



**hfma** idaho chapter  
healthcare financial management association



# The GemStatement

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## President's Message

### Calvin's Airplane Flight

By Sandy Dryden



Narrator: This is the story of Calvin's Airplane Flight. Calvin please do us the honor and come take your position as the Pilot in the airplane. Calvin here is your flight gear and wings. Make sure that all your passengers are buckled up and ready to fly. Do they get wings also? HFMA officers are flying with Calvin in his personal aircraft to an upcoming HFMA meeting. Luke is Calvin's copilot and following Calvin's leadership as President elect. Sandy is excited to be in the back seat as the Past President just along for the ride. Susan is riding along and learning from all of these fearless flyers what she has to look forward to as she moves up the chairs. Calvin, your task is to safely fly your crew to the upcoming HFMA meeting and to say two simple lines of which I will instruct you. We have all come to know and expect your words of wisdom so at the correct sound I want you to share those words of wisdom: "Just happy to be here" and "Party On". At the sound of the Bell you are to say "Just happy to be here" and at the sound of the Buzzer, I expect you to say "Party on". So now let's practice:

Bell-Calvin: Just happy to be here.

Buzzer-Calvin: Party on.

Narrator: One more time.

Bell-Calvin: Just happy to be here.

Buzzer-Calvin: Party on.

Narrator: Well now that the stage is set, have a safe flight to your destination. I am sure that you are in the best of hands. I hear the Tower calling, Calvin...

Tower: Calvin Papa Romeo Echo Sierra (call sign for Pres.) 1niner, niner, this is the FAA Tower, if you are heading to Post Falls you need to know that you are headed in exactly THE WRONG DIRECTION. Do a 180 slow turn to destination.

Bell-Calvin: Just happy to be here!

Tower (more urgently): Calvin Papa Romeo Echo Sierra 1niner, niner. You are turning TOO FAST! Papa Calvin! You are out of control, Romeo! You are in a tail spin! Pull It UP, Pull it UP!

Narrator (excitedly): As the plane rushes toward the ground, the people in the plane see their past HFMA experiences flash before their very eyes!

Buzzer-Calvin: Party On

Copilot Luke: Calvin, as your copilot and President Elect I just want you to know that I have always respected your vision. I just can't get the vision out of my mind; especially the one of you "milking the Bull".

Bell-Calvin: Just happy to be here!

Passenger 2: What are you talking about?

Passenger 1: Let me explain. It was when Calvin, Carla Terry, Ron Gleason and I attended Leadership Training Conference in Chicago and I caught Calvin on film milking a BULL statue. What a fond memory.

Buzzer-Calvin: Party on.

Passenger 2: Hey Calvin, you are quite a visionary and as such you aren't really concerned with the details. Remember your agenda for the summer HFMA meeting and you put on the wrong dates? It's a good thing that some of us pay attention to detail.

Bell-Calvin: Just happy to be here!

Passenger 1: Speaking of details, here's another memory for you. Remember all the evaluation forms that you prepared? They inevitably had questions on them that didn't even pertain to the sessions!

Buzzer-Calvin: Party on!

Passenger 2: Then there was the McCall summer meeting when Calvin was the education chair and he was out of the room for all the announcements and proceeded to repeat all the announcements upon his return. Including asking the golf organizer to get up a second time to repeat his spiel again!

Bell-Calvin: Just happy to be here!

Passenger 1: Hey, Calvin, I have one special memory that this airplane ride brings to mind. Remember the time that you opted out of attending the President's meeting with me in Vancouver, Canada without even letting me know. When you didn't show up I had visions of you in an airplane crashing to the ground flying through my head.

Buzzer-Calvin: Party on!

Copilot: We've had some really memorable times, Calvin. Remember our special breakfast in San Francisco; fit for (and costing enough) for two, three or four kings?

Buzzer-Calvin: Party on!

