

The Chili Pepper Express Newsletter

July 31, 2008

President's Corner

We're off and running in a brand new year:

I would like to take a moment to share my excitement in taking over the reigns as President of the South Texas Chapter of HFMA during our Annual Meeting at South Padre Island on May 30th. Based on the attendance and the positive feedback from the SPI conference, the year is already off to a great start. We are currently finalizing plans for our annual revenue cycle/reimbursement meeting which will be held in San Antonio at the Airport Hilton on October 23-24th. We have a great line-up of speakers scheduled, so please save the date and plan on attending.

From our Corpus Christi area members, we are excited to have Chris Janik join our Board of Directors. Thanks to Chris's leadership, we will be offering a half-day conference on preparing for RAC audits and denials management on September 19th at Christus-Spohn Hospital in Corpus Christi.



Paul Rubin
Chapter President
2008-2009

Following on the theme of our National Chairman, Bob Broadway, we are looking for ways to enhance your HFMA membership experience by helping you to "make connections" with other HFMA members throughout the upcoming year. To that end, we are organizing and promoting events in each of our chapter areas to help provide social and networking opportunities for our members. The initial response has been great, so look for upcoming announcements of events in your area.

The Board of Directors just completed its annual planning retreat, which included a review of the FY08-09 Strategic Plan. This document is available for your review on the chapter website at www.stxfma.org. We hope to build on the success of the past year by providing additional opportunities for quality education hours offered either directly by the Chapter or in partnership with other healthcare organizations such as ACHE, TAHFA, Greater San Antonio Hospital Council and the other HFMA chapters in the state.

I would be remiss if I did not thank our outgoing president, Bob Scofield, for all of his hard work and superb leadership during the past year. Under his watch and the outstanding efforts of our committees and Board of Directors, we have seen:

- Chapter membership grow from 374 to 377 members (no small achievement in the current economic climate)
- Total registered education hours per member increase to 13.52 for the year
- The highest number of certification exams (17) passed by any chapter in the United States (Congratulations to Brenda Cox, who led the Certification Committee last year!)

It was my honor to attend the recent HFMA Annual National Institute in Las Vegas and watch as Bob accepted the Bronze Awards for excellence in education and membership growth and retention as well as the Gold Award for excellence in certification on behalf of the Chapter. In keeping with the Olympic theme for 2008, we are going for the Gold in all of three categories this year.

Thank you again for allowing me the privilege to serve as your President, and for your tremendous support of the Chapter. If there is anything I can do to add value to your HFMA membership, please feel free to contact me at PARubin@seton.org.



Inside this issue:

Meetings	2
Changing the Status Quo: Moving Collections to the Front End of the Healthcare Revenue Cycle	3
Welcome New Members	4
The RACs are Coming Back	5
Meeting Recap: Board Retreat	5
Certification Corner	7
Membership on the Move	9
Member Updates	10
Editor's Alley	10
Officers and Directors	11
Other Happenings	12
Sponsors	12

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Meeting Calendar

Mark your calendars **NOW** so you won't forget to attend STX HFMA's meetings during the upcoming year. Our scheduled meetings are:

Date	Meeting	Location
September 19, 2008	STX HFMA Meeting	Corpus Christi, TX
September 21-23, 2008	HFMA/TAHFA Conference	The Woodlands, TX
October 23-24, 2008	STX HFMA Meeting	San Antonio, TX
December 3-5, 2008	Region 9 HFMA Conference	New Orleans, LA
December 12, 2008	HFMA/ACHE	Austin, TX
January 30, 2009	HFMA/ACHE/GSAHC	San Antonio, TX
March 29-31, 2009	Statewide HFMA Conference	Driskill Hotel-Austin, TX
May 28-29, 2008	STX HFMA Annual Meeting	Sheraton Hotel-South Padre Island

Registration Forms and Agendas for each meeting will be distributed by e-mail to all members about one month prior to each meeting date. Registration Fees for members vary based upon the number of CPE hours credit provided by each session, and other factors. If you do not receive a Registration Form via E-mail, please contact one of the STX Chapter officers. Please log on to the Chapter's website at www.stxhfma.org for updates!

