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healthcare financial management association
southern california chapter

2009 | 2010

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NEWSBRIEF

NEWSLETTER OF THE SOUTHERN CALIFORNIA CHAPTER OF H.F.M.A.

VOLUME 18 / NUMBER 3 WWW.HFMA-SOCAL.ORG DECEMBER 2009 / JANUARY 2010

. . Holiday Party . . . .

at Gazzella Restaurant

Scott Ujita

This year's HFMA holiday party was held at Gazzella Restaurant in Long Beach. There were a variety of hors d'oeuvres, desserts and free flowing drinks and cocktails. There was also an excellent jazz combo. I had a really good time. There were just about 100 people who attended the festivities. Many of the guests were generous enough to bring an unwrapped gift for our organization to donate to a charity. By the end of the night, there was a nice pile of presents. During the evening, I made a point to make my way around the room. I had a chance to relax and talk to most of the seven past Presidents that attended the event. This was truly a time to catch up with good friends. I would like to thank the hard work of the Networking Committee, the chapter sponsors, as well as everyone that attended the event this year. From the Southern California Chapter of HFMA, I would like to wish you Happy New Year and hope to see you in January at the Region 11 Symposium in Las Vegas.

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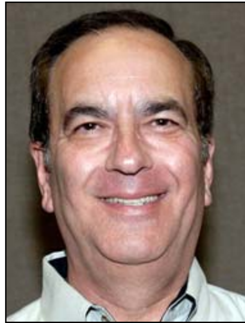
MESSAGE FROM THE PRESIDENT

Rick Lash



Dear Fellow HFMA Members,

On behalf of your Board of Directors of the Southern California Chapter of HFMA, I want to wish you and your families a very healthy, happy and safe Holiday Season! It is difficult to believe that Thanksgiving is behind us and that the New Years day has come and gone. I hope you were able to join us for the Annual Holiday Party, and if not in person, then certainly in spirit.

We had an excellent program at our Educational Program #2 which was held at Presbyterian Intercommunity Hospital on November 12, 2009. The comments shared with me were mostly favorable.

I encourage every one of you to take advantage of the Region 11 Symposium being held in Las Vegas from January 24 – January 27, 2010. The Education Committee has secured exciting speakers for a variety of topics. How do I know this? In addition to being a member of the Region 11 Core Committee, I am also the Education Committee Co-Chair. Please know that a lot of hard work has gone into to making the Region 11 Symposium an "educational feast." Don't let this opportunity pass you by.

Our Education Outreach Program #3 is scheduled for February 17, 18, and 19, 2010. Please save the dates. More information will follow.

On February 25, 2010, we are scheduled to hold a CFO/Controller Webinar. Again, please save the date. This, too, promises to be an awesome event.

Our Educational Program #3, full day session, will be held on March 18, 2010, at the Center for Health Communities in downtown Los Angeles. Also, on March 18, 2010, we will offer a Core certification coaching class. That's right. More information will follow.

Wishing you a joyous Holiday Season!

Rick Lash
President, HFMA Southern California Chapter

HFMA SO. CALENDAR 2010 EVENTS

January 24-27 – REGION 11 SYMPOSIUM
Caesars Palace, Las Vegas / *See website for more information*

February 17 / February 18 / February 19 – EDUCATION OUTREACH PROGRAM III
Different locations each day. Details will be posted when available.

February 25 – CFO/CONTROLLER WEBINARI
Details will be posted when available.

March 18 – CHAPTER EDUCATIONAL PROGRAM III
The Center for Healthy Communities, Los Angeles, 7:30am-4:00pm / *Details will be posted when available.*

April 14 / April 15 / April 16 – EDUCATION OUTREACH PROGRAM IV
Different locations each day. Details will be posted when available.

June 20-23 – HFMA ANNUAL NATIONAL INSTITUTE
Gaylord Opryland Resort and Convention Center, Nashville, Tennessee

June 26-29 – HFMA ANNUAL NATIONAL INSTITUTE
Gaylord Palms Resort and Convention Center, Orlando, Florida

Details on all events can be found on the chapter's website www.hfma-socal.org/ > click on Events Listings.

California Hospital Association Update

Steve Blake, California HFMA Liaison

The CHA Board of Trustees met on December 17, 2009 and reviewed 2009 regulatory activity on Federal and State levels. Following is an update for some of the key developments pending or under review.

Provider Fee:

A temporary hospital fee program to provide Medi-Cal supplemental payments to hospitals through December 31, 2010, was enacted in 2009 [AB 1383].

The provider fee approach is not uncommon. 21 states take full advantage of the federal match via implementation of a provider fee. CHA has taken this lead, embracing the following guiding principles:

1. Hospitals must be permanently protected with respect to payment and the amount of the tax (i.e. the State cannot use this as a pretext to reduce its level of support in other areas).

2. Hospitals should be paid by Medi-Cal at the highest level allowed under federal law.

3. The State must be required to ensure that criterion 2 is met even when General Fund money is required (state maintenance of effort).

4. All of the money generated from the hospital tax must be used solely to benefit hospitals.

5. Only the voters can make changes to the program.

Securing these principles is not assured and AB 1383 does not offer all of these safeguards to eliminate the risk. The additional federal revenue from this development promises to be approximately $2 billion annually. It is anticipated the program is expected to cover 18 to 21 months ending December 2010. The CHA is continuing to seek longer term solution for the foregoing principles.

Maintenance of Effort [MOE]:

Critical to the success of this program is the preservation of the State's contribution to care for the indigent. It is unacceptable for the State to take advantage of the provider fee to offset its already inadequate funding. A lot of legal analysis can be boiled down to a stipulation that this can only be accomplished with a ballot initiative on November 2.

The Association is prepared to move forward with a November 2010 ballot initiative to establish permanent protections in the event a future hospital fee is implemented. A decision on a specific initiative will be made in the coming months.