Passenger 2: Yeah, I have so enjoyed working with you. You have given us all a lot of great memories. Last year for LTC you made the reservations for the room but that didn't do you much good without making the plane reservations to get there!

Narrator: Well, Calvin's plane hits the ground in a fiery heap. With flames surrounding the plane and crew, Susan says:

Passenger 2: Looks like we have all gone to hell!

Copilot: Is this hell or is this Jackpot?

Devil: Let ME answer that question for you! Welcome!

Bell-Calvin: Just happy to be here.

Narrator: As Calvin leaves the President position please thank him for many laughs, a great time and a job well done!

## The Results Are In!

**The votes have been counted and the results were unanimous. The chapter membership has voted in Matthew Cox as the entering Treasurer. Vacancies in the Board were filled by Jennifer Young, Jake Smeltzer, and Tom Murphy.**

## CMS Implements a New “Bounty Hunter” Program – Can You Survive a RAC Attack?

To our Healthcare Clients and Friends:

In this issue of IMA Insights, we would like to take a look at one of the newest and most significant external “compliance threats” to healthcare providers – CMS’s new “Bounty Hunter” Program – commonly referred to as Recovery Audit Contractors (RACs)! This issue is the first in a series of Insights articles that will address RACs, as there is simply too much information to cover in this edition. Under the RAC program, CMS contracts with “bounty hunter” firms who are authorized to audit hospital and physician claims in search of improper Medicare payments that may not have been identified through the current fraud edits. These “bounty hunters” are paid on a *contingency basis* for every dollar in overpayments they recover through their “demand” letters. This so-called demonstration project resulted in RACs identifying over \$300 million in improper payments in just 18 months.

### BACKGROUND

The RAC demonstration project was created after the Secretary of the Department of Health and Human Services (DHHS) identified that Medicare net overpayments exceeded \$19 billion in 2003, and slightly more in 2004. As a result, Congress, under section 306 of the Medicare Modernization Act of 2003, directed the Secretary of DHHS to conduct a three year demonstration project designed to determine if the use of RACs would be a cost-effective means of ensuring correct payments are made to Medicare providers.

In March 2005, the program began in the three states with the highest Medicare utilization: California, Florida, and New York. There are two types of RACs, Claim RACs, who review claims and medical records for incorrect payments; and Medicare Secondary Payor (MSP) RACs, who identify Medicare as a secondary payor. RACs are paid a contingency fee based on the overpayments they identify and collect. This demonstration project is the first time that the Medicare program has ever paid a contractor on a contingency fee basis for this type of work.

In November 2006, CMS issued a “RAC Status Document – FY 2006”. In this document, they concluded, as we would expect, that the preliminary results of the demonstration project prove that RACs are a viable and useful tool for ensuring accurate payments. The following table from CMS’s report summarizes the total improper payments identified to date.

(In Millions)

	Overpayments Collected		Underpayments Paid Back		In The Queue		Total Improper Payments Identified
	\$68.6	+	\$2.9	+	\$232.0	=	\$303.5
Costs	(\$14.5)						
	\$54.1		Back to Medicare Trust Fund				

*By January 1, 2010, the Secretary is required to contract with enough "bounty hunter" firms to cover Medicare claims activity in all 50 states!*

As you can see from the table, less than 1% of the total improper payments have related to "**underpayments**" that have been returned to providers. Is anyone surprised that, once again, the vast majority of improper payments are "**overpayments**" due back to the Medicare program? Also, **it is important to note that the RACs have been paid \$12 million dollars in contingency fees** for \$68.6 million in overpayments collected to date. The remaining \$2.5 million represents RAC audit related expenditures (\$14.5 million in total audit costs) relates to database and other expenditures. That sure sounds like enough motivation for the "bounty hunters" to aggressively go after so-called overpayments.

