A most interesting question was posed at the HFMA of Northern California’s Board of Directors meeting this month. A Board member inquired if an organized continental breakfast period at a Road Show and/or Conference should count as educational hours for each member attending, as well as the chapter. While the National Board of HFMA may turn down our request to review this proposal, there is merit to the inquiry.

As our society morphs from a face-to-face business environment to one of teleconferences, webinars, text messages, blogging, and email, there is still a place for the old meet-and-greet. Putting a face with a name can make a big difference in making business happen in Healthcare.

I will admit that I am as guilty as anyone for pushing to adapt to the new generation’s way of doing business. This year alone the Chapter has rolled out a new website to provide more information to its members. More bells and whistles are on the way as the website’s ultimate goal is to make education and training available to members twenty-four hours a day, seven days a week.

As Chapter President, I am notified each time a new member joins Northern California. I make sure each new member is greeted with a personal welcome email. However, I realize even that is not enough. To capture a person’s attention, it is important for any business or organization to make personal contact. For HFMA, the best place to make such a contact is right before an HFMA event. Whether it is at the local Chapter level at Patient Financial Road Shows or Spring/Fall Conferences or at the Regional/National level with Region 11 Symposium or Annual National Institute (ANI), the morning continental breakfast time period is ripe with business and educational opportunities.

These casual time periods allow interaction for members to share the latest news in Healthcare, catch up with where fellow members are working, introduce yourself to a new fellow member, or find out how you can become more involved in HFMA.

One of the Chapter’s main goals is to make sure our membership is provided with multiple educational opportunities. However, life has taught us that just as much knowledge can be gained right outside of the classroom as in it.

Now I realize that time, distance, and expense can make attending one of the Chapter’s educational events impossible for some members. That is why a financial investment in the Chapter website as well as a push to have National add credited educational opportunities on the National Internet Website and through the hfm magazine each member receives as part of their membership.

Our Chapter will continue to provide social networking events as well. The Chapter’s annual golf tournament organized by Board Member Barry Brown just took place on October 10 at the Arnold Palmer designed course Hiddenbrooke in Vallejo. Past summers have seen the Chapter host “Day at the Ballpark” for both San Francisco Giants and Oakland A’s games. At the Region 11 Symposium in Las Vegas, the Chapter has put together cocktails hours and a group outing to see Jersey Boys. This year, HFMA Executive Committee member Jayne Kroner is organizing a group event to see the musical Wicked in early 2009.

The Chapter will continue to move into the 21st Century with use of modern technology, but we cannot forget how many members built success in Healthcare just one handshake at a time.

Editor’s Note: Chuck Acquisto is profiled in the November issue of hfm. Watch out for your copy!
Is Your Hospital in Compliance with the “Red Flags Rule” Effective 11/1/08?
Cindy Rudow, FHFMA
Director of Patient Financial Services
ValleyCare Health Systems
crudow@valleycare.org

Although the Federal Trade Commission (FTC) issued a “Red Flags Rule” in November 2007 which provided guidance on the definition of the term “creditors” under the Fair and Accurate Transaction Act of 2003, it didn’t show up on hospital compliance “radars” until AHA News clarified that hospitals were considered “creditors” on September 1, 2008. Consequently, the requirement to create a written policy and procedure for hospitals to prevent patient identity theft with a due date of November 1, 2008 became a priority for PFS Directors on September 2, 2008.

What exactly are “red flags”? Red flags include:

- Alerts, notifications or other warnings received from consumer reporting agencies;
- Notices from consumers, victims of identity theft, or law enforcement officers;
- Suspicious documents such as forgeries or a photo description that does not match a person;
- Suspicious personal identifying information (e.g. inconsistent or mismatched addresses, Social Security numbers, etc);
- Other events that indicate a likelihood of an occurrence of identity theft.

Hospitals must develop and implement a written identity theft prevention program that includes reasonable policies and procedures for detecting or mitigating identity theft.

Legislative Update
No Snooping Allowed: New Privacy Law Expands Protections and Imposes Stiff Penalties for Violations
Michael A. Dubin
Associate
Hooper Lundy & Bookman, Inc.
mudubin@health-law.com

On September 30, 2008, Governor Arnold Schwarzenegger signed into law two new health information privacy bills - AB 211 and SB 541 - that impose new obligations on health facilities and permit the Department of Public Health (DPH) to levy substantially increased administrative penalties. Taken together, these laws provide for new oversight, impose stricter privacy protections, and increase penalties for breaches of patient confidentiality. They become effective on January 1, 2009.

These companion bills were introduced in reaction to recent, high-profile medical information breaches summarized by the Assembly Committee on Health in the bill analysis to SB 541. In part, the Committee pointed to an incident at a prominent medical center where an employee was charged with illegally accessing confidential medical records 939 times and snooping into the medical information of more than 6,000 individuals – including Maria Shriver (Schwarzenegger’s wife), Farah Fawcett, and about thirty other celebrities. The employee was later indicted by a federal grand jury, but was just one of 127 people at that medical center who engaged in similar misconduct. In response to this and the ever-growing concern over the confidentiality of medical information, the Legislature expanded the reach of privacy protections beyond improper “use” or “disclosure” to the prevention of “access” of medical information.

AB211
AB 211 adds sections 130200 – 130205 to the California Health and Safety Code which now require every provider to establish and implement administrative, technical, and physical

What’s New in Balance Billing?
Brian M. Taylor, Esq.,
bttaylor@mhalaw.com and
Devan J. McCarty, Esq.
dmcarty@mhalaw.com
McDonough Holland & Allen PC

Legislative Update
Governor signs AB 1203 banning balance billing for hospital services and imposing strict notice requirements
On September 30, 2008, the Governor signed AB 1203 precluding a hospital from billing members of non-contracted “health care service plans” (i.e. HMOs) for amounts owed by the plan for post-stabilization services. Contracted hospitals are already precluded from billing members of HMOs by Health & Safety Code § 1379. AB 1203 prohibits a hospital from billing the member for any post-stabilization services payable by the plan. The only exceptions are when the hospital is unable to identify the member’s insurance or where the plan elects to transfer the member and the member refuses.

