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Indulge in education, networking, leadership development, family fun

Myrtle Beach Hilton, Myrtle Beach, SC
June 1-4, 2010

More info or to volunteer: Woody Turner 803-791-2915
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A Message from the Chapter President.....

I remember April 30th, 1994 like it was yesterday, since it was the day my twin sons were born. Now, I was not the squeamish kind of new dad, so fainting was never even a consideration. I wanted to assist the doctor with the delivery of my two new boys (by caesarean section) but I had to settle for just the videotaping. This year they will turn 16 years old! For those of you with children of your own, think back to the day that changed your life forever!

A vote of 219-212, which contained no Republican support and 34 dissident Democrats, sent H.R. 3590, The Patient Protection and Affordable Care Act to President Obama’s desk. Politics aside, March 21, 2010 will be a day forever remembered for changing our lives. President Obama has signed the legislation into law and now all of us begin the quest to understand what is in the bill and what happens next.

In the midst of uncertainty, I know I can count on HFMA to pave the way to discovering what the reform includes and the impact it will have on our hospitals. Though we will surely benefit from national educational opportunities, it is the personal connections we have made with friends and colleagues in our own chapter that will make the biggest difference.

Membership in such an outstanding organization has been very helpful. To have the opportunity to volunteer for various positions has been very rewarding. To have had the opportunity to serve the South Carolina Chapter as its President has been an honor. Thank you for entrusting in me such an important position. As I wind down my term, which ends with the installation of Ken Scheller of Palmetto Health as your next chapter president at the 2010 SCHFMA Annual Institute, I would like to take the opportunity to wish you all the best!

Making it Count!

Ray High

CMS Seeks to End Remittance Advice Confusion

James Carroll, for HealthLeaders Media, April 20, 2010

In a recently released transmittal, CMS has addressed an issue that has been a thorn in the side for providers since the RAC demonstration project. Transmittal 659 addresses the issue of reporting of recoupment for overpayment on the remittance advice (RA). A remittance advice is a notice of payments and adjustments sent to providers, billers, and suppliers.

Read More: http://www.healthleadersmedia.com/content/FIN-249796/CMS-Seeks-to-End-Remittance-Advice-Confusion
Navigating the course to accounts receivable success*

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*connectedthinking

Contact
Steve Lutfy, FHFMA
Managing Director
(803) 753-5209
stephen.g.lutfy@us.pwc.com
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Seven Ways to Minimize Your RAC Financial Risk

By Brian Shannon

The Recovery Audit Contractor (RAC) demonstration project found over $1,000,000,000 of improper payments from just a handful of states. The permanent program will likely generate several times that amount. Even though your organization may not be receiving many complex review letters yet, you should be preparing to minimize your financial exposure as much as possible. Here are seven ways to accomplish just that:

1) Mail Yourself a Mock RAC Letter
Many providers are concerned about how the RAC letters will be handled in their facilities. Some popular questions are: Who will the RAC letter be routed to within our hospital? How long will it take for that letter to get to the right person after we receive it from the RAC? Will there be any consistency to how our internal team treats this process?

One quick and inexpensive way to address these questions is to mail yourself a letter as if it was from your RAC. Go ahead and make it look official, address it to the person who is responsible for RAC letters and document exactly what day you put it in the mail. Then, wait to see what happens. Even if you are already receiving letters from the RAC and they appear to be handled correctly, I would suggest that you mail a sample letter every month to ensure that your process is still running smoothly. (If it is not, wouldn’t you want to learn that from a practice letter before you miss a deadline with your RAC because the right person did not receive their mail in time?)

2) Review All Four RAC Websites
All issues need to be formally approved and posted on the RAC websites before they can pursue those with providers. Given that, review your regional RAC website on a weekly basis to see if there are any updates. However, do not stop there. Take a few minutes every couple weeks and review the other three RAC websites as well. If a different region has had success with a series of DRGs, it only is a matter of time before your RAC will add that to their approved list as well. Be proactive and see what is going on from a national basis and get your team prepared. You can learn more about the four national RACs at: www.aha.org/rac.

3) Increase Your Billing & Coding Resources
While medical necessity was the category that produced the most improper payments during the demonstration project, the permanent program has only approved DRG related issues as of the first quarter of 2010. Many hospitals have built up their RAC team largely focused on clinical resources, but they do not seem to have added certified billers and coders to meet the increased demand that is soon to be coming. If your facility gets inundated with RAC letters, your existing team members will likely not be able to handle all of that additional work. I would encourage you to add another FTE if possible or partner with a company who could provide this as a service to you. Doing nothing will probably result in adding to your financial exposure from the RACs.

4) Plan for an Audit Revolution
Given the overwhelming financial success of the RAC demonstration project, all other payers must be salivating over the opportunity to perform similar audits on you in the future. While this is painful to think about, your audit concerns need to focus on more than just the RACs. Plan for Medicaid, Blue Cross, United, Aetna, etc. to quickly piggy-back off of the wild success that the RACs have had.

Accordingly, your internal committee should probably not be called your “RAC Team” but rather your “Audit Response Team.” Think more globally about how auditing will change in the near future. It would be helpful to have a plan in place to handle audits that come from any payer, not just RAC.

5) Focus on Getting it Right from the Start
While responding to the RACs is a necessary endeavor, your real goal should be much broader than that. In an ideal world, you would like the auditors to never find any reason to come calling. In order for that to happen, you must be focused on revenue integrity and data correctness right from the start. How do you do that?

Get more committed to your denials management process! Regardless of how good you think it is now, there is always room for improvement. You probably need to have parallel task forces to accomplish this. One would be for your newly named “Revenue Integrity Team” and the other would be your “Audit Response Team.” The combination of both of those efforts will produce short and long term results which will pay dividends to your organization.

