OVER THE EDGE

HFMA NORTHERN CALIFORNIA NEWSLETTER - DECEMBER 2003

healthcare financial management association northern california chapter

HFMA: It's Personal

Wishing you a Happy Holiday and Peace and Joy in the New

Northern California HFMA Board

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PRESIDENT'S MESSAGE

2003-2004 Strategic Plan

Last spring, at the annual Leadership Training Conference held in Chicago, IL, members of the Executive Committee spent time identifying the goals and values that we felt were most important to the chapter this year. In my first President's Message I spoke about the importance of being PHAIR (Partnership, Honesty, Acknowledgement, Inclusiveness and Respect), the values that we identified as most important in order to continue building a strong chapter. We also identified those goals that we most want to pay attention to this year. Those were incorporated into the updated strategic plan.

Educational Programs - We know that one of the best ways to serve you, our members, is to provide valuable educational programs. Each of the chapter's committees has been working hard to put on excellent programs for you. Those programs include the Fall Managed Care Joint Conference, where the hardworking committee chaired by Mike Laidlaw joined efforts with the Southern California chapter for a program that was held in Long Beach, September 14-16. Don't worry if you missed that one, there are at least two more programs you will be able to attend. The first is the Region 11 Symposium being held in Las Vegas on January 26 through 28. Nancy Arata and Christine Sarrico are serving on planning committees for that event. I have always found this program to be top-notch so please be sure to attend if you are able. It is also the single biggest contributor to our chapter finances. Our share of the profits from this event is partly based upon the number of our members who attend. Second, three different committees are working hard on this years' Spring Program, which will be held on March 18 & 19 in Berkley. The Patient Financial Services Committee, chaired by Kathryn Leppert, has taken the lead to get the ball rolling. The CFO/Finance Forum, chaired by Ken Jensen, and the Managed Care Committee, chaired by Brian Marrs, are joining with the PFS Committee to make this a 2-day institute. But wait, there is more!

Member Involvement and Fellowship – Last year we celebrated our 50th Anniversary as a chapter with a riverboat cruise & dinner in Sacramento. We received a lot of feedback that this is just the kind of event we need. We agreed so we there will be another social event this year at the Spring Program in Berkley. Thank you to last years' president, Paul DeMuro, for the inspiration. We are going to make the Spring Program an annual meeting and fellowship event. We also have a Social Activities Committee, chaired by Chuck Acquisto, devoted to organizing fun events such as this years' golf outing.

Improve Communication with our Members – This newsletter is an important way that we are improving communication with our members. A committee led by Christine Sarrico and Walt Luke has done an outstanding job of obtaining excellent content and putting together a first rate newsletter.

The people mentioned above are just a few of the many dedicated people who are taking time out of their personal and professional lives to serve our chapter. My gratitude goes to all of you who selflessly give of yourselves towards the accomplishment of these goals. I take great pride in being able to say I am the President of such an outstanding group of professionals. Thank you again for the opportunity and please join me in making this a fun a rewarding year for the chapter.

Laura Zehm, VP/CFO
Community Hospital of Monterey

Legislative Update - Hot off the Press

By Sherreta Lane, California Healthcare Association

Nurse to patient ratios:

CHA has been notified that the Administration will not delay the implementation of the nurse-to-patient staffing ratio regulations set to take effect January 1, 2004. However, CHA believes that the regulations exceed the purpose of the underlying legislation, and are inconsistent with the Governor's directive in 1999 to the Department of Health Services. CHA continues to work with the administration to seek regulatory relief. The regulations implementing this new law can be found in Title 22, California Code of Regulations, Section 70217.

The nurse ratio regulations apply to all licensed nurses working within an acute care general hospital. A licensed nurse is defined as a registered nurse (RN), a licensed vocational nurse (LVN) or a licensed psychiatric technician (LPT). LPTs are only allowed to provide care within psychiatric units. LVN's cannot comprise more than 50 percent of the nursing workforce within a general, acute-care hospital. However, LVNs cannot be counted as part of the ratio staffing levels for triage and trauma care within a hospital Emergency Department (ED), or for care provided in an Intensive Care Newborn Nursery (ICN). Only RNs can be assigned patients in an ED or ICN.A hospital must be in continuous compliance with the prescribed ratio staffing levels at all times of the day and night. No averaging is allowed.

The continuous compliance requirement of the nurse ratio regulations means that hospitals must provide additional, clinically competent nursing staff to cover for nurses on breaks and during meal periods. Nursing supervisors, nursing managers and charge nurses may relieve staff nurses on breaks and during meal periods as long as they are clinically competent to care for the patients in question.