Join Us in San Antonio for a South Texas HFMA Social Networking Event



What: San Antonio Missions vs. Frisco RoughRiders

When: August 21st at 7:05 p.m.

Where: Nelson Wolff Stadium

Why: Dollar night (Hot Dogs, Pizza, Beer, and Soft Drinks)

The Chapter will provide the tickets but they are limited. Please sign up with Jimmy Mendez by contacting him via e-mail:

jimmy.mendez@christushealth.org

Test Your Certification Knowledge

- Current Assets divided by Current Liabilities is the formula for the _____.
 - Operating margin ratio
 - Return on equity ratio
 - Total assets turnover ratio
 - Current ratio
- Medicare provides health insurance benefits to _____.
 - All persons 62 years of age or older
 - Individuals with transient renal failure
 - Individuals with certain disabilities
 - All individuals needing dialysis

Answers on page 8

Changing the Status Quo: Moving Collections to the Front End of the Healthcare Revenue Cycle

By Charlotte Pointek

The U.S. healthcare payment system processes \$1.9 trillion a year, consuming 15% or more of each dollar spent on healthcare (compared with about 2% for the payment system in the retail industry). Expenditures on the processing of bills, claims and payments, bad debt, and other transactions total more than \$300 billion a year.

In today's fiscal environment, healthcare organizations must increase revenue and improve administrative and collections processes in order to remain successful and financially viable. In fact, the need for hospitals and other healthcare service providers to be proactive in increasing upfront collections has never been greater. This is because the patient-responsible portion of the bill has increased dramatically in recent years for a variety of reasons, resulting in a higher number of self-pay patient accounts.

For example, trends such as increases in co-pays, co-insurance and deductibles for traditional insurance plans, and the creation of consumer-driven health plans such as health reimbursement arrangements and health savings accounts -- have shifted more financial responsibility to the individual patient. Many employers continue to shift a greater share of healthcare costs to employees. Just consider this telling statistic: Since 2000, the average out-of-pocket costs for deductibles, co-payments for medications, and co-insurance for physician and hospital visits rose 115%.

In addition, the more than 49 million uninsured and 16 million underinsured Americans are considered to be self-pay patients, and these populations continue to rise.

Many healthcare service providers are aware of the growing need to move collections from the back end of the revenue cycle to the front end -- but most want to do so by "keeping the status quo." The tendency to rely on collection agencies and early-out solutions in lieu of modifying the front end appropriately has become the norm. In fact, most healthcare service providers are sending indigent and government program eligibles to collection agencies, and they are not even aware that they are doing so.

The challenge for today's healthcare institutions is to become customer-focused and performance-based. These goals mean changing how they operate, beginning with pre-service and point-of-service patient interactions. It means changing the status quo.

While those revenue cycle management technologies and services that encompass the entire continuum of care -- from the front end to the back end -- are widely recognized as being most effective, providers have historically focused on post-service billing, denial management and collection activities. (That is, the back end of the process.) In fact, such large financial investments have been made to automate the back end of the revenue cycle that many healthcare service providers have been reluctant to abandon or significantly modify them. Healthcare decision-makers and hospital CFOs across the country are on the lookout for technological enhancements that will save their organizations both time and money. For healthcare providers, changing collections to the front end is such an enhancement.

Simply put, the sooner providers ask for what they are owed, the more likely they are to collect it.

In order to be successful in collecting payments upfront, providers must have appropriate policies and business rules in place for all patient types; they must be able to assist all healthcare consumers irrespective of their financial profile, insurance status or healthcare condition. For example, providers must be able to consistently and efficiently handle the accounts of those patients who fall under the following categories:

- No insurance -- but charity eligible
- No insurance -- but not charity eligible
- A government program with co-pays (Medicare/Medicaid)
- A government program without co-pays (workers' compensation)
- A self-insured or commercial insurance plan with and without co-pays

Test Your Certification Knowledge

3. Depreciation, long-term lease expense, and amortization of any incurred financing costs would be what type of cost behavior?
- A. Variable cost
 - B. Fixed cost
 - C. Semi-variable cost
 - D. Semi-fixed or stepped variable cost

Answer on page 8

(Continued on page 4)

Revenue Cycle

(Continued from page 3)

One strategy that will help organizations reduce the inefficiencies of denials -- not to mention delayed or reduced payments and re-bills -- is to determine the eligibility, benefits, and co-payments and deductibles for all patients from the outset. Today it is more important than ever to determine whether patients' insurance or patients themselves are responsible for fees, and what portion they are responsible for paying.

