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NEWSBRIEF

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2006 | 2007

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March Educational Offerings

We have two excellent programs set for this March.

The first one on March 8th is our Geographic Educational Program at San Joaquin Community Hospital in Bakersfield. It features Jayne Kroner from the Cirius Group speaking on the implementation of the UB04 and NPI. Time is short before both NPI and the UB04 is mandatory and Jayne provides some excellent insights. In the second part of the program, Sherreta Lane, from CHA, will be providing a timely update regarding the implementation of AB 774.

Our second program in March will be our all day Educational Program III on March 15th at The Center for Healthy Communities, The California Endowment in downtown Los Angeles. The Center is conveniently located next to the Union Station, so those of you who don't want to drive, can take the train.

There will be an opening general session with Lloyd Bookman from Hooper, Lundy and Bookman speaking on AB 774. There will be break-out sessions after the opening general session and after lunch. Sessions have been prepared by the Government Program Committee, Payer Relations/ Compliance Committee, Finance Managed Care Committee, CFO Roundtable Committee and Long Term Care Committee. The closing general session will be presented by Ron Bangasser, M.D., Beaver Medical Group and Tom Jeffrey, J.D., Davis, Wright & Tremaine, LLP on Pay for Performance.

Visit our web site www.hfma-socal.org for additional information on both programs.

SoCal Chapter Leads Successful Ninth Annual Region 11 Symposium Keynote Speaker Receives Standing Ovation

————— *Debby Chanen* —————

The Ninth Annual HFMA Region 11 Symposium kicked off Sunday January 28, 2007 at Caesars Palace in Las Vegas with an extremely well attended opening night mixer, perfect for networking, catching up with old friends and enjoyment of great hors d'oeuvres, libations and jazzy harp music.

Monday morning, after a very rousing surprise visit by Elvis, crooning personally to many of the female attendees, the educational program started with a keynote address by Dr. Regina Herzlinger, the Nancy R. MacPherson Professor of Business Administration Chair at the Harvard Business School. *Money* magazine has dubbed her the "Godmother" of consumer-driven healthcare and she gave attendees plenty

to think about on that subject. She compared healthcare to various other industries, especially the automobile industry to explain what works in industry and what doesn't and why some of the same principles would work in healthcare.

A panel discussion of State Hospital Association representatives from Region 11 states followed Dr. Herzlinger, highlighting the issues confronting each state organization, and the commonalities and differences amount the states.

Lunch was served in the Symposium Trade Faire where over 100 vendors were sharing valuable ideas and information through their newest systems, software or other products and services.

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FROM THE PRESIDENT'S DESK

Greg Labow



One thing in our line of business that you can count on is change. We are looking at some significant changes with the implementation of AB 774, UB 04 and NPI during the first five months of 2007. At the beginning of this year, Wellpoint formed National Government Services, a result of a merger between five Wellpoint Medicare business organizations. Mergers and acquisitions continue to change the landscape of healthcare. HFMA and the Regional Executive Council have approved a total revamping of the Davis Chapter Management System and the implementation of the Chapter Balanced Scorecard. I personally will be going through some professional changes in the next month or so as well.

We strive for our chapter to provide excellent service back to our membership. One of the ways we can provide this excellent service is to present timely, relevant and quality information through our educational programs. This was clearly the case at our Region 11 Symposium in Las Vegas. Those who had the opportunity to attend can attest to this fact. We will hold two separate geographic programs in less than thirty days with one in Anaheim and the other in Bakersfield. Both programs focus on important educational topics that help you to be equipped with the most up-to-date information available. Our all day program March 15th is packed with a lot of information that you need to work through the many changes that are taking place this year.

However, in order to keep up with changes as they arise and continue to provide quality programs with timely information, we need volunteers to become active within the chapter, serve on committees and move up through chapter leadership. Those who become active reap numerous benefits through volunteering. I can personally attest that only after I became more active in the chapter, did I realize the full benefits of my HFMA membership. Ballots to select next year's leadership are in the process of going out. Along with the ballots, will be a form to indicate your interest in participating on committees within the chapter. Please take a moment and complete the form and indicate the committee(s) that you would like to become involved in. After the forms are received, they will be distributed to the appropriate committee chairs for follow-up with you.

We have been blessed over the last decade or so with a strong base of volunteer leaders. However, this base cannot continue on forever. Change is inevitable and this is true for our chapter as well. We need new volunteers who are interested in leadership roles. Please consider becoming more involved through volunteering.

Sincerely,



Greg Labow, FHFMA

President, Southern California Chapter HFMA

2006 | 2007

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CHA February 11 Update

————— Sherreta Lane, Vice President, Reimbursement & Economic Analysis —————

Rogers Amendment Payment to non-contracting Medi-Cal managed care plans for emergency services

CHA continues to work with the California Department of Health Services (CDHS) to determine instructions and information provided to Medi-Cal managed care plans relative to implementation of the "Rogers amendment." This is the federal law that became effective January 1 which requires Medicaid managed care plans to pay the average fee-for-service contracting rate for emergency services provided by non-contracting hospitals. There are a number of questions (including does this even apply to California; although we can assume the health plans will err on the side of using the average CMAC rates). Information coming from CDHS has been minimal to date, but we continue to request implementation information.

Simultaneously, CHA is looking for data to quantify the impact of this. DHS current activities include sending an All Plan Letter to the Medi-Cal managed care plans instructing them to use the CMAC average geographic rate for payment of out-of-network emergency claims. They are continuing to work on developing the average acute and average tertiary rates that would resemble a fee-for-service rate. As work on development of the rate continues, CHA will be meeting with CDHS, to advocate for an adequate rate that allows DHS to comply with federal law.

Once the actual rates are determined, claims with dates of service January 1, 2007 and after will need to be reprocessed. A copy of the All Plan Letter will be made available to CHA and we will distribute to membership.

Medi-Cal Citizenship Requirement

On February 7, CDHS distributed a final draft All Counties Welfare Directors Letter with instructions for implementing the Medi-Cal citizenship requirement that was contained in the 2005 Deficit Reduction Act (DRA). The DRA requires evidence of citizenship and identity for Medi-Cal applicants and beneficiaries who declare they are citizens or nationals of the U.S.

There will be a final opportunity for stakeholder input in late February. Until the instructions from CDHS are final and the counties and state have received training, etc., current Medi-Cal eligibility processes will remain in place.

