The Edge

hfma northern california chapter
healthcare financial management association

Sixth Issue - FY09-10 March 2010

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President's Message

Ken Jensen
Chapter President
2009-2010

To begin with, I want to congratulate the chapter for exceeding the membership goal set by HFMA National. Our chapter has experienced positive growth, which is not consistent with other chapter membership losses. We have a very good blend of various disciplines for both providers and vendors. This creates a significant opportunity for our members to learn and deal with issues from their peers.

To that end, you can all have an opportunity to network and learn at our Spring Conference on March 25 and 26. The sessions are geared toward different interests and all have a lot to gain. The evening of the 25th will provide a chance to meet people who are having similar issues to deal with and positive initiatives to resolve them. There will be a number of vendors available to discuss their products.

Another positive is this newsletter, which through National's survey, has been positively received. This is a tool provided for you to keep in touch with current and "hot" issues. If you have a topic of interest, I encourage you to share your point of view by writing an article for publication.

One of the chapter's shortcomings are the education hours for each member. I know budget and time constraints are a reality. National has assigned us a goal of nine hours of education per member. Right now, we are averaging a little over four hours per member. Venues are organized to be informative and cost effective. You and your colleagues are encouraged to participate in the chapter's activities.

In closing, I want to thank all of the volunteers who spend their time to make our chapter a success. I hope that those of you who are not involved will see your way to participate.

Register Now for the HFMA Northern California 2010 Spring Conference March 25-26, 2010

- Multiple education tracks in Finance, Revenue Cycle, Compliance and Managed Care
- Back to Basics for Revenue Cycle Staff
- 1-1/2 days of networking with a must-attend social event
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HFMA Northern California Education and Events Calendar
Visit www.hfma-nca.org for details and to register online

March 17, 2010
Monthly PFS Forum: Top 5 Key Performance Indicators
Free Teleconference. To join, email jaynek@ciriusgroup.com.

March 25-26, 2010
HFMA Northern CA Spring Conference
Sacramento Marriott Hotel, Rancho Cordova, CA

Exhibit and sponsorship opportunities available. Contact Barry Brown at barry@rashcurtis.com

April 21, 2010
Monthly PFS Forum
Free Teleconference. To join, email jaynek@ciriusgroup.com.

June 20-23
HFMA 2010 ANI Conference
Nashville, TN
http://www.hfmaconference.org/

September 19-21, 2010
California Fall Conference
Long Beach, CA
http://www.hfma-mgdcare.org/

October 1, 2010
2010 HFMA Northern California Golf Tournament
Rancho Solano Golf Course, Fairfield, CA

Contact Barry Brown at barry@rashcurtis.com for sponsorship opportunities.

Healthcare Case Decision: Marin General Hospital vs. Modesto & Empire Traction Company

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Marin General Hospital v. Modesto & Empire Traction Company, No. 07-16518, 2009 WL 13169 (9th Cir. Sept. 10, 2009) represents a watershed development in ERISA law. Financially, it means hospitals finally found a legal means/theory by which they can pursue health plans for unpaid medical care which avoids the typical procedural traps raised by those plans in court. Until Marin General, health plans frequently escaped full payment for medical care they had authorized beforehand by claiming -- after the fact (i.e. after the hospital had treated the patient) -- that the patient had not paid premiums, or that the health plan's language only promised to pay "reasonable and customary" charges (not the hospitals' full billed charges), or that the patient had not "cooperated" with a claims adjuster, or that the patient had a pre-existing condition. Such excuses naturally left hospitals in an unfair position when they tried to collect because those excuses involved disputes entirely beyond the hospitals' control and contracts to which the hospital was not a party -- i.e., the health plan agreements between health plans and their members. In a lawsuit for payment of the unpaid or underpaid hospital bill, the health plans' favored maneuver by which to raise those excuses was to remove the case to federal court on the basis that the federal Employee Retirement Income Security Act ("ERISA") entirely "pre-empted" all actions against health plans. Then, once in federal court, the health plans would obtain dismissal by arguing that since the hospitals "stood in the shoes" of the health plan member, all defenses that could be raised against the member under ERISA could thus be raised against the hospital (e.g., the member failed to pay premiums or the member had a pre-existing condition).

> *"...hospitals finally found a legal means/theory by which they can pursue health plans for unpaid medical care which avoids the typical procedural traps raised by those plans in court."*

Since the nature of care for human illness demands treatment first and then payment afterwards, health plans in essence had shifted their underwriting risks to hospitals. Hospitals called up health plans before treatment, received assurances from a health plan that a particular patient was "covered," treated the patient, and then found out the health plan had found some reason to deny the claim. This meant the risk of whether a patient was truly "covered" under a health plan always came after treatment was rendered. Since medical care cannot be repossessed from a non-paying patient like a car, and since health plans withhold payment depending their post-treatment due diligence, hospitals not health plans carry the financial risk that a patient actually will be "covered" under a health plan. One would think that the risk-bearing entity regarding whether someone is "covered" under a particular health plan would be the health plan. After all, health plans collect premiums for just such a possibility, not hospitals. As a result, hospitals must raise their rates to make up for such shortfalls

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Washington Releases National Health Expenditures Data for 2008

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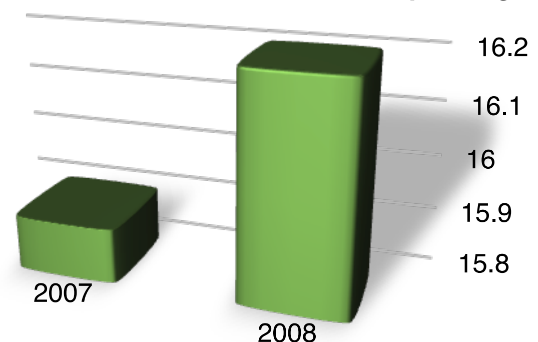
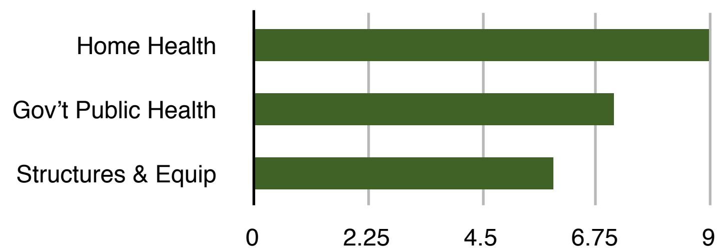
The Centers for Medicare and Medicaid Services has released data for health spending in 2008. This is the most recent data available. It shows that all health spending grew by 4.4 percent. This is well in excess of GDP growth of 2.6 percent. Economic downturns are typically marked by acceleration in the share of GDP allocated to health as GDP growth slows or contracts much more than health spending. National health spending as a share of GDP rose to 16.2 percent in 2008 compared to 15.9 percent in 2007. Some of the fastest growth in 2008 occurred in home health (9.0%), government public health (7.1%) and for structures and equipment (5.9%). Growth was slowest for government administration and the net cost of private health insurance (0.7%), research (2.6%) and other personal care (2.6%) which includes in-plant industrial health care and unspecified government health services. Hospital care, the largest category, grew by 4.6 percent; and physician and clinical services, the second largest category, by 5.0 percent. Hospital growth declined markedly from 5.9 percent in 2007. It is interesting to note that prescription drug spending growth fell to 3.2 percent. This growth was double digit from 1997 to 2003. It has slowed for a number of reasons including fewer new blockbuster drugs, a greater role for generics and effects of the recession.