Equity for net contributors:

By the nature of rules governing the application for enhanced matching funds, a smaller percentage of facilities will experience fees in excess of enhanced reimbursement. This has the potential for fragmenting industry support for the program. There has been widespread support for developing pledge agreements from providers who receive a net benefit to the California Health Foundation and Trust (CHFT). CHFT has designated a Government Health Care Program Grant Fund, designed to make awards out of these pledges to hospitals that do not receive an offsetting benefit to their fees. Pledges ranging progressively from 1% to 5% of the net gain to those hospitals that benefit are anticipated to accomplish this goal in 2010. The success of this program depends on widespread buy-in. CHA staff, Trustees and affiliated counsels stand ready to assist in presentation to hospital leaders and governing boards.

National Health Care Reform:

While CHA continues to support health care reform, several important issues need to be addressed in the Senate bill: the number of newly insured and readmissions policy is unresolved. It appears that the public plan was dropped early this week. Geographic variation proposals hold the potential to reduce Medicare revenues to California by $2 billion and there are proposals to cut both Medicare and Medicaid Disproportionate Share Payments.

Medi-Cal 1115 Waiver:

The Medi-Cal 1115 waiver is set to expire on August 31, 2010. It could be extended by CMS for several months. It is the intent of the Schwarzenegger Administration to make the next five-year 1115 waiver a broad waiver rather than a hospital waiver, bringing in other providers in an attempt to develop comprehensive systems of care.

Dissolution of Cal RHIO:

This week Cal RHIO board voted to dissolve. The State is going to designate a new governance entity to preside over the development of a Health Information Exchange (HIE).

I would like to take this opportunity to wish all a happy and safe holiday…and a new year that promises to be as interesting as the last!

Public Option, No Public Option, Medicare Rates Plus 5%, Republican Filibusters –

Will There Be Health Care Reform or Not?

Anthony F. Lewis, M.A.

About a week ago, I was thinking about what actions, if any, hospitals were taking in formulating their ten year financial plans given the fact that there is a high probability of health care reform legislation passing in the near future in Congress. Many details have yet to be ironed out, with countless amendments being added daily to whatever bill is "du jour" and, needless to say, fresh out of one of the Senate or the House committees. There is one universal here that has not changed and that is nothing yet is certain. But according to recent polls, 55% of Americans favor some type of health care reform. Where all of this comes together is still up for bets. Nevertheless, as providers, we can be certain that whatever is passed by Congress and signed by President Obama will impact all of our ten year hospital financial plans. Since this is the largest legislative act impacting health care reform since Medicare, it is probably accurate to say that all financial planning departments need to get busy and go back to the drawing board. Very little of what we forecasted five or ten years ago will hold true in this new regulatory environment.

This is probably why most financial planning folks have up to this point been caught in a state of budgeting/forecasting paralysis. And, it is understandable. How can one accurately forecast the picture of a provider's financial condition when Congress has not even figured it out? Being naturally inquisitive and concerned about what is on the horizon, many times I ask hospital executives what they are forecasting for the next five years from a budgetary perspective. The typical response has been one that suggests that everything will remain at status quo until more is certain. But is this the right response or is it even accountable to the provider community? Who knows!

Granted, health care reform is still a work in progress and my sentiments are with those who can not forecast the future without some specific legislation to anchor their projections. However, there are facts that we can not ignore that will serve as guiding principles to help us in our ten year forecasting. Some of these are:

- **Health care reform will have to be financed through cut backs in public programs such as Medicare, Medicaid, and State Children's Health Insurance programs. The offset of these cuts will be new revenue sources from within or outside the health system.**
- **Additional savings will come from modernizing the delivery of health care at all levels. Every member of Congress knows that the delivery of health care is highly inefficient and that is why there is so much emphasis on using modern technology to create electronic medical records. Information technologies will drive a set of savings associated with more efficiency.**
- **Future reimbursement models must emphasize quality over volume. Hospital budgeting will change as volume driven projections will have less importance as emphasis shifts to quality and promotion of quality services based on a bundling of services model.**
- **According to the Los Angeles Times (October 27, 2009), the private insurance industry has come to accord on the fact that there should be requirements that all Americans buy health insurance, there should be expansion of government insurance programs (such as Medi-Cal and Medicaid) to help the poor, and requirements that insurers offer their products to all without cherry picking to eliminate those with preexisting conditions. All of this means more business for physicians and hospitals and, of course, a boon for the private health insurance market. Additionally, with more demand, these conditions will impact premium prices.**

So what? Many executives will look at these scenarios from a position of uncertainty. Their response will still be one from a comfort zone of status quo, since nothing can really be forecasted until a piece of legislation emerges from all the "smoke and mirrors" of politics.

And yet, the comfort zone of "keep everything constant and status quo" is a slippery slope for many of us who have spent the last thirty years in the hospital industry and worry about the provider community's future. Hospital executives need to plan right now for health care reform. It is certain to be here very soon and now is the time to start dusting off those ten year plans or even starting over. And even if we start with some planning, be prepared to revise and revise those plans!

Having researched health care reform since my graduate school days, I put together some givens that will impact the hospital and physician community that can serve as a basis for our preliminary forecasts:

- **Start analyzing your revenue sources, especially those that are Medicare based and know the insurance market, including the number of uninsured in your market area.**

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Health Care Reform or Not?

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Two thirds of hospitals in the United States lost money on Medicare patients in 2007. To finance health care reform, there will be further cuts to the Medicare program to make it more efficient. Medicare per case and per visit payments will be further reduced. On the other hand, other expanded health care products will use Medicare rates as a basis for payments (the Public Option, if there is one, will use Medicare rates plus 5%), even though Medicare has never covered its costs in the hospital community. Are we prepared to increase reimbursement in our hospitals with Medicare cuts? If we manage a system of hospitals, do we know which hospitals are most likely to be negatively impacted by more Medicare cuts? On the other hand, which hospitals can be forecasted for added volume as a result of health care reform? It is very critical to do market research and try to determine the number of uninsured who may visit these hospitals in the future.

Both the Senate and House bills call for approximately 600 billion in savings to pay for health care reform. Again, I emphasize an analysis of payer mix, especially Medicare, as most of these cuts are right out of Medicare. Some examples:

1. Future cuts via competitive bidding for Medicare Advantage programs.
2. Reallocation of Medicare and Medicaid disproportionate share payments as patients without insurance finally obtain some form of coverage.
3. Huge reductions in pharmaceutical spending for Medicare and Medi-Cal patients.
4. More cuts as legislators pass payment reforms such as bundled-care payment systems (which might replace DRGs!) which pay for entire episodes of care and rewards providers based on high quality and efficient care.

