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Who’s Who in the Chapter .......................................................... 2
The President’s View ................................................................. 3
by Dotti Lindstrom ................................................................. 3
From the Editor ........................................................................... 4
by Elizabeth G. Litten, Esq. ........................................................ 4
Focus on Finance ................................................................. 28
Job Bank Summary ................................................................. 37
New Members ........................................................................ 38
Meet Some of Our New Members ........................................ 39
Who’s Who in Chapter Committees .................................. 40
Mark Your Calendar ................................................................. 40
Advertiser Focus .................................................................. 48

New Jersey’s Paramedic System Collapses: A Decade of Indifference Allows Financial Ruin
by Vincent D. Robbins ............................................................ 7

The New Jersey Hospital Industry: A Mounting Financial Crisis
by Joseph M. Lemaire and Sean J. Hopkins ........................................ 13

Federal and State Tax Exemption For Non-Profit Voluntary Hospitals – Part 2
by Andrew F. McBride, III, Esq. .................................................. 18

Department of Banking and Insurance Considers Rule Change Affecting Out-of-Network Non-Hospital Providers
by Darin S. Portnoy, Esq. & Susan G. Steinman, Esq. ......................... 24

CFO Spotlight: Michael Keen .................................................. 26

Member Spotlight: Caitlin Zulla, CHFP
by James Yarsinsky, CPAM ......................................................... 27

Consumerism: A Practical Approach
by John Manzi ........................................................................... 29

Much Ado About Nothing: Out-of-Network Standards
by Wardell Sanders .................................................................... 33

HFMA Certification: A Recently Certified Member’s View
by Rita Romeu, Ph.D., FHFMA .................................................. 35

Member Recognition Dinner, March 9, 2007 .................................. 42-44

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Who’s Who in the Chapter 2006-2007
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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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Dear HFMA Members

The last two months of cold, icy, snowy winter weather did not stop the Chapter and its volunteers from putting together another successful Quarterly session in March. Over 160 members attended the education-packed session, “Getting To The Bottom Line: Integrating Compliance with Operations.” A special thanks to B.J. Welsh, Nancy Graham and the Corporate Compliance / Ethics Committee members for all of their hard work and dedication in preparing for this session. In addition, many thanks to the other committees who participated with them in putting together an agenda that covered the varied interests of our membership.

We also honored our award winners on March 9, 2007 at the Marriott Hotel in Bridgewater. The event was less formal this year and we increased the allotted time for the cocktail hour so our members could network and enjoy their successes with other members. Congratulations to all the award winners. Please check out their photos in this edition.

The new slate of officers for 2007-2008 was approved by the membership at the March meeting. Three new members will be joining the Board come this June: Caitlin Zulla, Dennis Hancock, and Mike Richetti. Congratulations to all of them. I am certain that they will serve the Chapter well.

The Chapter website has been newly redesigned and the revamped look is great. The IT Committee deserves a great deal of credit for a job well done. Special accolades go to Mary Taylor for spearheading this effort and Jack Tenerelli and Al Rottkamp for their technical and creative expertise.

Since we have such a busy schedule over the next few months it will give you a reason to check the new website for additional information. Don’t forget to mark your calendars for the following events:

- April 18, 2007 Medicare Cost Report
- April 18, 007 Golf Warm-Up and Clinic
- May 8, 2007 PC Training Session
- May 10, 2007 Annual Golf Outing Fiddlers Country Club
- May 23, 2007 Golf Clinic and Outing Pine Barrens Golf Course.

We are still accepting applications for our Scholarship Program. Please go to our website for additional information and an application form.

Attendance at all of our programs has increased this year and the Board of Directors and I would like to thank all of the members who supported these educational events. As always, please contact me directly, or any Board member, with questions or suggestions you may have with regard to the NJ Chapter.

Happy Spring!

Dotti Lindstrom
Dear Readers:

The challenges of providing health care in New Jersey continue, but, despite the alarming connotations of this issue’s cover photo and even more alarming messages included in this issue’s lead articles, many of our New Jersey members are actively engaged in efforts to move the industry forward this spring and in the months ahead. We will begin featuring some of these forward-moving or thinking activities in upcoming issues, so as to inspire readers and to balance the more alarming and concerning issues faced by the New Jersey health care industry with a few uplifting, positive developments.

Speaking of positive developments, I hope readers will take the time to access the new New Jersey HFMA Chapter website (at www.hfmanj.org). Notice that the sky is blue, without a cloud in sight! Whether it’s spring fever, or simply my eagerness for good news regarding the financial future of New Jersey hospitals and other providers, I appreciate the new look of the website and the many hours spent by Chapter members in improving it.

Please also take time to read about a few of our new members on page 39. Nadinia, I’m with you when it comes to organ meats and slimy or unidentified substances! Also, while not profiled on page 39, I’d like to wish a warm welcome to a new member listed on page 38 – Stephen Farber. Stephen was my student advisor at Vassar College, and I had lost touch with him. I am thrilled to have reconnected with him professionally, and to see his name on our list of members.

Regards,

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Within the last three years, the state’s paramedic system has fallen into financial ruin. Virtually all Mobile Intensive Care Units (MICUs, also referred to as ALS, or advanced life support, units) in New Jersey are operating at varying degrees of fiscal loss. The issue has a long history at both the state and federal levels. New Jersey is the only state that mandates a two-tiered emergency medical services (EMS) system, prohibits paramedic units from transporting patients and provides no public funding of the paramedic tier. The two-tiered system is comprised of a local Basic Life Support (BLS) “first level” and a regional Advanced Life Support (ALS), otherwise known as the MICU or paramedic, “higher” level. The BLS ambulances respond to all 911 calls and transport virtually all the patients. The ALS, or paramedic tier, responds to only about a third of these calls, which are life threatening. The paramedic units are barred by regulation from transporting for the most part, and must use the BLS tier’s agencies to move patients to the hospital.

The paramedic tier is mandated by state law to be provided by hospitals through a Certificate of Need, in order to assure quality of care and overall system cost containment. These paramedic programs are “fee-for-service” based, billing for their services, but receive no tax subsidy or other public funding. They must rely solely on the revenue received from their patients and their patients’ insurance companies. Because ALS is a highly advanced level of care, the cost of providing paramedic service is very expensive, usually four to five times as much as BLS. The Commissioner of Health designates providers to serve established regions within the state comprised of multiple towns, where they interface with many BLS level agencies.

The BLS tier is provided by a mixture of unregulated, volunteer first aid squads and paid, vocation agencies. Some of these paid agencies are private, commercial ambulance companies, while others are municipally based services, both of which are partially subsidized by tax dollars. The volunteers

continued on page 9
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are not licensed and, therefore, cannot bill for their services. They survive on individual donations and tax subsidies primarily through town contributions. The paid services, whether commercial or municipal, are licensed, bill for their services and receive some form of tax subsidy. All BLS agencies, for the most part, interface with only one ALS provider. The town decides who and how their BLS service will be provided.

For many years this structure worked well because essentially all the BLS service in the state was provided by non-billing, volunteer first aid squads. In this scenario, the paramedic programs were able to bill Medicare and retain all the reimbursement revenue. New Jersey intentionally designed its EMS system this way, with a prohibition on ALS transport, to assure that the volunteer BLS agencies would not be supplanted by the paramedic services, clearly recognizing that all the funds from Medicare would be used to reimburse the ALS providers only.

However, with volunteer squads being replaced by billing BLS agencies more and more often, an ever increasing conflict has surfaced in New Jersey over the years. Unfortunately, under New Jersey's EMS structure, the paramedic providers and the paid, billing BLS ambulance agencies must fight over Medicare reimbursement. That's because Medicare, by federal regulation, only pays one bill, and that bill is for the level of medical transport, not the level of clinical care, provided to a beneficiary. Thus, when New Jersey's paramedic units answer a Medicare patient's life threatening emergency with a paid BLS agency, the paramedic unit automatically incurs an extra cost. The ALS provider must pay the BLS agency the latter's Medicare rate in order to retain the ability to bill Medicare at all. In other words, if the paramedic unit wishes to bill Medicare for its services, it must agree to split the reimbursement with the BLS agency. This has siphoned an ever growing amount of money from the paramedic programs in New Jersey to the benefit of the billing BLS agencies.

Even this was not too much of a concern ten years ago, when Medicare reimbursement for ALS service was much higher and the number of billing BLS agencies was much smaller. However, over the last decade many volunteer squads have been replaced with billing BLS ambulance agencies. In addition, since 2002 with implementation of its national fee schedule, Medicare has dramatically reduced the rate it pays for ALS service while simultaneously increasing what it pays for BLS transport. In 2006, the net reimbursement a paramedic program retained on each case after billing Medicare and paying the transporting BLS agency, was between $50 - $100.

Since the average paramedic program's cost to provide care is between $500 and $700 per case, the ALS providers in the state are losing significant amounts of money on every Medicare patient treated when interfacing with billing BLS agencies. And, since roughly half of all the patients paramedics care for are covered by Medicare, the ALS providers in New Jersey are losing millions of dollars a year. In fact, the New Jersey Association of Paramedic Programs (NJAPP) now estimates the annual drain on the state's MICU services exceeds $13 million. The number is so large now, that cost shifting to other payors, such as insurance companies, can no longer subsidize these losses.

