Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Finance and Management Committee Meeting Notice & Agenda

Wednesday, November 24, 2010
7:30 a.m. – 9:00 a.m.
Dal Cielo Conference Room A

Office of the Clerk: (510) 814-4001

Members of the public who wish to comment on agenda items will be given an opportunity before or during the consideration of each agenda item. Those wishing to comment must complete a speaker card indicating the agenda item that they wish to address.

I. Call To Order — Jordan Battani

II. Approval of Minutes — Jordan Battani

A. October 27, 2010 **ACTION ITEM [enclosure]**

III. Action Items

A. Recommendation to Accept September 2010 Financial Statements ACTION ITEM [enclosure] — David A. Neapolitan

B. Recommendation to Revise Time and Attendance Strategy [enclosure] — David A. Neapolitan

IV. Chief Executive Officer's Report

A. Low Acute Census Action Plan Update — Deborah E.Stebbins

V. Chief Financial Officer's Report

A. Seismic Financing Update — David A. Neapolitan

B. Managed Care Contract Performance [enclosure] — David A. Neapolitan

C. RAC Update [enclosure] — David A. Neapolitan

D. FY 2010 / 2011 Inter-Governmental Transfer Program and Hospital Provider Fee Update [enclosure] — David A. Neapolitan

This is being noticed as a Board Meeting as a quorum of Directors may be present. Ex-officio members and non-committee members cannot vote on any item, whether or not a quorum of the Board is present.

VI. Board / Committee / Staff Comments

VII. Adjournment

DRAFT

Finance and Management Committee Minutes
October 27, 2010

Members Present:	Jordan Battani, Chair	J. Michael McCormick	William Sellman, MD
	Robert Deutsch, MD	James Oddie	Alka Sharma, MD
Management Present:	Deborah E. Stebbins	Kerry J. Easthope	
	David A. Neapolitan	Mary Bond, RN	
Guests:	Nate Lensink, Jtech CM		
Excused:	Rob Bonta	Ed Kofman	
	Ann Evans	Leah Williams	
Submitted by:	Kristen Thorson		

Topic	Discussion	Action / Follow-Up
I. Call to Order	Jordan Battani called the meeting to order at 7:40 a.m.	
II. Approval of Minutes	A. September 29, 2010 There was one change to the minutes as indicated below. "~~Mr. McCormick~~ Ms. Battani called the meeting to order at 7:40 a.m. noting that a quorum of committee members were present"	Mr. McCormick made a motion to accept the minutes with changes. Dr. Sellman seconded the motion. The motion carried.
III. Action Items	A. Recommendation to Accept September 2010 Financial Statements Mr. Neapolitan presented the September 2010 Financial Statements noting the following. The acute average daily census (ADC) was 23 days or 2.7% less than budget and 8.2% below prior year. Mr. Neapolitan reviewed the Average Case Mix Index (CMI) over the last three years and the current year by month. In September, overall case mix increased to 1.4031, while the Medicare case mix remained relatively consistent to that of the prior month at 1.4111. The SNF program census was 22.0 for the month of September or 4.3% below budget. This unfavorable variance of only 30 days has again improved slightly in October with and ADC of 22.3 which is 3.0% below budget through October 25. Surgery cases declined for the month to 168 or 13.8% below budgeted expectations for September. The majority of the decline from the prior month was related to Outpatient Surgeries which accounted for 52 fewer cases in	Dr. Deutsch made a motion to recommend acceptance by the Board of Directors the September 2010 Financial Statements as presented. Mr. McCormick seconded the motion. The motion carried.

	September. ECC cases were only 1.8% below budget at 48.2 visits per day. Gross patient revenues $166,000 greater than budget in September and comprised of the following. Inpatient gross revenue was below budget by $30,000 and outpatient gross revenue was greater than budget by $197,000. Net patient revenues were unfavorable to budget by $24,000 or 0.5%. Net revenue from clinic operations exceeded the monthly budget by $15,000 as volumes continue to increase. Ms. Stebbins added that the increase in volume can be partially attributed to the number of physicians now providing coverage at the clinic (3 primary care physicians, 1 OB/GYN and 1 general surgeon). Expenses were $169.000 favorable to the fixed budget and $10,000 favorable on an adjusted patient day (APD) basis for the month. The primary cause for this positive variance was lower than budgeted health claim expenses which included stop loss recoveries of $96,000 and a $44,000 reduction to Incurred But Not Recorded (IBNR) requirements. Combined salaries and registry costs were $87,000 unfavorable to the fixed budget and $42.000 unfavorable on an APD basis. Non-productive salary costs exceeded budget as a result of the following; surgical stand-by cost ($20,000) which was offset by favorable variances in productive costs, higher than budgeted nursing inservice / orientation costs ($4.000), call back costs ($4,000), and accrued time off accruals ($23,000). Supply costs were over budget by $188,000. Key areas that contributed to the increase were Surgical Supplies ($74,000) including $61,000 of prosthesis, Pharmaceuticals ($67,000), Lab Supplies ($24,000), and Non-Medical Supplies ($21,000). Purchased Service costs were favorable to budget due to favorable variances in Medical Purchased Services ($38,000), Collection Agency Fees ($12,000) and lower than budgeted Repairs and Maintenance ($25,000). Cash collections in September were $5.3 million versus $4.3 million in August. For the month, there is a profit of $51,707 versus a budgeted loss of $112,699. On a year-to-date basis, the hospital is at a loss of $262,462 versus a budgeted profit of $165,642 for the 1st quarter of FY 2011. Ms. Battani asked Management what the plan was going forward to improve financial performance and the year to date loss for the 1st quarter of the fiscal year. Ms. Stebbins	

	stated that management is researching potential reasons why the census has been down compared to prior years and will be talking with key physicians to get their input. B. Recommendation to Approve Sesimic Budget Mr. Easthope and Nate Lensink from Jtech CM presented the Seismic Budget and asked the committee to recommend approval by the Board of Directors of the combine project budget in the amount of $10.3 million at the December Board meeting. Mr. Lensink reviewed the three components of the combined project budget. 1. Increment 1 includes structural work to the West Building, demolition work and soil liquefaction remediation. 2. Increment 2 is comprised mostly of moving the Kitchen to the West Building as required by SB 1953. 3. Enabling and Decommissioning includes the enabling moves that will be required prior to, during and after construction is completed. This component also includes decommissioning the 1925 building. The combined project budget was broken down into eight key categories: Fees, Entitlements & Permits ($418,834), Construction ($6,307,737), Equipment ($121,000), Furniture and Furnishings ($184,300), Communications ($125,000), Professional Services ($2,200,117), Legal & Real Estate ($15,000), and Contingency ($937,199). The budget, which will be used as a working document, outlined the amount committed, amount spent and budget remaining for each category and specific items under each category. C. Recommendation to Approve Fugro West-Geotechnical Services Contract Mr. Easthope presented the recommendation to approve the Fugro West – Geotechnical Service Contract. The contract is for an amount not to exceed $101,603 to perform CPT testing, analysis and documentation / reporting to OSHPD and the California Geological Service. The Structural Plans have already been submitted to OSHPD. OSHPD has asked for additional soil investigation and reporting in order to continue with the plan review. The contract amount has been included in the Seismic budget as previously reviewed. D. Recommendation to Approve Ratcliff Architect Contract for Seismic Project Mr. Easthope presented the recommendation to approve the Ratcliff Architect Contract for the Seismic Project. The contract is for planning, design, development of construction drawings, submittal to OSHPD to obtain the	Mr. McCormick made a motion to recommend approval of the Seismic Budget by the Board of Directors. Dr. Sellman seconded the motion. The motion carried. Mr. Oddie made a motion to recommend approval of the Fugro West – Geotechnical Services Contract by the Board of Directors. Mr. McCormick seconded the motion. The motion carried. Dr. Deutsch made a motion to recommend approval of the Ratcliff Architect Contract for Seismic Project by the Board of Directors. Mr. McCormick seconded the motion. The motion carried.

	required building permit and construction administration / oversight. The value of the contract, including all work performed to date on the seismic project is $911,850. The Board of Directors has already approved a "notice to proceed" on approximately $650,000 of this contract amount in order to have plans submitted to OSHPD by the required dates.	
IV. Chief Financial Officer's Report	Mr. Neapolitan informed the committee that the next Committee meeting would be held on the Wednesday (November 24) before Thanksgiving and asked if members would be available for the meeting. A quorum indicated that they would be in attendance. Mr. Neapolitan also stated that several items from the September meeting have been deferred in the interest of time and would be reported on at the November Committee meeting. Those items included, a RAC update and Seismic Financing update.	
V. Chief Executive Officer's Report	Ms. Stebbins reported that progress is being made with lease negotiations for the property located at Marina Village where the Wound Care Center is planned to be located.	
VI. Adjournment		The meeting was adjourned at 9:20 a.m.

THE CITY OF ALAMEDA HEALTH CARE DISTRICT

ALAMEDA HOSPITAL

UNAUDITED FINANCIAL STATEMENTS

FOR THE PERIOD ENDING OCTOBER 31, 2010

CITY OF ALAMEDA HEALTH CARE DISTRICT
ALAMEDA HOSPITAL
OCTOBER 31, 2010

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ALAMEDA HOSPITAL
MANAGEMENT DISCUSSION AND ANALYSIS
OCTOBER, 2010

The management of the Alameda Hospital (the "Hospital") has prepared this discussion and analysis in order to provide an overview of the Hospital's performance for the period ending October 31, 2010 in accordance with the Governmental Accounting Standards Board Statement No. 34, *Basic Financials Statements; Management's Discussion and Analysis for State and Local Governments.* The intent of this document is to provide additional information on the Hospital's financial performance as a whole.

Financial Overview as of October 31, 2010

- Gross patient revenue for the month of October was less than budget by $2,939,000 or 13.4%. Inpatient and outpatient revenue was less than budgeted by 18.5% and 3.0% for the month, respectively. As a result of the lower than budgeted patient days and lower overall case mix index, on an adjusted patient day basis gross patient revenue was 10.8% greater than budgeted at $4,874 compared to a budgeted amount of $5,466 for October. Both inpatient and outpatient gross revenues per adjusted patient day were below budget by $590 and $3, respectively.

- Total patient days for the month were 2,465 compared to the prior month's total patient days of 2,446 and the prior year's 2,692 total patient days. The average daily acute care census was 25.6 compared to a budget of 27.9 and an actual average daily census of 27.2 in the prior month; the average daily Sub-Acute census was 32.6 versus a budget of 33.5 and 33.9 in the prior month and the Skilled Nursing program had an average daily census of 22.49 versus a budget of 23.0 and prior month census of 22.0, respectively.

- Emergency Care Center (ECC) visits were 1,306 or 14.0% less than the budgeted 1,519 visits and were 16.3% less than the prior year's visits of 1,560.

- Total surgery cases were greater than budgeted expectations for the month at 215 cases versus the budgeted 197 cases. The current month's surgical volume was 35.2% greater than the same month prior year's 165 cases.

- Outpatient registrations were 14.0% below budgeted targets at 2,032 but increase from the prior months 1,964 outpatient visits.

- Combined excess expense over revenues (loss) for October was $55,000 versus a budgeted excess of revenue over expenses (profit) of $105,000. This brings our year-to-date loss to $317,000 versus a budget profit of $271,000.

  - Total assets decreased by $1,301,000 from the prior month as a result of a decrease in current assets of $1,326,000, an increase in net fixed assets of $14,000 and an increase in restricted contributions of $11,000. The following items make up the increase in current assets:

  - Total unrestricted cash and cash equivalents for October decreased by $1,671,000. This decrease in cash resulted from having three paid payrolls during the month which have averaged $1.5 million per pay period during fiscal year 2011. As a result day's cash on hand decreased to 0.4 at October 31, 2010 from 9.7 days at September 30, 2010.

  - Net patient accounts receivable increased in October by $298,000 compared to decrease of $692,000 in September. Day's in outstanding receivables increased to 65.2 in October from 62.1 at September 30, 2010. This increase in days outstanding was primarily the result of a delay at month end in the receipt of a promised payment from Alameda Alliance for over $2 million in outstanding gross receivables that was not

received until after month end. Had these claims been adjudicated prior to month end day's outstanding would have remained at 62.1 and days cash on hand would have been 1.6. Collections in October totaled $4.5 million compared to $5.3 million in September. Had the above referenced claims been adjudicated prior to the end of the month, October collections would have been $4.7 million.

