

2008 | 2009

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11th Annual Region 11 Healthcare Symposium

— Scott Ujita —

The HFMA Region 11 Symposium is one of the most anticipated events of the year. This year is no different, so mark your calendars to be at Caesars Palace in Las Vegas from January 25th to the 28th, 2009. The Symposium committee has put together an impressive line up of speakers. John Stossel, the co-anchor of *ABC NEWS' 20/20*, will highlight the Symposium this year. He will speak as the first keynote speaker on Monday morning about how American Healthcare is in critical condition. Cam Marston and Dr. Bertice Berry will also speak at the Symposium. Cam Marston will speak about his studies of workforce dynamics and the different generations in the workplace. Dr. Bertice Berry will close out the Symposium. She will give an inspirational talk titled "From the Patient's Perspective." There will also be two panels this year, "Healthcare in the Hot Seat" and "What Keeps a CFO Up at Night." Both of these should be very interesting this year

pending the change from President Bush to Barrack Obama and the current economic situation that is affecting everyone.

There will also be 16 breakout sessions to attend, so there should be something for everyone. The education committee for this year's Symposium worked very hard to get the best possible topics and speakers for you.

Sign up for Symposium by December 31st and take advantage of the \$100 savings for early registration. If you sign up before December 28, 2008 you will also be eligible to win a dinner at the Bradley Ogden restaurant at Caesars Palace. View and download the Symposium brochure at www.hfma-region11symposium.org and click on "Brochure" to get all of the information. You can go to the website to view the sponsors, register for a hotel room, register for the Symposium, view photos of past events and additional contact information.

\$100 Symposium Rebate for Southern California Chapter Members

As the 11th Annual Region 11 Healthcare Symposium approaches, the Southern California Chapter would like to make it more affordable for you to attend this year. To qualify for a \$100 Symposium rebate, follow these steps:

1. You must be a SoCal HFMA Chapter Member in good standing. (Go to www.hfma.org/membership/ to join).
2. Register for the Symposium (www.hfma-region11symposium.org or mail in the registration form).
3. **Attend the conference.** If you register and do not attend, you will not qualify for your \$100 rebate.
4. Within 30 days **AFTER** the Symposium, you will receive an e-mail from HFMA with the rebate form. Complete the form and return it to the Chapter Treasurer, Steve Blake, within the specified time period.
5. The chapter will mail you a rebate check within 30 days.

If you register before December 31, 2008, your net registration cost can be as low as \$495. (\$595 for early registration before 12/31/08 less the \$100 rebate.) I hope that you all consider this offer and the Southern California HFMA Chapter's chance to give back to the membership. If you have any questions, you can contact Lori Kuwahara at 714-279-8675 or e-mail at Lori@hfma-socal.org.

MESSAGE FROM THE PRESIDENT

James Cummings

2008 | 2009

COMMITTEES

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It's December, and my term as President of the Southern California Chapter of HFMA is half over. The first half of the year has been very successful. We have had a record number of educational sessions and attendance has been above average.

Our Geographic Programs continue to be a success at bringing education programs to our members in outlying areas including San Bernardino, San Luis Obispo, Bakersfield, and Orange County.

The CFO Round Table has sponsored several well-attended luncheons where CFOs have discussed many timely issues such as capital financing. Thanks to the efforts of the CFO Round Table committee, CFO involvement has increased significantly over the past few years. We expect that as CFOs continue to gain value from their membership, they will support membership of their staff.

The Membership Committee is diligently working to increase our membership. They are sponsoring a member-get-a-member drive to see who can recruit the most members. The winner will receive a one week stay in a Puerto Vallarta condo along with \$1,000 dollars to pay for a flight and to have a little spending cash. So if you know someone who is not yet a member, you can do them a favor and get them to join and, quite possibly, win a nice vacation.



Attendees at the Educational Program II, November 20th, Embassy Suites, Arcadia.

The chapter's performance this year is outstanding. We are on course to set a record for chapter sponsored education sessions, and I am receiving many positive comments from both members and prospective members on the quality of our education sessions and the excellent networking opportunities at our social events.



The Social and Networking Committee has been performing exceptionally well. I hope you enjoyed the Holiday party at Gazzella Restaurant in Long Beach. Our next big event is the Region 11 Symposium, at Caesars Palace in Las Vegas. I hope to see you there and remember to bring a colleague or friend.

Best wishes for the Happiest of Holiday Seasons.

James M. Cummings

James Cummings

President

HFMA, Southern California Chapter

Continuing Your Education?

