



The Business of Caring

Attend ANI
 Viva Las Vegas
 June 26 – 29, 2005

- Northern California
 HFMA Board**
- Chuck Acquisto
 - Kathy Cain
 - Cynthia Denton
 - Frank Fedor
 - Arlette Kendall
 - Jayne Kroner
 - Kathryn L. Leppert
 - Deborah Marsh
 - Bernadette Mills
 - Kim Miranda
 - Jack Porter
 - Mich Riccioni
 - Cindy K. Rudow
 - Jack Ruzic
 - Christine D. Sarrico
 - Jim Strong
 - Valerie Sutton
 - Laura Zehm

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Outgoing President's Message



My goal over this past year was to encourage all of you to get involved through participation in Chapter programs, volunteering on various committees and allowing your staff to become members and to encourage their growth through involvement with HFMA.

I want to thank all of you who took action. The Chapter has added 177 new members; we've had excellent attendance at our programs and new volunteers added to the ranks of our committees! It is through this participation that we will continue to be a very strong Chapter, enabling us to deliver quality programs.

I have had the pleasure of working with the Board and the members of the various Committees. Their dedication and enthusiasm contributed to a very successful Chapter year. I can't thank them enough for their support. As Past-President, I commit my support to them as I hope you will in the coming year.

Appreciatively,
 Bernadette Mills
 NoCA Chapter President 2004/2005

**A Morning With
 The Department of Managed Health Care
 On Current Hot Issues**

June 15, 2005 (Wednesday)
 9:00 AM - 12:00 PM
 One Capital Mall, Suite 100
 Sacramento, CA

HFMA invites you to meet with a representative of the California Department of Managed Health Care (DMHC). Take advantage of this opportunity to introduce yourself to the DMHC, network with your peers, hear the latest news and ask your questions on important/hot topics. Please reserve your space in advance. Send your RSVP to office@hfma-nca.org.

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HFMA NoCAL BUILDS SPRING PROGRAM SUCCESS

By Chuck Acquisto

The second annual HFMA of Northern California Spring Conference continues to grow with record number of topics and attendees. This year's event took place Thursday, April 21 and Friday, April 22 at the Downtown Oakland Marriott Hotel.

A record 168 registrants, up from 106 attendees in 2004, enjoyed the two-track program for CFO's and Patient Accounting Office personnel. A growing list of exhibitors, including CIL, Claim Assist, Kronos, NCO, PriceWaterHouseCoopers, RPM and The SSI Group, helped make the program a fiscal success. The law firm of Davis Wright Tremaine was the event's sponsor. Vision Share sponsored lunch on April 21.

Thursday began with an enlightening, five-member panel, moderated by Walter Kopp, discussing market trends in Northern California and the effects of delivery of health care. The excellent panel featured Dr. Jeff Kamil of Wellpoint Health Networks, Henry Loubet of Keenan Healthcare, Curtis Terry of AETNA, Robert Reed of Sutter Health and Dr. Larry Bonham of Pacific Partners Management Services.

Other highlights from the first-day sessions included: California Hospital Association's Sherreta Lane catching an audience up on Medi-Cal billing/policy changes, Attorney Ross Stromberg updating on class action lawsuits for the uninsured and the effects on billing, Dr. Arthur Lurvey of UGS going over current CMS regulatory changes, Stanford/ Lucile Packard's Betsey Moore providing tips on dealing with difficult people, a panel discussion on compliance for acute care providers, Richard Lyman on revenue cycle management, a panel discussion on current Medicare/Medi-Cal payment issues, and a discussion of practical/legal aspects of charity care led by Attorney Gerry Hinkley and ValleyCare's Ken Jensen.

Thursday evening began with a new member welcome cocktail reception that was followed by the installation of the new Chapter Officers and Board Members for 2005-2006. A sit-down dinner preceded a Casino Night of rolling dice and dancing shoes.

Friday's keynote speaker was Dr. Arthur Southam of Kaiser Foundation Health Plan, who was followed by a four-CFO panel discussing financial trends in the healthcare marketplace and their effects. The panel featured Sutter Health's Svend Ryge, Daughters of Charity's Marc Golan, Catholic Healthcare West's Michael Blaszyk and Kaiser Permanente's Jerry Bajada. The spring program concluded with Tim Solberg of CCM Advisors discussing Hospital investment trends.