The only alternative paramedic services have to generate more revenue under these circumstances, is to forfeit the right to bill Medicare, pursuing the elderly patient for the full cost of service. Instead of a senior in the state paying about $80 in co-pay cost associated with their Medicare paramedic bill, they would be forced to remit over $500 to $2,000, or more. These are the most vulnerable in society, living on fixed incomes and needing paramedics the most. It is not likely they will be able to easily pay such out-of-pocket costs. In fact, a growing number of cases are documented each year in New Jersey where elderly patients are refusing ALS care due to cost.

As of January, 2007, the largest paramedic provider in New Jersey (MONOC) began curtailing portions of its operations, directly affecting twelve towns in three counties. They found this action necessary because their warnings of this growing Medicare shortfall crisis and pleas for resolution over the last ten years, failed to result in any corrective action by the gov-

**continued on page 10**
Since the alarm bell was raised in 1996, only sporadic calls for some future, non-specific, compromised solution, by a so-called “EMS Coalition,” has been made by the industry’s constituent groups. Sadly, such an answer has never been crafted, proposed or implemented.

Even more onerously, the paramedic system has already begun to collapse. Thousands of calls for MICUs go unanswered every year in New Jersey because paramedic programs have been unable to afford placing needed additional units into service. These patients are denied state-of-the-art pre-hospital advanced medical care, now known to be vital in the survival of trauma, cardiac and stroke patients, and must settle for a rushed BLS ambulance ride, in unstable condition, to an overburdened hospital emergency department.

Since 2002, five paramedic programs in New Jersey have failed. In those cases MONOC absorbed their services and continued operations without interruption. This expansion of one provider, fueled by insolvent, smaller programs, acted initially as a hedge against the overall deteriorating reimbursement structure described. By increasing its economy of scale, dramatically reducing operating expenses and spreading remaining fixed costs, MONOC was able to fend off financial collapse until this year. Now, it is clear, no amount of expansion can forestall the losses inherent in the state’s paramedic system structure.

The Department of Health’s response to increasingly urgent requests for intervention has been very disappointing. Responding to MONOC in September, after being advised they expected to run out of money by the end of 2006 and be unable to continue full paramedic services, the NJDHHS wrote “…the Department will not be in a position to thoroughly evaluate the propriety of MONOC’s request …Accordingly, your request …must be denied.” And even worse, while meeting with them earlier in 2006, MONOC representatives were advised that the Department would be unable to intervene until there was a public health emergency, constituted by an inability to staff paramedic units!

The Department continues to defer to an EMS study mandated by the state legislature, which is not due for completion until the middle to end of 2007, as an excuse to refrain from intervening. Even the President of the state’s paramedic administrators’ group, NJAPP, was recently quoted in the state First Aid Council’s monthly publication as saying “MONOC needs help and so do the rest of us.”

Several possible solutions to this crisis have been proposed by some individuals in recent years, and include:

➢ A new statewide fund, established through new fees, accessible only to the degree needed to replace the Medicare shortfall suffered by paramedic programs.

➢ Reallocation of excess, existing monies from another fund, such as a portion of the State MedEvac fund currently earmarked to purchase a third, unnecessary helicopter, again restricting those monies to the paramedic services in need.

➢ A state administered subscription or insurance program for those on Medicare affected by this conflict, possibly funded through a portion of Homestead Rebates or the like.

➢ Legislative authority for MICUs to transport, eliminating the need for BLS ambulances to accompany the paramedics to the hospital and thereby reverting all Medicare monies back to their intended recipient, the ALS provider. This solution has the collateral benefits of being budget neutral while also increasing the efficiency of the BLS services by retaining more of their resources, more often, in their home towns.

➢ Or, an emergency, direct appropriation from the legislature to stabilize paramedic operations until the state takes more definitive action, through its commissioned EMS study.

continued from page 9

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Some have suggested that the hospitals responsible for paramedic units in the state should continue to fund this growing deficit. This is obviously an unrealistic expectation given the number of hospitals operating in the red and the razor thin margins within which the rest function. As previously mentioned, five hospitals have already found it impossible to do so. With more institutions on the verge of bankruptcy seemingly every quarter, it does not seem prudent to count on hospitals to bail out the paramedic system.

Two recent state bills, S-2302 and A-3749, were introduced in the legislature, proposing to authorize limited MICU transport in an attempt to temporarily mitigate this crisis. They were carefully worded, permitting paramedics to transport specifically when interfacing with billing BLS agencies, in an attempt to revert the reimbursement flow from Medicare back to its original design. Because of special interests, stiff opposition has stalled these bills: 1) Municipal and Commercial BLS agencies are opposed, since the bills would re-channel part of their new-found Medicare revenue back to the paramedic programs, 2) the New Jersey State First Aid Council (the group representing most of the non-billing BLS agencies in the state) opposes these legislative initiatives because many within their ranks have converted to billing in recent years and are now in a position to also lose part of their Medicare revenue, and 3) most of the state’s paramedic programs are publicly opposed because they fear enactment of such legislation would trigger a challenge to their CN exclusivity by the commercial and municipal BLS agencies, who have for years desired to break into the ALS portion of the industry. As with most controversial issues, a high level of passion among the debating parties has resulted in the interjection of extraneous arguments, not germane to the problem. This has caused distracting artifact to cloud the core issue and legitimate points of opposition to become needlessly confused.

About the Author

Mr. Vincent Robbins, MSc, FAHRMM, FACHE, was among the first NJ paramedics certified in 1977 and is now the President & CEO of MONOC, the state’s only 501(e) hospital cooperative, which specializes in EMS and medical transportation services. Over his 17 year incumbency, the company has grown 16 fold and is now the largest ambulance and paramedic provider in the state. MONOC is also the first and only CAAS (Commission on Accreditation of Ambulances Services) accredited agency in the state and is the only entity that provides all the levels of EMS/medical transport. In addition, it is the only NJ agency that has fully integrated the delivery of these service lines. Mr. Robbins is a NJ native and has participated in its EMS system for over 35 years, serving in the State Health Dept., various private sector companies, hospitals and organizations in both for-profit & not-for-profit venues. He has been recognized by both the Governor and state legislature as a leader in his field.

i BLS, the first tier of EMS, is provided by emergency medical technicians (EMT) who are trained to render non-invasive, urgent, low level on-scene medical care such as splinting fractures, bandaging wounds and administering CPR.
ii ALS, the higher tier of EMS, is provided by paramedics who are certified to render advanced medical care out-of-the-hospital, including invasive therapies like IVs and medication administration, defibrillation and cardioversion, endotracheal intubation and chest decompression, under the command of a physician.
iii The most recent data from the NJ DHSS indicates that more than half of all ALS cases in the state are transported to the hospital in billing BLS agency ambulances.
iv From study conducted in December, 2006 by the NJAPP (New Jersey Association of Paramedic Programs).
v Paramedic service per case gross charges in NJ range from about $500 to over $3,000.
v Paramedic service per case gross charges in NJ range from about $500 to over $3,000.
vi State reports reveal that paramedic units in New Jersey were unable to respond to 14,862 cases in 2004 and 13,435 in 2005. Data for 2006 was not available at the time of this article.
The New Jersey Hospital Industry: A Mounting Financial Crisis

by Joseph M. Lemaire and Sean J. Hopkins

In May of 2006, the leadership of the New Jersey Hospital Association (NJHA) recognized the need for an objective review of the financial condition of the New Jersey (NJ or State) hospital industry. Mounting financial pressures had resulted in deteriorating operating results and the announcement of two hospital bankruptcy filings underscored the level of urgency. Even more compelling was the indication that Governor Jon Corzine would appoint a commission to review the entire healthcare industry with the idea of developing a blueprint for the future of the State's hospitals. NJHA determined that what was needed was a fact-based study of the hospital industry with the goal of identifying why NJ hospitals struggle financially and to ensure that the Administration was provided with the complete story encompassing all the issues affecting the industry.

As a result, NJHA retained the respected consulting firm Accenture to put the State’s hospitals as well as the overall healthcare system under a microscope. During the summer of 2006, NJHA staff met with Accenture’s team to frame the report request and to reinforce the point that there would be no limitations placed on Accenture’s fact finding. It was critical that the report be completely independent. Subsequently, Accenture gathered data, reviewed existing research and conducted over 35 interviews with healthcare experts representing hospital providers, insurers, governmental payers, bond rating agencies, The NJ Medical Society and the NJ business community. The result is a 106-page report which provides a comprehensive look at the hospital industry and the factors that have contributed to the financial distress.

One of the early conclusions reached was that when comparing the NJ hospital industry to the national trends, the State’s hospitals lag the nation in every financial metric. From days cash on hand to operating margins to average age of plant, NJ hospitals were significantly behind the national averages. On average, NJ hospitals had less than half the cash, 80% lower operating margins, 20% more debt and an average age of plant that was 19% older than their peers nationally. A more detailed review of the data did uncover some interesting variations within the State. Using information from the New Jersey Healthcare Facilities Financing Authority’s Apollo Reporting System, the study revealed that financial performance varied widely in the State depending on geography. At a very high level, hospitals in Southern NJ fared much better financially than those in the Northern part of the State. In particular, Hudson, Union and Essex county hospitals, on average, fared the worst financially. While individual hospitals results within geography varied widely, these three counties had significantly lower operating results, cash reserves and excessive debt levels.