6) Be Prepared for the Long Haul or Partner with Someone Who Is
Even though a defined appeals process has been established for the RACs, that timeframe has turned out to be much longer than anyone expected. For example, there are many providers from the demonstration project that are still waiting to have resolution on their appeals. Given that
the permanent program will grow to 50 states, what will the appeal timeline look like for you? Common sense would suggest that many appeals in the future will take years to finalize. Given that, do you have the time, resources and patience to work through this process over the course of several years? If you are not sure, I would encourage you to partner with a company who can help you do just that. And, make sure they charge you a flat fee for the appeals; otherwise you may end up winning the RAC appeal but giving all of your proceeds to your vendor.

7) Build Your External Team and Plan for Implementation

Many providers THINK they have everything in place to manage all of the audits coming their way. However, so did most of the hospitals during the demonstration project. The unfortunate reality is that many of you need help. If you cannot pull together funds to add FTEs, then partner up with external resources who can help. You should have a RAC attorney who you can call when you need their services. Additionally, do you have a company that can provide both DRG and medical necessity claims review and support in the event your existing team cannot manage the increased volume? Hopefully you will not need to utilize all of these services, but since you cannot really tell what your workload is going to be it is wise to set some partnerships up now.

If you agree that you may need some external help, please remember that most partners need some time to implement. You need to sign an agreement and then given the nature of the RAC reviews, you may also need to set up electronic access to your system. This can take two or three months. Don’t wait for the RACs to create a problem for you, proactively plan for success in this area.

Hopefully these ideas will help minimize your current and future financial risk related to the pending audits. While it can sometimes be difficult to plan for the unknown, there is simply too much at risk not to be prepared. Do yourself a favor and implement the steps above. It would be great to have all of them in place and not need them than the other way around!

If you are interested in learning more about Brian Shannon, please visit www.brianshannon.net. You can contact Brian at brian@brianshannon.net or (704) 887-6707.

Web Offerings to Chapter Members

Healthcare Reform On-Demand Recorded Webinars
Impact of Healthcare Reform: A Conversation with HFMA's Dick Clarke

Webinar Summary
President Obama signed into law the most sweeping healthcare reforms since Medicare on Tuesday, March 23, 2010. Providers now need to turn their attention to understanding this new law and how it will impact their operations. HFMA's CEO Dick Clarke provides his perspective on the most important changes in the legislation and answer questions that will certainly be top of mind for hospital board members.

What's Discussed
• Anticipated timing of reforms and when they’ll impact hospitals
• Number of uninsured gaining coverage and a discussion of how that will occur
• Anticipated operational impacts from reforms
• What providers should do now to prepare

Speaker
Dick Clarke, President and CEO
HFMA

Pricing
Free to HFMA Members
$99 to Non-Members

Healthcare Reform: The Dust Settles

Webinar Summary
The first reforms that impact hospitals will go into effect in 2010. Providers have a limited time to prepare for the first wave of changes so it is crucial that they understand the details of the legislation. This webinar provides a detailed explanation of specific reforms that will affect hospitals.

What's Discussed
• Reductions to Medicare and Medicaid payment
• Changes in the reimbursement system that shift the economic incentives from volume to value
• Requirements for tax exempt hospitals
• Specific strategies providers should use to prepare

Speakers
Dick Clarke, President and CEO
HFMA
Cathy Jacobson, SVP, SP & Fin./CFO & Treasurer
Rush University Medical Center
Ed Giniat, Partner
KPMG

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Free to HFMA Members
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Publication Date: Thursday, April 15, 2010
Membership News
By Bob Minus, Membership Committee Chair

As the year is winding down, membership continues to increase. At the end of March, SCHFMA has 482 members. This is just below the CBSC goal of 485. Who would have thought that this could happen after tanking to 399 members in July? Please continue to recruit, encourage, bribe, etc., so that we may hit our membership goal. Here are some of our new members, and an interesting lot they are. Feel free to contact any of them to welcome them in the chapter.

Travis Skipper, Client Care Coordinator
Apria Healthcare
Originally from Marion, SC
Newberry College Graduate, working on MBA at the Citadel
Getting married in June to Emily Pinson
Enjoys running, golfing, the outdoors, and his Springer Spaniel
tskipp38@aol.com

Mark King, Manager of Government A/R
Palmetto Health
Originally from Hagerstown, MD
Attended Hagerstown Junior College
Married for 25 years
Former EMT
Enjoys motorcycles and singing with a traveling Southern Gospel Quartet
Mark.King@PalmettoHealth.org

Ashley Hindman, Manager, Revenue Cycle Integrity and Training
Greenville Hospital System
Originally from Anderson, SC
Graduated from The Citadel
Married with 2 daughters
Enjoys riding his Harley
Ahindman@ghs.org

Leisa Butler, Cost Analyst Decision Support
Self Regional Healthcare
B.S. in Health Information Administration
Hometown is Greenwood, SC
Married with 2 children-boy and girl
Enjoys cooking, traveling, and gardening
Lbutler@selfregional.org

Christy Powers Cunningham, Regional Account Manager
National Bank of SC
Hometown: Woodruff, SC
Education: Limestone College, Gaffney SC
Bachelor of Science in Business Management, 2002
Married: Dec 31, 2009 - no children
Hobbies: Working out, traveling, and having a good time!
ChristyPowers@NationalBankSC.com

Hospital Mortality Is Not the Way to Judge Quality
Cheryl Clark, for HealthLeaders Media,
April 22, 2010

To truly evaluate quality, hospitals would do better to look at avoidable events such as bloodstream infections, which kill 31,000 people a year in the U.S., rather than at mortality rates, a prominent safety expert wrote in a new report.