NDC Codes

The proposed rule published in the December 22 *Federal Register* indicates that CMS took a broader interpretation of the DRA legislation than the legislation intended. Comments are due February 20. This is the requirement that all outpatient settings report national drug codes to Medi-Cal to allow CDHS to apply for drug rebates.

The over-reach by CMS appears to be in the interpretation of "physician-administered drugs" and applying that to mean all drugs administered in outpatient settings. Another over-reach appears to be in that the legislation allows for the use of J Codes. AHA and CHA legal counsel are working on describing these legal issues and will include them in the comment letters.

CDHS developed a work-around to ensure 340B hospitals can still participate in that program. Some other states are exempting 340B drugs from the NDC reporting requirement. This issue also will be included in our comment letter.

The one thing that would assist both CHA and AHA is an estimate of the cost of implementing this requirement to your facility.

Charity Care

CHA has begun meeting with the sponsor of AB 774, the 2006 charity care legislation, Health Access. A list of issues and questions that need clarification has been developed based on input by CHA membership. CHA will be asking AB 774 workgroup representatives to participate in some of the discussions with the sponsor and DHS to better explain some of the challenges encountered with implementation of this bill. There will be clean-up legislation (the deadline for bill introductions is late February) on this issue in 2007. Some of the issues to be addressed include the application of the bill to patients (for example, those from out-of-state) and services (urgent/emergent to medically necessary to cosmetic), and calculation of the expected reimbursement.

NPI

The NPI becomes effective May 23, 2007. CHA and our national partners will be requesting a 12-month contingency period to allow for appropriate dissemination (and registry) of the NPIs. Medi-Cal is doing NPI training; further information is available on their website at www.medi-cal.ca.gov.

Medi-Cal Eligibility

Medi-Cal is eliminating the use of social security numbers (SSNs) for most eligibility queries/claims processing. This will begin with dates of services March 1, 2007 and later. DHS already has replaced Benefits Identification Card (BIC) numbers to no longer contain SSNs. All providers – with the exceptions of *hospitals*, long-term care health facilities, licensed primary care clinics and emergency medical transportation services – must use the BIC number for eligibility determinations and submitting claims.

Hospitals will be able to continue to use SSNs (although ALL providers – including hospitals – are urged to use the BIC number rather than the SSN) to submit claims. Beginning in

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CHA February 11 Update

Continued from page three

March, the ability to check eligibility without an issue date (available only on the BIC card) will be restricted to use of the AEVS system. Also, batch eligibility also will be subject to the issue date requirement.

CHA is advocating for hospitals to be able to continue to use SSNs for both eligibility verification and claims submission. We are introducing legislation in the event we are unsuccessful in working with DHS on this issue. More information will be provided as it becomes available. Hospital-based physicians and long-term care facilities are working with us on this issue.

Blue Shield 's Proposed Requirement Contracting Hospitals to Submit Laboratory Data

Correspondence between CHA and Blue Shield centered around the proposed Blue Shield requirement that contracting hospitals submit member-level laboratory results data. Many hospitals report they are addressing this issue on a facility-specific basis with Blue Shield.

Fresno Medi-Cal Field Office Closure

The California Department of Health Services announced in January plans to close the Fresno Medi-Cal Field Office. The earliest it could close would be at the end of the fiscal year and probably beyond that – likely the end of 2007. It will mean that all the functions they perform will be reassigned to other field offices, but none of that is known yet. The plan of action likely will appear in the next Medi-Cal provider bulletin.

Hospital-Sheriff Workgroup

Last year, SB 159 addressed the issue of reimbursement to non-contracting hospitals by local law enforcement for emergency services provided to inmates. The legislation also required the formation of a workgroup to address issues of concern to hospitals and local law enforcement. The workgroup has begun meeting and is reviewing a number of issues. The most challenging issue is payment for pre-booking and/or pre-arraignment exams. Some counties reimburse hospitals for these services while others do not.

On a related note, there currently is litigation on this subject. The Superior Court of San Diego issued a ruling in 2005 that found that the "County of San Diego has a legal duty to reimburse Plaintiffs' hospitals for health care services provided to pre-arraignment arrestees brought to one of Plaintiffs' hospitals by a law enforcement agency prior to the booking of the arrestee into the County jail."

As expected, the County is appealing this decision. Original briefs are expected within the next couple of weeks. *Hospitals are urged to continue billing counties for these exams (even if payment is not expected at this time) to preserve their rights in the case of a favorable decision on the appeal.*

Also, hospitals are requested to track examples of sheriffs who are either not complying with SB 159 (which does prohibit the release of an inmate for the purpose of receiving hospital care) or examples relative to the pre-booking issue. CHA will be filing an amicus in the appeal so pre-booking examples will be most useful in that regard. And, SB 159 does sunset December 31, 2008, so examples of "bad actor" sheriffs will be necessary for the debate that will result when the sheriffs go to the Legislature to reauthorize the legislation.

CHA will continue to keep members updated on both the workgroup activities and on the litigation.

UNIVERSITY CORNER

Student Recruitment, Scholarship and Mentoring Committee

Student Scholarship Applications

Applications for the student scholarship program have been distributed to the following campuses: UCLA, USC, CSUN and CSULB. As school has resumed our University Liaisons continue to encourage students to become an HFMA member at the \$18.00 discounted rate and submit applications for this outstanding scholarship opportunity by the 3/01/07 deadline.

Call for Speaker Volunteers

As part of our continued goal and commitment to our key universities, HFMA and its committee has provided some outstanding opportunities and scholarships to upcoming healthcare professionals at UCLA, USC, CSUN and CSULB. Because our goal is to recruit and mentor upcoming healthcare leaders and be part of what HFMA has to offer, we would like to call for volunteers who would be interested in becoming a classroom speaker. In this role you will be asked discuss your professional job, the benefits of a career in healthcare and how HFMA has played a role in your career, from educational events to networking. Interested members please contact:

Annalisa Abbs at aabbs@cbbinc.com or 626-303-1515

Our Committee Needs School Liaisons

As a Liaison, you will meet with the faculty and student organizations to introduce the benefits of HFMA student membership and distribute information on classroom speaker programs, conferences and scholarships. If you are interested in becoming a **Liaison** at USC or UCLA, please contact:

Kymblyn Brown at kbrown@mail.cvhp.org or 626-813-7805

The Student Recruitment, Scholarship and Mentoring Committee, is proud to announce that 21 new students have joined HFMA since July 2006 and we are still growing.

