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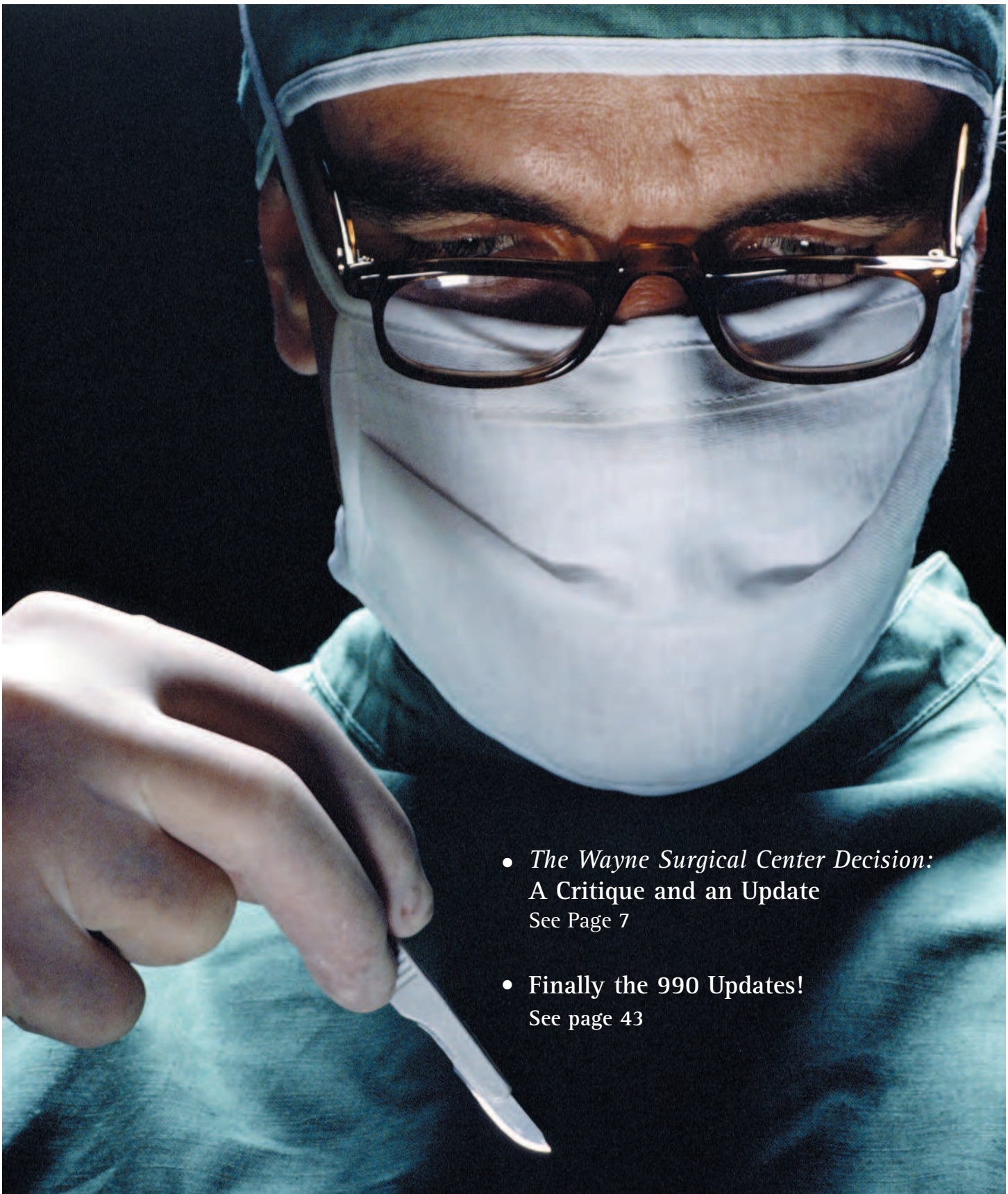

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DEADLINE FOR SUBMISSION OF MATERIAL

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OBJECTIVE

Our objective is to provide members with information regarding Chapter and national activities, with current and useful news of both national and local significance to healthcare financial professionals and as to serve as a forum for the exchange of ideas and information.

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The President's View . . .

Cheryl H. Cohen

HFMA Members:

The Holidays are now behind us. Looking forward, we have the darkest and coldest months ahead. However, it is the beginning of a New Year, where daylight starts getting longer, and warm weather will arrive soon.

So, what kind of challenges within the healthcare marketplace will we encounter this year? As you read through this list, think about how you can 'Make a Difference' for one or more of these events.

The release of the report written by the NJ Commission on Rationalizing Health Care Resources.

Our first big snowstorm.

Concern regarding the financial viability of our healthcare organizations.

The rebasing of Medicaid, with no new money being offered.

Joe Dobosh assuming the role of President of the New Jersey Chapter of HFMA in June.

No relief from the competition of ambulatory care centers.

Relief from the immense pressure we encounter daily.

The impact of MS DRG's on our healthcare organizations.

Vast improvement in the quality of health care services.

No additional relief for charity care funding.

The presidential debates and the upcoming primaries, specifically regarding healthcare issues.

Identified are some of the biggest challenges in the coming year. I ask each of you to get involved to 'Make a Difference'. It could mean joining HFMA forums/committees to discuss these challenges and make recommendations for change. It could mean buying a snow blower, clearing your driveway, and then your neighbors. It may include attending one or two of the social functions that HFMA offers to our members. It may mean getting involved politically and voting. Individually, each item seems like a tremendous task to undertake. Collectively, with all the great minds we have in HFMA, we can 'Make a Difference' through our creativity.

I wish everyone a Happy, Healthy New Year!

Respectfully submitted,

Cheryl H. Cohen
President, New Jersey Chapter of the Healthcare Financial Management Association

From the Editor . . .

Elizabeth G. Litten

Dear Readers:

The publications committee greeted the New Year with new ideas and renewed enthusiasm! A half dozen or so New Jersey HFMA chapter members braved below-freezing temperatures this morning to attend the first 2008 publications committee meeting, and another half dozen participated by conference call. As is typical at our monthly meetings (held the first Thursday of each month at 9:15 a.m., for those of you interested in joining us), we ploughed through an agenda covering the content and appearance of upcoming issues of the *FOCUS*, laughed a lot, and came up with an ambitious list of ideas for improving our communications with you, our members.

Some of our enthusiasm emanated, perhaps, from our committee's new role. Not only will we be working to publish the newsmagazine on a bi-monthly basis, but we will also be overseeing the Chapter's website communications. Here are just a couple of our goals and ideas for 2008 and beyond:

- *Improve the interactivity of the Chapter website and FOCUS magazine*

Many of you already use the website to check "Job Bank" ads, but we would like to develop new, user-friendly ways in which members and others interested in New Jersey health care finance issues can access the most recent, relevant information (including information related to topics covered in this magazine), and can communicate with each other. (See last bullet, below.)

- *Make it easier to find and use the Chapter website*

Is it www.njhfma.org, or www.hfmanj.org? If you know the answer (without checking the heading on the previous page), you're ahead of me. (It's the latter, by the way.) I can never remember, particularly since the email address for Laura Hess, our Chapter Administrator, is njhfma@aol.com. We plan to make sure the website is accessible via either address, and we hope to include links to the website in our other Chapter email communications, including the recently-launched "Pulse" emails.

- *Create an on-line "store" for meeting registrations and other Chapter purchases, an on-line bulletin board, blogs hosted by lead-article FOCUS authors, links to archived issues of FOCUS, and/or a link to an interactive member network site*

You will hear more about these ideas as we work to implement some of them in the near future; in the meantime, please contact me directly (elitten@foxrothschild.com) with your comments, questions, or suggestions.

Regards,

Elizabeth G. Litten
Editor

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The Wayne Surgical Center Decision: A Critique and An Update

by John Zen Jackson, Esq. and Elizabeth Litten, Esq.

On November 20, 2007, a Bergen County Superior Court Judge ruled that it was a violation of a 1991 New Jersey law for physicians to send their patients to an ambulatory surgery center ("ASC") owned by the physicians and at which the physicians personally performed the procedures. *Garcia v. Health Net of New Jersey, Inc. v. Wayne Surgical Center,* Docket No. C-37-06. The disruptive potential of this case is self-evident. There are many ASCs in New Jersey which are wholly physician-owned or in which physicians have ownership interests. The consequences of the ruling, however, may be mitigated by emergency action taken by the New Jersey State Board of Medical Examiners ("Board" or "BME") and discussed in this article.

The physicians involved in this case sent patients needing surgery from their medical practice office (which was "in network" and had contracted with Health Net of New Jersey, Inc. to provide services at agreed-upon rates) to Wayne Surgical Center (which was "out of network" or "OON"). The sending physicians then performed the surgical procedures at Wayne Surgical Center and Wayne Surgical Center billed Health Net for facility fee charges associated with the surgery at OON rates that were higher than those that would have been billed for in-network services.

The Court concluded that referrals by the physicians to the ASC in which they held ownership interests violated what is commonly referred to as the "Codey" law. Notwithstanding this violation, however, the Court found that the payer, Health Net, had no private cause of action against the physicians or the ASC because the Codey Act does not provide for a private cause of action. Furthermore, the Court held that there was no recognizable claim under the New Jersey Insurance Fraud Prevention Act ("IFPA"). Health Net had argued that the Codey violation "strips the Center of its entitlement to reimbursement. And if the Center was not entitled to reimbursement, it was fraudulent to seek reimbursement." The Court rejected this contention because the record before it established that there was long-standing and widespread acceptance in the health care industry that such referrals were proper. Accordingly, there was insufficient evidence to prove that the physicians knew they were committing a violation of the IFPA when they sought payment for the referred services.

The Codey Act: New Jersey's Version of the Federal "Stark" Referral Prohibition

The principal issue in the case emerges from legislation enacted in New Jersey in 1991 and codified at *N.J.S.A.* 45:9-22.4 *et seq.,* commonly known as the Codey Act. The purpose of the legislation was to regulate so-called self-referrals by health care practitioners to diagnostic and treatment facilities in which they had a financial interest. As noted in *Allstate Ins. Co. v. Greenberg,* 376 *N.J. Super.* 623, 634 (Law Div. 2004), "the Legislature was concerned with eliminating the financial incentive to practitioners to refer patients to entities in which they have any financial interest. The Legislature's concern clearly was centered around the belief that practitioners with financial interests in entities are more likely to base their referrals on financial motives instead of sound medical decision-making."

The Codey Act provides, in part, "a practitioner shall not refer a patient ... to a health care service in which the practitioner … has a significant beneficial interest." *N.J.S.A.* 45:9-22.5. The term "health care service" includes ambulatory surgery, and "significant beneficial interest" is defined as "any financial interest." *N.J.S.A.* 45:9-22.4. The referral prohibition thus encompasses referrals to a facility providing ambulatory surgery services in which a referring practitioner has an ownership interest. The Codey Act also includes two exceptions to the referral prohibition: the prohibition does not apply to either "a health care service that is provided at the practitioner's medical office and for which the patient is billed directly by the practitioner," or to "radiation therapy pursuant to an oncological protocol, lithotripsy, and renal dialysis." *N.J.S.A.* 45:9-22.4(c)(1). Moreover, the prohibition on referrals does not apply if the physician held the significant beneficial interest before July 1991, provided that a disclosure of this interest is made to the patient. Since the Wayne Surgical Center was only established in 1999, that exemption had no applicability.

Judge Contillo found that the language of the Codey Act "is plain and simple, and can yield no other conclusion but that the defendant-doctors' referrals of their private patients to the ambulatory surgical center, in which each of them has a significant beneficial interest, runs afoul of the Codey Act ban on such self-referrals."

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The "Practitioner's Medical Office" Exception to the Codey Act

Judge Contillo distinguished the facts involving Wayne Surgical Center from those set forth in a widely relied upon advisory letter from the BME from 1997. In the 1997 letter, the Board determined that referral of patients under the facts given did not violate the Codey Act because the ASC service "was so integral to the practice of the surgeon that it may be perceived as an extension of his/her medical office practice."

Notably, neither the Codey Act nor the Board's regulations specifically define the phrase "medical office" as it relates to the self-referral prohibition; however, this phrase has been the subject of regulatory interpretation not fully analyzed in the *Wayne Surgical* decision.

In 1994, the BME issued the first advisory letter regarding the Codey Act, stating that a physician surgeon could treat his own patient at a surgical suite owned by a separate professional association in which the surgeon held an ownership interest without violating the Codey Act. The facts underlying that inquiry to the BME involved a practice entity comprised of physician owners who also conducted their own separate, distinct medical practice out of different locations, but who each conducted surgery (on his or her own patients) at the single operating room surgical office they owned together. In its response to this inquiry, the BME focused on the fact that the physician sending the patient to the surgical office location was also personally performing the surgery services, and, thus, treating his or her own patient. The BME's 1994 advisory letter contains no mention of "referrals", other than to say that the arrangement did not violate the self-referral prohibition.

In this 1994 letter, the BME also stated that physicians, as owners of a Medicare-certified ASC, could charge a facility fee pursuant to BME regulations set forth at N.J.A.C. 13:35-6.17(h)(5). The 1994 letter states:

> I have been requested to inform you that physicians **may treat their own patients** in a Medicare-approved single room operating room owned and operated by a professional association owned by the same physicians. Such a scenario represents a physician treating his own patient at a surgical suite and specifically allows for the charging of a facility fee. **The Board does not believe that this is in violation of the self-referral prohibition.** [(Emphasis added.)]

OIG's Exemption for Physician "Own Office" Services

The BME's 1994 and 1997 conclusions that the physicians involved were treating their own patients in their own surgical suites, and not violating the self-referral prohibition of the Codey Act, was consistent with the approach taken in 1993 by the Office of Inspector General ("OIG") of the Department of Health and Human Services ("HHS"), the agency responsible for enforcing the federal anti-kickback statute, when it proposed a safe harbor for ASCs. This initial proposed safe harbor encompassed (and thus permitted payments related to) ASCs owned entirely by surgeons who performed procedures on their own patients at the ASC.