AB 1203 requires a hospital to call the member’s HMO before providing post-stabilization services. This obligation does not apply to minor post-stabilization services provided to “treat and release” patients. If the plan does not respond within 30 minutes of the hospital’s call, the plan is obligated to pay the hospital’s charges for necessary post-stabilization services. If the plan does respond within 30 minutes, it either must authorize the post-stabilization services or arrange to transfer the patient. If the plan elects to transfer, it must pay the hospital’s reasonable charges up until transfer, and must transfer the patient within a reasonable time. AB 1203 will revoke the current Health & Safety Code § 1262.8, which contains similar provisions that apply only to Kaiser Foundation Health Plan members.
safeguards to protect the privacy of patients’ medical information. They also establish the California Office of Health Information Integrity (the OHII) within the California Health & Human Services Agency to “ensure the enforcement of state law mandating the confidentiality of medical information and to impose administrative fines for the unauthorized use of medical information.”

AB 211 outlines that once it receives a referral from the DPH, the OHII may impose an administrative fine against any person or health care provider (whether licensed or unlicensed) for any violation of the medical privacy-related provisions of Confidentiality of Medical Information Act (CMIA), which has penalties ranging from $1,000 to $250,000. Exempt from the administrative fines of AB 211 are certain clinics, health facilities, home health agencies, and hospices. The OHII is not permitted to assess administrative penalties described in Health & Safety Code § 1280.15, which are described in detail below.

In determining the amount of a penalty, the OHII may consider a wide variety of factors, including attempts at compliance with the CMIA, the nature and seriousness of the misconduct, the harm to the patient, enrollee, or subscriber, the number of violations, the persistence of the misconduct, the willfulness of the misconduct, and the assets, liabilities, and net worth of the individual or entity engaging in the violation.

In addition, the OHII may recommend that the Attorney General, the DA, the county counsel or the city attorney bring a civil action under the CMIA and may send a recommendation for further investigation or discipline for a potential violation to a licensee’s relevant licensing authority. All relevant documentary evidence collected by the OHII must be forwarded along with such a recommendation.

**SB 541**

SB 541 amends sections 1280.1 and 1280.3 of the California Health and Safety Code, and adds new section 1280.15.

**Immediate Jeopardy**

The new law substantially increases the administrative penalties for a deficiency constituting an “immediate jeopardy” violation by a general acute care hospital, a psychiatric hospital, or a special hospital. “Immediate jeopardy” means a situation in which a licensee’s noncompliance with the licensing regulations is likely to cause serious injury or death to a patient. Prior to the enactment of SB 541, hospitals had to face administrative penalties, not exceeding $25,000 per violation. Effective January 1, 2009, this amount increases to $100,000 per violation, based on the following graduated scale:

- for the first violation, up to $50,000;
- for the second violation occurring within three years, up to $75,000; and
- for the third and subsequent violations occurring within three years, up to $100,000.

In addition, once regulations are adopted by the DPH as specified in SB 541, the maximum penalties at each level will increase by an additional $25,000 per violation. For deficiencies that do not rise to the level of “immediate jeopardy,” SB 541 increases the penalty from $17,500 to up to $25,000 per deficiency.

**Violations of Patients’ Medical Information**

SB 541 enacts new section 1280.15 of the California Health and Safety Code which gives the DPH authority to fine health facilities not only for unlawful use or disclosure of patient medical information, but for the failure to prevent “unauthorized access” to such information. The new statute defines “unauthorized” as the inappropriate access, review, or viewing of patient medical information without the direct need for medical diagnosis, treatment, or other lawful use permitted by CMIA or other statute or regulation. The new provisions apply to all health facilities (including hospitals, nursing facilities, chemical dependency and psychiatric health facilities), clinics, home health agencies, and hospices, including those exempt under the CMIA.

Effective January 1, 2009, the DPH may assess, after investigation, an initial administrative penalty of up to $25,000 per patient for those whose medical information is accessed unlawfully or without authorization, used, or disclosed. For each subsequent violation, the maximum sanction is $17,500. In determining what constitutes a fair penalty, the DPH must consider a facility’s history of compliance, the extent to which the facility immediately corrected the problem and instituted preventative measures, and other factors outside the control of the facility.

**Reporting Obligations and Penalties**

A health care facility is now required to report any unlawful or unauthorized access, use, or disclosure of a patient’s medical information to the DPH no later than five days after the violation has been detected by the facility. The facility also must report the breach to the patient or the patient’s representative within five days after detection of the breach. The failure to report a violation of patient privacy to the DPH and the patient within five days subjects a facility to a penalty of $100 per day. The combined total of the SB 541 medical information penalties discussed above and these per day violation penalties cannot exceed $250,000 for each reportable event.

**Appeal of Penalty Assessment; Referring Violations**

If a licensee disputes the assessment of a penalty for failure to prevent or report unlawful or unauthorized access, use, or disclosure, the licensee may request a hearing within ten days of the receipt of the penalty assessment. The penalties shall be paid when appeals have been exhausted and upheld. In lieu of disputing the penalties, the licensee can pay 75% of the total amount of the penalties within thirty business days of receipt.

The DPH may refer violations to the OHII for enforcement, which has the authority described above to assess additional penalties upon any person or providers involved in the violation and may refer licensed individuals to their appropriate licensing boards.

The program should enable the hospital to:

- Identify relevant “red flags”
- Detect the red flags
- Respond appropriately to detected red flags

ValleyCare Health System partnered with vendors to provide tools to detect and prevent patient identity theft. The first tool is access to a web-based program that confirms demographic information during the patient registration process. The registrar has the opportunity to ask the patient or guardian for clarification if there is a discrepancy from the web-based program with the information the patient or guarantor presents. The second tool is PALM (Patient Access Lifetime Match) because everyone’s palm vein pattern is unique. We use biometric technology to link a patient’s photo identification to their individual palm pattern that is stored on a secure server.

This is a very dynamic situation and I suspect many of you are still struggling with how to implement and control this process. I also suspect that many of you have developed approaches to handle the situation. If you have developed a solution that you would like to share with other HFMA members, I encourage you to send a copy of your process to me at crudow@valleycare.com. I will summarize the various solutions to share in a follow-up article for our next newsletter.
If the hospital fails to make the required call, the health plan is not obligated to pay for post-stabilization services provided to its members. Significantly, the hospital cannot bill the patient for these services either. The requirements of AB 1203 apply only to hospitals—not to physicians—and apply only to members of HMOs. The requirements of AB 1203 are effective January 1, 2009. A Bulletin with a detailed summary of AB 1203 and practical solutions for its implementation will soon be available at http://www.mhalaw.com/mha/newsroom/legalAlerts.htm.