Many in the provider community have been passively following this demonstration project wondering how successful it would be and, more importantly, if it would be expanded to additional states. Well, unfortunately, the wait is over. It didn't take CMS long to determine that the project was extremely successful in identifying and recouping provider overpayments. Accordingly, CMS has decided to expand the program. By January 1, 2010, the secretary is required to contract with enough "bounty hunter" firms to cover Medicare claims activity in all 50 states! Now is the time to consider the impact that this demonstration project may have on your organization or practice, and prepare accordingly.

### **ISSUES TO CONSIDER – HOW THE RAC PROGRAM WORKS**

Under this demonstration project, CMS sent each of the three firms designated as Claims RACs all of the claims that had been processed by Medicare from October 1, 2001 to September 30, 2005. This represents over one billion claims totaling \$167 billion in Medicare payments. Excluded from the demonstration project are physician evaluation and management services, hospice and home health services, claims previously reviewed by another Medicare contractor, and those involved in potential fraud investigations. Improper claims payments will be identified in a number of ways:

- **Automated Reviews** Designed to identify claims where it is clear (in the opinion of the RAC) that the claim was overpaid or paid incorrectly. No medical records are requested for these recoveries and demand letters requesting refunds of the overpayments are sent to the provider. Examples of this type of recovery would include items or services which are not covered by Medicare, services that were performed in an inpatient setting when they could have been performed in an outpatient setting, or those services which should not be billed together. Duplicate payments would also be included here. **Providers have 30 days to dispute the findings.** If a provider fails to dispute the claim within the 30 day window, CMS has the authorized the fiscal intermediary to offset the overpayment against current payments.
- **Complex Reviews** – Require a medical record review by a licensed professional, physician, or nurse. The provider will first receive a request for medical records pertinent to the claims in question. Examples of this would be for services that may not be medically necessary, or incorrectly coded services that must be verified with medical review. The RACs have 60 days to determine if an overpayment exists; again, providers have 30 days to dispute the findings.

One of the most concerning parts of this demonstration project is that each RAC will identify overpayments utilizing its own proprietary (i.e., confidential) data mining methodologies and software. This should be a major cause for concern for providers since the quality and completeness of these data mining methodologies and software programs directly impacts the demand letters that providers will be *forced* to respond to in short order. It is important to remember that the collection policies applied to this demonstration project are the same for those currently in place for Medicare claims processing contractors, including the assessment of interest on the portion of any debt that remains unpaid after 30 days after the issuance of the demand letter.

### **WHAT CAN YOU DO TO PREPARE FOR A RAC ATTACK?**

Before you receive your first medical record request or demand letter, there are things your organization can do to proactively address these issues. A "**RAC Readiness Review**" can help you plan for a RAC claims audit and can often mitigate significant exposure to your institution as well as reduce the strain on your organization's resources in responding and dealing with the RAC initiative. Below are some specific recommendations to help your organization prepare for a RAC review:

1. **Form a RAC Task Force** – The logical point person to lead this task force is your corporate compliance officer. Identify the right individuals to participate in the task force. Consideration should be given to your Director of Medical Records, Director of Patient Accounting, Director of Reimbursement, nurse auditor staff, and any other key

2. stakeholders. The task force point person should keep both the CFO and the Board of Directors abreast of its initiatives.
3. **Educate the Task Force First** – It is critical that your task force be educated and connected as quickly as possible. Consider having an external expert, ideally one who specifically has RAC audit experience, train your task force on the details of RACs, including an overview of the regulatory history, the RAC audit process, the “hot button” areas that a RAC is likely to focus upon, what to expect from the process and, more importantly, how to respond.
4. **Logistical Preparations Should Begin Immediately** – An external expert should also be able to help you identify the key issues that need to be addressed long before a RAC audit begins. For example, just some of the issues that should be considered include whether you will involve external legal counsel, where old medical records are stored, how can old records be accessed, and how long will it take to get access. Since many of these claims could be four years old, they may be stored off-site. Other issues that require consideration include how information requested by the RAC will be transmitted to them. HIPAA compliance is of the utmost importance. Also, are you going to have either internal or external group review, in detail, all of the medical records requested by the RAC to try and assess your potential exposure or are you going to simply wait to get their results?
5. **Get Ahead of the Curve** – If you are in one of the 47 states where RAC audits will not begin until 2010, we would recommend that you identify the top 10 “hot button” coding issues that RACs are looking for and start training your coding staff on how to make sure that your future coding assignments in these areas are correct. Keep in mind that the RACs are going to look back three years when they do their audits. Therefore, if you can focus on getting the coding for these “hot button” issues correct now, then **you can eliminate, or at least greatly reduce, your exposure to repaying significant overpayments to Medicare.**