- Total liabilities decreased by $1,206,000 compared to an decrease of $317,000 in the prior month. This decrease in the current month was the result of the following:

  - Accounts payable and accrued expenses increased by $312,000 while payroll and accrued expenses decreased by $916,000. As a result of this net decrease of $604,000 and decrease in average daily expenses as of October 31st, the average payment period decreased in October to 64.1 from 67.1 as of September 30, 2010.

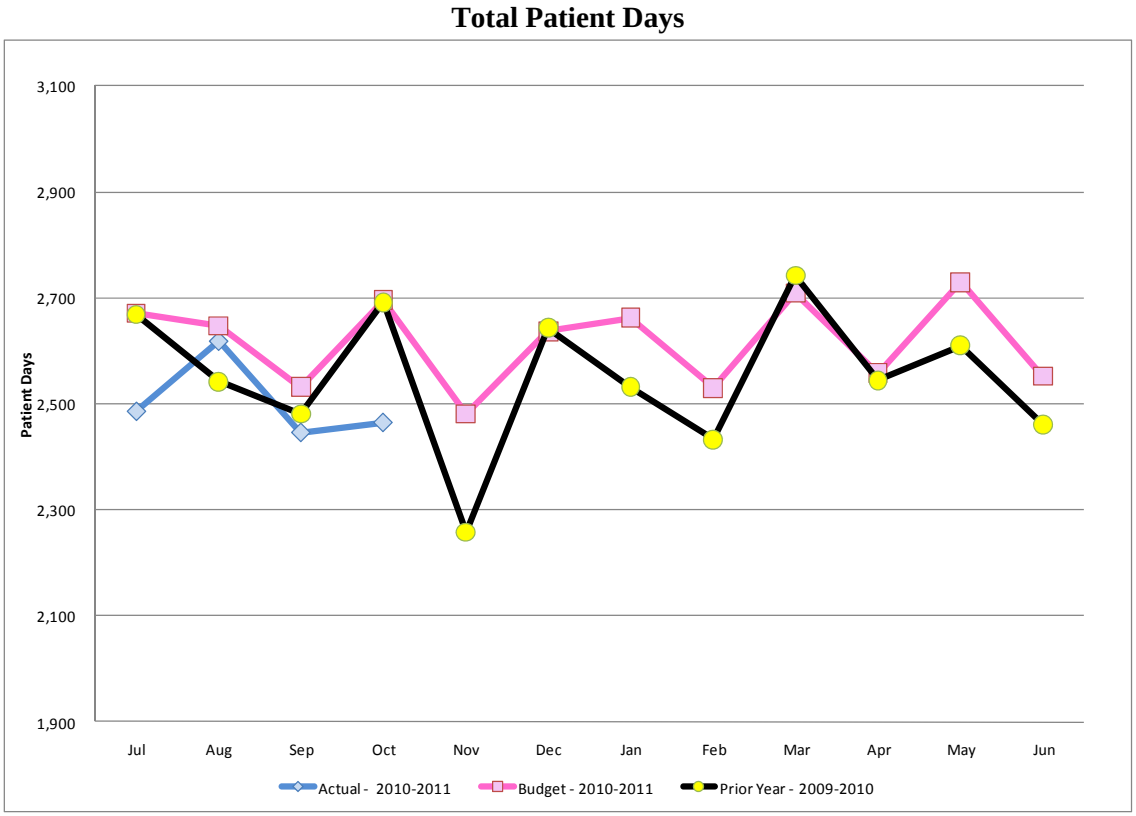
  - Payroll and benefit related accruals decreased by $916,000 from the prior month. This decrease was primarily the result of a decrease in accrued payroll and related payroll tax accruals of $977,000 offset by an increase in accrued time off of $60,000.

  - Deferred revenues decreased by $478,000 as a result of the amortization of one-twelfth of the annual parcel tax revenues for the 2011 fiscal year.

Volumes

The combined actual daily census was 79.5 versus a budget of 87.0. The current month's unfavorable variance from the budgeted census was the result of lower than budgeted census in all three inpatient programs with the largest unfavorable variance occurring in the acute care units. The acute care program was below budget by 20.0% with an average daily census of 24.6 versus the budgeted 30.5. The Sub-Acute program was below budgeted expectations with an average daily census of 32.6 versus the budgeted 33.5. In the Skilled Nursing unit the average daily census was 22.4 versus the budgeted average daily census of 23.0. This resulted in an overall unfavorable variance of 8.9% from budgeted expectations for inpatient utilization in the month of October.

The graph below shows the total patient days by month for fiscal year 2011.

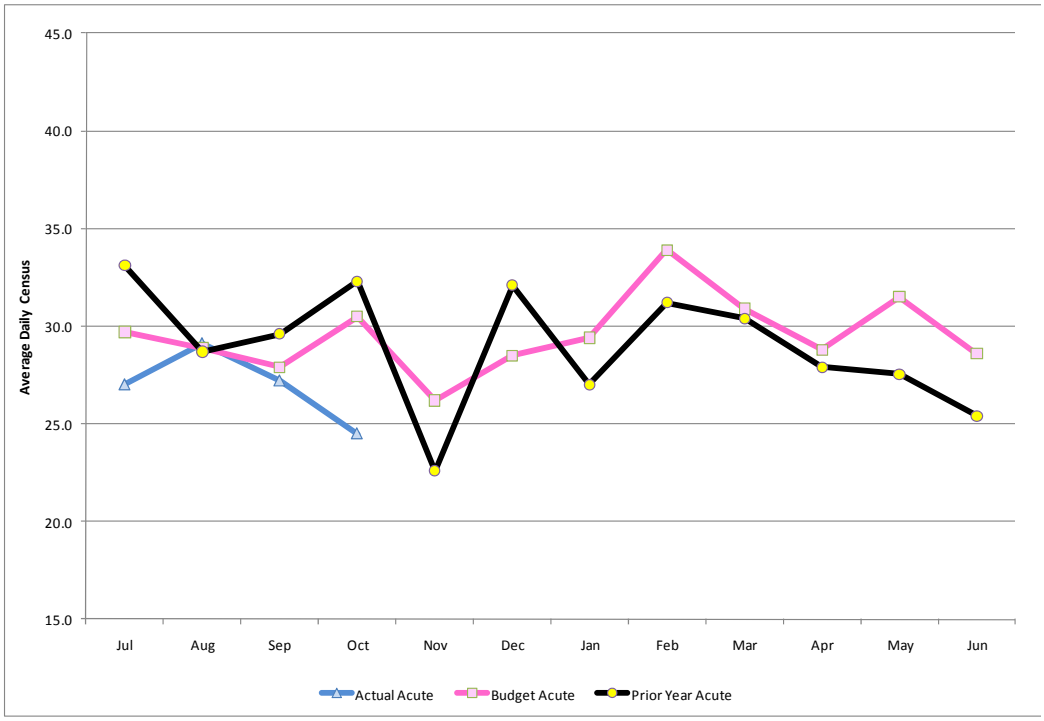


The various inpatient components of our inpatient volumes for the month of October are discussed in the following sections.

Acute Care

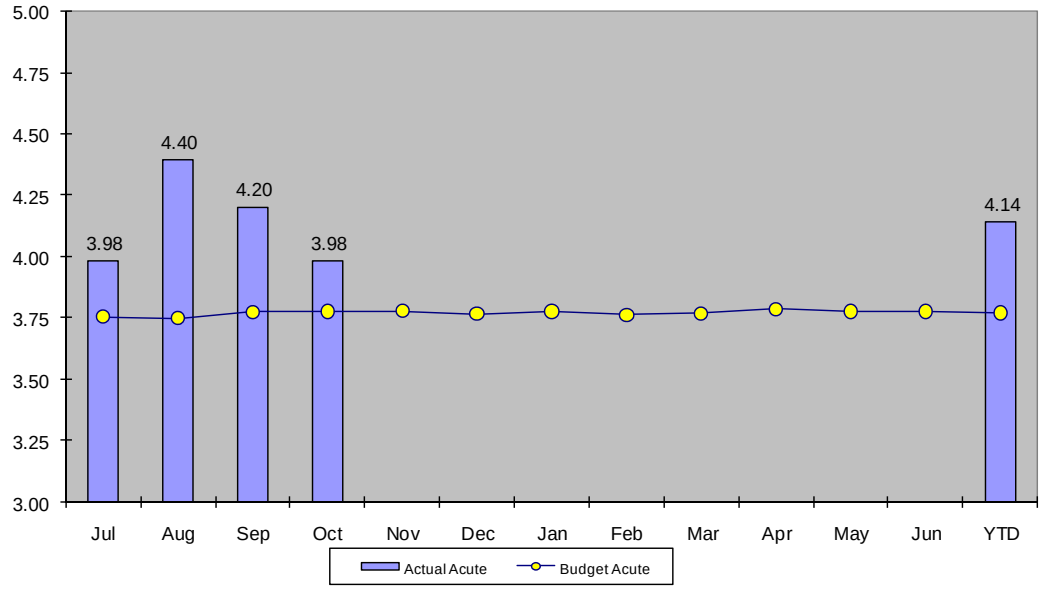
The acute care patient days were 19.4% (183 days) less than budgeted and were 24.0% less than the prior year's average daily census of 32.3. The acute care program was comprised of Critical Care Unit (4.2 ADC, 20.6% favorable to budget), Definitive Observation Unit (8.5 ADC, 24.7% unfavorable to budget) and Med/Surg Units (11.8 ADC, 24.5% unfavorable to budget). The graph on the following page shows the inpatient acute care census by month for the current fiscal year.

Inpatient Acute Care Average Daily Census



The average length of stay (ALOS) decreased from that of the prior month to 3.98 days for the month of October bringing the year-to-date average to 4.14 versus the budgeted FY 2011 average of 3.76. The graph below shows the month ALOS by month and the budgeted ALOS for fiscal year 2011.

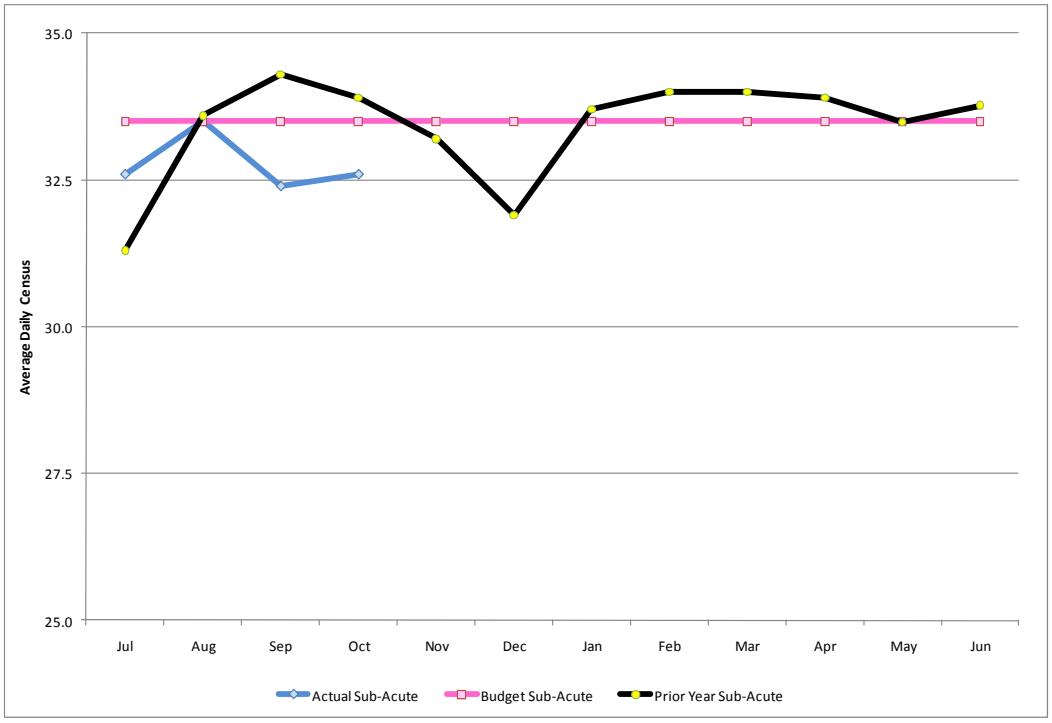
Average Length of Stay



Sub-Acute Care

The Sub-Acute program patient days were below budgeted projections with an average daily census of 32.6 for the month of October which was budgeted for and average daily census of 33.5. The graph on the following page shows the Sub-Acute programs average daily census for the current fiscal year as compared to budget and the prior year.