Governor vetoes SB 981, which would have banned balance billing for emergency physician services
Governor Schwarzenegger vetoed SB 981 on September 30. The bill would have statutorily precluded a non-contracted emergency physician, defined as a physician contracted to provide emergency services in the emergency room of a general acute care hospital, from billing health plan members for amounts owed by the plan for emergency services. The bill also would have required a health plan to pay non-contracting emergency physicians an interim payment of 250% of Medicare Allowable for emergency services, followed by the opportunity for either the plan or the emergency physician to seek an adjustment through an Independent Dispute Resolution Process established by the Department of Managed Health Care ("DMHC") or through any other available process.

The Governor’s veto does not mean the balance billing issue is resolved for non-contracted emergency physicians. As discussed below, the DMHC is attempting to regulate balance billing by non-contracted providers, and the Supreme Court will weigh in on the issue soon.

Regulatory Update
OAL approves DMHC Balance Billing Regulation
Early in September, the Office of Administrative Law approved a new DMHC regulation, Title 28 CCR section 1300.71.39, defining balance billing as an “unfair billing practice.” The new regulation, effective October 15, 2008, purports to make it an “unfair billing pattern” to bill members for amounts an HMO owes for emergency services.

The regulation covers all providers of emergency services (including hospitals, emergency physicians, and hospital-based physicians, such as radiologists, pathologists, anesthesiologists, and on-call specialists). The regulation is limited to balance billing for emergency services, does not apply to post-stabilization services, and does not prevent billing the member for copayments, coinsurance, or deductibles.

On September 26, 2008, the California Medical Association, along with other provider groups, filed a lawsuit challenging the DMHC’s authority to enact the regulation. Detailed updates on the status of the lawsuit will be provided periodically.

Judicial Update
The California Supreme Court will soon weigh in on balance billing members of non-contracted health plans
On November 5, 2008, the California Supreme Court will hear oral argument in the Prospect Medical Group v. Northridge Emergency Medical Group case. The issue to be decided is whether Health & Safety Code § 1379 prohibits non-contracted emergency physicians from balance billing health plan members. The Appellate Court held that section 1379 does not prohibit emergency physicians who do not have a written or oral agreement with the health plan from billing members for amounts unpaid by the plan. An article on Prospect Medical Group v. Northridge Emergency Medical Group will be provided when the court issues its decision.

Effects of the New 2008 PRRB Rules and Regulations on Group Appeals
Frank P. Fedor, Partner
ffedor@murphyaustin.com
and Jenny M. Phillips, Associate
jphillips@murphyaustin.com
Murphy Austin Adams Schoenfeld

Significant changes to Medicare reimbursement procedures became effective on August 21, 2008. These changes impact the way common issue related parties (CIRPs) initiate their appeals. The effect of the new regulations and rules is to force CIRPs to file most, if not all, appeals as group appeals. CIRPs will no longer have the luxury of filing an individual appeal and then transferring it to a group appeal once the group appeal is coordinated. As a result, CIRPs will now be responsible for coordinating their appeals process in such a way that alerts other providers to the group appeal. CIRPs will need to be aware of the other existing group appeals in order to comply with the new rules and regulations.

Under the 2002 PRRB rules, CIRPs filed an individual appeal for a single cost period. These appeals, filed within 180 days from receiving the intermediary’s Notice of Program Reimbursement (NPR), would likely be for only one issue, and would preserve the provider’s right to appeal the issue for that specific cost period. As providers found additional issues that needed to be appealed for that year, the provider would add the new issue to their existing individual appeal rather than initiate separate appeals. This process allowed providers to add issues to existing appeals for years after the initial filing of the original appeal because issues added to an existing appeal did not need to meet the 180 day deadline. Only the initial appeal had to be filed within 180 days from receipt of the NPR. Once these issues were added to the existing individual appeal, providers could transfer the issues to the appropriate CIRP group appeals.

The 2008 PRRB rules put an end to this practice because the new rules prohibit CIRPs from adding or initiating an appeal when there is an existing group appeal. Specifically, section 1835(b)(4) prohibits individual appeals of an issue where there is an existing group appeal for that issue by a CIRP for the same cost period. (See 42 C.F.R. § 405.1835(b)(4), effective August 21, 2008.) Under the new rules, before providers file an individual appeal they must certify that there are no other commonly owned providers appealing the same issue for the same cost period in a CIRP group appeal. (See 42 § 405.1835(b)(4), effective August 21, 2008.)

By the same token, new section 1835(c) allows providers to add issues to existing individual appeals within 60 days of filing the initial request, but in order to comply with section 1835(c)’s requirements for adding new issues to individual appeals, a provider also must meet the requirements listed in §1835(b), certifying that there are no other CIRP group appeals for the same issue, for the same cost period. (See 42 § 405.1835(c), effective August 21, 2008.) Therefore, new certification requirements in 1835(b) & (c) prohibit CIRPs from filing an initial individual appeal and, instead, force CIRPs to initially file a group appeal.

Marcia L. Augsburger, Esq.
McDonough Holland & Allen PC
maugsburger@mhalaw.com

Reporting Billing Errors
Some health care providers who have discovered billing errors and overpayments from Medicare or Medicaid have been reluctant to report the errors to government payers or their intermediaries for fear of becoming embroiled in OIG investigations and burdened with oppressive compliance obligations. Other providers have reported errors directly to the OIG, particularly where they were uncertain about whether billing errors would be interpreted as fraudulent, in an effort to avoid an appearance of attempting to hide fraud. Some providers and lawyers have felt that reporting directly and promptly to the OIG is safer than reporting to intermediaries, because, for example, if the OIG later becomes involved, providers may be disqualified from participating in the SDP based on delay and avoidance. Providers who have reported billing errors directly to the OIG have sought to take advantage of the SDP. The SDP offers a way to avoid the costs and disruptions of a government-directed investigation. However, the SDP process is also a lengthy, burdensome, and uncertain process.

On April 15, 2008, the Inspector General issued An Open Letter to Health Care Providers (“Open Letter”) that should encourage more providers to report errors and overpayments to Medicare, Medicaid, or their intermediaries instead of going to the OIG. In the Open Letter, the Inspector General emphasized “[d]isclosures that are characterized as mere billing errors or overpayments are not appropriately addressed by the SDP and should be submitted directly by the provider to the claims-processing entity, such as the Medicare contractor.” The Inspector General also emphasized whether an event implicates potential fraud or a mere overpayment is a determination the provider must make in good faith.