Finally, for those who manage operating and cash budgets for large urban based hospitals with many Medi-Cal patients, providers that are dependent on Federal DSH payments, expect as much as a 75% reduction in DSH allotments. Such large reductions in reimbursement will have to be offset elsewhere.

- **Start adjusting your operating plans which will address changes and future opportunities as a result of significant cuts to Medicare. Some points to consider:**

With an emphasis on quality via bundling, hospitals will have additional expense for new technologies, especially in developing electronic medical records and promoting other efficiencies. Bundling, in itself, will shift demand for various services. Of course, emergency rooms, laboratory and diagnostic services, such as radiology, will all be impacted.

With more individuals covered, the provider community will need more physicians (which is a concern since currently there is a shortage of physicians, especially in rural areas). With more patients visiting doctors, we should expect a drop in utilization of the emergency room with a decrease in expense as well as revenue. How will the traditional emergency room evolve with predicted drops in utilization?

With a demand for more diagnostic tests as a result of more patients seeing doctors since they now have health insurance, hospitals can expect more volume in the areas of laboratory testing, cat scans, physical therapy, and even psychological services. Hospitals should be prepared to budget more expense in these areas. In spite of the increase in volume and expense, hospitals may experience an overall decrease in expense if patients are no longer visiting the emergency room where costs, compared to a physician office visit, are so much higher.

Hospitals must do a better job in the area of providing "high quality" services. Again, this means more money spent on better technologies and devising better ways to provide more efficient services. Many proposals for health care reform, aside promoting bundling of payments, are also penalizing hospitals for patients that return to hospitals for follow-up treatments or acquire infections while a patient. Hospitals must stop budgeting from a volume perspective and begin a budgeting process that focuses on services that are high quality.

Many of these ideas are already in play, as we have seen Medicare reward hospitals, both on inpatient as well as outpatient, with higher payments depending on certain quality information being submitted to CMS. Many hospitals, too, are developing electronic medical records and forecasting expenses for better technologies that monitor episodes of care in the future.

No, the sky is not falling! None of this is going to happen overnight. But we all need to start thinking about the future of what health care will look like in our communities within the next few years. Right now is the best time to get busy!

Anthony F. Lewis, M.A., is the Manager of Reimbursement for Cottage Health System in Santa Barbara, California.

Shift the Power Back to California Healthcare Providers

Julie Hall, J.D.

On Thursday, November 12, 2009, the HFMA Revenue Cycle/Compliance Committee held the session"Ask the Attorney! Enforcing Claims Payment Compliance with Out-of-Network Payors" led by speakers Daron L. Tooch, Partner Hooper, Lundy & Bookman and George Colman, Esq., serving as national legal counsel to the American Association of Healthcare Administrative Management (AAHAM), and is the legal advisor to the California Association of Healthcare Admitting Managers (CAHAM). Payments from both governmental and private payors continue to squeeze ALL healthcare providers. The powerful paneled and Q&A session was designed to arm providers with proven cases, statutes, regula-tions and tools to prevent non-contracted payors from unfair payment practices such as: underpayments, untimely payments, failure to authorize post-stabilization services and care or transfer patients, paying claims directly to patients (anti-assignment of benefits clauses) and much more.

"Assignment of benefits"– a phrase now typically associated with a negative connotation by healthcare providers. The good news is that hospitals have become more informed and educated regarding payor contracts. Despite an increase in hospital refusal to enter into bad contracts, this is just the tip of the iceberg involving the battle providers face in combating anti-assignment of benefit clauses.

Background: Federal and California Law

EMTALA - this Federal statute imposes an obligation on hospitals to provide emergency care regardless of the patient's ability to pay. In addition, EMTALA does not contain a provision requiring payors to pay for emergency services.

To the contrary, in California, under Health and Safety Code Section 1371.4 involving HMO emergency claims, payors are mandated to reimburse for emergency services and care:

A health care service plan, or its contracting medical providers, shall reimburse providers for emergency services and care provided to its enrollees, until the care results in stabilization of the enrollee, except as provided in subdivision (c). As long as federal or state law requires that emergency services and care be provided without first questioning the patient's ability to pay, a health care service plan shall not require a provider to obtain authorization prior to the provision of emergency services and care necessary to stabilize the enrollee's emergency medical condition.

The parallel statute for California Non-HMO Emergency claims, per Health and Safety Code Section 1317.2(a) states:

Any third-party payor, including, but not limited to, a health maintenance organization, health care service plan, nonprofit hospital service plan, insurer, or preferred provider organization, or employer which has a statutory or contractual obligation to provide or indemnify emergency medical services on behalf of a patient shall be liable, to the extent of the contractual obligation to the patient, for the reasonable charges of the transferring hospital and the treating physicians for the emergency services provided pursuant to this article, except that the patient shall be responsible for uncovered services, or any deductible or co-payment obligation.

Regarding California HMO Post-Stabilization Claims, per Health and Safety Code Section 1262.8(d):

(1) A health care service plan, or its contracting medical provider, that is contacted by a non-contracting hospital [for authorization of post-stabilization care], shall, within 30 minutes from the time the non-contracting hospital makes the initial contact, do either of the following:

(A) Authorization for post stabilization care.

(B) Inform the non-contracting hospital that it will arrange or the prompt transfer of the enrollee to another hospital.

(2) If the health care service plan, or its contracting medical provider, does not notify the non-contracting hospital of its decision pursuant to paragraph (1) within 30 minutes, the post stabilization care shall be deemed authorized, and the health care service plan, or its contracting medical provider, shall pay charges for the care.