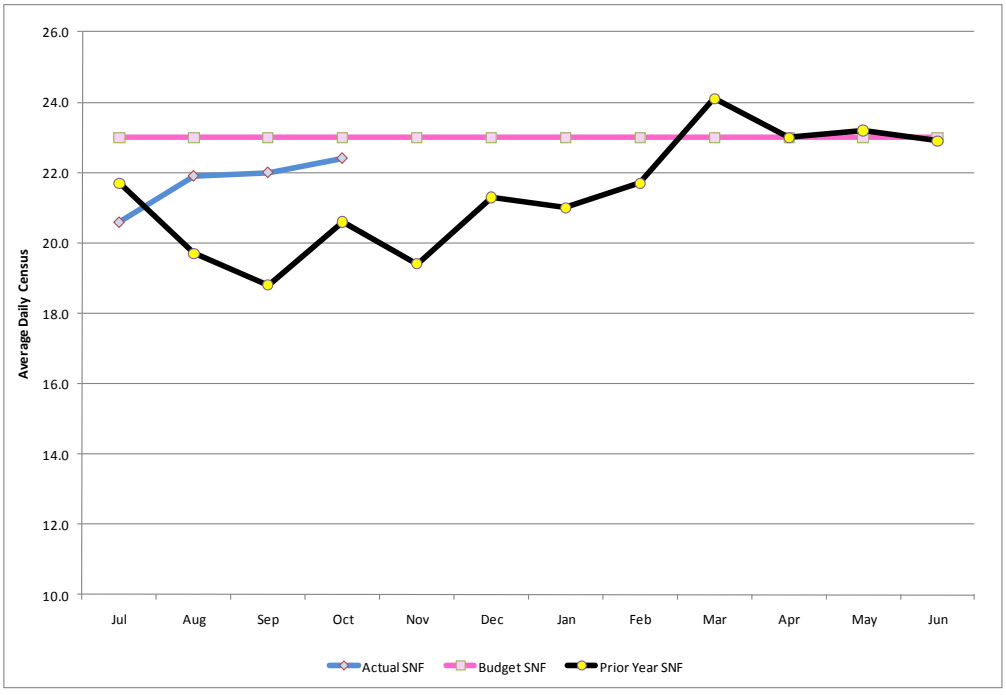
Sub-Acute Care Average Daily Census



Skilled Nursing Care

The Skilled Nursing Unit (South Shore) patient days were 2.7% or 19 patient days less than budgeted for the month of October. Comparing performance to the prior year this program remains slightly greater than the first four months of fiscal year 2010 with an average daily census of 21.7 versus 20.2. The following graph shows the Skilled Nursing Unit average daily census as compared to budget and the prior year by month.

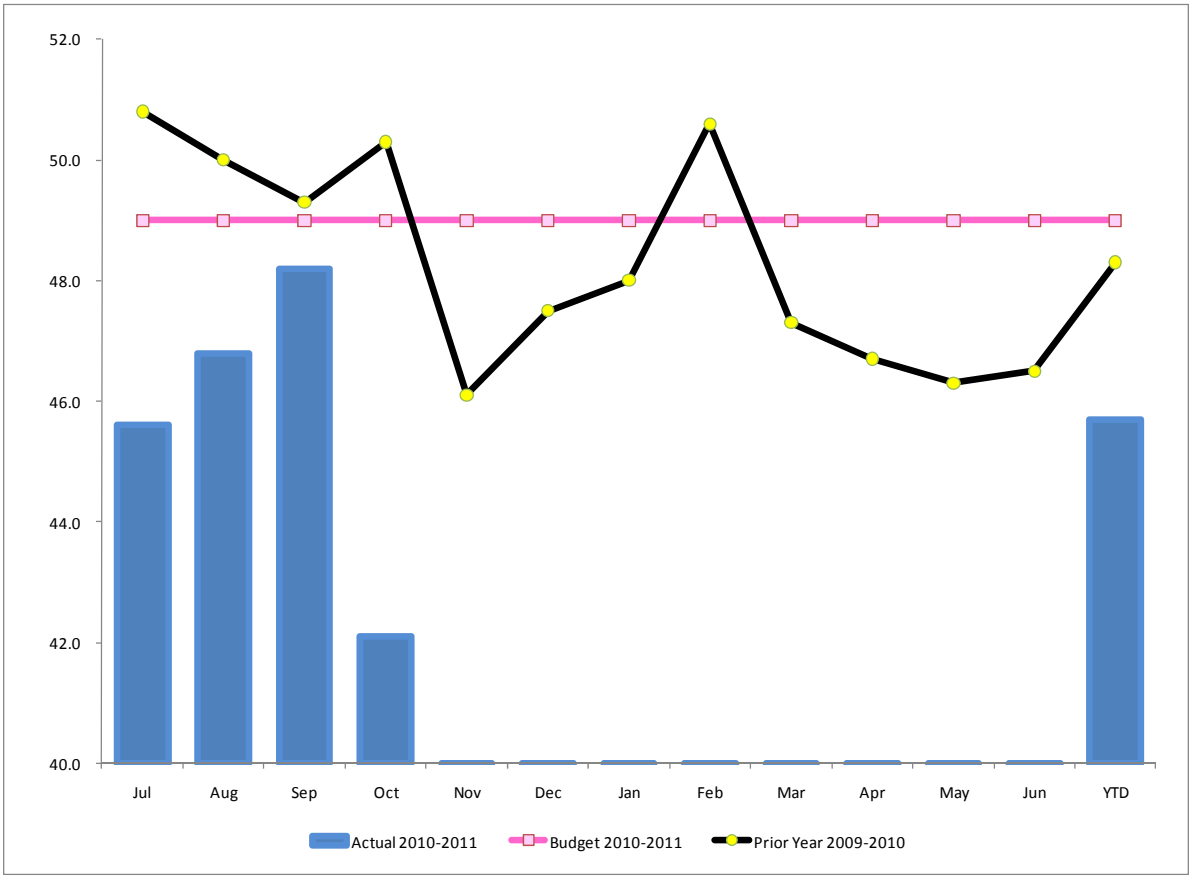
Skilled Nursing Unit Average Daily Census



Emergency Care Center (ECC)

Emergency Care Center visits in October totaled 1,306 and were 14.0% less than budgeted for the month and 15.9% of these visits resulted in inpatient admissions versus 14.1% in September. In October there were 253 ambulance arrivals versus 284 in the prior month, a decrease of 1.1%. Of the 253 ambulance arrivals in the current month 131 or 51.8% were from Alameda Fire Department (AFD) ambulances. The graph below shows the Emergency Care Centers average visits per day for fiscal year 2011 as compared to budget and the prior year performance.

Emergency Care Center Visits per Day

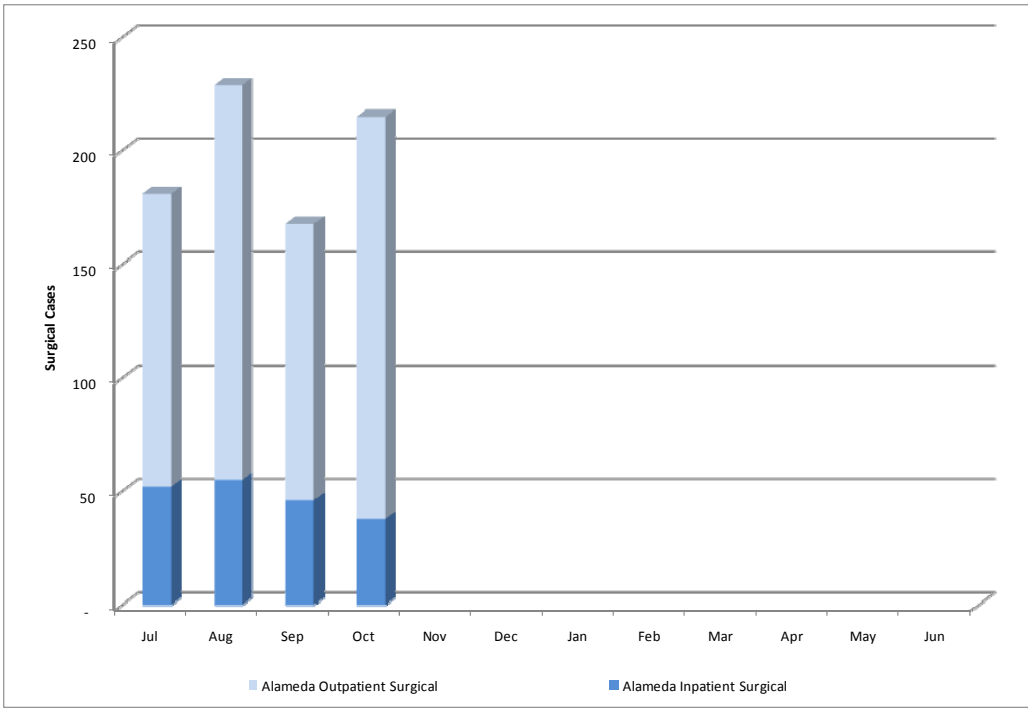


Surgery

Surgery cases were 215 versus the 197 budgeted and 159 in the prior year. In October, surgery cases increased over the prior month by 28.0%. The increase of 47 cases over the prior month was the result of an increase 55 outpatient cases offset by a decrease of 8 inpatient cases. Inpatient and outpatient cases totaled 38 and 177 versus 46 and 122 in September, respectively. The increase from the prior month was driven by increases in outpatient GI cases (27), Ophthalmology cases (12), General (8) and Gynecology (7). On the inpatient side the decrease was primarily in the Orthopedic (6) and Vascular (4) cases offset by an increase in General Surgical (5) cases.

The graph on the following page shows the number of inpatient and outpatient surgical cases by month for fiscal year 2011.

Surgical Cases

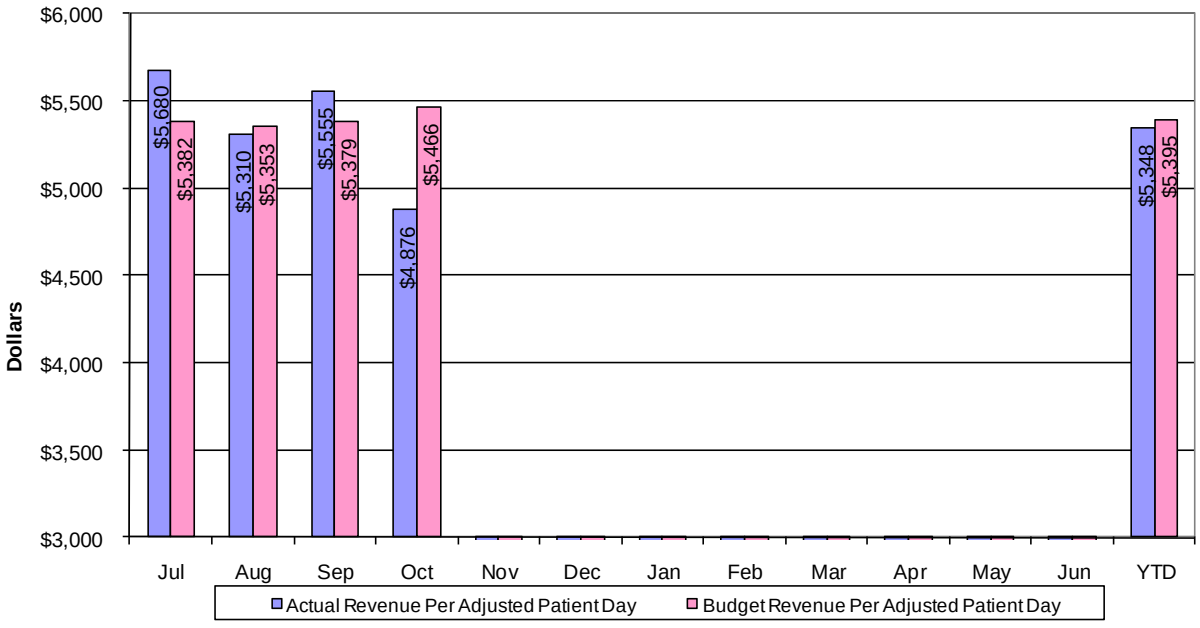


Income Statement

Gross Patient Charges

Gross patient charges in October were less than budgeted by $2,939,000. This favorable variance was comprised of an unfavorable variance of $2,723,000 and a $216,000 in inpatient and outpatient revenues, respectively. On an adjusted patient day basis total patient revenue was $4,874 versus the budgeted $5,466 or an unfavorable variance of 10.8% from budget for the month of October. The following table shows the hospitals monthly gross revenue per adjusted patient day by month the year-to-date for fiscal year 2011