Stephanie Martinez, Jayne Kroner and Deb Marsh

Welcome to our new Board Members and Executive Committee:

President – Frank Fedor

President – Elect – Jack Ruzic

Secretary – Chuck Acquisto

Treasurer – Christine Sarrico



(Left to right) Chuck, Jack, Frank and Christine being installed

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Chapter members were presented awards for their many contributions:

Presidential Award
Chapter Award of Merit

Laura Zehm
Walton Luke
Liz Marek
Kathryn Leppert
Nancy Arata
Christine Sarrico
Jayne Kroner
Sherreta Lane

Chapter Achievement
Chapter Leadership
Chapter Author Award



Laura Zehm and Colleagues

Receiving a Founder's Gold Award:

Jacob Lewis, FHFMA, CPA
Michael McGinnis, FHFMA, CPA
Raoul Miranda

Receiving a Founder's Silver Award:

Deborah Marsh
Bernadette Mills

Receiving a Founder's Bronze Award:

Tammy Caluya
Scott Aleveland, CPA
Kenneth Cohen
j. Maudine Dick
Frank Fedor
Barbara Griffin
James Hebert, FHFMA, CPA
Ronald Kreutner
Brian Marrs
Edward McDonald, CPA
Kimberly Oka
Subodh Sheth
David Singh, CHFP, MBA
Paul Smith
John Smits, MBA, CPA
Judith Van Horn
Shoshana Williams

Start-Up of a Comprehensive Denial Management Database

By Cindy Rudow and Elizabeth Fortes

John Muir/Mt. Diablo Health System (JMMDHS) includes two acute care hospitals in Contra Costa County. Prior to October 2004, the denied claims were handled in the course of regular business by the commercial and government follow-up reps. An attempt was made numerous years ago to implement an ad hoc solution or "denial management database" without dedicated staff to the project. However, due to many other daily "fires" the staff was already handling, the project was never completed and launched.

In December 2003 the JMMDHS' Senior Management asked H*Works (a division of the Advisory Board) to ascertain the Health System's operations and make recommendations for improvements. One such recommendation was to create a dedicated Denial Management Program.

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The four key components H*Works identified for a Comprehensive Denials Management Program are:

- 1) Denials Management Database (to consolidate all incoming denials);
- 2) Denials Coordinator (enter data, assign reason codes & payer follow-up);
- 3) Hardwired Appeals Process (separated clinical vs. technical denials);
- 4) Denial Reports (Management analyzes denial patterns & trends monthly)

JMMDHS hired two full time employees (FTE's) to address the Denial Management challenge and placed one dedicated Denial Management Analyst within Patient Financial Services Department to log technical and clinical denials and one dedicated Analyst within the Case Management Department to appeal the clinical denials. The two positions were filled by October 2004.

Here's a summary of the process of denial management:

- A) Denial given (hard copy) to the PFS Analyst by the follow-up staff;
- B) Follow-up Rep documents accounts with codes using specific canned text messages that clarifies type of denial:

Types of denials	Technical/Clinical	Action
IPA vs. Healthplan	T	Follow-up Rep appeals to Health Plan/IPA
Add'l info from Patient	T	Follow-up Rep contacts Patient
Incorrect Plan Code	T/C	Case Management Analyst requests a retro Auth with medical records
Patient Ineligible/ Benefits Maxed Out	T	If there isn't other ins – rep bills patient Or if there is other ins – Case Management Analyst requests retro auth
Denial – Other Reasons	C	Case Management Analyst reviews the Account to appeal when applicable

1. Concurrent review incomplete/account to appeal when applicable
2. Add'l info needed
3. Not medically necessary
4. No auth for services
5. Lower level of care
6. Failure to verify/slash report admission

- C) Technical denials are appealed and worked by the PFS Follow-up staff.
- D) Clinical Issues are forwarded to the Analyst in Case Management for chart review and appeal.
- E) Payment progress for both clinical and technical appeals is monitored by the PFS Analyst.

In the 4th quarter of 2004, 93,205 claims were billed and 74 accounts were denied. The total dollar value of the denied claims was in excess of \$1,000,000 and the recovery rate achieved to date is 38%.

In summary, the comprehensive Denial Management Database has provided the tools to track the additional cash collected and the reasons for denied payments (and payors who consistently deny our claims). This information will be communicated to the applicable departments with the recommendation to implement changes that will improve the collection of revenue and decrease denied claims. Another benefit of the tracking program is to advise the Managed Care Department of the payors that consistently deny claims so they can address their payment patterns in future contract negotiations.