The nurse ratio staffing levels are considered to be "minimum" staffing requirements that in no case hospitals fall below. Hospitals are required to augment these staffing levels as appropriate.
Every hospital must develop a written staffing plan, based on patient care needs, as determined by the hospital's patient classification system. The staffing plan must be developed and implemented for each patient care unit and shall specify patient care requirements and the staffing levels for RNs and other licensed and unlicensed personnel. In addition, the hospital must maintain detailed documentation as to the actual assignment of nurses by licensure category *(e.g. RN, LVN, LPT)* to individual patients on a day-by-day, shift-by-shift basis.

AB 1455 – Prompt Pay Legislation

AB 1455, Prompt Pay regulations become effective January 1, 2004. CHA filed a lawsuit in early November challenging three areas of concern in AB 1455:

- A “rate-setting” provision for contracted providers without a written contract and non-contracted providers.
- A 90 day limit on the submission of claims which is in conflict with established anti-forfeiture law; and
- A 365-day limit for providers to submit a claim dispute, which is in conflict with the current statue of limitations and the anti-forfeiture law.

December 14 is the deadline for DMHC to respond. It will likey go before a judge sometime in February.

For questions or more information please contact Sherreta Lane, CHA, slane@calhealth.org

PFS Committee's Successful Educational Events

By Walton Luke, FHFMA, MBA Presdient L.H. & Associaties, LLC

For the past several years, the Northern California Chapter's Patient Financial Services (PFS) Committee has held 2 educational events that were very successful and well attended. This year is no different.

The first PFS educational event is usually a one-half day seminar scheduled in the fall of each year, with speakers and agenda focused on the Staff and Supervisors of any Hospital System PFS Department. This year's Fall Program was held on October 23rd, 2003 and the seminar topic was, Self Pay Collections and HIPAA Code Sets. Kathryn Leppert Director of Patient Accounting Contra Costa County Health Services, the Chairperson of the PFS Committee reported,

"The seminar held at Washington Hospital was a success. We did well financially and had 73 paid attendees (over 70+ in attendance). The survey forms expressed overall "good", "very good" to "excellent". The attendees enjoyed the speaker presentations, content and the beautiful facilities at Washington Hospital. The speakers, Rodney, Terry and Mark were fantastic! Their messages were right on target for the audience… Thanks again to everyone on the (PFS) committee for their work on the successful Washington Hospital seminar!

The second PFS educational event has been held in the spring for the past several years in Sacramento. It is usually a one day conference with speakers and agenda focused on the Managers and Directors of any Hospital System PFS Department and has attracted over 100+ attendees. Last year, the Financial Forum Committee also had a one-half day seminar, the day before the PFS Spring Conference, as well as a dinner cruise on the Sacramento River that was well received by the many attendees. The event was considered a success.

Chapter to Continue Building on the Successful PFS Committee Spring Program

This year, there is considerable interest from the Northern California Chapter Leadership to build on the past success of the PFS Spring Program and have a chapter event that, in the past, took place either at Lake Tahoe (one of the South Shore Casinos) or Monterey. Laura Zehm, Vice President and CFO of Community Hospital Monterey Peninsula, current Chapter President, expressed the following to the PFS Committee,

"As you might have heard, your Spring Program is being expanded, and this has required a lot of flexibility on your part. Thank you for that. Here is why. There was a lot of feedback from the Chapter, both at the Leadership Retreat and over the year from individuals, that we need to have more events that build fellowship. What is almost always mentioned are, the prior annual meetings in Tahoe and Monterey. The Executive Committee has decided to pilot a resurrection of sorts by using the PFS Spring meeting as the foundation. That is why we are beefing up what was the CFO portion on Day 1 and adding a keynote speaker along with a general session PFS Speaker on Day 2 (what is normally all your day). In addition, we are continuing with the Thursday evening Social event from last year, for the fellowship piece. The Friday Keynote is to keep CFO/ Managed Care/ and others interested in staying overnight. Our intention is to build attendance at both the CFO (now General Financial) session and the PFS sessions, by doing this.

Thank you for all of your excellent work in keeping an Annual Program going. Without the foundation of the PFS Committee's Annual Program, this would be much tougher to do. You are a key part of what has kept the Chapter successful. You are to be commended for this, and the Executive Committee appreciates and recognizes your contribution."

Laura Zehm and the Executive Committee at the November, 2003 Board Meeting, established a Programs Committee to deal with these concerns. The Core Members of this Committee are:

Geli Argao, HFMA Chapter Administrative Assistant
Steve Edison, Senior Manager Cap Gemini Ernst & Young
Ken Jensen, Vice-President/CFO ValleyCare Health System
Walter Kopp, President Medical Management Services
Kathryn Leppert, Director Patient Accounts Contra Costa Health Services
Walton Luke, President L.H. & Associates, LLC
Brian Marrs, Senior Financial Analyst Kaiser Foundation Health Plan
Bernadette Mills, Chapter President-Elect, Director Certus Corporation
Debra Nystrom, Manager Reimbursement Finance Enloe Medical Center
Thelma Weiss, President TKW Search
Laura Zehm, Chapter President, VP/CFO Community Hospital Monterey Peninsula.