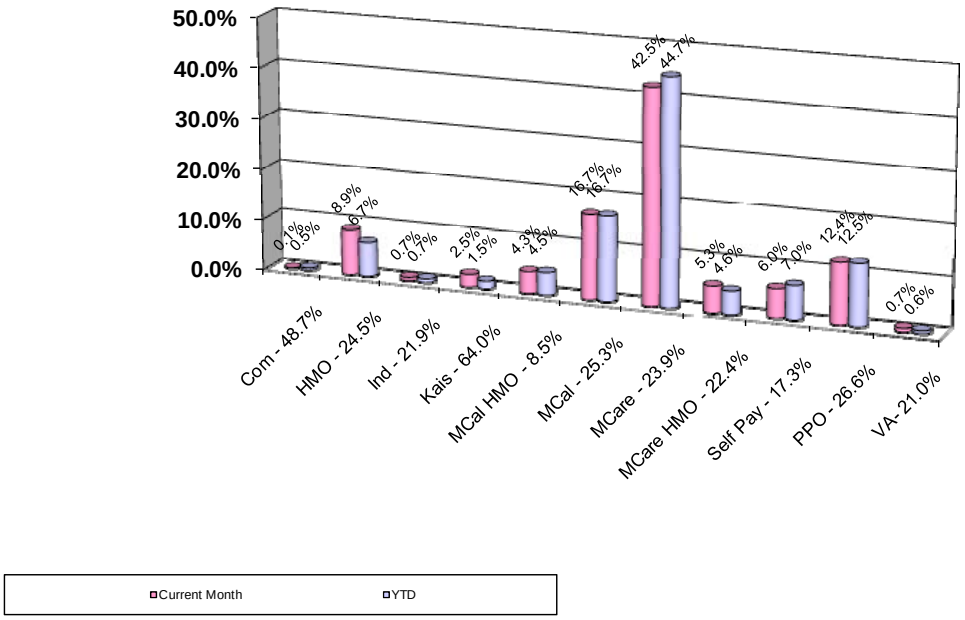
Gross Charges per Adjusted Patient Day



Payor Mix

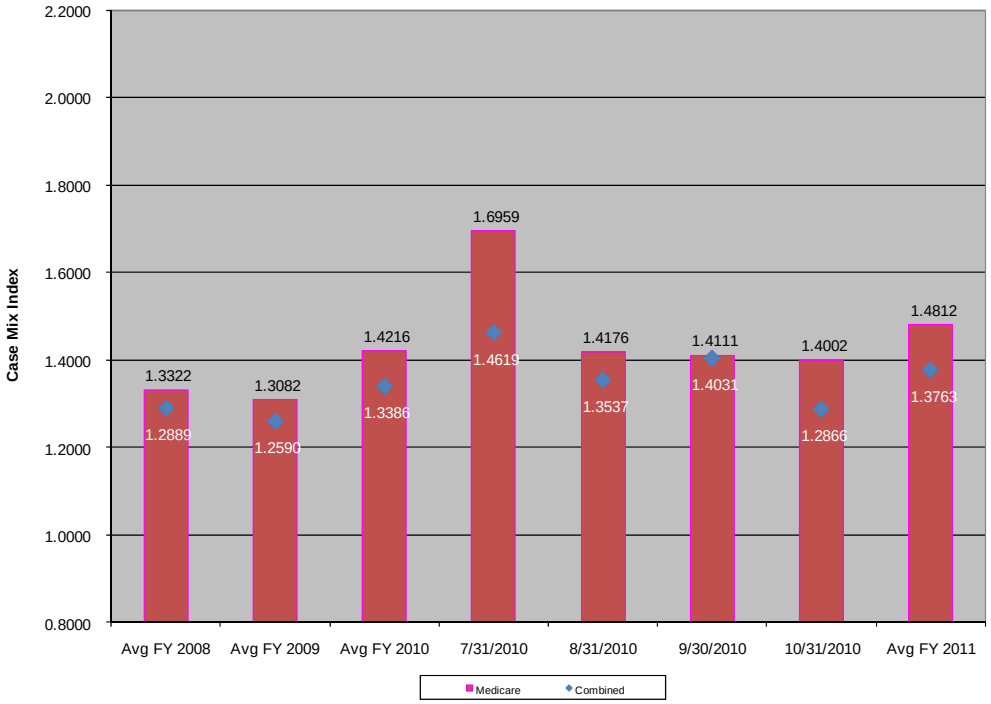
Combined inpatient and outpatient acute care Medicare and Medicare Advantage total gross revenue in October made up 47.8% of the months total gross patient revenue. Combined Medicare revenue was followed by HMO/PPO utilization at 21.3%, Medi-Cal Traditional and Medi-Cal HMO utilization at 21.0% and self pay at 6.0%. The graph below shows the percentage of gross revenues generated by each of the major payors for the current month and fiscal year to date as well as the current months estimated reimbursement for each payor for the combined inpatient and outpatient acute care services.

Combined Acute Care Services Payor Mix



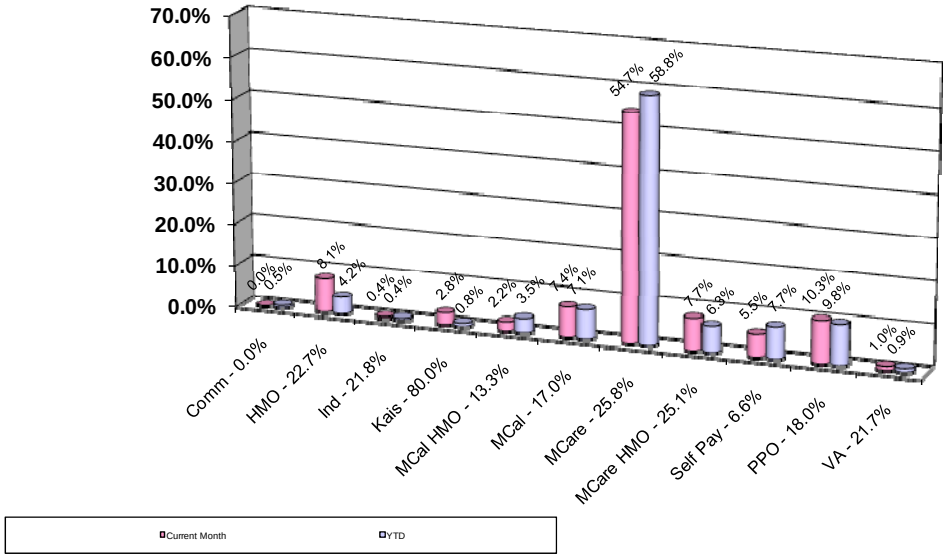
The inpatient acute care current month gross Medicare and Medicare Advantage charges made up 62.4% of our total inpatient acute care gross revenues followed by HMO/PPO at 18.4%, Medic-Cal and Medi-Cal HMO at 9.6% and Self Pay at 5.5% of the inpatient acute care revenue. The hospitals overall Case Mix Index (CMI) declined to 1.2866 from 1.4031 in the prior month while the Medicare CMI decreased only slightly over the prior month from 1.4111 in September to 1.4002 in October. In October there was one (1) outlier case in the month. The overall Medicare reimbursement increased to 25.8% in October versus 25.2% in September. The graph on the following page shows the CMI for the hospital during the current fiscal year as compared to the prior three fiscal years.

Case Mix Index Comparison



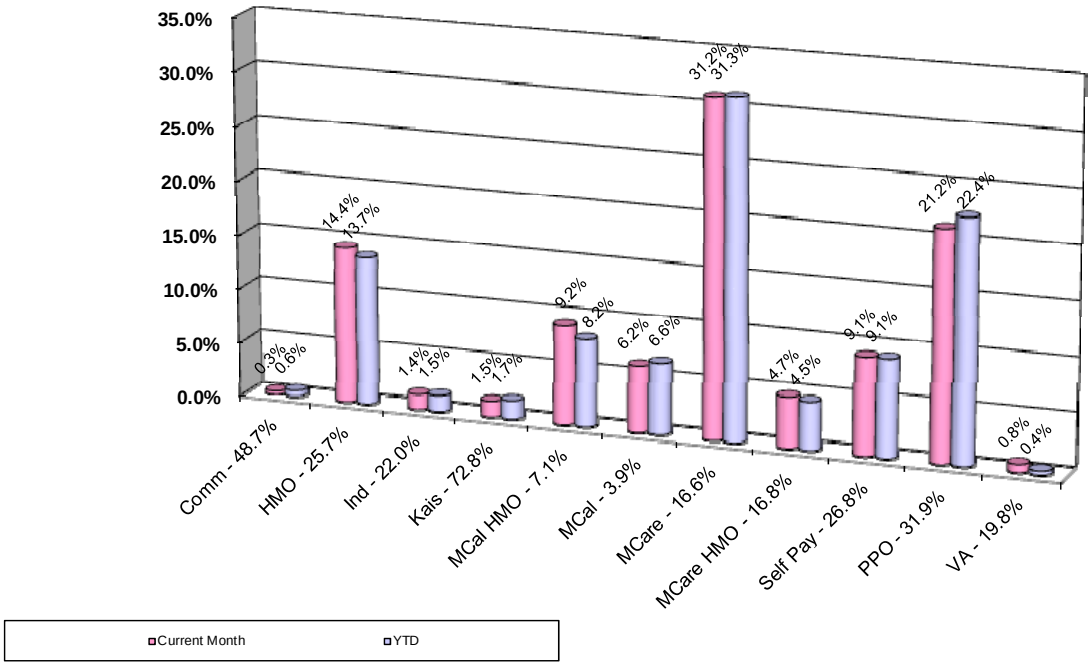
The overall net inpatient revenue percentage increased from the prior month to 26.2% in September versus 22.5% in September. The graph below shows inpatient acute care current month and year to date payor mix and current month estimated net revenue percentages for fiscal year 2011.

Inpatient Acute Care Payor Mix



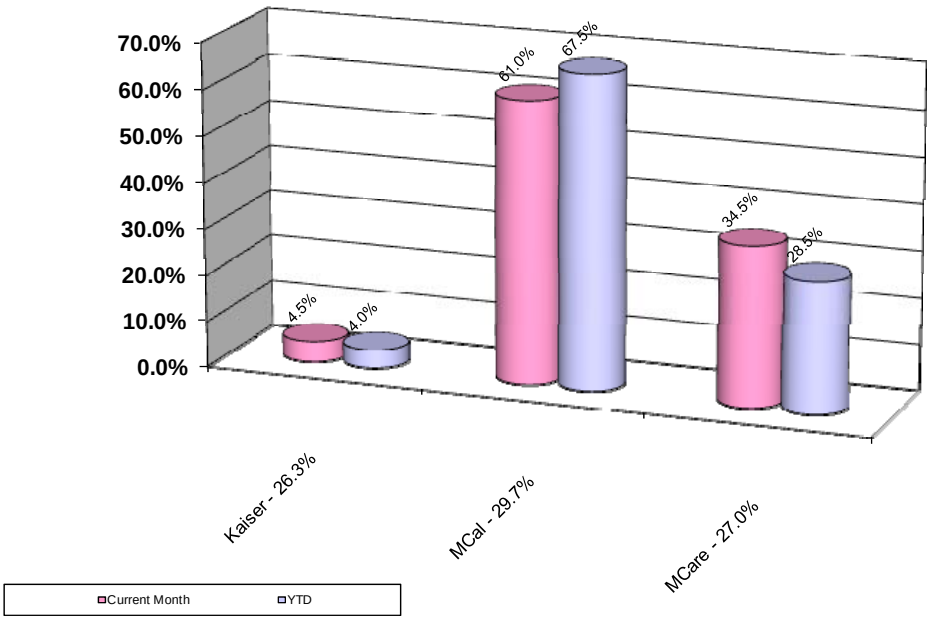
The outpatient gross revenue payor mix for October was comprised of 35.9% Medicare and Medicare Advantage, 35.6% HMO/PPO, 15.4% Medi-Cal and Medi-Cal HMO, and 9.1% self pay. The graph below shows the current month and fiscal year to date outpatient payor mix and the current months estimated level of reimbursement for each payor.