Hospitals suffered a 20.3 percent drop in other private revenue, a category driven by investment returns. On the other hand, there was rapid growth of Medicare revenues which increased 7.7 percent. This increase was associated with an increase in fee-for-service inpatient utilization.

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Marin General vs. Modesto & Empire Traction ... continued from page 2

while health plans can enjoy lower costs. Health plans got away with this because ERISA law allows health plans to insert restrictive language and limitations into plan agreements, which restrictions and limitations the courts would uphold.

Marin General changes that situation dramatically. Marin General recognizes hospitals have a legal right to pursue health plans independent of plan language and thus independent of possible ERISA defenses. Thus, even though a hospital may have an assignment of benefits from the patient, the hospital can forego that route and choose to sue on strictly state-law-based grounds regarding a duty to pay owed by a health plan directly to the hospital rather than derivatively through the patient.

It is hard to peg a hard dollar estimate to hospitals and health plans stemming from this decision. However, it should be large. Certainly, the ruling could and should have a clear impact on the current health care debate. Among other things, Marin General affects the Pre-existing condition issue, the "Who-should-pay-for-unpaid-care?" issue, and the "Why-are-hospital-rates-so-high?" issue.

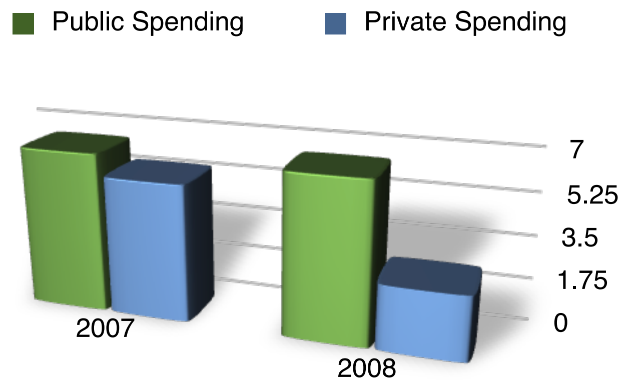
For consumers as a whole, the favorable effect Marin General ought to have on lowering hospital rates probably would be offset by health plans raising premiums as health plans are forced to tighten up their underwriting standards. Nevertheless, an individual consumer needing treatment should have greater certainty the health plan would actually pay their hospital bills and thus would not have to pay such bills personally.

Since this ruling came out of the Ninth Circuit, technically it affects only the Western United States. However, we believe it is the first case of its type to so clearly delineate the non-application of ERISA rules and limitations to disputes between health plans and hospitals (if hospitals choose to sue upon strictly state-law grounds). Thus, Marin General should have impact outside that area as other courts look for guidance.

National Health Expenditures Data for 2008 ... continued from page 2

Public spending in the health sector grew by 6.5 percent in 2008, the same as 2007, but private spending fell from 5.6 percent in 2007 to 2.6 percent in 2008. Public sector spending accounted for 47 percent of all national health spending in 2008, up from 38 percent in 1970. State and local spending on Medicaid actually fell in 2008 by 0.1 percent driven by budgetary difficulties. Total federal spending on Medicare and Medicaid in 2008 grew by 8.6 and 8.4 percent respectively. The slowdown in private spending is attributable to worsening economic conditions.

Health spending typically has not been very sensitive to modest economic downturns. But more severe ones, such as we currently face, or in the early 1980s, have had more pronounced impacts on the health sector. 2009 will likely show continued growth of the federal role in financing health expenditures and as well as other forms of restructuring. Health spending continues to grow faster than the economy as a whole. Health care reform is expected to accelerate this trend. The share of GDP allocated to health will rise. This in itself is not problematic. After all, the history of economic progress is driven by new technologies and many of them are now in health care. Unfortunately, there has not been enough productivity enhancing technical change in health care. Third party payment drives a wedge between price and cost. We cannot be assured that efficiency is obtained either in production at the lowest possible cost for a given level of quality, or in allocation to achieve maximum social welfare given all opportunity costs of scarce resources. There is a danger that aggregate productivity gains, which drive long run prosperity, will be undermined as rising health expenditures displace other sectors. Ironically, higher health spending could undermine health itself measured by life expectancy and infant mortality if non-health spending falls. There is a strong correlation between material standards of living and these measures.



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CIB PDF 0110-025

The Role of Health Care Reform on the 2010 Financial Markets

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A year ago, after the economic collapse, the only real financial transactions being completed were in pharmaceuticals, life sciences and health care. Once health care reform became a legislative priority in Washington, D.C., however, the health care M&A market came to a halt.

Over the course of 2009, health care reform took on greater shape in the public sector and the uncertainty in the capital markets decreased. Toward the end of 2009, there was a renewal of health care M&A activity.

Looking ahead, we believe 2010 offers a tremendous amount of opportunity for a variety of health care transactions. And the next 12 months should easily make up for the stop-and-start nature of last year's market. Indeed, many of our clients who used to do two to three health care deals a year prior to 2009 did none last year; but they're telling us they plan to make up for the lack of 2009 transactions in 2010.

> *"It's true that the financing environment isn't completely favorable today, but there are signs of life, and we see more and more lenders coming to the table with a renewed appetite for deals."*

They'll be encouraged by an economy that's slowly healing as it emerges from recession. It's true that the financing environment isn't completely favorable today, but there are signs of life, and we see more and more lenders coming to the table with a renewed appetite for deals.

The positive macro transition, plus some sort of signed health care reform legislation, should, in the end, make the next few quarters very active ones when it comes to health care M&A. The only red flag—and it's an important caveat—is that health care reform coming out of Washington, D.C., could have a profound impact on valuations.

There are three kinds of health care transactions we see unfolding in 2010, and each one necessitates a different approach to due diligence.