CHA Statewide Payer Relations Meeting

— Greg Labow, FHMA / San Diego / February 7, 2007 —

The CHA Statewide Payer Relations Committee met at Good Samaritan Hospital in Los Angeles on February 7th.

The committee meets quarterly at locations rotating between Sacramento, Los Angeles and San Diego.

The follow is a summary of topics discussed at the meeting.

NGS (formerly UGS) – Juliette Chenian reported that a new company, National Government Services has been formed, effective January 1, 2007. The company is a result of a merger of five Wellpoint Medicare business organizations; United Government Services, AdminaStar Federal, Anthem Health Plans of New Hampshire, Associated Hospital Service and Empire Medicare Services. There is a new web site link which is www.ngsmedicare.com. The home page has links back to the web sites of the five organizations. Juliette has also increased responsibilities. In addition to Provider Education, she is also managing Provider Enrollment for NGS. UB04 training is scheduled for April 5 and 19. Other earlier training sessions are already full. See the web site to sign up. Juliette indicated that more session can be set up if necessary.

Mutual of Omaha – Kelly Collins reported that he is back as the California representative. Computer-based training will be available on Benefit Periods. Kelly indicated that this area will become problematic for hospitals when SNFs begin submitting No-Pay Bills linking benefit periods. Also a presentation on the 3 Day Rule is being made available. He indicated that providers are including charges on claims that are unnecessary, which indicates that more training is needed. SNF Clinical and Billing Training will be provided in Buena Park on March 28th. UB 04/NPI will be covered in upcoming "Ask the Contractor Sessions". See web site for additional information.

Blue Cross Commercial – Cathy Kiaha reminded providers that NPI numbers need to be registered on the Wellpoint web site. This begins 3/1/07. There are two options for this. First is individually and second is to provide a spreadsheet with all of the facility's numbers. Providers questioned their ability to provide physician's NPIs as easily as Blue Cross assumes. There ensued a discussion of all of the problems associated with this issue and the fact that it applies to all carriers who are expecting providers to enroll NPI numbers on their individual sites. Clearly this is a large concern and CHA is working with AHA to push for a delay on NPI implementation.

In terms of UB04/1500 readiness, Nancy Reno reported that they can accept claims, but it is a manual process. The automated process will be effective March 18th. From March 18th to May 23rd both current and new versions can be accepted.

Blue Shield – Yolanda Huston mentioned that those providers having an issue with the new laboratory results requirement should be discussed directly with your Network Manager. This precipitated a long discussion regarding pro-

viders' belief that this decision was completely inappropriate. This "requirement" was apparently based on some decisions arrived at by the CHART group. CHA will invite representatives who can speak to this process at the next meeting in May.

Yolanda reported that they are currently accepting the new UB 04/1500. James Hoey indicated that following up on electronic eligibility, HDX is currently on-board and other companies will be coming up throughout this year.

Aetna – Liz Smalley reported that Aetna will be accepting the UB04 and new 1500 effective March 1st. Peter Van Duine reported that Aetna was rolling out a private fee-for-service Medicare plan called Medicare Open Plan. "Contracting" will be based on provider-initiated calls at time of service. If you accept coverage on these calls, you are accepting the plan and plan rates. If you do not call or do not accept entrance into the network for the patient, payment will be at Medicare rates. This is similar to fee-for-service Medicare plans that other health plans offer. Providers are encouraged to investigate these plans thoroughly in order to be completely aware of what you are getting into.

DHS – Rosemary Lamb reported that the Fresno Field Office will be closing. There have not been decisions yet as to how that work will be distributed to other field offices. They are currently looking at telecommuting capabilities for the on-site nurses. The plan for having only one level of appeal is currently with the Office of Administrative Law. Once that is signed, implementation will be within 30 days. Watch for Medi-Cal bulletins reporting on this.

New committee members were introduced. First was Emilito Smith, Chief, Operations Management Branch, DHS. Second was Mary Hughes, Chief, Provider Assistance Unit, DHS. Their contact numbers respectively are 916-464-3002 and 916-464-1243.

EDS – Cindy Garrett indicated that the sunset of proprietary OP claim forms has been extended to February 19th. The February Medi-Cal bulletin clarifies the March implementation of requiring the BIC number instead of the SSN for eligibility. The SSN will still be OK for use when accessing eligibility through AEVS. Sherreta Lane indicated that CHA will be sponsoring legislation from this requirement.

Cindy reported that only 12% of providers currently are registered for NPI. Medi-Cal will not be implementing all

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Payer Relations Meeting

Continued from page five

aspect of NPI initially. A dual-use period will begin May 23rd. The date for UB04/1500 was moved from March 26th to April 23rd with a two month transition extending until June 23rd. Training will be held March 29th (Long Beach), April 12th (Anaheim), June 14th (Pasadena). Separate NPI sessions will be held in February and March.

Nona Carpenter indicated that providers may be seeing patients coming to them for reimbursement of out-of-pocket expenses going back to 1997. This is due to a court case decision that is explained more completely in the January bulletin.

Blue Shield/ TriCare – Diane Alper reported that TriCare will be implementing Medicare OP PPS effective 6/1/07.

CHA Updates – Sherreta Lane reports in another article, included in *Newsbrief*, most of the pertinent updates coming from CHA. The following are only those items from the meeting that were not in this comprehensive update.

CMS made a number of changes to a proposed rule (April 5, 2006) regarding the Important Message from Medicare in the Final Rule released November 27th. CMS will be developing the revised version of the IM and will obtain public comments on the revised version and the detailed notice in preparation for a July 1, 2007, implementation of the new process. CMS intends to test it with beneficiary focus groups. The policies in this rule take effect July 1, 2007.

AB774 OSHPD reporting requirements have been delayed until January 1, 2008.

Since the transition to Blue Cross Life for CMSP, many operational problems have surfaced in terms of administrative burdens required of providers, as well as claims issues. CHA has held a series of meetings to collect and document these

issues for providers. These issues have been brought up to the CMSP Board and to Blue Cross in an effort to identify a resolution. This ongoing process will be reported on at the next meeting. A meeting with Blue Cross has been requested.

Administrative Day rates for Medi-Cal were to have increased in August 2006. It appears that this may not have occurred but this was not clear in the meeting. Nona Carpenter from EDS will check into this and report back at the next meeting.