When the financial results were looked at over time, it was noted that seeds of today’s problems were being sowed over the past three decades. From the demise of the Chapter 83 rate setting system in 1993 to the Balanced Budget Act of 1997, today’s problems were well underway back in the 1990s. One of the findings of the report was that the crisis really began in 1998 but was mitigated for about 6 years as a result of two events, the successful conclusion of

continued on page 15
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the Medicare Disproportionate Share Appeal and Medicare outlier payments. Both events infused significant funding into some of the State’s most vulnerable hospitals and delayed for several years the effects of the underlying financial drain that was occurring.

The report goes on to look at some of the major issues affecting New Jersey. The first area reviewed was payment from governmental payers (Medicare, Medicaid and Charity Care). In all three programs, the report documents that for the vast majority of NJ hospitals, these payment systems do not reimburse hospitals their full costs for the treatment of their beneficiaries. From the billion dollar gap between charity care subsidies and the estimated cost of documented charity care to Medicaid payment rates (that cover only 72% of the cost of care), NJ hospitals start each year with a multi-billion dollar shortfall. For an industry that generates approximately $16 billion in revenue, this is a significant cost shift that gets pushed to the commercial payers. For many hospitals, governmental payers comprise such a large percentage of their business that the resulting cost shift is so large they are unable to pass this on to commercial payers. This group of hospitals is put in the position of either operating at a loss or, in the most severe cases, relying on direct governmental grants to remain open.

In the most recent State budget, $55 million dollars was directly allocated to specific hospitals that had structural deficits. If this problem is left unchecked, the State may find itself in the business of running specific institutions, in particular the inner-city safety net hospitals.

The commercial insurance market was also looked at as part of the study. Here the issue noted was the increasing consolidation of the insurance industry, increasing market clout, and the positive financial results the insurance industry has enjoyed for the last several years. While more and more hospitals in NJ are reporting operating losses, the health insurance industry has seen increasing profits while its medical loss ratio (the percentage of premiums collected that are paid to hospitals and physicians for services rendered to beneficiaries) has declined. The report notes the financial imbalance between the providers of care and those charged with arranging for the payment of care. One of the interesting, but certainly not surprising, findings of the report was that NJ has the dubious distinction of having the highest medical insurance premiums in the country.

The report also focused on the practice of medicine and the supply of physicians in the State. One intriguing data point was that New Jersey has the highest percentage of physicians...
who are foreign medical graduates. Several reasons were offered for this phenomenon, including the high cost of living in New Jersey, the lack of large medical groups who could employ new physicians, and the lack of tort reform and the resulting high malpractice costs. It was offered that new physicians are going to other parts of the country and the resulting vacuum is being filled by foreign medical graduates.

The study also looked at utilization rates in New Jersey. It has long been held that utilization rates in the Northeast are much higher than on the West Coast. Utilizing data from the Dartmouth Atlas of Healthcare 2006, it was discovered that NJ ranked either first, second or third in multiple utilization measures such as days spent in the ICU and physician visits in the last six months of life. The Dartmouth report overwhelmingly documents the high utilization rates in NJ. Of particular interest was that most of these utilization measures are physician-directed. As the vast majority of payers reimburse hospitals on a per case basis, excess utilization has a direct negative impact on hospitals’ finances and could be one of the major factors in the State’s adverse financial position. The report recommended that hospitals drill down into their own utilization data and work collaboratively with physicians in an effort to effectuate positive change.

Beginning in the late 1980s, the State began to relax the Certificate of Need regulations controlling the number of hospital facilities and services. One result of this deregulation was the explosion of free-standing ambulatory surgery centers (ASCs) and other ambulatory care facilities (ACFs). While in many industries a larger supply results in lower prices, this has not been the case in the health care industry in NJ. Rather, the proliferation of free-standing for-profit ASCs and ACFs with significant physician investment has resulted in economic triaging of profitable patients out of the hospital and into these free-standing centers. Although New Jersey now taxes many free-standing ASCs and ACFs to support the charity care subsidy program, the sheer number of these centers has resulted in a significant volume shift and a severe revenue drain of profitable business out of the hospitals. The report goes on to note that there is an uneven playing field as it relates to the free-standing centers and suggests a number of reporting and inspection changes that would bring these facilities more in line with the hospitals.

The report also addresses the issue of capacity and the need to consolidate the industry. It notes that use rates vary widely across the State and that these variations need greater study to understand how best to address the issue of overcapacity. The report found that during the interviews, there was general agreement that there are too many hospitals in New Jersey and that this was contributing to the industry’s financial distress. What was not generally agreed upon was which hospitals should close, the ability of State government to reduce the number of facilities, and who would pay for the stranded costs (e.g., bonds, pension liabilities, severance etc.). One need only look to New York and the legal fallout from the Berger Commission’s recommendations to see the reaction to direct governmental intervention in hospital closures.

The report closes with a series of considerations for the Governor’s healthcare commission, including a complete inventory of healthcare providers, a full study of healthcare trends, and the implication of new technologies on the delivery of care. It is clear that the current system cannot be sustained and that radical change is needed. The hope is that the commission can develop solutions in a timely fashion and in a manner that is practical and politically acceptable. The consequence of not finding an answer is the continued decline of a large number of hospitals and the real possibility of a crisis in access to needed hospital services in New Jersey.

During the fourth quarter of 2006, the report was unveiled to the NJHA Board and was subsequently presented directly to Governor Corzine and Department of Health and Senior Services Commissioner Fred Jacobs. The report has also been given to the members of the Governor’s healthcare commission in preparation for their review and deliberations.

About the Authors
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Hospitals and other health care providers regularly face difficult and complex tax issues. For many institutions, protecting tax-exempt status is paramount. For others, reducing the impact of taxation is critical. For all, careful attention to issues arising under state and federal tax laws is a must.

At Norris McLaughlin & Marcus, our health care attorneys and our tax attorneys, led by John Eagan, collaborate to bring sophisticated expertise on these issues to our clients. John has a Master’s Degree in Taxation from New York University and more than 20 years experience in tax law.

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- Representing clients in tax-related litigation or administrative proceedings.
- Advice and assistance regarding “intermediate sanctions” and “excess benefit transactions” under the Internal Revenue Code.
Federal and State Tax Exemption For Non-profit Voluntary Hospitals:

What’s the Beef? Where’s the Beef?

Part II

by Andrew F. McBride, III, Esq.

The Industry Reaction

There is near unanimous agreement within the non-profit exempt hospital industry in favor of community benefit reporting as a short term answer to head off the potential for sweeping federal legislative changes during 2007 to the current Community Benefit Standard for federal tax exempt status for hospitals. In 2006, the Catholic Health Association (“CHA”) was praised by Senator Grassley for its efforts in developing “A Guide for Planning and Reporting Community Benefit.” The purpose of the Guide is to assist not-for-profit mission driven health care organizations develop, enhance and report on their community benefit programs. CHA has developed an additional resource for standardized reporting of Community Benefit, entitled “Hospital Community Benefit Report IRS Form 990, Supplement to Part III.” The CHA Form 990 Supplement to Part III (the “Supplement”) is divided into two sections. Section 1 is a qualitative description of Community Benefit programs. The outline of issues to be covered in Section 1 of the Supplement are derived from the CHA’s Guide on basic concepts and principles underlying Community Benefit. In Section 1, the hospital has an opportunity to describe its mission and primary exempt purpose. Also, the hospital may summarize its approach to providing Community Benefit with reference to: geographic area, major needs and problems in the community, major strategies to address needs, community organizations collaborating with the hospital and staff which is dedicated to Community Benefit activities. The Supplement also asks the hospital to address the standard 501(c)(3) criteria for exemption: independent governing board, open medical staff, open emergency room, medical and scientific research, health care education and participation in government sponsored health care programs (i.e., Medicare, Medicaid, CHAMPUS and Tricare). Finally, the hospital is asked to describe its financial assistance policies and programs (i.e., discounting and charity care for the poor and uninsured) and the means by which the availability of these programs is communicated.

Section 2 of the Supplement – Quantifiable Community Benefit is particularly important in the context of the broader discussion because it is an attempt to standardize the reporting of dollars expended by hospitals for charity care using uniform definitions. So the financial information is reported pursuant to the following guidelines:

- Charity care should be reported at cost, not charges;
- Charity care expenses should not include bad debt, contractual allowances, and quick pay discounts;
- The Medicare shortfall between payment and cost should not be considered charity care; and
- The net expense of Community Benefit programs is reported after applying revenue from patients, payers and other sources.

Once all hospitals report their charity care expenses using uniform guidelines, there should be an opportunity to assess...
and analyze each hospital's specific dollar contribution to charity care as well as compare each hospital to its peer group.

PricewaterhouseCoopers, auditors and consultants to hospitals and health care providers, have released through their Health Research Institute, a preliminary report on Community Benefit provided by hospitals entitled “My Brother’s Keeper: Growing Expectations Confront Hospitals on Community Benefits and Charity Care.” The PWC summary report also emphasizes the importance of hospitals using a common language when reporting charity care expenses. PWC agrees with CHA that charity care should be reported at net costs not charges. In this regard, the PWC summary report clarifies three controversial concepts:

- Prices are what insurers, the government and individuals must pay for the health care services they receive;
- Costs are the resources required for the health system to provide the health care services (i.e., what it costs the hospital); and
- Charges are a standard health care finance measure used for analytical and statistical purposes, but have little to do with price or actual cost of services.