Outpatient Services Payor Mix



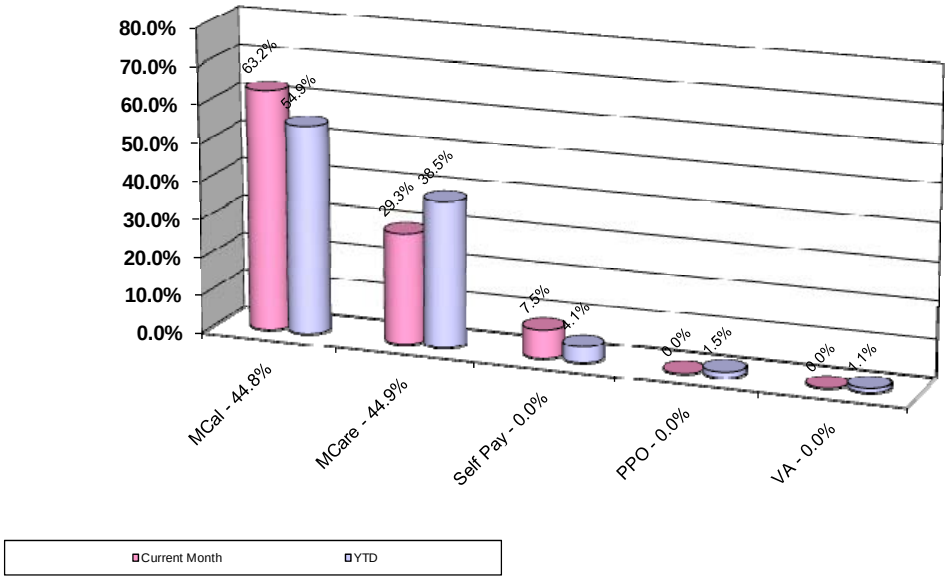
In October the Sub-Acute care program again was dominated by Medi-Cal utilization of 61.0% versus 62.2% in September. The graph below shows the payor mix for the current month and fiscal year to date and the current months estimated reimbursement rate for each payor.

Inpatient Sub-Acute Care Payor Mix



In October the Skilled Nursing program was again comprised primarily of Medi-Cal at 63.2% and Medicare at 29.3%. The graph below shows the current month and fiscal year to date skilled nursing payor mix and the current months estimated level of reimbursement for each payor.

Inpatient Skilled Nursing Payor Mix

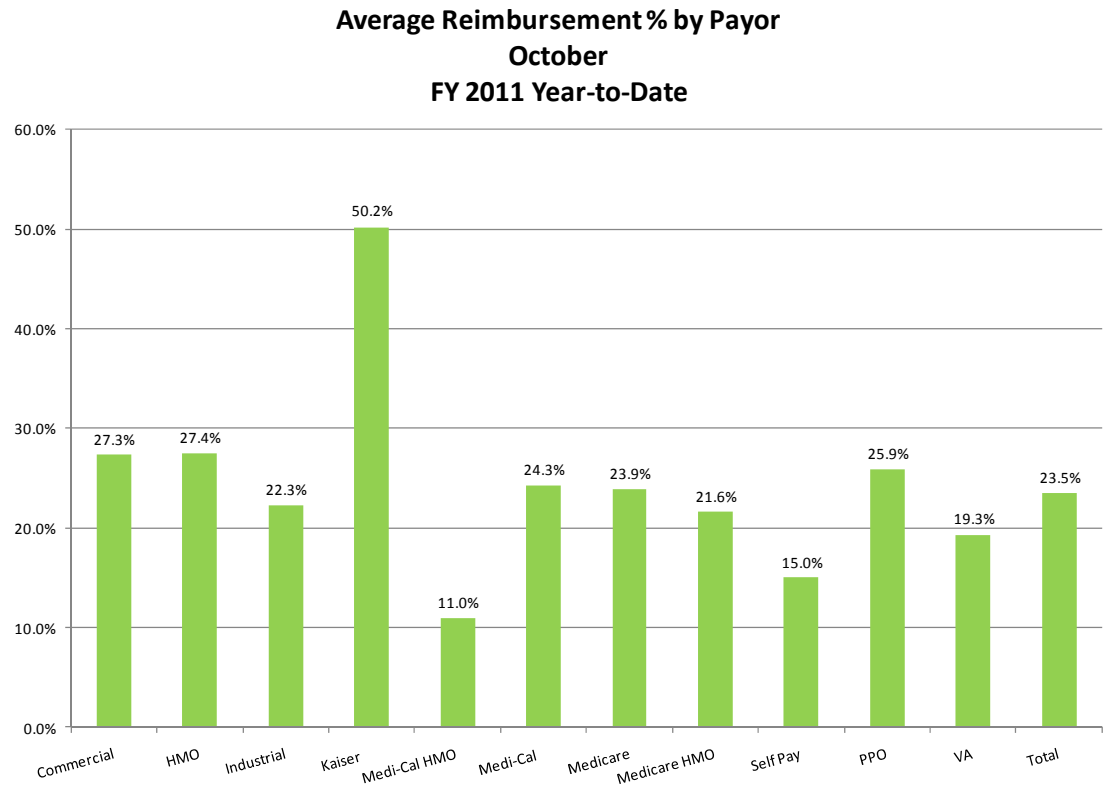


Deductions from Revenue

Contractual allowances are computed as deductions from gross patient revenues based on the difference between gross patient charges and the contractually agreed upon rates of reimbursement with third party government-based programs such as Medicare, Medi-Cal and other third party payors such as Blue Cross. In the month of October contractual allowances, bad debt and charity adjustments (as a percentage of gross patient charges) were 73.8% versus the budgeted 76.1%.

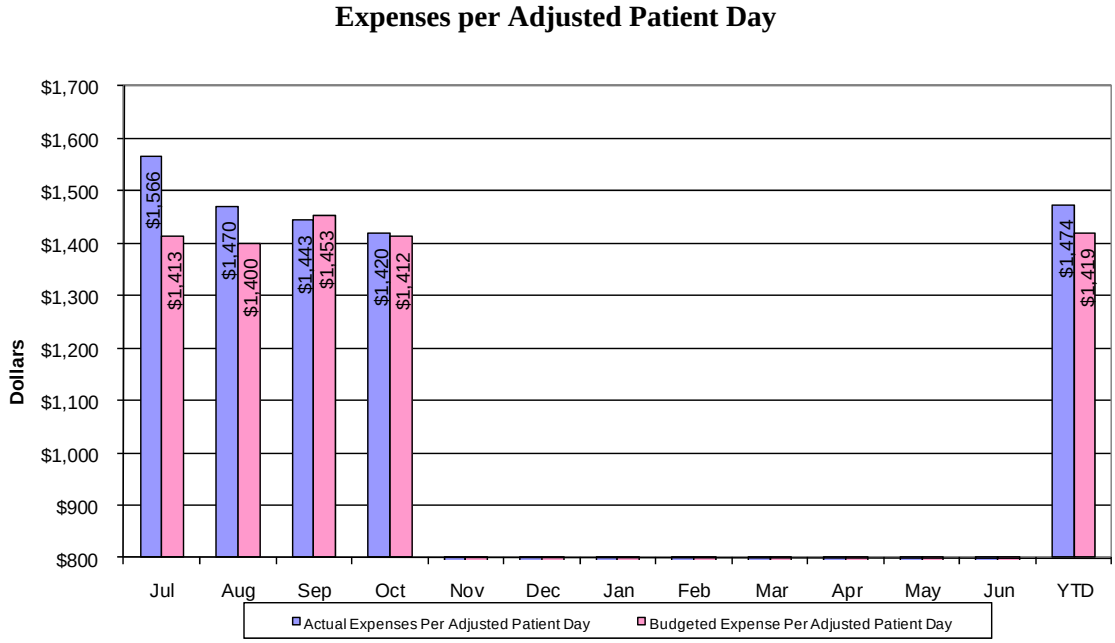
Net Patient Service Revenue

Net patient service revenues are the resulting difference between gross patient charges and the deductions from revenue. This difference reflects what the anticipated cash payments the Hospital is expecting to receive for the services provided. The graph on the following page shows the level of reimbursement that the Hospital has estimated for fiscal year 2011 by major payor category.



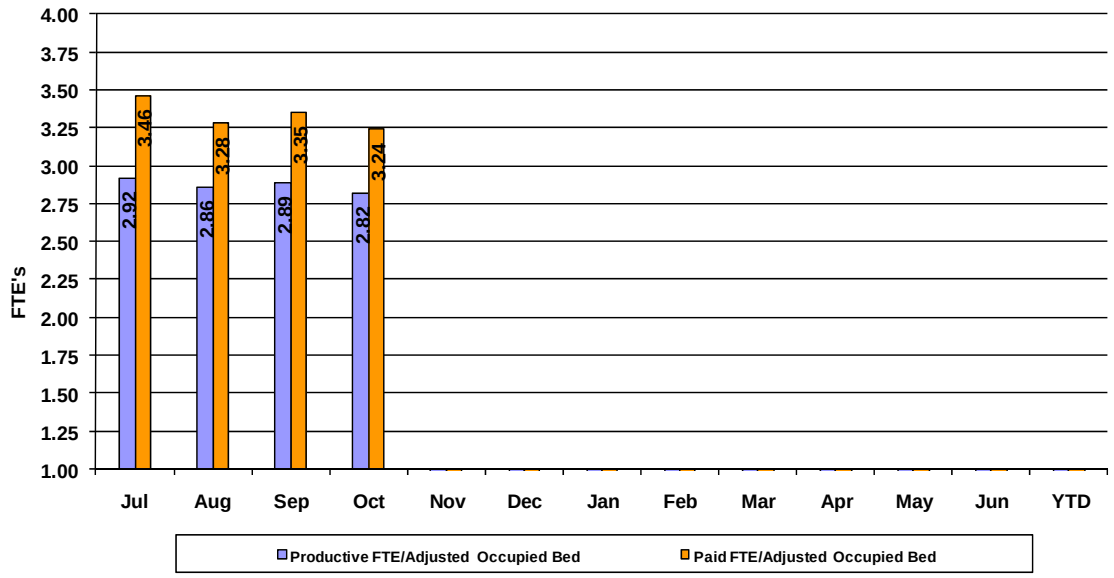
Total Operating Expenses

Total operating expenses were less than the fixed budget by $132,000 or 2.3%. On an adjusted patient day basis, our cost per adjusted patient day was $1,420 which was $8 per adjusted patient day unfavorable to budget. This variance in expenses per adjusted patient day was primarily the result of an unfavorable variance in salaries and registry costs of $11. The graph below shows the hospital operating expenses on an adjusted patient day basis for the 2011 fiscal year by month and is followed by explanations of the significant areas of variance that were experienced in the current month.



Salary and Registry Expenses
Salary and registry costs combined were favorable to the fixed budget by $43,000 but were unfavorable to budgeted levels on a per adjusted patient day basis by $11. On an adjusted occupied bed basis, productive FTE's were favorable to budget by 0.5% at 2.83 FTE's versus the budgeted 2.84 FTE's. The graph below shows the productive and paid FTE's per adjusted occupied bed for FY 2011 by month and year to date.