Dietmar Grellmann reported on the Hospital Value Initiative (HIV) initiated by Calpers, PBGH and union interests. It is an initiative focused on fundamentally impacting hospital costs to health plans and other payers. The initiative has a number of serious flaws. While CHA and providers were not included in the process initially, recent correspondence and discussions have resulted in providers and CHA having a full "seat at the table" and the opportunity to impact the ultimate direction the initiative takes.

Dietmar also reported on DMHC's pilot Independent Dispute Resolution Process (IDRP) that will run for six months. This process is non-binding. Maximus has been selected as the independent review organization. The pilot IDRP will utilize a "baseball style" arbitration model. In this process, the provider's original billed amount and the payer's original paid amount will be used to determine which amount better reflects the reasonable and customary value of the services performed. To make that determination, the independent review organization must first consider the applicability of existing regulatory criteria outlined in Section 1300.71 of Title 28, California Code of Regulations. If other criteria are deemed applicable to render that determination, the independent review organization is required to describe any additional criteria used and why the criteria was deemed appropriate.

HFMA SO. CALENDAR

2007 EVENTS

- March 8** **GEOGRAPHIC PROGRAM** San Joaquin Community Hospital, Bakersfield / 7:30 am-12:00 pm
- March 15** **CHAPTER EDUCATIONAL SEMINAR #3** Center for Healthy Communities, Los Angeles / All day
- April 19** **CFO ROUND TABLE** Deloitte and Touche, 1500 Rosecrans Blvd., Manhattan Beach / 11:30 am-1:30 pm
- April 22-24** **LEADERSHIP TRAINING CONFERENCE** Manchester Hyatt, San Diego
- May 17** **ANNUAL AWARDS DINNER** Cicada Restaurant, Los Angeles / Time: TBD
- June 23-27** **ANNUAL NATIONAL INSTITUTE** San Diego
- Sept. 9-11** **FALL CONFERENCE** Harrah's Lake Tahoe

Details on all events can be found on the chapter's web site www.hfma-socal.org/

CERTIFICATION EXAMS are scheduled for 8:00 am on the third Friday of each month at Cedar Sinai Financial Services, 6500 Wilshire Blvd 8th floor Training Room (Corner of Wilshire and San Vicente)

Keynote Speaker Ovation

Continued from page one

Monday afternoon consisted of four tracks with two breakout sessions each on topics ranging from Generating Capital from Non-Core Business to Hot Topics in Fraud and Abuse. Following the breakout sessions, attendees again headed to the Trade Faire for an evening reception.

Lou Holtz, one of the most successful college coaches (including several seasons with Notre Dame) was Tuesday's Keynote speaker and his motivational message on overcoming seemingly impossible challenges by setting your own goals and working to achieve them, appeared to be inspiring to all as he was given a rousing standing ovation after his presentation. He was followed by a panel of representatives of three major national payers (Aetna, CIGNA, Wellpoint) and the Blue Cross/Blue Shield Association discussing Health Plan challenges to transparency and quality initiatives. HFMA's National President, Dr. Richard Clarke moderated the panel and after the panel members presented what their organizations were doing in regard to quality and transparency Dick followed up with some questions on how the providers could succeed in the environment that is becoming more challenging to stay profitable. Questions from the audience such as how providers could trust payers, kicked off an informational dialogue between panel members and the attendees.

Tuesday lunch was again served in the exhibit hall for a third chance for attendees to see the many vendors and continue networking opportunities. Breakout sessions on Tuesday afternoon included PRRB Update: Medicare Appeals Today. On Track for 2007: UB-04 and ICD-10 as well as CFO and PFS Roundtables allowing attendees great sharing of new business ideas.

The final day of the 2007 Symposium started with a panel of industry insiders speaking to issues that are still fresh in our mind: Katrina, 9-11 and Bird Flu. The Title was "What Hospitals and Medical Professionals Must Do to Respond to Pandemics and Calamities" and the speakers did offer numerous practical solutions to do this. The Symposium closed with Dr. Dean Ornish, founder, president and director of the non-profit Preventive Medicine Research Institute and also a Professor of Medicine at the University of California, San Francisco, speaking on the Power of Lifestyle Change. The Clinical research that he has directed is demonstrating for the first time that lifestyle changes may begin to reverse even severe coronary heart disease without drugs or surgery. His message was not only good from a personal perspective for most attendees but highlighted some of the newest trends in healthcare that could affect many of our organizations.

Attendance at the event is still being tallied but appears to be once again in the 500 attendee paid registrants range. Total attendees including exhibitors and guests was in the 900 range and once again from throughout the United States. Planning

EMPLOYMENT OPPORTUNITIES

Monterey, California

The gorgeous Monterey Peninsula is located just 2 hours south of San Francisco and at the doorstep of the Big Sur Coast. It is home to seals, otters, Pebble Beach Golf Club, Victorian Homes and an extraordinary 205-bed hospital on a hill that surveys this tranquil setting of forest and ocean. A rare opportunity exists for a

MANAGER OF REIMBURSEMENT

We are searching for a technically proficient Reimbursement Professional – a self-starter and persuasive team builder to lead a change in how reimbursement supports all aspects of revenue capture in our facilities. Our Reimbursement Manager will, of course, be responsible for all Cost Reports, contractials, intermediary audits, and service line analysis. But with the supervision of a CDM coordinator and Revenue Integrity Coordinators our Reimbursement Manager will also interact extensively with all fellow managers of our hospital Revenue Cycle and be expected to have broad influence there.

To view this unique community and the hospital's serenely constructed healing environment, visit Community Hospital of the Monterey Peninsula's website at www.chomp.org. To inquire about the opportunity to become our Manager of Reimbursement contact:

Vickers Chambless / Vickers Chambless Managed Search
vc@vcmsSearch.com or 404-365-0030

SoCal Website Changes

Donna Anglin, FHFMA

As a reminder, the website is in transition. The chapter has contracted with an outside vendor to make our website easier to update so that the information is current. If you haven't visited lately, check it out at www.hfma-socal.org. The home page displays the next three upcoming events, along with links to the HFMA National membership directory and our local educational materials. The Jobs page now has a link for employers to add a job listing themselves. Once approved by the webmaster, the job is posted for a specified time period. We are working on getting the Photo Gallery back up so please be patient while we're "under construction". We hope everything will be updated and working correctly soon. If you have specific comments or questions, please contact Donna Anglin, the chapter Website Contact, at 562-933-1915 or danglin@memorialcare.org.

is already underway for the 2008 Region 11 Symposium which will be held January 27-30, 2008 at Caesars Palace. Mark your calendar now to participate in another outstanding educational and networking experience.