The first involves venture-backed health care organizations seeking to acquire similar accretive business units because they want to create a larger health care organization that would be attractive to an upstream consolidator for future sale. Due diligence

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Health Care Reform - What Will EFT Mandate Mean for Providers?

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Both the Senate and House versions of health care reform legislation include an electronic funds transfer (EFT) mandate for claims payments. This has been a long time coming as the original provider and payer testimony to Congress in the early 1990s included support for replacing checks with electronic funds transfers. For providers this should be a welcome transition from paper-based processing to an electronic solution for payment receipt. This is the greener and less expensive way to do business. Today EFT receipt is still primarily an exception to the rule as the vast majority of claim payments are made via check. Most hospitals have been receiving EFT for Medicare Part A since 1993, yet in many health systems only a handful of other payers have converted from checks to EFT. Steps can be taken by providers to increase receipt of EFT today even before the mandate goes into effect. This mandate should act as a catalyst for revenue cycle professionals to work with their bankers to expedite payment processing and reduce costs.

WHY ELECTRONIC PAYMENTS?

Working with paper checks requires manual labor and is expensive whether your deposits are processed by your bank's lockbox operations or by your staff. With electronic payments there is no processing labor required as there are no envelopes to be opened and no deposit tickets to prepare. As an added benefit, funds are often available for expenditure or investment days earlier than in a paper environment. Use of EFT also minimizes the risk of check fraud which is a real threat to any organization working with paper documents. Properly controlled, EFT has far fewer risks than check based payments. There is one challenge to increasing the volume of electronic claim payments. That issue is the "re-association" of data and dollars. This can be solved with proper planning and use of the services of an EDI capable bank. While all banks must be able to receive electronic funds transfers, your bank also must be able to provide you with information about each funds transfer that allows you to match that payment to a related electronic remittance advice (ERA).

RE-ASSOCIATION - THE PROVIDER CHALLENGE FOR EFT RECEIPT

In a paper world, the check and the remittance advice are mailed together and the clerical staff determines if the remittance amount matches the payment amount. In a bank lockbox setting, the bank deposits the check and sends a photocopy or provides an image of the check to the provider to allow for that same

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The Role of Health Care Reform ... continued from page 4

here demands that the acquiring health care organization substantiate robust EBITDA, a healthy payor mix, lucrative contracts, strong management teams, and a strategic market hold. The due-diligence process also must look for potential liabilities, such as unrecorded tax issues or regulatory issues that might place undue burden on the heath care organization. Finally, the due-diligence effort must examine structural integrity, which includes considering outdated IT systems, at-risk key employees, and deteriorating market reputation.

The second type of deal involves not-for-profit health care organizations seeking to acquire specific assets of target health care companies in order to strengthen or fill in current business needs. In this case, due diligence should consider the same items noted above, but to a lesser degree. Instead, the buyer must closely analyze the strategic nature of the target assets while minimizing possible liabilities.

The third type of deal involves health care organizations—either for-profit or not-for-profit—looking to divest themselves of unprofitable divisions, facing unpalatable regulatory requirements, confronted with an unworkable monopoly, or seeking a white knight to save the day with an acquisition. Due diligence in these distressed situations is usually more focused on the financial assets being acquired, the fair value of those assets, and the minimum purchase price that is acceptable.

The general rule of thumb is that the longer a due-diligence process takes, the greater the likelihood the deal will falter. That's why we recommend that health care buyers and sellers today focus on the push-pull dynamic, which leads to the ultimate sales price. In this dynamic, the buyer typically slows the due-diligence process down to make sure all the variables are considered and the lowest price is achieved; at the same time, the seller generally tries to speed up the process to complete the sale at the highest possible price.

These due-diligence guidelines and approaches are not hard and fast, but they do represent several potential courses of action that we believe will help buyers and sellers in the health care market as they complete necessary and meaningful transactions in 2010.

What Will An EFT Mandate Mean for Providers? ... continued from page 4

evaluation. When payers send ERA files through a clearinghouse or ask providers to download ERA files from a website the provider has to "re-associate" that data with a funds transfer or a check. Matching ERA files to a check is very labor intensive because it can mean looking for one item among hundreds or thousands. Matching ERA and EFT can be automated because the HIPAA implementation guideline provides for the use of a trace number segment sent in both a remittance file and the related EFT. The use of this trace number methodology is widely supported by payers today but often providers have not enabled EDI reporting from their bank to receive this deposit data complete with trace numbers. The service should be available from your bank but you have to ask for it. Providers have commonly not realized this functionality exists within current EDI transaction capabilities, and banks do not always market it.

PLANNING FOR THE EFT MANDATE - TALK TO YOUR BANK!

At Kindred Healthcare we work with multiple banks that were chosen for both their lockbox services and other electronic tools to facilitate our strategy of moving paper claim payments to ERA and EFT receipt. While some service providers may write or buy software to manage re-association, Kindred partners with our banks to provide ERA retrieval solutions from payers and clearinghouses. The bank provided electronic "re-association" service eliminates the manual matching of check and deposit and allows for immediate electronic file payment posting with accompanying deposit and remit reconciliation. Performing re-association manually by matching bank deposit reports to ERA files is very time consuming and requires more and more labor as EFT activity from payers increases. As regional and smaller payers adopt EFT, Kindred welcomes the chance to "go green" by saving trees and cutting costs. By adopting use of the "trace number segment" within existing bank EDI processes for EFTs and ERAs, the health care industry can rapidly eliminate the costs of printing, mailing, and processing between 500 million and one billion checks annually. Now that is a lot of green.

MACs Move to Limit Re-openings

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On August 21, 2008, the Centers for Medicare and Medicaid Services (CMS) enacted sweeping changes to the Medicare appeals process. These changes have made the appeals process increasingly difficult to navigate. Elements included in the filed Medicare cost report, such as a comprehensive protest list, are imperative for Providers to preserve their opportunity to pursue specific appeal issues.

Further complicating matters are the positions that the Medicare Administrative Contractors (MAC) are beginning to take regarding filed Medicare cost reports. The official that signs the certification page of the filed cost report is asserting that the report is true, correct, complete, and prepared from the books and records of the provider, in accordance with applicable instructions. Recently, MACs are taking the position that, based on this certification, the cost report reflects all applicable accurate information and that no further additions or changes should be made to the cost report. This effectively eliminates the opportunity to pursue additional Medicaid eligible days or additional Medicare bad debt if the issue is not raised as a protest item.

> *"...the Medicare cost report re-opening process can no longer be counted on as a viable solution for implementing Provider initiated corrections to audited Medicare cost reports."*

More discouraging is the recent position that some MACs have taken in denying cost report re-openings to correct errors or omissions of data on the basis that cost report re-openings are made solely at the discretion of the MAC. As a result, the Medicare cost report re-opening process can no longer be counted on as a viable solution for implementing Provider initiated corrections to audited Medicare cost reports.