In addition, the federal Stark regulations have consistently contained an exemption from the referral prohibition when the services involved in the "referral" are personally provided by the physician. *See* 42 *C.F.R.* §411.355(a)(1). Indeed, the term "referral" is defined in the federal regulations as "not including any designated health service personally performed or provided by the referring physician." 42 *C.F.R.* §411.351.

Thus, federal regulators have accepted the basic rationale that when a surgeon performs surgery **on his own patient,** whether in his own single room operating suite or at a facility having several operating rooms owned by a number of surgeons, and **directly bills the patient for his professional fee,** there is no referral.

In 1999, with the adoption of the ASC safe harbor rule, the federal regulators confirmed their position that both the professional fee and the profit distribution to the physician owners deserved protection from prosecution under the anti-kickback statute, provided the physician's return on equity was not tied to the volume or value of surgery performed on the physician's patients at the ASC.

Wayne Surgical Center Not the Surgeons' Own "Medical Office"

In the *Wayne Surgical Center* decision, Judge Contillo found that, notwithstanding the 1997 BME advisory letter and the Codey Act exception for services provided "at the practitioner's medical office," the facts involved in the Wayne Surgical Center scenario supported his conclusion that the Codey Act had been violated:

> Obviously, the ambulatory surgical center here at issue is not the individual practitioner's medical office. It is a distinct facility, at a different location from the individual doctors' variously located medical offices. The support staff at the Center – the clinical staff, the nurses, the medical assistants and technicians – are not employees of the individual doctor (he does not bring his people, in tow, for each procedure) but rather are employed by a distinct, legal entity, Wayne Surgical Center, LLC. The Center is not the medical office of any physician, and therefore, it cannot be plausibly contended that surgical procedures performed at the Center are being performed at the doctor's office. Plainly they are not. They are being performed at the Center, which is not the doctor's

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> office. Simply calling the Center the doctor's office does not advance the analysis and, instead, eviscerates the plain language of the Codey Act (*N.J.S.A.* 45:9-22.5) as well as Board regulations (*N.J.S.A.* [sic] 13:35-6.17), both of which bar self-referrals to ambulatory surgery centers.

Judge Contillo suggested that, had the facts been different, he would have reached a different conclusion:

> If the doctor performed the "health care service" (*e.g.,* the surgical procedure) at her own medical office, and billed the patient directly for it, that arrangement would not violate the Codey Act ban on self-referrals because that would satisfy the statutory exception afforded to doctors who perform such procedures and bill the client directly for it. *N.J.S.A.* 45:9-22.5(c)(1). There is no "referral" in such a process. That limited exception is simply inapplicable to what the uncontroverted record establishes in the case at hand.

Hospital-Physician Joint Ventures – Exempt from the Codey Act?

Judge Contillo also found that the arrangement that was the subject of the 1997 advisory letter involved a hospital-physician joint venture, and that this "hospital affiliation was an important component" of the BME's reasoning "because that arrangement `appears to protect' the professional judgment of the doctors from being `impacted by the business decisions of the hospital'." Judge Contillo does not specifically detail how this "hospital-physician nexus," which was "not present" in the facts involving Wayne Surgical Center, protects the physicians' professional judgment from being impacted by the hospital's business decisions, or why the absence of this nexus would endanger or undermine the physicians' professional judgment.

More significantly, though, Judge Contillo's discussion of the hospital-physician joint venture aspect of the 1997 arrangement does not provide guidance as to whether he would have concluded there was no Codey Act violation if Wayne Surgical Center were partly owned by a hospital. The Judge's ensuing discussion of the facility fee revenue received by the investing physicians in the Wayne Surgical Center, which exceeded the "de minimus" facility fee revenue received by the investing physicians in the 1997 BME letter's hospital-physician joint venture scenario, suggests the view that physicians are less likely to let their professional judgment be influenced by profit-making motives when facility fee revenue is de minimus. However, Judge Contillo does not explain why or how the source of physician-investor revenue (whether related to professional services or facility fees) from an ASC relates to the plain terms of the Codey Act.

Neither the Codey Act nor implementing BME regulations define the term "practitioner's medical office." Likewise, neither describes how (or whether) physician-investors' receipt of facility fee revenue relates to this term. In fact, one could argue that where physicians receive a smaller percentage of facility fee revenue (such as in the hospital-physician joint venture scenario in 1997), the ASC facility appears less like the practitioner's own "medical office," and more like a separately-licensed entity in which the practitioner performs surgery services.

When State and Federal Laws Conflict

The relationship of the Codey Act and the federal Stark Law must also be examined. The apparent effect of Judge Contillo's decision is the prohibition of a surgeon's treatment of a Medicare-eligible patient at an ASC in which the surgeon has an ownership interest. Such a result, however, is directly contrary to federal law, which permits the surgeon to receive payment from Medicare for these services. This raises the issue of whether the Codey Act (as interpreted by Judge Contillo) is, or should be, preempted by federal provisions.

Under the Supremacy Clause in the Constitution, federal law completely preempts state law if it encroaches on the administration of federal law in any way. *Louisiana Pub. Serv. Comm'n v. F.C.C.,* 476 *U.S.* 355, 368-369 (1986); *Rievley v. Blue Cross & Blue Shield of Tennessee,* 69 *F. Supp.* 2d 1028, 1032 (E.D. Tenn. 1999). A federal statute's preemptive effect can be derived from Congress' clearly expressed intent to preempt state law, but preemption of state laws may also be found to be implied in several circumstances. The Supremacy Clause applies not only to Federal statutes, but also to rules and regulations adopted by Federal agencies.

Preemption of state law must be analyzed on a law-by-law basis. If it is impossible to comply with both the federal statute and the state or local law, the federal statute must be followed. However, if a federal law sets a minimum standard while the state's law is stricter, state law is not preempted. Preemption would only occur if the federal and state laws were mutually exclusive. Additionally, if state law impedes the achievement of a federal objective (such as when a state or local law interferes with a goal or objective Congress was trying to attain), state law is preempted. Thus, the purpose of each law must be determined and compared to the other. If both laws are trying to achieve the same goal, federal law will preempt the state or local regulation.

A state law that conflicts with federal law is "without effect." *Cipollone v. Liggett Group,* 505 *U.S.* 504, 516 (1992). Thus, if the state law would render illegal that which federal Medicare law allows, there is a conflict in the provisions which would preclude enforcement of the state

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law. Likewise, there is a conflict where complying with the state law will lead to inconsistency among the Medicare and Medicaid programs from state to state. Uniform application is needed to insure that the Medicare and Medicaid programs achieve their intended purpose. In *Fischer v. United States,* 529 *U.S.* 667, 680 (2000), the United States Supreme Court described the purposes of the Medicare program as follows:

> Medicare is designed to the end that the Government receives not only reciprocal value from isolated transactions but also long-term advantages from the existence of a sound and effective health care system for the elderly and disabled. The Government enacted specific statutes and regulations to secure its own interests in promoting the well being and advantage of the health care provider, in addition to the patient who receives care.

The Medicaid program likewise serves the interests of the patient, the provider, and the government. The Medicaid program was described by the United States Supreme Court in *Wilder v. Virginia Hosp. Ass's,* 496 *U.S.* 498, 502 (1990) as follows:

> Medicaid is a cooperative federal-state program through which the Federal Government provides financial assistance to States so that they may furnish medical care to needy individuals. 42 *U.S.C.* § 1396. Although participation in the program is voluntary, participating States must comply with certain requirements imposed by the Medicaid Act (Act) and regulations promulgated by the Secretary of Health and Human Services (Secretary). To qualify for federal assistance, a State must submit to the Secretary and have approved a "plan for medical assistance" 42 *U.S.C.* § 1396a(a), that contains a comprehensive statement describing the nature and scope of the State's Medicaid program.

Accordingly, while participation in the Medicaid program is voluntary, a participating state must comply with federal law in order to receive Federal funds. *See Public Health Trust v. Dade County Sch. Bd.,* 693 *So. 2d* 562, 566 (Fla. 3d DCA 1996) (recognizing that Florida must comply with Federal Medicaid statutes and regulations); *Antrican v. Odom,* 290 *F. 3d* 178, 187 (4th Cir. 2002) (recognizing that when North Carolina chose to participate in the Medicaid program they were required to follow federal Medicaid requirements).

A State legislature cannot ignore federal law and pass legislation that prevents payment of claims for which the Federal medical programs expressly provide coverage and payment. In *Geier v. American Honda Motor Co.,* 529 *U.S.* 861, 873 (2000), the Supreme Court confirmed that implied conflict preemption occurs when the state law is:

> [a]n obstacle to the accomplishment and execution of the full purposes and objectives of Congress–whether that 'obstacle' goes by the name of conflicting; contrary to; ... repugnance; difference; irreconcilability; inconsistency; violation; curtailment; … indifference, or the like.

Where federal law expressly permits surgeons' referrals to ambulatory surgery centers for services performed by the surgeons themselves, a state law prohibiting these very referrals conflicts with the federal law and would therefore be preempted as "an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." *Gade, v. National Solid Waste Management Ass'r,* 505 *U.S.* 88, 98 (1992).

A strikingly similar fact pattern to that arising from Judge Contillo's interpretation of the Codey Act was addressed by the Florida Supreme Court in *State v. Harden,* 938 *So.2d* 480 (Fla. 2006), *cert. denied,* 127 *S.Ct.* 2097 (2007). In *Harden,* a dentist was prosecuted under the anti-kickback portion of Florida's Medicaid Provider Fraud Statute, section 409.920(2)(e), for paying drivers a commission for solicitation and transportation of Medicaid-eligible children to dental facilities for treatment. The Florida Supreme Court ruled that the anti-kickback portion of Florida's Medicaid Provider Fraud Statute was preempted by the federal anti-kickback statute, 42 *U.S.C.* § 1320a-76(a), which applies to both the Medicare and Medicaid programs, because the federal statute contains safe harbor provisions that exclude certain types of payments from being considered "illegal remuneration." Specifically, with regard to the safe harbors present in the federal law, but not in Florida law, the Court found that "Florida's anti-kickback statute criminalizes conduct that the federal law specifically intended to be lawful and shielded from prosecution." As a result, the Court held that "the Florida anti-kickback statute is preempted because it presents an obstacle to the accomplishments of the purposes of the federal law."

Similarly, the Codey Act, as interpreted in *Wayne Surgical* and lacking the exceptions found in federal Stark self-referral and anti-kickback legislation, penalizes activity that is protected under Stark as well as the anti-kickback safe harbors and thus stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress. As in *Harden,* the State statute at issue here (if construed in a manner consistent with Judge Contillo's decision) seeks to prohibit activity that federal law specifically permits.

What Happens Next?

In the short run, it is foreseeable that

insurance carriers may now try to argue that the *Wayne Surgical* decision has put the industry on notice that referring patients to physician-owned ASCs violates the Codey Act, and that the submission of any subsequent claims by the ASCs for services provided to patients referred by a physician-owner should be considered illegal and fraudulent. Moreover, even though the Court held that there is no private cause of action under the Codey Act, insurance carriers could withhold future payments for services to physician-owned ASCs. The insurance carriers could argue that the illegality created by the physician ownership in the ASC causes the insurance claims to be invalid claims, and thus, providers would not be entitled to payment.

Since this decision is only a trial level decision, its immediate impact is limited to the parties in the case. However, it raises a number of issues and concerns for ASCs throughout New Jersey. Some, but not all, of those concerns have been addressed by action taken by the Board of Medical Examiners at its January 9, 2008 meeting.

After its regularly scheduled December 12, 2007 Board meeting, the BME issued an official statement ("Statement") in which it pointed out several facts particular to the Wayne scenario that may be used by an ASC to distinguish and (perhaps) insulate itself from allegations of illegality. The Statement noted that the Wayne case involved (i) an ASC at a location that was different from the location of the surgeons' medical offices; (ii) ASC personnel who were not controlled by the surgeons; and (iii) different bills being generated for the professional services rendered by the surgeons and for the ASC facility fees. The Statement also noted that the BME's past focus had been on "the facts of a particular entity, making certain that it is the doctor himself of herself who is performing the service and a bill is being generated in the name of the practice." The BME admonished that it did not view certain ASC referral arrangements as permissible under the Codey Act and BME's regulations, such as arrangements where physician investors refer to an ASC where another physician performs the surgical procedure.

At the January 9, 2008 meeting, the BME approved the adoption of an emergency regulation clarifying when a physician can refer to an ASC in which the physician holds an ownership interest. If the Governor concurs with the BME's statement that an imminent peril necessitates the emergency rulemaking, the rule takes effect immediately upon filing with the Office of Administrative Law, and remains in effect for a limited period of 60 days. The emergency rule may be continued if concurrently proposed by the BME for adoption as a permanent regulation and pursuant to the regular rulemaking procedures (which include opportunity for comment by interested parties) as set forth in the Administrative Procedures Act. At the January 9 meeting, the BME announced its intention to concurrently propose the emergency rule for permanent adoption.

The new emergency regulation clearly states that a "practitioner's medical office" includes a "practice site" at which ambulatory surgery and/or special surgical procedures that are integrally related to a practitioner's field of practice are performed if all of the conditions set forth are met. These conditions include: operation in a business form otherwise permitted by the Board's practice structure regulation; participation by the referring practitioners in the governance of the practice site; personal performance of the procedure by the referring practitioner; provision to the patient of written disclosure of the referring practitioner's financial interest at or before the referral is made in a manner consistent with the existing grandfather provisions of the regulation; and documentation of the disclosure in the practitioner's chart together with a listing of the full names of all other practitioners having an interest in the practice site. In addition, if applicable, there must be disclosure that certain parts of the bill may be handled by payors differently on an in-network or out-of-network basis. Ownership interests are not to be related to referral volume. Payments to owners are not to be based on referral volume or value but must be directly proportional to the amount of capital investment.