NINTH ANNUAL REGION 11 SYMPOSIUM

JANUARY 28, 2007

CLOCKWISE
FROM TOP RIGHT

Dr. Regina Herzlinger, the "Godmother of Consumer-driven Healthcare" gets the Symposium started with a fascinating presentation

Gail Margolis and Paul DeMuro reconnect with Kathleen Glassie in from Rhode Island

The Symposium Committee gets together with Lou Holtz

State hospital associations update the attendees on the latest developments state-by-state

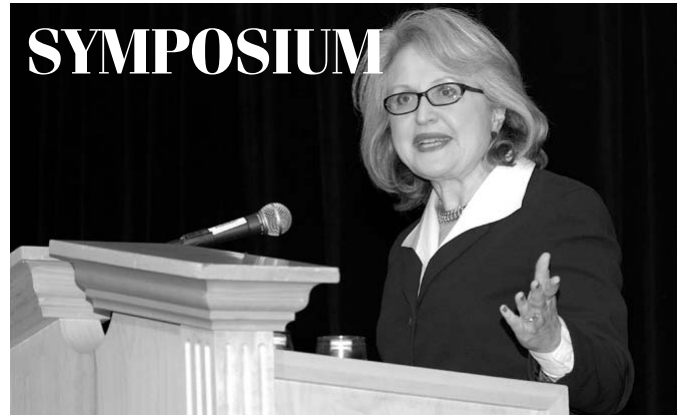
HFMA's own Dick Clark moderates the national payer panel

Lou Holtz captivates the audience

And the winner is...

One of the lucky winners at the Vendor Faire

Elvis serenades one of the Symposium attendees



Banks Can Ease Hospital's Burden Created by California Law AB 774

— Mitch Patridge —

If you're concerned about the ramifications of the newly enacted California Assembly Bill 774, the Mandated Hospital Discount Program, you're not alone.

Though many hospitals throughout the state have already implemented charity care and discount programs, several industry experts predict dire consequences of AB 774 for California hospitals. The mandated offering of zero interest loans under extended payment terms will delay collections and curtail a hospital's cash flow, and more relaxed collection activities (including the elimination of wages garnishment and liens) will likely reduce total overall collections. Additionally, hospitals (or their vendors) must now implement potentially costly systems to manage and collect on these zero interest loans, reducing profits further. In effect since January 1, the new law mandates fair pricing, discounted bills, interest-free extended payment loans and restrained collection practices to two primary groups of patients: (1) financially qualified uninsured patients and (2) financially qualified patients with medical costs that exceed 10% of family income.

California hospitals need not suffer financial or administrative hardships under the state's new law. There are a number of banks that specialize in offering qualifying hospital patients

zero interest loans, taking the burden of this process off hospitals while at the same time increasing cash collections. Further, hospitals can leverage the capabilities of these banks to easily provide other patients with healthcare loans.

Hospitals should consider partnering with an experienced and reputable bank that can meet AB 774's mandates in a cost effective manner. Banks that already have programs in place to meet AB 774's criteria include Torrey Pines Bank in San Diego, the Business Bank of Nevada in Las Vegas and the Sun West Bank in Las Vegas. These specialized banks offer additional expertise and capabilities to address various sections of the new law, including different credit reporting requirements.

If chosen carefully, a bank partner can immediately increase cash flow to the hospital and also reduce overhead costs over the long term by eliminating the need for new in-house programs to address various mandates prescribed by the new law. Here are some important questions to consider before partnering with a bank to meet AB 774's criteria:

- Does the bank have a proven program already implemented in other hospitals?
- Does it have the infrastructure and resources in place to quickly provide zero interest loans to patients? Can it eliminate the necessity for a hospital to hire additional people and implement costly administrative procedures?
- Does the bank have the processes in place to advance the hospital cash against future collections? (This increases cash flow immediately and allows the facility to quickly comply with AB 774 without incurring the added cost of systems and additional staff to manage patient payment plans.)
- Can it offer revolving lines of credit and flexible interest bearing loans to patients who aren't financially eligible under AB 774?
- Does the bank have the processes in place to carry out compassionate collection practices to meet the patient disclosure mandates and credit reporting guidelines of AB 774?

The hospital's goal should be to reduce stress on the patient and boost the hospital's financial health at the same time. There are many people who won't qualify for discounts or loans under AB 774 who still can't pay their bills. It's vital for a hospital to address the financial needs of all patients, at all levels, and to do so with respect and compassion.

For a complete discussion of AB 774 guidelines, refer to the text of AB 774 at http://info.sen.ca.gov/pub/05-06/bill/asm/ab_0751-0800/ab_774_bill_20060929_chaptered.pdf.

Mitch Patridge is CEO of CSI Financial Services in San Diego. He can be reached at 858-200-9201 or at www.csifinancial.com.

SAVE THE DATE

Annual Awards Banquet Thursday, May 17

We have a great tradition of holding our annual May event in unique locations. This year will be no exception. It will be held at the beautiful Cicada Restaurant in the historic Oviatt Building, in downtown Los Angeles. The restaurant, right out of the twenties, originally served as a stylish haberdashery to the Hollywood set in the 1920s. This promises to be a memorable night so make plans now to attend. We are looking into transportation to Union Station for those who may ride the trains into town and into the possibility of conducting tours of the fabulous penthouse.

For further information, please see our web site www.hfma-socal.org. If you are interested in information about the restaurant, the Oviatt Building or the Penthouse, please check out these related web sites:

www.cicadarestaurant.com/

www.oviat.com/html/history/history.html

www.laconservancy.org/tours/downtown/oviat.php4

UB04: The Next Generation of Claim Form

— Carol Eaton —

On May 23, 2007, all claims must be submitted utilizing the new UB-04(CMS-1450) claim form. The UB-92 will be obsolete. The transitional period is between March 1 and May 22, 2007, during which time either UB -92 or UB-04 may be used.