Read more:
http://www.healthleadersmedia.com/content/QUA-249908/Hospital-Mortality-Is-Not-the-Way-to-Judge-Quality
Numerous volunteers throughout the state have been working diligently to update the manual and training materials for next year’s South Carolina Certified Revenue Cycle Associate (CRCA) Program. Covering topics such as Medicare, Medicaid, and TRICARE to sections on Legal and compliance-related issues, and HIPAA, the CRCA training manual addresses relevant topics within the Revenue Cycle. We have updated our manual with the latest payer requirements, and have added new information on South Carolina collection laws, coding, and reimbursement. At the request of prior graduates, we have also included practice questions and answers at the end of each chapter. The CRCA Program is essentially a self-study course. Its purpose is to both educate as well as to recognize those staff who have demonstrated that they have met an accepted proficiency in the revenue cycle field. This program is a great opportunity for staff education!

Registration materials for the CRCA program will be available in the middle of May at www.SCHFMA.org. The charge for joining the CRCA program is $50. For that $50 the member will be given a CD of the updated manual, a study guide, and a training CD. Our live educational seminar will take place on June 18th at Palmetto Health in Columbia. The charge for taking the Certification Exam is $100 and $50 for the retake exam. The examinations will take place next fall throughout the state.

Continued on page 13
At a glance

Hospitals will receive lower annual inflation updates for the next 10 years and significant reductions in disproportionate share (DSH) payments.

Some of these reductions may be offset because an estimated 32 million uninsured Americans will have coverage by 2019.

The legislation also contains dozens of provisions that are intended to improve the efficiency of the healthcare system. Many of these changes may also decrease revenues for providers.

Background


This report focuses on aspects of the final healthcare reform and reconciliation legislation that are expected to be most significant to providers. For purposes of this report, except as expressly stated otherwise, the term “the Act” refers to PPACA as modified by the 2010 Reconciliation Act.

Expansion in insurance coverage

The Act requires everyone to have health insurance coverage beginning Jan. 1, 2014. Individuals who cannot afford health insurance will be eligible for either tax subsidies or Medicaid, depending on their income levels. Employers would be subject to penalties if they do not provide health insurance coverage to their fulltime employees.

The Act also improves coverage for many people who are currently insured by prohibiting lifetime and annual limits on coverage, and eliminating pre-existing conditions exclusions. Plans must offer coverage for children of covered individuals up to age 26. Many of these changes begin for the first plan year within six months of enactment.

The Act expands Medicaid to all U.S. citizens and legal residents less than 65 years of age who earn less than 133% of the federal poverty level (FPL) based on modified adjusted gross income – which guarantees a benchmark benefit package that provides essential benefits.

Observation: An estimated 32 million uninsured Americans will gain coverage under the Act; half of those will be covered under government insurance programs, such as Medicaid and CHIP, according to CBO. Providers will need to consider several strategies in this new environment. The newly insured will have more options seeking coverage and may not continue to seek care at traditional safety net hospitals and clinics. Government reimbursement rates will have an increasing influence on a provider’s payer mix so they should align operational costs with these payments. Providers may want to start modeling different scenarios around serving the newly insured and the resulting potential reductions in total bad debt and uncompensated care against scenarios that include a smaller percentage of uninsured and the new Medicare reimbursement cuts described in the following sections.

Essential benefit package and administrative simplification

Beginning in 2014, state-based insurance exchanges will be available to U.S. citizens and legal immigrants and employers with up to 100 employees to purchase qualified health insurance coverage. Beginning in 2017, states may permit larger employers to purchase coverage through these insurance exchanges. All plans offered through these exchanges must provide a minimum level of benefits, as defined by HHS. Plan designs must cover at least 60% of the actuarial value of the benefits and limit cost-sharing to current high deductible health plan (HDHP).

Administrative simplification requirements for all insurers include adopting a single set of operating rules for claims status and eligibility verification, electronic funds transfer for healthcare payment and remittance, health claims and encounter information, enrollment and disenrollment, premium payments, referral certification and authorization. These requirements become effective between 2013 and 2016. Health plans that are not able to document compliance may be fined up to $1 per covered life per day.

Observation: Administrative simplification could reduce costs for all providers. In addition, insurance exchanges could either add complexity with new plans or bring simplicity by reducing the number of plans, depending on how the market responds. Plans offered
through the insurance exchanges could decrease bad debt and collections for providers because health benefits will meet requirements around cost sharing and provide more standardization of benefits.

Direct changes to provider reimbursement

The Act will implement several changes in Medicare and Medicaid reimbursement rates that could lower reimbursement over time. These changes include:

• Decreases in the inflation update paid to hospitals by Medicare
• Reduction in Medicare and Medicaid (DSH) payments to hospitals
• Increases in Medicaid and Medicare rates paid to primary care physicians

Observation: Government reimbursement will be reduced as more uninsured get subsidies through the insurance exchanges or enroll in Medicaid programs. These effects may not be equal, and some hospitals may lose more than they gain. In addition, higher payments to primary care physicians could attract more physicians to that field, but access problems are likely, especially in certain geographies.

Indirect changes to provider reimbursement

While the Act implements some large-scale changes in provider reimbursement, there are other provisions in which changes are more selective, dependent on actions, outcomes, and the quality of provider services. These include:

• Medicare hospital readmission payment reductions
• Medicare and Medicaid hospital-acquired conditions payment reductions
• Medicare value-based purchasing program

Observation: The government is moving from being a passive payer to a more active purchaser, which means that hospitals will increasingly earn reimbursement based on outcomes, quality and patient satisfaction. Medicare also will be experimenting with episodic and global payments. Hospitals that can align interests with physicians could be rewarded under these new programs.

