

2008 | 2009

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EARLY BIRD REGISTRATION ENDS AUGUST 10

18th Annual California Fall Conference

SEPTEMBER 14-16 • 2008 • HYATT NEWPORT BEACH

Every SOCAL HFMA member should have received a brochure in the mail in June but time is flying and there are only a few weeks until the early bird registration bargain goes away. **GO TO THE WEB SITE AND REGISTER!** at www.hfma-cafallconf.org.

Hotel rooms are limited so after you register be sure to enjoy the group rates at the Hyatt Newport Beach by referencing Code G-HFMA when making your reservations. Group rates vanish after August 1st as well.

Every senior financial executive in California (700 people) received a brochure for the CFO Roundtable event that overlaps with the conference. The CFO Roundtable on Saturday, September 13, 2008 combines Golf with a unique capital markets forum. HFMA has been fortunate enough to enlist Charles Plimpton, one of the nation's pre-eminent investment bankers, to lead the roundtable on capital access. Given the recent melt down in the auction rate security market many CFOs will be sharing war stories and planned campaigns to restore a lower cost of capital and avoid such problems in the future. Participating CFOs will also have the opportunity to play a round of golf at the Pelican Hills Golf Course and then stay over to participate in the very strong Finance Track program on Sunday or enroll in the whole Conference to enjoy Monday and Tuesday sessions.

This year's Fall Conference, jointly sponsored with the Northern California HFMA chapter, returns to Southern California after two years in a row up north. No flights needed for most



of our members to get to Newport Beach (although a helicopter to avoid the 405 would be attractive).

The keynote speaker will be **Steve Ford** (LEFT), Actor and son of President Gerald Ford and Betty Ford, whose keynote is entitled

"Inside the White House and Hollywood, Getting to the Top with Character". On August 9, 1974 Gerald R. Ford assumed the reins of the presidency following the resignation of Richard Nixon. Suddenly, Steve Ford was thrust into the role of "First Son".

Steve's unique perspective on life as the President's son encompasses a broad range of fascinating subjects: being 18 years old and having ten Secret Service agents as constant companions, his father's pardon of President Nixon to help put an end to the infamous Watergate affair, two assassination attempts on his father's life, and his mother's bouts with alcoholism and breast cancer. As an adult actor Steve has been in too many movies and television shows to list here but for a start *When Harry Met Sally*, *Baywatch*, *Dr. Quinn Medicine Woman* and many, many others. Our HFMA committee heard his presentation at the WA/AK chapter and came back with rave reviews. It is not to be missed.

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MESSAGE FROM THE PRESIDENT

James Cummings

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Each year, the HFMA National Chairman chooses a theme for his or her year as Chairman. This year's National Chairman is Bob Broadway, and his theme is "Making Connections". I really like this theme because I, too, believe that HFMA is a great place to make both professional and personal connections.

Our chapter provides an excellent platform for you to make connections. There are committees which are geared toward career tracks in Healthcare finance, and there are committees that are designed to support chapter administration. If you work in Patient Financial Services, we encourage you to join the PFS committee; if you work Medicare Reimbursement, you would be wise to join the Government Programs Committee; and if you are a CFO, I strongly urge you to join the CFO Round Table. Committees meet regularly and discuss current

industry issues. Often times, speakers are invited to committee meetings to give an in depth presentation on a topic of interest. For a list of all committees, visit our chapter web site at <http://www.hfma-socal.org>.

In addition to career-related committees, there are committees that provide administrative support to the chapter. There is the Social and Networking committee that does just what its name implies. In the past, we have gone to plays and sporting events that were planned by the Social and Networking committee. Our first social event this year will be a luncheon and tour of the Getty Villa. Sign up now as there is limited space. There is also the Membership Committee, which plans new member mixers and develops and implements programs designed to increase membership. Last year we had a "Member Get A Member" contest, and the winner received a free trip to Puerto Vallarta.

The current year started on June 1, 2008 and already we have done and planned so much. Many of our chapter members attended the Annual National Institute (ANI) in Las Vegas, Nevada. The Program Planning Committee has put together an excellent education session for August 14, 2008 in Long Beach California at the Airport Marriott and the Geographic Program Committee has set up an excellent program which will be staged in Orange, San Bernardino, and San Luis Obispo counties. Look for announcements regarding the details of these programs in your email soon. Should you happen to miss the email announcing these events, you can always find out what's going on in our chapter by visiting the chapter web site at <http://www.hfma-socal.org>.

If you ever wish to contact me or other chapter leaders, our contact information is listed on the chapter web site. I hope to see you "making connections" at one of our chapter events.

Sincerely,



James Cummings
President, Southern California Chapter




2008-2009 HFMA Board/Committee Chairs

Selling Bad Debts – Making the Decision

— Scott Abram, FHFMA, Director of Collections for Kaiser Permanente —

You've received the calls, emails and mailings from vendors who solicit your interest in selling bad debts. There are many well known companies who specialize in purchasing receivables and bad debt accounts in particular and I'm sure you've heard from them. The concept of selling bad debts is relatively new to healthcare, but it is a long-standing practice in other finance and capital markets such as credit cards, personal loans, etc. Hospital CFOs and revenue cycle leaders have been sheepish about selling debts, and for good reason; it's a new concept to us and there is an element of the unknown that makes us tread cautiously. And besides, bad debts are generally written off so they don't relate to our Days Revenue Outstanding calculation (or as most of us call it, A/R days outstanding) that, beside cash, is our major performance metric for revenue cycle. But bad debt recovery remains an important source of cash, especially when we're managing millions if not hundreds of millions in bad debts. So when should you consider selling bad debts, how would you go about such a transaction, and most importantly, when would you know if you're getting a good deal? To be an effective and progressive leader in the modern healthcare finance and accounting field, it's important to understand this alternative to bad debt management and to formulate a strategy for engaging bad debts sales when appropriate.

Issues and Concerns about Selling Patient Accounts

Perhaps the most significant issue that arises first when considering the sale of patient accounts is the loss of control. Once you sell the accounts, the purchaser owns them and can do whatever they want to collect those debts. This can be rather scary for CFOs, revenue cycle and other administrative leaders who worry about their organization's image in the community. And typically, the conversation is quite short because this concern alone is often enough to quash the entire concept. But there is a solution to this issue and it's quite simple; don't relinquish complete control. It's possible to include a provision in the sales agreement that will allow you to recall accounts that you've sold just like you do now with debts you've placed with your collection agencies. More about this important feature later, but I mention it now because most people would probably stop reading because they know that they would never consider selling accounts due to the loss of control issue. Like most problems, there is a solution.

How It Works

Bad debt purchasers aren't stupid or reckless. On the contrary, they have deep analytical skill and often create proprietary software and algorithms to evaluate the liquidity of a given portfolio to determine its value and craft purchase proposals that include a reasonable margin. They are in the business of buying accounts for a price that is less than they can recover that not only covers their cost, but provides a net gain on their investment. We should expect nothing less from a shrewd and

respectable business partner. They operate a profit-based business and they accept a certain degree of calculated risk in purchasing a portfolio and it's important to keep that in mind. Bad debt purchasing agents generally assess the liquidity of a portfolio and will speak in terms of 'basis points' or what they think the portfolio is worth. One basis point is equal to 100th of one percent and can generally be converted into pennies on the dollar and / or fractions thereof. Once general terms of a transaction are agreed, the Purchase Agreement defines the transaction and legally binds the parties to the agreement so it's important to know what you will agree to in such a transaction and how to craft a Purchase Agreement that meets your needs. But we're getting ahead of ourselves.