What This Means to Providers
Providers may rely on these instructions and on the expressed underlying policy of easing the OIG’s administrative burden. Providers who are referred to the OIG after reporting to government payers or their intermediaries may use their reliance on the Open Letter to convince the OIG of their good faith and to avoid penalties or sanctions. The OIG will have a difficult time disqualifying providers from the SDP or accusing them of attempting to conceal a fraud where the providers show they weighed and considered the OIG’s expressed concerns against the possibility that an event constituted fraud. As always, providers who discover billing errors or other potential violations of federal health care law should investigate thoroughly, document their findings carefully, and hire independent consultants if the issues are complex or questions remain.

What This Means to Intermediaries
Intermediaries can increase the likelihood they will be promptly reimbursed for overpayments and avoid becoming embroiled in expensive and protracted OIG investigations or SDP processes by supporting providers’ efforts to report billing errors to the intermediaries. If an intermediary’s contract terms relating to overpayments are too burdensome, costly, or risky, providers will be disincentivized to report or reimburse. Making it easy and non-threatening for providers to return overpayments to intermediaries furthers the OIG’s interest in having money wrongfully paid out of federal health care funds returned to the government.

Relaxed Compliance Obligations
The Inspector General’s April 15, 2008, Open Letter promises meaningful relief for providers who invoke the SDP by softening the requirement that providers enter Corporate Integrity or Certification of Compliance Agreements (“CI/CC Agreements”). The OIG will not generally require CI/CC Agreements from providers who submit complete and informative SDP disclosures in good faith, fully cooperate with the OIG, timely provide information, and perform accurate audits. In addition to the information required in the SDP, a provider’s initial submission must contain:

1. a complete description of the conduct being disclosed;
2. a description of the provider’s internal investigation or a commitment regarding when it will be completed;
3. an estimate of the damages to the federal health care program(s) and the methodology used to calculate that figure or a commitment regarding when the provider will complete such estimate; and
4. a statement of the laws potentially violated by the conduct.

According to the Inspector General, a full, carefully drafted, and informed initial submission will facilitate the expeditious resolution of self-disclosures. The investigation and damages assessment is to be completed within three months after the provider is accepted into the SDP. Providing the additional information with the initial submission allows the OIG to presume that the provider has adopted effective compliance measures and is committed to acting in good faith and with integrity. This presumption is designed to promote full reporting, efficiency, and fairness and to reward providers who act with integrity.

Of course, compromises are almost always rebuttable, and the Open Letter is carefully phrased to give the OIG plenty of latitude. Complete, carefully considered and drafted, sophisticated submissions are critical. Optimally, accounting and claims experts and knowledgeable attorneys should participate in all aspects of the investigation, compliance plan, and disclosure to the OIG.

EDITOR’S MESSAGE
I want to encourage anyone who is interested to submit articles for the next issue of the newsletter scheduled for late December. Let’s go over The Edge and submit your articles now. We are always looking for work related hot topics, maybe a new problem or solution related to compliance, the latest trends, AB774, HIPAA, RAC audits or maybe a personal experience from a Conference or a Road Show you attended. Do you have an interesting hobby? I hope you read a more personal article submitted by Dan Dreblow (page 13) that everyone on the newsletter committee really enjoyed. Please send all articles to terry@rashcurtis.com.

Terry Paff
Chairperson, News & Publicity Committee
President, Rash Curtis & Associates
ValleyCare is the first hospital in the Western U.S. to install the latest security system for patient registration. ValleyCare's Patient Access Lifetime Match - PALM - is leading-edge technology designed to prevent identity theft and is a failsafe way to guard medical records.

Developed in Japan for use at ATMs in place of PINs, PALM is a biometric identification system that uses a near-infrared light wave to scan a patient's palm. The scan produces a distinctive, biometric signature to that patient's vein pattern, which is 100 times more unique than fingerprints, making it far more secure. This "signature" is then attached to the patient's medical record and stored in a secure system at ValleyCare that complies with federal and state security regulations.

Secure and Fast
ValleyCare launched this latest system in its registration process on September 30, 2008. It is exciting to be the first on the West Coast to employ this security registration system. It not only streamlines the registration process, but also prevents identity theft and fraud. In addition, if an unconscious patient arrives in emergency, a PALM scan could quickly and easily identify that patient if previously enrolled in the program.

While completely voluntary, the system has had widespread acceptance among patients. Painless and simple, the patient places his/her hand on the scanner and the unique "signature" is created in seconds. Initially, other forms of identification will be required to match up medical records, but once the scan is part of a patient's record, registration will be quick. Patients have made many positive comments such as "it's cool" and "that's pretty high tech".

"Providing the best health care possible is our number one priority at ValleyCare," says ValleyCare CEO Marcy Feit. "We are proud to be the first in the West to install this patient security system, and it is one more example of how we use forward thinking technology to advance our quality patient care."
Permanent RACS Are Announced by CMS

On October 6, 2008, CMS (Centers for Medicare and Medicaid Services) announced the four permanent recovery audit contractors and their selected regions. They are:

- Diversified Collection Services, Inc. of Livermore, CA: Region A, initially working in Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, and New York.
- CGI Technologies and Solutions, Inc. of Fairfax, VA: Region B, initially working in Michigan, Indiana, and Minnesota.
- Connolly Consulting Associates, Inc. of Wilton, CT: Region C, initially working in South Carolina, Florida, Colorado, and New Mexico.
- Health Data Insights (HDI), Inc. of Las Vegas, NV: Region D, initially working in Montana, Wyoming, North Dakota, South Dakota, Utah, and Arizona

According to CMS, it chose the contractors and their regions based on three values:

- A “best value determination” that includes a strong technical approach and “exceptional” customer service
- Conflict of interest reviews
- Lowest contingency fee

The new RACs were selected under a full and open competition and will begin to educate and inform providers later in October and November about the program. The RACs will be paid on a contingency fee basis on both the overpayments and underpayments they find. In addition, CMS has taken the first steps in phasing in its Recovery Audit Contractor (RAC) program. Under the law CMS will implement Medicare recovery auditing in all states by January 1, 2010.

California is included in Region D and the most recent information indicates that the RAC will start in California by March 2009. This gives hospitals and other healthcare providers some time to get organized and develop or purchase RAC tracking tools/software. According to the CMS news release, “The three year RAC demonstration program in California, Florida, New York, Massachusetts, South Carolina, and Arizona collected over $900 million in overpayments and nearly $38 million in underpayments returned to health care providers.” The new national RACs can be found at www.cms.hhs.gov/RAC. For more information about CMS RAC Web site, visit: www.cms.hhs.gov/RAC/Downloads/RAC%20Expansion%20Schedule%20Web.pdf

POA Facts for FY09

One of the biggest healthcare issues today is “Hospital Acquired Conditions” (HAC) and “Present on Admission” (POA) impacts on payment. Medicare no longer pays for the additional costs of certain preventable conditions (including certain infections) acquired in a hospital. The Centers for Medicare & Medicaid Services (CMS) were mandated under the Deficit Reduction Act (DRA) of 2005 to implement a requirement that hospitals report Present on Admission (POA) information for secondary diagnoses to Medicare. The DRA required hospitals to report POA indicators on all inpatient Medicare patients starting on October 1, 2007.