The PWC summary report also comments on hospital policies which pursue payment of full charges against those with the least ability to pay (i.e., the poor and uninsured). A PwC recommendation in this area is to formulate payment rates for the uninsured and poor based upon discounted managed care prices or Medicare rates as opposed to discounts off of charges.

Many non-profit tax exempt hospitals have uninsured patients’ compassionate care billing policies. Such uninsured charity care policies at non-profit tax exempt hospitals have been criticized for varying reasons including the following: hospitals fail to make the poor and uninsured aware of the existence of the charity care discounts; the charity care discounts are calculated on the hospital’s charges (which is the premium rate) as opposed to a percent of Medicare or HMO rates; the payment arrangements are unreasonable and burdensome and lead to defaults and collection proceedings; and the charity care policies only apply to medically necessary care. It is generally true that the low operating margins at hospitals cause them to judiciously administer their uninsured self pay charity care policies, particularly because this is only one area in which they provide Community Benefit. The other broad based community health programs, including Emergency Department care has a direct economic impact on hospitals’ operating margins.

The reality is that the voluntary tax exempt health care system, notwithstanding its valuable commitment to Community Benefit, does not have the financial resources to provide unlimited health care for America’s uninsured.

There are approximately 47 million Americans without health insurance. This means that these individuals for various reasons do not qualify for Medicare, Medicaid or state charity care programs where they exist. Many of these individuals are the working poor unable to afford health insurance. Legislators and the public expect that voluntary tax exempt non-profit hospitals must assume some responsibility for providing medically necessary health care services to this population. On the other hand, as a public policy matter, it seems unreasonable to ask non-profit health care providers to solve alone what is a national problem, even if they had the resources to do so, which most participants in the health care policy debate do not believe they do! Almost all non-profit hospitals are under significant financial pressure as they do their best to assist the indigent while trying to make ends meet.

In New Jersey, not atypical of other states with significant numbers of poor and indigent in urban areas, twenty (20) hospitals have closed their doors since 1985, ten (10) of those in the past seven (7) years. During 2006, one general hospital

continued on page 20
A recent news article headlined “Hospitals Profit Margin Hits 6 Year High in 2004.” A close read of the article discloses that Moody’s is reporting that the average operating margin for 500 non-profit hospitals is 2%. This margin moves up to 4.5% when investment income is added. Most industry analysts recommend a minimum operating margin of 4.5% with a suggested goal of 5.5%. The take away from this article should be that while hospital operating margins have slightly improved, they are nowhere near adequate to sustain the industry. For a more informed view of the pressures facing hospitals in the marketplace, one should review the American Hospital Association’s “Trends: An Overview of 2003.” This publication identifies both longstanding and emerging trends and offers insights into what the future may hold for hospitals.

Notwithstanding the financial pressure on non-profit hospitals, they continue to be the mainstay of inpatient hospital care with 70% of hospital beds in the country compared to 14% in investor owned hospital beds and 16% in state or federal government owned hospital beds.

State Regulators

Me Too! Most states have common law authority and also provide their Attorney Generals with statutory authority for the regulation of charities, which include non-profit tax exempt hospitals. The federal class action litigation against hospitals focusing on charity care and billing and collection practices also received scrutiny from some states attorneys general. Attorney General Hatch of Minnesota conducted an investigation of Fairview Health Services. Thereafter, Fairview announced an agreement with the Attorney General that would expand its charity care by offering greater discounts to low and middle income residents. Fairview also agreed to revise its debt collection practices, and will not file a debt collection lawsuit against a patient unless a third-party reviewer appointed by both it and the Attorney General verifies there is a reasonable basis to believe the patient owes the debt to Fairview.

More recently, seeking to quantify the public contributions non-profit hospitals make in exchange for property tax, income tax and other tax breaks, Minnesota Attorney General Mike Hatch, Illinois Attorney General Lisa Madigan and Montana Attorney General, Mike McGrath have asked non-profit health care providers to comply with an array of new reporting requirements. These AGs have cited their inability to access federal Form 990 filings as a basis for the secondary reporting burden.

States generally approach the tax exemption of non-profit hospital property in several ways. In the first example, the state statute automatically assumes in the first instance that the property of a non-profit organization is exempt from property tax if used for the non-profit purposes. So in New Jersey, the statute states,

“the following property shall be exempt from taxation under this chapter:

Notwithstanding the financial pressure on non-profit hospitals, they continue to be the mainstay of inpatient hospital care with 70% of hospital beds in the country compared to 14% in investor owned hospital beds and 16% in state or federal government owned hospital beds.

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The reality is that the voluntary tax exempt health care system, notwithstanding its valuable commitment to Community Benefit, does not have the financial resources to provide unlimited health care for America’s uninsured.

In the second example, the Texas state statute requires non-profit hospitals to provide a certain dollar amount of indigent care to establish themselves as charitable organizations and therefore entitled to tax exemption. The dollar amount for a non-profit hospital to qualify as a charitable organization is charity care and government sponsored indigent health care to the hospital in the amount of 4% of the hospital’s net patient revenues. This amount must also equal 100% of the state tax exempt benefits; or in the alternative, charity care and community benefits in a combined amount equal to 5% of net patient revenues, provided that the charity care and government sponsored indigent health care are provided in an amount equal to at least 4% of the hospital’s net patient revenue.

Under the Texas statute, non-profit hospitals are exempt from the revenue requirement and are considered charitable organizations if they are a disproportionate share hospital under the state Medicaid program; operate in areas designated as health professional shortage areas or provide all of their health services through donations with no revenue from any other third party payer. Also, Hospitals are excepted from the charity care obligation if the payment of the charity care obligation would endanger compliance with bond covenants or
be detrimental to financial operations. Hospitals do not automatically lose their exemption if not in compliance but have an opportunity to correct the deficiency in the next year.

In the third example, the state statute creates no ipso facto exempt category like non-profit hospitals but looks to a charitable use test. So in Illinois, the State Constitution permits the Legislature to exempt from taxes, property that is “exclusively used for charitable purposes.” The Illinois Legislature has adopted such an exemption for non-profit hospitals under 35 ILCS 200/15-65. Illinois courts have applied a six factor analysis articulated by the Illinois Supreme Court in Methodist Old People’s Home v. Korzen to determine if property is used exclusively for charitable purposes. The six factor test applied in the Methodist Old People’s Home case and which is applied to non-profit hospitals includes an assessment of whether:

- The benefits derived are for an indefinite number of persons for their general welfare or in some way reduces the burdens on government;
- The organization has no capital, capital stock or shareholders and does not provide profit in a private sense to any person connected with it;
- Funds are derived mainly from private and public charity, and the funds are held in trust for the objects and purposes expressed in the organization’s charter;
- Charity is dispensed to all with need and who apply for it and the hospital does not place obstacles in the way of those who would avail themselves of it;
- The property is actually and factually used for charitable purposes; and
- The exclusive (having been interpreted to mean “primary”) use of the property is for charitable purposes.

Provena Covenant Medical Center
A Case Study:
The Charity Care Benefit Standard

Recently the Director of the Illinois Department of Revenue, Brian Hamer, using the Methodist Old People’s Home criteria, entered a final administrative decision denying Provena Covenant Medical Center tax exemption (a tax exemption benefit of $1,100,000) on its property for 2002. Provena Health is a Catholic non-profit health system that includes six hospitals, including Covenant, 16 long term care and senior residential facilities, 28 clinics, 5 home health agencies and other health related activities operating in Illinois and Indiana. Covenant’s 2002 tax exemption renewal application was denied by the Champaign County Tax Board. This decision was reversed by an administrative law judge (“ALJ”). Director Hamer declined to accept the ALJ’s recommendation and applying the Methodist Old People’s Home criteria gave the following reasons for his denial of tax exemption:

- “The primary basis of my conclusion is simple: [Provena] Covenant admitted that its 2002 revenues exceeded $113,000,000 and that its charitable activities cost it only $831,724 or about .7% of total revenue.”
- “This small amount of charitable care is so seriously insufficient that it simply cannot withstand the constitutional scrutiny required to justify a property tax exemption.”
- Hamer highlighted several other facts in support of his decision: Provena referred patients with unpaid charges to collection agencies (“A practice lacking in the warmth and spontaneity indicative of charitable impulse”); Provena failed to meaningfully publicize its charity care policies; Provena received only $6,938 of its total $106,828,488 revenues from public and private donations. Hamer, also rejected that the shortfall between Medicare and Medicaid rates and Provena’s cost was charity care. Also, Hamer noted that the ER physicians and others (i.e., radiologists) were for profit operations which billed patients notwithstanding their ability to pay. Finally, he observed that the burden of proof was on Provena to demonstrate that its primary purpose is the provision of charity care and given the evidence presented it failed.