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This is a "Pulse Check" - ICD 10 Preparation!

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Okay, let's be honest now…. Have you done "ANYTHING" to prepare for ICD-10 Implementation yet? **Stop waiting, there is lots to do!**

With **ICD-10 implementation date of October 1, 2013**, we have to first be aware of the 5010 transaction date of January 1, 2012. This is the precursor to ICD-10, without the 5010 in place and working we can't use ICD-10. So, get your IT team and Patient Financial Services leadership together and start creating a plan. You'll need to conduct an IT assessment first. Include a process and steps to test and validate the system(s) both internally and externally. Some key aspects to focus on include:

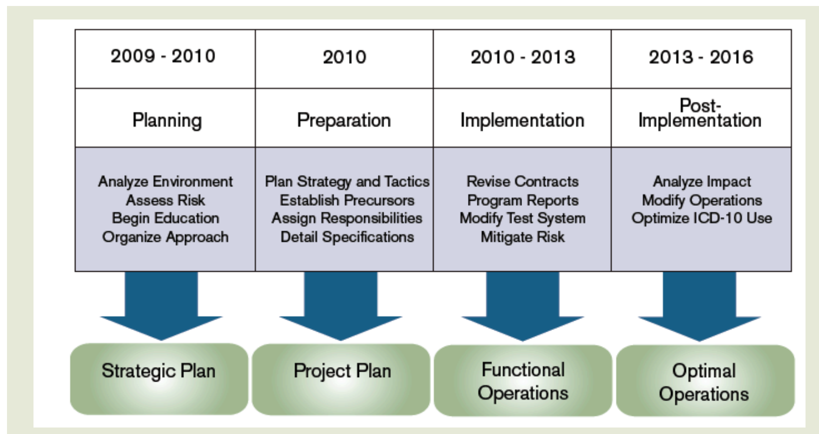
INTERNAL

- ☑ Populate files used for testing purposes.
- ☑ Validate that the changes are properly recorded in the specific section of the HIPAA transaction standard.
- ☑ Monitor whether appropriate security methods are used including log-in and tracking of individuals.

EXTERNAL

- ☑ Communicate with insurers about your testing and validation plans.
- ☑ Identify various production scenarios that should be used during the testing period.
- ☑ Consider getting results from a reimbursement perspective and validate that the payment is similar to what you got under ICD-9-CM.
- ☑ Confirm go-live date with health plans.

Hospital and Healthcare Systems should review all technology vendors, including the level of risk associated with each system or vendor, and perform a gap analysis describing tasks and dependencies to move from the current ICD-9-CM world (and associated X12 4010 transaction sets) to ICD-10 and its associated X12 5010 transaction sets.



Some questions to ask include the following:

1. What parts of the work force must be trained in health plans, health care provider organizations and others?
2. How will the training be delivered?
3. What methods can be used for training hundreds of individuals?

Your ICD-10 Implementation Team should have representation from the several departments:

- ☑ Billing
- ☑ Compliance
- ☑ Finance
- ☑ Health Information Management/ Coding
- ☑ Information Systems and Technology
- ☑ Revenue Cycle Management

The ICD-10 Steering Committee members will vary according to the organization's implementation needs. Industry experts recommend that the planning and impact analysis should be completed by the end of first quarter 2010.

More and more organizations and vendors are developing tools and information to help increase an understanding of ICD-10 implementation and to increase overall awareness. A recent white paper on ICD-10 provided the table shown on this page to help demonstrate the aspects and timeline for implementation. (Source: Milliman, ICD-10 Industry Perceptions and Readiness, January 2010)

Are you going to be ICD-10 Compliant? Don't wait to find out!

RAC Status… The Fun Has Begun!

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It's here finally after much waiting and anticipation, RAC (Recovery Audit Contractor) requests for medical records have started to be received from HDI (HealthDataInsights), Medicare Recovery Audit Contractor. These requests are referred to as "complex" reviews. HDI covers Region D which includes California.

There has been an increase in the "issues" listed for RAC targets. These include many MS-DRGs, both for over and under payments. These new issues bring the total number of DRG validation issues to 530 out of a possible 747 DRGs. Here are some of those targets, for a complete listing go to the HDI website at: https://racinfo.healthdatainsights.com/Public1/NewIssues.aspx?State=CA

DRG Validation-Amputations	DRG Validation requires that diagnostic and procedural information and the discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician description and the information contained in the beneficiary's medical record. Reviewers will validate for MSDRGs 239, 240, 241, 255, 256, 257, 474, 475, 476, 616, 617, 618, principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRGs (At this time, Medical Necessity excluded from review).
DRG Validation-Blood & Immunological Procedures	DRG Validation requires that diagnostic and procedural information and the discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician description and the information contained in the beneficiary's medical record. Reviewers will validate for MSDRGs 799, 800, 801, 802, 803, 804, principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRGs (At this time, Medical Necessity excluded from review).
DRG Validation-Burns	DRG Validation requires that diagnostic and procedural information and the discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician description and the information contained in the beneficiary's medical record. Reviewers will validate for MSDRGs 927, 928, 929, 933, 934, 935, principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRGs (At this time, Medical Necessity excluded from review).

Hospital HIM (Health Information Management), Revenue Cycle, and Finance departments currently have and will continue to have much work to do with the great expansion of the MS-DRG targets. Being proactive is key; and conducting your own RAC defensive audits will be a good first step. In addition, looking closely at the clinical documentation and the need for improvements will also be a focus for MS-DRG auditors.

Another interested HDI RAC target is readmissions:

Acute Readmissions -No B4	An improper payment occurs when two separate acute hospital claims are paid for a Medicare beneficiary who is discharged and re-admitted on the same day and for the same DRG and there is no B4 condition code on the second claim

With readmissions there will be involvement with Care Management, Utilization Review, and the Medical Staff. Your facility RAC team should include these stakeholders.

It's important to note that prior to the three-year RAC demonstration, the national error rate for underpayments was determined through the Comprehensive Error Rate Testing (CERT) program and the Hospital Payment Monitoring Program (HPMP) to be at 9%.

HDI has a *Provider Portal* which offers information and communication on RAC activities in Region D. I encourage you and your RAC committee members to be watching the HDI website. Let's all stay turned as more fun will be coming, that's a given.