— Debbie Lewis —

At a recent HFMA education held in November at the Embassy Suites, Arcadia, I had the opportunity to speak with fellow chapter members and attendees about career paths and education, so I thought of passing along information for those interested in investing in your development and success with a specific Health Care MBA program that meets one weekend a month. The UC Irvine Paul Merage School of Business has a program to meet the needs of busy working professionals.

The **Health Care Executive MBA (HCEMBA)** is a comprehensive academic experience exclusively for individuals working in the healthcare industry, designed for professionals who want to expand their business expertise, and gain the fundamentals of management and a thorough understanding of the economic, political, and social dynamics that have reshaped the global healthcare industry. Students come from the intersecting worlds of pharmaceuticals, medical devices,

managed care, insurance, health care services and health care policy. Participants have significant relevant work experience averaging about 12 years and demonstrate leadership abilities and a proven track record of success. This 24-month program begins each fall and classes meet one weekend/month, starting Thursday at 7pm and continuing until noon on Sunday, for 8 consecutive quarters at The Paul Merage School of Business.

The curriculum is a carefully structured program that assures each student's exposure to the full range of disciplines, which are essential components of a management education. The core and elective courses are specifically customized for application to a healthcare professional's daily challenges. Distinguished speakers from the industry augment the educational content and are integral in the program. This activity has been approved for Continuing Medical Education (CME) credit.

In addition to the two weeklong residencies, students participate in an in-depth academic, weeklong seminar where students meet healthcare industry leaders and learn legislative and regulatory process that effect healthcare.

AND – for a limited time there is an extra incentive to pursue the program as soon as possible to avoid paying 3-5% more in tuition costs. Candidates who submit a completed* application on or before February 1, 2009 midnight, receive an offer of admission, accept their seat prior to March 2, 2009, and enter the program in Fall 2009, and will lock in the current tuition rate of \$86,250 for the duration of the 24 month program.

[*a completed application includes the online application, 3 applicant essays, 2 letters of recommendation, official GMAT score reports (if applicable) and all official transcripts. Offers of admission are extended by the Admissions Committee upon review of a completed application.]

Further information may be obtained by contacting the University of California, Irvine, The Paul Merage School of Business, Executive MBA Programs office at, MPAA 101, Irvine, CA 92697-3130; calling 949-824-0561; visiting www.merage.uci.edu/HealthcareExecutiveMBA or contacting Associate Director for Recruiting, Debbie Lewis, directly at 949-824-7241.

Debbie Lewis is Associate Director of the Health Care Executive MBA Program at The Paul Merage School of Business.



Certification Exams

The HFMA Southern California Chapter would like to encourage its Members to take and pass the National HFMA Certification Examinations.

2007-2008 Exams are available until December 31, 2008 for a first-time attempt at that exam. Candidates who are unsuccessful on the 2007-2008 exams are eligible to retake it one more time after the requisite 90-day wait period has been met and prior to April 11, 2009. After April 11, 2009, only the 2009-2010 exams will be available for any subsequent retakes. All retakes require a new exam application be submitted with the appropriate fees.

2009-2010 Exams will be available January 12, 2009. The exams cost \$125 each. Exam applications submitted after December 31, 2008 will be charged at the new rate.

Administrative procedures remain the same. Exam candidates and proctors will receive the needed passwords via the e-mail address in their member record approximately 3-5 business days in advance of the exam date. Candidates will receive exam results immediately and are sent a score confirmation message via e-mail.

For more information, please call Peter Lee, Chair Certification Committee at 818-991-4622 or e-mail him at peter.lee@prosperusrcm.com.

DMHC SESSION HIGHLIGHTS

Underpayments and Using the State Provider Complaint System

— Ed Norwood —

On November 20, 2008, the PFS/Payor Relations/Compliance Committee hosted a session on the DMHC Complaint Process, Balance Billing and How to Use the New IDR to Challenge Underpayments. Gary Baldwin, Senior Counsel with the California Department of Managed Health Care was our guest speaker and below is a few highlights from his presentation and the engaged interaction (or discussion) that followed:

1. Independent Medical Review (IMR)

IMR is available to providers if a plan denies authorization *BEFORE SERVICES ARE RENDERED* as not medically necessary, investigational or experimental.