Now, beginning October 2008, specific HACs that are “NOT” present on admission will impact the MS-DRG grouping and payment. Cases with the specific Preventable Conditions would not be assigned to a higher paying MS-DRG unless they were present on admission. POA is defined as present at the time that the physician orders for inpatient admission. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered present on admission. POA indicators are appended to each ICD-9-CM code reported for patients’ conditions and diagnoses documented in the medical record by physicians/providers. POA data will be used for measuring hospital performance, public reporting, and payment.

Basically, under IPPS Medicare will no longer pay for the additional costs of certain preventable conditions (including certain infections) acquired in the hospital. Thus, as of October 1, 2008, CMS will only pay for those HACs (Hospital Acquired Conditions) coded with the following indicators:

- “Y” (present on admission)
- “W” (not possible to determine POA status based on data and clinical judgment)

CMS will not pay for HACs coded with the following indicators:

- “N” (not POA)
- “U” (documentation insufficient)

In the proposed IPPS rule, if the patient is discharged AMA, expired, or transferred, and the HAC diagnosis (for example, catheter-related UTI) has a POA of “U”, then CMS will reimburse that case as if the POA were Y. However, this DID NOT get approved!

The CMS IPPS conditions (and their ICD-9-CM codes) include:

- Foreign Object retained after surgery (998.4, 998.7)
- Air embolism (999.1)
- Delivery of incompatible blood products (999.6)
- Catheter-associated urinary tract infection (996.64 and various other urinary tract infection codes112.2 (CC), 590.10 (CC), 590.11 (MCC), 590.2 (MCC), 590.3 (CC), 590.80 (CC), 590.81 (CC), 595.0 (CC), 597.0 (CC), 599.0 (CC)
- Pressure Ulcer stages III and IV (707.23, 707.24)
- Vascular catheter-associated infection (999.31)
- Mediastinitis after CABB (519.2) and one of the following procedure codes: 36.10–36.19
- Hospital-acquired Injuries – Fractures (800-829), Dislocations (830-839), Intracranial Injury (850-854)
- Crushing Injury (925-929), Burns (940-949) Electric Shock 991-994

CMS also finalized three new HACs in the IPPS final rule that take effect on October 1. CMS has determined the following three conditions to be reasonably preventable through proper care:

Continued on page 8
Post Acute Care Transfer Policy (PACT) and the Financial Impact

Barbara Rodenbaugh, RHT, CCS
PACT Manager
Catholic Healthcare West
brodenbaugh@chw.edu

Focus: Medicare Inpatient

In 1998 when the Centers for Medicare and Medicaid Services (CMS) first implemented the Post Acute Care Transfer (PACT) policy for the Inpatient Prospective Payment Policy (IPPS), it included only ten Diagnosis Related Groups (DRGs). Over the years it rapidly evolved and now includes a total of 273 Medicare-Severity-DRGs (MS-DRGs). Because the majority of these DRGs represent most IPPS providers’ top volume DRGs, it is an operational challenge for the facilities it affects from a compliance and financial perspective. In order to stay on top of the changes to this policy, you must stay up to date with revisions that CMS continues to make and expands with this policy. The purpose of the PACT policy is to protect the Medicare funds and the American taxpayer.

The CMS PACT policy states that when an IPPS hospital discharges a patient to a facility that is excluded from the IPPS (e.g. skilled nursing facility), the case is defined as a “transfer” and not a “discharge.” In this case, if the patient is transferred prior to meeting the geometric mean length of stay (GMLOS) for transfer DRG, the transferring hospital receives a per-diem amount for the services rendered instead of receiving the full DRG payment. The receiving facility will receive the full DRG payment. Of course, their payment will also depend on their patient status code/discharge disposition. Medicare has determined that an IPPS facility is not entitled to the full DRG payment if the patient is transferred prior to meeting the GMLOS for that DRG.

Because of the number of transfer DRGs, tracking and monitoring the compliance and accuracy of the patient status code/discharge disposition is a very complex process, not to mention easier said than done. Each year hospitals lose significant revenue due to underpayments because the patient status code/discharge disposition assigned during the original coding/billing process may not reflect the actual post acute level of care rendered to the patient. For example, the medical record documentation at discharge supports that the patient was discharged to home however, Medicare notifies the Patient Financial Services/Business Office that the patient received Home Health within three days of the discharge. The fiscal intermediary/Medicare Administrative Contractor (FI/MAC) will instruct the facility to make the appropriate change to their claim and retrack any overpayment the facility would have received for that inpatient hospital stay if the patient did not meet the GMLOS for that specific DRG for that admission. This kind of Medicare determination is supported because a Home Health Agency (HHA) billed Medicare for their services within that three-day timeframe and the Medicare Common Working File (CWF) reflect that the claim was submitted by a licensed HHA for their services. On the other hand, if the scenario were reversed, Medicare would not notify the hospital of any underpayment thus resulting in lost revenue; and this does occur when the hospital documentation reflects that the patient is going to receive home health post discharge within three days AND the patient does not receive these services at all or later than the three-day timeframe. CMS has claim edits to capture only overpayment, not underpayment, so hospitals need to develop and establish their own data mining processes to validate the patient status.

Again, to focus on potential lost revenue, one needs to understand that an incorrect patient status code or discharge disposition does not necessarily mean it was captured wrong during the initial coding or billing process. It can also mean that the level of care we anticipated at the time of discharge was not carried out, the patient did not receive home health services within three days of discharge, the patient may have expired en route during transport to the transferring facility, or the patient was admitted as outpatient at the receiving hospital and not as inpatient. Once the patient leaves the hospital, the HIM coding staff is not aware that the intended post discharge care was not carried out. This is where the data mining and a validation process comes into place.

Over the past two years, CHW has had a very successful retrospective data mining project addressing the patient status code/discharge disposition for traditional Medicare claims. The project was handled by an external vendor who specializes in data mining and claim validation techniques. In an effort to continue to derive the financial benefits of this project, CHW made the decision to in-source the management and operation of the patient status validation process. The data mining and validation of the project identified that less than 4% of the transfer DRG cases were reimbursed incorrectly. The error variance rate was relatively low but the dollar impact was significant. As a system, the

Continued on page 9
the results also supported a potential increase in several million dollars in additional revenue for the calendar year (CY) 2008.