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We are pleased to have the opportunity to provide this information to you. If you have any questions, need assistance with evaluating the risks of a RAC attack to your organization, or need assistance identifying the top 10 areas of exposure, please do not hesitate to contact either Sandy Newstein, Senior Consulting Manager at (610) 742- 1424 or me at (215) 669-3988.

Yours very truly,

Anthony J. Scarcelli, Jr., Principal  
IMA Consulting



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## **The Lucky Winners for the Expense Paid Trip to the Region 10 and 8 Conference in Sante Fe, New Mexico Have Been Announced!**

**The four Idaho HFMA Chapter members that were picked to go are as follows:**

**Tom Murphy  
Andrea Smasne  
Peter Sorenson  
Calvin Carey**

**Mary Wright 1<sup>st</sup> Alternate  
Don Hagen 2<sup>nd</sup> Alternate**

## Understanding the Need for a TPL Program

A Third Party Liability Collections program is an intensive endeavor with the goal of maximizing reimbursement for medical services rendered, while at the same time providing excellent patient care by helping to alleviate unnecessary medical debt. A Third Party Liability program approaches each and every patient account with one question in mind: Why are we, the medical provider, subsidizing a legally responsible insurance company?

The program's success hinges on the ability to find and pursue reimbursement opportunities. Creativity and diligence are important as these opportunities are not always obvious. In fact, many patients are unaware of their own insurance coverage and the insurance industry has become accustomed to the subsidies given by the medical community and is not always forthcoming in regards to reimbursement responsibility.

Although a patient may have commercial health insurance coverage, it does not and should not absolve responsibility from a third party. A carefully planned and organized TPL program will not only decrease the number of private pay accounts but it will also increase reimbursement rates on individual accounts. Reimbursement at 100% of account charges becomes common.

As a medical provider you have the unique opportunity to advocate on behalf of your organization as well as on behalf of the patient. A TPL program is the foundation for this advocacy. A well structured TPL program begins with competent and knowledgeable account managers. The account manager is the conduit between payment obstruction and reimbursement. Comprehension of legal statutes, application of case law and the ability to stay current with administrative and revised codes is imperative to a successful program. Knowledge of damage issues and how they are applied for reimbursement can have a wide range of effects upon the amount of reimbursement owed to the patient and medical provider. Personal Injury Protection, MedPay, Bodily Injury liability, First and Third party coverage all have positive and negative effects dependent upon the order in which they are applied and utilized, hence the importance of capable account managers.

To take full advantage of all reimbursement opportunities, the first objective of a TPL program is to screen all patient accounts, regardless of dollar amount. Each account is thoroughly screened for possible third party liability by reviewing account information, such as reason for admit. If there appears to be a potential reimbursement source, the account manager then begins his investigation. The investigation may include patient interviews, review of medical documentation such as medical records, acquisition of law enforcement reports and insuring agreements. With this documentation in hand the account manager is able to identify:

- Act that caused the liability exposure
- Target Defendant or Tort-feasors
- Indemnification coverage supported by the insuring agreement for the tort-feasor who committed the liable act

Upon completion of these steps, properly securing funds for reimbursement is essential whether by the use and implementation of a protective medical lien, filing a lawsuit or entering into inter-company arbitration.