The Provena Covenant Medical Center decision raises the real question of whether any nonprofit hospital in Illinois can satisfy the exemption test as applied by Director Hamer. The Illinois Hospital Association (“IHA”) asserts that Director Hamer’s decision ignores 100 years of legal precedent and public policy. IHA argues that in 1907, the Illinois Supreme Court recognized that a hospital that treats patients regardless of their ability to pay and that does not provide profits to private individuals is charitable and merits an exemption from property taxes, without regard to the specific amount of free care it provides. IHA emphasized two additional policy arguments which are mainstays of the Community Benefit Standard for exemption:

- The exemption from property taxes is society’s way of investing in the health and well being of the people and communities served by non-profit hospitals. Without non profit hospitals like Provena, the burden on the government to provide for the health of people would be enormous.
- All earnings of non-profit hospitals must be re-invested in the hospitals’ community in the form of providing services, enhancing access to care, improving quality, purchasing new life-saving technology, upgrading facilities, educating physicians and other health care professionals and conducting research.

continued on page 22
It's clear that in Illinois, the battle has been joined between a Community Benefit Standard and a Charity Benefit Standard as the basis for non-profit hospital tax exemption.

Public Policy Considerations
Recent events at both the federal and state level have cast the spotlight on non-profit hospitals and the role they play in the health care delivery system. Any such re-appraisal of non-profit hospitals immediately brings into focus the inescapable problem of 47 million uninsured Americans, most of whom are the working poor. The nagging and unanswered question remains, whose constituents are the poor and uninsured? With this as a backdrop, several important public policy questions arise:

- To what extent should non-profit hospitals be required to help resolve the national problem of 47 million uninsured Americans?
- Is the essential rationale for federal tax exemption for non-profit hospitals (i.e., non-profit hospitals promote the health of a broad cross section of the community by providing services the government does not, and, therefore, serves a charitable purpose) still valid?
- If the rationale underlying the Community Benefit Standard for federal tax exemption for non-profit hospitals is still valid, what additional factual criteria should be required to establish Community Benefit?
  - Should a mandatory dollar specific obligation be imposed on non-profits as exists in certain states like Texas?
- Given the fact that the federal government is the principal third party payer, under Medicare and Medicaid to hospitals, to what extent, if at all, should the federal Community Benefit Standard for tax exemption preempt the state exemption standards?

Conclusions
Leadership in the Congress has changed. Notwithstanding, most observers in Washington believe that Senator Baucus the new Chair of the Senate Finance Committee will retain Senator Grassley’s concern about reform of the tax exempt sector. The unknown is how high this is on Senator Baucus’ priority list. In any event, it is highly likely the IRS will follow through with revised 990 reporting requirements which will likely create uniform charity care reporting definitions.

A reasonable template for this uniform reporting of Community Benefit is the Catholic Hospital Association’s Hospital Community Benefit Report as a supplement to Part III of the Form 990. Hospitals should carefully review their charity care policies and collection policies. These charity care programs should be real and not illusory. Charity care discounts should be applied to hospital costs not charges and deferred payment programs should be designed to reasonably accommodate patients’ income levels. Hospitals need to pay attention to executive compensation, even if higher salaries are deserved. This is a flash point for the public and legislators.

Non-profit hospitals need to be proactive, in terms of communicating to the public the role they play in providing Community Benefit. The marketplace within which non-profit hospitals operate is extremely complex; hospitals have thin operating margins and significant capital demands to maintain themselves as state-of-the-art high quality providers. The fragile balance which they maintain can easily be upset with disastrous consequences (witness the potential in Illinois for the loss of property tax exemption by all non-profit hospitals). Sadly a million or two million dollar property tax exemption may make the difference between continued operation and closure of a health facility.

Finally, non-profit hospitals are most knowledgeable about the environment in which they operate and, therefore, should be actively in working with federal and state legislators to address perceived issues and problems. The health care delivery system in this country has many moving parts, therefore, it is prudent to walk before running. Knee jerk legislation is likely to be the parent of significant unintended consequences.

About the Author
Andrew F. McBride, III, Esq. is a Principal and Director of Kalison, McBride, Jackson & Murphy, P.A., a 15 attorney health care law firm located in Warren, New Jersey, concentrating its practice in all aspects of health care. Mr. McBride’s practice is concentrated exclusively in hospital and health care law. With extensive experience representing hospitals and physician groups, he is involved with a wide range of health care issues involving corporate, exempt organization, administrative, antitrust, managed care law, litigation and arbitration.
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Department of Banking and Insurance Considers Rule Change Affecting Out-of-Network Non-Hospital Providers:

Adoption Will Affect All Providers’ Receivables

by Darin S. Portnoy, Esq. & Susan G. Steinman, Esq.

The New Jersey Department of Banking and Insurance (“DOBI”) has published a Proposed Rule Change to N.J.A.C. 11:22-5.2 and 5.6. The rule change will affect Out-of-Network, Non-Hospital Provider Claims. The DOBI advises that the 60-day period for comment is extended to May 2, 2007.

[Editor’s Note: For a different perspective, see the article on page 33.]

The proposal would change the way non-hospital, out-of-network providers are paid. Currently, carriers use the "Prevailing Healthcare Charges System" ("PHCS") to determine benefit levels. According to the DOBI, a number of carriers (as yet unnamed) are using, or want to use, the "Resource Base Relative Value Scale" ("RBRVS"), which is the system used by the Centers for Medicare and Medicaid Services (i.e., the Medicare Fee Schedule). The proposed rule change would permit carriers to compensate out-of-network, non-hospital providers by "no less than 150 percent of the RBRVS amount." Further, an insured’s coinsurance "could be no greater than 40 percent of the carrier’s allowed charge using the Medicare Fee Schedule."

The DOBI specifically notes that the amendments will include definitions of "health care provider" and "hospital" to emphasize that the rule change applies "only to out-of-network non-hospital providers."

Carriers will still be required to offer a health plan that pays in accordance with PHCS rates. This requirement is intended to provide "choice" to the insured.

The rule change is heavily premised on the notion of consumer choice and cost savings. The RBRVS reimbursement plan, it is proposed, will enable the carrier to offer a lower cost insurance plan alternative. Further, since the RBRVS information is not proprietary and is available to the public, consumers will be able to access cost information and calculate what amount of money they will owe the out-of-network non-hospital provider. The theory underlying this approach assumes that knowledgeable consumers will make informed choices and decisions about their treatment and accompanying financial obligations.

The goals of cost-saving and consumer choice are admirable. However, it is the opinion of the authors, as collection attorneys who represent medical providers, that this rule change will have a pro-
found and negative impact on out-of-network non-hospital providers. The Medicare Fee Schedule is substantially lower, and the 40% cap on the insured’s coinsurance responsibility, based on that lower reimbursement, will negatively impact provider reimbursement rates.

Consumers will not benefit as the proposal predicts. As much of our collection experience shows, a majority of consumers do not utilize information that is provided to them, even if the information is physically handed to them and they are told it is critical to their informed decision making. Medical decisions are emotionally laden. Even in the best of circumstances, insurance plan information can be difficult for a professional to comprehend, much less the "least sophisticated debtor," which is the standard our firm must utilize when working with a consumer debtor.

The consumer and provider must be viewed in the context of their interdependent relationship. The provider – who is highly competent to treat the patient’s condition – is forced to treat consumers, not as sound practitioners, but as commercial efficiencies, does the consumer no good and invites further indictment of our "broken" healthcare system.

The rule change at hand may only be the bottom of a "slippery slope." Carriers likely will use the leverage of this rule change to lobby for extension of the rules to out-of-network hospital providers.

The efforts at rule change may be considered a “back door” effort on the part of carriers to "force" affected providers to join a network. This remains to be seen as the context develops. Proactive measures on the part of all providers to defeat this proposal are crucial.

About the Authors
Darin Portnoy and Susan Steinman are attorneys with Schachter Portnoy, LLC, a NJ Law Firm Representing Healthcare Providers in Insurance Denial/Appeal, Workers' Compensation, PIP, Collection, and Contract Matters.

They can be reached at 609-514-8668 or sp@lawfirmcollections.com for questions.

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CFO Spotlight: Michael Keen, Bayshore Community Health Services

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

MICHAEL: I’ve grown up in healthcare finance. Immediately out of college I started work in a hospital accounts payable department, working my way up to the Controller’s position over a 13-year period. Wanting to further expand my background and experience, I sought a consultant position with Ernst & Young. I spent 10 years in consulting prior to joining Bayshore in August of 2004.

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

MICHAEL: Well, I’ve always enjoyed the challenges presented by the healthcare industry, and knew early-on that there was tremendous opportunity for professional advancement. A career goal has long-been to become CFO of a hospital/healthcare system. So, to that extent, yes, I believed that I would be a CFO some day. I’ve been very fortunate for the many opportunities this industry has afforded me, and the incredible number of exceptional professional associates I have had the pleasure to meet and work with along the way.

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

MICHAEL: There are so many, but here are a few:
• Plan and be forward focused, without forgetting the lessons of the past.
• Become a good evaluator of talent.
• Seek out a good mentor.
• Be able to effectively apply technology.
• Be creative in providing the necessary capital for funding growth.
• Develop great communication skills (verbal and written).
• Hone your skill to be able to quickly extract relevant information from the mountains of data we produce every day.
• Don’t forget to sharpen the saw!

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.