Health and Safety Code 1370.4 (c) states: *The independent medical review process shall also meet the following:*

(1) *The plan shall notify eligible enrollees in writing of the opportunity to request the external independent review within five business days of the decision to deny coverage.*

(2) *If the enrollee's physician determines that the proposed therapy would be significantly less effective if not promptly initiated, the analyses and recommendations of the experts on the panel shall be rendered within seven days of the request for expedited review. At the request of the expert, the deadline shall be extended by up to three days for a delay in providing the documents required. The timeframes specified in this paragraph shall be in addition to any otherwise applicable timeframes contained in subdivision (c) of Section 1374.33 (Emphasis added.)*

Section 1374.30 (d) (2) adds: *In any case in which an enrollee or provider asserts that a decision to deny, modify, or delay health care services was based, in whole or in part, on consideration of medical necessity, the department shall have the final authority to determine whether the grievance is more properly resolved pursuant to an independent medical review as provided under this article or pursuant to subdivision (b) of Section 1368.*

In conclusion, an enrollee may apply to the department for an independent medical review when all of the following conditions are met:

- *The enrollee's provider has recommended a health care service as medically necessary, or*
- *The enrollee has received urgent care or emergency services that a provider determined was medically necessary, or*

Amy Bernardino and John Marshall speaking on *How To Prepare For The "Red Flag Rules" and Other Privacy and Identity Theft Issues.*



- *The enrollee, in the absence of a provider recommendation under subparagraph (A) or the receipt of urgent care or emergency services by a provider under subparagraph (B), has been seen by an in-plan provider for the diagnosis or treatment of the medical condition for which the enrollee seeks independent review. The plan shall expedite access to an in-plan provider upon request of an enrollee. The in-plan provider need not recommend the disputed health care service as a condition for the enrollee to be eligible for an independent review. For purposes of this article, the enrollee's provider may be an out-of-plan provider. However, the plan shall have no liability*

for payment of services provided by an out-of-plan provider, except as provided pursuant to subdivision (c) of Section 1374.34.

- *The disputed health care service has been denied, modified, or delayed by the plan, or by one of its contracting providers, based in whole or in part on a decision that the health care service is not medically necessary.*
- *The enrollee has filed a grievance with the plan or its contracting provider pursuant to Section 1368, and the disputed decision is upheld or the grievance remains unresolved after 30 days. The enrollee shall not be required to participate in the plan's grievance process for more than 30 days. In the case of a grievance that requires expedited review pursuant to Section 1368.01, the enrollee shall not be required to participate in the plan's grievance process for more than three days (1374.30 (j)).*

Decisions in favor of the provider require the plan promptly implement the decision. In the case of reimbursement for services already rendered, *the plan shall reimburse the provider or enrollee, whichever applies, within five working days*. In the case of services not yet rendered, *the plan shall authorize the services within five working days of receipt of the written decision from the director, or sooner if appropriate for the nature of the enrollee's medical condition, and shall inform the enrollee and provider*

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DMHC SESSION HIGHLIGHTS

Underpayments and Using the State Provider Complaint System

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of the authorization in accordance with the requirements of paragraph (3) of subdivision (h) of Section 1367.01.

H&S §1374.34 adds: (b) A plan shall not engage in any conduct that has the effect of prolonging the independent review process. The engaging in that conduct or the failure of the plan to promptly implement the decision is a violation of this chapter and, in addition to any other fines, penalties, and other remedies available to the director under this chapter, the plan shall be subject to an administrative penalty of not less than five thousand dollars (\$ 5,000) for each day that the decision is not implemented. Administrative penalties shall be deposited in the State Managed Care Fund (Emphasis added).

2. IPA Payment Failures

Mr. Baldwin also provided insight on how the DMHC grades IPA or risk-bearing organizations that have delegated payment responsibilities under Knox Keene Plans:

(1)(A) A process for reviewing or grading risk-bearing organizations based on the following criteria:

(i) The risk-bearing organization meets criterion 1 if it reimburses, contests, or denies claims for health care services it has provided, arranged, or for which it is otherwise financially responsible in accordance with the timeframes and other requirements described in Section 1371 and in accordance with any other applicable state and federal laws and regulations.

(ii) The risk-bearing organization meets criterion 2 if it estimates its liability for incurred but not reported claims pursuant to a method that has not been held objectionable by the director, records the estimate at least quarterly as an accrual in its books and records, and appropriately reflects this accrual in its financial statements.

(iii) The risk-bearing organization meets criterion 3 if it maintains at all times a positive tangible net equity, as defined in subdivision (e) of Section 1300.76 of Title 10 of the California Code of Regulations.

(iv) The risk-bearing organization meets criterion 4 if it maintains at all times a positive level of working capital (excess of current assets over current liabilities) (Emphasis added.)