Important dates:

03/01/07: Payors start accepting UB-04 forms

05/23/07: Hospitals MUST submit UB-04 forms

The National Uniform Billing Committee (NUBC) has taken great strides to review and develop the new claim form. The benefits of a new form include greater detailed data going to payers, public health data capturing, added parallel format to the 837 electronic format and future changes that will come down the pipeline. Further detailed information can be obtained by visiting <http://www.nubc.org>.

Modifications include:

ELIMINATED FIELDS

Fields that existed on UB-92, but have been eliminated on UB-04

- 7 – Covered Days replaced by Value code 80
- 8 – Non-Covered Days replaced by Value code 81
- 9 – Co-Ins Days replaced by Value code 82
- 10 – Life Time Reserve Days replaced by Value code 83
- 11 – Unlabeled
- 16 – Marital Status
- 54 – Patient Prior Payments
- 55 – Due from Patient
- 57 – Unlabeled
- 64 – Employment Status Code
- 66 – Employer Location
- 79 – Procedure Coding Method Used
- 85 – Provider Rep Signature
- 86 – Date Bill submitted

NEW FIELDS

- 2 – Pay to Name Address City State-Pay to ID
- 3B – Medical Record Number-Unit Number
- 8 – Patient Name ID Report if different than Subscribers ID
- 9 – Patient Address and Country Code
- 26,27,28 – New Condition Codes
- 29 – Accident State
- 36 – 2 New Occurrence Span codes
- 66 – DXVersion Qualifier
- 67I-67Q – Other Diag
- 70 – Patient Reason for Visit Code
- 71 – PPS Code
- 72 – External Cause of Injury
- 79 – Other ID Qual/NPI/Qual/ID
- 81 – Code overflow fields

The work for hospitals to complete the conversion is a new challenge. Data capture is a large part of what we do in this industry behind the goal of world renowned patient care. The flow of that data has a character of its own. Talented staff is involved and with the ever increasing amount of industry requirements, we're stretched to a fine thread. The cost involved may never really be known. It will depend on each facility.

The code-to-code compatibility should allow for state data dissemination nationwide. HCPCS/Rate/health insurance PPS code reporting will accommodate multiple modifiers and national drug classification numbers (NDC); these could not be handled easily before. The new Present-on-admission indicator will allow for the patient's reason for visit to flow to the claim. The UB-04 was developed with flexibility incorporated into the form for future changes that are expected with ICD-10-CM, increase in diagnosis and procedure codes and more. The following items are potential issues.

The National Provider Identifier (NPI) is the unique new standard identifier for health care providers and HIPAA requires that NPI be used on all electronic transactions by May 23, 2007. We're waiting for the finalized NPI regulations. The task of working with all of the providers to obtain their NPI is on-going. Most physicians have applied or in the process of applying. Teaching providers about the NPI has become a duty of staff that has been self taught or thrives to read the enormous amounts of articles and newsletters on the subject. The hospital and other providers have the duty of entering the NPI in systems and spreadsheets to upgrade systems and communicate with trading partners. Crosswalks may be needed from legacy (provider numbers) to NPI's.

The Taxonomy Code application for our facility types has been confusing for many. The old OSCAR (Online Survey Certification and Reporting System) codes are now cross walking to our appropriate Taxonomy Codes. Facilities (Subparts) must have a clear understanding of how these are used. MLN Matters Number: MM5243 Revised, along with Related CR Transmittal #:R1054CP has the full details.

NPI and Taxonomy Codes are both defined by individual types and facility/organization or provider/human specific categories. This basic understanding helps in the steps to communicate among ourselves to do the necessary work to know what forms and where they will be required.

Many of us come from the days of the UB-82 and hand typing many claims. Now we've moved to the new paper forms and electronic formats. We are now in a generation of constant change. Paper claims will still present challenges to show all of the data elements necessary to show each patient's full picture of services, information and medical conditions.

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UB04: The Claim Form

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Keep a close eye on the information that will be necessary to make the changes. Check with the NUBC web site frequently. Work still to be done will include formatting rules, expanding states and provinces to include foreign countries, separating segments for other operating physicians, rendering provider and referring provider, requirements to report back-dated claim received by re-pricer.

Learn and teach your staff the new form and its unique changes. The staff can be the best tool in finding issues before go-live. TEST, TEST, TEST, that's the best way to migrate to a new form. This will help you work with clearinghouses, vendors, software, edit development and your trading partners. Take ownership in reaching out to these entities and obtaining the steps necessary for us as providers to make the successful move timely.

Related Publications/Articles:

SE0608 – CMS Subpart Policy

SE0659 – Guidance for reporting NPI in Medicare claims

MM4023 – CMS policy for NPI-stage 2 implementation

MM5229 – Modification of NPI editing requirement
of CR4023/MM4023

MM5243 - R1024CP – reporting Taxonomy Codes
for Subpart NPI's

MM5072 – UB-04 Implementation

NPI – <http://www.cms.hhs.gov/hipaa/hipaa2>
and <https://nppes.cms.hhs.gov>

Taxonomy Codes – July 2006 version 6.1
www.wpc-edi.com/taxonomy

*Carol Eaton is Chargemaster/Reimbursement/Compliance
Manager at Citrus Valley Health Partners, Covina, CA.*

Region 11 CFO Round Table

For those who were unable to attend the January 30, 2007 event, following is a consensus summary of Top Educational Topics for the upcoming year:

Region 11 CFO Round Table Educational Planning Summary January 30, 2007

Top Topics (in order of priority)

I. Rate-Setting and Pricing Transparency

- Measuring and reporting community benefits [CA issue AB774-Charity]
- Defending rates [CA – DMHC appeals]
- Self pay management (60% outsourced), focus on intake
- Contract management

II. Regulatory Compliance

- Quality management
- Pay for Performance
- Clinical Research
- Date Share v. HIPAA
- Risk Management
- Patient Safety

III. Cost Management

- Construction Management [CA Earthquake Remediation]
- Staffing Ratios, Sitters
- Managing Pay for Call Coverage
- Workman's Comp Management
- Incidental Overtime Avoidance, Shift Report, 12hr v 8hr shift, Attendance

Other Topics discussed (but accorded lower interest):

Financial Reporting and Disclosure Issues
Reporting on Internal Control
Tax Issues for Tax Exempt Organizations

If you have additional suggestions or questions please contact:

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JANUARY 17, 2007 COMPARISON

Health Care Reform Proposals

— Sherreta Lane, Vice President, Reimbursement & Economic Analysis —

Governor Schwarzenegger, as well as Assembly Speaker Fabian Núñez and Senate President Pro Tem Don Perata, have announced comprehensive plans to fix our broken health care system.