MACs Move to Limit Re-openings ... continued from page 5

In a recently issued email to Providers, a MAC made the following statements regarding Medicare cost report re-openings:

- The cost report submission and re-opening processes are not intended as vehicles for providers to make claims for Medicare payment on a piece-meal basis, either in the originally submitted cost report, or later in a request for cost report re-opening.
- The re-opening process described in 42 CFR 405.1885 allowing the MAC to re-open and revise specific claims for Medicare payment covered by a cost report is discretionary (or based upon explicit direction from CMS).
- The Provider has no right to a re-opening.
- Only in the exceptional case, where a provider can demonstrate by a preponderance of evidence that true, correct, and complete claims for Medicare payments could not otherwise be determined and presented in the originally submitted cost report, will we grant a provider's request for cost report re-opening. This does not apply to providers' requests for cost report re-opening due to obvious, material and inadvertent errors of omission, or misstatement, which we believe would be isolated and infrequent.

As a result of this changing landscape, it is extremely important to carefully review the protest item listing included with your cost report to ensure that you have protected your appeal rights for all applicable issues. Future revenue streams through the Medicare appeal process could be forever lost by way of jurisdictional impediments if appeal protections are not built into your Medicare cost report filing process.

Life Cycle Cost Analysis: An Asset Management Strategy

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Many healthcare facilities treat building systems upgrades as large maintenance expenses. But these projects are not merely maintenance exercises, and such an approach short-changes management on two key points.

While the upfront cost of major system components can represent only 5 percent of their total cost of ownership over twenty or more years, many organizations plan purchases on a first-cost basis. They issue requests for proposals (RFPs) that seek the lowest possible pricing for the initial equipment purchase. But given that the installations are intended to last for decades, they are clearly capital investments.

In addition, system components are prime energy consumers (HVAC systems, for instance, account for approximately 45 percent of a typical hospital's energy use according to the Consortium for Energy Efficiency). Purchase decisions therefore should also be driven by an institution's long-term energy management strategy.

Instead, the upgrades would be better managed according to their "Life Cycle Cost" (LCC).

According to the *NIST Handbook* from the U.S. National Institute of Standards and Technology, life cycle cost is "the total discounted dollar cost of owning, operating, maintaining, and disposing of a building or a building system" over a given period. A full Life Cycle Cost Analysis (LCCA) compares initial, maintenance, repair, and operating costs over the life of a building system upgrade. The LCCA particularly examines such critical variables as equipment materials behavior, intended facility use, environmental conditions and projected energy costs.

A comprehensive LCCA can pinpoint bad bargains such as supposedly "low-price" systems that turn out to feature unacceptably short lifespans or excessively large lifetime operational costs.

- **Initial Planning and Variables** Each RFP should include an LCCA, conducted as early as possible. The goal is to create a system that can operate at peak efficiency throughout its lifetime, making use of noncorrosive materials in harsh environments and eliminating system shutdowns.

  The LCCA equation contains three vital variables: 1) the costs of ownership, 2) the period of time over which costs are incurred, and 3) the discount rate applied to future costs to equate them with present-day expenses.

- **Cost Variable — Initial Expenses** Costs incurred prior to system installation include capital costs for the system and its controls. Since flexible controls are the most important factor in maintaining a high-performance environment systems at your hospital, emphasize issues such as centralized command and control; precise temperature and humidity control; ease of changing settings; control of core functions such as laundry,

Continued on page 9

Automated Charity Program Cuts $1 Million from Uncompensated Care

Bruce Nelson
Vice President
SearchAmerica

Touchette Regional Hospital, with campuses in Centreville and East St. Louis, Ill., offers cardiopulmonary, laboratory, radiology, physical therapy, behavioral health and obstetric services; an oncology infusion clinic; a 24-hour emergency department; and an intensive care unit. It also provides inpatient and outpatient medical and surgical services.

As a safety net facility, Touchette Regional Hospital fulfills its mission of providing care within their medically indigent population. More than half of the patients served at Touchette are on Medicaid or are self-pay customers. However, Touchette realized that if good systems were not in place to support the charity-care policy, their mission could be taken advantage of.

"We really had to balance providing good care in our community to those who need it and aren't able to pay for it, which is our mission, with performing a gate-keeping role to identify those who do have some type of ability to pay or have access to providers in their community," explains John Majchrzak, CHFP, CPA, MBA and Vice President of Finance at Touchette.

As recently as two years ago, anyone who walked into the hospital asking for care would receive it, says Majchrzak. "We didn't have a good system to verify income, and we didn't have a good system to verify someone's address, so it was all on your honor," he says. "We saw a lot of patients driving over an hour, passing by several other providers and coming to our facility simply because somebody said you can get free care here."

Administrators knew it was time for an overhaul of their front-end process, so they completely re-tooled their charity-care policy. To implement the new policy within an automated registration process, they teamed with SearchAmerica®, a part of Experian, which provides automated financial screening services, and Emdeon®, which provides revenue and payment cycle solutions for health care.

The revamped registration process included technologies designed to implement Touchette's new charity-care policy and verify patient identity. Frontline personnel were trained on the new system and interpersonal skills, both of which are needed to make staff and patients comfortable with the computerized verification and eligibility system.

Registration personnel at Touchette were accustomed to doing everything manually, so it was necessary to have 30 people trained on how to use a new, automated eligibility system. "It was quite a kick-start, but I have to admit that it has made a dramatic change in our patients' attitude, our revenue, and our handling of charity," explains Pat Niel, Admitting Director at the hospital.

The hospital worked with SearchAmerica and Emdeon to customize a system that would retrieve information from credit reporting agencies and insurance carriers so that it could automatically calculate a patient's co-pay or eligibility for the hospital's charity-care policy based on existing coverage, the size of the household, household income, and address.

Search*America*'s service provides Touchette registrars with one of three possible responses to frontline personnel at the point of service:

Continued on page 9

Life Cycle Cost Analysis ... continued from page 8

pharmacy, and security; and ease and efficiency of testing and balancing equipment.

Estimate initial construction costs by referencing historical data from similar facilities, and by consulting government and commercial cost estimating guides and databases.

- **Cost Variable — Future Expenses** Future costs are incurred after the system is in place. They include energy, water, and other utility costs, non-fuel operating costs, and maintenance and repair (OM&R) costs.

  Energy and utility modeling software can help analyze a building's projected use, occupancy rates, schedules and more. A thorough LCCA factors in an energy price projection as well as rate type, rate structure, seasonal differentials, block rates and demand charges.

  Since operating schedules and standards of maintenance vary widely from building to building, so do OM&R costs. HVAC systems usually remain in place for several decades. If a low-cost system comes with exorbitant upgrade costs, your preparer should consider alternative options that may bear a higher initial price tag but are more cost-effective to upgrade over the system's lifetime.