A dedicated upfront collections program allows front-line employees to increase early cash collection through targeted yet discreet methods, as well as to establish various patient payment options to make revenue collection more efficient.

In addition, a successful system will screen patients for eligibility programs and consistently apply discounting and charity policies where appropriate. Although the details vary from state to state, under most current hospital payment systems, there is some reasonable payment to providers for uncompensated care, treatment and service performed for the medically indigent. Demographic patient analysis can allow this type of care to be identified on the front end.

Meeting these goals requires tools specifically designed for the unique needs of healthcare organizations -- tools that can capture, organize and verify patient information. For this approach to work in healthcare, three components must be in place, according to a McKinsey Quarterly report:

- Providers must be able to tell patients how much they will owe while they are still at the hospital or doctor's office. (The real-time adjudication of claims, while technically feasible today, could take years to gain acceptance in the providers' offices. Meanwhile, providers could give good-faith estimates by using pricing tools.)
- Providers must have systems to accept cash, credit or debit payments. For hospitals and providers undertaking larger transactions, financing options should be available.
- Providers must become firmer at the time of treatment about requiring patients to arrange for payment, even if they have insurance coverage.

In order to spend their healthcare dollars wisely, consumers need to know their financial responsibility in advance. Many patients find the billing process that takes place in the healthcare arena to be the number-one area of dissatisfaction with healthcare services. With an effective self-pay management system in place, providers can ensure patients receive visibility into their healthcare costs, their specific financial responsibility, and their payment options. This ability to effectively communicate an estimate of the patient's responsibility can result in dramatically improved patient relations.

Why the Status Quo Doesn't Work

Most patient accounting systems do not offer a payment solution that supports upfront collection efforts. In fact, front-line cashiers and registrars typically have no access to the availability of discount options, charity guidelines and price transparency for the patient portion of the bill, even if they do know an insured patient's co-pays and deductibles. Without the integration of all of this

(Continued on page 8)

It is imperative that healthcare organizations have a strategy for dealing with the ever-growing self-pay population in all situations -- from inpatient admissions to the ED to doctor's office visits to outpatient procedures.

Welcome New Members!

The South Texas Chapter HFMA welcomes the following new members since 4/30/08:

Brandon Bonser, Integrated Medical Systems

Russell Fail, Baptist Health System

Michelle Hays, Heart Hospital of Austin

David Pearson, Texas Organization of Rural & Community Hospitals (TORCH)

Revi Pillai, Center for Pain Management, PLLC

Mark Pinckard, Girling Health Care Inc.

D. Reynolds, Jr., Austin Software Foundry, Inc.

William Schlotter, Capitol Anesthesiology Association

David Tapia, Exegete Consultants, LLC.

Darlene Ulmet, Baylor Health Care System

Ricardo Villanueva, Valley Baptist Health System

Kyla Warren, CPC, CCS-P, E-MDs

Bob Wright, South Texas Health System

Montasser Youssef, Monzer H. Yazji M.D. & Associates

The RACs Are Coming Back

By Bill Richburg, M.S., FHFMA, Director, Government Programs & Compliance, Accuro Healthcare Solutions

Editor's note: This article highlights the CMS RAC Status Report FY 2007, published February 2008.

The Centers for Medicare and Medicaid Services (CMS) recently closed down the Recovery Audit Contractor (RAC) demonstration March 27 as it prepares to roll out the program nationally in the next two years.

In fact, CMS is expected to announce names and companies chosen to be permanent RACs for its four regions – jurisdictions that match those for Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) – this spring. CMS also says that this summer it will work with new RACs and provider associations to facilitate what it calls “extensive provider outreach.”

Measuring Progress

In FY 2007, CMS reports that improper payments amounted to \$10.8 billion in the Medicare Fee-For-Service (FFS) program – representing over and under-payments that did not comply with Medicare coverage, coding, billing or payment rules.