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Legislative Update

By Sherreta Lane, CHA

Hospital Financing/Medi-Cal Redesign

CHA continues to work with state and federal officials to preserve adequate Medi-Cal supplemental payments for disproportionate-share hospitals as changes to the existing systems are being weighed. In light of the upcoming June 30 expiration of the current Selective Provider Contracting Program waiver, information on either a revised or current proposal is expected soon.

Medi-Cal Redesign also would significantly expand Medi-Cal managed care. CHA is working with other interested parties to assure that any managed care expansion does not adversely affect hospitals and the patients they serve. Negotiations on Medi-Cal managed care expansion will begin in earnest upon resolution of the hospital-financing proposal.

Billing and Collection Practices

Despite the CHA Board's adoption of *Voluntary Principles & Guidelines for Assisting Low-Income Uninsured Patients* and most California hospitals' implementation of the guidelines, two bills have been introduced this year with charity care requirements. **SB 24** (Ortiz) would impose charity care and reduced payment policies on all hospitals. Not-for-profit hospitals would be subject a specified threshold of charity care provided and sanctions. SB 24 will be heard in the Senate Appropriations Committee later this month. **AB 774** (Chan) would impose significant new requirements on hospitals with respect to self-payers, charity care, and billing and collections. The bill would authorize the Attorney General to levy civil penalties against hospitals for violation of the new requirements. This bill is currently on "suspense" due to the potential increased cost to the state.

"Chargemaster II" Legislation

SB 917 (Speier) would require hospitals and the Office of Statewide Health Planning and Development (OSHPD) to distribute charge information by DRG. Additionally, this bill requires hospitals to provide an actual copy of their chargemaster to anyone upon request. CHA is opposed to SB 917, which will be heard on the Senate floor this month.

Similarly, **AB 1045** (Frommer) would require OSHPD to compile charge information for both inpatient (utilizing DRGs) and outpatient procedures. Hospitals would then be required to distribute the information. Additionally, AB 1045 requires hospitals to provide an estimate of charges upon request. CHA is urging an amendment that would require estimates only for non-emergency care be made to uninsured patients and include an estimate of expected reimbursement rather than charges.

Other

AB 117 (Cohn) would require DHS to centralize Medi-Cal treatment authorization request (TAR) operations and standardize the criteria to be used in the approval of the requests. CHA supports any streamlining to the TAR process. AB 117 will be heard in Assembly Appropriations.

SB 159 (Runner) would set rates for sheriffs to reimburse non-contracting hospitals for emergency services provided to jail inmates. CHA is currently opposed to SB 159, but currently is working with the sponsor to reach a compromise.

SB 616 (Speier) would require the Department of Corrections to attempt to re-negotiate contracts for provision of health care to state prison inmates at 115 percent of Medicare rates. CHA is opposed to SB 616. These two bills will be heard on the Senate Floor this month.

AB 1614 (Klehs) would deem a hospital to be operating for profit if its operating revenues exceed operating expense by ten percent or more during the preceding fiscal year. CHA is opposed to AB 1614 which next will be heard on the Assembly Floor.

Parnell v Adventist Health

The California Supreme Court ruled April 4 that a hospital may file a lien against a judgment or settlement received by a patient whose health plan paid a portion of the hospital bill. However, the contract between the hospital and the health plan must permit the hospital to file the lien authorized by the Hospital Lien Act.

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Hospitals should review their contracts with health plans to determine their ability to file liens against judgments and settlements received by enrollees of those health plans. Hospitals may wish to consider negotiating amendments when necessary to clarify the hospital's ability to file liens under the Hospital Lien Act/Parnell v Adventist Health

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Hospitals should review their contracts with health plans to determine their ability to file liens against judgments and settlements received by enrollees of those health plans. Hospitals may wish to consider negotiating amendments when necessary to clarify the hospital's ability to file liens under the Hospital Lien Act.

Medi-Cal Non-Contract Hospital Lawsuit

A group of 74 California hospitals recently filed a lawsuit against the Department of Health Services for freezing rates for Medi-Cal non-contracting hospitals based on 2003 costs (*San Antonio Community Hospital et. al. v Shewry*). The freeze was part of the 2004-05 state budget and as noted above is not part of the 05-06 budget. The lawsuit was filed April 15 and the state was given 30 days to respond. The state response has not occurred, so subsequent action from the court is expected soon. Updates on this litigation will be provided in this forum.