- **Cost Variable — Non-Monetary Benefits** These include the capabilities of a system to optimize environmental advantages, including indoor air quality (IAQ), filtration, pressurization, airflow, and acoustics. Example: the non-monetary benefits derived from a particularly quiet system.

- **Time Variable** Typically, the LCCA study period for evaluating ownership and operations expense ranges from 20 to 40 years — generally less than the intended life of the facility. The NIST suggests dividing the study into planning/construction and service periods.

- **Discount Rate Variable** The discount rate is the rate applied to future costs to equate them to present-day expenses. It's the number that would make you indifferent whether you received a smaller payment now or a larger one later. Your preparer may consult the U.S. Department of Energy, whose discount rate is updated annually.

  Constant-dollar analyses exclude the rate of general inflation; current-dollar analyses include the rate of general inflation in all dollar amounts, plus discount rates and price escalation rates. Both types of calculation result in identical present-value life cycle costs.

Building systems upgrades are not maintenance projects. Utilizing a Life Cycle Cost Analysis in their planning and purchase reinforces their place as key assets to an institution's operations, efficiency, and performance and allows for their accounting, and management, as such.

Automated Charity Program ... continued from page 8

- Probable — A patient qualifies for 100 percent charity
- Review — A patient qualifies to have 30 percent to 70 percent of their medical costs covered by charity care; the amount is determined after further financial information is provided by the patient to Patient Accounts
- Unlikely — A patient does not qualify for any charity care and is responsible for paying the full estimated cost of the procedure prior to receiving the service

With this information, frontline staff members know how to proceed with financial counseling of each patient even though they do not have access to a patient's personal information, which is available only to the Patient Accounts department.

"There are going to be occasions when someone may have just lost their job within the week. That may not show up, but when you can be 90 percent free of all that [manual retrieving of information] and you can instantly communicate financial assistance to a patient at registration, that is excellent customer service," Niel says. "Patients can now be qualified for charity at the time of registration. This eliminates the additional step of asking patients to return with financial documentation and be subject to a timely review process."

"In the first six months of 2008, Touchette had about $8.8 million in uncompensated care, and in the first six months of 2009, we had $7.8 million, so we had $1 million in improvement," says Majchrzak. Even more interesting, while that improvement was occurring, the amount of charity care the hospital provided went from $3.5 million in 2008 to $5.6 million in 2009.

"Even though our total uncompensated care went down, our charity care has gone up, so to me this is showing that we are meeting the mission of taking care of those in our community who don't have the ability to pay while at the same time performing a gatekeeper role for those who do have the ability or who don't live in our community," Majchrzak explains.

In addition to coming out ahead financially, the hospital has ample evidence that frontline personnel are much happier, according to Niel, who oversaw implementation of the new system. Employees formerly had to make multiple calls, inconvenience patients, and sometimes send patients home to retrieve pay stubs or other documentation. Now staff can verify addresses, income, insurance and charity-care eligibility via computer at the point of registration. "It provides the staff with sufficient knowledge at the time of registration to counsel the patient on their insurance eligibility and/or their charity eligibility," Niel adds.

HFMA NORTHERN CA REVENUE CYCLE FORUM
FREE EDUCATION AND NETWORKING
MARCH 17, 2010, 12:00 NOON, VIA TELECONFERENCE

Join Us! We are healthcare providers in the Northern and Central CA geographic region that get together once a month and chat about various "hot topics" surrounding Revenue Cycle. Our format is that for 30 minutes we discuss the pre-determined "hot topic" and then we open the floor the last 3 minutes for an opportunity to share what's on your mind today.

Our next session topic is: **TOP 5 KEY PERFORMANCE INDICATORS**. Grab your lunch, munch and share with us for one hour, once a month. We meet **every third Wednesday at noon**. If you miss us this time, find our next gathering on the HFMA Northern CA website, for your convenience.

Beyond the Medi-Cal Payment Lawsuits: The Supremacy Clause Opens the Door to Provider Challenges to State Laws that Conflict with Federal Laws

Kathryn Doi, Partner, and Asha Jennings, Associate
Murphy Austin Adams Schoenfeld LLP

The recent successful federal court challenges to the State of California cuts to Medi-Cal reimbursement rates are notable not only because they have offered providers relief from the rate cuts, but also because they have established the viability of provider challenges to California state laws on the grounds that they conflict with federal health care laws.

While States may enact laws governing Medicaid and Medicare program standards and administration requirements beyond those created by federal law, such laws are subject to challenge if they are inconsistent or in conflict with federal Medicaid or Medicare laws. In such a case, providers can claim that the State law or conduct violates federal rights secured by the Supremacy Clause of the United States Constitution. Under the Supremacy Clause, federal law (such as the Medicaid or Medicare statute) takes precedence over state law (*i.e.*, the state's interpretation or application of federal Medicaid or Medicare law) to the extent that they conflict.

In a series of Medi-Cal reimbursement rate cases, providers alleged that the State of California violated the "equal access" provision of the federal Social Security Act when it enacted legislation that cut Medi-Cal fee-for-service rates by 10 percent. The equal access provision requires States to establish provider reimbursement rates that "assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available [to the population served by Medicaid] at least to the extent that such care and services are available to the general population in the geographic area." The federal courts have found that providers can bring a legal action to challenge the rates cuts as violating the Supremacy Clause. The courts also found that even though federal Medicaid law vests States with considerable discretion over Medicaid payment rates, federal law requires that rate cuts must be supported by responsible cost studies that consider the impact of rate cuts on efficiency, quality and access to care. Since the State did not support the rate cuts with such cost studies, the courts have prevented the State from implementing the cuts. (*See Independent Living Center of Southern California ("ILC")* v. *Shewry* (9th Cir. 2008) 543 F.2d 1047, *cert den. Maxwell-Jolly* v. *ILC* (2009) 129 S.Ct. 2828.)

The Medi-Cal rate cut cases have paved the way for providers to challenge other State action that is taken contrary to the federal Medicaid or Medicare laws, or other federal laws. For example, the Supremacy Clause theory also provided the basis for a provider lawsuit challenging the State's implementation of the so-called Rogers Amendment, in which the State issued guidelines purporting to set rates for non-contracted emergency services provided to Medi-Cal patients. (*California Hospital Association* v. *Maxwell-Jolly*, United States District Court, Central District of California, Case No. CV09-3694.) In another case, an air ambulance company used the Supremacy Clause theory to challenge the application of workers' compensation rates to air ambulance services, alleging that the State's regulations conflicted with the federal government's exclusive right to regulate the prices of air carriers under the Federal Aviation and Airline Deregulation Acts. (*California Shock Trauma Air Rescue* v. *State Compensation Insurance Fund*, United States District Court, Eastern District of California, Case No. 2:09-cv-00090.) These actions are still pending.