In a January 2008 report by the GAO, Medicare is one of the top three federal programs with improper payments in FY 2007.

Improper Payments FY 2007

Medicaid	Earned Income	Tax Credit	Medicare
\$12.9 B		\$11.4 B	\$10.8 B

SOURCE: Federal Executive Branch Agencies' Fiscal Year 2007 Improper Payment Estimate Reporting. Government Accountability Office, January 23, 2008, Report Number GAO-8-377R

Most of the improper payments, according to CMS, occurred because providers submitted claims to Medicare for services that were not medically necessary or were incorrectly coded. CMS also noted that RACs had undertaken actions to recoup those overpayments and prevent future improper payment but conceded that it would be “difficult” to prevent all improper payments since over one billion claims are processed annually.

CMS also reported that about 85 percent of the overpayments collected by RACs were from inpatient hospitals and that based on a random sample of claims, 45.4 percent of the improper payments in Medicare were made to inpatient hospitals.

In explaining the relatively high rate of improper payments to inpatient hospitals, CMS acknowledged that since RACs were paid on a contingency fee basis, their claims review strategy focused on high dollar improper payments such as inpatient hospital claims, giving them the “highest return” relative to expenses associated with reviewing claims and medical records.

CMS also said that during the demonstration, RACs were prohibited from reviewing certain types of claims like physician visits. Other claims excluded from the review process were those previously reviewed by other Medicare contractors and claims un-

(Continued on page 6)

Board Retreat in Austin

By Pete Seaman

On July 12, 2008, the STC Board of Directors met at the Mansion at Judges Hill in Austin to update the Chapter's Strategic Plan, further develop the plan for STC's educational meetings during the 2008-2009 fiscal year, and attend to other business matters. The meeting was led by Paul Rubin, STC President, assisted by John Montaine, President-Elect and Chair of the Program Committee. Also participating in the meeting were Patti Bethke, STC President 2006-2007; Bob Scofield, STC President 2007-2008; Sandra Melendez, STC Treasurer; Brenda Cox, STC Secretary; and STC board members Jeannine Ruffner, Jimmy Mendez, Pete Seaman, Stephen Jewell, Christopher Janik, and David Glazener, .

The Board reviewed the Chapter's Strategic Plan, and updated a number of items. The Board focused significant attention and discussion on increasing the level of involvement of physician practice managers and senior financial managers in the Chapter's activities. After completing the review of the Strategic Plan, the Board received reports from the Chairs of several STC Committees, including Certification, Newsletter, and Finance. In addition, the Board discussed the goals for the Membership Committee, which will be co-chaired by Tammie Jackson and Wayne Williams during the current fiscal year.

The Board discussed in detail the educational content and speakers for each of the STC meetings planned during the 2008-2009 fiscal year. Coordination issues relative to STC's joint meetings with TAHFA, ACHE, and the two other Texas Chapters of HFMA (please see "Hold the Date" article regarding meetings scheduled during 2008-2009) were also reviewed. The meeting began at 8:00 AM, and wound up at about 1:30 PM.

RACs

(Continued from page 5)

der review for potential fraud. Hospice and home health services claims were also excluded.

By the end of FY 2007, RACs had been given \$239.6 billion in claims that were originally paid between 2002 and 2006. These were claims that were originally paid by Medicare claims processing contractors between October 1, 2002 and September 30, 2006 and for which the RAC corrected the overpayment or underpayment between October 1, 2006 and September 30, 2007.

According to CMS, RACs identified and corrected \$371 million in improper payments during FY 2007 of which 96 percent were overpayments collected from providers and four percent were underpayments repaid to providers. In fact, \$14 million in underpayments were repaid to providers in FY 2007, and most of these were repaid to inpatient hospitals.

In the end, RACs turned over \$247.4 million to the Medicare Trust Funds, less money repaid to providers for underpayment and operating costs for the RAC program during FY 2007.

Test Your Certification Knowledge

4. Which of the following methods for determining reimbursement is the traditional means of billing by health providers for each service performed in specific amounts?