The Problem

The anti-assignment clause is an obstacle to the traditional approach to standing for non-participating providers. The anti-assignment clause has become a component of health insurance contracts, which prohibits or limits the assignment of the insured's benefits to third parties, including healthcare providers, and precludes the non-participating provider's standing to sue as an assignee and/or third party beneficiary. A New Jersey Superior Court stated:

The anti-assignment clause has been deemed to advance the overarching public interest in limiting health care costs, for if the patient could assign his or her rights to payment to outside medical providers, it would undercut the pre-arranged costs with in-network providers...Accordingly [courts in other jurisdictions] have held that the purported assignment of benefits to a non-participating medical provider, in the face of an anti-assignment clause in a group health care policy, is void and unenforceable against the insurer as contrary to public policy. [1]

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Shift the Power Back to California

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To date, California cases have upheld non-assignment clauses.*[2]* These provisions are impeding on healthcare providers' ability to render medically necessary services and care. Payors' use of anti-assignment provisions has a negative impact on provider reimbursement. Simply put, an anti-assignment provision is a contract strategy utilized by payors to influence healthcare providers to contract directly with the payor, which warrants healthcare providers to take preventive measures.

What Can We Do?

There are several preventive measures a healthcare provider can take to prevent a potential issue with an anti-assignment benefit clause as well as increase revenue.

I. The Relevance of an Authorization

Not only does California law prohibit a payor from rescinding or modifying an authorization, but once the authorization is obtained, in theory a contract has been created between the payor and the healthcare provider, as well as a strong case for additional civil causes of action.

Health and Safety Code Section 1371.8 states:

> *A health care service plan that authorizes a specific type of treatment by a provider shall not rescind or modify this authorization after the provider renders the health care service in good faith and pursuant to the authorization for any reason, including, but not limited to, the plan's subsequent rescission, cancellation, or modification of the enrollee's or subscriber's contract or the plan's subsequent determination that it did not make an accurate determination of the enrollee's or subscriber's eligibility.*

Validity of Conract

Arguably, when the authorization is obtained by the healthcare provider, a valid contract has been created. There are two theories under contract law a healthcare provider can assert: an implied-in-fact contract and an implied-in-law contract.

An implied-in-fact contract is a contract agreed by non-verbal conduct, rather than by explicit words. "An agreement implied in fact is founded upon a meeting of the minds, which, although not embodied in an express contract, is inferred, as a fact, from conduct of the parties showing, in light of the surrounding circumstances, their tacit understanding."*[3]* Such contracts are formed when one party accepts something of value knowing that the other party expects compensation. For example, when a payor provides an authorization to a healthcare provider, the payor accepts something of value, the medically necessary services and care rendered to their member, in return for compensation to the healthcare provider.

Under this theory, although unwritten, a court of law may find a valid contract. This theory would allow for the best recovery and may result in a healthcare provider receiving the reimbursement it should have under the contract between the payor and insured.

On the other hand, an implied-in-law contract is one that at least one of the parties did not intend to create but that should, in all fairness, be created by a court. Under this theory, a court of equity may find that although a contract does not exist, the law will imply a contract between the parties because to do otherwise would be unjust. An implied-in-law contract may afford less recovery, "merely remedies granted by the court to enforce equitable or moral obligations in spite of the lack of assent to the party to be charged."*[4]* Remedial measures of an implied-in-law contract usually are limited to the cost of labor and materials because it would be unfair to force a person who did not intend to enter into a contract to pay for profits.

Other Civil Causes of Action

Additionally, an authorization will support a civil cause of action for negligent misrepresentation. A claim for negligent misrepresentation "must establish that the defendant negligently made an incorrect statement of a past or existing fact, that the plaintiff justifiably relied on it and that his reliance causes a loss or injury."*[5]* Thus, when the payor has provided an authorization to a healthcare provider, the payor has essentially acknowledged notice that the non-participating provider is rendering necessary medically necessary services and care to the insured. When the payor provides the authorization, the healthcare provider relies on this authorization or promise that the payor will reimburse for the care rendered.

II. Get an Assignment of Benefits

Always get an insured to sign an assignment of benefits form. The assignment of benefits will aid to refute any standing argument a plan may argue when the healthcare provider refutes payment directly to the provider. Even if there is an anti-assignment provision in the health insurance contract, a defense such as unconscionability may invalidate the provision. Better to be safe than sorry.

III. Document Everything!

A non-participating provider may able to argue the invalidity of an anti-assignment clause due to a health insurer's waiver of an anti-assignment clause. "An anti-assignment clause may be waived by a written instrument, a course of dealing, or even passive conduct, i.e., taking no action to invalidate the assignment vis-à-vis the assignee."*[6]*

In other words, if a payor has paid directly to the healthcare provider before, arguably the payor has waived the anti-assignment provision in the health insurance contract. Paper trails, proper documentation, organization of records are all critical to the success of a waiver argument.

Currently, there is a lack of documented incidents involving an insured's failure to forward reimbursement to the healthcare

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Power back to California

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provider. It is vital that healthcare providers document issues involving assignment of benefits. With this documentation, statistics and information can be reported publicly and place payors on notice of the harm and burden the anti-assignment provisions have placed on healthcare providers and the negative impacts on the overall quality of healthcare in the state of California. If healthcare providers can communicate to payors as well as regulatory agencies the consequences these provisions have on the healthcare industry, payors will be challenged in defending the validity of anti-assignment provisions.

Conclusion: Public Policy Disfavors Forfeiture

Public policy disfavors forfeiture. Civil Code Section 3275 states:

> *Whenever, by the terms of an obligation, a party thereto incurs forfeiture, or a loss in the nature of forfeiture, by reason of his failure to comply with its provisions, he may be relieved there from, upon making full compensation to the party, except in case of a grossly negligent, willful, or fraudulent breach of duty.*

In an economic rescission, when an insured receives a check from a payor, the financial viability of a healthcare provider should not be contingent on whether the insured will forward the reimbursement. In a benefit versus burden analysis, clearly the benefits of direct payment from the payor to the healthcare provider substantially outweigh any burden placed on the payor to do so.

As healthcare providers become informed and educated in this area, anti-assignment provisions will no longer have a negative impact on the financial viability of the provider. The fulcrum of California healthcare rests on claim reimbursement. It is essential to the financial viability of healthcare providers, to do its due diligence.

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ENDNOTES

[1] See *Gregory Surgical Services, LLC v. Horizon Blue Cross Shield of New Jersey,* No. Civ.A.06-462(JAG) 2006 WL 1541021 (D.N.J. 2006).

[2] *Davidowitz v. Delta Dental Plan of Cal., Inc.,* 946 F.2d 1476 (9th Cir.1991).