Relief in these actions can come in the form of an injunction, which is a court order requiring the State to stop enforcement of a challenged law. A court can also order that the state revise its actions or laws.

Relief in these actions does not necessarily come quickly or easily. The State has a strong incentive to defend its actions and has often mounted early

Continued on page 11

Welcome New Members!

- **Neera Aggarwal** - Manager, Triage Consulting Group
- **Van A. Anderson** - Underwriting Consulting Director, CNA
- **Jeffrey M Anub, RN**
- **Kim Auerbach** - Revenue Cycle Solutions, Dell Perot Systems
- **Seth P. Catalli** - National Sales Manager, Oracle
- **Rick Dasheid, CPA** - Chief Financial Officer, Community Hospice
- **Katherine Djiauw** - Auditor, Moss Adams
- **Doris Fung**
- **Bruce Gekko** - Business Development, Eligibility Plus Inc.
- **Karl Peter Korinek** - Senior Consultant, Kurt Salmon Associates
- **Michael Kovacs** - Manager Revenue Cycle, Palm Drive Hospital
- **Paul Kroupa** - Senior Consulting Program Manager, NCAL Kaiser Permanente
- **Cyndi L. Farnham** - Coordinator Chargemaster, El Camino Hospital
- **Alisanne Frew** - Director of Sales and Marketing, GCS Healthcare Switzerland
- **Aadam Hussain** - Strategy & Financial Analyst, Kurt Salmon Associates
- **Travis Lackey** - Director of Finance, Mayers Memorial Hospital District
- **Ben Lamorte**
- **Stacy S. Lorenzen** - Finance Manager, Kaiser Permanente
- **LeeAnn Lumbert** - Patient Access Manager, Enloe Medical Center
- **Tracy L. Marshall** - Consultant, Marshall Consulting Group
- **Lori E. Mulliniks** - Finance Manager, Kaweah Delta Health Care District
- **Gopi Padakandla** - Project Manager
- **LaTonya H. Robinson** - Assistant Corporate Controller, Kaiser Permanente
- **Kevin L. Smith** - Area Finance Officer, Kaiser Permanente
- **Jeannette C. Tarver** - Sr. Accountant, Palm Drive Hospital
- **Larry W. Thomas** - Sr. Financial Analyst, St. Helena Hospital
- **James B. Warburton** - Sr. VP, CTP Solutions
- **Thomas Erich Wurster** - CAPSTAN Equity Partners
- **Mario Ybarra** - Contracts Manager, St. Rose Hospital

Welcome Members Who Transferred In!

- **Gary J. Burdick** - Chief Executive Officer, Designed Receivable Solutions Inc.
- **Jake Carl** - VP of Sales Healthcare Initiative
- **David Patrick Delaney** - Vice President Financial Planning and Performance, Kaiser Permanente
- **ReJena M. Harris** - Chief Executive Officer, Revenue Cycle Resources, Inc.
- **Corinne F. Karp** - Senior Manager, Kaiser Permanente
- **Samuel L. King** - Chief Financial Officer, St. Mary's Regional Medical Center
- **Kenneth T. Gacka** - Healthcare Ratings Analyst, Standard & Poor's
- **David B. Latzer** - Senior Manager, Ernst & Young, LLP

HFMA NORTHERN CALIFORNIA - SPOTLIGHT ON A MEMBER

Chuck Acquisto
Senior Associate Attorney
Law Offices of Stephenson Acquisto & Colman

Past President, HFMA Northern California Chapter

Years in Healthcare: 13

Years in HFMA: 13

"Great friendships are formed while acquiring education in HFMA"

How did you end up in Healthcare? Did you choose it or did it choose you?
Genetics? It runs in the family. So when I ran away from the East Coast winters to California, I joined the fun.

Tell us about yourself
I look a lot like ex-MLB player Wally Joyner, throw and bat left-handed but do everything else right-handed, enjoy writing and unwind with 6-mile runs after work. Plus, I never turn down pizza.

There's no right or wrong answer, but if you could be anywhere in the world right now, where would you be?
Parma, Italy, playing for pizza (with family in tow).

What do you like to do for fun in your spare time?
I coach Little League baseball and CYO basketball, read my 6-year-old daughter Gabbie's numerous mini-novels, work very little at keeping my golf handicap in the low 20-neighborhood and cut my small California lawn with an electric mower (because using clippers would look too silly).

What's the last book you read?
"Are You Kidding Me" by Rocco Mediare and John Feinstein (although I just began Schultz to learn about the man behind Peanuts).

What would you do if you won the lottery?
Fall down laughing because the only time I buy a ticket is when it is ridiculous jackpot.

What is your greatest achievement outside of work?
First, being a Dad/Husband. Second, getting my book published. Third, passing the California Bar in one try. Fourth, learning to juggle cats (relax, they are my daughter's stuffed animals).

If you could be a superhero, who would you be and why?
Batman because he is super rich and has a butler

What's the best movie you've seen in the last three years?
Up!

Who are your heroes?
My Mom and Dad followed very closely by Brooks Robinson.

The best advice I ever had was
"If you wanna dance, you've got to pay the fiddler." A close second was "Hell's fire" by my Catholic high school baseball coach and spiritual wiseman Steve Walker.

The best part of my job is
Bringing resolution to health care chaos on a daily basis. Working right across the street from the Stoneridge Mall ain't bad either.

My favorite food is
New York Pizza (Ray's ... any of the originals will do)

My first car was
1973 Chevy pick-up that got 3 mpg

My favorite car was
1983 Jeep CJ Ragtop

Favorite quote
"You'll Shoot Your Eye Out!" (I have a soft spot for Christmas)

Beyond Medi-Cal Payment ... continued from page 10

challenges to such lawsuits on procedural grounds. The State has previously challenged the providers' legal standing to bring the action or whether the action is properly brought in federal court (as opposed to State court). The State has also appealed decisions favoring providers to the Ninth Circuit Court of Appeals and even the United States Supreme Court.

On the other hand, victories by providers in the early stages of these legal proceedings can also lead to negotiated resolutions with the State. For these reasons, providers should consider a Supremacy Clause challenge to be a viable option in response to State action that is inconsistent with federal law.