The use of a medical lien is simple but elemental. According to Idaho State law, any medical provider who rendered services for any person who has received a traumatic injury has the right to file a protective medical lien upon any potential settlement received as direct result of the treated injury. The lien gives the hospital the ability to collect reimbursement directly from a patient's settlement or award, rather than relying on the patient to satisfy their own debt. With that said, and as previously stated, it is crucial to have trained and experienced account managers when securing funds for reimbursement. Familiarity with state law and the medical lien process is vital. If filed incorrectly, the lien may have no legal standing, thus inhibiting the collection of proper reimbursement.

Enforcement of the lien may also be necessary. A creditor's action can be taken against an insurance carrier who has refused or neglected to honor the medical lien. One Washington State hospital recently had success with the filing of a creditor's action in Superior Court. The liable insurance company in this matter failed to honor the lien by paying the policy limits to the patient's estate. Through the successful use of the creditor's action, the insurance company was required to pay the statutory amount due to the hospital as well as all attorney fees and related costs incurred to enforce the lien.

The use of inter-company arbitration is also an important aspect of any TPL program. Inter-company arbitration is a group of approximately 3500 signatory members. All members have agreed to waive any formal appeal, injunction, or other litigation tactic, with the goal of settling a disagreement over damages and liability in a cost effective and time efficient manner. The same Washington State hospital referenced above also recently had success with inter-company arbitration. The liable tort-feasor, in this matter, originally denied all liability and refused payment. The hospital's TPL program manager filed inter-company arbitration. Both parties presented their positions, and the three-person arbitration council declared the tort-feasor 20% negligent. The hospital was awarded several thousand dollars as a result of this decision. The patient in this case was eligible for Washington State Medicaid; however with the successful use of inter-company arbitration, the hospital was able to secure a higher reimbursement from the proper payer, while saving the State of Washington thousands of dollars.

The increasing numbers of private pay accounts and the decreasing health insurance compensation rates are common yet disconcerting problems within the medical community. In regards to third party liability, the insurance industry has succeeded in creating an environment of ignorance and has profited from it. Their profit is directly related to the medical community and its acceptance of private pay accounts and low reimbursement rates. With a well structured TPL program you, as a medical provider, can gain the knowledge needed to pursue the insurance industry. The money is out there, it is up to you to pursue it.

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## Financing Hospital Energy Services Projects

Capital allocation on mission critical investments is a challenge for many hospitals and health systems. Many hospitals have chosen to minimize or defer capital investments in non-core competency assets such as central utility plants and other facility infrastructure assets. Properly developed and financed energy services projects can help hospitals reduce and manage energy costs, while funding important facility infrastructure renewal.

A recent Healthcare Financial Management Association publication entitled "How are Hospitals Financing the Future?" reported that half of the surveyed healthcare chief financial officers believe their infrastructure is deteriorating faster than they can make capital improvements. Statistics for average age of plant support these beliefs. HFMA concludes: "These findings suggest that deteriorating plants are likely to demand significant capital investment in the next five years."

Deferring energy efficiency and facility improvements leads to unfunded or even unrecognized capital expenditures and higher operations and maintenance costs for utilities, labor and repairs. This results in a subtle but steady decline in facility performance, financial performance and environmental stewardship. Increasing energy costs compound these challenges for energy-intensive healthcare institutions with around-the-clock operations.

Energy services projects require significant design, engineering and development efforts to create projects that are technically and economically compelling for the hospital's facilities and financial executives.

### Getting Started

There are typically three parties involved in an energy-services project transaction:

- the hospital or health system (end use obligor)
- the energy services company (ESCO)
- the lender or investor representing the broader capital markets.

The first step in developing an energy services project is a thorough assessment of the existing energy and operational costs, supported by a detailed engineering analysis of infrastructure assets and systems. This process, commonly referred to as an investment grade audit, is normally conducted by an independent third party ESCo or engineering firm working in partnership with the hospital. The objective is to identify opportunities for greater efficiency and to suggest a mix of facility improvement investments, energy conservation measures and operational changes to produce savings.