[3] *Baltimore & Ohio R. Co. v. United States,* 261 U.S. 592 (1923).

[4] *Gray v. Rankin,* 721 F. Supp 115 [S.D. Miss. 1989].

[5] *Masone v. Levine,* 382 N.J. Super. 181, 187 (Sup. Ct. App. Div. 2005).

[6] *Gregory Surgical Services, LLC v. Horizon Blue Cross Blue Shield of New Jersey, Inc.,* No. Civ.A. 06-462 (JAG) 2006 WL 1541021 (D.N.J. 2006).

Solution Must Include Uncompensated Care

Joy Stephenson

The current debate over health care reform is a much needed one.

Everyone, from politicians to the health care industry to consumers, all agree and recognize that access to affordable, quality health care is critical for the future well-being and prosperity of our nation. But in the debate over possible solutions, we also must look at aspects of our current health care system that, if left as they are today, could easily undermine all the good we are trying to achieve with this reform.

One of these areas is "uncompensated care," or the care that hospitals, by law, are required to give whether or not they are ever compensated by patients, insurers or the government for its true cost.

Everyone likely would agree that ensuring this type of access is a reasonable and fair-sounding proposition that contributes to the greater good. Indeed, countless numbers of people have received urgent and needed medical attention that they otherwise would not have received because of it.

Unfortunately, no one could have foreseen that providing this care without having any mechanism in place to fund it would eventually raise the costs of health care in the United States to incomprehensible levels that would threaten to cripple the health care system itself.

The numbers involved are simply staggering and impact the financial well-being of virtually every player in the health care delivery system. In 2008 alone, U.S. hospitals provided upwards of $42 billion in care, which went unpaid because of patients having insufficient or nonexistent health insurance. This situation is further exacerbated by the fact that many underinsured or uninsured Americans use the emergency room as a substitute for non-emergency care, which results in some of the most basic medical care being provided at the higher costs associated with an ER.

To help offset these losses, hospitals and doctors need to charge everyone more for the services they provide. These higher prices then create a corresponding increase in the costs to insurance companies and other health care payment programs. They, in turn, pass these on to consumers and businesses that purchase their insurance coverage in the form of higher premiums. The result is a seemingly never-ending spiral in the escalation of health care costs.

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How to Deliver Excellent Service

David McNulty, VP Client Development
Integrated Health Management Services (IHMS)

As competition increases among companies specializing in third party screening and eligibility, outstanding service is more than something to be strived for, it's an absolute necessity. Health care providers have a lot of choices available, and if one company can't deliver, another can easily step in to fill the void.

This is not to say that existing relationships between providers and their eligibility and recovery partners aren't valuable, but in the face of mounting government pressure to control costs, every dollar counts. Companies that can streamline processes while increasing cash payments from such programs as Medicaid, Medi-Cal and AHCCCS, have a definite edge. That said, exactly what does distinguish companies that provide excellent service from those whose service is just adequate? A number of things:

Keep your eye on the money.

Maximizing cash intake is the main reason your customers partnered with you in the first place, but in the process of delivering other services, an eligibility and recovery company can lose sight of this fact. This is especially true when you consider the broad spectrum of services providers have come to expect. Jess Martinez, Business Office Director at Northwest Medical Center, acknowledges that revenue enhancement is one of the most important, if not the most important aspect of the relationship.

"We're looking for responsiveness to facility concerns and issues, excellent customer service, no delays in the company's processes that result in a delay in reimbursement for the facility, and finally, a tremendous improvement in the revenue cycle as a result of their work. My facility has experienced this with our eligibility and recovery partner in that we have seen a 100 percent cash turnaround with regard to Medicaid collections and a 200 percent increase in Medicaid application approvals."

Keeping the revenue stream flowing is obviously job one, but other factors also come into play when great service is the goal.

Be very good at what you do.

As providers become more aware of their options, the need for eligibility and recovery companies to provide added services increases. Larry Roberts, co-founder of Integrated Health Management Services, believes companies must be able to respond to changing demands within the industry.

"Providers are expecting more and more. What we are finding is that they feel more comfortable asking us to take on additional responsibilities. We are often asked to handle deficiencies that are inherent in their infrastructure when the client lacks the resources to correct those problems on their own."

Maintaining an organization that consistently exceeds both provider and patient expectations requires experienced administrators and industry-savvy collections and field staff members. Hiring people with direct experience at the county or state level brings a unique insight into how best to expedite the application process.

Field staff must also be willing and able to meet the patient whenever and wherever the job requires, from hospital admitting rooms to homeless shelters if necessary. By going where hospital staff often can't, you're opening up collection opportunities most providers do not have the personnel or budget to pursue.

Finally, if a significant percentage of a provider's self pay clients are not fluent in English, a bilingual staff is needed to achieve greater access and credibility among the patient population they serve.

Become collections experts.

When partnering with a new client, many eligibility and recovery companies are faced with a tremendous backlog of unpaid claims involving a number of different health plans. Dividing and assigning the caseload by health plan allows Collectors to become experts on the particular plan(s) assigned to them. Collectors can then work individual aging reports and sort spreadsheets according to claim issues. This approach not only allows Collectors to acquire expertise in specific health plans, but also yields a wealth of detailed data to discuss with representatives of various plans and government programs when contracting and resolving global issues.

Specific knowledge of a particular health plan is also critical to understanding your client's rights under that plan. Armed with this knowledge, Collectors can much more effectively advocate on their clients' behalf by identifying and appealing inaccurate denials, as well as escalating issues to state agencies if the situation warrants.

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How to Deliver Excellent Service

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Foster government and community alliances.

Hiring staff with government program experience is just the beginning when striving for service excellence. Staff members must also understand that a cooperative, non-adversarial relationship with government agencies is in the best interest of all stakeholders. Regular meetings with government agencies can provide much needed updates on the latest regulations, as well as opportunities to develop collaborative relationships with agency personnel.

Because many self pay patients are in fact homeless, companies should participate in provider-based homeless roundtable discussions that address the specific needs of this community. Forming ongoing relationships with homeless shelter Directors provides opportunities to deliver your message to patients who may not realize their options under Medicaid or similar programs. Participation in hospital health fairs also offers opportunities to introduce your services to the patients who need them most.