So save the date—March 18 and 19, 2004, as the Northern California Chapter plans for their First Annual Spring Conference, 2004.

E-mail questions to Walton at **mailto:wluke007@aol.com**

Strategic Pricing - A Source of Added Net Revenue

By Blake Edwards, PriceWaterhouse Coopers

Healthcare organizations continue to search for ways to meet their annual goals despite the serious financial constraints. Decreased reimbursement from government entities, regulatory requirements, and more stringent managed care models, to name a few, combine to present financial challenges. There are ways in which hospitals can look at competitive pricing strategy without raising red flags from governmental agencies. Using data elements and managed care contract profiles, hospitals can receive the financial assistance to proactively increase net revenue while being cognizant of Medicare outlier and other regulatory issues.

A strategic pricing analysis of the line items within the charge description master can change a hospital's existing charge structure in order to achieve uniform charging of like services across departments, identify additional net patient revenues, and determine whether outpatient third party fee schedule reimbursements are being realized. In addition, a review of the local market pricing will help a hospital make critical decisions regarding how they compare to their competition. There are a number of vendors that offer tools and assistance in conducting a strategic pricing study. At a minimum, the study should take into consideration all payer, market value and competitive pricing issues. Art DeNio, CFO at NorthBay Health System, recently completed such a study to increase net revenue, validate that prices met or exceeded third party fee schedules, and evaluate the system's pricing against other local systems. According to Mr. DeNio, "the analysis gave us a good indication of reimbursement enhancement opportunities for our system. We were also interested in assessing NorthBay's competitive position in order to identify departments where rate adjustments should be made. RateAnalyst's ability to consider specific procedures made it easier for us to attain our reimbursement increase goal."

A process of strategic pricing begins with an analysis of a hospital's patient encounter level charge data at the individual service code level to determine each procedure's contribution to incremental charge-based, cost-based, and fixed revenues. All managed care contracts and government reimbursement mechanisms are reviewed, modelled, and are entered into the software in order to determine the individual line item incremental contribution to net revenue for each service code. Further, calculations of the percentage of Medicare outlier payments to DRG payments to assess the facility's current Medicare outlier percentage should also be done. Calculating outlier payments at a case level allows one to assess the impact of any price changes on Medicare outlier payments and the Medicare RCC in order to comply with federal guidelines.

Market data is collected in an effort to compare the hospital charges to those of their competition. As a result, facilities make intelligent educated decisions regarding their goals for accurate CDM charges and are able to determine appropriate parameters in which overall department and procedure revenues may fluctuate during the analysis. Following numerous management conversations and direction, the hospital is presented with a concise deliverable that offers multiple scenarios for review.

Then one should run any number of "what if" scenarios in order to "fine tune" specific departmental and individual line item needs based on input from senior and department level management. Because specific items may be market driven, it may be necessary to limit increases or reduce prices in order to meet the needs of the community at large.

Once the final scenario is determined, additional back-end edits should be run in order to maintain the integrity of the CDM. Like CPT/HCPCS codes are grouped together in an effort to ensure consistency across departments, while groups of charges that must maintain tiered pricing have appropriate prices for each line item within the group. According to DeNio, a well-done project should result in "improved net revenue on a go forward basis following implementation, a competitive pricing structure, and improved accuracy in charging for like items across departments."

Please contact Joel Lipin, MD at 310-791-8505 or Blake Edwards at 213-217-3609 at Pricewaterhouse Coopers for questions or more information.

Reasonable Safeguards under HIPAA: What is Reasonable?

By Craig Henderson, Murphy Austin Adams Schoenfeld LLP

The need for safeguards to protect patient privacy is not a new concept. Long before the passage of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), hospitals and healthcare institutions have understood the need to protect a patient's privacy. The HIPAA Privacy Rule merely formalizes many of the policies and procedures some healthcare institutions currently use to safeguard patient information.

Under the HIPAA Privacy Rule, a covered entity[1] must have in place "reasonable" administrative, technical, and physical safeguards that limit the use and disclosure of individually identifiable health information to the minimum necessary.[2]

There is no precise definition of "reasonable" in the statutes and regulations, and there is no case law to delineate the bounds of what is and is not "reasonable." The general legal guidance is that covered entities must evaluate their practices and enhance safeguards as needed to limit unnecessary or inappropriate access to protected health information.