In many cases, projects are developed to be self-funded, meaning the savings achieved are greater than the cost of the project, with the savings guaranteed by the ESCo contracted to do the work. Other times, projects are developed to satisfy acute technical needs, such as additional heating and cooling capacity for facility expansions or improved conditioning of existing space such as operating rooms or patient towers. Such projects might not be self-funding, but are usually developed to achieve maximum energy efficiency and lowest lifecycle cost with the ESCo assuming guaranteed performance obligations.

Healthcare executives are faced with varying financial objectives for facility renewal. The energy services market offers a wide range of technical and financial solutions.

### Private Placement, Tax-Exempt Financing

The most common solution that results from an investment grade facility audit is an energy performance contract (EPC) project. EPC projects are developed to be self-funding, meaning the project costs, including financing and ongoing service, are less than or equal to the savings developed during the investment grade audit. The scope of work in an EPC project is dictated by the amount of savings identified. The larger the savings opportunity, the broader the mix of asset renewal, energy conservation and facility improvement measures that can be funded by the guaranteed savings.

Tax-exempt private placement debt is the most common financing solution for EPC projects. Tax-exempt debt is normally issued through the same financing conduit as the hospital's bonds and is typically structured with amortizing terms of seven to ten years or longer. By documenting the transaction as a tax-exempt lease or loan, the hospital is able to access attractively priced tax-exempt capital with significantly lower cost and greater ease than a public bond financing. Because the issuance, underwriting and documentation of private placement financing is highly standardized, transactions can be completed in as little as two months from origination to closing. The overall efficiency of private placement financing enables borrowers to issue tax-exempt debt as small as \$2 million or less and still achieve significant savings over commercial rate debt financing.

## **Off-Balance-Sheet Financing**

For institutions concerned about adding leverage to their balance sheet, off-balance-sheet financing is available.

The most common approach to achieving off-balance-sheet accounting treatment is to structure the energy project financing as an operating lease. To do so, the lease must satisfy the lease classification criteria of Statement of Financial Accounting Standards No. 13 (FAS 13) which governs lease accounting. To obtain such off-balance-sheet treatment, operating leases are usually structured with relatively short terms, ranging from three to seven years.

## **Off-Credit Financing**

For many healthcare institutions, the key structural objective is actually off-credit financing of their energy services projects. This objective may be driven by internal capital policies, balance sheet impact, credit capacity concerns, external credit analyses and strategic interest in outsourcing non-core competencies such as facilities management and central plant operations. In this case, the structural solution is a highly customized transaction wherein the customer pays for energy services under some type of long-term contract, such as an Energy Services Agreement, Utility Services Agreement or Shared Savings Agreement. In order to gain off-credit treatment, these contracts must be truly executory, requiring ongoing performance by the parties and not containing a mandatory payment obligation based upon the passage of time. The customer's payment obligation is based upon outcomes, such as actual energy savings or the provision of thermal power.

Structuring an off-credit energy services transaction requires close collaboration among the three key parties: the customer, the ESCo and the lender or investor. Although the parties share the objective of achieving an off-credit transaction for the customer, each party also has their own requirements and limitations to consider. Therefore, it is essential for the parties to work closely in good faith negotiation to achieve a successful result, the basic framework of which would include a contingent "pay-for-service" payment obligation for the customer, a clean sale of the project assets by the ESCo in conjunction with an ongoing services agreement and a bright line separation of performance and credit risk for the lender or investor.

## **Summary**

By being aware of investor solutions and working collaboratively with a knowledgeable and experienced financing partner from the earliest stages of project development, hospitals and their ESCo partners can avoid delays and develop compelling financial solutions. The capital markets have an unlimited capacity to fund creditworthy, properly structured energy services transactions. Whether the concern is cost of capital, balance sheet impact or credit exposure, there are numerous solutions available with experienced capital providers.

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**2006 – 2007**

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