Reasons to Consider Selling Bad Debts

Selling bad debts could be a good strategy for you if you need an immediate injection of cash to your organization. It will be 'found' money and can be done relatively quickly. In essence, selling bad debts accelerates the recoveries that you would expect to trickle in over the course of months or years. But that acceleration comes at a slightly discounted value. Other less obvious advantages include the elimination of regular reconciliations of your bad debt inventory and will dramatically simplify cash projections from bad debt sources. Even if you decide not to execute a sale of your bad debts, the examination of your portfolio's value is useful and the process will send a clear message to your collection agency partners that you have high expectations for maximizing the liquidation of your inventory of bad debts.

How to Get Started and Formulate a Strategy

The first thing to do when considering the sale of your bad debt portfolio is to assess its value. This can best be done by preparing a Net Present Value (NPV) calculation of your bad debt portfolio. There's probably a NPV button on that fancy HP calculator that you use all of the time, but you've never had a reason to press it until now. It's wise to segregate your bad debt portfolio into aging categories and identify the historical recovery rate for each aging bucket. Collection agencies typically provide very useful actuarial reports that will serve this calculation well. It's also useful to compare the NPV to the expected recovery rate if you were to do nothing and continue to receive monthly recoveries from your collection agencies. The resulting NPV will be the base from which you can assess whether the proposal that you'll receive seems reasonable given your knowledge of the historical recovery rate. Notwithstanding a detailed dissertation on NPV, suffice it to say that knowing the value of your portfolio in terms of NPV is the key to assessing proposals for purchase and having a logical calculation of value that can allow you to sleep comfortably at night after a decision to accept or reject an offer to purchase.

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Selling Bad Debts – Making the Decision

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Your bad debt portfolio is likely already at collection agency(s) and selling it means that you will be recalling all or part of it from the agency. Your collection agencies are your business partners and you should treat them as such, with respect and professionalism. So, you should advise them of your intent to offer the portfolio for sale and invite them to participate in the bidding process even if purchasing receivables is not one of their current offerings.

Next, develop a Request for Information or Request for Proposal and be sure to include:

- A general description of your organization, the general nature of the bad debts and expected outcomes
- Philosophical requirements relative to the organization
- Healthcare industry expertise of potential purchasers
- Technical specifications for the format and content of an electronic file of the portfolio

Most potential buyers will want to apply their valuation techniques to the portfolio before making an offer. This will require you to prepare an electronic file of the portfolio with all of the data elements necessary for bidders to assess value. Those data elements are basically all of the demographic and transaction data that you have, less things like detailed notes from collection activity. Prior to submitting the data file to potential bidders, you must execute a Confidentiality Agreement, Business Associates Agreement and a Non-Disclosure Agreement or a document that suits all of these concerns.

Once you've evaluated the responses from the bidders, assessed their proposals and selected a winning bid, the next task is negotiating terms of the transaction. It's important to remember that you are the party offering the sale and it is you who should direct the negotiations. The Purchase Agreement must be carefully crafted to include or exclude certain items and other important terms of the sale such as:

• **Whether you will sell the accrued interest.**

The value of your bad debt accounts can be significantly larger than the gross principal balance if you include interest in the sale, but you will likely be required to attest to the accuracy of the interest calculation.

• **Terms for recalling accounts.**

This is where you address your concerns about losing control of the accounts. You may include a provision in the Agreement that allows you buy back accounts at an agreed rate (such as your historical recovery rate) or to recall sold accounts and replace them with accounts of similar age and value. You may hold some accounts in reserve and exclude them for the sale for this very purpose.

• **Flow-forward agreement.**

Besides purchasing the existing portfolio, the purchaser may offer to buy debts on an ongoing basis as you write them off to bad debt rather than send them to a collection agency. Or you may send them to a collection agency and then sell them after a short duration in collections. It's worth exploring if you are satisfied with the purchase price and the overall process. You might also expect slightly better purchase rates from the buyer when a flow-forward process is in place.

• **How to handle accounts with government or other coverage discovered after sale.**

You should give consideration for how you want to handle accounts where insurance coverage is discovered by the purchaser after the sale particularly when government coverage is involved. If you do not want the purchaser to bill third parties with your Provider ID and Tax ID, you may wish to arrange to recall / replace or buy them back.

Conclusion

The sale of bad debts should not be mysterious or perceived as a scary venture. It should be considered as a viable alternative to bad debt management. It is important to understand what selling debts is all about, how it works, and when it's right for you. It's also important to realize that the offer of sale is a process and you should treat it as such. You need to be willing to go through the process and not execute a sale if it doesn't make good business sense for you. At the very least you will end up with a much clearer understanding of your bad debt portfolio's worth and be more likely to project cash flow from recoveries. And, if you formulate a strategy and know what you want out of the transaction, you will be able to control the process. If you know what you want and how you want to arrange the transaction, you'd be surprised at how selling bad debts may be a wise strategy.

RAC'em Up: Are You Prepared for the National Recovery Audit Program?

George Coleman, Vincent Acquisto and Barbara Skier

To date, healthcare organizations in only a few states have experienced the financial impact of the RAC program, but soon, the program's reach will span the United States.

AT A GLANCE

CMS's changes to the recovery audit contractor (RAC) program may not be sufficient to resolve lingering concerns.

With the national RAC program looming, providers should be alert to the challenges the program poses and start developing a strategy to address them.

Filing appeals to challenge RAC determinations can be a lengthy process, requiring a substantial amount of organization and determination.

The federal government believes that the recovery audit contractors (RAC) program, which is scheduled to go national at or before the start of 2010, will recover about \$3 billion in overpayments to providers. The Centers for Medicare and Medicaid Services (CMS) has tested the program in a demonstration project initially in three states: California, Florida, and New York. CMS has had time to take stock of the program and make adjustments in preparation for its ultimate expansion to a national program.

Yet questions remain: Are the changes to the program sufficient to adequately address all of the objections to the program? And when the program begins to take effect for all U.S. healthcare providers, how should providers prepare for it?

The RAC Review Process

Once the national program is under way, healthcare providers across the United States will begin to routinely experience the RAC review process. For those as yet unfamiliar with the process, here's a quick look at how it works.

RACs perform two types of reviews: automatic reviews and complex medical reviews.

An automatic review is a computerized analysis of claims and coding practices. An example of the type of errors identified might be where the provider billed for two units of physical therapy evaluation (a non-time-based procedure may be billed only once).

By contrast, in a complex medical review, auditing personnel study the actual medical record or other documentation. Such a review could, for example, lead to a denial of payment for admission to an inpatient rehabilitation facility (IRF) as not medically necessary, or the recalculation of resource utilization group (RUG) score based on a documented resource use.