Now is the time to put down on paper the organization's existing privacy policies and to examine those policies for their appropriateness to the organization and its patients.

Reasonable Under the Circumstances

The Office for Civil Rights ("OCR") states in its guidelines that "the HIPAA Privacy Rule is not intended to impede customary and essential communication practices."[3] The OCR contemplated that the standards would be affected by the size of the organization and the financial burden of implementing particular safeguards.

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[1] A covered entity includes health plans, healthcare clearinghouses, and any healthcare provider who transmits health information in electronic form in connection with transactions for which the Secretary of Health and Human Services has adopted standard under HIPAA.

[2] 45 CFR 165.502(a), 164.502(b), 164.514(d).

[3] See Summary of the HIPAA Privacy Rule, United States Department of Health & Human Services, Office for Civil Rights Privacy Brief, revised May 2003, pgs. 1-2.

Examples of Reasonable Safeguards

The OCR has suggested the following reasonable safeguards: speaking quietly when discussing a patient's condition with family members in a waiting room or other public area, avoiding using patients' names in public hallways and elevators, posting signs to remind employees to protect patient confidentiality, isolating or locking file cabinets or records rooms, and providing additional security, such as passwords, on computers maintaining personal information.[4]

Distributing the policy, training employees, designating a person responsible for implementing the policy, and providing a summary of the policy to patients are all common sense practices to comply with the Privacy Rule. Each healthcare institution must examine its own situation to determine what safeguards are "reasonable" under the circumstances.

The Value of a Policy

There is a value in implementing safeguards, even if the safeguards do not protect against every disclosure of protected health information. Pursuant to OCR guidelines, if the covered entity has applied reasonable safeguards and implemented the minimum necessary standards, incidental use or disclosure of protected health information that occur as a by-product of another permissible or required use or disclosure are permitted.[5]

What seems to be clear from HIPAA and the pronouncements of the OCR is that good faith efforts to adopt and implement privacy policies and procedures will likely minimize the risk of an enforcement procedure against the organization. Healthcare administrators and their legal counsel are well-advised to draft and develop a workable privacy plan and to communicate that plan to medical professionals and staff.

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A True Leader Generates Commitment....

By Tim Wright, President, Wright Associates

Whether you are hospital CFO, department senior manager, or head of a specific project within your group, your leadership only works to the degree of your team's commitment. To be an effective leader, you must generate true commitment throughout your team.

Let's distinguish between _compliance_ and _commitment._ We are not speaking of "compliance" in its healthcare usage: Medicare compliance, HIPAA compliance, billing & reimbursement compliance, and such. We are referring to an individual's compliance with a team's, department's, or organization's goals, objectives, direction, and motivation. In this context, "compliance" means doing what is expected, going along with the requirements. A compliant team member obediently cooperates. A compliant person may not do more than that.

Commitment means a good deal more. The team member who demonstrates commitment actively pledges or engages herself to the objectives. Rather than going along, this player "goes ahead." The committed team member channels her time, energy, efforts, and creativity—in full force—to achieve those goals and objectives.

[4] Id. at pg 2.
[5] See Office for Civil Rights HIPAA Privacy, "Incidental Uses and Disclosures," pg. 1, December 3, 2002, revised April 3, 2003, citing 45 CFR 164.502(a)(1)(iii).

Your objective is to move individuals on your team from mere compliance to true commitment. Below are six actions that, taken with care and attention, heighten commitment within your team. Such commitment produces efficient and effective results, thanks to your leadership.

Educate about goals and objectives. You should provide information—in an educational format—to everyone who in anyway can impact your team's progress. The player who understands the expected results and the reasons for targeting is much more ready to commit his skills and motivations to working toward those results.

Delegate possession. Do not simply delegate the assignment; delegate *ownership* of the assignment. Merely handing out task responsibility only tells someone what to do. If you help a person understand what is to be done, what it will lead to, and why that is beneficial, you help her accept full ownership of her assignment.

Appreciate process and progress. By consistently observing and discussing an ongoing project, you preserve momentum toward the desired ends. No need to micro-manage. By demonstrating your active care about what is being done, you contribute to your team's commitment to succeed.

Evaluate the work being performed. Here you want to appraise the quality of the work being performed and the qualities of the work. The difference? Qualities are the separate but related steps that make up the work. Quality is the value, the worth, and the success measure of that work. Both formal and informal evaluation tools help you know degree of progress toward goal attainment.

Elaborate changes as necessary. When changes in the plan, the project, the process, the strategy, or the players occur, be certain you provide sufficient detail of the changes. You also want to provide the reasons for the changes. Review "Educate" and "Delegate" above to reinforce that respect for the "why" contributes to full ownership of responsibility.