Notably, the emergency regulation requires that "all of the ownership interests" must be held by investors who are "referring practitioners, referring practitioners in conjunction with other non-referring practitioners, closely allied health care professionals or a licensed hospital." This condition appears to exclude ownership by a lay person or business entity, even though such person or entity would qualify for ownership of an ASC licensed by the New Jersey Department of Health and Senior Services ("DHSS"). The rule provides for a 120-day transitional period for practices sites to achieve compliance with the ownership interest limitations.

The proposed permanent rule will be subject to review and comment, and the potential for further changes, in accordance with the usual regulatory procedures. In addition, bills have been introduced that would amend the Codey Act to provide a specific exemption for referral to an ASC licensed by the DHSS as of the effective date of the amended Codey Act. The bills would not restrict ownership in the ASC to physicians and hospitals, but would allow lay persons and entities, such as management companies, to own an interest in the licensed ASC. Notably, single operating room facilities owned by physicians, which are not currently licensed by DHSS, would not qualify for the exemption.

At this point, it is uncertain whether the *Wayne Surgical* decision will stand.

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Motions for reconsideration of the trial court's ruling were filed and appellate review is likely. Several additional ASCs and trade associations also petitioned the trial court for permission to intervene in the case and be heard on a reconsideration motion. In a motion for reconsideration, the trial court can, if it deems fit, modify or reverse its prior decision. The request to intervene was denied by Judge Contillo on December 10, 2007, but may be the subject of further review on appeal.

In the meantime, though, the *Wayne Surgical* decision has left many New Jersey health care facilities and physicians picking up the pieces of their shattered understanding of permissible physician structures under the Codey Act.

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Safe Patient Handling Act Is Now Law in New Jersey

Legislation Requires Health Care Facilities to Establish Safe Patient Handling Programs

by Patricia McManus

Patricia McManus

On January 3, 2008, the Safe Patient Handling Act (the "Act" or the "legislation") became law in New Jersey. The legislation addresses the high number of occupational injuries and illnesses sustained by health care workers engaged in manual patient handling and movement. The Act sets forth a public policy of "minimiz[ing] unassisted patient handling" through the use of "safe patient handling equipment and patient handling aids[.]"

The Act applies to special and general hospitals, as well as nursing homes. Within 36 months of the Act's effective date, those facilities must establish a safe patient handling program ("program"). The facilities must maintain a detailed written description of the program, provide a copy of the program to the Department of Health and Senior Services ("DHSS") or the Department of Human Services ("DHS"), and make the description of the program available to the facility's health care workers and the workers' collective bargaining representative. The facilities must designate a representative of management to oversee the program.

The program must contain a safe patient handling policy that favors minimizing unassisted patient handling and addresses a patient's right to refuse the use of assisted patient handling. That policy must be posted in a location that is easily visible to staff, patients, and visitors. Additionally, the program shall include an assessment of the assistive devices needed to carry out the facility's policy, a recommendation for a financially reasonable 3-year capital plan to purchase the equipment and handling aids necessary to carry out the policy, protocols and procedures for assessing and updating the handling requirements of each patient, a plan for achieving prompt access to and availability for mechanical handling equipment and handling aids, a provision requiring that the equipment and aids be stored and maintained in compliance with manufacturers' recommendations, and a training program for the facility's workers.

The training program must be conducted upon the commencement of the safe patient handling program and at least annually thereafter, with appropriate interim training for new workers. The training program is to be provided during paid work time and must cover identification, assessment, and control of patient handling risks, the appropriate use of equipment and aids, and safe handling techniques. The facilities must supply educational materials to patients and their families to inform them about the facility's safe patient handling program. Trainees are required to demonstrate proficiency in the techniques and practices presented. Finally, the facilities must conduct the initial training within 36 months of the Act's effective date and must evaluate the program annually.

Within a year of the Act's effective date, each facility must establish a safe patient handling committee, which will be responsible for all aspects of the facility's safe patient handling program, including the evaluation and selection of handling equipment and aids. In the case of a health care system that owns or operates more than one covered health care facility or DHS facilities, the committee can be operated at the system or department level provided that committee membership includes at least one health care worker from each facility and a facility-specific program is developed for each facility. At least half of the committee's members must be health care workers; the other members must have experience or expertise relevant to operating the program. The committee must meet as needed, but not less than quarterly.

The Act also provides that covered facilities may not retaliate against health care workers who refuse to perform a patient handling task due to a reasonable concern about worker or patient safety or the lack of handling equipment or aids. A worker who refuses to perform a patient handling task must promptly notify his supervisor of his or her refusal and provide a reason. The definition of "retaliatory action" is the same as that provided under the Conscientious Employee Protection Act. The Act provides that the Commissioner of Health and Senior Services shall provide free training on the development and implementation of safe patient handling programs. Facilities that violate the Act will be subject to penalties determined by the DHSS pursuant to N.J.S.A. 26:2H-13 and -14. The Commissioner must adopt rules and regulations within 12 months of the date of the Act's enactment.

Randy Minniear, Assistant Vice President of Legislation and Policy at the New Jersey Hospital Association, expressed support for the intent behind the current version of the legislation. He explained that, as originally drafted, the legislation raised administrative and financial concerns because it would have imposed a "zero-lift" policy and did not provide covered facilities enough time to implement the required programs. He stated that the amendments to the Act addressed the feasibility concerns and properly recognized the perspectives of nurses and patients.

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MS-DRG's:
The Importance of The Medicare Cost Report is Re-Emphasized

by John Manzi

John Manzi

BACKGROUND ISSUES

The MCR is required to be completed annually by the Centers for Medicare and Medicaid Services (CMS). The completion of the cost report still requires a high level of reimbursement expertise even though its revenue impact has diminished over the years. This change is designed, in part, to further CMS's continual goal to fully integrate an inpatient and outpatient prospective payment system. This transition, though successful, still does not encompass all aspects of allowable Medicare reimbursement included on the MCR. Cost reimbursement is still utilized for nursing and allied health education programs, specialty hospitals and Medicaid state plans. The computation of the Medicare cost outlier is impacted by the inpatient ratio of costs to charges (RCC) and other reconciling items, including bad debts, DSH, ESRD and GME/IME. The omission of accurate and detailed information can still cost your healthcare facility thousands, or even millions, of dollars. Besides the above revenue issues, there are other considerations that will affect the importance of the MCR.

KEY ISSUES

Medicare Cost Report Background Issues – The initial question that a Senior Financial Executive (SFE) should consider is: who is completing the MCR? The ideal candidate should have five or more years experience with a background in finance or accounting. The preparer should be adept in communicating effectively internally with healthcare staff and externally with auditors and other governmental agencies. The reality of this situation is that some cost reports are completed by entry level employees, temporary workers, or employees from other finance departments. The SFE is weighing the importance of the MCR with the expertise of the staff completing the return. The MCR states on the certification page that "Misrepresentation or falsification of any information contained in this cost report may be punishable by criminal, civil, and administrative action, fines, and/or imprisonment under federal law." Additionally, when the SFE signs the MCR, he or she certifies "that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in **compliance** with such laws and regulations." The issue of the importance of the MCR now takes on new meaning, in that it becomes a major compliance consideration, and is not a revenue issue only. To perform this due diligence, the SFE should always have the MCR reviewed for accuracy and compliance, whether this task is performed internally or externally.

MS-DRG's Issue – In 2005, MedPAC reported that the charge methodology is inconsistent and should not be utilized as a proxy for DRG relative weights. In response to this concern, CMS decided to switch from charges to costs to calculate these weights. To ease the impact of this change on healthcare providers, CMS began a three year transition to utilize cost weights, beginning in 2007, with full implementation by 2009. Unfortunately, the source of information to make this change successful is the MCR. CMS is utilizing costs that are not consistently reported by healthcare facilities and has encountered a number of issues that limit the accuracy of the MS-DRG's. CMS considered various comments from the Proposed Final Rule, including the observation that cost weights were affected by applying a lower percentage markup to higher cost services and a higher mark-up for lower cost services. This may undervalue high cost items and overvalue low cost items if a single RCC is applied to items of widely varying costs in the same cost center. The terminology for this occurrence was "charge compression." CMS also utilized various cost finding methodologies, including regression analysis, from outside vendors and will continue to monitor this directive. The 2008 Inpatient Prospective Payment System (IPPS) will utilize fifteen revenue centers to apply costs from the MCR matched against the mapping of the MedPAR data. The results of this initiative on healthcare providers have been far from perfect.

Mapping Issues – As stated above, if the MCR is perceived to have lost revenue importance and the level of expertise completing the report is diminishing, is it really surprising that there would be mapping issues? Some exam-

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ples of inconsistent mapping that CMS is observing include: (1) the mapping of Intermediate Care Unit costs to the Intensive Care Unit. (2) Medical/Surgical Supplies and Drugs are being mapped throughout the Medicare revenue cost centers, and (3) Cardiology and Radiology services not grouped consistently to match MedPAR data. The methodology on which CMS relied to implement a new cost-based DRG system is flawed. To try and mitigate some of these concerns for 2008, CMS added two new revenue categories for Emergency and Blood and Blood products. It is widely agreed that more precise and accurate cost reporting mapping is the best method to correct these inequities.

In 2007, a cost report workgroup was established comprised of the American Hospital Association, consultants, and other healthcare associations. This workgroup was charged with identifying potential changes to the MCR and other input source documents to improve the accuracy of DRG weights under the new CMS cost-based IPPS methodology. Their recommendations and acceptance by CMS may make significant changes to the instructions for the completion of the MCR. The task at hand, to improve the accuracy and consistency of the MCR, will be monumental. Will the goal of fair and equitable MS-DRG weights be accomplished? The unanswered question is: What do we have to do?

INSIGHTS

To accomplish the task of preparing an accurate MCR that should match MedPAR data, an experienced preparer needs to begin at the **end** of the process by reviewing the Provider Statistical and Reimbursement (PS&R) report. The PS&R program data is utilized by CMS to reconcile the billed Medicare claims. Revenue is listed by revenue level codes and is mapped to the revenue centers on the MCR based on internal assignment that is approved by the Fiscal Intermediary. One of the most important aspects of computing accurate RCC's and comparing them to the PS& R program revenue is to insure that the expenses on Worksheet A and the revenue on Worksheet C are consistently mapped by cost center. The problem faced by the preparer is that both Worksheets A and C are not mapped by revenue codes as is the PS&R. The preferred method to map Worksheet C is to request general ledger/revenue utilization charges by internal revenue codes. Most healthcare providers map revenue by cost center and then will utilize reclasses to be consistent with the PS&R and cost data. This method does not insure that all charges are properly mapped since CDM's are constantly being updated. Once the Worksheet C and the PS& R data is consistent, the preparer will concentrate on the Worksheet A expenses utilizing A-6 reclasses to match to the gross and Medicare program revenue. This will be the most time-consuming and difficult step. After these steps are accomplished, the RCC's should be consistent with the PS&R data and the costs utilized in the development of the MS-DRG's should be accurate.

SUMMARY

With the anticipated MCR instructions expected to focus on proper mapping, the final issue that the SFE should consider is: who will be the experienced preparer to make sure the cost report is prepared and reviewed accurately. If you are confident that your preparer is qualified, then you are covered, but if you have doubts, where do you turn? Additional education is not only desired, but should be considered critical. The completion of the MCR just became elevated in importance and will become an integral reporting tool to obtain accurate MS-DRG's.

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In Memory of
Paul C. Dabrowski, CPA

A friend to many in the healthcare industry.

HFMA members extend their deepest sympathy to his family.

•Focus on Ethics•

Ask the Ethics Guy®!
iPhone Ethics

by Bruce Weinstein, Ph.D., The Ethics Guy®

Bruce Weinstein

Does the 'i' stand for "isolation"?

Ten years ago, Apple Inc. began using the phrase "Think different" in its advertising campaign, and the phrase quickly became as iconic as "Where's the beef?," "Got milk?," and other catchy slogans. On June 29, the company released its newest invention, the iPhone, and Wall Street analysts predicted that Apple would sell three million units in the first weeks of the phone's release, according to The New York Times. This combination cell phone-iPod-camera-Web browser is the sleekest, hippest consumer electronic device in years, and the phone has gotten nearly as much press as the Iraq war, Spider-Man 3, or Paris Hilton.

Surely everyone who hopes to be cool will want an iPhone, and what could be wrong with owning what is already the most talked-about accessory since, well, the iPod?

A lot, as it turns out.

Our society has devolved into a mass of turned-on, tuned-out, and plugged-in technophiles. Whatever distinction used to exist between public and private life is all but gone, as one can witness on any city street, bus, plane, or shopping mall. Waiting in line at the grocery store or post office used to mean striking up a conversation with the person in front of you. It now involves blurting the intimate details of one's love life into a cell phone for all to hear, or scrolling through a playlist for just the right song, or surfing the Web for something we want but don't really need.

I will call this new form of behavior "iSolation," and there are three major costs associated with it.

The first is an opportunity cost. Our social fabric is in danger of being ripped to shreds as we swap electronic connection for personal relationships. The very nature of community depends upon us being connected to one another. Being civil means, or at least used to mean, valuing our relationships beyond our immediate circle of family and friends. If upon leaving home we immerse ourselves in idle chatter on the phone, listen to music nonstop at volume levels that preclude hearing the world around us, read every piece of e-mail sent since the last time we checked, or hunt for bargains on the Internet, we miss the chance on the way to work to make new friendships, renew old ones, or simply say hello to a stranger. A community is not merely a collection of individuals. It is a web–the kind with a small "w–of interconnectedness, and this web cannot exist for long if each of its constituents is concerned primarily or exclusively with itself.

The second cost of iSolation is to our psychological health. I don't know about you, but my best ideas come when I'm either doing something mundane like brushing my teeth, or simply daydreaming. That's right, daydreaming. A waste of time, you say? Not at all. To be creative is to have the freedom to dream, to let thoughts appear and evaporate, and to–dare I use such a word in a business column–play. "But I'm too busy to play," you reply. Nonsense. Some of the time spent fidgeting with a cell phone or MP3 player is time we could put to better use, such as doing nothing at all. When our brains are constantly stimulated by electronic data, they are, of necessity, precluded from taking anything else in, such as the random thoughts that can be the genesis of great ideas. The nonstop avalanche of images and sounds from electronic media (among other distractions) is a barrier, not a portal, to creativity.