Potential changes to provider reimbursement

The Act includes multiple pilots, demonstrations and programs to change the way care is delivered and reimbursed. Certain pilots and programs allow providers to share in cost savings and efficiencies they achieve with the Medicare and Medicaid programs or receive additional payments for the coordination of care. These include:

• Accountable care organizations (ACO)
• Medicaid medical home program
• Medicare and Medicaid bundled payment pilot project
• Medicare Independent Payment Advisory Board and CMS Innovation Center

Observation: The Act contains several new initiatives, experiments and demonstrations. However, not all of them are expected to be expanded nationally. In the meantime, providers should review all of the new offerings to see which ones may work for their organizations and be ready to respond if the effort is mandated for all providers. Hospitals that can align interests with physicians could be rewarded under these new programs. Since hospitals are exempt from IBAP’s recommendations until 2020 and since hospitals account for the single largest category of Medicare spending, it may be difficult to control overall spending growth.

Focus on fraud and abuse

The Act enhances existing programs (such as the holding period on durable medical equipment) and creates new powers and programs to reduce waste, fraud, and abuse (such as federal and state database sharing and use of a national provider identifier, as well as increased penalties and funding).

Observation: The increased focus on fraud and abuse is further bolstered by new funding allocations for HHS and its Office of Inspector General, the FBI, Medicare and Medicaid Integrity Programs, and the Department of Justice. These combined with the expansion of RAC audits means providers will have more compliance and oversight issues to manage.

Requirements to qualify for section 501(c)(3) – charitable hospital organization

Historically, the tax exemption of organizations has been based upon the “community benefit” standards of the IRS. The Act contains four new specific requirements that hospitals must meet to qualify for tax-exempt status relating to the areas of community health needs assessment, financial assistance policy, limitations on charges, and billing and collections.

In addition to the requirements placed on hospitals, the Act also requires the IRS to review the tax-exempt status of each hospital every three years.
Observation: The new requirements to qualify as a section 501(c)(3) organization will make information and reporting more publicly available. Annual reporting will allow more hospital-to-hospital comparisons of community benefit efforts. Training and education of hospital staff that communicate these policies will be even more important because of the IRS tax-exempt review. Conducting community needs assessments will require hospitals to maintain close connections and collaborations with community and public health organizations.

Other issues
- The Act includes a number of other important issues:
  - Medical malpractice
  - Financial disclosure
  - Community health
  - Physician-owned hospitals

Observation: The increased focus on fraud and abuse is further bolstered by new funding allocations for HHS and its Office of Inspector General, the FBI, Medicare and Medicaid Integrity Programs, and the Department of Justice. These combined with the expansion of RAC audits means providers will have more compliance and oversight issues to manage.

Timeline

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<tr>
<td>2010</td>
<td>Physician-owned hospital Medicare provider agreements must be in effect prior to December 31</td>
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<td>2011</td>
<td>Demonstration grants for medical malpractice reform begin</td>
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<td>10% Medicare bonus for primary care &amp; general surgeons in a health professional shortage area</td>
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<td></td>
<td>Innovation Center for CMS established</td>
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<td></td>
<td>Prohibits federal Medicaid payments to states for services related to hospital-acquired conditions</td>
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<tr>
<td></td>
<td>Federal funding of Medicaid medical home program</td>
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<tr>
<td></td>
<td>New funding for community health centers, school based clinics, and trauma center program</td>
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<tr>
<td>2012</td>
<td>ACO demonstrations begin</td>
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<tr>
<td></td>
<td>Medicare readmission reductions</td>
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<tr>
<td></td>
<td>Medicare Value-based Purchasing (VBP) program begins</td>
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<tr>
<td></td>
<td>Medicaid bundled payment demonstration projects begins</td>
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<tr>
<td>2013</td>
<td>Medicaid bundled payment demonstration projects begins</td>
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<tr>
<td></td>
<td>Medicaid primary care payment must be at least 100% of Medicare payment</td>
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<tr>
<td></td>
<td>Financial relationship disclosure required between providers and drug manufacturers and suppliers</td>
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<tr>
<td>2014</td>
<td>Independent Payment Advisory Board (IPAB) submits first recommendation on reducing Medicare spending growth</td>
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<tr>
<td></td>
<td>Medicare DSH payments reduced by 75% and then modified based on uninsured and uncompensated care</td>
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<tr>
<td></td>
<td>Expand Medicaid to 133% FPL</td>
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<tr>
<td></td>
<td>Reduction in states’ Medicaid DSH allotment</td>
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<tr>
<td>2015</td>
<td>Reduce Medicare payments for hospital-acquired conditions by 1%</td>
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To read Healthcare reform sector implications: Provider in its entirety, please visit www.pwc.com/healthreform.
Form 990 and Implications of Healthcare Bill: Time to Belly Up to the Table & Dig In

By Amy Bibby, CPA, Senior Manager, Dixon Hughes PLLC

• Doing Business with Board Members; conflicts of interest; independence
• Healthcare Bill’s ‘Special’ section for Hospitals: Community Health Needs Assessment, Financial Assistance Policy, and more
• Sch H & K: Bond Compliance & Community Benefit/Charity Care

In Scandinavia, a ‘smorgasbord’ is a buffet style meal, but in the South we call it ‘a mess of somethin’. It’s nothing new that hospitals are being hit with all kinds of new rules and regulations. However lately, with the revised Form 990, Healthcare Reform, etc. hospitals are being hit with a smorgasbord of new rules on a whole new level. The kicker is – we can’t pick and choose as if we were at the buffet line. We must eat EVERYTHING. On this grand buffet board relationships and conflicts of interest are the lima beans, the collard greens are Schedule H’s charity care and community benefit calculation, Community Needs Assessments/Financial Assistance Policies/Billing & Collection Practices are those strange fruit salads that have way too much mayo, and post issuance bond compliance is definitely the mystery fish swimming in a translucent liquid.