Celebrate success. But do not wait to celebrate only the ultimate success. Give affirmative recognition to actions that lead to achievement and then the final achievement itself. Both types of recognition (and it need not be in the form of money!) cement commitment for this and subsequent projects.

Your success in generating true commitment among those on your team will go well beyond six ordinary verbs. Such success will be determined by your putting those verbs' actions to work.

Commitment Generation Tips

1. **Appreciate** the person by showing that you care, not just for the job but also for the person who holds the job.
2. **Delegate** with precision: answer the questions Who? What? When? Why? (No need to answer How? Leave that up to the individual).
3. **Educate** for the sake of the individual and her performance, rather than for the sake of "educating."
4. **Elaborate** changes in an operation with honest details.
5. **Evaluate** consistently and with consistency.
6. **Celebrate** not only the achievements but also the actions that led you there, the actions performed by people.

Please contact Tim Wright, President, Wright Results for questions or more information. 512-733-6453 or tim@WrightResults.com

Medicare Does Not Govern Commercial Contract Rates

By Frank P. Fedor, Murphy Austin Adams Schoenfeld LLP

A recurring theme in the operation of hospital contracts is the payer's unilateral reduction of negotiated contract rates. One of the latest contract breaches is the payer's disallowance of certain of the hospital's normal charges on the basis that the charge does not conform to Medicare billing guidelines.

This charge rejection of course only applies when some of the negotiated rates are stated as a percent of the hospital's charges. For example, "X" percent of charges for certain procedures, or a stop loss rate based on a threshold of "Y" dollars of charges at which point additional payment is due at "Z" percent of total charges or charges incurred after the threshold is met. The theory of the disallowance goes something like this: because hospitals try to comply with Medicare billing rules, these rules in effect create a national standard of practice. A payer may reasonably rely on the hospital's charge master complying with this national standard of practice. The rejection of charges may occur at the claim's adjudication and show up in the remittance advice, often without specification and only as a total amount of disallowed charges. It more frequently occurs during an audit.

There is no legal basis for this claim that a hospital's charges to payers other than Medicare must meet Medicare billing guidelines. The first thing you will notice is that the payer will be unable to cite a statute, regulation or any other law supporting its position. That is because there is none.

Instead, the custom and practice in the hospital industry is that there are a wide variety of methods of billing for services and supplies. This is primarily because hospitals are unique in their size, scope of services, case mix, competitive position, and many other factors. This variety of charge structures is reflected by the flexibility of the UB-92 Manual. Although revenue codes are assigned to types of services and supplies, there is a wide variety of options available for the use of these codes (e.g. several different ways to bill for a routine room) and very limited specificity as to the scope of what should be included under each revenue code description. Thus while the payer may argue that the Medicare billing rules establish the "practice" in the industry, the reality is much different.

It is the law of contracts, and not a Medicare billing rule, that determines the amount of payment under a contract between a hospital and a payer. The mutual intent of the parties expressed in the contract at the time the contract was signed controls.

When the parties agree on a percent of charges rate, the mutual intent is to accept the hospital's normal charge master rates. Hospital contracts never address the nature and content of the hospital's charge master because the hospital contracts with many payers, but can have only one set of standard charge master rates. When payers do have an issue about a hospital's particular charges or levels of rates they address it by the selection of contract rates (e.g. per diem or case rates), or possibly by negotiating a cap by how much the rates may rise, but not by negotiating the particular content of the charge master.

When the contract does contain one or more rates based on charges these typically make up only a part of the overall package of negotiated rates. This package of rates is modeled by both parties to estimate the yield to the hospital and the cost to the payer. The data that both parties use to conduct this modeling consists of the hospital's charges at its normal charge master rates. Hospitals can thus prove the payer's knowledge of the hospital's normal charge master rates (through the payer's receipt of UB-92s and itemized listings) and reliance upon such rates in modeling a level of cost that the payer ultimately agreed upon.

The payer also has a problem proving damages. For example, many of the charges the payer rejects are characterized as "unbundling". "Unbundling" occurs where an actual rule exists requiring a collection of services to be billed together at a lower combined rate, usually because of the efficiencies gained when all of the services are performed at the same time. The classic example is lab tests. A rate for a panel is generally less than the combination of rates for each test run separately because of the efficiencies in running the panel at once. "Unbundling" occurs when the laboratory uses the individual rates to receive more than the panel rate, and thereby misrepresents that it did not benefit from the efficiencies of the panel. The charges that payers are rejecting from hospitals are not "unbundling". For example, payers may reject a charge for incremental nursing because the payer claims it should have been included in the charge for the routine room. Of course, if the hospital had chosen to

include the cost of this service in the charge for the room, the room charge would have been higher. Thus the payer rejecting this charge is not damaged. Instead, the payer just wants to receive the service for free because the hospital chose to bill for this service separately, and thus only to those patients who consumed it.