The third cost of our absorption in technology may be the most serious of all: an increased risk of morbidity and mortality. A study published in the New England Journal of Medicine concluded that drivers who use a cell phone are four times more likely to be involved in an accident than are drivers who do not. The American Automobile Association has challenged that study, but it doesn't really matter who is right. Imagine that your son or daughter has just gotten a driver's license and is taking your car out for a spin. Would it matter to you if other drivers are yakking away on a cell phone while cruising next to, or heading toward, your child? Of course it would…and it should. Driving is challenging enough without having to worry about people around you being literally driven to distraction. We are, to borrow a phrase from the late author Neil Postman, amusing ourselves to death.

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In response to two MP3-player-related pedestrian deaths in his district earlier this year, New York State Senator Carl Kruger proposed a bill that would ban people from using cell phones, "personal data assistants," and other electronic devices while crossing the street in New York City and Buffalo. Many were outraged by the proposal, but it makes a lot of sense. When you're arguing with your colleague or spouse on the phone, or reading the latest memo from the boss, you simply cannot be on guard against traffic. There is a limit to how much even the most skilled multitasker can accomplish.

None of what I am saying is a call to return to the days when people got their entertainment by huddling together in front of a radio (though that sounds pretty good, if you ask me). Nor is it an indictment of capitalism and the push to sell bigger, better, newer, and faster gizmos. There's nothing wrong with that, as far as it goes. After all, technology is morally neutral. It can be put to useful or harmful purposes.

So if the introduction into our culture of several million iPhones results in more self-absorption, less time to daydream, and more pedestrian and driver accidents, it won't be the fault of Apple, or the IT industry as a whole, or Madison Avenue, or the news media, or the automobile industry, or anyone else we care to blame.

It will be our own fault.

But it's not too late to think different.

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Tightening Credit in the Housing Markets:

The Ripple Effect on Healthcare Collections

Will the declining housing market impact healthcare collections? You bet!

Mitch Patridge

by Mitch Patridge

Executive Summary

Until the recent sub-prime mortgage crisis burst the housing bubble, homeowners were able to tap into increased property values to meet other financial obligations, including healthcare bills. But the recent tightening of underwriting standards and rapid decline in housing prices have limited the consumer's ability to access capital.

The end result is an increasing inability for many consumers to meet financial commitments -- a situation that will clearly impact the healthcare industry as providers attempt to collect from patients.

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By now, we're well aware that the housing market is in the midst of significant crisis, and that this crisis is having a ripple effect throughout the U.S. economy. Recently, the Wall Street Journal reported that more than 130 million home loans were obtained in the past decade and that risky mortgages were approved in nearly every corner of the nation. According to the report, lenders made a combined $1.5 trillion in high interest loans – and the meltdown is hurting a far broader array of Americans than many realize, cutting across differences in income, race and geography. The report also states that subprime lending continued into 2006 and the effects could last through 2007 and beyond.

Many healthcare providers are wondering how the mortgage meltdown will impact the business of collecting healthcare debt. To date, there has been little or no analysis regarding the impact of the housing crisis on healthcare collections. But even without rigorous analysis, there are several clear trends.

Healthcare Debt *Before* the Declining Housing Market – and *After*

In the housing bubble of the last five to seven years, consumers were able to pay out-of-pocket healthcare costs in a number of ways. Many patients paid healthcare bills by tapping into their "new-found" home equity or by "taking cash out" by refinancing their homes.

Concurrently, in order to compete with the home mortgage market, underwriting standards for unsecured debt (e.g. credit cards) were loosened, providing many consumers with the ability to use credit cards to pay healthcare debt. But, this is no longer the case. The meltdown in the housing market has caused a general tightening throughout the consumer lending market. Today, underwriting standards for mortgages have significantly tightened, and many credit card issuers have followed suit, cutting back offers to less creditworthy customers and lowering credit limits.

As Figure 1 indicates, a 2005 healthcare cost survey revealed some startling statistics. Fifty-two percent of all respondents had depleted their nest eggs to pay healthcare costs, and 15 percent had declared bankruptcy. In today's financial climate it is difficult, and often impossible, for consumers to tap into home equity or obtain consumer credit lines (e.g. credit cards) to pay hospital bills. Often, those consumers are using credit cards to meet their daily needs and are already at their credit limit.

When you combine the credit crunch and housing crisis with escalating healthcare costs, the results are

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FIGURE 1:
2005 Healthcare Costs Survey

(Conducted by the Kaiser Family Foundation, Harvard School of Public Health)

- 52% of all respondents stated they had used up all or most of their savings in order to pay outstanding medical bills.
- 69% had been contacted by a collection agency
- 35% had obtained a loan or gotten another mortgage on their home
- 15% declared bankruptcy

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bound to be disastrous. As Figure 2 shows, most people have less discretionary income to spend, yet out-of-pocket healthcare costs are skyrocketing, and are expected to continue to do so.

As one industry spokesperson succinctly put it: "There are only so many ways to stretch a budget, and mortgage, credit card and auto payments will always take precedence over hospital and doctor bills."

Preparing for the Worst

The trends are clear: Out-of-pocket healthcare costs will continue to rise, and patients will have increasing difficulty paying their debt. So how do healthcare providers prepare for this eventuality? How can providers help their patients pay their healthcare bills and avoid being sent to collections?

Here are some suggestions collected from hospitals that are already addressing these challenges.

1. **Provide your patient finance department with additional tools enabling them to increase efficiencies, automate work processes and improve customer service.**

   Patient finance departments are notoriously understaffed and overworked. Even in hospitals where this is not the case, PFS departments often lack flexible payment options. Not having this tool significantly hampers collection efforts and limits the hospital's ability to adequately meet the needs of financially strapped patients. A strong loan program will enable your PFS department to meet cash goals and reduce the number of patients that are referred to collections. Implemented properly, a hospital will also be able to reduce or reallocate staff to more productive areas.

2. **Stay competitive with other hospital programs. You've provided your patients with excellent healthcare services, now follow through with superior patient financing options.**

   As consumer credit becomes more difficult to obtain, patients are rapidly becoming more aware of the various healthcare financing options being offered by other direct and indirect (e.g. surgery centers) competitors. A patient may choose to obtain care from another provider if the patient believes that better financing options will be available. It's therefore very important for your facility to be able to offer competitive loan solutions that meet the needs of your patients.

   Remember that a flexible and robust loan offering is only half the battle. It is vital that healthcare providers insure that the lender they partner with has experience in healthcare lending and utilizes a customer service department trained in patient-centered counseling approaches and compassionate collection practices.

3. **Develop clear-cut charity guidelines and make sure hospital staff is adequately trained and adhering to those guidelines.**

   Patients who cannot pay their obligation have a significant impact on healthcare resources. Unfortunately, significant time and resources are required to either identify these patients as candidates for charity care or collect from those who do not meet charity care guidelines. Hospitals should not substitute a loan program for a well thought-out charity program. Instead, providers should utilize credit scoring or similar programs to quickly identify patients who may be eligible for charity. These same tools can be used to identify patients who will qualify for a loan program. There are many third-party vendors that provide an electronic means to identify these patients. The key is to clearly quantify the charity care parameters, automate the process, identify the qualifying patients, and apply resources in the most effective manner.

4. **Develop an internal collection policy and have the PFS department adhere to the guidelines.**

   Virtually all hospitals have collection guidelines that specify the length of time (typically 3 to 6 months) patients will be given to pay their

FIGURE 2: Less Money to Go Around

- About 50% of all renters and 37% of all homeowners pay 30% or more of more of their income on housing.
- In California, the leader in foreclosures, 51.8% of mortgage holders pay at least 30% of their incomes for housing.
- In 2005 and 2006, 25% of all renters spent half of their income on housing.
- In 2006, 14% of all mortgage holders spent half of their income on housing.
- Incomes have not kept up with housing prices; some people owe more on their houses than they are worth.
- The national average healthcare cost for family coverage is now $12,106.
- Since 2001, health costs have increased 78% -- more than four times the pace of prices and wages.
- Health costs are predicted to increase in 2008 by 7 to 11%.

obligation. Yet most PFS departments frequently make exceptions to the repayment guidelines. The longer term zero interest payment plans create an unneeded burden on the hospital's cash flow and workload. By partnering with a lender that offers easy-to-qualify-for patient loans and low monthly payments, the healthcare provider can offer patients a needed benefit. Importantly, this type of program increases cash flow to the hospital while also decreasing costs and the hospital staff's workload associated with billing, collecting and posting cash on payment plans.

5. **Consider partnering with a lender instead of offering internal patient payment plans.**

   Instead of acting as a both a bank and loan servicer, hospitals are partnering with experts in automated patient financing. With the right financial partner, hospitals can improve cash flow and reduce the administrative costs related to monthly billing, tracking, posting, skip tracing, and other collections activity. And, this all can be accomplished while improving the patient experience at your facility.

6. **If you partner with a lender, make sure to optimize your results by choosing a vendor with direct experience in patient finance.**

   Any licensed lender can grant patients loans, but for best financial results for your facility and better treatment of your patients, you should partner with a lender that has direct experience in patient lending. Banks that lack experience in this field will not have the performance data or knowledge needed to grant loans to those patients who should receive them, nor the information required to decline loans to patients that will not be able to pay. Nor will the hospital or the local bank have the infrastructure to adequately service the accounts and keep them from defaulting. Hospitals will achieve considerably better results by partnering with a lender that specializes in, and has significant experience with, patient lending.

7. **Develop a relationship with a patient loan company that can quickly approve and fund patient loans.**

   Make sure that your partner can quickly and efficiently approve and fund loans. A delay in this area will result in lost collection opportunity for the facility. Use the checklist below to evaluate possible third-party vendors:

   ☐ **Type of programs –** Work with the lender to determine the type of payment plan you want to offer. Make sure that all options have low monthly payments.

   Other choices are almost limitless including: zero interest financing; flexible underwriting parameters; lines of credit for the patient's obligation to the hospital; programs that can include financing for physician groups

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and/or clinics; and loan programs for high balances as well as specialized programs for low balances. (Lighten the PFS workload!)

- ☐ **Where in the revenue cycle can you (should you) offer the loan option?** Your lender should advise you on the various points in the revenue cycle that the loans can be offered. By implementing programs at various stages, hospitals can greatly increase the success of the program. Your banking partner should have the experience and the expertise to guide you in this area. Be sure that their advice is backed by actual loan results with other similar hospitals.
- ☐ **Application or non-application based loans –** Do you want to spend your staff's time and energy attempting to obtain written applications or would you and your patients be better served by implementing a non-application based program? Again, be sure that the lender's advice can be substantiated by actual loan results with other hospitals.
- ☐ **Terms of use –** Terms of use can be restrictive (some loan programs can be used only for hospital charges) or flexible (charges from both the hospital and hospital-owned physician practices or clinics can be placed on the line of credit). Think about what would be best for your facility and patient population.
- ☐ **Payment options and rates/ fees charged to patients –** Make sure you know what the lender's policies are in regards to down payment, minimum monthly payment, punitive rates (interest rate increases due to patient delinquency), overlimit fees, returned payment fees and other charges.
- ☐ **Banking partner –** Evaluate the experience of the lender as well as the flexibility and reasonableness of their contract terms. If possible, partner with a lender that has access to more than one banking partner so that you do not run the risk of the bank "exiting the market" and leaving you and your patients without a viable loan program.
- ☐ **Loan servicing/Patient satisfaction –** Know who is servicing the accounts and interfacing with your patients. Make sure that the servicing department has direct experience in healthcare lending and servicing. Banks that offer patient loan programs deploy different servicing strategies which come in many "flavors" including i) billing only, ii) placing accounts with generic credit card collection platforms, iii) off shore collections, and iv) industry-rated servicers that specialize in revolving lines of credit used for patient loans. A specialist will have the experience and knowledge necessary to treat your patients properly, which will result in better collections and a better patient experience.
- ☐ **Recourse rates, what can you really expect?** When selecting a lender spend time understanding the lender's experience and their ability to manage recourse. Make sure that the lender has the loan performance data sufficient to adequately quantify and manage loan risk. Understand how recourse is calculated and what the repurchase terms and conditions are. It is always best to align the hospital's interests with the lender.
- ☐ **Insure success by partnering with a lender that provides tools to promote the loan program and patient benefits –** Collateral materials, such as patient brochures, Question & Answer sheets, posters, press releases and other tools, can be generic or customized to your hospital. Choose a lender experienced in healthcare lending that can guide you in this area before you make a decision.
- ☐ **Service fee –** Costs vary; some lenders charge a fixed rate; others base the fee on the interest rate charged to the patient and the type of loan program chosen by the hospital. There are multiple options available to the hospital, and it is important to select a lender that has flexibility and can design a program specifically to meet the hospital's mission as well as the patient demographics for the market served by the hospital.

It's time to meet the challenges of the new economic situation with innovative solutions. Doing so will improve your hospital's bottom line as well as the overall patient experience.

About the Author

Mitch Patridge is CEO of the San Diego based CSI Financial Services which provides patient financing for hospitals and other healthcare providers throughout the U.S. He can be reached at (858)200-9201 or at mpatridge@csifinanical.com.

Managing Funding Ratio Risk and Return

by Aaron Meder, FSA, EA

Introduction

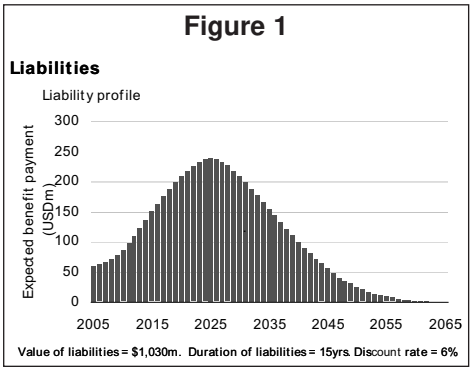
Asset-Liability management is at the top of many pension managers' minds. The key to successful pension plan investing is finding an investment solution that manages the volatility of asset returns relative to liabilities and generates enough return so that the plan's commitment is fulfilled.

