideas have come from thoughtful discussion with another HFMA member. I also like the HFMA sponsored white papers.

What is your favoriteHFMA event and why?

I always have enjoyed the SC HFMA summer event in Myrtle Beach. There is something about being on the beach that relaxes people. I also like it because folks seem to have fun because many times family members are enjoying the trip with them.

What is your favorite HFMA memory?

I earned my first CFO position at a hospital when I was 27. Needless to say, I was a little “green” at the time. I will never forget my first HFMA show where I was able to network and learn from more experienced members….it was truly an educational opportunity for me.

What can the HFMA do to make itself better?

Vary the topics from year to year. A number of years ago, I was inundated with revenue cycle topics, but had a hard time learning about anything else. Make sure to keep a nice balance of issues that are discussed and shared. They are many different facets of healthcare that interest CFOs……
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Kimberly Farmer
Betsy Lott
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Charles Felsberg

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