Build true partnerships based on communication.

Working closely *with* providers means listening closely to them—their needs, their concerns, their goals. At the beginning of the relationship, eligibility and recovery companies must meet with providers to establish Standard Operating Procedures. These detailed roadmaps help define the hospital's goals, identify areas for improvement and set parameters for any work that needs to be done. This meeting should include appropriate hospital staff such as admissions/registration and patient financial services personnel, as well as other staff members who will regularly interact with your company.

Another method of keeping the lines of communication open is the Monthly Operational Review meeting. These interactions provide an effective means of solving problems, refining procedures and obtaining the kind of constant feedback that enables eligibility and recovery companies to keep their services up-to-date and on-track.

Leverage technology.

At the forefront of technology is the move to web-based applications and connectivity. Companies need to provide access to data from a variety of work environments that may span thousands of miles. Identifying and implementing the most effective web interface technologies provides access to critical operational data from anywhere in the world. Eligibility and recovery companies that can harness the flexibility offered by such technologies have a definite advantage in today's evolving health care market.

While the ability to access and store large amounts of data is a key component of any eligibility and recovery company's services, it isn't a selling point unless that company can safeguard data using advanced techniques such as retinal scan technology and state-of-the-art encryption. Hospitals today are keenly aware of regulatory requirements regarding patient privacy and are continually searching for newer and better ways to protect confidential information. Eligibility and recovery companies offering proactive security solutions enjoy a decided edge over those that fail to anticipate and act against potential threats.

As crucial as technology is to delivering superior service, human relationships still play a vital role. Your staff's ability to function collaboratively with a provider's Information Technology department is crucial to leveraging technology. Updating system information requires solid cooperation with hospital IT staff as you work to set up a business-to-business VPN connection. Your staff should view every customer interaction as an opportunity to build a positive working relationship.

Once your technical team has formed a strong partnership with the provider's IT staff, the next step is establishing a seamless connection to existing hospital patient accounting and registration systems. Ensure that your team has the knowledge and skills necessary to connect with the most commonly used systems, including MEDITECH, Siemens, SMS, MS4, HBO, and IBAX. Reliable remote or onsite access to the hospital system is essential to follow-up, tracking payments and adjustments, and updating billing information.

Offer superior accountability & follow-up.

Delivering excellent service means fostering practices that create an environment of transparency and integrity. Providing documentation of notes and follow-up directly on the hospital system ensures providers with real-time access to comments, information and workflow.

Monthly reports containing expert analyses are another effective way of helping providers fully understand the value of your services. Used in tandem with monthly operational reviews, they keep hospital administrators well informed on all aspects of the engagement.

Other standard reports should include Monthly Referral Reports listing all accounts referred to the eligibility and recovery company. More traditional collection data can be communicated in a Referrals Summary Report that shows (as of the run date) what was referred by month referred; total collected, paid, adjusted, and closed; and what is currently open from that month's referral.

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How to Deliver Excellent Service

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Close Reports should list all closed accounts, while Close Summaries categorize closes by reason (close code). The latter helps clients better understand what the most common close reasons are for their businesses. Looking forward, Application Submitted/Approved Reports help hospitals plan ahead by analyzing the number and dollar amount of all pending applications.

Finally, if your company does go the extra mile to meet with discharged patients in locations such as shelters, private vehicles, even an often frequented street corner, monthly Field Visit Results show providers how many positive contacts were made. Clients who are particularly interested in field visit results may even ask to see a Field Visit Log. Companies committed to outstanding service should be prepared to provide this information.

Be your own strongest critic.

One of the worst things that can happen to a company is falling short of client expectations without knowing it. Some clients will tell you when you're not meeting their needs, while others will simply take their business someplace else. For this reason, internal audits are essential. They provide a kind of compass that facilitates workflow and verifies that work and compliance standards are continuously being followed. Maintaining an internal audit department to review client accounts, (including each client's unique Standard Operating Procedure) allows you to take a critical look at the quality and quantity of your work and make necessary changes before the client does.

To ensure exceptional management of both HIPAA Privacy and Security Compliance guidelines, contract with an outside firm that specializes in these programs. This third party association provides both your company and clients with a unique layer of protection. It also validates a company's commitment to health care and to its role as a valued business partner.

Deliver added value.

In addition to services clients routinely expect, adding something extra is often the difference between a mediocre and excellent eligibility and recovery company. Providing extensive field services on inpatient referrals, as well as on select outpatient referrals, is a good place to start. Looking for accolades from providers and patients alike? Provide transportation to and from interviews, pay for babysitters, help patients complete applications at home or in a shelter, and assist patients in obtaining documents such as birth certificates, bank statements and pay stubs. Other complimentary services might include Charity applications, Section 1011 Border Funding applications, financial statements, patient demographic validation, and identification of misclassified accounts.

At the end of the day, it's about the patient.

The best providers always put the patient first. Delivering excellent service requires that members of our industry follow that lead. Obtaining the patient's cooperation is essential to completing the eligibility process as you work together gathering supporting documentation. Obtaining a patient's *trust* is essential in ensuring that they understand the system and are willing to rely on it whenever they or members of their family need medical care.

Sara Sheats, a Manager for Integrated Health Management Services, sums up the potential rewards; "*The benefits to getting a non-insured or under-insured community member on Medicaid does not stop at the one ER visit they just had. The benefits reach preventive health care that will lower costs for all of us—including the providers that are not fully reimbursed for their service*s."

By putting the patient first, eligibility and recovery companies can best serve their clients and the community.

Get Prepared for the Symposium!

Scott Ujita

With the holidays now past us, that means that the HFMA Region 11 Symposium is soon to follow. The Region 11 Symposium will be held at Caesars Palace, Las Vegas from January 24th through January 27th. I am excited to see that the Symposium committee has put together a great selection of 25 breakout sessions to choose from this year. There will certainly be a breakout track that will interest you.