CHA welcomes the leadership of Governor Schwarzenegger and legislative leaders as they seek to make changes to California's health care system. For too long, the problems facing our health care system have languished because they are complex and not easily resolved. The Administration and the Legislature have publicly stated that health care reform is one of their top priorities in 2007. This is a hallmark of courage and leadership that will benefit all Californians.

CHA will actively participate in the legislative process, and we are hopeful legislation will be enacted that will ensure California hospitals have the resources necessary to provide quality care to patients. As the details of the various proposals are flushed out, there must be adequate funding, including funding for the safety-net system. Even when coverage is expanded, the reality is that many individuals will inevitably fall through the cracks. People served by safety-net hospitals must continue to have access to the care they need.

Analysis: The Three Major Health Care Reform Proposals

Governor Schwarzenegger's Health Care Proposal

The Governor's proposal is not yet contained in any specific piece of legislation. Instead, the Governor and his staff announced his proposal on January 8 and released various documents containing the basic elements of his proposal. The following summary is based on these documents.

1) Prevention, Health Promotion and Wellness

The Governor's proposal would implement "Healthy Action Incentives/Rewards" programs in both the public and private sectors to encourage the adoption of healthy behaviors. The program will be based on evidence-based practices and behaviors that have been shown to both reduce the burden of disease and are cost-effective. Individuals in public programs would earn rewards that may include gym memberships or weight-management programs. Health plans and insurers would be required to offer a health benefit package that includes incentives/reward programs, including premium reduction, in the event that an employer wishes to make them available to their employees.

There are four main elements included in the Governor's proposal to prevent medical errors and health care-acquired infections:

1. Require electronic prescribing by all providers and facilities by 2010;

2. Require new health care safety measures and reporting requirements in California's health facilities to reduce medical errors and hospital-acquired infections by 10 percent over four years;
3. Call upon health facility leaders to implement evidence-based measures to prevent harm to patients and provide state technical assistance; and
4. Create a university-based academic "re-engineering" curriculum designed to improve patient safety and streamline costs.

The proposal includes a statewide initiative to institute proven interventions for pre-diabetes and diabetes screening, primary prevention and self-management. The proposal also includes a public health program to tackle obesity, relying on the state's anti-tobacco campaign as a model.

Tobacco use would be reduced further by increasing access to cessation services like the California Smokers' Helpline and maximizing utilization of cessation benefits.

2) Covering All Californians

One of the most important aspects of the Governor's proposal is that the state is finally acknowledging the impact of inadequate funding for the Medi-Cal program. The proposal acknowledges that Medi-Cal, combined with the crushing burden of the uninsured, results in a massive "hidden tax." Thus, the Governor believes that by providing insurance coverage for all Californians, this hidden tax can be substantially reduced or eliminated.

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Health Care Reform Proposals

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2a. Individual and Employer Mandate

Under the Governor's plan, all Californians would be required to have a minimum level of health insurance coverage, enforced through the state income tax filing process. Individuals would be responsible for securing health coverage for themselves and their children, and for helping to pay the cost of their coverage. For very low-income individuals, the governor's plan would provide financial assistance to help pay for health coverage.

A minimum benefits package would be available to all individuals with a maximum deductible of \$5,000 and maximum out-of-pocket limits of \$7,500 per person and \$10,000 per family. This package would include Knox-Keene-mandated benefits plus prescription benefits applicable to commercial HMOs.

Coverage through a new purchasing pool would fulfill an individual's obligation to obtain health coverage. Although dental and vision benefits would not be included in the subsidized benefits, the pool would also offer non-subsidized products so members could purchase richer benefits at their own expense. People between 100 percent and 250 percent the Federal Poverty Level (FPL) would have the option to purchase this subsidized coverage.

Complementing the "individual mandate" would be reforms in the health insurance marketplace that would require all insurers to guarantee coverage for all individuals, regardless of preexisting conditions. At least 85 percent of premiums to insurers must be devoted to patient care.

Employers with 10 or more workers would be required to either offer health insurance coverage or contribute 4 percent of payroll into a purchasing pool.

2b. Coverage for Uninsured Children

All children below 300 percent of FPL, regardless of residency status, would be eligible for state-subsidized coverage. Approximately 220,000 uninsured children below 100 percent FPL would be enrolled in Medi-Cal, while 250,000 between 101 and 300 percent would be enrolled in the Healthy Families program. The remainder would be enrolled through employer-sponsored coverage or pursuant to the coverage mandate.

2c. Coverage for Uninsured Adults

Uninsured legal resident adults below 100 percent of FPL would be eligible for no-cost Medi-Cal. Those between 100 and 250 percent of FPL would be eligible through a state purchasing pool operated by the Managed Risk Medical Insurance Board (MRMIB). The remainder would be expected to enroll through employer-sponsored coverage. Family contributions would range from 3 percent to 6 percent of gross income depending on income level.

In order to maintain equity for low-income people who are already contributing toward the cost of their care, people with individual or employer-sponsored coverage who are between 100 and 250 percent of FPL would be eligible for assistance through the purchasing pool. Anticrowd-out provisions are included to provide a disincentive to employers and employees from dropping current coverage, such as purchasing pool premium contribution levels that are higher than employee-only contribution levels, and making it an unfair business practice to differentiate the employer premium contribution by class of employee.

3) Coverage Dividend

The Governor's proposal includes a "coverage dividend" imposed on hospitals based on 4 percent of net patient revenue (the use of the term gross revenue is meant to identify receipts prior to expenses). (There is a similar 2 percent dividend on physicians). The dividends would be deposited into the newly established Health Care Services Fund, which would be segregated from the state General Fund and used to pay for the coverage initiative.

Statewide, this would generate approximately \$2.4 billion from hospitals. While the proposal indicates this is a trade-off in exchange for relief of the costs associated with caring for the uninsured and Medi-Cal, CHA is concerned about the impact of this component of the proposal on hospitals, and more information is required.

4) Medi-Cal

The Governor's proposal cites a report by the New America Foundation which discusses the "hidden tax." Every insured Californian pays a "hidden tax" in the form of higher premiums to offset the effects of the uninsured and Medi-Cal underfunding. CHA is pleased that this proposal addresses the shortfall that all providers face when treating Medi-Cal beneficiaries.