FTE's per Adjusted Occupied Bed



Benefits
Benefits were favorable to the fixed budget by $24,000 or 2.8%. On an adjusted patient day basis benefits were equal to budget at $218 per adjusted patient day. This favorable variance from the fixed budget was the result of further reductions to the IBNR requirements which are the result of lower than anticipated health insurance claims costs.

Supplies
Supply costs were $18,000 favorable to the fixed budget in October but were slightly unfavorable to budget on an adjusted patient day basis. The favorable variance from the fixed budget was from a favorable variance of $27,000 in non-medical supplies offset by a net unfavorable variance of $9,000 in medical supplies. The primary cause for the unfavorable variance in medical supplies was related to the continued levels of pharmaceutical costs that are being incurred related to the IVT program.

Purchased Services
Purchased services were $26,000 favorable to the fixed budget and $4 per adjusted patient day favorable to budget as a result of lower than budgeted costs incurred for medical purchased services and repairs and maintenance $18,000and $8,000, respectively.

The following pages include the detailed financial statements for the four months ended October 31, 2010, of fiscal year 2011.

ALAMEDA HOSPITAL
KEY STATISTICS
OCTOBER 2010

	ACTUAL OCTOBER 2010	CURRENT FIXED BUDGET	VARIANCE (UNDER) OVER	%	OCTOBER 2009	YTD OCTOBER 2010	YTD FIXED BUDGET	VARIANCE	%	YTD OCTOBER 2009
Discharges:										
Total Acute	191	250	(59)	-23.6%	285	800	956	(156)	-16.3%	1,007
Total Sub-Acute	1	2	(1)	-50.0%	1	6	6	-	0.0%	6
Total Skilled Nursing	7	12	(5)	-41.7%	14	35	51	(16)	-31.4%	52
	199	264	(65)	-24.6%	300	841	1,013	(172)	-17.0%	1,065
Patient Days:										
Total Acute	761	944	(183)	-19.4%	1,001	3,313	3,598	(285)	-7.9%	3,803
Total Sub-Acute	1,010	1,039	(29)	-2.8%	1,052	4,031	4,119	(88)	-2.1%	4,093
Total Skilled Nursing	694	713	(19)	-2.7%	639	2,672	2,829	(157)	-5.5%	2,488
	2,465	2,696	(231)	-8.6%	2,692	10,016	10,546	(530)	-5.0%	10,384
Average Length of Stay										
Total Acute	3.98	3.78	0.21	5.5%	3.51	4.14	3.76	0.38	10.0%	3.78
Average Daily Census										
Total Acute	24.55	30.45	(6.10)	-20.0%	32.29	26.93	29.25	(2.32)	-7.9%	30.92
Total Sub-Acute	32.58	33.52	(0.97)	-2.9%	33.94	32.77	33.49	(0.72)	-2.1%	33.28
Total Skilled Nursing	22.39	23.00	(0.63)	-2.8%	20.61	21.72	23.00	(1.28)	-5.5%	20.23
	79.52	86.97	(7.70)	-8.9%	86.84	81.43	85.74	(3.03)	-3.5%	84.42
Emergency Room Visits	1,306	1,519	(213)	-14.0%	1,560	5,616	6,030	(414)	-6.9%	6,163
Outpatient Registrations	2,032	2,362	(330)	-14.0%	2,651	7,970	9,009	(1,039)	-11.5%	10,342
Surgery Cases:										
Inpatient	38	54	(16)	-29.6%	59	191	210	(19)	-9.0%	249
Outpatient	177	143	34	23.8%	465	602	575	27	4.7%	1,796
	215	197	18	9.1%	524	793	785	8	1.0%	2,045
Kaiser Inpatient Cases	-	-	-	-	5	-	-	-	-	39
Kaiser Eye Cases	-	-	-	-	172	-	-	-	-	665
Kaiser Outpatient Cases	-	-	-	-	188	-	-	-	-	700
Total Kaiser Cases	-	-	-	-	365	-	-	-	-	1,404
% Kaiser Cases	0.0%	0.0%			69.7%	0.0%	0.0%			68.7%
Adjusted Occupied Bed	125.46	129.72	4.26	3.3%	150.96	123.72	129.26	(5.54)	-4.3%	148.60
Productive FTE	355.04	368.95	13.91	3.8%	415.55	358.02	363.62	5.60	1.5%	399.98
Total FTE	407.15	418.89	11.74	2.8%	458.98	414.94	417.68	2.74	0.7%	451.43
Productive FTE/Adj. Occ. Bed	2.83	2.84	0.01	0.5%	2.75	2.89	2.81	(0.08)	-2.9%	2.69
Total FTE/ Adj. Occ. Bed	3.25	3.23	(0.02)	-0.5%	3.04	3.35	3.23	(0.12)	-3.8%	3.04

City of Alameda Health Care District
Statements of Financial Position
October 31, 2010
$ in thousands

	Current Month	Prior Month	Prior Year End
Assets			
Current Assets:			
Cash and Cash Equivalents	$ 72,350	$ 1,742,907	$ 3,480,668
Patient Accounts Receivable, net	10,100,021	9,802,096	9,558,147
Other Receivables	6,876,657	6,851,838	6,654,035
Third-Party Payer Settlement Receivables	467,417	444,202	374,557
Inventories	1,149,394	1,153,441	1,149,706
Prepaids and Other	687,919	685,024	453,872
Total Current Assets	19,353,758	20,679,508	21,670,985
Assets Limited as to Use, net	518,605	507,717	476,630
Property, Plant and Equipment, net	7,176,793	7,162,621	6,993,735
Total Assets	**$ 27,049,156**	**$ 28,349,846**	**$ 29,141,350**
Liabilities and Net Assets			
Current Liabilities:			
Current Portion of Long Term Debt	$ 422,456	$ 409,761	$ 450,831
Accounts Payable and Accrued Expenses	6,782,865	6,471,170	6,112,296
Payroll Related Accruals	4,218,659	5,134,632	4,351,133
Deferred Revenue	3,823,823	4,301,670	5,736,951
Employee Health Related Accruals	565,180	591,933	645,750
Third-Party Payer Settlement Payable	290,000	400,000	500,000
Total Current Liabilities	16,102,983	17,309,166	17,796,961
Long Term Debt, net	1,113,763	1,164,499	1,236,831
Total Liabilities	17,216,746	18,473,665	19,033,792
Net Assets:			
Unrestricted	9,243,805	9,298,464	9,560,928
Temporarily Restricted	588,605	577,717	546,630
Total Net Assets	9,832,410	9,876,181	10,107,558
Total Liabilities and Net Assets	**$ 27,049,156**	**$ 28,349,846**	**$ 29,141,350**

City of Alameda Health Care District

Statements of Operations

October 31, 2010

$'s in thousands

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Patient Days	2,465	2,696	(231)	-8.6%	2,692	10,016	10,546	(530)	-5.0%	10,384
Discharges	199	264	(65)	-24.6%	301	841	1,012	(171)	-16.9%	1,064
ADC (Average Daily Census)	79.5	87.0	(7.45)	-8.6%	86.8	81	85.7	(4.31)	-5.0%	84.4
CMI (Case Mix Index)	-				1.2684	1.4062				1.3234
Revenues										
Gross Inpatient Revenues	$ 12,014	$ 14,737	$ (2,723)	-18.5%	$ 14,796	$ 53,629	$ 56,899	$ (3,270)	-5.7%	$ 57,563
Gross Outpatient Revenues	7,000	7,217	(216)	-3.0%	10,926	27,958	28,766	(807)	-2.8%	43,762
Total Gross Revenues	19,014	21,953	(2,939)	-13.4%	25,722	81,587	85,665	(4,078)	-4.8%	101,325
Contractual Deductions	13,266	15,861	2,595	16.4%	19,178	58,411	61,710	3,299	5.3%	75,735
Bad Debts	649	674	24	3.6%	645	2,523	2,614	91	3.5%	2,101
Charity and Other Adjustments	113	168	56	33.0%	24	609	654	44	6.8%	318
Net Patient Revenues	4,986	5,250	(264)	-5.0%	5,875	20,044	20,687	(643)	-3.1%	23,171
Net Patient Revenue %	26.2%	23.9%			22.8%	24.6%	24.1%			22.9%
Net Clinic Revenue	9	28	(19)	-68.1%	35	120	112	9	8.0%	44
Other Operating Revenue	10	14	(4)	-31.0%	22	37	55	(18)	-32.5%	291
Total Revenues	**5,005**	**5,292**	**(287)**	-5.4%	**5,932**	**20,202**	**20,854**	**(652)**	-3.1%	**23,506**
Expenses										
Salaries	2,867	2,871	4	0.1%	3,317	11,810	11,356	(454)	-4.0%	12,891
Registry	143	182	39	21.4%	167	628	703	75	10.7%	739
Benefits	850	875	24	2.8%	926	2,985	3,529	543	15.4%	3,667
Professional Fees	306	313	8	2.5%	216	1,232	1,254	22	1.8%	1,229
Supplies	692	710	18	2.5%	947	3,113	2,807	(306)	-10.9%	3,659
Purchased Services	366	392	26	6.6%	422	1,455	1,554	99	6.4%	1,628
Rents and Leases	65	70	5	6.6%	75	258	277	19	6.9%	280
Utilities and Telephone	63	73	10	13.6%	81	231	290	58	20.1%	294
Insurance	33	36	3	8.5%	44	128	145	17	11.6%	180
Depreciation and amortization	81	74	(7)	-10.1%	101	328	293	(34)	-11.7%	403
Other Opertaing Expenses	75	77	3	3.3%	94	321	327	6	1.9%	366
Total Expenses	**5,540**	**5,672**	**132**	2.3%	**6,389**	**22,489**	**22,535**	**46**	0.2%	**25,336**
Operating gain (loss)	**(535)**	**(380)**	**(155)**	-40.8%	**(457)**	**(2,287)**	**(1,680)**	**(607)**	36.1%	**(1,829)**
Non-Operating Income / (Expense)										
Parcel Taxes	478	477	1	0.2%	477	1,912	1,908	3	0.2%	1,908
Investment Income	1	-	1	0.0%	1	6	-	6	0.0%	7
Interest Expense	(10)	(14)	4	28.2%	(8)	(32)	(46)	14	-31.2%	(35)
Other Income / (Expense)	12	22	(10)	-46.4%	24	84	89	(5)	-5.9%	92
Net Non-Operating Income / (Expense)	**481**	**485**	**(5)**	**-1.0%**	**493**	**1,970**	**1,951**	**19**	**1.0%**	**1,972**
Excess of Revenues Over Expenses	**$ (55)**	**$ 105**	**$ (160)**	**-152.1%**	**$ 36**	**$ (317)**	**$ 271**	**$ (588)**	**-217.2%**	**$ 142**