Because of the complexity of the Medicare PACT rule, we have found that the patient status code/discharge disposition can at times be coded or reported incorrectly resulting in lost revenue. It is important that the patient status/discharge disposition codes are assigned correctly, or payment to the hospital may be less than what you are rightfully entitled to, nothing more and nothing less.

Also noteworthy is the Recovery Audit Contractor (RAC) pilot program for California and Florida. The patient status code/discharge disposition was the number one variance identified as the source for underpayments to IPPS facilities. This resulted in $19.6 million in lost revenue for 8,584 Medicare claims. This truly demonstrates the financial need to have PACT validation practices in place.

Hospital providers have a responsibility to make sure that what is assigned is both compliant and correct. It would behoove any IPPS provider to have some sort of policy and procedure in place to validate the coding, billing, and receiving of reimbursement that you are entitled to, based on supporting documentation of course. For the smaller hospital providers, it might be easier to implement the process as opposed to a larger facility or healthcare systems with multiple facilities. However, it is definitely worth it to have an internal validation process in place.

This entire process is very complex and requires that the healthcare provider make sure they are capturing the most accurate data. The provider is responsible to ascertain that the data submitted to your FI/MAC is accurate and compliant data.

In order to prevent putting your organization at risk, it is imperative that you understand the PACT policy, make sure you stay on board with the changes, and validate that your reimbursement is legitimately what you are entitled. Failing to maintain current knowledge of the policy no doubt results in leaving money on the table, money which I believe a provider cannot afford to lose. In addition to staying on top of the regulations, you are preventing compliance risk and payment issues for your organization. If you’d like more information about PACT data mining, contact Gloryanne Bryant (Ggbryant@chw.edu) or Barbara Rodenbaugh (Brodenbaugh@chw.edu).

Post Acute Care .... continued from page 8

Fall Conference at Newport Beach
Steve Thompson, FHFMA
Director, PFS
Marin General Hospital
thompsst@sutterhealth.org

There is an old saying, “you should have been there.” On September 14th through the 16th, the Northern and Southern California Chapters of HFMA presented our annual Fall Conference, and if you missed it, “you should have been there.” As a compliment to the conference, we were fortunate to have the event at the Hyatt in Newport Beach, and we were further graced with weather that was postcard perfect. We have included pictures from the conference as a part of this newsletter.

The conference did not officially begin until Sunday, but we could not pass up the opportunity to provide a CFO Roundtable Saturday morning followed by a golf tournament at the world-renowned Pelican Hills Golf Course. I am quite certain that there were some priceless levels of networking mixed with the missed putts. To complement the day further, Charlie Plimpton from CitiBank spoke with the CFO group during lunch and discussed the current economic crisis and its effects on the healthcare industry.

Sunday was devoted to a pre-conference with sessions in Finance, Revenue Cycle, and Managed Care. The programs focused on Payments to Non-Contracted Hospitals, Capital Market updates (who would have guessed that the financial crisis was looming and this panel was very strategic in process), Legal Updates and more. Sunday evening offered a unique opportunity to network with vendors and providers while enjoying a slightly balmy Newport Beach evening.

Monday started with a wonderfully insightful presentation from Steven Ford (son of Gerald Ford). He was able to provide a very personal and loving look at the former president and the Ford family. The rest of the day was devoted to a number of educational break-out sessions covering topics of interest in Managed Care, Revenue Cycle, and Finance. Regardless of the speaker, the attendees also offered a great deal through their questions and interaction with the speakers. Monday evening was further extended with a second reception for mingling and enjoying the Newport Beach weather.

Continued on page 10
Fall Conference at Newport Beach ... continued from page 9

Tuesday started with a keynote presentation by Jeanne Scott, self-proclaimed “Talking Head in Chief,” who enlivened the group with her remarkable, if not irreverent, insights about politics and healthcare. There were further presentations from the Department of Managed Healthcare and Department of Insurance, who provided a very in-depth look at the Sacramento political environment.

The remainder of the day was devoted to break-out sessions and closed with a spirited panel discussion on “Universal Health Care, where do we go from here?” The panel consisted of Herb Schultz, Senior Advisor for Health Policy to Governor Schwarzenegger’s Office; Don Crane, CEO of California Association of Physician Groups; Duane Dauner, CEO of California Hospital Association; Joe Dunn, CEO of California Medical Association; and Chris Ohman, CEO of California Association of Health Plans.

To at least one person, the conference added one more highlight as one name was chosen to receive a paid trip to Hawaii. Can we say “ALOHA”?

A review of the preliminary evaluations has clearly demonstrated that each of the attendees walked away with an increased level of knowledge and understanding. In addition, the attendees also were able to take tools and other material back with them that can be used at each facility.

This conference, in addition to all of our educational sessions, was geared to meet the overall needs of our membership. A great deal of work and effort was provided by volunteers who are too numerous to mention, but their tireless efforts are always appreciated.

Next year the Fall Conference will be held in Monterey at the Hyatt. We will be providing more information about it throughout the year. I’m looking forward to seeing all of you there.
2008 Northern California Golf Tournament

Barry Brown
Tournament Chair, HFMA Golf Tournament
VP Marketing, Rash Curtis & Associates
barry@rashcurtis.com

“They say golf is like life, but don’t believe them ... golf is more complicated.”

And if you don’t believe that, try golfing at Hiddenbroke Golf Course in Vallejo. This course provided our HFMA members an exciting challenge and a fun day of golf on a beautiful course in the hills outside of Vallejo.

Friday, October 10, was a beautiful, breezy day on the green where almost fifty HFMA members and guests enjoyed a fun day of golfing and networking with a chance to win one of many prizes. Prize titles included: First, Second, and Last place foursomes. In addition, prizes were awarded for a putting contest sponsored by Triage Consulting Group and Marshmallow Drive sponsored by Toyon Associates. The winners of a $25 Visa gift card for the putting contest were:

- Kathryn Leppert - Contra Costa County Regional Medical Center (best woman)
- Jeff Bartholomew - Eclipsys Corporation
- Pat Godley - Contra Costa County Regional Medical Center (tied for best man)

The longest marshmallow drive was won by Jed Lowe of Merry X-Ray (for some reason, the women boycotted the marshmallow drive this year... I suspect conspiracy).

The scramble / shotgun start format began at 11AM on the nose and it was off to races. As we did last year, golfers were allowed to purchase three mulligans, however the controversial “Gimmie String” was axed this year.