In challenging the disallowance of charges hospitals must be prepared to defend the rationale of their charge structure. They must show that the charge is for an actual service or supply that is not already included in another charge.

Hospitals should defend their normal charge master rates with confidence. What is unreasonable is not the structure of the hospital's normal rates, but the conduct of the payer who freely accepts these rates during the negotiation of the contract, and then later raises a new inconsistent argument to obtain these services for free.

Frank P. Fedor is a partner with Murphy Austin Adams Schoenfeld LLP in Sacramento. He may be reached at ffedor@murphyaustin.com

2002 HFMA Golf Champs Defend Title at Canyon Lakes

San Ramon -- This time, only the course had changed. For the second consecutive year, the hacker foursome of Tom Knight, Pat Godley, Mike Smith and Art DeNio captured the HFMA of Northern California Golf Tournament.

The Knight-Godley-Smith-DeNio team, one of a record 14 teams, captured the 4th Annual Golf Tournament on October 3 with a six-under par 65 at the Canyon Lakes Golf Course in San Ramon. The previous three tournaments had been held at Boundry Oaks in Walnut Creek. Second place went to the foursome of Chuck Acquisto, Jerry Klusky, Mike Moody and Chris Pass with a 66 while third place (67) went to Vince Acquisto, Mike Laidlaw, John Duda and Kes Duda. The Acquisto-Laidlaw-Duda-Duda team actually beat the foursome of Phil Boehm, Wayne Silveria, Katrina Bennett and Kevin Lonergan, who also shot a 67, in a tiebreaker format determine ahead of time.

Chris Pass and Katrina Bennett, who bested Barbara Braga by a yard, won the long drive competitions for men and women while Mori Moriuchi captured closest-to-the-pin contest on the tricky, par 3 fifth hole. Stories of success and failure were swapped at the 19th hole over libations and food. Prizes were handed out and the new winner's trophy, to reside with the champions for one year, was unveiled. Even the San Francisco Giants late-inning collapse against the eventual World Champion Florida Marlins could not ruin the festive mood.

"The event was such a success we are please to announce next year's date will be at Canyon Lakes too," said Golf Tournament Chairman Vince Acquisto, who also thanked the day's sponsors: AHC; the Law Offices of Stephenson, Acquisto & Colman; Laidlaw Consulting and Toyon Associates, Inc.

The 2004 HFMA of Northern California Golf Tournament will take place on October 1, 2004, at Canyon Lakes Golf Course in San Ramon. The tournament, expected to be a shotgun format, is expected to fill up fast. For more information, contact Vince Acquisto at 9925) 734-6100 or vaa4sac@aol.com.

SAVE THE DATE : OCTOBER 1, 2004

The 13th Annual Managed Care Conference

Eleana Aguilera, Terri Mainfesto, and Mike Laidlaw speaking a on a panel at the HFMA Managed Care Conference in September.

Hundreds of colleagues, over 50 speakers, 38 corporate sponsors plus a beautiful venue. That's the short story of the Managed Care Conference that the Northern and Southern California HFMA chapters put on September 14-16 in Long Beach. But that doesn't begin to convey the depth of learning opportunities, the networking or the great restaurants on Pine Avenue.
Here are some quotes from attendees:

This was the first time I attended Sunday sessions. Right out of the box, the Financial System and Analysis presentation was great. The desktop business intelligence software demonstration was impressive (I love data), and it was nice to get a demo of the software to play with!

The Contract Review Process Sunday session was excellent. Well-organized, well-presented--basic nuts and bolts on how to improve the contracting process.

I needed some additional clarification after the Silent PPO session, and the networking lunch gave me an opportunity to seek that clarification. The extra handouts (which I missed at session, but was able to pick up at the handout table late) were appreciated, as they also helped in deepening my understanding of this issue.

My impression from the 2002 conference was that while universal or single-payor healthcare was a fun topic du jour to bat around, no one was taking it seriously. My impression from the 2003 conference is that we are beginning to talk seriously about these models.

Presenters were telling it like it is--patient welfare is currently subordinated to a complex, rigid, inherently unequal reimbursement system; the system grew--no one would design a system where the purchaser does not directly use the service; consumer-directed is really consumer-deflected; and (ya gotta love this one) the more docs think about/focus on compensation, the less satisfied they are.

Good time - getting to know the Northern CA folks one evening after the conference activities were finished--reminded me of the great after-parties with fellow musicians after gigs (and we didn't even have to stay up until 4 a.m. . . .). Very glad I got more involved this year--much easier for me to network this way, and the folks who volunteer to support the conference are great folks.

Ian Morrison was a good choice for an early morning speaker. He was entertaining as well as knowledgeable.