- A. Per diem
- B. Fee for service
- C. Case based
- D. Capitation

Answer on page 8

Selecting Claims for Review

CMS said it did not instruct RACs as to which claims should be reviewed, reporting instead that claims selection methodology was left up to individual RACs. CMS did say that RACs used reports from the OIG and GAO that highlighted Medicare services that were vulnerable to improper payments.

Incorrect Coding

CMS reported that almost 50 percent of the improper payments were the result of incorrect coding such as a provider submitting a claim for a procedure but the medical record indicated that a different procedure was actually performed.

Approximately one-third of improper payments were related to medical necessity. CMS said payments were made for services that were not medically necessary or did not meet Medicare's medical necessity criteria for the setting where the service took place; for example, a claim from a hospital for three colonoscopies for the same beneficiary on the same date of service when only one colonoscopy per day is medically necessary.

Other errors were identified as not having or not providing medical records as requested by RACs, billing separately for services already included in other payments, submitting duplicate claims, using outdated fee schedules or being paid twice because duplicate claims were submitted.

Lessons from the Past, Moving Forward

Based on past performance, CMS plans to make the following improvements when the RAC program becomes permanent:

- Then: CMS did not provide a maximum look back date in the demonstration.
Now: It will now be changed from four to three years. In the permanent program, the RACs will not be able to look for any improper payments on claims paid before October 1, 2007.
- Then: RACs were prohibited from reviewing claims during the current fiscal year.
Now: In the permanent program they can.
- Then: RACs only had to pay back the contingency fee if they lost at the first level of appeal during the demonstration.
Now: In the permanent program this has been changed to all levels of appeal.
- Then: In the demonstration, RACs were not required to have certified coders.
Now: Certified coders will be mandatory.
- Then: Individual RACs were able to set an optional medical record limit in the demonstration.
Now: In the permanent program CMS will set mandatory limits.
- Then: In the demonstration, RACs did not offer a Web-based application, allowing providers to customize addresses and contact information or see the status of cases during the demonstration.
Now: In the permanent program each RAC must have this Web-based application by January 1, 2010.
- Then: In the demonstration, a request by the provider to discuss a denied claim between the RAC and the medical record director was at the option of the RAC.

(Continued on page 9)

Preparing for Certification Exams—Coaching Courses

By Lenora Johnson

The South Texas Chapter is committed to helping our members achieve the Certified Healthcare Financial Professional (CHFP) status. Achieving this designation helps prepare you – the healthcare finance professional - for increasingly responsible positions in the healthcare industry. Additionally, the designation of CHFP **demonstrates your dedication to professional development.**

You can study and prepare for the exams through a variety of methods. One way is using the HFMA study guides or other material as part of independent or group study.

Another method to prepare is to attend an HFMA coaching course sponsored through the ANI or a local chapter event. These courses provide an overview of the content areas of the targeted exam and help you learn how to best use the HFMA study guides to prepare.

PowerPoint presentations with sample questions are usually a part of the coaching courses along with handouts for further study. Practice exams are often administered and correct answers discussed in the group setting. The coaching courses allow for group interaction and collective sharing of the attendees' body of knowledge. You will have the opportunity to ask questions of the coaches and other attendees regarding specific issues with which you need further clarification.

Combining self study with a coaching course can be a useful preparation method. If you have already completed some of the self-study guides, the coaching course can provide a good review and help you identify areas requiring more focused study. If you have not done much self-study for the exams, the coaching course can help you determine how to better focus your efforts for studying and preparing. Coaching courses were recently held in Austin at the State HFMA meeting during March and at South Padre Island in May as part of one of a South Texas Chapter meeting. We have had positive feedback from candidates who took exams (and passed them!) shortly after attending these meetings. We highly encourage you to consider this option as you start preparing for certification.

You will pass two exams, a core exam and a specialty exam, as part of the certification process.

Core Exam

Every candidate must pass the Core Exam which is general in nature and covers a broad array of financial topics pertinent to healthcare. These topics include accounting, finance, patient financial services, physician practice management and managed care.

Specialty Exam

Accounting and Finance: Content consists of accounting and finance theory and application as it applies to the healthcare industry. Having a CPA designation is not directly related to passing this specialty exam. A candidate can expect to spend about 15 hours of study in preparation.