Our Champions this year and winners of a $50 Visa card each went to two foursomes who tied with a remarkable 14 under par:

- Chuck Acquisto - Stephenson, Acquisto & Colman
- Jeff Bartholomew - Eclipsys Corporation
- Jeff Sousa - California Healthcare Insurance Co. and Lee McCormick of Ping Golf

The second team was:

- Tom Knight - Toyon Associates,
- Pat Godley - Contra Costa County Regional Medical Center
- Dave Cameron - Santa Clara Family Health Plan and some secret, unknown player referred to only as “Chris”....Hmmm.

The trophy (if we ever find it) will go to Chuck’s team as the score cards indicate a two stroke lead over the second team on the back nine (I heard “Chris” is hiding the trophy – Tom could not be reached for comment).

Other Winners
Second Place Foursome:
Brad Allen - Perot Systems, Bob DeMarco - CCI Group, Jonathan Cramer - Winthrop Resources and Barry Woerman.

Last Place Foursome:
Ken Jensen - ValleyCare Health Systems, Bernadette Mills-Jensen - Mirrus Systems, Kathryn Leppert - Contra Costa County Regional Medical Center and Jed Lowe - Merry X-Ray.

Longest Drive:
Lois Maxwell - Enloe Medical Center and Tom Schmidt - Gardner Group

Continued on page 13
18 Triathlons Later….
Dan Dreblow
Regional Sales and Consulting Director
J&L Teamworks
Dan.d@jlteamworks.com

At the urging of several of my friends I decided to write this article. This is a story of an overweight fifty-seven year old man who suddenly began competing in sprint triathlons, 200-mile bicycle rides, one mile ocean swims, and half marathons. In hindsight, I can see that the lessons I learned from being a healthcare financial manager prepared me for these newfound challenges.

About four years ago, I was standing as a spectator at the finish line of the Carlsbad Triathlon – an event that included a ¼ mile swim, a sixteen mile bike race, and 3.2 mile run in my home town. A middle-aged woman finished the race who must have weighed between 250 to 275 pounds. I thought to myself, “If she can do this, I can do this.”

That evening I called my seventeen year old son – who lived with his Mom – and I asked, “Derek, would you like to do a triathlon?” His immediate response was “Yes.” Four years and eighteen triathlons later, we are still going strong (except for a break related to a deadly shark attack in Solana Beach).

How does this all relate to a career in healthcare accounts receivable?

One of the first challenges of participating in a triathlon is learning how to prepare for such an event physically and mentally. One also must consider what type of equipment is needed. This is similar to the challenge faced by all healthcare financial managers where the payer environment is constantly shifting and a manager must be able to self-taught and adapt to a changing situation. While involved in triathlons, my son and I also developed a love of long distance bike ride events. We started with a MS event in Palm Springs at 40-miles but that clearly was not a big enough challenge. We were soon doing 100-mile rides with the greatest difficulty being the Sea Otter Classic in Monterey: Ten miles at an 8% grade and three miles at a 10% grade, all within a 100 mile event.

As my son discovered young women, his participation became more unpredictable; however, I quickly learned that I was doing these events for my own enjoyment of the challenge, and Derek’s involvement was only a bonus.

Recently, my wife and I headed to Seattle for me to complete in the Seattle to Portland bike ride: a 2-day 200-mile event. My dear Mary Anne provided support by car and was readily available by cell phone. The first day was a perfect day of bike riding... sunny weather and scenery unsurpassed. On day two I started the event at the midway point, however I got no further than twenty-five feet before I knew I had a flat tire.

Due to my weight, (250 pounds plus), I have special heavy duty tires that are difficult to work with. My wife drove me to the event mechanic and he changed the tire. By the time I reached Portland about 5 hours later, the temperature had reached 95 degrees.

During this day I noticed an older lady (older than my 57 years – ha) who had special clothes to protect her from the sun. Every twenty miles there is a refreshment break, I would stop and then return to the route. That day, I passed her three times. Basically, it meant she never stopped riding.

So I ask again, what is the point of sharing these stories with healthcare financial professionals?

During my ten-year career in healthcare financial services sales, I have shared my triathlon and biking event stories with many professionals (also a one-mile Oceanside ocean swimming race that I came in last!), and have encouraged them to join me.

For those who are interested in participating in an event, 90% of these professionals justify any delay by stating that they are waiting until they are “fully prepared.”

We all agree that preparation is a critical element to the success of any project; however, as healthcare has taught us, we are in an industry in which we have learned more “by doing” than by watching or listening.

There is no school of healthcare financial management that will fully prepare a student for the environment in which healthcare professionals live. Changes are non-stop and we each must learn how to respond to them.

The same goes for a triathlon or distance event – being fully prepared is an unobtainable goal.

What triathlons have taught me about healthcare financial management

I am fifty-seven years old and had only minor athletic success when I was young. I am clearly overweight at 250 pounds. I love bike riding, but my training is inconsistent. Only when I am truly afraid of an event do I lose weight or train more than three times per week.

I have learned that the greatest challenge to doing a triathlon is walking to the starting line. I recognize that the greatest challenge with moving into sales after a 20+ year career in A/R management was asking for the sales job.

Many financial managers are eager to retire and are waiting for that opportunity to present itself. My advice would be to reconsider: find an aspect of your skill set that is a totally new challenge and one in which approaching the starting line is not a given, but an accomplishment in itself.

I’ll see you at the starting line….

Too Busy to Join a Committee?

Would you like to get more involved, but unsure of the commitment and time? HFMA is wonderful way to network with your peers and meet new friends. Volunteering at HFMA encompasses a wide range of possibilities from leadership in a committee to suggesting a topic, recommending a great speaker to writing an article of interest, or simply participating in conference calls and giving your feedback. We have many committees to choose from and certainly welcome you to join! If you’re interested, please contact Ramona Hernandez, Membership Chair, at rhernandez@californiaservicebureau.com.
HFMA – What Does It Mean to You?
Steve Thompson, FHFMAMarin General Hospital
thompsst@sutterhealth.org

The Northern California and Southern California Chapters of HFMA jointly sponsored the annual Fall Conference in Newport Beach this past September. This program has always been a success for both chapters, although it is noted that when the event is held in Southern California, we lose many of our Northern California members. This is a major concern to your Chapter leadership and we want to seek ways to see a greater attendance at this annual conference, and all of our events.

The Fall Conference will be held in Monterey in 2009, so this will allow dance at this annual conference, and all of our events.