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My Membership Story

Carly Kerper
Contract Manager
Genentech USA
Carly.Kerper@gmail.com

I would like to share my HFMA experience because HFMA has provided me with opportunities to network, learn about the healthcare industry, and develop my career. I grew up in Southern California and went to college at the University of Southern California. When I graduated I moved to San Francisco and started working for Triage Consulting Group. While at Triage, I worked on a project at Marin General Hospital and met **Steve Thompson**, a devoted HFMA member. After getting to know Steve, I asked him to become my mentor and he agreed. He is tremendously supportive and has lots of great advice to share.

Steve recommended that I join HFMA. He explained that it has been an incredibly fulfilling experience for him. He thought I would have similar experiences that would really benefit me. He sent out a few e-mails and before I knew it, I was an HFMA member. I wasn't sure what membership would mean for me, but I was excited to get involved. Steve sent me information on the Managed Care Committee and I got a call from **Will McCammon**, the Committee Chair. Will explained the goals and responsibilities involved in becoming a committee member and I signed on the dotted line.

I am now the Managed Care Committee Co-Chair and I have enjoyed helping to plan the Spring Conference, the Legislative Conference, and several Road Shows. This year the Managed Care Committee has focused on recruiting members from the physician community. We created Road Shows that focus on the issues facing the physician sector of the healthcare finance community. The Road Shows have been well received and I know it is due in part to the dedication and teamwork of the Managed Care Committee.

Last year I was invited to the HFMA Leadership Training Conference (LTC) in Florida. It was inspiring to see what HFMA chapters around the country were doing to serve their membership. While at LTC I bonded with some of the leaders in the Northern California Chapter. When I came back from the conference I had a new appreciation for the talented and hard working individuals that make the Northern California Chapter a success. I felt so proud of our Chapter because it really stands out from the crowd. It has many unique educational programs and services for its members. My involvement with HFMA has enriched my life. I have met wonderful and passionate people and learned so much about the health care industry. Steve was right, HFMA is a wonderful organization. You truly get back what you put in and more.

First You Have to Survive Health Care Before You Can Prosper

Dan Dreblow
Regional Sales Director
J&L Teamworks
Dan.d@jlteamworks.com

One of my favorite expressions to share with a health care financial manager, who is experiencing a stressful time in his or her career, is that “first you have to survive this industry before you can prosper.” Industry pressures have never been greater and health care careers have never been more unpredictable.

Michael Kramer is a good friend and business associate of mine as a director at Prime Health in Ontario, CA. Michael has a unique ability to make strong friendships quickly… with many people calling Michael their “good friend.”

I share this information with you because Michael Kramer is one of those good people who did not survive having a career in health care. In spite of having the support of a wonderful wife and five children (three biological and two step daughters), Michael recently suffered a heart attack from which he did not survive.

Having a very stressful management job - never leaving work before seven o’clock p.m. – plus being seriously overweight, created a health risk that ended Michael’s life at the age of 38.

My oldest son Kevin, who is adopted, is disabled with mental health challenges. Kevin is also over-weight and trying to quit smoking. Due to the mental health situation, we have tolerated Kevin’s weight and smoking as long as he was stable. That has always been our justification for not being more proactive against both being overweight and smoking.

Kevin had the opportunity to meet Michael and since their ages are very close, Kevin was especially shocked by Michael’s death. In fact, Kevin asked me to join a gym and asked my wife for some diet coaching; meanwhile he is also attempting to quit smoking.

Last night, when I was at my workout gym preparing for the Tour de Palm Springs (a 100 mile bike ride), I was on a stationary bicycle when a personal trainer named Melita approached me. She is a beautiful young lady in her 20s.

Melita is a new personal trainer at the gym and asked me if I was interested in some free personal training sessions with her. My immediate response was “Yes! Not for me but for my son Kevin.” If impressing Melita won’t motivate Kevin to get into better condition, nothing will!

My own “hot button” is being able to participate in events. During the past year, I have completed three marathons, finished my 20th triathlon, and during my career, ridden over 1,000 biking event miles. I am now 58 years old!

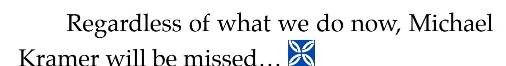
I frequently see people in the gym who look uninspired … barely moving on a workout machine. Obviously, they have nothing to motivate them to try harder; that is why I schedule events for myself all 12 months of the year.

If you have tried a walking event and it wasn’t fun, try a running event, a biking event or a swimming event. Or in the case of **Jim Strong** from Sutter Health, a triathlon. Jim has little experience doing events; however, Jim is registered for both the Solana Beach Triathlon and Malibu Triathlon this summer. ”The hardest part of a triathlon is approaching the starting line.”

I share with you these personal stories to help motivate you to re-examine your management of your own health. Are you doing enough to meet your personal health goals?

We are all very disappointed that Michael didn’t do more to protect his health. My family is also more motivated, due to his untimely death, to do something to improve my son Kevin’s health condition. I also invite you to join my friends and me in one of a variety of events, one event is sure to interest you, just drop me an email and I will forward our event schedule to you.

Regardless of what we do now, Michael Kramer will be missed…



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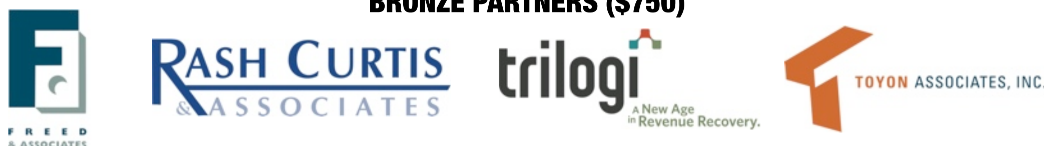

Job Opportunities

Visit the chapter website (http://www.hfma-nca.org) for details and a complete listing of job openings

- **Hospital Business Services Manager** - San Mateo Medical Center, San Mateo, CA (posted 2/22)
- **Chief Financial Officer** - Natividad Medical Center, Salinas, CA (posted 2/22)
- **Interim Accounting Managers, Financial Analysts, Sr. Project Coordinators** - HFS Consultants, Various Northern CA (posted 12/22)
- **Revenue Cycle Sales** - CSB - Collection Service Bureau, California (posted 2/12)
- **Sr. Accountant** - Enloe Medical Center, Chico, CA (posted 2/11)
- **Financial Analyst** - Enloe Medical Center, Chico, CA (posted 2/11)
- **Contract Manager** - Genentech, South San Francisco, CA (posted 2/9)
- **Sr. Financial Analyst** - Kaiser Permanente, Oakland, CA (posted 2/8)
- **CFO** - HFS Client, Northern CA (posted 2/5)
- **Accountant** - Enloe Medical Center, Chico, CA (posted 2/3)
- **Charge Description Master Coordinator** - Bakersfield Memorial Hospital, Bakersfield, CA (posted 1/13)

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