Patient Financial Services: Content consists of claims administration, patient access issues, collections processes, and other issues pertinent to the entire revenue cycle. The content focuses primarily on issues applicable to hospitals and health systems and requires about 12 hours of study in preparation for the exam.

Physician Practice Management: Content consists of issues pertinent to the physician practice, including ICD-9 and CPT-4 Coding, physician compensation methods, Relative Value Units, and credentialing. This exam requires about 12 hours of study for preparation.

2008 Coaching Course Dates

- Sunday, **September 21st**, 1:00-5:30 pm
HFMA/TAHFA Joint Symposium
The Marriott Waterway Hotel, The Woodlands
- Thursday, **October 23rd**, 1:00-5:00 pm
STX Chapter Meeting, San Antonio

2008 Exam Dates & Proctor Information

All exams will be held at Baptist Health System School of Health Professions (8400 Data Point, San Antonio 78229) and begin at 12 Noon.

- Friday, **September 12th**
Proctor Brenda Cox, bcox@onr.com
- Friday, **November 14th**
Proctor LeNora Johnson, durango500@sbcglobal.net

For questions about certification exams, please contact Brenda Cox, Certification Chair, 512-496-9989 or bcox@onr.com.

A few sample exam questions are available at the following link: www.hfma.org/certification/chfp/examcontent/SampleExamQuestions.htm

You can purchase printed Study Guides at the following address: https://www.hfma.org/site/certification/self_study_aids_form_0506.cfm

(Continued on page 8)

Revenue Cycle

(Continued from page 4)

information, easily and quickly accessible, it is difficult to have a helpful conversation about the financial aspects of care.

It is imperative that healthcare organizations have a strategy for dealing with the ever-growing self-pay population in all situations -- from inpatient admissions to the ED to doctor's office visits to outpatient procedures. And this strategy must include tools and policies for consistently and appropriately offering discounts.

In many cases, self-pay patients are not offered discounted care, and hospitals effectively shift costs on to the uninsured. (CMS has reassured hospitals that deductions for self-pay patients are permitted.) Over the past several years, federal and state lawmakers and consumer advocates have taken action to ensure that low-income uninsured and underinsured Americans are charged fair (e.g., discounted) prices for their care and are protected from aggressive debt collection practices. Many healthcare providers are struggling to determine and implement proper, consistent processes for applying these discounts and sharing these prices at point of service.

With an effective upfront system in place, service providers can offer discounts at the point of service, taking into account a patient's current capacity to pay, total account balance and type of service. This enables fairness and consistency in the discounting process, as truly needy patients are identified, compared with those patients who simply choose to go without health insurance, even if they have the financial ability to obtain it.

Finally, out-of-pocket healthcare costs will only continue to rise, and patients will have increasing difficulty paying their debt. As a proactive, successful, caring facility, there are steps providers can take to help patients with their healthcare bills. Here are just a few ideas to consider:

- Move financial counseling to upfront collections so patients will know what to expect and your organization will know what it is going to be paid.
- Provide patient access areas with additional tools that enable them to increase efficiencies automate work processes and improve customer service.
- In addition to providing your patients with excellent healthcare services, offer superior patient financing options.
- Develop clear charity guidelines and make sure hospital staff are adequately trained and adhering to those guidelines.
- Develop an upfront collection policy and adhere to the guidelines.
- Consider partnering with a lender instead of offering internal payment plans.
- Develop a relationship with a patient loan company that can quickly approve and fund patient loans.

In the case of self-paying patients, the best practice is to determine financial responsibility from the outset. Organizations that are unwilling or ill-equipped to implement this practice pay dearly. And, as patients are required to take on more and more costs for their healthcare, the importance of this practice will grow.

For more information, please contact Charlotte Piontek at 972.393.0867 or charlotte.piontek@ntelagent.com

References

- 1 The McKinsey Quarterly, Overhauling the US health care payment system, June 2007 (Web exclusive)
- 2 National Coalition on Health Care, <http://www.nchc.org/facts/cost.shtml>. Accessed June 4, 2008

Certification

(Continued from page 7)

Certification Study Guide

The South Texas Chapter has a complete study guide set available for members to borrow which includes the Core Specialty exam study guides of your choice, applicable for exam dates through 12/31/2008. The Chapter will loan the study guides for a two (2) week period, depending upon availability. Please contact Brenda Cox (512-496-9989) or LeNora Johnson (210-394-1521) to arrange a time to borrow the materials. You return them at your expense.