In either case, the review process comprises several basic steps: The RAC requests records from a facility, reviews the record

and makes the determination, and then communicates with the facility by letter with the reasons. The RAC also communicates the determination to the fiscal intermediary (FI), which then adjusts reimbursement and documents the adjustment via a remittance advice.

Of course, the facility may rebut an unfavorable decision.

Areas of a RAC review vary between states. Frequent targets in California include diagnosis-related group (DRG) assignments for joint diagnoses, RUG categories, Part B billing, one-day stays, and IRF admissions.

Objections to the RAC Program

The RAC program has been subject to criticism for many reasons. Some critics have questioned the RAC program's emphasis on capturing overpayments. Although the program is also intended to identify underpayments, the amount of underpayments identified as of March 2008, \$10.4 million, is far below the several hundreds of millions of dollars in overpayments that have been identified, giving the unmistakable impression that the program is steeply tilted in CMS's favor versus providers.

Another common criticism is that contractors are paid on a contingency fee basis, which means that they have a financial incentive to find alleged errors. Some critics have expressed concern that such an incentive could tempt RACs to identify errors where none actually exist. Moreover, the contingency fees reflect an additional cost to the Medicare program and the nation's healthcare system, even taking into account the monies that CMS hopes to recover through the program.

Critics of the RAC demonstration also have expressed concern that RAC medical reviews and collections were being performed by unqualified, unlicensed personnel in a manner inconsistent with Medicare rules and regulations. Hospital
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RAC'em Up: Prepared?

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associations in many of the states have requested that the Office of Inspector General investigate the auditing practices of the different RACs.

Another common complaint is that letters informing providers of the RAC's determination have tended not to be specific, often providing only a general statement that the admission or service does not meet Medicare criteria. The provider is thus forced to review its entire medical record to prepare an appeal. Providers are already concerned about the strain on their resources to respond to a high volume of RAC requests, notwithstanding the significant resource commitment required to meet an overpayment determination that the provider believes is unjustified.

And still other concerns have been voiced. Key questions include: What impact will denials have on monies received from patients and secondary insurance for copays and deductibles? Will those amounts need to be adjusted and refunded? To what extent will past claims be subject to new standards? And will the increase in denials resulting from the program lead to reduced access for medically appropriate care and treatment for patients?

Remedial Measures

These objections have not fallen completely on deaf ears. Steps have been taken by states, the federal government, and CMS to improve the program. Here's a look at some activities and developments.

The California experience. In California, CMS has investigated concerns about the RAC charged, under a three-year contract, with reviewing Medicare payments to California providers. After several months of investigation, at the urging of U.S. Reps. Lois Capps (D-Calif.) and Devin Nunes (R-Calif.) and in response to concerns expressed by the California Hospital Association, CMS halted the RAC program during October 2007 to review the program. At the time, the program had already cost IRFs in California an estimated \$105 million in denied reimbursement (see sidebar). CMS requested no more repayments and allowed no medical record requests while the process was reviewed.

CMS hired a company to conduct a validation review of some cases audited by the California RAC. The RAC agreed to forgo its commission on cases that are currently being overturned, and indeed, under its contract, it would be required to return its commission on cases overturned in the first two steps of the appeals process. (In subsequent changes to the program, CMS now requires a RAC to forfeit its commission on cases overturned at any time in the appeals process.)

Beyond the temporary halt to the program, the California Hospital Association requested that CMS address its underlying concerns of the program—in particular, the questions of whether qualified staff were being used to review issues of medical necessity and whether standards or guidelines are being established to allow for a more appropriate audit process and procedure on claims.

The national response. California Reps. Capps and Nunes introduced a bill into Congress, the Medicare Recovery Audit Contractor Program Moratorium Act of 2007 (H.R. 4105), which would place a one-year halt on the RAC program while CMS and the government accountability office conduct in-depth studies of the demonstration project. This bill has 42 cosponsors and potential for Senate support and/or a companion bill.

Hospitals affected by the RAC program have been asked by their respective hospital associations to contact their congressional representatives and request that changes be made to the program to reduce its financial impact on healthcare providers.

CMS's response. CMS has responded to some concerns even in advance of the legislation presented in Congress. The following changes have been implemented:

- As previously noted, there will be no contingency fee when a denial is overturned at any level of appeal.
- Each RAC is now required to have a medical director.
- No claims with a payment date prior to Oct. 1, 2007, will be reviewed regardless of the actual start date for the RAC in a particular state.
- The look-back period for review will be limited to three years.
- Expansion of the RAC program will be staggered in particular regions and states.
- The number of medical records a RAC can request in a particular month will be limited to an as-yet-to-be determined number.
- A web-based application will be required to be in place by January 1, 2010.

How Providers Should Prepare

Healthcare providers should immediately begin to develop a strategy for preparing for the RAC program in their states. That strategy will require the creation of policies and procedures for addressing all RAC-related notifications. Procedures will be required for notifying clinical and reimbursement staff of requests for medical records and of the determinations, to monitor remittances for reimbursement and adjustment, and to maintain records of RAC review requests and all subsequent documentation and communications.

Dedicated staff will be needed to oversee these processes and perform various RAC-related tasks. These staff should come from the clinical-medical area, to handle questions of medical necessity, and from the financial area, to assess impact on overpayment and underpayment decisions. At least one compliance officer also should be included.

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RAC'em Up: Prepared?

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Providers' records of RAC review requests and ensuing activity should include, in the very least, the following:

- Number of claims requested
- Number of denied claims
- Date of reimbursement or recoupment by CMS
- The amount of reimbursement recouped
- All communications between the facility and RAC
- Status of appeals
- Complete timelines

In some ways, it is difficult for healthcare providers to fully prepare for the RAC program because experience with the test program, the administrative law process, the follow-up secondary appeals, and litigation in the U.S. District Courts is as yet still limited. Nonetheless, as a consequence of the RAC program's auditing activities, providers should reassess their operations, admission policies, referrals of patients to rehabilitation, and overall provider services to minimize their vulnerability to RAC reviews due to procedural and documentation deficiencies.

Ultimately, providers should fully understand the RAC appeals process so they can quickly and confidently launch an appeal of any RAC determination that appears to be unjustified and in error.

RAC to MAC: The Appeals Process

In considering appeals, providers should consider:

- The benefit versus the cost of the appeal
- The resources that would be required
- The quality of the medical records, charts, and other documentation
- The implications of challenging or not challenging the denials
- The availability of clinical support and input
- Whether legal counsel should be retained

The question of challenging or not challenging the denials warrants additional comment here. Not challenging a RAC's determination could have a negative impact on a facility's policies and procedures by giving credence to the RAC and causing the facility to institute changes in its patient care. The result could even be an increase in error rates, subjecting the facility to more medical audits.

A provider also has the option of requesting a payment plan, subject to interest, if it cannot financially bear a take-back or denial. Providers can appeal the decision through a normal FI appeal process. During the process, the appeal may be to different persons or organizations, such as the FI, a qualified independent contractor (QIC), an administrative law judge, and the Medicare appeals counsel (MAC).