The traditional asset-only approach to pension investing has resulted in portfolios invested in 60%-70% equities with the remainder in average duration nominal bonds. These investment policies may be efficient in an asset-only framework but are exposed to unrewarded risk when evaluated relative to liabilities. The asset-only framework does not properly integrate the liability's fundamental exposures to interest rates, inflation and growth. These unrewarded risks were masked by the bull market of the 90's, and subsequently exposed during the perfect storm of falling equities and falling interest rates during the 2000-2002 period.

Constructing an investment policy that achieves both objectives more efficiently is best demonstrated using a case example. We focus on the plan's funding ratio (value of assets divided by value of liability) since it is the funding ratio that ultimately drives plan costs. We will show how funding ratio risk (volatility of the funding ratio) can be significantly reduced without reducing expected return.

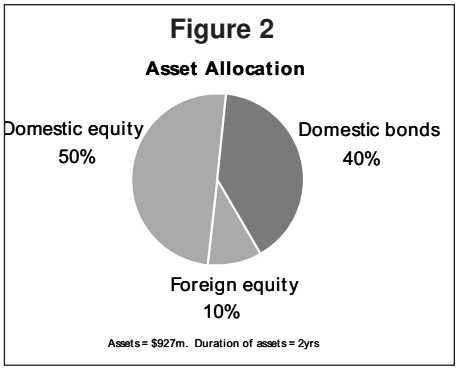
Our case example, ABC Corporation, currently has $927 M in assets, a funding ratio of 90%, typical final salary liability profile and a typical asset allocation as described in Figure 1 and Figure 2.

Figure 1



To evaluate how assets behave relative to liabilities we explicitly model the liability in the same framework in which we model assets. To do this, we focus on the fundamental factors than influence both assets and liabilities. Recognizing that pension liabilities are the present value of deferred wages and inherently sensitive to changes in interest rates and wage growth, the fundamental factors we select are real rates, inflation, economic growth, the equity premium, and the bond premium. By understanding how sensitive both assets and pension liabilities are to these fundamental factors, we are able to derive correlations between assets and liabilities that capture the inflation and wage growth risks in addition to the interest rate risk of the liability. With these correlations, we can then develop a portfolio of assets that mimics the exposure of the liability.

Figure 2



For ABC Corporation this liability-mimicking asset portfolio (LMAP) consists of 80% long duration nominal bonds, 10% equities, and 10% inflation-linked bonds. The LMAP is the low risk investment in our framework. This means that investing in this portfolio results in the best chance of tracking the liability as it grows and evolves over time. In addition, this is also the appropriate investment benchmark because if the return on the fund's assets beats the return on the LMAP, all stakeholders should be satisfied since the pension promises underlying the liability will be paid. Table 1 highlights the fundamental differences between the traditional asset-only framework and our funding ratio framework.

Table 1

	Asset-only approach	Funding ratio focused approach
Liability exposures	None	Term structure, inflation, growth
Low risk investment/ Benchmark	Cash	Liability mimicking asset portfolio

With the LMAP calculated we are ready to analyze the funding ratio risk of ABC's pension plan. Since the LMAP is designed as a best offset to the liability's risks, funding ratio risk can be described as the volatility of a portfolio of assets which is long the investment policy and short the LMAP. Using our proprietary model we are able to analyze the funding ratio risk for ABC Corporation's pension plan given their current investment policy in Table 2.

Table 2

Risk/Return (1 Yr)	Current (60/40)
Return vs liability	2.3%
Correlation (A,L)	56%
Funding ration risk	11%
Prob. FR below 80%	9%
VaR (5%, $millions)	(150)

ABC Corporation's current policy is expected to earn 2.3% in excess of the expected liability 'return' as denoted in Table 2. Expected liability return is defined as the return due to the passage of time, i.e. the interest cost of 6.0%. We've made the simplifying assumption that future service costs are met with future contributions for this case example, and therefore exclude future service costs from the calculation of liability 'return'.

While this return may be adequate to defease the plan's obligations over the long haul, the policy has a funding ratio risk of 11%, which means that the plan should expect its funding ratio to drop by at least 11% approximately once every seven years. In addition there is a 5% chance of the deficit increasing by at least $150m over the next year. Large drops in funding ratio and increases in the deficit can have significant adverse consequences not only for a pension plan but also for the plan sponsor's earnings, cash flow, and balance sheet. Given the nature of looming pension reform, these large drops in funding ratio will carry more severe and immediate penalties. Further, for corporations where the plan is large relative to the size of the company, the risk of a large drop in funding ratio should be carefully analyzed.

While there are many sources of funding ratio risk, there are three major sources:

1. **Interest rate risk or the duration mismatch between assets and liabilities:** When the duration of the portfolio differs from the duration of the liability, changes in the level of interest rates will impact the value of assets and liabilities in different amounts, thus causing a change in the funding ratio. ABC Corporation's current duration mismatch is large and amounts to approximately 13 years (15 year liability duration minus the 2 year duration of the investment portfolio). Further, the majority of the liability's interest rate exposure comes from the long end of the curve and the majority of the assets' interest rate exposure comes from the short end of the curve. This means that even if the level of interest rates stays the same, but the slope and/or shape of the yield curve changes, the plan's funding ratio may be impacted. Thus, for ABC Corporation, large changes in the level, slope, or shape of the yield curve can cause large changes in the plan's funding ratio.
2. **Inflation risk:** ABC's liabilities are linked to salary growth and thereby to wage inflation. In addition, many plans have benefit payments that are indexed to inflation (e.g., most of the UK plans and the majority of public sector US plans). If actual inflation differs significantly from assumed inflation and the inflation exposure remains unhedged the funding ratio will be exposed to inflation risk. ABC Corporation's current policy has no allocation to inflation-linked assets.
3. **Equity market risk:** Plans with high allocations to equities in their asset allocation are exposed to a third source of funding ratio risk–equity market risk. While a small allocation to equities will be beneficial for long-term hedging purposes, a high allocation to equities will increase short-horizon risk considerably. ABC Corporation currently has half of their pension plan's assets in domestic equities.

The ALIS approach

There is no simple one-size-fits-all solution to the pension problem. We are faced with the challenge of building, measuring and managing investment policies that reduce funding-ratio risk while generating enough return to keep the expected cost of defeasing the obligation at a tolerable level.

ABC Corporation could invest in the LMAP and this would be the low risk investment. This means that investing in this portfolio results in the best chance of tracking the liability as it grows and evolves over time. However, by definition, the LMAP is meant to mimic the liability, not outperform it. Thus, it will not provide an expected return in excess of the liability and therefore future

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service benefits and benefits earned by future participants could only be defeased by future cash contributions.

Often, this low risk strategy will be too expensive for plan sponsors to maintain over the long run. Therefore, in most cases, we do not recommend investing in the low risk portfolio, but only measuring investment risk against it. The challenge is to find the most efficient way to allocate more assets to "higher returning" asset classes such as equities while minimizing the amount of unrewarded risk taken versus the liability. This can be approached in two steps. First, hedge unrewarded (liability) risk, and, second, generate returns more efficiently.

Step 1: Hedge unrewarded risk

First, we must tackle the duration mismatch by reducing interest rate risk – the liability's largest risk factor. Under most market conditions a plan is not rewarded for a duration mismatch between assets and liabilities. By reducing or eliminating it, we can decrease funding ratio risk significantly. Interest rate derivatives can be used to synthetically represent the interest rate exposure of the liability within selected key rate duration buckets, essentially eliminating the funding ratio risk attributable to changes in the level, slope, and shape of the yield curve. For example, interest rate swaps can be a very efficient way to accomplish this. Additionally, utilizing derivatives to hedge requires far less capital than cash investment, thus, freeing up capital to be invested in "higher returning" assets.

Next, we look at inflation risk. The active cash flows of ABC's plan are sensitive to salary growth. One part of overall wage growth is wage inflation and wage inflation is linked to general inflation. As a result, the plan needs exposure to asset classes with cash flows that vary with inflation, such as inflation-linked bonds. This is exactly why ABC Corporation's LMAP includes an allocation to inflation-linked bonds. Plans that provide inflation indexation to retirees are even more sensitive to inflation changes and would require a larger allocation to inflation-linked bonds or inflation swaps.

Finally, we consider real wage growth risk. The active cash flows of ABC's plan are not only linked to wage inflation, but also to real wage growth. Real wage growth is linked with economic growth through labor's share of productivity increases. Equities' cash flows through corporate earnings are also related to economic growth and will provide a long-term link to changes in the liability cash flows attributable to future real wage growth. This is why ABC Corporation's LMAP includes an allocation to equities.

Thus, by adding an interest rate swap overlay and shifting 10% of their assets from nominal bonds to inflation-linked bonds, ABC Corporation can hedge their liability risk with minimal changes to their current cash investment portfolio. The benefits of hedging liabilities this way can be seen below as the first step in Figure 3.

Step 2: Efficient Return Generation.

To defease the liability as it evolves over time and manage the long-horizon economic cost of the plan, we must also focus on return generation. ABC Corporation's plan has three weaknesses in its approach to return generation.

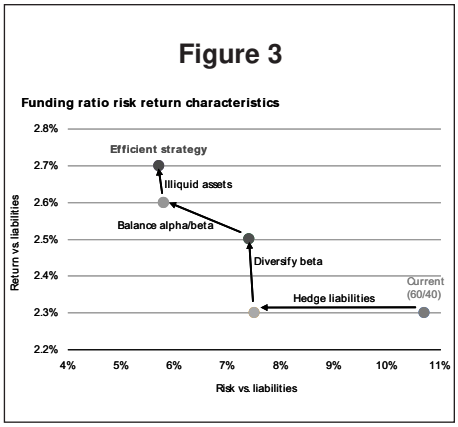
- First, it concentrates almost all of the market exposure to domestic assets. Simply by diversifying their equity exposure across the globe, allocating a larger percentage of overall equity beta to foreign equity and emerging market equity, ABC Corporation can increase expected return and decrease funding ratio risk.

- Second, ABC has a poor balance between alpha and beta. ABC Corporation's current investment policy only has a 1% relative risk budget. By allocating more risk to active management ABC Corporation can reduce its allocation to market risk and maintain or even increase the returns they need. As a result, allocating more risk towards active management provides an opportunity further reduce funding ratio volatility and increase return.

- Lastly, ABC Corporation does not take advantage of the illiquidity premium that certain asset classes offer. Like most pension funds, many of ABC Corporation's obligations don't come due for over thirty years so they are in a unique position to take advantage of the illiquidity premium the market grants for assets classes such as private equity and real estate. Taking this final step can further increase return while providing even more diversification.

Thus, to improve return generation we consequently allocate assets to a wider investment universe in search of alpha and we better diversify and dynamically manage the sources of market return. Visually, the benefits of first hedging the liability and then generating return more efficiently can be seen in Figure 3.

Figure 3



Investment Proposal

Our recommendation includes the use of bonds, and interest rate swaps to manage the impact interest rate changes have on the funding ratio. The remainder of the solution includes a well-diversified portfolio, including domestic equities and inflation linked bonds to track the wage growth of the liabilities, and an allocation to illiquid assets to provide further diversification and additional expected return. We also allocate more risk to active management, which allows us to offset the reduced return from lowering the overall equity exposure. Of course, if the manager does not actually deliver a positive alpha, then the expected benefits of active management will not be realized. The current allocation and proposed "efficient" allocation can be seen in Table 3.

As Table 3 shows, by taking this approach:

- The correlation between assets and liabilities has be increased significantly and therefore the funding ratio risk has almost been cut in half
- The probability to fall below 80% funding ratio decreased from 9% to <1% and the worst 5% of outcomes are now significantly more tolerable.
- The expected return on assets relative to liabilities has actually increased from 2.3% to 2.7%. This is mainly due to the fact that capturing a broader set of return opportunities and expected returns from dynamic management of market, currency and security selection and the allocation to the higher returning asset classes of private and emerging market equity more than offsets the reduced overall exposure to equity markets.

Investment policy	60/40	Efficient
Domestic bonds	40%	33
Foreign bonds	0	12
Inflation-linked bonds	0	15
Domestic equity	50	15
Foreign equity	10	10
Emerging market equity	0	5
Private equity	0	5
Real Estate	0	5
Total	**100%**	**100%**
Active Risk	1%	2%
Information ratio	0.50	0.50
Asset Duration	2	4
Overlay Duration	0	11
Liability Duration	15	15
Duration Group	-13	0
Exp Return over liability	2.3%	2.7%
Correlation (A, L)	56%	94%
Funding ratio volatility	11%	6%
Prob. of FR below 80%	9%	<1%
VaR (5%, $millions)	(150)	(81)

Less volatility, better returns

This example illustrates how modern investment tools along with innovative asset-liability modeling techniques can help pension plans reduce funding ratio risk while keeping or even increasing the expected returns. Thus, this concept offers a promising new approach to sponsors who are willing to lead the way and implement investment solutions that are based on their real objectives–their liabilities.

About the Author

Aaron is Head of Asset-Liability Investment Solutions, Americas at UBS Global Asset Management. In this role he is responsible for developing, implementing, and managing Liability Driven Investment (LDI) solutions for Defined Benefit pension plans.

•Certification Corner•

There is a financial reward for certification!!
Have you thought of becoming certified? Now is a great time to do it. The NJ HFMA Board has agreed to fund a drawing raffle this year with $50 per person that achieves the CHFP or FHFMA designation (up to a maximum of $500). If you achieve your certification between June 1, 2007 and May 31, 2008, you will automatically be entered into the June 2008 drawing and could be the lucky winner of up to $500.00.