I liked and learned from the 2 sets of attorneys (Washington/West and Hooper, Lundy, and Bookman) about underpayment litigation. It was good to see what other providers are doing and experiencing.

William Hale from Beech Street was also an excellent speaker about the future of PPOs and what they are looking to do in the future.

Jeanne Scott, the luncheon speaker was funny and informative to a certain extent, but I'm not sure I got the full gist of what to expect from Washington in the upcoming year.

Overall, I liked the conference. The topics were relevant to today's marketplace.

There was a real effort to get a wide variety of topics and diversity of opinion among the speakers. The program committee did not shy away from controversy! There were some sessions that people might have attended just to see if a fight would break out. There were also many sessions in the "News You Can Use" category. The latest regulatory and legislative activity was covered and new products and services were displayed.

Most of us have our nose to the grindstone five or more days a week, which doesn't always give us the best perspective. That's why the networking at conferences like this is so valuable. Whether you accepted a dinner invitation from one of the corporate sponsors or went with a few friends to find a karaoke bar, getting together with fellow HFMA members gives us a chance to see what challenges our counterparts in other organizations are facing. It also lets us hear things "through the grapevine" and we all love that, right?

It is unfortunate that because of the economy, budget cutbacks and time constraints, attendance was down slightly from the year before. Next year, the 14th Annual Managed Care Conference will be held in San Francisco. I hope to see you there – they just keep getting better every year!

-Brian Marrs, Kaiser Foundation Health Plan

Have you registered for the Region 11 Conference in Las Vegas, January 25-28??
Visit the Website at www.hfmaregion11symposium.org
Early bird discount expires December 20; so do not put it off!

This conference is designed to provide current practical information to all healthcare financial professionals. The featured keynote speakers are George Will, a Pulitzer Prize winning columnist, John Kitzhaber, former Oregon Governor and Stedman Graham.

Come learn, network, and enjoy the fun of Las Vegas!

In an effort to get to better know our active HFMA of Northern California chapter executives, Board members, chapter chairs and committee members better, profiles of HFMA leaders will run in each newsletter.

This week, former HFMA of Northern California President Vince Acquisto and current Board Member as well as Special Projects officer, Mike Laidlaw, are featured. You may often find these two golfing buddies discussing handicaps, drivers and putters as much as HMOs.

Name: Vincent A. Acquisto

HFMA Position: Past HFMA President of Northern California (on current sabbatical)
Occupation: Liar, Liar (AKA lawyer). Also, partner in Law Offices of Stephenson, Acquisto & Colman
Hometown: Dublin (California that is)
Born: Thanks to a few shots of whiskey, in a house in Pittston, PA and survived.
On a Free Day I Like To: See other people working
Hobbies: Golf, biking and keeping my darling wife happy.
Favorite Read: John Grisham
Favorite Movie: My Blue Heaven, My Cousin Vinny, Any Movie that Starts with My and Some Like It Hot.
Favorite Music: Willie Nelson
Favorite Food: Unspoiled
High School: Grover Cleveland High School, "The Presidents"
College: Canisus (Buffalo, NY where I lettered in outdoor tennis which is quite a feat in Buffalo with a 1-match season.)
Graduate School: Loyola College in Baltimore (MBA), University of Maryland Law School
Worst Job Ever Worked: Mailman in Buffalo in the winter
Best Job (excluding now): Management Negotiator
Family Activities: Biking and watching my son work hard
Favorite Vacation Spot: Beach
If I Could Change OneThing In Health Care It Would Be....: Wish I knew where to start.
Pets: None
When I Retire, I Plan to: What's retire? Death?

Name: Michael Laidlaw

HFMA Position: Special Projects Officer
Occupation: Consultant
Hometown: Dublin
Born: Medford, MA on 10/03/1948
On a Free Day I Like To: Play golf or read.
Hobbies: Golf, reading and writing
Favorite Read: Jack Higgins, Alstair MacLean
Favorite Movie: Good Will Hunting
Favorite Music: Country
Favorite Artist: Alan Jackson
Favorite Food: Swordfish
High School: Medford High (MA)
College: University of Massachusetts
Graduate School: St. Mary's College
Worst Job Ever Worked: Cleaners
Best Job (excluding now): O'Connor Hospital
Family Activities: Dinners
Favorite Vacation Spot: Inn at Spanish Bay.
If I Could Change One Thing In Health Care It Would Be....: Breakdown interdepartmental fiefdoms to achieve better healthcare delivery
Pets: None
When I Retire, I Plan to: Play golf, read and travel

Movers and Shakers

We are excited to present our new HFMA members who have joined our chapter this year and would like to extend a warm welcome.