Filing rules. The filing rules, which are the elementary principles in the appeals process, basically state that filing deadlines begin from the date of the receipt of the RAC's notice of

its decision (presumed in law to be five days after the date of notice) and/or the date of the take-back. This date is referred to as the initial determination.

Appeals are deemed filed when they are received by the reviewing party.

The initial rebuttal. The provider has the option of submitting an initial rebuttal of a RAC's determination that CMS should deny a claim and recover monies paid for the delivery of health-care services. If the provider decides to submit this rebuttal, it must do so within 15 days of the initial determination. However, no such rebuttal is required to proceed to a next level of appeal, and results from initial rebuttals to date suggest that this step may even be a waste of the provider's time and resources. Probably the most compelling reason to submit an initial rebuttal is to gain additional time for considering whether to move on to the first step in the formal appeals process—a "first level" appeal.

First level appeal. A first level appeal is also referred to as a redetermination. This appeal must be filed with the FI within 120 days of receipt of the initial determination. On the appeal, a provider should raise all issues and submit all relevant documents. The FI has 60 days to decide whether the RAC's finding should be sustained or modified. Experience to date is that the initial determination usually is sustained after this level of appeal.

Appeal to the QIC. After receiving a decision of the FI, the provider has 180 days to file an appeal with the QIC. All issues need to be raised in this appeal and supported by all available evidence. Documents and evidence not submitted in this appeal will not be considered in any subsequent appeal, except at the discretion of other tribunals.

In an appeal before the QIC, no appearance by provider staff, clinical personnel, or legal counsel is necessary. The QIC has 60 days to make a decision. This level of appeal has rarely resulted in a reversal of the prior decisions.

Appeal to an administrative law judge. Sixty days after receipt of the QIC's reconsideration decision, the provider may appeal to an administrative law judge in writing or via a face-to-face hearing or teleconference. This is the most formal appeal, short of a court proceeding, in the appellate process, and there has been at least one notable administrative law judge decision in San Diego in which prior denials were overturned.

The administrative law judge hearing is limited to the documentary evidence that was presented at the QIC level. Absent good cause, only the documents submitted at the initial appeal will be considered. Oral testimony is important at this level, and the administrative law judge may request that CMS or the FI participate as either a party or nonparty.

Generally, the hearing will be set within 90 days. Discovery, the legal term for the process of inquiring and gaining information about the appeal from the documentation presented, is permitted only if CMS or the FI participates as a party.

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Providers should keep in mind that all cases involving the same issues may be consolidated for the hearing.

Appeal to the MAC. Sixty days after receipt of the administrative law judge's decision, which may be 90 days after the actual hearing, the provider may submit an appeal to the MAC. The MAC may review the administrative law judge's decision on its own motion, or at the request of CMS. This review is called a review de novo when appealed by a party. A de novo appeal by the MAC is a proceeding, as if a hearing before an administrative law judge had never taken place.

No appearance is required before the MAC, and the MAC may adopt, reverse, modify, or remand the case back to the administrative law judge. The appeal at this stage is limited to the record as presented before the administrative law judge and the possible submission, upon request, of a brief supporting the position of the appellant. The MAC's decision will be received in all likelihood within 60 days following its review, although this time frame is not specified.

Further legal recourse. Sixty days after the receipt of the MAC decision, the provider, if still dissatisfied with the outcome, may file a legal proceeding in the U.S. District Court in the district in which the provider resides, questioning the decision of MAC and the findings of the administrative law judge. The evidence presented at the U.S. District Court is limited to the administrative record only.

Factors and Arguments to Consider on Appeal

In considering an appeal, many factors come into play: There are strict deadlines that cannot be missed, and documentation to support the provider's position on appeal must be secured in an appropriate filing or documentation retrieval system.

Clinical arguments should be specific and indexed to particular patients. Specific portions of the medical record referred to should be clearly organized and tabbed so they can be easily identified for presentation. The provider's response should address, specifically, the reasons for the denial and emphasize why the provider believes that the services were necessary.

A number of arguments have been put forth on appeals that could be compelling to the entity hearing the appeal.

The claim or service was, indeed, medically necessary.

The appeal should document that service was ordered by a physician who understands the appropriate rules governing the determinations that the services are medically necessary. These rules are often unclear, and the RAC is not likely to understand them nearly as well as the physician does. Moreover, if a physician has determined that a service is medically necessary, he or she likely would not know or have reason to know that

the claim would not be covered. Often, providers are justified to question the qualifications of the RAC reviewer who made the determination that the service was not medically necessary.

Past experience has indicated that the service is covered. If the services were deemed medically necessary and covered in the past, the provider can make a compelling case that the services should not now be denied if they had never been audited and disallowed previously. The provider also may be able to point to other providers within the same community that are using the same standards.

The RAC legislation and program have inherent shortcomings. On appeal, a provider has every right to argue the legal issues underlying the RAC program. The financial incentive that RACs enjoy to receive a contingency payment based on the amount of dollars or cases that they recoup remains a controversial point of the program. The FI, QIC, or other entity hearing the appeal may find this point compelling in the provider's favor.

The provider also should ask that the entity hearing the appeal examine whether the RAC's assessment included a physician review and whether the RAC applied its own screening criteria and rules, without any CMS oversight or monitoring. Such a review could expose the RAC's inexperience and the defectiveness of the contractor's review.

A Murky Future?

Ordinarily, establishing an audit process is a legitimate means for the government to examine the provider community. However, it is critically important that such a program be established with appropriate standards and guidelines, and not be conducted by inexperienced contractors with skilled workers who are not given a financial incentive to find errors. The RAC program, it could be argued, has not enjoyed an excellent track record in this respect, and many concerns about the program remain for the future.

At this time, it is not clear what the outcomes will be for the overall appeals processes of providers already affected by the program. No final determinations have been issued in a U.S. District Court, although there have been many hearings before administrative law judges, and the California Hospital Association has reported an 88 percent overturn of the RAC denials.

For most of the provider community, beyond making what preparations can be made today, many of the challenges that the RAC program poses lie ahead in an uncertain future.

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THE REGION 11 EXECUTIVE: Voice of the Region Chapter Leaders to National's Board of Directors and Just One of Several Challenging Roles Bringing Value Back to Chapter Members

————— *Walton K. Luke, FHFMA, MBA, Principal, L.H. & Associates, LLC* —————

The Yearly Change-over

On June 1st of every year, the 11 regions of HFMA, nationally change their Volunteer Leadership. On that day I changed my role from Region 11 Executive-Elect for 2007-2008, to becoming the Region 11 Executive for 2008-2009, assuming this new role from Vickie Morgan, Past President of the Southern California Chapter and Region 11 Executive for 2007-2008. Mickey Duke, Past President of the Nevada Chapter is now the Region 11 Executive-Elect. Each of us has always been mentored through these very challenging positions from our predecessor, and each of us brings our own unique perspectives in trying to make these roles effective and representative for the 7 chapters in our region.