Managed Care: Content consists of issues pertinent to managed care companies as well as to providers of care participating in managed care contracts. A candidate can expect to spend approximately 14 hours of study in preparation for this exam.

Additional information is available regarding dates, application forms, and fees at <http://www.stxfma.org/pages/certification> and <http://www.hfma.org/certification/chfp/>.

Good luck on your journey toward becoming a Certified Healthcare Financial Professional (CHFP)!

Answers: 1. (d) Current Ratio; 2. (c) Individuals with certain disabilities; 3. (b) Fixed Cost; 4. (b) Fee for Service



Membership on the Move: New and Improved!

By Wayne Williams

We've all seen the marketing line of "New and Improved!" used to describe everything from detergent to microwave dinners. Usually it just means some new packaging surrounding the same old product. But as we enter the 2009 HFMA fiscal year, we really can say "New and Improved" for our chapter membership activities. In fact, we have added three new players to our Membership Committee and have resolved to improve the level of support that the Chapter provides in helping grow our membership numbers.

Joining the team as Membership Co-chair is Tammie Jackson, an Account Executive with TransUnion. Tammie has chaired the membership teams in both the Gulf Coast and First Illinois chapters and brings some great ideas from those experiences. Additionally, we have added Clint Owen, a Business Development Manager for DECO Recovery Management, as well as Saul Colodny, VP Professional Services for Ormed Information Systems. Both Clint and Saul bring new blood and enthusiasm to our team. Returning this year are our veterans, Brenda Saxon and Jimmy Mendez. Brenda is an accountant with Dell Children's Medical Center and Jimmy is a Senior Reimbursement Manager with Christus Health. Please don't hesitate to contact any of us if you have questions about recruiting or other membership-related topics.

As always, I would like to encourage each of you to reach out to at least ONE friend/client/student/colleague about joining our chapter. We all know the official list of membership benefits, but only you can share your experience with the people around you. Try sharing with someone the benefits and satisfaction you've realized and encourage them to join you at one of our upcoming meetings in Corpus Christi, The Woodlands or San Antonio. Bring your friends and let's take our chapter to a new level!

RACs

(Continued from page 6)

Now: Moving forward, it will be mandatory.

Then: The demonstration called for limited reporting by the RACs on problem areas they had identified.

Now: In the permanent program, frequent problem area reporting will be mandatory.

Now: An external and uniform validation process will be mandatory for the permanent program. During the demonstration it was optional and varied by state.

Problem Areas in the Future

In the table below, CMS describes some of the vulnerabilities that RACs uncovered among inpatient hospitals in FY 2007. The figures are net of appeals as of September 30, 2007 and represents data collected from New York, California and Florida.

Moving Forward

CMS believes that the RAC demonstration program was successful in returning overpayments to the Medicare Trust Funds and identifying underpayments for providers. The program returned a significant amount of improper payments to the Medicare Trust Funds. It also believes in the viability of the contingency fee payment for RACs because it correctly aligns incentives among CMS, its providers and the RACs.

How it Began

In Section 306 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Congress directed the Department of Health and Human Services (DHHS) to conduct the RAC demonstration program to detect and correct improper payments in the Medicare FFS program. The RACs were to be guided by the same Medicare policies and rules to identify improper payments as the Medicare claims processing contractors. Under the demonstration, the RACs were paid a contingency fee based on the amount of the improper payments they corrected for both overpayments and underpayments.

In 2006, Program Safeguard Contractors – what CMS identified as specialized fraud fighters – were established nationwide across all provider and supplier types. These fraud fighters were established to identify potential problem areas, investigate potential fraud, develop fraud cases for referral to law enforcement and coordinate Medicare fraud, waste and abuse efforts with CMS' internal and external partners.