28 CCR §1300.75.4 (b) requires every contract involving a risk arrangement between a plan and an organization to require the organization to submit to the Department, not more than forty-five (45) days after the close of each quarter of the fiscal year, a quarterly financial survey report in an electronic format to be supplied by the Department of Managed Health Care (Department) pursuant to section 1300.41.8 of Title 28, California Code of Regulations, containing various requirements including:

(B) A statement as to what percentage of completed claims the organization has timely reimbursed, contested, or denied during

the quarter in accordance with the requirements of Health and Safety Code sections 1371, and 1371.35, section 1300.71 of Title 28 of the California Code of Regulations, and any other applicable state and federal laws and regulations. If less than 95% of all complete claims have been reimbursed, contested or denied on a timely basis, the statement shall be accompanied by a report that describes the reasons why the claims adjudication process is not meeting the requirements of applicable law, any action taken to correct the deficiency, and any results of that action. This claims payment report is for the purpose of monitoring the financial solvency of the organization and is not intended to change or alter existing state and federal laws and regulations relating to claims payment settlement practices and timeliness (Emphasis added).

By the way, this is great for contracting departments to use on anniversary dates to negotiate better rates or correct deficiencies with plans.

3. Plan Terminations

Mr. Baldwin said that if a plan contract affects 2000 or more enrollees and is being terminated with a hospital or medical group, the DMHC must be notified (See 28 CCR § 1300.67.1.3).

4. Refund Requests

Mr. Baldwin reported that the DMHC has seen quite a few Knox Keene Plans violating the notice requirements for Reimbursement Requests and Offsets. They are just arbitrarily recouping the money without 1.) Providing prior (separate) notices identifying the overpayment and 2.) A written explanation as to why they believe the claim was overpaid as required by law. The DMHC would like to see any examples of similar problems with your facility.

5. Balance Billing Regulation

The Balance Billing Regulation only applies to emergency services and care (medical screening, evaluation and examination), NOT authorized post-stabilization care as defined under section 1262.8. The balance billing regulation affects claims with a date of discharge of 10/15/08 and after.

6. Independent Dispute Resolution Program (IDRP)

The IDRP is a voluntary program, which means even if you attempt to arbitrate an underpayment, the plan can still refuse to participate which leaves you at a standstill. It needs massive overhauls, which may not take place unless the DMHC sees a large number of affected claims filed by providers with refused participation by the plan.

(I've included law references for your review and added additional commentary that may support your appeal positions in the future.)

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Underpayments: Using the State Complaint System *Continued from page five*

Application for Providers

If you're a non-contracted provider, I would encourage you to:

- Track payment trends prior to October 15 to determine what % of billed charges you are receiving in all underpaid claims.
- Then track payment trends since October 15 to see if that percentage has dropped.
- Submit all underpaid payment trends to jerilin.Cummings@valleyhealthsystem.com so we may analyze and bring them to the attention of the DMHC.

If you'd like a copy of Gary's PowerPoint Presentation or to join our committee, send an e-mail to ednorwood@ementerprises.org.