On this day, we also changed-over the 7 Chapter Presidents for Region 11 and I welcome:

Alece Hon

Scripps Memorial Hospital
San Diego Chapter & Imperial County

Greg Moga

Outreach Services / Washington-Alaska Chapter

Traci Kobayashi

Sh Consulting, LLC / Hawaii Chapter

Barbara White

Legacy Health System / Oregon Chapter

James Cummings

J.M. Cummings & Associates / Southern California Chapter

Chuck Acquisto

Law Offices of Stephensen, Acquisto & Colman
Northern California Chapter

Mike Seeley

Seeley Healthcare Consulting LLC / Nevada Chapter

Together, all of us will face our new challenges with enthusiasm and resolve to get things done for our Chapter members in Region 11.

The Role of Region 11 Executive

We all know how challenging the role of the Chapter President has become, but few of us understand the role of the Region Executive. First of all, we have to be elected by the Chapter President-Elects during the Fall President's Meeting (I was nominated and elected 2 years ago by Jack Ruzic, Northern California Chapter President 2006-2007 at the meeting held in Kaanapali, Maui) prior to beginning my term of office as Regional Executive-Elect. We have to be a member in good standing (yes, that means I pay my dues as well), a Chapter Officer for at least 2 years (I am a Past-President of the

Northern California Chapter 1999-2000) and not serving concurrently as a chapter officer (nobody in their right mind would even consider doing that given the amount of time spent doing both roles).

There are a number of duties that the Regional Executive is required to perform:

- **Regional Executive Council** – At least 5 times a year, the 11 Executives join on a conference call with a member of the National Board plus HFMA Staff, to discuss specific agenda issues. In addition, we have face-to-face meetings at ANI, Chicago with the National Board at our National Offices and at LTC. The key to these meetings are representing the needs of the chapter leaders and members in each region, be it Chapter Balance Scorecard (CBSC) issues or regional concerns for the chapters or in our case the Region 11 Symposium.

- **Best Practice Assessments** – At every regional meeting, we solicit best practices from any chapter in our region and we discuss the success of that practice for common goals that any chapter from another region could gain in improved performance. There is also the concern of chapter improvement activities and follow-up with the Chapter Presidents or President-Elects on what they are doing that is different.

- **Annual Chapter President's Meeting** – Each year the Chapter President-Elects, led by the Regional Executive-Elect, review different sites and vote on attending in August/September of any year, a Fall Presidents' Meeting. Last year when we held our Fall Presidents Meeting at the Sun Valley Resort in Sun Valley Idaho, we voted on this year's meeting at Turtle Bay Resort on the North Shore of Oahu on August 16th through the 18th, 2008.

- **Leadership Training Conference (LTC)** – In April of this year, we all attended LTC in San Antonio, Texas; in April of 2009, LTC will be held in Fort Lauderdale, Florida. The Region 11 Chapters will hold a Presidents' meeting there and discuss face-to-face, any issues of concern as well as hold individual Chapter meetings to plan for the on going year. In addition, the Region Executive acts as a Course Coordinator for various training sessions that includes leading group interaction or focus sessions.

- **Fall President's Meeting** – Each of the 11 Regions have chosen different sites in their region to have these meetings; one region will hold their meeting on the Royal Caribbean Adventure of the Seas ship, while 2 of us will hold ours in Hawaii and even another at Fisherman's Wharf in San Francisco, California.

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Annual Fall Conference

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Jeanne Scott, Talking Head in Chief, will kick off Tuesday's keynote with her update on the political scene in Washington. Given that the conference will be in the heat of the pre-election season, healthcare policies should be flying fast and furious. Jeanne will bring her usual wit and insights to provide a sanity check for the sound bites.

Additional General Session speakers include a regulatory update from the California Department of Insurance (Steve Poisner California Insurance Commissioner) and the California Department of Managed Care (Cindy Ehn, Director). Finally, the successful panel that ended last year's presentation will discuss the status of California Healthcare reform and Universal Access. The panelists: Herb Schultz, Senior Advisor for Health Policy, Governor's Office; Duane Dauner, CEO, CHA; Don Crane, CEO, CAPG; Chris Ohman, CEO, CAHP; and Joe Dunn, CEO, CMA.

The Fall Conference's winning formula is to provide many breakout sessions (21 in all), which give our members tools to be used back at the office. The breakout sessions are divided into three tracks; **Patient Financial Services, Finance and Managed Care**. Refer to the brochure you received or download it from www.hfma-cafallconf.org for the complete details.

The Patient Financial Service track will cover CORE topics to help every attendee learn process improvements for the revenue cycle. Two panels of experts will address the important topics of Case Management and Pre-Registration Best Practices. Rudy Braccili from Tenet Corporation will present a session entitled **RAC Audits, When, not If**. In order to keep up with additional Medicare administrative change, we have invited a speaker from the new MAC claims processing organization, Pat Boardley, (J1) Provider and Customer Service Manager of, Palmetto GBA. Another highly specialized program for PFS will be presented by Frank P. Fedor called **Payment for Non-contracted Hospital Emergency Services**.

The Finance track has an unprecedented participation by Southern California CFOs who will participate in a panel discussion on physician hospital incentive alignment. Mitch Thomas from PIH in Whittier and Tim Maurice from CHW Ventura will work with Laura Jacobs of the Camden Group to present the pros and cons of different physician alignment strategies. The finance track will also have financial advisors and investment bankers from Kaufman Hall and Stifel, Nicolaus & Company, to continue the capital markets discussion. The topic of physician hospital relations will also be treated in a novel fashion in a presentation about physician billing companies and hospital relations. Our presenters will include the Executive Director of the HBMA and the CEO and Compliance officer of one of the nation's largest emergency physician billing organizations, EPBS. Other finance track presentations will deal with

Region 11 Executive

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• **Regional Planning** – For the past 11+ years, the Region 11 Symposium has been held in January in Las Vegas, Nevada at Caesar's Palace. The Region Executive, in this case me, will conduct not only a Chapter Presidents' meeting on Symposium issues that covers operations, finance, sponsorship and general concerns, but also HFMA issues on CBSC or region specific issues. Each chapter in the region shares education hours based on attendance by a chapter member as well as sharing of revenues from the success of the event, which also funds the activities of the Region 11 Executives when HFMA National does not pay for their expenses of Volunteer Leadership.

Closing – The Region 11 Symposium

The role of the Region 11 Executive changes yearly dependent on the priority issues involved. For my year, as the Chapter Balance Scorecard re-emphasizes education hours and the economy impacts how many Healthcare professionals can actually attend this conference, we face the reality of looking at how we operate the Region 11 Symposium to continue its success; the issues of "continuity of Volunteer Leadership" and "Succession Planning" are now priority as we move to a new year.

The Southern California Chapter has in the past taken a very active role in running the Symposium; we thank them for their intense involvement but hope that we have not "burnt-out" their Core Volunteers. Our concern as we move forward is to continue involving key Volunteer Leaders into the "Core Leadership" from all of the 7 chapters and prioritize our focus on continuing this successful event. I am thankful to have these 7 Chapter Presidents and their President-Elects to work with, in continuing my role as the Region 11 Executive.

supply chain improvement, fraud protection and Medicare profit improvement with speakers who have gotten top marks from other chapters and the HFMA ANI.