Name	Organization
R. George Adams	Colusa Regional Medical Center
Enitan Adesanya	Kaiser Permanente
Anita Agarwal	
Julie Aitchison	Sutter Medical Center
Jeff Baldwin	MedAmerica, Inc
Paul S. Blanke	Lucile Packard Children's Hospital
Grant Buckman	
Feliz L. Casanova	
Richard Catalano	
Cindy Coit	Stainslaus County Health Services
Brian P. Conner	Moss Adams
Wendy H. Davies	
Paul Engbritson	Mercy San Juan Hospital
Paul Evans	Power Solutions
Shepley E. Evans	
Roberta Forrest Delucca	The RAD Group
Belinda Gee	
Mesrak Gessesse	St. Mary Medical Center
JoAnn Hamilton	St. Rose Hospital
Bruce A. Herrmann	
Gina Huang	
Steven Johnston	QuadraMed Corporation
Diana S. Juan	
Tabitha L. Kircher	
David A. Lari	Bakersfield Memorial Hospital
Pamela J. Lauder-Haskell	
Jeffrey Lockhart	MEDITECH
Jim Lockhart	
Cheryl Mann	Goals InSight Coaching
Jose L. Martinez	Gardner & Associates
J. Maul	
Joan McAllister	Redbud Community Hospital
Sherry L. McCormick	Banner Lassen Medical Center
Greg D. McCulloch, CPA	Adventist Health
Jess Merten	Moss Adams
Ann Nelms	
Erica A. Nelson	
Mary K. Okerrins	
Jeanne Olson	Kern Valley Hospital District
Eileen Paul	Sierra View District Hospital
Bonnie Poletti	Medi.Com Subsidary of Medifax-EDI
Valerie Quinn	
William K. Russ	Sutter Coast Hospital
Chris Sauder	Adventist Health
Douglas A. Shaw	Mad River Community Hospital
Jeffery A. Shultz	
Marie A. Sorci	St. Joseph Hospital-Eureka
Peter A. Szekrenyi	
Tammy J. Thompson	Tuolumne General Hospital
Chi M. To	Lucile Packard Children's Hosp.
Megan K. Upham	Healthcare Financial Solutions
Robert B. Van Gelder	Tahoe Forest Hospital District
Donald Whiteside	Witt/Kieffer, Ford, Hadelman, Lloyd
Jennifer Willis	Murphy Austin Adams Schoenfeld

Transfers from other Chapters:

Name	Organization
Brandi Baker	CSI Financial Services
Daniel B. Dreblow	
R Neal Gilbert, CPA	
Richard L. Gilbert	
Galen R. Gorman	St. Joseph Health System
Joseph W. Haney	
Sharon M. Richards	Lodi Memorial Hospital
Whitney J. Walker	

HFMA Calendar of Events	
January 25- January 28, 2003	**HFMA Region 11 Conference, Las Vegas Nevada**
March 18, 2004	**HFMA Board of Directors Meeting**
March 18-19, 2004	**HFMA No. Calif. Spring Conference and Social Event Berkeley, CA**
April 25 - April 27, 2004	**HFMA National Leadership Training, San Francisco, CA**
June 27- July 1, 2004	**HFMA Annual National Institute, Nashville, Tennessee**
October, 2004	**HFMA No. Calif Golf. Tournament, Canyon Lakes, San Ramon, CA**

MEMBER-GET-A-MEMBER
CHANCE TO WIN A VOUCHER WORTH $500 TOWARDS A VACATION OF YOUR CHOICE

Rules: For each new California member that is sponsored by a current member from June 1, 2003 thru May 3, 2004, the current member receives 1 chance for the voucher. At the May HFMA Board meeting of the year, a drawing will be held for the winner. It is the responsibility of the current member to keep track of the members they register. The membership chair will get reports starting mid year of the member-get-a-member totals and bimonthly after that. Should you have any questions please call:

Deborah Marsh, Membership Chair, Rubin and Raine, 1-888-354-8174x324
Thomas Trautman, Membership Co-Chair, Fremont Rideout Health Group, 1-530-749-4567.
For more information and to register a new member, visit the following websites:

http://www.hfma.org/membership/join.cfm (click regular member) http://www.hfma.org/

On the bottom where it states member-get-a-member have the applicant fill in your name and your member number.

Volunteering for a committee is the best way to fully reap the rewards of membership. Through committee activities, you will be able to help shape educational initiatives and develop closer ties with your colleagues. To inquire about participation in a committee, visit our website to identify a committee (or two) of interest and contact the committee chairs.

We hope that this newsletter will help keep you; our members, involved, informed and more connected to our chapters activities. Our goal is to help make you the best healthcare professionals you can be. We are always looking for authors for newsletter articles. If you would like to help please email any one of us,
News and Publicity Committee

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