In this short article, we will attempt to address each of these issues and hopefully provide some insight and helpful ideas to get things started.

Business, vendor, and family relationships between both the organization and officers, executives, and key employees AND between officers, executives, and key employees themselves are now reportable to a much greater degree on the Form 990. They challenge is that the person in charge of completing the 990 (perhaps the controller and/or CFO) can’t always know about these relationships. If you’ve had the pleasure of delving into the 990 form and instructions, the questions to identify reportable transactions can become very cumbersome. Varying rules apply to different situations with varying thresholds. For example, if a board member’s sister-in-law works in the cafeteria (making over $10,000), that relationship as well as the sister-in-law’s name and compensation has to be disclosed on the Form 990. The IRS REQUIREAS that the organization put forth a ‘reasonable effort’ to collect this data (i.e. they have to be ASKED). Current and former officers, directors, trustees and key employees should be given a questionnaire on an annual basis. The questionnaire works well as an ‘addendum’ to the organization’s conflict of interest policy and the completion of this form fits well within the board meeting setting. TIP: Ask your 990 preparer for a sample ‘relationship questionnaire’ and have them attend the board meeting in which this questionnaire will be addressed.

Charity care and community benefit calculations bring in a whole other dynamic to the Form 990 reporting. There is no doubt that this section of your hospital’s Form (Schedule H) will be compared and contrasted with other hospitals by the IRS, your community, ‘watchdog’ groups, and other hospitals. The Health Care Bill stipulates that the Secretary of the Treasury will be required to review a hospital’s community benefit activities at least every three years. Presumably this would include a review of the 990 and Schedule H. Tax exempt status could be questioned for those statistics fall outside of the norm. TIP #1: Gather your team – 990 preparer, reimbursement person(s), community events coordinator(s), etc. and get them on board. They should be familiar with Sch H way before it comes time to actually file the return. You can also lean heavily on specialists in this area to complete a ‘mock Schedule H’. Tip #2: Keep in mind that the hospital’s estimate of bad-debt expense (at cost) attributable to patients eligible under the charity care policy is an extremely important number. Watch this closely as things unfold in healthcare reform because there will be an obvious connection between these numbers on the Schedule H and Medicare/Medicaid disproportionate share payments and funding.

Largely due to the efforts of Senator Chuck Grassley, the Health Care Reform Bill (Patient Protection and Affordable Care Act) has enacted many new requirements directly addressed at tax exempt hospitals. Among these includes a “tightening up” of hospitals financial assistance policy, policy relating to emergency medical care, limitations on charges, and billing and collection practices. We’ve seen a flurry of activity in these areas over the past few years, so no new surprises here. Perhaps a little more news-worthy is a mandate for hospitals to complete a Community Health Needs Assessment. These Assessments must be completed once every three years, with the first one ‘due’ by March 23, 2012. A $50,000 penalty applies each year that a hospital doesn’t comply (presumably $150,000 for one three-year cycle). Of course the bigger ‘penalty’ could be further IRS attention and unwanted publicity. Here’s a few
of the more thought provoking requirements: (1) if the hospital operations more than one facility, an assessment would need to be completed for each facility (2) the hospital must also adopt an “implementation strategy” that meets the needs identified in the assessment, and (3) input is required from persons in the community including persons with expertise in public health. The third point raises the issue that the hospital is being charged with a task that is more of a local government obligation. TIP: Plan on completing early. Talk to your audit partner to see if they can lead you in the right direction. Make sure you understand the planned components of the ‘public input’ portion prior to work being performed.

Although tax exempt bonds were not a part of the Health Care Bill, they deserve an honorable mention. Most entities with tax exempt bonds will be required to file on the Form 990 a new Schedule K. This Schedule is similar to the Schedule H filing (for charity care and community benefit) in that Schedule K also requires advanced planning, many employee hours, and, very often, external assistance. Bond counsel and the trustee can also play an important role in completing this Schedule. We know that the IRS has initiated a very concerted effort to grow their personnel to allow for more audit activity. We have already seen more tax exempt bond audits in the last year, especially among healthcare providers. Schedule K will provide the IRS a very convenient way to determine who gets audited. Don’t be fooled by the brevity of Schedule K (only 4 parts, 2 pages). Schedule K is loaded with pitfalls. TIP #1: Complete Schedule K now. Almost all of the data on the Schedule K is not specific to the tax year, so no time will be wasted by preparing now. Fiscal year entities will complete the entire Schedule for fiscal year ending in 2010. TIP #2: Coordinate with the bond counsel, trustee, and tax preparer to address problem areas. Some common areas that may need improved documentation include: (1) data related to proceeds allocation, (2) tools [schedules or outside software] that track compliance with private use rules including the use of bond financed property, and (3) arbitrage rebate and yield restriction calculation/report.

Your buffet of areas to address is likely much more expansive than the few discussed above. Some are more palatable than others. If these issues are the lima beans of your ‘to-do’ list, 2010 is the year to address these four key areas. The effort needed to achieve successful compliance will be great. The process will be made easier by organizing internal staff and enlisting the help of specialists. It’s time to belly up to the table & dig in!