The Managed Care track continues its long tradition of being the best place for managed care professionals to learn the latest in contracting and operational developments. There will be one payer panel dealing with commercial and Medicare contracting issues and another payer panel dealing with Medi-Cal Managed Care, a unique learning opportunity for California-based providers. A third panel will present the provider point of view in "Effective Strategies for Maximizing Contract Performance; Tackling Recent Payor Initiatives". Carol Burkhart from Marsh Consulting will lead a session on Pay for Performance and Paul DeMuro, former President of the Northern California chapter will present a legal update specific to managed care.

Be sure to join us September 14-16th for a wonderful program!

CHA UPDATE

Proposed State Budget Cuts and Impact on Medi-Cal

— Laura Zehm —

There is a slew of information about the Governor's May Revision to his 2008-09 Proposed State Budget and the impact on Medi-Cal Payments. I am sure you have all seen much of it. I will attempt to narrow it down to the key points.

How much are the cuts?

CHA reports that the May Revision of the 2008-09 State Budget includes up to \$232 million in *new* cuts. This is on top of the more than \$1.3 billion in Medi-Cal reductions to all health care providers that were enacted earlier this year and are scheduled to take effect on July 1, 2008.

What gets cut?

- \$22 million for inpatient services provided at hospitals that do not contract with the Medical Program through the California Medical Assistance Commission (CMAC). This represents a 10% rate cut. There is language in the proposal that describes a rate to be applied to hospitals that have no contract with either CMAC or another Medi-Cal managed care plan that is based upon the average CMAC rate for a region less 5% (the so called Roger's Rate). CHA estimates that in most cases this rate is less than half of what hospitals would have received from Medi-Cal with their cost-based weights.
- \$54 million in cuts to some public hospitals through the Safety Net Care Pool.
- \$48 million in reductions to the Disproportionate Share Hospital (DSH) program
- \$12 million in payment reductions in the Medi-Cal managed care program
- \$96 million in losses as a result of changes being proposed to Medi-Cal eligibility and benefits. This is a particularly troubling component of the Governor's proposed budget since it will remove many working poor and uninsured from the Medi-Cal system.
 - Requires enrollees to submit paperwork four times annually to retain eligibility for Medi-Cal services, eliminates dental and other benefits for adult Medi-Cal beneficiaries.

The Administration estimated that half a million Californians would lose coverage.

- Substantially restricts Medi-Cal eligibility for low-income patients with children, which would decrease the number of parents covered by Medi-Cal by approximately 430,000 by August 2011. The restrictions include a reduction in the maximum income level to 61 percent of the poverty line (\$10,736 for a family of three in 2008). Requires that family's principal wage earner works less than 100 hour per month.
- Reduces the services provided to certain legal immigrants.
- Requires unauthorized immigrants to reapply for Medi-Cal monthly to receive emergency services.

What is CHA doing about this?

CHA and other statewide associations sued the state to reverse the 10 percent cuts that are effective in July of this year. CHA has proposed to the state a solution for the two Medi-Cal payment delays and are working for adoption before the first scheduled payment delay in June. CHA is working to block the proposed cuts that are contained in the May Revision. CHA has prepared a Media Statement, Talking Points for hospitals and a Code Blue media kit. CHA is working through the Hospital Councils to schedule hospital meetings with local media about this issue.

What can you do about this?

Work with your Hospital Council and CHA to inform your communities about this issue. As an example, Steve Packer MD, our CEO, Pamela Smith Martin (our Hospital Council representative) and I met with the editor of our local newspaper using the Code Blue presentation prepared by CHA.

Please call me if you have any questions or comments.

Laura Zehm, Vice President & CFO

Community Hospital of the Monterey Peninsula

HFMA Representative on the CHA Board

831-625-4915 / Laura.zehm@chomp.org

HFMA SO. CALENDAR

2008 EVENTS

August 14 **CHAPTER EDUCATIONAL PROGRAM I** Long Beach Airport Marriott / 7:30am - 12:00 pm

Sept. 14-16 **18th ANNUAL FALL CONFERENCE** Newport Beach Hyatt

November 20 **CHAPTER EDUCATIONAL PROGRAM II** SAVE THE DATE / Location TBD / 8:00am - 12:30 pm

2009 EVENTS

January 25-28 **REGION 11 SYMPOSIUM** SAVE THE DATE / Caesars Palace, Las Vegas

March 19 **CHAPTER EDUCATIONAL PROGRAM III** Center for Healthy Communities, LA

June 14-18 **HFMA'S ANNUAL NATIONAL INSTITUTE** SAVE THE DATE / Seattle, Washington

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

Annual Awards Banquet and Installation of the Board Scott Ujita



This year, the awards banquet was held on the 54th floor of the Wells Fargo Center at The City Club on Bunker Hill. This location was secured thanks to the help of Chapter Director David Volk and his colleagues at Davis Wright Tremaine, LLP. The reception and banquet rooms had magnificent views of the city. Scanning the views from one side of the room to the other, I could see Pasadena to Palos Verdes to Hollywood. A couple of hours later, the view transformed into a sparkling sea of city lights as you can see in the above photo.

The evening began in the triangular Angeles Room where you had some time to mingle and catch up with colleagues that you haven't seen in a while. With a drink in one hand and a bacon wrapped scallop in the other, I walked around the reception perusing the guests. It was nice to see past HFMA presidents still attending the awards dinner. I think that the Chapter has been very successful in recent years because of the continued involvement of the past presidents to lend their knowledge and guidance to the new chapter leaders. Here is what a couple of them said about the dinner:

Ira Alexander, Past President 2003-2004.
It is always gratifying to see HFMA members come out to celebrate and recognize the outstanding work that the President, Board and Committee Members accomplish each year. It gets better every year! I am very proud to be involved with the HFMA organization and its commitment to excellence.

Victoria Morgan, Past President 2000-2001.
It's always so nice to see long time friends and especially so many Past Presidents come out to celebrate the Southern California chapter successes. There really is truth to the saying we really are just one big happy HFMA family.

George Colman, Past President 1995-1996.
A beautiful place, wonderful evening...the annual awards and installation banquet is always a special time for HFMA... celebrating the success of the prior year, outgoing officers and board and anticipating another successful and fruitful year with new faces and new ideas...it's a tribute to a wonderful organization...

David Canfield, Past President 1994-1995.
The awards banquet is first and foremost the Region's HFMA Chapter's time to recognize those individuals who have given and contributed to making the Chapter a success over the prior year. It also provides the members with the opportunity to network with friends and associates. A must attend event.



The Crawford Vintage Dance Orchestra.

2008-2009 HFMA President James Cummings with Immediate Past President Debby Chanen.

The transition from reception to the dinner was a brief walk down a window lined hallway with the same magnificent view. The Crawford Vintage Dance Orchestra provided the entertainment for the evening. Dinner started off with tiger prawns wrapped in prosciutto, next was a salad and the main course was a selection of filet mignon, salmon, pasta (for the vegetarians), and chicken. I tried the filet mignon and was very surprised that the steak was a thick, tender piece, cooked with a nice pink center. Very tasty! *Continued on page thirteen*



David Canfield [LEFT] and Pat Nikkhoo from Kaiser are joined by Nick Nikkhoo.