Certification Examination Content
The HFMA Core and Specialty Exams have been revised for 2007-2008. The areas of study and relative weightings of each are listed in the table below:

Core Exam *(150 questions)*
5% Healthcare Industry Overview
6% Cost Analysis & Management
3% Financial Analysis Techniques
6% Accounting Concepts & Principles
5% Auditing and Internal Control
3% Capital Planning & Financing
6% Budgeting
6% Strategic Planning
3% Investments & Cash Management
6% Information Systems
6% Patient Financial Services/ Revenue Cycle
6% Corporate Compliance
6% Managed Care
6% Regulatory Environment
5% Health Information Mgmt. & Case Mgmt
3% Quality & Patient Safety
3% Management Skills
3% Human Resources Management
5% Legal Aspects
6% Physician Practice
2% HFMA Overview

Patient Financial Services Specialty Exam *(75 Questions)*
4% Organizational Forecasting
15% Accounts Receivable Management
4% Financial Analysis Techniques
9% Information Technology
12% Policy, Planning, & Evaluation
13% Access Management
13% Claims Processing
11% Managed Care
11% Legal Aspects
4% Physician Entities
4% Other Related Entities

Accounting and Finance Specialty Exam *(75 Questions)*
12% Cost Analysis & Management
15% Financial Planning & Budgeting
15% Capital Planning & Financing
10% Investments & Cash Management
10% Internal Control
15% Financial Reporting, Accounting Principles & Auditing
15% Regulatory Environment & Corporate Compliance
8% Employee Benefits, Insurance, & Risk Mgmt.

Physician Practice Management Specialty Exam *(75 Questions)*
10% Physician Coding & Payment Systems
10% Encounter Processing
16% Accounts Receivable: Collection, Policy & Evaluation
8% Information Systems
10% Budgeting & Benchmarking
6% Cost Analysis & Management
14% Physician Compensation & Leadership
8% Contracting, Negotiating, Reimbursement Methodologies
4% Insurance & Risk Management
7% Legal and Regulatory
7% Other Management Issues

Managed Care Specialty Exam *(75 Questions)*
5% Overview of Managed Care
10% The Healthcare Delivery System
35% Financial Management
15% Managed Care Operations
10% Contracting and Negotiating
5% Medical Management
5% Regulation and Accreditation
5% Forces Driving State & Federal Health Policy
10% Medicare & Medicaid

Certification Awareness Survey
Thanks to all that completed the Certification Awareness Survey in December.

The committee will use the results to plan future communications and programs.

Test your Knowledge:
Of all the means of equity financing, the least expensive is usually:

A. Long-term.
B. Internal.
C. External.
D. Restrictive.

For the answer, go to the NJ Chapter's Certification webpage at: http://www.hfmanj.org/Certification

For more information about the HFMA certification program or certification maintenance, go to www.hfmanj.org/Certification, or contact:

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CFO Member Spotlight:
Garrick Stoldt, Saint Peter's University Hospital

Garrick Stoldt

FOCUS: CFO backgrounds are diverse, please tell us about yours. How did you get started? What is your education and professional background?

GARRICK: I received my undergraduate degree in Economics from New Jersey City University. My electives were in accounting which allowed me to earn the credits needed to sit for the CPA exam. My first healthcare job was with Horizon Blue Cross performing Medicare and Medicaid cost report audits. Although I only stayed at Horizon for two years, it provided me with the knowledge of reimbursement fundamentals. Then I moved onto public accounting for Pannell Kerr Foster and Ernst & Young. My public accounting experience started with performing financial statement audits for hospitals and related entities. Given my reimbursement experience, I was regularly assigned reimbursement consulting assignments in addition to audit assignments. Again, my reimbursement and healthcare finance knowledge was key. The combination of reimbursement and consulting experience along with public accounting experience provided me with the basics to work in hospital finance.

FOCUS: Did you ever think, all those years ago, that you would be here, doing this today?

GARRICK: Early in my career, I was interested in public accounting and becoming a partner in a CPA firm. It was several years in public accounting before I considered working in a hospital. The idea of being a CFO was not really considered until I was first offered the position.

FOCUS: What new skills do you think are needed for rising CFOs?

GARRICK: Today's CFO needs to be a strategic planner and a source for strategic vision for the organization. Planning for the hospital's financial results, as well as establishing the strategic vision for the departments that report to the CFO are crucial. The standard skill sets of accounting, compliance, reimbursement and finance are important, but are not enough to move the organization to the next level. The other critical factor is leadership. Setting the strategic vision does not mean very much unless your staff has accepted and actively works toward achieving that vision.

FOCUS: What are your hospital's specifics – are you a single facility or part of a system? Do you have a religious affiliation? Please describe your location, demographics and the services offered at your hospital.

GARRICK: Saint Peter's University Hospital, located in New Brunswick, is a Catholic teaching hospital sponsored by the Diocese of Metuchen and is part of the Saint Peter's Healthcare System. The system operates a hospital, nursing home, surgical center and cardiac cath lab joint ventures, a properties holding company, a durable medical equipment company, a fundraising foundation along with a few other strategic entities. We maintain clinical affiliations with Drexel University, Children's Hospital of Philadelphia, UMDNJ-Robert Wood Johnson Medical School and Rutgers University. We are best known for the high quality of our nursing care as evidenced by earning the Magnet Award for nursing excellence for three consecutive survey cycles and, most recently, the Beacon Award for nursing excellence in critical care services.

We are renowned for women's and children's services with a catchment area that reaches five counties, and consistently have over 6,000 deliveries each year. In addition, we provide a wide array of clinical services and are expanding services in oncology, surgery and cardiology.

FOCUS: Can you tell us about your hospitals: a) turnaround, b) new building? c) New infrastructure, d) new procedures offered, etc?

GARRICK: We just completed a tax exempt bond sale of $67,000,000 in a very turbulent bond market. It was very gratifying to have a successful sale when many other planned transactions were delayed until the first quarter of 2008 for fear of the current market conditions. Most of the proceeds will be used for renovating patient care areas for multiple service lines. More importantly, we will be converting many patient rooms from two beds to single-bed occupancy.

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Although we were facing many financial challenges, we clearly have turned around our operating results and are on an upswing. The primary drivers of the improvement are increased admissions, streamlining operating expenses, a new aggressive marketing campaign, a heightened focus on patient satisfaction and several revenue initiatives. With the infusion of needed capital, our facilities will have a modern look to match the quality of our clinical services. This positions us well for the future.

FOCUS: What types of financing are utilized to meet the hospital's goals?

GARRICK: We primarily look to the tax exempt markets to meet our major capital needs. With our latest bond financing completed, we will rely on operating results and philanthropic support to meet our capital needs for the next few years.

FOCUS: What are your spare time activities?

GARRICK: I spend most of my spare time with my wonderful wife and three fantastic children. (Can you tell my oldest kid was proofreading this for me?) My kids' sporting and extracurricular activities keep me well occupied but, when I can find the time, I do like to play golf.

FOCUS: What are your professional memberships?

GARRICK: My membership in the HFMA has been my most enjoyable and fruitful professional membership. I also maintain memberships in the American Institute of Certified Public Accounts and the New Jersey Society of Certified Public Accountants. Currently I am on the board of directors and Chairman of the Board of the Healthcare Employees Federal Credit Union.

FOCUS: You are just told you have 30 minutes to pack – you are going to a sparsely populated island. What would you bring, besides food, clothes, hygiene products, etc?

GARRICK: I have extensive camping experience from my days in Boy Scouts (my two brothers and I are Eagle scouts). My first thoughts are to bring key survival gear. After that I would be sure to bring several books (I try to read as often as possible) and a short wave radio that will pick up signals from vast distances. I don't believe I can stay disconnected from civilization for too long.

Save the Date!

Annual NJ HFMA Golf Outing

May 1, 2008

Fiddler's Elbow Country Club • Far Hills, NJ

Member Spotlight:
Roger D. Sarao, CHFP

by James Yarsinsky, CPAM

Roger Sarao

FOCUS: Please provide us with a brief bio about yourself.

ROGER: For the past ten years I've had the privilege to work for the New Jersey Hospital Association, located in Princeton. NJHA is a not-for-profit trade organization committed to helping New Jersey hospitals and health systems provide quality, accessible and affordable care to their communities. We offer an array of services and resources, including advocacy, data, education and many others, to support hospitals in their caring mission. My official title is Vice President of Economic & Financial Information, but like most titles, it paints only a partial picture of my day-to-day responsibilities, which are varied and always changing. My primary responsibility is to oversee the production of numerous financial reports designed to help our membership make sound decisions on reimbursement and budget issues.

Prior to joining NJHA, I spent five years with Kaden Arnone, a healthcare consulting and software development firm. During this period I split my time between consulting services – where I learned the intricacies of healthcare reimbursement, hospital budgeting and managed care contracting – and software development. By building hospital-based cost accounting systems from the ground up, I learned about the need for – and the value of – quality data for problem-solving within the hospital industry.

I am an active member of the NJ Chapter of HFMA, serving on both the Patient Financial Services Committee and the Publications Committee. In addition, I periodically provide updates on critical healthcare issues at the NJ HFMA's Board meetings and quarterly educational sessions. Shortly after joining HFMA, I took and passed the exam to become a Certified Healthcare Financial Professional (CHFP).

FOCUS: Roger, please describe your responsibilities at the New Jersey Hospital Association.

ROGER: In addition to overseeing the periodic decision support reports from NJHA, one of my key responsibilities is to assist the hospital industry in reacting to proposed regulatory and legislative changes that may impact the current business of healthcare. For example, Medicare recently stated its intention to terminate a specific wage index provision that had been in place for three years and benefited more than 30 NJ hospitals by approximately $70 million annually. By quantifying the benefit and identifying the hospitals that gained from this provision, NJHA was able to play a significant role in getting Congress to pressure Medicare to extend the provision for an additional year. We are now working to make this wage index provision permanent.

Another issue I'm working on is the NJ charity care program. By helping build consensus around a set of guiding principals, we were successful in not only modifying the distribution formula to make it more equitable, but also in securing additional funds to be paid to hospitals for the charity care services they provide. Granted, we still have a long way to go to "fix" this contentious issue, but each year we are able to build upon the successes of the prior year. The opportunity to actively participate in finding solution to these ever evolving and ongoing healthcare issues is one of the most personally rewarding aspects of my work.

FOCUS: How did you get where you are today professionally?

ROGER: I graduated from Rutgers University in 1990 with a bachelors' degree in political science. Subsequently I received a Masters in Public Administration (MPA) from the University of Missouri-Columbia. As part of my graduate studies, I worked for a summer as an academic intern at St. Mary's Health Center in Jefferson City, where I spent a week shadowing each member of the executive team, from the CEO to the Human Resources Manager. I also worked on special projects, including a comprehensive physician recruitment plan that identified the community's need for physicians in specific specialties. Prior to the internship, the idea of working in healthcare had never seriously entered my mind. However, that experience led me to select Hospital Administration as my area of concentration for my MPA. When I returned

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home, I knew I wanted to do something "hospital-related," and when a friend approached me about an opening at a healthcare consulting firm, I decided to interview and was offered a position as Financial Analyst.

FOCUS: To what do you contribute your success?

ROGER: Hard work, always being honest and straightforward with colleagues and clients, maintaining a positive outlook, recognizing one's role as a team player, building a team of talented individuals with which to work, developing relationships within the healthcare industry, luck, and more hard work!

Also, I have had the good fortune to work for certain individuals who have not only taught me a great deal, but have done so through leading by example. Guy Evans, my first supervisor, taught me that hard work could be fun and rewarding and encouraged me to think "outside the box." Sean Hopkins, current Senior Vice President of Health Economics at NJHA, has been my supervisor, mentor and friend for over a dozen years now. From Sean I learned the value of one's integrity – how long it takes to build, and how quickly it can be dismantled by taking shortcuts. I sincerely thank them both for their guidance and friendship over the years.

FOCUS: What do you think are the most pressing issues facing healthcare executives today?

ROGER: NJ hospitals are facing their most difficult times financially at this very moment. The overwhelming majority of hospitals in our state are classified as "not-for-profit" organizations. This does not mean that our hospitals can survive without generating a bottom line. This is a misconception that has existed in the minds of the public for far too long. Creditors and ratings agencies agree that non-profit hospitals still need to maintain a bottom line, or operating margin, of at least 3 to 5 percent in order to reinvest in their physical infrastructures, develop new services, purchase new medical technologies, and pay their employees competitive salaries.

Through September 30, 2007, the average statewide operating margin for NJ's acute care hospitals was barely above break-even at 0.5 percent. Nearly half of our hospitals ended that period in the red. In fact, one would have to go back to 1996 to find a NJ statewide operating margin above two percent. One of the key drivers of this fiscal crisis is inadequate reimbursement from almost every major payer group. Medicare pays hospitals only 89 percent of actual costs. Medicaid pays just 69 percent of costs. Charity care varies greatly between hospitals but, on average, reimburses hospitals a little over 50 percent of the true cost for treating those patients. Managed care companies use other tactics in addition to low payment rates. They find creative ways to deny or delay payment of valid claims. Hospitals have responded by aggressively cutting costs and lowering lengths of stay, but there is only so much cost-trimming that can be done before it produces more harm than good. Unfortunately, we are seeing the results of this crisis – a rapid growth in recent hospital bankruptcies and closures.

FOCUS: What advice do you have for members who want to move up in their current healthcare careers?

ROGER: Regardless of what your "first job" is in healthcare, immerse yourself in it and do it to the best of your ability. Always do more than asked. Try to deliver what you promised sooner rather than later. Recognize that some work – particularly entry-level positions – may seem like thankless work. But ultimately, people do notice those who work harder, who want to learn more about why they are doing their job, and who perform their responsibilities with a positive, unselfish attitude. Trust that anything you learn while working for an organization is a skill that you will take with you wherever you may go next. If you find yourself in a bad situation, don't be afraid to leave and try something new. You will know that you have discovered a good fit when you find yourself excited about coming to work and interacting with your co-workers.

FOCUS: What are your hobbies and outside interests?

ROGER: Right now, my fiancé, Amanda and I are busy finalizing our wedding plans; we are getting married in April. We're both looking forward to the honeymoon – two weeks of no work, sightseeing, fine dining and relaxation in Paris and London. Other than that, I am an avid book collector and reader, and have recently discovered the great "classic" films from the old masters. I also love animals. We have a four-year-old cat named Novi that we've spoiled rotten, but she gives us back hours of entertainment and unconditional love.