About the Author

Amy Bibby is a CPA with Dixon Hughes. Amy focuses 100% on healthcare tax issues and not for profit organizations. Amy can be reached by calling 828.254.2254 or by email, abibby@dixon-hughes.com.

Below are some of the questions that staff will learn the answers to through this program:

1. According to the SC Prompt Pay Law, how many days does a payer have to pay a clean electronic claim?
2. What are the components of a successful pre-admission program?
3. When is a Medicare Secondary Payer questionnaire required?
4. What are important listening skills when interacting with patients?
5. What are the correct values for the Present on Admission indicator?
6. What are the three TRICARE programs and how do they work?
7. When a patient presents with more than one insurance plan, how does registration know which plan to enter as primary?
8. How are fraud and abuse different and give examples of each?
9. What is EMTALa and how does it affect your hospital?
10. What is a Qualifying Event under COBRA Continuation Coverage?
11. What were the major changes in Privacy and Security under the HITECH Act of 2009?

CRCA Program-Where Knowledge & Experience Come Together to Form Expertise!
Member Spotlight Article

By Brian Shannon

Personal:
Name: Benjamin M. Cunningham, Jr., CPA
Title: Vice President of Finance
Hospital name & location: Palmetto Health; Columbia, SC
Hospital website: www.palmettohealth.org
College attended & degree earned: University of South Carolina; Bachelors in Finance
Current member of HFMA?: Yes, SC chapter

About Your Health System:
What is new and exciting at your health system?
We have implemented a Leadership Institute here at Palmetto because we are very focused on developing our employees and giving them the resources they need to be successful. We set aggressive goals and this new program helps our team members achieve them. Whereas, we started this several years ago, we are now seeing the benefit in the training our leaders are getting. All of our key measures are improving.

Also, we have done a great job of weathering the economic storm which is a success in and of itself. I believe we are even stronger today as a result of the fiscal responsibility we have displayed over the last year or two.

What is it like to work for your health system?
It is a real pleasure to work for an organization that is so dedicated to its mission. We always put our mission and consequently our patients first. We are lucky because we possess a great board and executive team and their stewardship has helped us greatly over the years. Regardless of what your role is within our health system, we really try to make everyone feel comfortable and part of the overall team.

About Your Career:
What are some of your personal priorities for your health system this year?
Continue to grow cash and reduce our days in A/R. Last year we reduced days in A/R by seven, and while our revenue cycle has made good progress, I know we have more opportunities for improvement.

What is your business philosophy?
I am a straight-forward type of person and like it when others are as well. I like communication to be concise, transparent, honest and sincere. I think we all should speak from the heart and help team members whenever necessary.

What is the best way to keep a competitive edge?
One must constantly stay current with news and events in the industry by reading literature, networking, attending events, etc. Also, I think it helps to have internal and external mentors to help guide you through your life. I know from personal experience that having these resources can help you a great deal.

How do you measure success?
Employee satisfaction is measured by the smiles on people's faces. I spend a lot of time simply observing people's facial expressions and mannerisms because they provide true insight into how satisfied someone is with their job.

In terms of finance, we measure everything first to understand our baseline. After that, we set goals to improve on that starting point, and then establish an action plan to achieve success. This process allows us to look back and clearly determine if we made progress or not.

What are your biggest accomplishments in the last 24 months?
Our finance team has done a great job of growing cash for the organization and decreasing our days in A/R at the same time. We also completed a joint venture with our Easley campus as well, which was a big accomplishment for all parties involved.

What goal have you set, but not yet achieved?
From an organizational perspective, my short-term goal would be to get our A/R days in the low 50's. We are getting closer to that goal, but we still have some work to do. In terms of my personal goals, I would like to become a CFO some day.

What has been your toughest business decision?
Human resource issues can be difficult to handle especially when an employee needs to leave the organization. Anytime you make a decision that affects a person's life in that way it is tough.

What has been your biggest business lesson learned?
Surround yourself with great people.

What is your career advice?
Make sure you have a strong team that is not afraid to give you their opinion, especially if it differs from yours. I want people who will challenge my thinking and provide me with a different perspective on issues. I may not always agree, but value their input nonetheless.

What do you like least about your job?
This goes along with answer #9, but dealing with HR issues is a draining part of my job. It can be difficult sometimes to separate the personal relationship you have with someone with what is best for the organization.

What do you like most about your job?
Every day I am challenged with something different and I love that diversity. I also really enjoy the team members I work with. The people here make this a great place to work.
When you were a kid, you thought you would grow up to be a Marine.

More About You:
What is your pet peeve?
People who bring us return on investments that are outrageous and cannot be validated with real data.
What are your greatest passions in life?
My wife and my two sons.
What is your favorite book?
Halsey's Typhoon by Bob Drury.
What is your favorite movie?
Braveheart with Mel Gibson.
What is your favorite way to spend your free time?
I love any activities with my family and also enjoy attending University of South Carolina football and baseball games.
If you could meet anyone, who would it be?
Franklin Delano Roosevelt.

If you could change one thing about yourself, what would it be?
I would like to be more patient at times.

About HFMA:
What do you like most about HFMA?
I enjoy attending HFMA events and networking with peers. It can be a great forum to discuss and share ideas on what is going on in the industry. Also, HFMA provides a great opportunity to meet people on a more social basis as well.
What is your favorite HFMA event or memory?
The summer event in Myrtle Beach is always one of my favorites.
What can HFMA do to make itself better?
Continue to diversify the educational content. While revenue cycle is important, it is also refreshing to learn about other issues that impact hospitals. Overall though, HFMA does a great job.