MICHAEL: Bayshore Community Health Services is small hospital based system located in Holmdel, in Monmouth County, just off exit 117 of the Parkway. In addition to the 225-bed community Hospital, we also own and operate a 200 bed nursing home, a 74 unit assisted living facility, and we are partners in two fitness centers and a surgi-center. We are independent, but we have a clinical affiliation with the Robert Wood Johnson Health Network.

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

MICHAEL: Along with many of the other hospitals in the state, we are dealing with volume challenges, managed care contract issues, inadequate reimbursement from the large majority of payers, inadequate charity care reimbursement and cost pressures that never seem to let up. Other than that…

We are evaluating options regarding our clinical and financial information systems and recognize that our decisions here will play a fundamental role in our future success. We’ve invested a great deal of time and energy in the evaluation process and we are nearing a decision. While the selection is important, the execution and implementation will be the real key.

We continuously evaluate new programs and services. We are planning to aggressively grow our oncology service line and have recently recruited a top-line oncologist to help facilitate that growth. The entire organization is excited about the potential of this program.

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

MICHAEL: Pretty typical approaches here. Bond financing, pool loans, SWAP agreements, LOC backed short term notes. Some leasing, but not a significant component.

FOCUS: What are your spare time activities?

MICHAEL: Spending time with my family, attending my daughter’s sporting events, attending concerts, golf and vacationing at the Jersey Shore.
FOCUS: What are your professional memberships?

MICHAEL: HFMA, AICPA, PICPA

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?

MICHAEL: Assuming there is a mode to return home, my IPod, my laptop, cell phone, a compact satellite dish (all with aux solar power), some small tools, a beach umbrella and chair……..and plenty of sun screen!

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Member Spotlight:
Caitlin Zulla, CHFP

by James Yarsinsky, CPAM

CAITLIN: Currently, I am the Director of Client Service for MD-X Solutions. Prior to joining MD-X, I provided third-party reimbursement and profitability consulting for CBIZ KA Consulting and worked in the finance office of Atlantic Health System. I have an undergraduate degree in Ecology and Evolutionary Biology with a minor in African Studies from Princeton University, and a Masters in Public Health focused in Health Management from Columbia University. I have been married for over three years and I live in Princeton, NJ.

FOCUS: What are your hobbies and outside interests?

CAITLIN: A life outside of work? I love to travel – last year my husband and I visited Greece and we are in the midst of planning a safari to Rwanda, Kenya and Tanzania for this summer. I also spend a lot of time visiting with friends and family and attending sporting events.

FOCUS: Please talk about MD-X and your duties within the organization.

CAITLIN: MD-X Solutions is a fast-growing Revenue Cycle company that provides outsourcing solutions and web-based software applications geared towards maximizing reimbursement. As the Director of Client Service, I manage a team that guides our 260+ clients through the implementation of the firm’s silent PPO, denial, software and A/R outsourcing engagements and ensure that they are kept well informed regarding our collections, identified trends, strategies to prevent future revenue loss, and opportunities to recapture additional revenue.

FOCUS: What special challenges you face in your position?

CAITLIN: As MD-X continues to grow and gain more out-of-state clients, the Client Service team must also be able to grow and ensure that every client receives the same high level of service. The Client Service team is the liaison between our clients and MD-X’s sales and operations groups and, as such, we are constantly working to meet the needs and expectations of both groups.

FOCUS: What greatest changes have you witnessed within the health care industry over the last several years?

CAITLIN: I have always been fascinated with system level interaction, especially the interplay between the for-profit payers/insurers and the largely not-for-profit provider base. More recently, the consolidation of power in the payer base has had a dramatic impact on the bottom line of NJ hospitals. While the HCAPPA legislation took great steps towards reducing the inequality inherent in the appeals process, there is still more work to be done.

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

CAITLIN: Thank you, Jim, for taking the time to interview me!

About the Author
Jim Yarsinsky, CPAM is president of Expeditive (www.expeditive.com), a BESLER Consulting affiliated company. Jim can be reached at 732-392-8300.
Q: With regards to the “Tax Relief and Health Care Act of 2006,” which provisions were affected?

A: On December 20, 2006, the “Tax Relief and Health Care Act of 2006” was signed into law by the President. Among other changes, the Act extended a number of provisions, modified others, and created some new provisions. Some of these provisions are as follows:

One-time-only rollovers from Health Flexible Savings Accounts and Health Reimbursement Arrangements into Health Savings Accounts.

For distributions and contributions on or after December 20, 2006, and before January 1, 2012, a limited amount may be distributed from a Health FSA or HRA and contributed through a direct transfer to an HSA. The amount can't exceed an amount equal to the lesser of:

1. the balance in the Health FSA or HRA as of September 21, 2006; or
2. the balance the Health FSA or HRA as of the date of the distribution.

Only one distribution with respect to each Health FSA or HRA of the individual is allowed. The benefit in allowing this transfer is providing a way to keep the taxpayer from losing unutilized money in the FSA or HEA account within the allocated time period.

Refundable credit for unused Alternative Minimum Tax credit.

For tax years beginning after December 20, 2006, if an individual has a “long-term unused minimum tax credit” for any tax year beginning before January 1, 2013, the amount determined under the limit on the minimum tax credit for the tax year can't be less than “the AMT refundable credit” amount for that tax year. This will provide relief for taxpayers who paid AMT from exercising incentive stock options.

Information reporting of stock transfers from option exercises.

Effective for calendar years beginning after December 20, 2006, corporations must report to IRS the transfer of stock from exercises of incentive stock options or purchases from employee stock purchase plans.

Tax Court jurisdiction in innocent spouse relief.

Effective for a liability for taxes arising or remaining unpaid on or after December 20, 2006, the Tax Court has jurisdiction to review IRS’s denial of equitable innocent spouse relief from joint liability even if no deficiency was asserted against the requestor of relief.

Whistleblower awards.

Effective for information provided on or after December 20, 2006:

1. An above-the-line deduction is allowed for attorneys' fees and court costs related to whistleblower rewards.
2. Whistleblower rewards are increased to a maximum of 30% of collected proceeds, interest, penalties, and additional amounts.

Opportunity for fiscal year taxpayers to make certain revived elections.

The Act gives fiscal year taxpayers with tax years ending after December 31, 2005 and before Oct. 20, 2006, an opportunity to change elections already made on their originally filed returns to take into account the Act's extension of provisions that expired at the end of 2005. Under the Act, an election of the alternative incremental credit in lieu of the regular research credit or an election of reduced research expense credit for a tax year ending after December 31, 2005 and before December 20, 2006, is treated as having been timely made for the tax year if it is made not later than the later of April 17, 2007 or such time as IRS may specify. Similar rules apply for elections under any provisions that had expired and were revived by the Act.

About the Author

Ralph Loggia, CPA, is a senior tax associate with Withum-Smith+Brown, Certified Public Accountants and Consultants, in the firm’s New Brunswick office. If you have further questions regarding this topic, Ralph can be reached at 732-828-1614 or rloggia@withum.com.

If you have a question related to accounting or tax that you would like answered in the next issue of Garden State FOCUS, please email it to elitten@foxrothschild.com. Your questions are greatly encouraged!
HFMA recently surveyed many of its senior-level financial executives and to no surprise the top healthcare issues mentioned included: Revenue Cycle Improvement, Cost Containment, and Consumerism. We often wonder how the next buzz word becomes a healthcare headline, but the word Consumerism is near the top of the list. The HFMA Consumerism Guiding Principles state: if consumers could better understand and more effectively use health services, community health services could improve and the value of health care to the consumer could be enhanced. Additionally, the rate of increase in healthcare costs could be reduced.

The ongoing discussions about Consumerism have found their way into news stories and educational sessions. Everyone should be an expert by now on how to set charges, educate the consumer, train staff, and improve the Revenue Cycle. Of course, healthcare providers have a long journey ahead of them to accomplish these initiatives. The current process needs to be replaced by a cohesive healthcare delivery system. Most providers have begun serious discussions about Consumerism and how to prepare for these changes but, who, when and what are they facing? The answer is the consumer, who will eventually become educated and price savvy and will force a major change in the healthcare delivery system. Much has been written on how healthcare providers can begin preparing for Consumerism, but very few articles or educational sessions have focused on the consumer.

We anticipate that an educated consumer can be viewed as an enhancement or challenge to healthcare, but costs keep escalating even though quality and life expectancy continues to rise. Most Americans and businesses simply cannot afford the current healthcare system. This article’s goal is to present a practical approach on what healthcare providers and physicians should be preparing for and a useful guide for members to save money while maintaining their health.

If you are a hospital or physician provider, I want to utilize my experience completing the first year under a Consumer Driven Health Plan (CDHP) with an associated Health Savings Account (HSA) to prepare you for what will eventually be the true test of Consumerism. Of course, my experience will be different from that of the average consumer, since I began this new journey with many years of working in a hospital and also performing healthcare financial consulting.

Let us begin our journey by mentioning that participation by employers in HSAs continues to escalate. Over 39% of workers enrolled in an employer-sponsored CDHP had no choice for other health coverage and, when given the choice, only 19% choose a CDHP. Based on the results of these statistics, does the employer think they will save premiums and does the worker think it will cost more money? The last consideration for the consumer may be that the CDHP is just too complicated to understand and they resist change.