Welcome New HFMA Members For 2008-2009 Fiscal Year

J. Bouganim	Cedars-Sinai Medical Center	Megan North	Cap Management Systems
Gil Dolormente	Cedars-Sinai Medical Center	Richard Olsen	Cedars-Sinai Medical Center
Eric Tescher	Decision Intelligence Metrics	Vanessa Tu	Presbyterian Intercommunity Hospital
Oumar Toure	Magan Medical Clinic	Ann Watts	Skomar Systems
Kevin Abbott	Toshiba America Medical Systems	Caroline Wong	LTC Properties
Pian Lau	Orange Coast Women's Medical Group	Karen Dizon-Villegas	Catholic Healthcare West
Sal Esparza	California State University Northridge	Lailani Payumo	Catholic Healthcare West
Michael Kent		Dennis Kikuno	Torrance Memorial Medical Center
Wendy Newman	Amn Healthcare	Donovan Ayers	Clear Vision Information Systems, Inc.
Blaine Ung	The Optimus Group	Nancy Figueroa	Healthcare Resource Group
Paul Cloney	White Memorial Medical Center	Barbara Grant	
Amanda Han	Riverside Regional Medical Center	Scott Gregory	Gallagher Benefit Services
Chris Fritz		Kimberly Harris	Marina Del Rey Hospital
Aaron Neuharth	Irvine Medical Center	Layla Walle	Progressive Management Systems
Renu Chokshi		Don Phan	MSO Inc. of Southern California
Mimi Extance	Scripps Healthcare	Narasimham Kota	Desert Valley Hospital
Brad Armstrong	Top Tier Consulting	Melba Espiritu	Chapman Medical Center
Maurice Smith	Medassets	Diana Davis	Community Memorial Health System
Vi Colunga	Bear Valley Community Healthcare District	Jaimie Ucuzoglu	Navigant Consulting
Michael Engelhard	Caloptim	Connie Horstkotte	FSC Securities Corporation
Sindy Vasquez	Asap Staffing, Inc.	Kelvin Matute	Good Samaritan Hospital- Los Angeles
Sarah Acosta	Kaiser Permanente	Benjamin Laube	Kaiser Permanente
Linda Kaplan	Kaplan Communications Group	Brian Swan	Cygnus Health Care
John Osborne	Siemens Medical USA Inc.	James Gin	Chino Valley Medical Center
Richard Eidinger	Heidrick & Struggles Inc.	Meixiang Zheng	Chino Valley Medical Center
Alan Stearns	Lockton Companies	Sandra Draper	
Tom Szostak	Toshiba America Medical Systems	Donna Montague	City of Hope Medical Group
Reid Aaron	Doheny Eye Centers	Ramon Olivera	Cedars-Sinai Health System
Leigh Bohnet	Readylink Healthcare	Paola Puentes	UCLA Patient Business Services
Lou Sico	Kaiser Foundation Health Plan	Helen Remenyuk	Apria Healthcare
Jeffrey Lawrence	GHX	Deborah Crimmins	Health Information Partners
Carol Jeske	Telecare Corporation	Laura Drake	New Leaf Staffing, Inc.
Marianna Kmbikyan	CHW - Glendale Memorial Hospital	Michael Ruggieri	Wells Fargo
Erica Roach	CHLA	Ed Palomo	Hit Management Consulting
Maria Alizondo	Caban Resources, LL	David Pape	MedAptus
Diane Angone	Eisenhower Medical Center	Jack Delpit	UCLA Resnick Neuropsychiatric Hospital
Robert Beresford	Skomar Systems	Howard Kung	Paramount Healthcare Resources Llc
Mike Foster	EmCare	Susan Smith	The Camden Group
Carolyn Frate	St. Joseph Health System	Tamara Austin	City of Hope National Medical Center
Blanca Gutierrez	City Of Hope Medical Center	David Carter	DaVita, Inc.
Cindy Hirsch	CDR Financial	Ben Harber	College Health Enterprises
Anita Howse	Cedars-Sinai Medical Center	Susan Taylor	Bakersfield Memorial Hospital
Julie Larkins	CDR Financial Products	Queen King	St John's Pleasant Valley Hospital
Charlie Lydon	Allied Irish Bank	Casandra Blocker	Alliance Bank
Denise McDowell	Motion Picture & Television Fund	Linda Mounce	GHX
Joanne McLaughlin	Skomar Systems	Janice Gunter	Children's Hospital Los Angeles
Jason Merkel	Affinity Bank	Brandy Rosero	Hayes Management Consulting
Helen Mosley	White Memorial Medical Center	Anita Johnson	

GEOGRAPHIC EDUCATION PROGRAMS

Programs Return to Bakersfield for the Second Time This Year

— Sam King —

Our chapter covers extremely large geographic regions. As such, one of the challenges of providing quality educational programs is to offer on-site sessions to the members in outlying areas. Thanks to the chapter volunteer efforts and support from facilities, the Geographic Programs Committee was able to offer the 2nd half-day event this year in Bakersfield on November 14th at Mercy Hospitals of Bakersfield, co-sponsored by the Northern California Chapter.

The topics of the November 14th session were "Winning the Battle for Workers Compensation Account Recovery", and "Protecting Your Revenue with the Power of Proof". The first speaker, Alice Branch, was back by popular demand after three consecutive days of speaking in July's educational sessions. As in the previous sessions, Alice captured everyone's attention by providing interesting and useful information and discussions in a fun and interactive way. Attendees gave very high remarks for the subject and the speaker. They were able to learn:

- What is a "Work Injury" and "First Aid" and what are your recovery options
- How the fee schedules work
- How to assert penalties and interest for non-payment

- Which laws to wield to get insurers to pay attention to you
- When it's time to stop wasting your time and go to the Workers' Compensation Appeals Board (WCAB)

The second speaker, Ken Cassell, discussed "Protecting Your Revenue with the Power of Proof". As Ken stated: "Every day, hospitals render services for which they never receive payment. To obtain accurate reimbursement, hospitals need tangible evidence of steps taken to secure payment." He presented the concept of a communication management system that documents routine business exchanges to improve revenue cycle performance. Attendees heard how hospitals have leveraged communication records to protect revenue, prove compliance and drive performance system-wide. The attendees' positive feedback indicated that they achieved their learning objectives:

- Use communication records as evidence to prevent and overturn denied claims.
- Streamline communication to reduce costs and improve staff productivity.
- Monitor archived communication to improve quality and accountability.

In summary, this educational program attracted a high number of attendees from in and around the Bakersfield area and was intended to serve both Northern and Southern California members. My special thanks and appreciation go to Mercy Hospitals of Bakersfield, particularly two executive coordinators, Arlene B. Ramos-Aninion and Sandra Perez, and Vice President of Finance, Chief Financial Officer Rodney B. Winegarner, for their generous support for providing the conference facility, food and on-site assistance.