FOCUS: Thank you Roger for taking time out of your busy schedule to be interviewed for this edition of FOCUS.

ROGER: Thank you, Jim. I enjoyed the experience.

About the Author

Jim Yarsinsky, CPAM, is president of Expeditive, a BESLER affiliated company. He can be reached at jyarsinsky @expeditive.com.

Reducing the Incidence of Hospital-Acquired Infections

by Aline Holmes, RN, APNC, MSN

Momentum for the public reporting of a variety of data on the performance of our healthcare system has been increasing over the past several years. Consumer demand for healthcare information also has increased. Consumer groups are demanding tools for stakeholders to help them make more informed choices when considering different healthcare providers whether hospitals, nursing homes or physicians.

Public reporting of healthcare data usually is shown through either process or outcome measures. Process measures demonstrate adherence to evidence-based practices and likely are tied to better outcomes. Process measures include things like giving an aspirin to every patient in the emergency department who presents with a possible diagnosis of a heart attack, smoking cessation advice or ensuring that every patient with diabetes gets an annual eye exam. Outcome measures explain the results of care being delivered and include measures such as mortality, falls and complications of care such as healthcare-acquired infections (HAI).

There has not been enough research to determine whether there is a clear relationship between adherence to process measures and consistent results with better outcomes. As Shih and Schoenbaum[1] noted in their article for The Commonwealth Fund, both outcome and process measures are useful for improving care, but outcome measures alone, such as mortality rates, may be related to many other factors outside of the provider's control. This is important especially when one discusses the public reporting of HAIs.

HAIs are infections that patients acquire during the course of receiving treatment for other conditions. As defined by the Centers for Disease Control's Healthcare Infection Control Practices Advisory Committee (HICPAC), HAIs are localized or systemic conditions resulting from an adverse reaction to the presence of an infectious agent(s) or its toxin(s) that 1) occurs in a patient in a healthcare setting, 2) was not found to be present or incubating at the time of admission unless the infection was related to a previous admission to the same settings and 3) if the setting is a hospital, meets the criteria for a specific infection site as defined by CDC.[2]

Measures for public reporting should include data that is meaningful not only for the public but also for healthcare providers to use in quality improvement efforts.

In 2005, HICPAC performed a scientific literature review to evaluate the merits and limitations of HAI reporting systems and found no published information on the effectiveness of public reporting systems in reducing HAIs. They therefore concluded there was insufficient evidence at that time to recommend for or against public reporting of HAIs.

However, given the current demand to put such systems into place, HICPAC did develop a framework for the design and implementation of such a system. These recommendations were endorsed by the association for Professionals in Infection Control and Epidemiology, the Council of State and Territorial Epidemiologists and the Society for Healthcare Epidemiologists of America. Measures for public reporting should include data that is meaningful not only for the public but also for healthcare providers to use in quality improvement efforts.

Measures should include both process and outcome measures, and these measures should be endorsed by the National Quality Forum (NQF), the lead agency charged with the development of healthcare performance measures through a voluntary consensus process. NQF has membership consisting of not only providers, but also payors and government and consumer groups like Leapfrog. The NQF has convened a task force that has been developing consensus standards for the reporting of HAI data over the past year.

Process measures might include coverage rates for vaccination of patients for influenza and pneumonia, surgical antimicrobial prophylaxis and adherence to surgical site preparation. Outcome measures could cover central line-associated, laboratory-confirmed primary bloodstream infections (CLABSI) in intensive care units and surgical site infections (SSI) following selected operations. Both of these infections occur at relatively low rates but

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are associated with substantial morbidity and mortality, as well as excess healthcare costs. Also, there are well established evidence based guidelines for the prevention of these types of infections. The evidence for other types of HAIs, like ventilator-associated infections (VAP) and catheter-associated urinary tract infections (CAUTI) is not as good and the NQF has not yet adopted formally a clear definition of these and other infections. In addition, outcome measures also need to be adjusted to account for differences in risk factors of patients.

The reporting of some outcome measures may be difficult for the consumer to use, especially when they are device related. For instance, the determination of a CLABSI rate is determined by dividing the number of CLABSIs for a period of time by the number of central line days for that same period of time and then multiplying by 1,000 to get a rate that defines the number of infections per 1,000 central line days. One of the key prevention strategies to reduce the incidence of these infections is to get the central line out as soon as possible, a strategy used with many other device-related infections like ventilators and Foley catheters. As providers reduce the number of device days, the denominator goes down. So while the numerator may be going down, (i.e. the number of infections) the denominator also is going down, and infection rates may go up.

The New Jersey Hospital Association (NJHA) has endorsed the concept of public reporting and transparency, but only where there is clear definition and endorsement by national agencies such as NQF and CDC and where there are resources devoted to the development of a system to collect and report this data.

New Jersey's public reporting bill, S919, was signed into law on Oct. 31, 2007. This legislation requires the reporting of hospital process of care measures and infection rates as identified by the New Jersey Department of Health and Senior Services Quality Improvement Advisory Committee (NJDHSS/QIAC). The department must develop and adopt a set of rules and regulations for this legislation, and this process could take 12 months or more. The department already has made the decision to use the CDC's online HAI system named the CDC National Healthcare Safety Network (NHSN) as the tool to collect the data from hospitals. Many New Jersey hospitals already are beginning to use the system voluntarily for benchmarking purposes.

NJHA has been actively involved in working with member hospitals to reduce the incidence of HAIs through both its ICU Collaborative in 2004-2006, which focused on reducing the incidence of VAP and CLABSI and its current Antimicrobial Resistance Collaborative. Working with 35 hospital ICUs, the rate of VAP was reduced by 55 percent, and the rate of CLABSI was reduced by 73 percent in 2006. All of our hospitals worked hard to reduce the device days, i.e. get patients off ventilators as soon as possible and get central lines out quickly, and did see their rates go up as described above.

About midway through the collaborative, with many of our hospitals seeing months with no VAP or CLABSI, NJHA Quality Institute staff encouraged them to track both rates of infection and also how many months they could go with no such infections. There are many New Jersey hospitals reporting no VAP and/or no CLABSI for one or more years. Both of these infections have significant mortality rates and for the finance people, the average cost of a CLABSI is $45,000 per hospital admission.[3]

In summary, NJHA has supported the public reporting of HAIs where there is endorsement of the reported measures by the NQF and there is a valid, reliable system to collect and report the data consistently with appropriate risk adjustment. All of these criteria will be in place when the NJDHSS begins to require reporting through the CDC NHSN system.

NJHA also supported the recently passed MRSA screening and reporting law, and the reporting of that data also will be through NHSN. NJHA has endorsed the principle of transparency and already posts hospital-specific quality data on its Web site at http://www.njhospitalcarecompare.com/. Through its Quality Institute, NJHA has developed a public resource Web site at http://www.njha.com/qualityinstitute/consumer.aspx. We will continue to develop resources to reduce the incidence of HAIs and to provide information to the public on a variety of healthcare-associated issues.

About the Author

Aline Holmes, RN, APNC, MSN, is the senior vice president, clinical affairs, for the New Jersey Hospital Association and the director of its Quality Institute. She is an advanced practice nurse with many years of hospital and nursing administrative experience and has worked in a variety of other healthcare settings including the U. S. Navy Nurse Corps, long term care and managed care. She has also taught in both undergraduate and graduate levels of nursing.

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[1] Shih, A. and Schoenbaum, S., Measuring Hospital Performance: The Importance of Process Measures, The Commonwealth Fund, July 2007.

[2] McKibben, L. et al., Guidance on Public Reporting of Healthcare-Associated Infections: Recommendations of the Healthcare Infection Control Practices Advisory Committee

[3] CDC 2002 Guidelines for the Prevention of Intravascular Catheter Related Infections

•Focus on Finance•

Answers to your Accounting and Tax Questions

IRS Releases Redesigned Form 990

Q. On December 20, 2007 the IRS released in final format the redesigned Form 990; what is the Form 990?

A. The Form 990 is the tax return filed annually by an organization recognized by the IRS as a tax-exempt organization. These organizations typically include charities, hospitals, foundations, nursing homes, colleges and universities. The official name of the Form 990 is "Return of Organization Exempt From Income Tax".

Q. Before now when was the last time the IRS significantly changed the Form 990?

A. The last time the IRS significantly revised the Form 990 was in 1979; 29 years ago.

Q. Why did the IRS decide to significantly redesign the Form 990?

A. The IRS felt that the prior Form 990 failed to keep pace with changes in the laws, rules and regulations of the tax-exempt industry and the increasing size, diversity and complexity of the tax-exempt industry. As a result, the Form 990 in its format prior to this major revision failed to meet the IRS' tax compliance interests or the transparency and accountability needs of the state taxing authorities and the general public.

Q. What is the effective date of the redesigned Form 990?

A. Organizations are required to use the redesigned Form 990 for the year ending December 31, 2008, to be filed in 2009. Organizations will file the old format Form 990 for the year ending December 31, 2007.

Q. What is the structure of the redesigned Form 990?

A. The redesigned Form 990 consists of an 11-page main part, or "core form" as the IRS refers to it, containing 10 different parts. In addition, the IRS also created supplemental schedules which may also have to be completed as part of the Form 990 annually. These schedules begin with the letter A and continue through the letter R (except no Schedule P). Part IV of the main part of the redesigned Form 990 is called Checklist of Required Schedules and is comprised of 37 questions. These 37 questions will determine which Schedules A through R an organization must also complete annually. It is important to note that hospitals will be required to complete many of these supplemental schedules.

Q. In recent years the IRS has implemented various compliance and enforcement initiatives with respect to the tax-exempt sector, particularly with hospitals. Are any of these initiatives and the results and findings incorporated into the redesigned Form 990?

A. Yes, both Part VII of the main part of the redesigned Form 990 and Schedule J, Compensation Information, relate to compensation of officers, directors, trustees, key employees, highest compensated employees and independent contractors and ask for more detailed information than the prior Form 990. For example, Schedule J requires compensation of certain individuals to be disclosed by specific elements such as base compensation, bonus/incentive compensation, other compensation, deferred compensation and nontaxable benefits. These schedules reflect certain results and findings of the May 2006 IRS Form 13790, Compliance Check Questionnaire for Tax Exempt Hospitals and the 2004 IRS executive compensation and benefits initiative.

In addition, Schedule H, Hospitals, is applicable specifically to hospitals and asks for information relating to community benefit provided by the hospital. This schedule also reflects certain results and findings of the May 2006 IRS Form 13790, Compliance Check Questionnaire for Tax Exempt Hospitals.

Schedule K, Supplemental Information on Tax-Exempt Bonds, also incorporates certain portions of the recent IRS tax-exempt bond initiative and related IRS Form 13907, Tax-Exempt Bond Financings Compliance Check Questionnaire.

However, there is some good news with respect to both Schedules H and K. The IRS granted some transitional relief for organizations in order to allow them to prepare and implement the procedures to accurately accumulate and report the requested information. For the 2008 redesigned Form 990, certain sections of both schedules are optional. Of course, organizations may still fully complete both Schedules H and K with their 2008 Form 990 (filed in 2009) if they desire. Both Schedules H and K must be fully completed with the 2009 Form 990 (filed in 2010).

Q. With respect to Schedule H and tax-exempt hospitals, the determination of what constitutes community benefit and how it is quantified has been highly publicized; does the final version of the Schedule H help clarify the issue?

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A. Yes. The draft version of the redesigned Form 990 reflected the Catholic Health Association interpretation of community benefit which does not recognize Medicare shortfalls and bad debt as part of its quantification of community benefit costs. The final version of the redesigned Form 990, Schedule H now includes a separate section which allows a hospital to show its Medicare shortfalls and bad debt costs which is a position supported by the American Hospital Association and many tax-exempt hospitals. Although not included in the section relating to charity care and community benefit costs on Schedule H, at least Schedule H now allows a hospital to fully disclose costs associated with Medicare shortfalls and bad debt.

Q. What other parts of the redesigned Form 990 and supplemental schedules do you feel that a hospital should pay particularly close attention to in addition to those noted immediately above?

A. A hospital must review in depth Part VI of the main part of the redesigned Form 990 entitled Governance, Management and Disclosure. Part VI is very important and relates to the organization's governance practices. It is important to note that certain questions in this part of the redesigned Form 990 require written explanations and not just yes/no responses.

In addition, I recommend that a hospital closely examine the following supplemental schedules to ensure adequate preparation and full and proper disclosure:

Schedule C
Political Campaign and Lobbying Activities
Schedule D
Supplemental Financial Statements
Schedule L
Transactions with Interested Persons ("Conflicts")
Schedule R
Related Organizations and Unrelated Partnerships

Q. How should a tax-exempt organization approach the preparation of the redesigned Form 990 and when do you recommend the process begin?

A. I recommend that an organization start planning for the redesigned Form 990 immediately. An organization should form an internal working group to review the redesigned Form 990 and assign duties and responsibilities as appropriate. The working group should include finance personnel; in-house counsel; patient account personnel; corporate compliance and human resources. An organization's CEO and COO should also be involved on high level issues. An organization may also want to present the redesigned Form 990 to its Board of Trustees for review and their consideration. An organization should also seek assistance externally from its advisors, including its attorneys and accountants. Starting the process now allows an organization to implement certain changes due to the redesigned Form 990 and the new disclosures.

The redesigned Form 990 and supplemental schedules constitutes the largest and most significant revision to anything we've seen in the last 20 years in the tax-exempt sector from a tax perspective. The redesigned Form 990 and supplemental schedules are exhaustive and will require a significant amount of additional time and effort not previously associated with the old format Form 990.

Q. Do you foresee any further changes with the community benefit standard and qualification for tax-exemption for hospitals as a result of the redesigned Form 990 in the future?

A. Yes, I believe that the IRS will likely attempt to change the basis for tax-exemption for hospitals. The current community benefit standard as the basis for tax-exemption was outlined in IRS Revenue Ruling 69-545; almost 40 years ago. Under this Ruling the criteria for tax-exemption includes a requirement to provide health care services to all individual's regardless of ability to pay, including charity care, self-pay, Medicare and Medicaid patients; operating an active emergency room for all persons; which is open 24 hours a day, 7 days a week, 365 days per year; maintaining an open medical staff, with privileges available to all qualified physicians; and ensuring control rests with its Board of Directors; which is comprised of independent civic leaders and other prominent members of the community.