There will be great keynote speakers like David Feherty, Susan Dentzer, Ross Shafer, Janet Rush and David Brailer. I am particularly interested in hearing Susan Dentzer. She is the Editor-in-chief of "Health Affairs", the nation's leading journal of health policy. With all of the uncertainty with healthcare reform, she will certainly be able to give us a good look at what may be in store. This session should give us some very timely information about our current healthcare situation.

Don't forget to come in early to catch the opening reception from 5:00 to 7:00 pm on Sunday, January 24th. This is a wonderful time to network and catch up with friends. There will be plenty of good food and drinks available.

For more information about the Symposium, visit www.HFMARegion11Symposium.org and you can download the brochure at http://www.hfmaregion11symposium.org/documents/2010/Brochure_HFMA_Region11_Symposium.pdf.

I hope to see you all in Las Vegas!

Healthcare Reform – What Will an EFT Mandate Mean for Providers

Renae D. Price, CPA, CHBME, CMPE
Senior Director, Revenue Cycle, Kindred Healthcare Hospital Division

Both the Senate and House versions of healthcare 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 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 "reassociation" 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).

Reassociation – 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 evaluation. When payers send ERA files through a clearinghouse or ask providers to download ERA files from a website the provider has to "reassociate" 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 reassociation, Kindred partners with our banks to provide ERA retrieval solutions from payers and clearinghouses. The bank provided electronic "reassociation" service eliminates the manual matching of check and deposit and allows for immediate electronic file payment posting with accompanying deposit and remit reconciliation. Performing reassociation 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 healthcare industry can rapidly eliminate the costs of printing, mailing and processing between 500 million and 1 billion checks annually. Now that is a lot of green . . . . .

January 8, 2010

Share Your Email Address with TriWest

TriWest Healthcare Alliance is developing a more effective means of communicating with providers by collecting provider e-mail addresses. The goal is to obtain provider e-mail addresses that will allow TriWest to communicate the right information to the right person at the right time.

For example, it will allow TriWest to inform you about:
- TRICARE program changes
- New TriWest processes, policies and/or resources to help you care for TRICARE beneficiaries
- Educational opportunities or events in your community

TriWest will not sell or distribute your e-mail address to other companies – with the exception of your local network representative. TriWest will not send spam e-mails as all communications will be TRICARE/TriWest-related information only, and TriWest will not overload your e-mail account.

You can share your e-mail address(es) with TriWest by registering for the TRICARE eNews on our website by contacting your local representative, or by calling TriWest at 1-888-TRIWEST (888-874-9378).

TriWest Healthcare Alliance provides access to quality health care for 2.7 million members of America's military family in the 21-state TRICARE West Region.

CFO Committee Update

The CFO luncheon on October 29th at Deloitte & Touche in Manhattan Beach was well attended with over 22 attendees. Two speakers, A.M. Best Company and Anne McLeod from CHA, presented.

Planning is underway for a lunchtime webinar in February for the next CFO event. The announcement should be distributed and posted by mid-January.

We welcome suggestions for topics of interest for the CFO tracks/events to better meet the desired education needs of the members. Forward your ideas to Kathy Hammack at Kathy.Hammack@IHHIOC.com. Your suggestions will be shared and considered for future events at the monthly CFO Committee conference calls.

EDUCATION UPDATE

Government Programs

Donna Anglin, FHFMA

At the recent chapter educational program held in Arcadia on November 12th, the Government Programs committee provided two great sessions for the members. First up was Dale Baker of Baker Healthcare Consulting, Inc. Dale gave a scintillating presentation covering several topics related to the Medicare Wage Index. From the basics to hot topics, Dale touched on many interesting and informative areas of the wage index. He even gave us some tips on scrubbing our data for the recent deadline to submit corrections to the data that will be used for FFY 2011 (hopefully you got yours in on time). Dale also talked about the Occupational Mix Adjustment and pointed our members to his website for a free impact calculator. You can find this at http://www.baker-healthcare.com/current_projects/wage_index/occupational_mix/index.html. Dale capped off his presentation with a review of proposed wage index reform along with his idea of an alternate methodology that he is proposing to hospital associations around the country.

Next up was Byron Gross from Hooper, Lundy & Bookman, Inc. Byron provided a review of recent Medicare & Medi-Cal issues for hospitals. This included a review of cases related to Medicare DSH and an update on the various cases regarding Medi-Cal rate cuts. He then gave a detailed overview of the recently passed AB 1383; also known as the Provider Tax. His presentation was very informative and the attendees were eager to hear about this legislation.

If you'd like to download the presentations from this and other sessions at the November 12th program, go to the chapter web-site at http://www.hfma-socal.org/education_materials.html. You can find materials from previous programs here as well.

CHAPTER INCENTIVE PROGRAM FOR CERTIFICATION

Take National HFMA Certification Tests for *Free**

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

Why does the Chapter encourage this?

- To earn a healthcare professional title granted by an independent nationally recognized professional healthcare financial management organization, HFMA.
- To show your current employer what you have done to improve yourself and your knowledge of healthcare finance and increase your value to your employer.
- To demonstrate to yourself that you can do it.
- To meet our chapter goal of having as many certified members in our chapter as possible.
- To have our national office recognize your professional achievement

What will the Chapter do to encourage and support its members?

- The Chapter will encourage/reward you by reimbursing you for the cost of the exam when you pass the exam or reimburse you for half the cost of the test if you take it but don't pass - details below.*
- The Chapter will loan you the study guides, which are costly to buy on your own.
- The members of the Chapter Certification Committee will help and coach you on how to take the examinations.
- You can take the examination anytime and anywhere, as long as the time and location are agreed upon between you and your proctor. We have many willing proctors across Southern California to assist you.
- Help is a phone call and/or an e-mail away.

*How will the Chapter help me to pass/take the examinations and how much?**

- For each exam passed, a $125 check will be sent to you after the Chapter receives notice from National HFMA that you have passed at least one of the exams.
- If you don't pass, you will be paid half of the exam fee for the first time only. You will be required to have borrowed the study guide prior to the exam for this reimbursement.
- The check will be mailed to you within 30 days of our receipt of your request as long as we have received notification by National of your exam status.
- Your membership status in the SoCal Chapter must be current when you request your incentive reward.
- Each member can receive up to 2 exams for free (Core and a specialty) as both are required to be certified.