City of Alameda Health Care District

Statements of Operations - Per Adjusted Patient Day

October 31, 2010

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Revenues										
Gross Inpatient Revenues	$ 3,079	$ 3,669	$ (590)	-16.1%	$ 3,162	$ 3,519	$ 3,584	$ (64)	-1.8%	$ 3,149
Gross Outpatient Revenues	1,794	1,797	(3)	-0.1%	2,335	1,835	1,812	23	1.3%	2,394
Total Gross Revenues	4,874	5,466	(592)	-10.8%	5,496	5,354	5,395	(41)	-0.8%	5,543
Contractual Deductions	3,400	3,949	549	13.9%	4,098	3,833	3,887	53	1.4%	4,143
Bad Debts	166	168	1	0.8%	138	166	165	(1)	-0.6%	115
Charity and Other Adjustments	29	42	13	31.0%	5	40	41	1	2.9%	17
Net Patient Revenues	1,278	1,307	(29)	-2.2%	1,255	1,315	1,303	12	1.0%	1,268
Net Patient Revenue %	26.2%	23.9%			22.8%	24.6%	24.1%			22.9%
Net Clinic Revenue	2	7	(5)	-67.1%	7	8	7	1	12.5%	2
Other Operating Revenue	2	3	(1)	-28.9%	5	2	3	(1)	-29.7%	16
Total Revenues	**1,283**	**1,318**	**(35)**	-2.6%	**1,268**	**1,326**	**1,314**	**12**	0.9%	**1,286**
Expenses										
Salaries	735	715	(20)	-2.8%	709	775	715	(60)	-8.4%	705
Registry	37	45	9	19.1%	36	41	44	3	7.0%	40
Benefits	218	218	(0)	-0.1%	16	196	222	26	11.9%	201
Professional Fees	78	78	(0)	-0.3%	46	81	79	(2)	-2.4%	67
Supplies	177	177	(1)	-0.3%	202	204	177	(28)	-15.6%	200
Purchased Services	94	98	4	3.9%	90	96	98	2	2.5%	89
Rents and Leases	17	17	1	3.9%	16	17	17	1	3.0%	15
Utilities and Telephone	16	18	2	11.0%	17	15	18	3	16.8%	16
Insurance	8	9	1	5.8%	9	8	9	1	7.9%	10
Depreciation and Amortization	21	18	(2)	-13.4%	22	22	18	(3)	-16.4%	22
Other Operating Expenses	19	19	0	0.5%	20	21	21	(0)	-2.2%	20
Total Expenses	**1,420**	**1,412**	**(8)**	-0.6%	**1,183**	**1,476**	**1,419**	**(57)**	-4.0%	**1,386**
Operating Gain / (Loss)	**(137)**	**(95)**	**(43)**	-44.9%	**84**	**(150)**	**(106)**	**(44)**	41.9%	**(100)**
Net Non-Operating Income / (Expense)	**123**	**121**	**2**	**2.0%**	**105**	**129**	**123**	**6**	**5.2%**	**108**
Excess of Revenues Over Expenses	**$ (14)**	**$ 26**	**$ (40)**	-153.6%	**$ 189**	**$ (21)**	**$ 17**	**$ (38)**	-219.0%	**$ 8**

City of Alameda Health Care District
Statement of Cash Flows
For the Four Months Ended October 31, 2010
$ in thousands

	Current Month	Year-to-Date
Cash flows from operating activities		
Net Income / (Loss)	$ (54,660)	$ (317,122)
Items not requiring the use of cash:		
Depreciation and amortization	81,057	$ 327,780
Changes in certain assets and liabilities:		
Patient accounts receivable, net	(297,925)	(541,874)
Other Receivables	(24,819)	(222,622)
Third-Party Payer Settlements Receivable	(133,215)	(302,860)
Inventories	4,047	312
Prepaids and Other	(2,895)	(234,047)
Accounts payable and accrued liabilities	311,695	670,569
Payroll Related Accruals	(915,973)	(132,474)
Employee Health Plan Accruals	(26,753)	(80,570)
Deferred Revenues	(477,847)	(1,913,128)
Cash provided by (used in) operating activities	(1,537,288)	(2,746,035)
Cash flows from investing activities		
(Increase) Decrease in Assets Limited As to Use	(10,888)	(41,975)
Additions to Property, Plant and Equipment	(95,229)	(510,838)
Other	1	(1)
Cash provided by (used in) investing activities	(106,116)	(552,815)
Cash flows from financing activities		
Net Change in Long-Term Debt	(38,041)	(151,443)
Net Change in Restricted Funds	10,888	41,975
Cash provided by (used in) financing and fundraising activities	(27,153)	(109,468)
Net increase (decrease) in cash and cash equivalents	(1,670,557)	(3,408,318)
Cash and cash equivalents at beginning of period	1,742,907	3,480,668
Cash and cash equivalents at end of period	$ 72,350	$ 72,350

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

DATE: November 22, 2010

TO: Finance and Management Committee of the Board of Directors

FROM: David A. Neapolitan, Chief Financial Officer

SUBJECT: Revised Time and Attendance Strategy

Recommendation:

After three years of working with McKesson and as a result of the inability of McKesson to deliver a time and attendance system that meets the requirements of Alameda Hospital the core team of the Time and Attendance Committee, comprised of Mary Bond, Executive Director of Nursing, Phyllis Weiss, Director of Human Resources and myself recommends that Alameda Hospital not continue with the implementation of the McKesson Time and Attendance System.

The core team also recommends that it conduct further review of other options for the automation of hours worked through an automated time and attendance system. The results of this review, including a cost benefit analysis will be brought back to the Finance and Management Committee along with management's recommendation on how to proceed with the replacement of this application. The goal is to find an application that will reduce the amount of time spent by hospital managers and staff summarizing and data entering the bi-weekly payroll information, improve the uniformity of interpretation of pay practices and improve the monitoring of staff productivity in the first quarter of 2011.

Background:

In August of 2006 hospital management entered into an agreement with McKesson to purchase its ANSOS Scheduling application and implementation services at a cost of approximately $162K. The agreement included the intention to purchase its then unreleased time and attendance system that was currently being developed with an intended release date of the fourth quarter of 2006. The ANSOS Scheduling application was successfully implemented and is still the primary application used by the nursing department for the scheduling of nursing staff coverage at Alameda Hospital as well as many other hospitals throughout the country.

In May 2007 management of the hospital then entered into an agreement with McKesson to be the first hospital to purchase the newly released *beta* version of their Time and Attendance System. The anticipated implementation time frame for this product was estimated to be six months under normal conditions. The cost of the application and related McKesson implementation services was $56K and was paid in advance of the

start of the implementation per the terms of the agreement. In addition to this cost there would be additional costs related to Alameda staff time necessary to develop and test the rules for the hospital pay practices, automated time clocks (10 clocks - $19K) and an additional server ($15K) that would be required to operate the time and attendance application.

Discussion:

Hospital management, after evaluating several options for a time and attendance system including KRONOS, entered into an agreement with McKesson on May 29, 2007, to purchase its still *beta* version of a time and attendance system. While the decision was primarily the result of a significantly lower application cost, management also felt that due to McKesson's intention to have the time and attendance system fully integrated with the ANSOS Scheduling application, it was decided that the McKesson application was the better application for the hospital.

In the second quarter of 2007 the implementation of the McKesson Time and Attendance system began with a focus to improve the uniformity of hospital pay practices and to take advantage of a system that would improve productivity management, provide better staffing forecasts and improved financial analysis and projections. A team consisting of staff from Human Resources, Nursing, Information Technology and Finance was established to lead the development of the time and attendance application.

One of the first tasks that were identified was to develop a detailed requirements document that described the complex pay practice rules for each of the five bargaining units as well as the rules for management and unrepresented staff. This important document was not completed by the Alameda team until July 2008 as a result of changes in management personnel that occurred in the Fall of 2007. From this document McKesson began the build of the Alameda system and in December of 2008 anticipated that a June 2009 "Go Live" was appropriate.

However in April 2009, McKesson had completed only approximately 80% of their internal testing and requested their first implementation delay to August of 2009. Then in May 2009, the McKesson team indicated that the August 2009 date would need to be further delayed due to an internal reorganization that had occurred at McKesson. As result, the "Go Live" date was moved to late October 2009.

During the testing of the application in September 2009, despite McKesson's assurance of good quality control procedures, Alameda staff identified significant differences between the delivered application build and current pay practices. At this point there were many uncertainties about the accuracy of the final requirements document, which McKesson was in control of since it was first delivered in July 2008, and the build that was developed from this document. As a result it was determined that Alameda staff would completely review this document to ensure that it was reflective of current pay practices at Alameda Hospital. In December of 2009 this review was completed and provided to McKesson.

After McKesson's review and another iteration of staffing changes, McKesson indicated that an April 2010 "Go Live" would be possible. However, in February 2010, McKesson again informed management that they had identified additional problems with their internal quality assurance process. They identified a need to modify the process for implementing the time and attendance system into groups of similar pay practices (PPM's) in order to more accurately develop the application and make it easier for future modifications to these groups. In addition to the development of test scripts for the rules in each PPM, McKesson decided that a Summary Requirements Document would also be provided as an aide during the testing process. As result, McKesson indicated that these PPMs would begin to be delivered in May 2010 with a goal of delivering the final combined application in July 2010.

In May 2010, the first PPM was delivered along with the Summary Requirements Document and testing of this group moved along very well. However, when the second set was delivered later in the month, it is identified that the test scripts appeared to be correct but Alameda staff found significant discrepancies in the Summary Requirements Document that required a significant amount of time to sort through during the testing process that again cause a significant delay to the completion of the project as well as significant concern about McKesson teams ability to understand the complexities of the project. In June 2010 the team decided that these documents must be thoroughly reviewed and corrected so that all documentation was in sync in order to ensure that the product can be completely tested and approved for "Go Live".

In September 2010 management was again informed of another change in the McKesson team which delayed the completion of the correction and update of the time and attendance documentation. McKesson staff attempted to get Alameda to accept a rushed implementation time frame of late October with no solid deployment plan that would assure that the application would work correctly. As a result, management asked McKesson to revaluate its proposal and to deliver a complete implementation plan that included parallel testing as well as a progressive roll-out across the organization versus the "Big Bang" approach which would be necessary under McKesson's latest implementation proposal.

As a result of the latest implementation delay and a continued concern about McKesson's ability to deliver this application, management requested an opportunity to talk with an organization that had successfully implemented both the McKesson ANSOS and Time and Attendance Systems in an integrated fashion as was intended at Alameda Hospital. As a result of this request McKesson provided us with an opportunity to discuss the implementation of these applications with the one facility that was still using the applications in an integrated fashion.

We discussed with Ms. Gitta Gilyan, Sr. Director, Patient Care Finance, at Cambridge Health System. The Cambridge Health System is a three hospital system with over 2,000 employees and fourteen bargaining units. Ms. Gilyan indicated that they too had chosen the McKesson products due to the significantly lower time and attendance cost and its

integration with the ANSOS Scheduling application. Some of the feedback that was provided by Ms. Gilyan included:

- McKesson Time and Attendance group has experienced significant staff turnover beginning approximately three years ago which has resulted in their not being able to provide the necessary number of experienced staff to support the implementation process.
- McKesson team does not understand payroll and continually confuses rules as the application coders are not versed in payroll practices as well as hospital requirements.
- Interfaces between the scheduling and time and attendance system take long periods of time to complete and require multiple iterations which result in excessive amounts of time required to finalize payroll processing. As result there is concern as to whether the interface between these systems will ever work well.
- Believes that the relationship between ANSOS and Time and Attendance is a good idea, it will be a burden to hospital departments that do not require the use of a scheduling system.
- McKesson continues to believe that the "Big Bang" approach is the best approach to rolling out a very complex application.

Based on these factors we believe that McKesson will not be able to deliver the quality product that has been expected from the beginning of this implementation and promised throughout the three years of effort that has been expended to implement this application. Therefore, management strongly believes that we must find an alternative solution to this much needed process automation which may include the identification of a different time and attendance module, the possibility of outsourcing components of the process through a payroll processor such as ADP or the hiring of clerical assistance to prepare and summarize the bi-weekly time cards of departments where that would be appropriate.

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

DATE: November 22, 2010

TO: Finance and Management Committee

FROM: David A. Neapolitan, Chief Financial Officer

SUBJECT: Informational Update - RAC

The Tax Relief and Health Care Act of 2006 made permanent the Medicare Recovery Audit Contractor (RAC) program to identify improper Medicare payments - both overpayments and underpayments-in all 50 states. RACs are paid on a contingency fee basis, receiving a percentage of the improper overpayments and underpayments they collect from providers.

RACs may review the provider claims with a payment date on or after October 1, 2007 for the following types of services: hospital inpatient and outpatient, skilled nursing facility, physician, ambulance and laboratory, as well as durable medical equipment. The RACs use proprietary software programs to identify potential payment errors in such areas as duplicate payments, fiscal intermediaries' mistakes, medical necessity and coding. RACs also conduct medical record reviews of selected accounts.

From March 2005-March 2008 the RAC program operated as a demonstration program and in July 2008, the Centers for Medicare & Medicaid Services (CMS) reported that the RACs had succeeded in correcting more than $1.03 billion in Medicare improper payments. Approximately 96 percent ($992.7 million) of the improper payments were overpayments collected from providers, while the remaining 4 percent ($37.8 million) were underpayments repaid to providers.

As required by *The Tax Relief and Health Care Act of 2006*, the permanent RAC program is now implemented in all 50 states. HealthDataInsights (HDI) was awarded Region D, which consists of 17 states and 3 territories and includes California.