Many, including the IRS, feel the criteria in this Ruling is outdated like the prior Form 990 and needs to be updated to reflect the changes in the laws, rules and regulations of the tax-exempt industry. To that end, I believe that sometime in the near future the IRS will attempt to enact some criteria whereby a hospital will need to meet a certain minimum dollar amount of community benefit costs annually in order to maintain classification as an Internal Revenue Code Section 501(c)(3) tax-exempt organization. The redesigned Form 990 is a significant first step in this direction as the IRS will be receiving community benefit costs information annually on each hospital's Schedule H.

About the Author

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If you have a question related to accounting or tax that you would like answered in the next issue of Garden State Focus, please e-mail it to elitten@foxrothschild.com. Your questions are greatly encouraged!

hfma new jersey chapter
healthcare financial management association

Dear Fellow HFMA Members:

Each year the NJ Chapter awards an education scholarship to a member, members' spouse or members' dependent based on certain criteria. I am pleased to invite you to apply for this years' 2008 HFMA Scholarship. The New Jersey Chapter of HFMA will award at least one scholarship of up to $3,000. You, your spouse or dependent may be eligible for the scholarship if you meet the following criteria:

- Member, in good standing, of the New Jersey Chapter for the last two years.
- Spouse or dependent of a member, in good standing, of the New Jersey Chapter, for the last two years.
- Enrolled in an accredited college, university, nursing school or other allied health professional school.

Preference will be given to applicants pursuing degrees in finance, accounting, healthcare administration or a healthcare related field of study. Tuition not paid by an employee or other scholarship will qualify for the HFMA scholarship.

We make our selection based on merit, academic achievement, civic and professional activities, course of study and content of your application and essay. We do not use income in our selection process. To apply, please submit a completed Scholarship Application, no later than April 1, 2008. Members of the Board of Directors, Officers and Advisory Council and their spouses or dependents are not eligible for scholarships.

We will announce the recipients of the 2008 NJ HFMA Scholarship at our quarterly meeting on June 11, 2008. If you have any questions or wish to receive additional applications, please email me at dlindstrom@somerset-healthcare.com.

We look forward to receiving your application and wish you success in your academic endeavors.

Wishing you continued success,

Dorothy Lindstrom
Chairperson, 2008 Scholarship Committee

NEW JERSEY HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION MEMBER'S ANNUAL SCHOLARSHIP APPLICATION

MEMBER INFORMATION

Members Name _____
Member Address _____
_____
Membership #_____

#Years in HFMA _____ # Years in NJ Chapter

Member Employer _____

APPLICANT INFORMATION
PART 1 - PERSONAL DATA

Applicant Name _____
Address _____
_____
Relationship to Member_____
College _____
_____
Course (s) to be taken _____
_____

Matriculated Student YES _____ NO _____
Degree/Program Pursued _____
Anticipated Graduation Date _____
Major _____ Annual Tuition _____
Amount of Employer Support _____
Amount of Other Scholarships Awarded _____

(Proof must be provided supporting tuition, employer's reimbursement policy and enrollment in school

PART 2 – EDUCATION BACKGROUND

Highest Level of Education Attained _____
School _____
_____
GPA _____ Degree_____ Major _____

(Proof must be provided documenting Grade Point Average)

PART 3 – PROFESSIONAL CAREER

Employment History (List employment history as Attachment A.)

PART 4 – COMMUNITY AND PROFESSIONAL ACTIVITIES

Please describe your civic and professional activities and contributions to your community, profession, HFMA or other organization. (Please label as Attachment B.)

PART 5 - ESSAY

Please submit an essay describing your educational and professional goals and the role of this scholarship will Play in helping you achieve them. (Please label as Attachment C.)

PART 6 - REFERENCES

Please furnish three formal reference letters (Please label as Attachment D.)

SIGNATURE _____ DATE _____

Please return completed package no later than April 1, 2008 to:

Dorothy Lindstrom
Director PFS
Somerset Medical Center
110 Rehill Ave
Somerville, NJ 08876-2598

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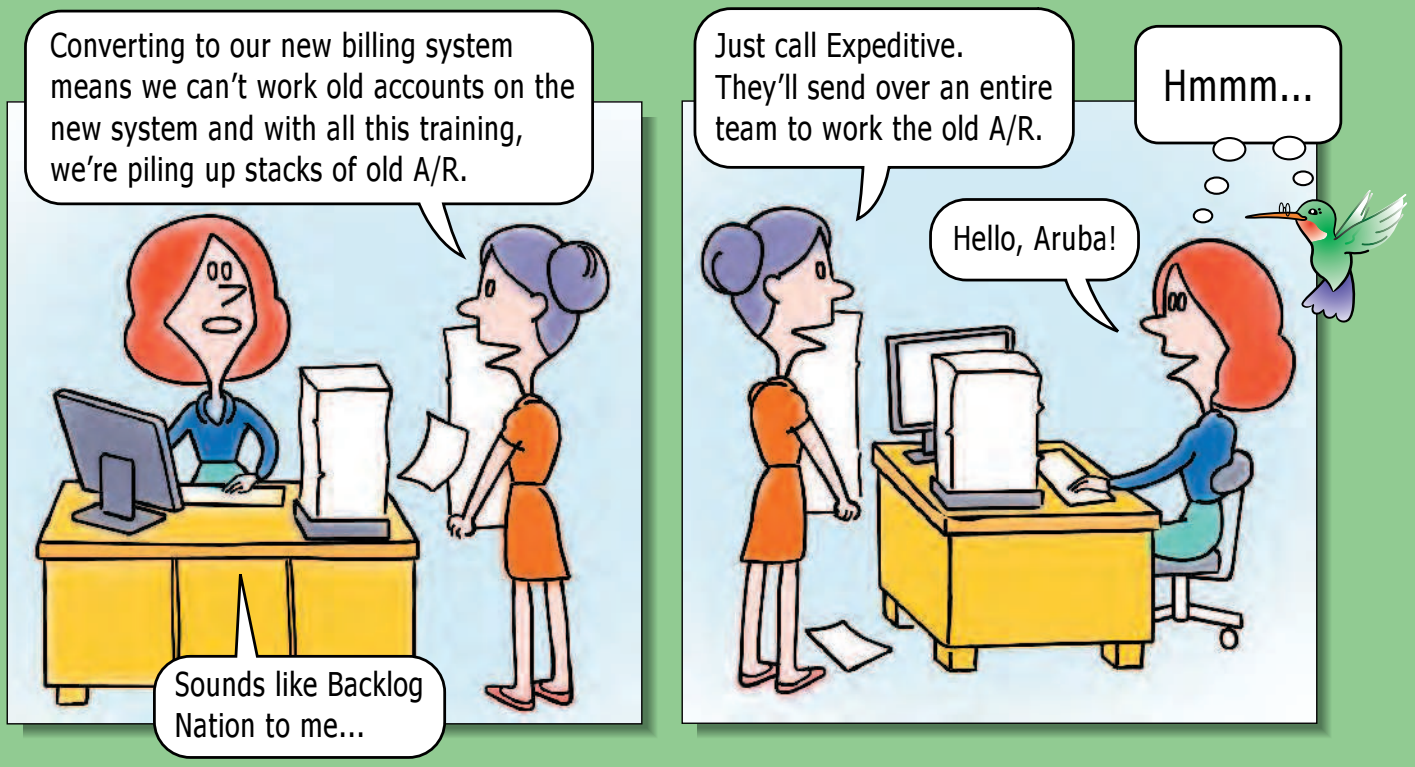

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•Who's Who in NJ Chapter Committees•

2007-2008 Chapter Committees and Scheduled Meeting Dates

For more information on our committees, including each committees' goals and objectives, please visit our website at www.hfmanj.org. NOTE: Committees have use of the NJHFMA Conference call line. The call in number is (866) 459-4772. If the committee uses the conference calll line, their respective attendee codes are listed with the meeting date information below.

COMMITTEE	CHAIRMAN/EMAIL/ PHONE	CO-CHAIR/EMAIL/ PHONE	SCHEDULED MEETING DATES/TIMES
Certification	Michael Alwell/mike.alwell@ahsys.org 973-656-6949	Kevin Lenahan/kevin.lenahan@ahsys.org 973-451-2085	TBD Attendee Code: 8412570
CARE (Compliance, Audit, Risk, & Ethics)	Tom Flynn/tflynn@humed.com 201-996-5611	Nancy Graham/ngraham@beslerconsulting.com 732-392-8243	First Thursday of the Month 9:00 AM Attendee Code: 7165283
Education	Rita Romeu/romeur@comcast.com 973-614-9100	Sue Bonfield/bonfields@deborah.org 609-893-1200 x5580	First Friday of each month 9:00AM Attendee Code: 7719071
Events & Networking	Lori Deitch/ldeitch@withum.com 973-898-9494	Jeff Weinstein/jlw717@aol.com 908-806-8222	Third Tuesday of each Month 5:30 PM Attendee Code: 7090412
FACT (Finance, Accounting, Capital & Taxes)	Julius Green/jgreen@parentenet.com 215-972-2352	Heather L. Weber/hweber@parentenet.com 215-557-2016	First Wednesday of each Month 8:30 AM Attendee Code: 2916514
Institute 2008	Tracey Davison-DiCanto tdavison-dicanto@princetonhcs.org 609-430-7796	John Brault/john.brault@ehmc.com 201-894-3099	First Tuesday of each Month 9:00 AM Attendee Code: 3322355
Materials/Procurement	Bill Schweber/bschweber@ptcmedsol.com 917-523-7079		Fourth Friday of each month 9:30 AM Attendee Code: 3427858
Membership Services/ Directory	Deborah Shapiro/dshapiro@wfs-services.com 201-617-7100	Rosemary Nuzzo/rosemary.nuzzo@atlanticare.org 609-383-2114	Third Wednesday of each Month 9:00 AM Attendee Code: 6752870
Patient Access Services	Holly Marciniak marciniak.holly@hunterdonhealthcare.org 908-237-7012	Marilyn Rohrbach mrohrbach@carrierclinic.com 908-281-1317	(no August Meeting) Second Thursday of each Month 9:30 AM Attendee Code: 5084608
Patient Financial Services	Anne Goodwill-Pritchett agoodwillpritchett@humed.com 201-996-3364	Laurie Grey laurie.grey@princetonhcs.org 609-620-8383	Second Friday of each Month 10:00 AM Attendee Code: 7182515
Proaction	Kevin Pleasant/kpleasant@accurohealth.com 732-383-4994	Mary Cronin/mcronin@beslerconsulting.com 732-839-1217	Second Thursday of each Month 9:00 AM Attendee Code: 6104186
Publications	Elizabeth Litten/ELitten@foxrothschild.com 609-896-3600	Joan Hendler/joanh@remexinc.com 609-921-8950	First Thursday of each month 9:15 AM Attendee Code: 4172885

Meet Some of our New Members

	Mitch Blume	Kevin Margolis	Michelle Merchant
Who is your employer, and what is your position?	Newark Beth Israel Medical Center, Director of Patient Financial Services	Aetna, Contract Negotiator	Horizon Blue Cross Blue Shield of New Jersey, Hospital Account Executive
What was your first job as a teen?	Cook at Arby's	McDonalds at 14	The card girl at the local Hallmark store in Bergenfield, NJ. I was responsible for stocking and ordering all the cards on the racks.
What do you like best about your work responsibilities?	Take Pride. Take Ownership. Deliver Excellence. Patients 1st.	Successfully negotiating long term agreementst that benefit both parties	Visiting my network hospitals and working with their managed care and clinical professionals on collaborations that are designed to improve the health of their patients, our members.
A job I would enjoy doing without pay is...	College Football coach for my alma mater, Tulane University	White House Secretary	An antique dealer
My favorite place is...	Saint Lucia	Montreaux, Switzerland	My home
I will not eat...	Liver	Shellfish (allergic)	Mussels
If I'm not at work, you will find me…	With my two boys, ages 4 and 2.	Traveling	At home

New Members

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JOB BANK SUMMARY LISTING

HFMA-NJ's Publications Committee strives to bring New Jersey Chapter members timely and useful information in a convenient, accessible manner. Thus, this Job Bank Summary listing provides just the key components of each recently-posted position in an easy-to-read format, helping employers reach the most qualified pool of potential candidates, and helping our readers find the best new job opportunities. For more detailed information on any position and the most complete, up-to-date listing, go to HFMA-NJ's **Job Bank Online** *at* **www.hfmanj.org.**

[Note to employers: please allow five business days for ads to appear on the Web site.]

Job Position and Organization

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ASSISTANT DIRECTOR OF QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT INITIATIVES
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✔ Mark Your Calendar

February 7, 2008	6-9 pm	Current Trends In Physician Practice Mgmt. – Module 2 The Physician Practice Regulatory Environment Strategic Planning & the Successful Practice	Woodbridge Hilton
February 21, 2008	all day	Business Writing Seminar	Atlantic Health Systems, Morris Plains
February 28, 2008	6-9 pm	Advanced Financial Mgmt Series – Module 1 – Programs for the Uninsured	Woodbridge Hilton
March 5, 2008	all day	Quarterly Meeting – Compliance, Audit, Risk, & Ethics (CARE)	Woodbridge Hilton
March 12, 2008	9-12am	Women's Session	Woodbridge Hilton
March 12, 2008	6-9 pm	Current Trends In Physician Practice Mgmt. – Module 3 Physician-Hospital Business Relationships -- Addressing the Legal Issues	Woodbridge Hilton
March 27, 2008	6-9 pm	Advanced Financial Mgmt Series – Module 2 Surviving the Widening Credit Chasm	Woodbridge Hilton
April 24, 2008	6-9 pm	Advanced Financial Mgmt Series – Module 3 Hospital Profiling	Woodbridge Hilton

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