To better understand a CDHP and an HSA, the following summary will attempt to educate and provide reasons for selecting this plan option over the traditional $250, $500 or $1,000 deductible coverage. My CDHP and HSA Plan require a $4,000 deductible in-network, but include free coverage for yearly routine physicals, mammography’s, etc. for a family of four. Based on my initial experience, the positives for the $4,000 CDHP with an HSA include the following:

1. The $4,000 is pre-tax and is withdrawn from my pay in equal payments to a bank which holds the HSA.
2. The out of pocket premiums are $1,200 less under the HSA Plan compared to the $500 deductible traditional plan.
3. I can utilize a debit card from the bank with access to my account to pay for any qualified healthcare expense. I am responsible for verifying deductions if questioned by the IRS.
4. The account earns interest and once it exceeds $1,000, I have the option of investing these funds.
5. If I don’t utilize all the funds during the year, the money is not lost as in a Medical Flexible Plan and can be treated as an additional retirement plan similar to an IRA.
6. There is no out of pocket payment for $10 or $15 per visit coinsurance.

continued on page 30
Focus

continued from page 29

7. Once the $4,000 deductible is met, all qualified healthcare costs will be fully covered by the insurer.

8. The Plan should benefit higher income earners, those who utilize few medical expenses or those who consume costs higher than the deductible level, yet whose traditional plan’s premium and out-of-pocket amounts equal or exceed the HSA deductible.

The negatives for the Plan include the following:

1. I can only pay for qualified healthcare expenses with money that is accumulated in my account. Under Medical Flexible Plans, I am able to incur a healthcare expense and the Plan will reimburse me even before the funds are deposited with the expectation that my paycheck withdraws will equal the payment within the current year.

2. I must pay the balance of certain qualified healthcare expenses (described below) after the insurer pays the negotiated rate between the healthcare provider and Physician with the insurer. For instance, a chest x-ray may cost $400 and the insurer has negotiated a $180 discount which would leave the consumer a balance to be paid of $220. Each discount will be different for each healthcare provider.

3. I am charged a monthly bank fee which, initially, will exceed the interest earned on the account.

4. I must keep better records and verify that all discounts and payments are properly paid.

5. The high-deductible insurance plan does not cover Dental or Eye Care, but the HSA can be utilized to pay for their cost.

Now that the pros and cons have been explained for the Plan, it is time to search out healthcare providers and Physicians to supply the best quality care at the least cost. If I am able to keep my healthcare costs below the $4,000 yearly deductible level, I will have more money for retirement. If my healthcare costs exceed the $4,000 deductible, my coverage continues 100% free. My healthcare decision just became a financial investment in my family’s future. Now is there anything else to consider? The first question that a consumer must answer is: how important is my health? Would you rather have a million dollars or your health? If you answered your health, then you must make sure all preventive and follow up healthcare treatments are pursued, even if it takes money from your Plan.

Once we have decided to try and stay healthy, we begin our practical healthcare journey by selecting a routine physical from a medical physician. Remember, this visit is free, so cost should not be an obstacle in this healthcare decision. Based on your age, sex, and prior history, your doctor will decide the best care for you. The routine and free part of your visit now ends as further tests are recommended by your physician. These tests, which are a great preventative tool, will cost you, the consumer, money. Do you now nod your head and say “sure Doc, whatever you say,” or do you ask questions about further tests? To ask questions, you must be educated. How many patients know what all the different lines on a routine lab test mean? What is the good cholesterol – the HDL, or the LDL? Do you, as a patient, bring your latest test results, procedures, and medical history with you to every visit? If not, do you think healthcare providers and physicians make any mistakes because of lack of communication? After receiving the expected professional response back from your physician, you leave his office and enter a new challenge: you must now see the office staff.

The first thing you need to do is to remind the staff that you are insured under a CHDP and that you do not need to make a co-payment. The next step is harder – ask the staff what the insurance discount is for the services that are not part of the routine (free) visit. Their blank stare answers your question and you know you will just have to wait for the remittance from the insurer, call them yourself, or wait for the bill from the physician to see what services besides the routine physical will cost. The last thing the consumer must do besides making a new appointment, is deciding where to have any additional tests performed. The lab test, if not done in the office, should be an easy choice, but where should you have that X-ray or MRI done? Your initial response is to ask the office staff which area provider has a contract with your insurer to make sure the treatment is in-network. The next request is to ask for two or three locations and don’t forget, as in a restaurant, ask the staff which one they would recommend.

You are now armed with choices, so what is your next step? Some of the major health insurers have websites that estimate the cost and out of pocket expenses for most tests and procedures. Cigna, Horizon, United, and Aetna are among those that can provide valuable consumer information. Consumer Reports now has a Medical Guide that will give the subscriber treatment ratings, drug reviews, best buy drugs and natural medicine ratings. The best advice is still to call each provider and ask about prices. This process may be exhausting considering the expertise you encounter on the other end of the phone and your own medical knowledge. The choice does not always end by the lowest price. What about reputation, quality and convenience? Reputation can be answered by the referring physician’s office, and, of course, convenience is
easy, but how do we measure quality? The answer is: we wait! The government and the insurers have begun this directive, but it is still too early to get effective information.

We have now completed our free physical; we will pay the deductible for the lab and radiology tests with the HSA debit card and now attempt our next adventure, the drug prescription. Our focus on this choice is first dependent on whether it will be a one time or a maintenance drug. Let us assume that we now need two different drugs. To understand this choice better, we need to complete the consumer drug quiz listed below (note that I am not opining as to the advisability of selecting any of the listed choices):

1. Where should we buy our drugs?
   a. The local pharmacy
   b. Food store
   c. Canada
   d. Insurer’s pharmacy
   e. An enrollee in a CDHP who has exceeded their deductible and received free drugs

2. What quantities should we purchase?
   a. One month supply
   b. Three month supply
   c. A three month supply at twice the dosage
   d. A one month supply at twice the dosage
   e. None of the above

3. What questions should the consumer ask the doctor about the drugs?
   a. If I exercise, lose weight and eat healthier do I need the drugs?
   b. Is there a generic or less expensive drug?
   c. Can I try the drug for awhile and then stop the drug if the condition improves?
   d. Is there a vitamin or natural supplement that can work just as well as the drug?
   e. Do you have any free samples?

Now that I have your attention and your grin, what are your choices? I would suggest purchasing your drugs from the insurer’s pharmacy since it should be less expensive and more convenient. Purchasing a three month supply will save you money, but if you are able to split your pills, you will save even more. Some drug companies charge the same for a double the dosage pill. Ask your doctor to prescribe the higher dosage, and ask whether he or she believes it would be safe and effective to utilize a pill splitting tool to cut your pills in half. Yes, you just saved 50%. If you can, make a life adjustment and do all the right things for your body, and see if a lifestyle change will work in lieu of medication. The natural supplement is another great alternative, but again, education and expertise are critical for this choice. The best choice may be to ask if there is a generic brand available instead of the name brand, and to consult with your physician about all possible options.

Now that our healthcare journey to the physician’s office and other healthcare providers is complete, we should evaluate our success as an educated consumer. We saved $100 on the X-ray by price shopping the service. For one of the drugs we split the higher dosage and saved $500 for the year. The other drug was available as a generic at Wal-Mart for $48 a year instead of $1,048. We just saved a total of $1,600, which can be used for our retirement. We also drove down the cost of healthcare by using our education, our desire to stay healthy, our willingness to shop, our patience in our journey and our focus for our future, to properly choose the best path for our families and ourselves.

This article is Part One of our healthcare journey and explored the selection of a CDHP with a HSA and a visit to the physician’s office and related healthcare providers. In the next issue of the FOCUS we will continue our journey into the hospital healthcare provider’s delivery system and their pricing transparency options. Will the provider prevail and maintain revenue, or will the educated consumer force efficiencies and economies and lower the cost of healthcare? Stay tuned!

About the Author
Mr. Manzi is a Director with CBIZ KA Consulting Services, LLC (CBIZ) a financial management consulting company that provides financial, clinical and outsourcing services to the healthcare industry. He is also the immediate Past President of the New Jersey HFMA Chapter. He can be contact at jmanzi@CBIZ.com for any questions.
Save the Date!

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May 10, 2007

Fiddler’s Elbow Country Club
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“Much Ado About Nothing” might aptly sum up concerns about a recent New Jersey Department of Banking and Insurance (DOBI) rule proposal on out-of-network benefits.1 The proposal, published in December 2006, would set minimum benefit levels for out of network non-hospital provider claims under health benefit plans issued to large employers (i.e., those with 51+ employees) and would explicitly permit what already is available in the market, benefit packages that use Medicare fee profiles as a basis for determining benefit levels.

After publication, critics rushed to the Legislature, the Governor’s Office and the DOBI, alleging that this proposal would decrease payments to the medical community, and would result in doctors leaving New Jersey in droves. It would not. Here are the facts:

• Many health plans already reimburse out-of-network benefits based on Medicare payments. The proposed regulation merely establishes minimum standards for plans that pay out-of-network benefits based on Medicare. The only action required by the regulation would be for health plans reimbursing out-of-network benefits based on Medicare below the standards articulated in the proposal to raise their benefit levels under such contracts.

• A letter from a group representing providers sent to member of the Legislature asserts “insurance companies are using DOBI to promote and carry out antitrust activity.” To the contrary, insurance companies design insurance plans based on employer demand, taking into account pressure from employers to reduce cost. As the cost of medical services continues to increase, employers either apply pressure to insurance companies to develop less expensive insurance plans or they drop coverage.