Annual Awards Banquet

Continued from page twelve

The awards portion of the program showcased the members that contributed to the chapter during the 2007-2008 year. The night ended with the installation of the new Chapter officers. It was a very fun evening. Here is a list of the following members and awards that were recognized:

HFMA Southern California Annual Awards

Founders Award | Bronze

David Allen | Stan Augustine | Ed Redfern
Michelle Taylor | Scott Ujita

Founders Award | Gold

Steve Blake | James Cummings

President's Award

Donna Anglin

Outstanding Members

Rick Lash | Scott Ujita

Outstanding Committee Chairs

Steve Blake | James Moynihan
Ira Alexander | King Bechtel

Outstanding Committee Members

Frank Matricardi | Paul DeMuro

Best Article

Greg Labow

Best Presentation

Dave Yerger | Tim Yuen | Ron Knapp

Outstanding Student Volunteer

Natalie Vu

Appreciation Awards | Board

Kymblyn Brown | Kristina Cabral | Sam King
Lynn Otani | Valeria Ruggieri | David Volk

Appreciation Awards | Officers

Chris Kinsey | Greg Labow | James Cummings

Company Support Appreciation Awards

Center for Healthy Communities –
The California Endowment
Deloitte & Touche LLP | KPMG LLP
Latham & Watkins | Progressive Management Systems

Special Appreciation Awards

Lori Kuwahara | Lisa Wada | Agnes Morales

Ten Years with HFMA

Chris Kinsey

Member-Get-a-Member Contest Awards

James Stewart Trip to Puerto Vallarta
Irene Padron Trip to ANI
Satchel Keifer Free Chapter Educational Session of Choice
in 2008-2009

Scholarship Awards

Marilyn Carroll Jackson | Rebecca Mihelic

Battle Of The Alamo: Leadership Training Conference

Each year volunteer leaders from across the country meet at the Leadership Training Conference (LTC) where quality forums are provided to help in planning and achieving your local chapter goals for the fiscal year. This year LTC was held in San Antonio, Texas April 13-15, 2008 at the Hyatt Regency directly on the River Walk and across from the historic Alamo.

LTC is a way for chapter Board Members and Committee Chairs to exchange ideas in different forums and committees to bring back to their chapter that may better improve the value in our Educational programs and *Newsbrief* to name a few. At LTC, hundreds listened to some fabulous speakers such as our National Chairwomen Mary Beth Briscoe, who is always refreshing to hear as she graciously introduced this year's National Chairman, Robert Broadway. In addition, we had two remarkable guest speakers, Roger Crawford and motivational speaker Nicholas Boothman who closed the session.

The Southern California Chapter of HFMA has over a thousand members and is a non-profit organization, so we depend a great deal on the wonderful volunteers that give countless hours on top of their real jobs to give back to the membership. We hope that the tools gained at LTC will help to achieve our chapter goals in the 2008-2009 HFMA year with much success.

Chapter Leaders at the 2008 LTC in San Antonio



Leasing Fixed Assets?

No Silver Bullets, but You Can Simplify and Optimize Your Decisions

— Rich Boyd & Blaine Ung, MBA —

In these challenging economic times, many financial and purchasing executives are focusing on leasing. The financial advantages of leasing are numerous but the major benefits are improved cash flow through lower payments, flexibility when technology becomes obsolete and off balance sheet financing.

- **Too lease or not to lease?**
- **\$1 buyout vs. FMV?**
- **Operating vs. capital?**
- **Direct or B2B exchange?**
- **Fixed vs. floating?**
- **Synthetics vs. tax lease with E.B.O.s?**

Should IT be making leasing decisions or should Treasury? All of the above are good questions but the answer to all of them unfortunately is: It Depends.

When making large fixed asset purchasing decisions, like MRIs or thousands of laptop computers, the method you use to acquire the assets, cash, bank loan, or lease, can devolve into an endless quagmire of decision trees that rely heavily upon your organizations financial policies, corporate philosophy, near and short term cash position, and bank covenants to name a few.

But the two most critical and often overlooked issues lessees face when negotiating fixed asset leases are (1) Are the contractual terms and conditions in the master lease in conflict with your future plans for the technology; and (2) Do you have adequate lease administrative controls in place to manage your lease obligations. ***You may be surprised by the number of issues and the depth of their financial impact!***

Analysis of 3,000 Leases

Having closely evaluated over 3,000 individual lease transactions and interviewing dozens of chief financial officers, treasurers, assistant treasurers, IT professionals and in-house legal counsel over the past 17 years, I can tell you that what many of these decision makers considered at the time to be prudent, financial decisions, quickly turned into ticking financial time bombs because they did not consider the nuances of the master lease agreement and how it can conflict with their organizations short and long term goals.

Let me share with you a real world example of a new client, who incidentally is international in scope and has over \$2B in revenues. Prior to our arrival, this client had acquired 35 telecommunication systems on 60 month leases. In the discovery phase of our engagement, 18 of these systems were in automatic renewal status and had been in that status ***for up to 7 years AFTER the original lease term ended.*** The financial implication of this unfortunate situation resulted in over \$252,000 in excess lease payments (which we could only assume would have continued if it had not been identified by our audit). Consider that because of these excess payments, the original economics of the transactions had been horribly altered. The

over \$252,000 in auto-renewal payments had caused the client to have paid well over 150% of the original equipment cost and they still did not OWN the equipment.

This example points out two key lessons. First and foremost, even though the purchasing and financial executives responsible for equipment acquisition did an excellent job of creating a competitive bidding environment based on just the stated interest rate, there was not enough focus on the terms and conditions of the overall lease. Poorly defined terms or conditions in lease documentation led to the equipment being allowed to enter and remain in an endless automatic renewal status.

Secondly, once the lease was in place, from an administrative perspective, inadequate lease management controls on the part of the company allowed this situation to continue for over 7 years! While you may think this is a rare occurrence, we see this situation on a routine basis.

According to David C. Nelson, former Vice President and Treasurer of URS Corporation, a \$6 Billion engineering and construction management firm, "As I see it, there are a number of pervasive problems within treasury groups across America as it relates to technology leasing. The biggest ones are our limited visibility to lease transactions and our ignorance of how complex the contracts really are. We tend to oversimplify the leasing market and treat it like we are bidding a term loan, which is a rather straightforward proposition. Treasury must take a more active role and help IT and facility groups with leasing decisions."

Conclusion

Please do not let this article diminish the valuable option leasing represents when acquiring fixed assets. As stated in the beginning of the article, the financial advantages of leasing are numerous including improved cash flow through lower payments, flexibility when technology becomes obsolete and of course off balance sheet financing.

However many lessors can be faulted for designing documents that are confusing and difficult to understand and do not take into account the known post acquisition habits of its customers. We highly recommend that you review even the smallest details in lease documentation or seek out the assistance of a specialized advisor. And while there are no silver bullets to handle all situations, make sure you have an exit strategy that fits your organizations needs.

Authors:

Mr. Rich Boyd, Senior Vice-President and Mr. Blaine Ung, MBA, Vice President are from The Optimus Group / 949.862.0555 or info@optimusgroup.com

Who Can You Trust with Your Electronic Claims?