The Governor's proposal would increase inpatient rates from current levels to approximately 100 percent of Medicare rates. Similarly, outpatient rates are proposed to increase to approximately 80 percent of Medicare. These increases would result in a significant increase in Medi-Cal revenues for most California hospitals. The inpatient rate proposal reduces, if not eliminates, the need for Medi-Cal contracting in California.

The proposal would link future Medi-Cal provider and plan rate increases to specific performance improvement measures, including measuring and reporting quality information, improvements in health care efficiency and safety, and health information technology adoption.

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Health Care Reform Proposals

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4a. Safety Net Care Pool

The Safety Net Care Pool, which was part of the 2005 Medi-Cal hospital financing waiver, currently is used for funding hospital care provided to the indigent by safety-net hospitals. Under the Governor's proposal, most of the funds in the Safety Net Care Pool (\$766 million) would be used to increase Medi-Cal rates and to subsidize coverage for Californians currently without health insurance. This would leave approximately \$24 million in the pool for funding safety-net hospitals.

4b. Safety-Net Hospitals

As many details about the proposal are still unknown, there are a number of questions about the impact of this proposal on California's public and private safety-net hospitals.

5. Affordability and Cost Containment

5a. Hospital Revenues

The Governor's plan contains a requirement that 85 percent of hospital revenues be directed to patient care. (A similar provision is imposed on health plans.) The details of this provision are lacking, and further information is being sought.

The proposal also makes a reference to out-of-network care and health plan reimbursement. This appears to be a reference to the Department of Managed Health Care's (DMHC) proposed regulations regarding non-contracted reimbursement. Thus, it appears the proposal includes some elements of the DMHC regulatory package.

5b. Tax Incentives and Streamlining Initiatives

The proposal would make Health Savings Accounts tax deductible under state law (presently only tax deductible under federal law.) It would also require employers to establish "Section 125" plans so employees can make tax-sheltered contributions to health insurance and save employers additional FICA contributions.

The Governor's proposal would also implement a "24-hour coverage" program that combines and coordinates the health care component of workers' compensation with traditional group health coverage. CalPERS would participate in a five-year pilot program. Statutory and regulatory barriers to expansion of lower-cost models of health care delivery would be removed. This would apply to retail-based medical clinics by making scope of practice changes for "physician extenders," such as nurse practitioners and physician assistants.

Health plan costs would be reduced by reviewing health plan benefit and procedural mandates, allowing electronic transmission of documents between plans and enrollees,

eliminating unnecessary reporting requirements, streamlining product approvals and developing a technology assessment process that would promote evidence-based care.

5c. Health Information Technology (HIT)

The Governor proposes appointing a Deputy Secretary of HIT to lead and coordinate the state's HIT-related efforts to achieve 100 percent electronic health data exchange within 10 years. The proposal would also require universal e-prescribing by 2010, and would provide support for uniform interoperability standards and HIT adoption.

The proposal would allow standardized Personal Health Records, and include the use of the Internet and smart cards portable between health plans. At the county level, a pilot of an Electronic Medical Record system would be implemented utilizing requirements under the Mental Health Services Act.

The proposal would also expand broadband capability to facilitate the use of telemedicine and telehealth, particularly in underserved areas throughout the state.

Assembly Speaker Núñez: AB 8

AB 8 would build on current employer-based coverage, expand existing state/federal programs and extend health coverage to all children as a top priority.

Employers would be required to provide coverage for employees and their dependents or pay a fee based upon a "fair share" percentage of payroll. Businesses with two or fewer employees and less than a \$100,000 payroll would be exempt. Employees would be required to accept coverage when it's offered, provided it does not exceed a "reasonable percentage" of their income.

The bill would create a purchasing pool, the California Cooperative Health Insurance Purchasing Program (Cal-CHIPP), through MRMIB to negotiate and purchase health insurance for businesses and employees who buy into the system.

AB 8 also proposes to expand existing public programs, Medi-Cal and Healthy Families, to those below 300 percent of FPL. AB 8 would standardize screening of applicants for health coverage and increase oversight of pre-existing conditions used to deny coverage. The proposal would impose a surcharge on health coverage premiums to provide coverage for people who are denied coverage because of pre-existing conditions. AB 8 also would specify a uniform minimum package.

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Cost-containment provisions include ensuring coverage of preventive care and disease management, progress toward universal adoption of electronic personal health records and promotion of healthy lifestyles.

The Speaker's proposal aims to implement the children's coverage and the shared employer/employee responsibility by 2008, and then expand coverage to reach unemployed single adults within five years.

Senate President Pro Tem Perata: SB 48

SB 48 would require employers to choose whether to spend a yet-to-be-determined percentage of Social Security wages or to pay an equivalent amount into the Health Insurance Trust Fund (Trust Fund), a fund to purchase health coverage through a purchasing pool. Employers electing to contribute to the Trust Fund also would be required to collect for the Trust Fund an unspecified amount from employees. Employees would be required to show proof of health coverage to claim certain tax credits for themselves and their dependents. Employer contributions and employee fees would be collected by the Employment Development Department (EDD), building on the existing Unemployment Insurance (UI) and State Disability Insurance (SDI) systems.

The state purchasing pool created by SB 48, the Health Insurance Connector (Connector), would be administered by MRMIB, which would be authorized to negotiate rates and offer employees a choice of plans. Competition among plans would be based on price and quality. The Connector would be authorized to "buy in," on a negotiated basis, coverage through the Medi-Cal managed care program. The Connector would be authorized to develop standards for coverage that would include medical, hospital and prescription drug benefits. The bill would require individuals who are employed and those who are self-employed to maintain a minimum policy of health coverage for themselves and their dependents, to be determined by MRMIB.

Subject to future appropriation of funds, to maximize federal funding for low-income families, the bill would expand the Healthy Families program and Medi-Cal to cover children and their parents up to 300 percent of FPL. The bill declares the intent of the Legislature that the Connector pays from the trust the nonfederal share of cost for eligible employees and dependents. Participating plans would be required to cap administrative costs and implement evidence-based practices. Cost containment would include preventative care, promotion of HIT, case-management for chronic diseases, standardized billing practices, reduction of medical errors, incentives for healthy lifestyles, patient cost sharing and "rational use" of new technology.

Plans contracting with the Connector would be required to provide guaranteed issue and community rating. Individuals with pre-existing conditions would be eligible for coverage through the Connector.