SAVE THE DATE
HFMA’s 2010 ANI:
The Healthcare Finance Conference
June 20-23, 2010
Nashville, Tennessee
Gaylord Opryland Resort and Convention Center

Get Certified!
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Additionally, any SCHFMA chapter member who passes a CHFP exam is entitled to receive a full refund of their exam fee. This includes certified members who take and pass a specialty exam.
Today, most hospital business offices rely on third party vendors, such as collection agencies, extended business office partners and eligibility firms, to augment their internal collection efforts. Every day, accounts and financial updates flow back and forth between a hospital and its vendors. Despite everyone’s best intentions, the current operating routines and processes often result in inconsistencies between the inventory records of a hospital and its vendors.

Always thought to be a relatively minor issue, recent research suggests the inventory reconciliation problem is significant, pervasive and critical. Reconciliation issues between providers and their vendors can lead simply to lost cash and high operating costs or go so far as to create regulatory issues and major public relations problems.

### The Magnitude of Inventory Reconciliation Issues Can Be Significant

Based on findings from inventory reconciliation initiatives at multiple providers around the United States, between 5% and 34% of inventory held at vendors had reconciliation issues with the providers’ records.

The average reconciliation error rate across this sample of providers was 13%. However, even in situations where the provider had only a single vendor, the reconciliation error rate was high.

Reconciliation issues broke down into five categories:

1. **Accounts are closed in the patient accounting system, but not recalled from the vendor;**
2. **Accounts are closed by the vendor, but not updated as such in the patient accounting system;**
3. **Accounts on payment plan appear at the vendor, but are not documented as such in the provider’s records;**
4. **Vendor is continuing collection efforts on accounts on hold for review at the provider; and,**
5. **“Missing transactions” or transactions that are recorded in the patient accounting system, but are not sent to the vendor, and vice versa.**

Over time, the small numbers of account problems compound and mature into the 5% to 34% inventory reconciliation issues noted earlier.

### Possible Negative Outcomes from Reconciliation Issues

Not only are the number of accounts involved significant, but these reconciliation problems lead directly to problematic outcomes. Some of the more concerning problems include:
In almost every situation, reconciliation issues are elevating operating costs, distracting management attention and reducing cash recovery. It also creates the opportunity to undermine patient satisfaction, generate negative PR in the local community, and put the provider at risk with regulators, CMS and other oversight organizations.

What Can a Provider Do to Address Inventory Reconciliation Issues?

Many hospital business offices only perform spot checks or “rough reconciliations” due to the volume of activity, inaccessible account data and limitations with patient accounting system. Many hospitals also use time consuming, manually intensive account matching, thinking they can solve their reconciliation problems with human intervention. While better than doing nothing, they are insufficient.

The scale and scope of the previously mentioned research plus the trend to use more outsourcers in business office processes suggest providers and their vendors need to enhance key routines:

<table>
<thead>
<tr>
<th>Reconciliation Issue</th>
<th>Possible Ramifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Account open at hospital, but not at agency</td>
<td>• No work is being done on the account so no money is being collected. • Patient may incorrectly be told that their financial obligations are complete.</td>
</tr>
<tr>
<td>Hospital and vendor have different balance due</td>
<td>• Vendor is either pursuing too much or too little money, both of which are problematic. Too much exposes the hospital to legal and public relations issues. Too little leaks cash. • Unexplained changes to the balance due undermine patient confidence in the accuracy of the bill now and in the future. This breakdown delays patient payment as the patient is expecting the billed amount to change. • Creates unproductive administrative costs at both the vendor and provider when the gap is identified and needs to be explained.</td>
</tr>
<tr>
<td>Account closed at hospital, but open at vendor</td>
<td>• Vendor is requesting payment on an account that has been resolved or otherwise closed. • In the event that the account has been written off to charity or taken as bad debt on a cost report, significant legal and compliance issues are created. • Patient goodwill and community relations put at risk. • Vendor is incurring costs to collect.</td>
</tr>
<tr>
<td>Account at wrong vendor</td>
<td>• Collection efforts may be inappropriate for the type of account. Different agencies are often contracted to operate under different policies, processes, and commission rates. • Patient satisfaction risked by exposure to more aggressive collection tactics than warranted.</td>
</tr>
<tr>
<td>Account at two vendors</td>
<td>• Patient is pursued by more than one vendor, creating frustration with the provider and potentially excess payment. • Hospital potentially paying commissions to both vendors. • Extra collection costs incurred by vendors.</td>
</tr>
</tbody>
</table>

Long term, cost effective approaches generally are technology enabled, automating the exception identification process.

Ultimately, whenever a provider corrects existing inventory reconciliation issues and prevents new ones from occurring, they are improving the patient experience, reducing operating costs and compliance risks, and enabling their vendors to be more effective. It is a true win-win-win experience.

About the Author

Steven Levin is CEO and co-founder of Connance. Contact him at slevin@connance.com or visit www.connance.com
Top 10 Ways to Maximize Your Hospital’s Physician Collections Through Efficient Billing Processes

By Lee Matricaria

Efficient billing and collections processes are critical components to a successful and profitable medical practice. Any efforts you make to improve efficiencies can help better capture the money you earn. Most practices leave anywhere from 5 to 30% of their reimbursement on the table because they either lack the proper processes, staffing, training or technologies. By following this Top 10 list, you can regain control of your billing operations and be on the road to increased revenues.

Verification of Benefits and Patient Registration. A step frequently overlooked in establishing best practices in billing is verification of benefits. It is increasingly important to take the time to verify the patient’s benefits prior to the date of service. Determining if the patient has coverage for the upcoming procedure can decrease the cost of collections, as well as minimize the risk of having to write-off a balance. This is also when a practice should address outstanding patient balances and co-pays. An efficient registration process can significantly improve your cash flow.