Renae D. Price CPA, CHBME, CMPE

Sixteen years of medical records covering 2.2 million patients — with 1.3 million social security numbers — stolen from a Salt Lake City hospital due to vendor neglect.

It's the kind of story that makes compliance officers nervous.

Nearly every vendor will claim something like "protecting your data is our highest priority." But public relations crises like these raise the question: "How can we be certain that a vendor's security and HIPAA-compliance assurances are real?" For hospitals, health systems, medical groups, and other health-care organizations, that's an increasingly difficult question to answer with confidence.

As a provider, you should be aware that there is an independent, non-profit accreditation organization that represents you. It's called EHNAC (Electronic Healthcare Network Accreditation Commission). Part of its core mission is to ensure that clearinghouses, electronic health networks (EHNs), and other vendors adhere to a range of standards regarding management of claims data. If you're dealing with a clearinghouse that is not EHNAC accredited, you may want to reconsider your risk exposure.

For 15 years, EHNAC has promulgated standards for secure and efficient processing of healthcare transactions. These standards are the product of transparent, voluntary collaboration among EHNs, payers, security organizations, hospitals and health systems, physicians, consumer groups, financial services firms and vendors.

As technologies and best practices have changed, EHNAC standards have evolved as well. Version 9.4 of the EHN standards is freely available online, and EHNAC uses these guidelines for its accreditation activities. Somewhat comparable to Joint Commission accreditation, the first step in the process is a self-assessment. EHNAC's independent reviewers then perform site visits to ensure that physical and organizational safeguards are in place and operational — not just filed away in a three-ring binder.

EHNAC has accredited more than 40 EHNs, and that number is growing precisely because it's a practical way to gain confidence in business partners' security and quality practices. Payers like Aetna, United Health Group, and Kaiser Permanente, for example, require accreditation. And as a proactive measure, New Jersey and Maryland require that payers in those states use EHNAC-accredited clearinghouses.

"We have to ensure that our member's data is secure and privacy is protected," says Tony Rizzi, an EHNAC commissioner and Compliance Director, National EDI Business Operations at Kaiser Permanente. "The EHNAC process allows for a low-cost, private-sector solution that allows us to have greater trust in our EHN vendors. In addition, the EHNAC structure allows

security requirements to evolve as we learn more about the implications of conducting business electronically. Input from the EHNAC commissioners and the public allows us to steadily refine data protection standards that are only generally described in the HIPAA legislation."

EHNAC commissioner Dave Schinderle, VP of finance at Children's Hospital of Orange County (CHOC) sees EHNAC as an efficient mechanism for better business: "EHNAC is the industry's answer to develop and promote best practices within the private sector in a cost-effective fashion. Commissioners are unpaid, and fees paid by accredited entities are kept low by our non-profit approach. At CHOC, we insist that our clearinghouses are EHNAC accredited. We feel that this eliminates substantial risk because we have taken the extra step of having our vendor prove to an external body that security procedures are in place and effective."

The EHNAC seal of approval is spreading to other industries. EHNAC also accredits EHNs that provide e-prescribing services. Draft criteria are also under development for third-party medical billers.

As healthcare information exchange grows, the importance of building trust among trading partners increases. At no cost to providers, EHNAC offers a proven, private-sector solution for establishing business relationships with confidence, avoiding the kind of episodes that make compliance officers nervous.

Renae D Price, CPA, CHBME, CMPE is a member of the HFMA Kentucky Chapter and has been actively involved in the development of EHNAC criteria for third party medical billers.

Welcome New HFMA Members

Gil R. Dolormente Cedars-Sinai Medical Center
Stacy Orfeo Orfeo Consulting
Julie Warfield KForce Professional Staffing
Roxann Leverett Cedars-Sinai Medical Center
Fabian E. De La Torre Student
William DeVitt MPA Consulting
Crystal King City of Hope
Martin J. Coyne Phyxian, Inc.
Krislyn Aldridge Kaiser Permanente
Warren D'Avirro DB Technology
Chris Williams Kaiser Permanente
Jorge Rojas Hoag Hospital
Simin Bemani Health Care Legal Services
Jerilyn A. Newton Downey Regional Medical Center
Bill Wise Karl Store Endoscopy-America
Morrie Maple ALC Healthcare Network
Mark D. Peters Catholic Healthcare West
David J. Coughlin Wachovia Securities
Robert A. Flores
Rosamaria Gonzales Cobery
Rebecca L. Mihelic
Debon Dayrit
Marina Reyes
Matthew S. Bonello

EMPLOYMENT OPPORTUNITIES

REIMBURSEMENT SPECIALIST

Little Company of Mary Hospital, Torrance, CA

Description: Must be able to prepare Medicare/Medi-Cal cost report(s) for acute, SNF, HHA, hospice and home office, and quarterly and annual OSHPD Reports. Experience working with Medicare/Medi-Cal/ Financial auditors and Medicare or Medi-Cal appeals. Preparation of monthly contractual allowances/third party liabilities and financial analysis as requested by Director. Must possess general accounting knowledge.

Requirements: B.A. in Finance or Accounting required. Expert in EXCEL, WORD, ACCESS. Working knowledge of Monarch, Lawson and Medi-Tech systems a plus. Must possess 3-5 years of hospital reimbursement experience. Job posted: 6/30/08.

Apply online at: www.providence.org/careers

Contact: Chris Lewis / L. Natsume – Job Requisition#35609 /

HEALTHCARE SYSTEM CFO

CFO for Benefis Healthcare System in Great Falls, Montana

Benefis is the largest hospital in Montana (516 beds on two campuses) and the largest non-government employer (2,400 individuals) in Cascade County. Benefis provides exceptional health care to approx. 225,000 people in a 15-county service area in North-Central Montana, covering 44,814 square miles.

The CFO will have responsibility for the dual campus enterprise with direct oversight of accounting functions – financial reporting, payroll, accounts payable, and reimbursement/cost reports; as well as patient accounting, patient registration, and materials management. The CFO will work on system-wide projects and be a key member of the System's leadership team.

Contact: Zack Reynolds, Principal at Quick Leonard Kieffer
zreynolds@qlksearch.com / 312.876.9800 / 312.604.7074 (direct)

REGIONAL MANAGER / SALES & DEVELOPMENT

California based receivable solutions company (Collections) is seeking a Regional Manager of Sales and Development for the West Coast.

Company

- Young company (~10 years old), but well established; number one in its field, with an 87% retention rate.
- 8 Regional Sales Managers – each located in 'hot spot' territories designed to expand.
- Growth rate ~33% each year; 235 employees in 33 states.

Candidates should have:

- Direct and indirect hospital business office sales experience.
- Demonstrated experience exceeding goals/quota.
- Knowledge and experience with local market and hospital claims processes.
- Bachelor's degree.

Compensation/Benefit Structure

- Competitive base salary.
- Commission: 4% for first 6 months and 2% thereafter (for as long as you work for the company) for each new account.
- Total compensation by year 2 or 3: 300-400K.

Interested candidates should contact:

Kate Harlow with the Monticello Group
590 Peter Jefferson Parkway, Suite 175
Charlottesville, VA 22911
434-817-5300 x220 / FAX 509-695-8565