For more information, to get certification study guides, or schedule and exam, please call Debby Chanen, Chair Certification Committee at 818-409-8446 or e-mail her at chanenda@ah.org

*** The budget for this program is limited. Notice will be posted on our website when the funds have been exhausted*

Uncompensated Care

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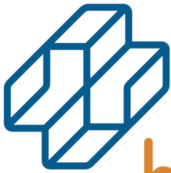
We are now reaching a point where the hospitals providing the most needed care to some of the United State's most vulnerable populations are facing the very real prospect of financial collapse and closure because of the levels of uncompensated care they provide. Ensuring that those most in need of health care can continue to receive it while the hospitals that provide this care are adequately compensated so they can keep their doors open must be an element of the current debate on health care in this country.

Additional government grants and health care charity private funding are two possible options to ease the strain on hospitals. Public outreach to enroll more low-income Americans who qualify for subsidized coverage will also help offset some costs. There are countless charities that address illnesses and research cures for terminal and debilitating diseases, but without viable hospitals where the treatment is done, these charities can do nothing.

Joy Stephenson is founding and managing partner of Stephenson, Acquisto & Colman (SAC), a law firm that specializes in representing major California hospitals.

CORPORATE SPONSOR PROGRAM



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southern california chapter

2009-2010 Corporate Sponsorship Program

The Southern California Chapter of HFMA is now accepting Corporate Sponsors at the chapter level. Companies that participate in the Corporate Sponsorship Program strengthen the chapter while at the same time increasing their own corporate visibility. As a corporate sponsor, you will be listed on the corporate sponsor page of the chapter website with a link to your corporate website, or a link to the email of a corporate representative, or just an informational page about your company. In addition to the visibility provided on the web site, you will be featured on the Corporate Sponsor page of the chapter's *Newsbrief*.

The Southern California Chapter of HFMA has over one thousand members who receive *Newsbrief* and visit the chapter website on a regular basis. HFMA members from around the country, as well as other interested parties, visit our chapter's website.

Becoming a Corporate Sponsor will increase your company's visibility to healthcare finance professionals and will also ensure that the Southern California Chapter of HFMA is able to continue to provide excellent education programs and networking opportunities.

For more information on sponsorship opportunities contact James Cummings, Sponsorship Chairperson, cummingsllc@aol.com.

WHY BE A CORPORATE SPONSOR?

Visibility is a powerful advantage, and as a sponsor of the Southern California Chapter of the Healthcare Financial Management Association (SCCHFMA), you gain exposure to a select audience that is over 1000 members strong, consisting of CEO's, CFO's, Patient Financial Services Directors, and other healthcare finance professionals. You emerge as a leader by demonstrating your support of professional education and quality programs.

As an SCCHFMA sponsor, a wealth of recognition opportunities are yours to explore. At minimum, you will see your organization's name and logo on pertinent marketing materials and gain on-site acknowledgement and signage at educational conferences. Additional promotional opportunities are available, depending on the category of sponsorship you choose.

With your support and technical expertise, SCCHFMA can continue to thrive and provide more valuable services to our members and other healthcare professionals. The Southern California Chapter is proud of its previous affiliations with sponsors and looks forward to hearing from you.

All sponsorships are received with great appreciation and in good faith, as we are managers of your investment.

I. CATEGORIES AND BENEFITS OF CORPORATE SPONSORSHIP

BENEFITS	BRONZE $1,000	SILVER $2,500	GOLD $3,500	PRESIDENT'S CLUB $5,000
Posting at all chapter meetings according to sponsorship category.	X	X	X	X
Listing of sponsor according to level in all Chapter program brochures.	X	X	X	X
Listing of sponsor according to category in each issue of the Chapter newsletter and on Chapter website.	X	X	X	X
Option to sponsor an Information table at all chapter education events.				X
Listing in the membership directory if joined before publication of directory.	X	X	X	X
Free registration certificates at any one chapter education session (as indicated).	(1)	(2)	(3)	(5)
Quarter (¼) page ad in every newsletter.				X
Option to host a hospitality suite at any Chapter educational program, with President's approval (i.e. sponsoring company will pay fees of suite).				X
Special ribbon and/or name tag designating Chapter Sponsor.	X	X	X	X

CORPORATE SPONSOR PROGRAM

II. CORPORATE SPONSOR INFORMATION SHEET

START DATE This Corporate Sponsorship Program begins on June 1, 2009 and runs through May 31, 2010.

DETAILS OF THE PROGRAM Enrollment period will be throughout the chapter year. An email announcement will be sent to all chapter members and vendors listed in the current membership directory. Selected vendors who have expressed an interest in sponsoring past HFMA events will also be contacted.

PAYMENTS Payments are due with application / agreement, and can be submitted at any time during the chapter year. Quoted rates assume a full year's sponsorship at the various levels. Sponsorships agreements can be entered into at any time during the chapter year. The donation amount will be prorated based on time remaining in the chapter year. A confirmation letter will be mailed after the potential sponsor commits to the agreement. The sponsor will be sent a "thank you" once the payment is received. The website will be updated to reflect sponsor ship agreement within a week of receiving payment.

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southern california chapter

Corporate Sponsor Application

PLEASE COMPLETE AND RETURN THIS FORM TO:
James M. Cummings, SCCHFMA Sponsorship Chair
20638 Merridy Street, Chatsworth, CA 91311

NOTE: Please make checks payable to "HFMA Southern California Chapter"

SPONSOR'S COMPANY NAME ____________________

CONTACT NAME ____________________

CONTACT PHONE NUMBER ____________________

BILLING ADDRESS ____________________

CITY I STATE I ZIP ____________________

E-MAIL ____________________

WEB SITE ADDRESS ____________________

We would like to participate at the following sponsorship level:

☐ **PRESIDENT'S CLUB ($5,000)** ☐ **GOLD ($3,500)** ☐ **SILVER ($2,500)** ☐ **BRONZE ($1,000)**

☐ We would like to make two installment payments.

For more information, contact:
James M. Cummings, Sponsorship Chair, HFMA Southern California Chapter: cummingsllc@aol.com

2009-2010 CORPORATE SPONSORS

PRESIDENT'S CLUB

GOLD

SILVER

BRONZE