Physician Recruitment – A Success Story

By Laura Zehm, CFO, Community Hospital of Monterey

If you have been to the Monterey Peninsula then you know it is a place with an abundance of many good things in life. Things like golf, sea, beautiful coastline, desirable climate and world-class restaurants (am I sounding like a chamber of commerce ad?). Oh, and I have to add, a wonderful community hospital. What we do not have in abundance are physicians who practice in certain specialties.

We have a serious aging of our population and that includes some of our physicians. About five years ago we were facing a looming shortage of primary care physicians (PC's) in our community. We were already hearing stories of PC's closing their practice to new patients, patients having to wait many weeks before getting a routine appointment or patients having to wait until someone moved away or died before they could get into a practice. This was not good for our community and it was not good for our hospital.

Our solution, we started a physician recruitment program in 2001. Here is how it works.

- First, we identify how many of each physician specialty we need for the population we serve. We compare that to our list of existing community physicians to determine where we have shortfalls. We also take into account those physicians we know will be retiring soon. In this way we identify our high need specialties, areas where we do or will soon have a significant shortfall.
- Next, we decide how much we are able to spend each year on the program.
- Then we identify a certain amount of money we will make available for each physician in a specialty. We use a percentage of the annual income for that specialty in our market area.
- By using all of these numbers we decide how many of each physician specialty we will attempt to recruit. So, for example, say we have \$500,000 available for 2005, we have determined that we will offer each PC \$100,000 and we need 10 PC's. We will recruit the maximum number of PC's we can, which is five in this example.

There are two parts to our program, an income guarantee loan and housing loan.

- Income Guarantee – Simply stated, this is a guaranteed monthly earnings amount, net of certain expenses, paid to the physician if her or his income falls below the guarantee amount. A physician “pays back” this loan by staying in the area with an active practice for a specified period of time.

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- Housing Loan – We will assist a physician with purchasing a residence here in the Monterey area by providing a second mortgage. A physician “pays” this mortgage by staying in the area a certain amount of time.

By far the housing loan is the more popular of the two options. The reason is threefold: first, the high cost of housing is one of the reasons it is difficult for physicians just out of medical school to move into this area. Second, the regulatory complexities of the income guarantee make it unattractive to physicians. Third, there is such a pent-up demand for PC’s in our area that all one has to do is open her or his doors and they have a thriving practice.

There are many new strategies we have employed here at CHOMP to improve access to care. Most seem to require a lot of effort and money with a very small real benefit, if any. This is one that has really worked. Since the inception of the program and as a result, we now have 20 new, young physicians in our community. I am able to make referrals for my friends and family. Something that was very tough to do before. These new young MD’s are also the next generation of physician leadership for our hospital. Many of them have demonstrated a commitment to our organization by serving on physician leadership committees. Yes, there are regulatory complexities and you must work with your legal counsel to stay free of the orange jumpsuit risk. We have found that the results are well worth the effort.

This was a good idea that worked. Isn’t that what we are all looking to find?

Value of HFMA membership demonstrated by PFS educational workshops

By Jack Porter, MBA, Northern California HFMA PFS Committee Chair 2005-06

In the summer of 2004, the Patient Financial Services (PFS) Committee of the Northern California HFMA Chapter re-affirmed their commitment to provide and promote educational opportunities to all members of the Northern California HFMA chapter.

Historically, educational events were held only in one location, making access to distant locales difficult for members from all corners of Northern California. Many members were unable to benefit from the education venues offered due to geographic constraints. Consequently, members who are unable to take advantage of the benefits of HFMA membership may allow their membership to lapse.

In the fall of 2004, the PFS Committee presented three educational workshops on different dates, at different locations within Northern California, and all focusing on the topic of coping with the uninsured, charity and bad debt patients. The Committee specifically targeted two locations that had not hosted HFMA education workshops for many years. Several Committee members dubbed these events as ‘The Traveling Road Show’.

The result was that almost 100 PFS professionals from Northern California attended one of the three regional workshops. For most, this was the first HFMA-sponsored educational workshop that they had ever attended. The attendees at the workshops recognized the value of being an HFMA member.

There were several factors that made the fall series of workshops successful:

- Workshops were provided locally so more members could attend ½ day sessions
- Presented a topic that was timely and beneficial to the members
- Credible and informative speakers provided information that members could apply at their workplace
- Pricing was reasonable to demonstrate the benefits of HFMA membership.