Our Chapter goals are clear: to provide timely and appropriate levels of education, networking, and sharing with our members. HFMA is a personal membership decision and we want to be sure that you are receiving the maximum benefit from your membership. We are also aware of the financial restraints each hospital has and want to find ways to meet your needs within these budgetary constraints.

I have been a member of HFMA since 1975 and certified since 1978. Over the years I have always worked to be an active member, and I personally challenge myself to evaluate what HFMA nationally and, more importantly, locally offers me in my career. Each year the Chapter continues to meet my needs and the needs of everyone. We are constantly working on educational programs that reach out to each of you, in addition to e-mail notices to members of issues that are occurring right now.

Even as we continue to find ways to offer you more, we are constantly seeking ways to determine what our members are looking for from our Chapter. To do this, I would like to reach out to the membership and challenge all of you to step up and offer assistance and ideas. As a close personal friend stated, and I know as a past Chairman, “HFMA IS PERSONAL.” I cannot think of any other time that this is more relevant than right now. Make this personal and let us hear your thoughts and desires to be more active in YOUR Northern California Chapter.

For the past four years we have been providing PFS Road Shows, taking the program to our members. We brought programs to Fresno, Fremont, Monterey, Sacramento and Chico. In addition, the Managed Care Committee recently met in Sacramento to seek access to decision makers. The annual spring conference in the Sacramento area is a multi-day program geared towards Finance, Managed Care, and Revenue Cycle. Publications such as The Edge offer timely and relevant information to each of you, in addition to e-mail notices to members of issues that are occurring right now.

Our Chapter goals are clear: to provide timely and appropriate levels of education, networking, and sharing with our members. HFMA is a personal membership decision and we want to be sure that you are receiving the maximum benefit from your membership. We are also aware of the financial restraints each hospital has and want to find ways to meet your needs within these budgetary constraints.

I have been a member of HFMA since 1975 and certified since 1978. Over the years I have always worked to be an active member, and I personally challenge myself to evaluate what HFMA nationally and, more importantly, locally offers me in my career. Each year the Chapter continues to meet my needs and the needs of everyone. We are constantly working on educational programs that reach out to each of you, in addition to e-mail notices to members of issues that are occurring right now.

Even as we continue to find ways to offer you more, we are constantly seeking ways to determine what our members are looking for from our Chapter. To do this, I would like to reach out to the membership and challenge all of you to step up and offer assistance and ideas. As a close personal friend stated, and I know as a past Chairman, “HFMA IS PERSONAL.” I cannot think of any other time that this is more relevant than right now. Make this personal and let us hear your thoughts and desires to be more active in YOUR Northern California Chapter.

Welcome New Members!
Liz Allan - Sourcecorp
Deliverex
Tricia M. Bailey - Kaiser
Permanente
Robert Barad - Children’s
Hospital of Central Valley
Vandana Behl - Alameda
Hospital
Margaret Bistrovich - Gaffey
and Associates, Inc.
Diane Byrd - Stanislaus
Surgery Center
Gina Carroll - UC Davis
Medical Center
Janet Cheung - Moss Adams
LLP
Leon Dalva - Alameda
Hospital
Goldie K. Dhillon - Chan
LLC
Matt Elam - Catholic
Healthcare West
Wayne Fairchild - Redwood
Regional Medical Group
Pamela Frazer - Tenet
Healthcare
Amy Gutierrez - Sutter
Health
Ann Marie Heidingsfelder -
GE Healthcare Financial
Services
Judith Kanapicki - Protiviti,
Inc.
Jay Lipps - Ernst & Young
LLP
Cheryl Martiniano - Burbble,
Inc.
Hewitt Moten - KFHP
Gigi Pappas - Kaiser
Permanente
Rani Radhakrishnan -
PricewaterhouseCoopers
Mino K. Sastry - Medefinance
David Shellenberger -
FairIsaac
Carla J. Smith - Hanford
Community Medical Center
Jill Sullivan - Lucile Packard
Children’s Hospital
Kimman Tong - Moss Adams
LLP
Lynne Vargas - Kaiser
Permanente
Joyce Walker - Alameda
Hospital
David White - Chamberlin
Edmonds
Dan Wosolowski - Sutter
Health
Christine Ybarra - Stanislaus
Surgical Hospital
Farhat Yousufzai - Moss
Adams LLP

The Edge - Northern California Chapter's Newsletter
In Appreciation

Thank you to our 2007-2008 Corporate Sponsors for their continuing support of the Northern California chapter

Getting Ready to Retire? Need Assistance with your Membership Dues?

Did you know that there is assistance for Members who are in transition, or if your employer has cut membership out of the budget?

National HFMA has assistance programs to help dedicated HFMA Members with their membership dues. National will help with membership dues for one year for those in need while in transition. HFMA wants our members and their employers to utilize the countless benefits of their membership!

If you know any members who are retiring or thinking of dropping their membership because they are retired, please share the word that National has a special program for those who are retired. Retirees are a priceless resource and we want to keep them involved with HFMA!

Please contact Ramona for more information: rhernandez@californiaservicebureau.com or (415) 475-4595

Job Opportunities

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

- Director of Community Clinic Operations - California Primary Care Association (posted 10/21)
- Billing & Collection Manager - Pathways Home Health (posted 10/16)
- Manager, Patient Business Services - Legacy Health System (posted 10/16)
- Director of Divisional Finance - Group Health Cooperative (posted 10/15)
- Director of Healthcare Product Strategy - Oracle (posted 10/15)
- PFS Director - Oroville Hospital (posted 10/6)
- Patient Account Manager - Natividad Medical Center (posted 10/2)
- Business Office Manager - Alameda Hospital (10/1)

Northern California Chapter
Board of Directors

Chuck Acquisto - President
Kenneth Jensen - President-Elect
Jayne Kroner - Secretary
Kathleen Cain - Treasurer

Mary Ackley  Aimee Arata  Barry Brown  Dan Dreblow  Maria Dryden  Ramona Hernandez  Peter Hugenroth

Deborah Knight  Brian Marrs  Terry Paff  Cindy Rudow  Jack Ruzic  Christine Sarrico  Steve Thompson

Newsletter Committee

Terry Paff - Committee Chair
Walt Luke - Co-Chair

Mary Ackley  Geli Argao  Gloryanne Bryant  Kathleen Cain  Ramona Hernandez  Arlette Kendall  Deborah Knight

Jayne Kroner  Frank Fedor  Kathryn Leppert  Brian Marrs  Kim Miranda  Cindy Rudow  Steve Thompson