In section 302 of the Tax Relief and Health Care Act of 2006 (TRHCA), Congress required DHHS to make the RAC program permanent and nationwide by no later than January 1, 2010.

In the Spring of 2007, CMS added one state to each of the current three RAC jurisdictions. At the same time, CMS began the process to procure four RAC contractors through a full and open competition.

(Continued on page 10)

Member Updates

Editor's Alley

As always, an important part of this organization's newsletter is input and feedback from you, the members of the South Texas Chapter of HFMA! If you have an idea for an article or feature to be included in future newsletters or have updates for our current features (Member Updates, Events, etc.), please e-mail them to:

Pete Seaman
peteceo1@sbcglobal.net,
 Newsletter Chairman

or to Becky Turner
rturner@npscmgmt.com,
 NPSC Newsletter Designer.

Thank you for investing your time in a great organization like South Texas HFMA.

Lauralinda Moore has been promoted from Senior Accountant to Finance Manager - Foundation at CHRISTUS Spohn Health System ("CHSS"). Lauralinda has worked in the Finance department at CHSS since August, 2005, and has been a member of STX HFMA since 2007. Congratulations Lauralinda!

Carol Reineck, PhD, RN, FAAN, CNAA-BC has been elected Treasurer, American Organization of Nurse Executives for 2008-2009. Carol also serves on the American Hospital Association Operations and Investment Committees, the Joint Commission Nursing Advisory Council, and she is Chair of the AONE Regulatory Monitoring Committee. Carol, what do you do in your spare time?

Gene Deutscher, who is a member of the STX HFMA Board of Directors and Program Committee Chair, has established a new relationship with The CollectionConductor (www.collectionconductor.com) for business development in Texas.

Valerie Puckett, MBA, CHC, CPC, advised us that she recently left KCI in San Antonio to relocate to Alpharetta, Georgia near Atlanta. She will be joining the HFMA chapter there soon, and has started in her new job as Director of Audit and Monitoring in the Legal Department at McKesson Technology Solutions.

Member Updates is where we highlight members that have moved to other companies, received promotions within their organizations, or have advanced themselves by way of receiving some Degree, Certification or Awards. It is our way of helping members keep in touch as well as to recognize and congratulate others on their achievements. If you have news which you think should be mentioned in *Member Updates*, please e-mail the information to Becky Turner, NPSC Newsletter Designer at rturner@npscmgmt.com.

RACs

(Continued from page 9)

NOTE: The CMS RAC Status Report FY 2007 focuses on the operations and findings of the Demonstration Claim RAC Program during fiscal year (FY) 2007 (from October 1, 2006 – September 30, 2007). This report excluded data on the Medicare Secondary Payor (MSP) RAC Program.

Description of Service	Amount Collected Less Cases Overturned on Appeal (millions)	Claims Found in Error Less Cases Overturned on Appeal	Location of Problem
Excisional Debridement	\$ 30.5	2,603	New York
	\$ 3.2	423	California
	\$ 2.5	346	Florida
IRF services following joint replacement surgery	\$ 20.8	1,833	California only
Heart Failure and Shock	\$ 7.8	835	New York
	\$ 2.0	306	California
	\$ 9.5	2,190	Florida
Surgical Procedures Wrong Setting	\$ 17.1	1,610	NY only
Respiratory System Diagnoses with Ventilator Support	\$ 9.5	577	New York
	\$ 4.1	266	California
	\$1.7	123	Florida

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Other Happenings:

“Other Happenings” is where we will list educational and networking opportunities in collaboration with other HFMA Chapters, primarily the Gulf Coast and Lone Star Chapters here in Texas. We will work in conjunction with the Newsletter Chairs from these Chapters to provide you with as many educational opportunities as possible.

Gulf Coast Chapter HFMA Events:

A full schedule of GCC events can be found at <http://www.hfmatxgc.org/hfmacalendar.php>.

August 22

Conference - 8:00 am to 4:45 pm
The Revenue Cycle & All Those RACs!!
featuring a keynote address by **David S. Lopez** -
CEO, Harris County Hospital District

September 21-23

HFMA/TAHFA Joint Symposium
Ride the Wave of Change
The Marriott Waterway Hotel, The Woodlands

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