CAREER OPPORTUNITY

Title: Head of Reimbursement
Company: Providence Health & Services
Location: Portland, Oregon

Providence Health & Services in Oregon is recruiting for a leadership position responsible for reimbursement activities for the entire network of seven hospitals within the Oregon region, with revenues totaling \$2.8B. Successful candidates will hold a Bachelors degree and at least 10 years of experience preparing Medicare, Medicaid, and Champus cost reports for mid to large-size hospitals and/or health systems. Providence Health & Services is rated one of the best employers in Oregon and is a national award winning health system across a five-state area: Alaska, Washington, Montana, Oregon and California. The system employs more than 47,000 employees, operating 27 acute care hospitals, and more than 35 non-acute health care facilities, as well as physician clinics, health plans, and numerous other health and education services.

Apply at www.providence.org/careers #43249 or contact our recruiter: Fiona Gladden / Executive Recruiter-Oregon 503-215-4163 or fax: 503-215-4770
fiona.gladden@providence.org

HFMA SO. CALENDAR

2009 EVENTS

January 25-28 REGION 11 SYMPOSIUM
 Caesars Palace, Las Vegas

February 20 CFO LUNCHEON
 Santa Ana / 11:30 am - 1:30 pm

March 19 CHAPTER ED PROGRAM III
 Center for Healthy Communities, LA / 8 am - 4:30 pm

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

Gaining Visibility and Control Over Your Collection Agencies

How to Adequately Compare Your Collection Agencies' Performance

————— Steven Levin, President, Connance, Inc. —————

Hospitals increasingly rely on third-party collection agencies to work patient accounts. Today, day-to-day management of these relationships is cumbersome and unproductive as hospital resource time is consumed with auditing and reconciling vendor invoices and files. Limited visibility into vendor activity and inconsistent reporting make performance reviews across vendors virtually impossible.

As patients today are directly shouldering a greater share of healthcare costs than ever before, hospitals need to gain visibility and control over their self-pay collections in order to maximize cash flow. By better managing agencies, hospitals can realize more cash with greater oversight while substantially reducing administrative burdens. In addition, hospitals must ensure they continue building stronger relationships with their patients by being able to supervise agencies' daily activities.

Step 1: Consider New Approach

Innovative companies in other industries, such as telecommunication companies and multi-line financial institutions, have embraced technology to improve collection agency management. Using three or more primary and secondary collection agencies, these companies do not rely on alpha splits and account balance size to simply place accounts. Instead, they use technology to manage the placement, reconciliation, and auditing activities – all activities that tax scarce internal resources. These creditors have realized consistently increased cash yields from any single agency, reduced clerical costs, improved handling of exceptions in the collections process, enhanced customer satisfaction with their agencies, and the ability to optimize their portfolio of agencies. Their agencies also experience improvements including less clerical activity, fewer administrative calls and better creditor engagement.

The technology solution for collection agency management establishes a single placement platform that sits between the hospital and its agencies and collection resources. The best platforms include a database and a rules engine that captures the hospital's work requirements. The database maintains an inventory of accounts being worked by all vendors and receives daily updates on recent activity by the hospital and the vendor. As a result, the central database has all the information needed by hospitals to analyze performance. The rules engine continually analyzes the database to find activity that should be flagged for review.

Step 2: Evaluate Your Options

When choosing agency management technology, hospitals should evaluate their current agency management issues and then compare the features and benefits that existing solutions can offer. Some factors to consider :

A single platform for all of the hospital's agencies.

All agency activity (including early out and late stage collection agencies, attorneys, and debt buyers) should be centralized to compare consistent agency performance.

A full reporting suite. A framework for consistent reporting across all collection agencies is necessary to support account audit and reconciliation requirements and to conduct agency performance comparisons. Daily reports of agency activities can provide insight into the number of letters sent, calls made, and "promises to pay" taken, which allows hospitals to respond quickly to changing agency dynamics and performance.

Ability to execute the hospital's business rules.

A system that offers automatic rules-based workflow allows hospitals to monitor and control compliance to their business rules.

Ability to change agencies quickly. A more robust, comprehensive system enables users to change vendors quickly and with minimal business disruption.

Quick and easy installation. Implementation of an agency management system can be done on a small scale. Many web-based solutions don't require investment in hardware and software upgrades, have reasonable installation fees, and are predominantly pay-as-you-go.

Limited maintenance. Web-based systems simplify maintenance and software upgrades. They have limited requirements for internal resources.

Regulatory compliant. The system should ensure full regulatory compliance with the Health Insurance Portability and Accountability Act.