Attendee evaluations were very positive for the topic and presenters, but also very positive on the location and venue of the workshops. These comments verified the need to continue to hold educational seminars in locations that members can easily access.

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With this success, plans are underway for another 'Traveling Road Show' in the Fall of 2005, this time adding an additional location and selecting a new topic that is current to PFS professionals.

Healthcare Finance professionals join and remain active in HFMA for a variety of reasons; one of which is for educational opportunities that may not be available outside of HFMA. Committees within HFMA chapters need to keep educational events topical and accessible to members, which will allow our chapters to grow and retain membership by providing beneficial educational events to our membership.

From Public Focus to Private Friendly: The Changing Face of County Hospitals

By: Valerie Yv. Woolsey, MBA

Financial woes? Join the club. Seems like hospitals administrators face a never-ending challenge of how to balance their budgets in the face of increasing health care costs. Emergency room visits are up. Bed availability is down. Reserves set aside in the middle are being squeezed by the introduction of either mandatory Medicare or new managed care products that are of questionable benefit to the bottom line.

Public hospitals are no different. Unlike many healthcare systems, we act as safety net facilities that care for roughly two-thirds of a County's indigent population yet receive undifferentiated MediCal reimbursement. Our comprehensive offerings include Emergency, Psychiatric, Acute Inpatient Medical /Surgical Services, Ancillary Services and Ambulatory Services available to anyone without regard for ability to pay. Great care for the patient, but how do you balance providing such care against continually dwindling State and federal funds?

One solution is for more public hospitals to look toward contracting with commercial payors. Its no surprise that a financially well-run hospital is one with a well run managed care program. Public hospitals have much to gain from adopting the same type of infrastructure and operating gatekeeper products focused on managing the outliers. The foundation is already there. They are positioned to be a low-cost alternative provider of medical care in an environment where payors are looking to show cost savings to their shareholders. Because social factors are just as great a concern as the actual medical diagnosis with our traditional patient base, County facilities are required to be more cognizant in linking hospitalists, discharge planning, and home health care to streamline inpatient costs. Our provider makeup up of small clinicians versus large core providers lends itself to close tracking of referral patterns. Aggressive utilization review strengthens our benchmarking as we share a mutual goal to manage capitated lives. Our core population is generally the aged, blind, and disabled; strategic partnership planning within area hospital networks as they face the challenge of adopting this actuarially unknown population could be the beginning of a beautiful relationship.

Becoming "private friendly" is not easy. Much of the infrastructure necessary to support private payors is not inherent in County hospital settings and the intangibles of social stigma or those who feel that accepting private payors may compromise a County hospital's core mission of service can pose significant obstacles. But County hospitals' need to change their financial perspective may soon become a matter of survival. Passage of recent legislation such as Section 1011 of the Medicare Modernization Act is helpful but only a band-aid for a longer-term fix. More than one-third of our patients are uninsured, reflecting the national trend of Americans who are un- or underinsured. The cost of medical supplies and drugs are increasing and employers are shifting costs to employees who cannot handle the extra financial load. We also face the added burden of shrinking reimbursement from government funding agencies and significant cuts in state mandated reimbursement to fund indigent care while still having to treat a higher percentage of the indigent population.

County hospitals face a great opportunity by becoming private friendly purveyors of care. It's a natural transition that, with some perseverance, can mean the difference between continuing to serve a growing need—or becoming extinct as a relic of the past.

Valerie Yv. Woolsey, MBA, is the Director of Payor and Provider Contracting at the San Mateo Medical Center, a 509 bed acute care County hospital, skilled nursing facility, and 12 clinics located across San Mateo County..

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HFMA Calendar of Events See www.hfma-nca.org for more information	
June 15, 2005	A morning with the Department of Managed Care 9am - 12 pm One Capitol Mall, Sacramento
June 26-29, 2005	Annual National Institute, Las Vegas, Nevada
July 23, 2005	Come out to the Ball Game SF Giants vs. Florida Marlins
September 30, 2005	Sixth Annual HFMA No Ca Golf Tournament Canyon Lakes, San Ramon

JOBS! JOBS! JOBS!
Members can view and post jobs directly on our web site
CHECK WWW.HFMA-NCA.ORG TO POST OR REVIEW CURRENT JOB OPPORTUNITES

We hope that this newsletter will help keep you, our members, involved, informed and more connected to our Chapter's 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.

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