Medical Coding. Insist that AAPC Certified Professional Coders perform your coding. This step is critical in ensuring that all codes are billed correctly the first time. Missed or improper codes could equate to thousands of unbilled dollars, as well as expose you to potential liability and compliance issues. Consider hiring an auditing consultant or firm annually to ensure that claims are being coded correctly and completely. This can either confirm that your coding processes are correct or serve to help rectify any problems.

Charge Validation. Prior to submission, claims should be scrubbed via an industry specific tool which utilizes both standard and custom edits. This system should automatically detect coding combinations related to unbundling, modifier appropriateness, and mutually exclusive procedures. Medical necessity concerns can be discovered, and proper channels are exercised to improve or amend documentation.

Remittance Management & Payment Posting. The retrieval and processing of claims should be done with electronic remittances from government and large commercial payers whenever possible. Automating this process reduces human error and highlights claims that need additional follow-up. The ERA/EFT combination puts money into your account quicker, and allows for timely billing of secondary claims.

Denials Management. Understanding the issues surrounding a denial is critical to know what course of action to take to rectify the situation and obtain payment. Denials management is often a neglected area of the billing cycle due the labor involved and intrinsic knowledge needed to work outstanding claims. A dedicated team should be assigned to the posting and follow-up of denials. Trends in payer reimbursement can be identified and addressed. Appeals and reviews to combat payer tactics should be submitted and followed through to conclusion. Try and target problem areas that affect the bottom line in order to obtain the maximum reimbursement for all the services you provide. Managing the process can be time consuming and sometimes difficult, but it is essential in optimizing cash collections. Having a team of individuals who understand this process is the number one factor in maximizing cash collections.

Insurance Follow Up. An essential element to help you maximize collections is to have a timely, effective follow-up process in place. You should initiate follow-up efforts with insurance payers on unresolved claims at the right time based on their payment patterns. Your follow-up specialists can use a variety of tools including claim status websites and phone calls to achieve results in the shortest amount of time. Diligence in this area keeps patients out of the loop until the patient responsibility amount is fully determined.

Reporting Capabilities. Your end of month reports should be customized to provide you with the specific metrics that are most valuable to your practice. They should provide a comprehensive view of your practice’s financial performance and give you the insight to make smart business decisions. If you can’t measure it, you can’t manage it. Understanding these details and how they affect your business are the foundation of effective practice financial management.

Hold the Collection Agency Accountable. Your collection agency handles many accounts, so it can be easy for mistakes to occur. While the occasional error may not significantly harm the practice, if it happens repeatedly and is not detected in a timely manner, the impact could be significant.

Technology. To do medical billing right, your technology platform needs to be state-of-the-art. You should invest in the right billing platform, claim scrubber software, have the ability to submit claims electronically, have a robust document imaging system and use electronic remittance for posting. The use of outdated technology may prevent the practice from running its billing operations to maximum efficiency. The long-term benefits and savings of investing in the right technology can often easily surpass the costs.

Choosing a Billing Company. It is important to understand that not all billing companies are the same. Some items to consider are experience in your specialty, technology platform, service offerings and the willingness to customize their services to your requirements. Be aware of the benchmarks and ranges for what billing companies charge for your specialty, and understand that not all operations are equal.

Sometimes, a low price option can undercut the competition because the services offered may neglect some of the labor intensive practices that are required to capture every dollar. Make sure there are no hidden costs for items like billing secondary payers, patient statements, and postage fees that you will need to factor in. Saving a little money on the rate charged by the billing company is shortsighted if they skim on the steps addressed above.

To collect all of the money you have worked for requires fully optimizing each of these billing functions to realize efficiencies. Each area might only be responsible for a small percentage of collections, but taken together you can quickly find your practice leaving a large amount of revenue on the table. The first 80% of your payments are relatively easy to collect, it’s the next 20% that is harder to obtain and more expensive for an office or a billing company to properly staff the functions that are required to collect your money. You need to efficiently manage each of these billing functions so as to not leave any money on the table. This is money you have earned, so it’s important that you have a team or a partner that is willing to go out and fight for every dollar.

Lee Matricaria is president of Data Management, Inc. (www.dmimd.com)
Should you have questions or comments about this article, please e-mail Lee@dmimd.com or call (309) 693-2636.
Images from the 2010 Region V Dixie Institute in Charleston, SC
Of the more than 450 members that attended, many had group pictures taken during the Wednesday night event, Hollywood Comes to Charleston.
If you missed this Dixie Institute, you missed one of the best Institutes that Region V has put on! At least since the last Dixie SCHFMA sponsored in 2005!
Quotes and Survey Results from the Dixie Institute

“Great topics, speakers, and location - great conference!”

“I want to take a moment to thank the entire team but with special appreciation to Deborah Hunt. She was so special to us and we just feel that she did an incredible job”

“Great job - great sessions - good food and networking”

“Excellent conference. Great location.”

Dear Camie and Tommy:
I wanted to thank you both for organizing what I consider to be one of the best events I have attended in a long time. The planning, the agenda and the attention to detail was terrific. You had a good number of folks supporting you, but it all starts at the Top. Thanks for a great Dixie Institute.

I wanted to take a moment to thank you and all the members of the HFMA Region V Dixie Institute planning committee for showing us what Southern hospitality is all about. I though the conference provided the perfect balance between useful information and networking opportunities...Thank you again for making our first Dixie Institute meeting such a positive experience.

“...What a terrific Institute! I believe the best I’ve ever attended. Thanks for all your many hours, days, weeks and months of hard work.”
A Big Thank You to the Sponsors and Exhibitors who supported the Dixie Institute

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