A platform for future analytics. The system should be able to accommodate analytics to achieve maximum financial performance. Analytics ensures that each account is sent to the collection agency most likely to maximize collections on that type of account.

Step 3: Implement and Compare

Once you have selected the technology that is right for your organization, ensure executives and managers are taking control of patient revenue by better managing the collection agencies.

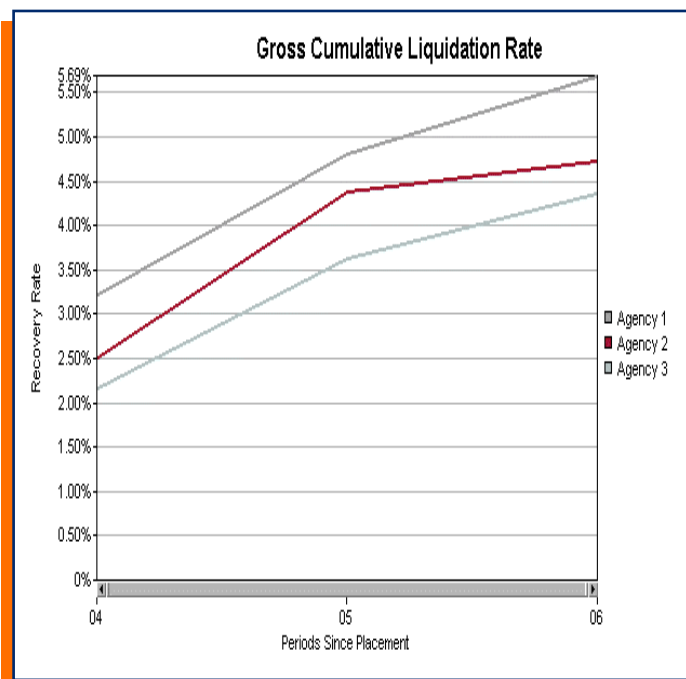
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Collection Agencies

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The hospital CFO should monitor and compare current and trendline performance of the collection agencies and evaluate performance on gross and net liquidation rates to get a complete view of the true relative value of each vendor.

How do my agencies liquidation rates compare?



The revenue cycle executive should access information necessary to manage the vendors, not just audit them. The executive can find the collection sweet spots for each of the collection agencies by comparing performance on different classes of accounts. The revenue cycle executive should make more informed decisions with respect to assignment timing and recall decisions, optimizing internal resource costs against vendor demonstrated performance. Over time, the executive should quickly identify true underperformers and replace them with a new proven vendor, already connected to the agency management network, who has a demonstrated strength in the desired area.

The day-to-day manager of a hospital's vendors should monitor service level agreements, rapidly reconcile invoices and inventory, and broadcast new information to all vendors.

Providers that are adopting new agency management technologies will be more efficient and effective, know where performance is slipping and be able to respond quickly. Their personnel will sleep better at night knowing what the agencies are and are not doing for their patients.

Steve Levin, president, Connance, Inc. slevin@connance.com

TriWest HEALTHCARE ALLIANCE

Gastric Bypass Surgery An Update on What's Covered

Laparoscopic bariatric surgical procedures and adjustable gastric laparoscopic banding are covered TRICARE benefits. A TRICARE beneficiary who is interested in having gastric bypass surgery to lose weight for health reasons needs to meet one of several conditions to be eligible for the surgery.

If ordered by the surgeon, the beneficiary may undergo a pre-surgical psychological assessment, a specialized appointment for patients being considered for gastric bypass surgery. This typically involves a psychological evaluation and brief psychological testing. This specialized patient care service is part of a multidisciplinary approach. Prior authorization is required for the pre-surgical psychological testing.

If it is determined there are no psychological contraindications to surgery, gastric bypass, gastric stapling or gastroplasty (to include vertical banded gastroplasty) may be covered when one of the following conditions are met:

1. The patient is 100 pounds over the ideal weight for height and bone structure and has one of the following associated medical conditions: diabetes mellitus, hypertension, cholecystitis, narcolepsy, Pickwickian syndrome (and other severe respiratory diseases), hypothalamic disorders and severe arthritis of the weight-bearing joints.
2. The patient is 200 percent or more over the ideal weight for height and bone structure. An associated medical condition is not required for this category.
3. The patient has had an intestinal bypass or other surgery for obesity and, because of complications, requires a second surgery (a takedown).

In determining the ideal body weight for morbid obesity (using the 1999 or most current Metropolitan Life Table), TriWest applies 100 pounds (or 200%) to both the lower and higher end of the weight range. Payment will be allowed when the patient meets all requirements for morbid obesity surgery, including the ideal weight within this determined range.