At the completion of the demonstration project Alameda Hospital established a RAC Task Force to monitor the Federal Governments implementation of the permanent RAC program and in the summer of 2009 partnered with the Advisory Board to utilize its Revenue Integrity Compass (RIC) tool to monitor and evaluate the hospitals performance under the RAC program.

Since January 1, 2010 Alameda Hospital has received potential incorrect payment notices from HDI on sixty-six (66) patient accounts. The table on the following page summarizes the categories of claims that have been reviewed by HDI through November 12, 2010:

		Closed Accounts	
	Total	No. of Accts.	$ Impact
3 Day Rule	1	1	(29.28)
Discharge Status	9	9	5,091.63
DRG / Medical Necessity	38	21	(16,198.60)
Medically Unlikely Edit	18	18	(1,408.53)
	66	49	(12,544.78)

Definitions:

3 Day Rule	Outpatient services incurred within 3 days of admission must be included as part of the inpatient stay if same diagnosis.
Discharge Status	Patient received services from another provider and DRG payment was not appropriately shared in accordance with Post Acute Transfer Rules.
DRG / Medical Necessity	Review of appropriateness of assigned DRG and / or review for medical necessity of services provided.
Medically Unlikely Edits	Patient received combination of services that are not likely to be appropriate, i.e., male patient receiving a hysterectomy.

The DRG / Medical Necessity category is the most complex of the four categories that have been reviewed by HDI to date as these accounts require the submission of a copy of the entire medical record for each selected account. Of the thirty-eight (38) accounts selected in this category HDI has completed the review of twenty-one of these accounts and identified net overpayments of $16,198.60 on six accounts. These twenty-one accounts had discharge dates ranging from December 2007 through May 2010. The table below summarizes the Major Diagnostic Categories (MDC's) that have been reviewed to date:

		Closed Accts.			Open Accts.	
Major Diagnostic Category	Total	No. of Closed Accts.	No. of Accts. With Adj.	$ Impact	No. of Accts.	Add'l Medical Nec Rev
Cardiovascular Disease	10	6	-	-	4	3
Endocrine, Nutrional and Metabolic Disease	4	3	1	139.37	1	1
Gastro Intestinal Disease	4	1	-	-	3	1
Joint Procedures	2	2	1	(2,711.12)	-	-
Kidney and Urinary Tract Disease	8	6	3	(8,222.60)	2	1
Nervous System Disease	5	-	-	-	5	2
Respiratory Disease	4	2	-	-	2	-
Septicemia	1	1	1	(5,404.25)	-	-
Totals	38	21	6	(16,198.60)	17	8

As a result of the audits conducted to date in this category it is apparent that the RAC auditors are looking very closely at the entire body of documentation contained in the patient medical record to ensure that the DRG and related diagnosis code assignments are appropriate based upon the physicians documentation of care throughout the entire stay and not simply based upon a discharge summary document. Management has reviewed the findings of the RAC for these six accounts and agrees with all but one of the accounts which has been appealed and is awaiting a response from HDI. While we feel that the documentation generally supports the coding that was assigned we feel that because documentation in the chart could have been better there is a likelihood that we will not prevail in this appeal.

Additionally, we have recently received the initial notification that HDI will be reviewing eight accounts identified in the "Additional Medical Necessity Review" column of the table above. As we have just been notified of this additional level of review on these accounts the outcome of this additional level of review is uncertain at this time and will be reported in a future report.

While Alameda has only had a total of $12K taken back through the permanent RAC program during the first six months of its operations the process is still in its very early stages and will continue to expand in the upcoming months and years. However, management feels that going forward as we continue to improve our clinical documentation and with the implementation of an electronic health record that can assist in the completion and monitoring of patient care documentation the incidence of take backs through programs such as the RAC can be minimized.

Management will continue to provide periodic updates on the RAC program as the program progresses.

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

DATE: November 22, 2010

TO: Finance and Management Committee

FROM: David Neapolitan, Chief Financial Officer

SUBJECT: Informational Update
- FY 2010 / 2011 Inter-Governmental Transfer
- Hospital Provider Fee

Intergovernmental Transfer (IGT)

On September 16, 2010 management submitted a request to participate in the 2010/2011 IGT program (copy attached) as requested in the California Medical Assistance Commission's notice that was distributed in August 2010. Our application to participate included a cover letter describing the hospitals financial needs and requested an IGT of $3 million.

The latest from CMAC is that CMAC and the Department of Health Care Services (DHCS) are still trying to work through issues related to the amount of Upper Payment Limit (UPL) that will be available for the 2010 / 2011 IGT Program through the Selective Provider Contracting Program (SPCP). They remain hopeful that they will be able to clarify the issues soon so that they can move forward with negotiation with interested hospital. They went on to further indicate that it is unlikely, that payments would be processed in the 2010 calendar year.

If the State is unable to finalize this until after the close of the calendar year and depending upon the final amount of funds that Alameda Hospital will be able to transfer through the IGT program there may be an unfavorable impact on our fiscal year 2011 financial results. Included in the 2011 fiscal year budget was a net IGT of $2.2 million which was based upon the fiscal year 2010 approved IGT amount at the current 62.28% matching rate. However, beginning January 1, 2011 the matching rate is currently legislated to decrease to a 57% match and then on April 1, 2011 to be further reduced to a 56% match before returning to the normal 50 / 50 matching rate on July 1, 2011.

If the State cannot iron out its issues before the first quarter of 2011 and Alameda Hospital is allowed to participate with an IGT equal to only the budgeted amount there will be an unfavorable variance of approximately $450K for this critical component of our Medi-Cal contract.

As more information is available additional updates will be provided.

Hospital Provider Fee

In 2009, California lawmakers created a hospital fee program. The law, AB 1383 (*Jones, D-Sacramento*), *imposes a fee on hospitals for the specific purpose of generating matching monies which, in turn, will be used to draw down additional federal Medicaid funds. These new funds will be used to increase Medi-Cal payments to hospitals and provide funding for children's health care coverage.*

- In 2009, CHA along with the California Children's Hospital Association (CCHA) and the Daughters of Charity Health System jointly sponsored AB 1383, which authorized the state to assess a fee on California hospitals. The fee will be used by the state to generate new matching federal funds for the Medi-Cal program without tapping into the state General Fund.
- The fee, which covers a 21-month timeframe *(April 1, 2009, through December 31, 2010)*, is based on a three-tiered assessment on patient days. The program will provide more than $2.6 billion in net supplemental Medi-Cal payments to California hospitals and will provide the state with up to $1 billion in new funding, including $560 million to be used for health care coverage for children.
- California's Medi-Cal program ranks 50th in the nation when it comes to funding health care for Medicaid patients. In 2009, California lost $4.6 billion in actual costs for treating patients enrolled in the Medi-Cal program. The supplemental payments resulting from the hospital fee will help narrow, but not eliminate, this funding shortfall.
- The 21-month timeframe for the hospital fee coincides with a temporary rise in the federal matching rate for the Medicaid program that was enacted by Congress as part of last year's federal economic stimulus package. California's Federal Medicaid Assistance Percentage (FMAP) was raised to a 62.38 percent rate *(up from the normal 50-50 matching rate)* through December 31, 2010.
- Public hospitals are exempt from paying the fee (in order to meet federal requirements), but they will receive increased funding generated by the program.
- Beginning October 1, 2010, the Department of Health Care Services (DHCS) began implementation of the hospital fee program by invoicing hospitals for the fee payments with distributions being made in four installments beginning on October 25th, November 15th, December 6th and December 27th of 2010.

As of November 15th there has been 95% participation in the program among all California hospitals and we have received the first two installments under the program totaling approximately $160K.

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

DATE: November 22, 2010

TO: Finance and Management Committee

FROM: David A. Neapolitan, Chief Financial Officer

SUBJECT: Informational Update – Managed Care Contracting

In the third quarter of fiscal year 2008 Alameda Hospital management began the process of seeking regular and focused contract negotiations with all of its managed care payor contracts in an effort to increase the reimbursement rates for these agreements where appropriate. These payors include Anthem Blue Cross, Blue Shield, United Healthcare, health Net, Aetna, CIGNA and many other multi-employer based plans such as Interplan.

Since 2008 the contracting team has been successful in achieving an increase to the overall average per diem rates for inpatient cases of almost 30%. This increase brings the average inpatient per diem reimbursement to $3,163 per patient day. On the outpatient book of business our rate per visit has increased by slightly over 50% to an average of $767 per visit during this same time frame. The two tables below summarize the performance of our managed care contracts over the last two fiscal years for inpatient and outpatient services using fiscal year 2008 as the base line.

	FY 2008	FY 2009	FY 2010
Inpatient Services			
Patient Days	1,612	1,611	1,266
Average Reimbursement per Day	$2,440.12	$3,014.24	$3,163.16
Percent Reimbursement	23.8%	27.1%	27.1%
Payor Mix (% of Charges)			
Blue Cross	35.3%	39.2%	31.8%
Blue Shield	20.0%	20.8%	27.5%
United Healthcare	12.1%	13.6%	18.0%
Health Net	9.7%	14.1%	9.7%
Aetna	3.4%	5.8%	5.6%
CIGNA	3.4%	4.4%	5.9%
All Others	16.1%	2.1%	1.5%
Total	100.0%	100.0%	100.0%

	FY 2008	FY 2009	FY 2010
Outpatient Services			
Visits	11,096	10,602	9,757
Average Reimbursement per Visit	$ 506.90	$ 723.85	$ 766.99
Percent Reimbursement	36.0%	36.5%	37.4%
Payor Mix (% of Charges)			
Blue Cross	41.6%	44.1%	44.2%
Blue Shield	11.6%	16.5%	20.6%
United Healthcare	14.5%	12.2%	11.7%
Health Net	7.5%	7.1%	8.4%
Aetna	8.6%	5.9%	6.9%
CIGNA	6.9%	10.2%	5.0%
All Others	9.3%	4.0%	3.2%
Total	100.0%	100.0%	100.0%

Contracts have been evaluated to ensure that appropriate carve-outs for high cost items such as chemo therapy drugs and implantable devices are specifically identified which require additional reimbursement above and beyond the base charge for cost of the facility and related staff costs to cover the cost of these items which are generally a significant portion of the cost to provide care to the patient.

In order to assist with the evaluation and negotiation process management implemented the Alliance Decision Support tool beginning in March of 2009. This decision support tool allows contract management staff to evaluate past contract performance and to model the future impact of proposed contract terms during the negotiation process to ensure that proposed terms are in the best interest of the hospital assuming similar utilization patterns.

In addition to the evaluation of contract terms during the negotiation process this tool has also been used to validate that payments received on managed care claims are correctly processed in accordance with the terms of those agreements. Since implementing this system contract management staff has recovered $146,000 in underpayments on our managed care contracts and has identified an additional $156,000 in amounts that are currently under review.

While significant improvements have been made over the last two years there still appears to remain opportunities for further improvement in our managed care contracting. The basis for this assumption is based upon the review of our self insured medical insurance plan payments where reimbursement to area hospitals has been as high as 80% of billed charges. In addition, we have review recent Office of Statewide Health

Planning and Development (OSHPD) Annual Financial Disclosure Reports our competitor hospitals on a routine basis to determine what the market may bare when we enter into contract negotiations. The table on the following page shows the combined inpatient and outpatient percentage reimbursements reported by our competitors in the most current available Annual Disclosure Report:

Facility	12 Month Period Ended	Reported Managed Care Net Revenue %	Combined Net Revenue %	% Medi-Cal Untilization	2008 Reported CMI
Alta Bates - Summit	12/31/2009	44.8%	27.3%	16.9%	1.79
Eden Medical Center	12/31/2009	49.3%	25.5%	15.3%	1.24
Doctors Hospital - San Pablo	12/31/2009	22.3%	18.0%	22.9%	1.55
St. Rose	9/30/2009	27.7%	19.7%	34.7%	1.15
Washington Hospital	6/30/2009	49.6%	23.1%	17.5%	1.26

From this table it is apparent that the larger facilities in the area have been able to garner significantly higher reimbursement rates from managed care payors than the smaller community based hospitals. As we begin the process of our second cycle of contract negotiations this year, we will continue to emphasize the quality and value of services provided at Alameda Hospital while maximizing our reimbursement rates and educating payors about the quality and level of services available.