Facilities

Network providers should only use network facilities for gastric bypass procedures. Requests for non-network facilities may result in higher out-of-pocket expenses for the beneficiary. If TriWest receives a request for a non-network facility, TriWest may contact the patient and suggest a network facility alternative.

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HFMA Needs Your Help!

Scott Ujita

The HFMA Southern California Chapter needs your help. If you would like to get involved with HFMA and do not know how, just ask any one of the 15 Board members or the chapter Administrative Assistant, Lori Kuwahara. They will make sure that they introduce you to all of the right people. There are many functions within the organization that can use help. There are committees for all talents and opportunities for anyone that has some time. Here is a list of [some of the committees](#) that need help: Certification, CFO Roundtable, Geographic, Government Programs, Legislative Committee, Long Term Care, Managed Care, Membership, Networking and Social Committee, Newsbrief, Payor Relation/Compliance, and Student Recruitment/Mentorship/Scholarship Committee. Each Committee has a chairperson that can be contacted if you are interested. To get contact information for any of the committees, you can go to www.hfma-social.org/committees.html anytime or you can call 323-266-4362. Whether you want to start off slowly or just check things out, I invite you to take a step and get involved with this award winning HFMA chapter.

Gastric Bypass Surgery

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Exclusions

TRICARE will not reimburse providers for nonsurgical treatment of obesity, morbid obesity, dietary control or weight reduction. Excluded procedures include:

- Biliopancreatic bypass (jejunioileal bypass, Scopinaro procedure CPT procedure codes 43645, 43845, 43847 or 43633).
- Gastric bubble or balloon
- Gastric wrapping/open gastric banding (CPT procedure code 43843)
- Unlisted CPT procedure codes 43659 (laparoscopy procedure, stomach); 43999 (open procedure, stomach); and 49329 (laparoscopy procedure, abdomen, peritoneum and omentum) for gastric bypass procedures.

You should contact TriWest Healthcare Alliance at 1-888-TRIWEST (888-874-9378) if you have a question on whether a beneficiary is covered for one of these procedures.

For further information, please refer to the TRICARE Policy Manual, Chapter 4, Section 13.2 at www.tricare.mil.

Governor Declares a Fiscal Emergency for State 2009-10 Legislative Session Convenes

Due to the failure of the state Legislature to act on correcting California's \$11.2 billion budget shortfall in a special session last month, the governor has declared a fiscal emergency for California. This action gives Governor Schwarzenegger the authority to call a Proposition 58 special legislative session, which requires lawmakers to send legislation to resolve California's financial crisis to the governor's desk within 45 days. If legislation is not passed in 45 days, the Legislature cannot adjourn or act on other bills until the problem is addressed.

The governor also declared a second special session to address the state's troubled economy. "... we must implement an economic stimulus package to help retain and create jobs, keep Californians in their homes and fix the state's Unemployment Insurance Fund," said Schwarzenegger. The governor previously released an economic stimulus package that would inject \$160 million into hospital construction projects to create jobs. The two special sessions are expected to be held this month.

CHA Staff Testifies at CMAC Hearing on Hospital Economic Conditions

Testifying before a November 20 California Medical Assistance Commission (CMAC), CHA staff underscored the financial burden on hospitals caused by the seismic mandate coupled with the current economic conditions. CHA Senior Vice President Roger Richter pointed out that recent studies put the cost of compliance at \$110 billion. However, with the increase in the cost of scarce credit, that number will continue to grow.

The testimony emphasized the importance of hospitals on the state's economy, contributing more than \$57 billion for a total of more than \$146 billion toward California's finances. CHA V.P. Anne McLeod indicated that the California hospital industry supports more than 1 million jobs. Due to the current credit crisis, more than one-third of hospitals with pending construction projects or equipment purchases have halted their plans. In addition, 36 percent of hospitals report that they are not able to comply with the 2013/2015 seismic deadlines.

California ranks 49th in the U.S. with respect to the number of hospital beds per 1,000 population. Richter and McLeod emphasized that hospitals facing such tremendous financial pressures are being forced to cut back on needed health care services or close completely. "The timing couldn't be worse for hospitals to be weighed down by unfunded mandates and economic pressures," said Richter.

Anne McLeod – Vice President, Reimbursement and Economic Analysis, California Hospital Association
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Happy Holidays



Thank you for joining us for the annual HFMA/AAHAM holiday party held this year at the beautiful Gazzala Restaurant in Long Beach. Over 110 chapter members in the healthcare industry enjoyed the cocktail reception with a wide variety of delicious hors d'oeuvres, desserts, and free flowing wine. Guests had the opportunity to meet and greet colleagues for this festive event while listening to the sounds of the season by Susan Leigh Picking.



If you were unable to attend, we certainly hope you can join us in the New Year for future networking events. **Happy Holidays!**