• In addition to offering employers plans with this Medicare-based out-of-network benefit, the regulation would require insurers to offer employers plans with other bases of out-of-network reimbursement. Again, the choice belongs to the employer.

• The minimum plan allowance under the regulation would be 50% higher than what the federal government reimburses providers under Medicare.

• The scope of the proposed rule is limited to the insured large group market. It would not apply to the individual or small employer markets, and would not apply to self-funded arrangements, which is the prevalent form of coverage for most large employers. So, this rule has a very limited application.

Please understand, the NJAHP is not in favor of rules limiting what insurers can offer to employers and intends to comment on and oppose the proposal, but we felt a need to correct the gross misstatements about these proposed regulations. While the proposed regulations are not changing how much is paid for out-of-network services, market dynamics are.

This is the real issue, and presumably why DOBI felt a need for minimum standards. We may disagree on whether these are the right standards, but the danger is that the distorted message about the effect of Medicare-based reimbursement will poison emerging market-based initiatives, which is what is now changing and will continue to change what benefit plans look like.

The commentary circulating says little about why plans based on Medicare standards would be inadequate – this is a minimum allowance that provides fifty percent more than the single largest payer in the nation pays. To understand the issue, it’s necessary to look at the difference between the Medicare-basis and charge-based plans. The older out-of-net-

continued on page 34
work plans are built on provider-set charges, while Medicare’s RBRVS system is built on the value of the services provided. Charge-based fee schedules are created solely from charges billed by providers for services within a geographic area. This creates a perverse incentive to continually increase billed amounts without any relationship to the time, effort or overhead required to provide the service. When physicians continue to increase charges, they can expect future reimbursements based on charge-based systems to increase. No wonder the market is moving toward the value-based Medicare system, and the out-of-network providers are objecting.

When a medical provider does not contract with an insurer, how much the insurer pays is purely a matter between the insurer and the insurance purchaser, just as how much the provider collects is purely a matter between the provider and his or her patient. They can’t have it both ways – lobbying against government price-setting while looking to government to support payment rates under private contracts to which they are not parties.

If adopted, the scope and impact of DOBI’s rule proposal will be very modest; the tempest that was predicted will not occur. But the larger issue here should not be obscured: health plans need the flexibility to develop plans with premiums that employers can afford, and one way to do that is to offer products that base benefits on a value-based system rather than on a charged-based system.

About the Author
Wardell Sanders is the president of the New Jersey Association of Health Plans, which represents all of the commercial and Medicaid health plans in New Jersey. Mr. Sanders served in state government for over 15 years, first as a Deputy Attorney General and later as the Executive Director for the State’s individual and small employer market reform boards.

1 A copy of the proposal was published at 38 N.J.R. 5309, and is available on the DOBI website at: http://www.state.nj.us/dobi/proposed/prn06_405.pdf.
Having co-chaired the Certification Committee for the New Jersey Chapter over the past several years, and helped to prepare and teach many of the review courses we offered, I have been impressed by the efforts of those members who have sat for the exams and those people who have volunteered and gone “above and beyond” to assist them in their preparations. This is the first article in a series I am planning to write where I will interview recently certified members, so that others may gain some insight into why they decided to pursue certification and how they prepared for the exams.

The first interviewee is Caitlin Zulla. Caitlin has been very active in our Chapter and most recently has co-chaired the Education Committee. She will also be joining the Board of Directors this year. Since she is very modest, and does not offer this information in the interview I will happily share this on her behalf. When Caitlin took the Core exam last year, she obtained the highest score in the country. The Chapter is very proud of her! I am hoping that others thinking of taking the exams will be inspired by her accomplishment. Here is her interview:

Rita: What is your current position and title?

Caitlin: I am the Director of Client Service for MD-X Solutions. In this position, I lead the implementation of our PPO, Denials and AR services and work with the operations teams to provide regular updates to our existing clients – over 150 and counting.

Rita: What prompted you to pursue HFMA certification?

Caitlin: I pursued certification to expand my knowledge regarding healthcare financial management concepts, and because I have been impressed by the respect that healthcare professionals in New Jersey and nationwide have for the CHFP designation.

Rita: Which specialty exam did you take and how did you prepare for the exams?

Caitlin: I took the Accounting and Finance specialty exam. While I have an MPH focused in Healthcare Management, I have little or no background in accounting and I wanted to learn basic accounting concepts. To prepare, I studied the CHFP preparation guides and took the practice exam questions listed on the HFMA website.

Rita: How do you feel certification has/will help you with your career goals?

Caitlin: The certification process broadened my understanding of the healthcare financial marketplace and provided me with additional knowledge that I utilize every day to deliver meaningful client updates and recommendations. Additionally, as a professional in the early stages of my career, I believe that the CHFP designation helps to build my credibility.

Rita: Do you have any advice for members contemplating certification?

Caitlin: Do it! The exam is not as daunting as it may seem and the end result is very worthwhile. You will have to dedicate sufficient time to prepare, and I recommend studying the HFMA preparation guides.

Rita: Any ideas of how the Chapter could better assist members with certification?

continued on page 36
continued from page 35

Caitlin: I would have appreciated additional group review courses; the one that was held coincided with New Jersey’s Annual Institute preparation and therefore I could not attend. Additionally, members interested in taking the exam could be provided with the names of other interested members and have the opportunity to create their own study groups or sessions.

Thank you, Caitlin. For anyone who is interested in learning more about the certification process, please contact Laura Hess, our Chapter Administrator at NJHFMA@aol.com. The New Jersey Chapter has copies of the HFMA study guides for loan, and we will soon announce the programs we will be sponsoring to help members with their preparation.

When Caitlin took the Core exam last year, she obtained the highest score in the country.

About the Author
Rita Romeu is a partner and Vice President of ARMDS. She is currently co-chair of the Certification Committee of the New Jersey Chapter. Rita is a fellow in the HFMA and obtained her Ph.D. from the University of Pennsylvania.
**Focus on...New Jobs in New Jersey**

### 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](http://www.hfmanj.org).

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

### Job Position and Organization

<table>
<thead>
<tr>
<th>Job Position and Organization</th>
<th>Organization/Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>INTERNAL AUDITOR, CORPORATE COMPLIANCE</td>
<td>St. Barnabus Health Care System</td>
</tr>
<tr>
<td>SENIOR AND JUNIOR ACCOUNTANTS</td>
<td>Serluco &amp; Company</td>
</tr>
<tr>
<td>AVP REVENUE MANAGEMENT</td>
<td>Holy Name Hospital</td>
</tr>
<tr>
<td>ASSISTANT CONTROLLER</td>
<td>HealthSouth Rehabilitation Hospital of Toms River</td>
</tr>
<tr>
<td>SALES DIRECTOR</td>
<td>Expeditive</td>
</tr>
<tr>
<td>DIRECTOR OF PERFORMANCE IMPROVEMENT</td>
<td>Cooper University Hospital</td>
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<tr>
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</tr>
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<tr>
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<td>BUSINESS ANALYST</td>
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<td>MANAGER OF BUDGET AND REIMBURSEMENT</td>
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<td>QuadraMed Corporation</td>
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<tr>
<td>BILLING MANAGER</td>
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<tr>
<td>SENIOR REVENUE CYCLE CONSULTANT</td>
<td>Besler Consulting</td>
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**Meet Some of our New Members**

<table>
<thead>
<tr>
<th>Who is your employer, and what is your position?</th>
<th>Erik Carlsen</th>
<th>Nadinia Davis</th>
<th>Niall Handley</th>
</tr>
</thead>
<tbody>
<tr>
<td>Winthrop Resources, Territory Executive</td>
<td>Kean University, Assistant Professor, Health Information Management</td>
<td>SoftCo - Vice President</td>
<td></td>
</tr>
</tbody>
</table>

| What was your first job as a teen? | Customer Service Representative for Menards Lumber Corporation | I worked as a sales clerk at a bakery in Linden, NJ | A caddy at Essex Fells Country Club |

| What do you like best about your work responsibilities? | The best part of my job is interacting with executives in the ever changing healthcare field and providing them with financial support, allowing them to achieve their goals | When my students succeed, either in the classroom or professionally | It's a great company with a spectacular product. I really enjoy the challenge of growing the business. |

| A job I would enjoy doing without pay is... | Coaching a high school football team | Singing on Broadway | Professional golfer |

| My favorite place is... | On the water fishing, skiing, swimming | Home | The golf course |

| I will not eat... | Popcorn, I just can’t go near it | Organ meats, anything slimy or unidentified substances | pickles |

| If I’m not at work, you will find me... | At our cabin in Northern Minnesota | Either at home or shopping; outlets and antiques are my favorites | On the golf course |
•Who’s Who in NJ Chapter Committees•

2006–2007 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.

<table>
<thead>
<tr>
<th>COMMITTEE</th>
<th>CHAIRMAN/EMAIL/PHONE</th>
<th>CO-CHAIR/EMAIL/PHONE</th>
<th>SCHEDULED MEETING DATES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Certification</td>
<td>Rita Romeu/romeur@ARMDS.com (973) 614-9100</td>
<td>Michael Alwell/mike.alwell@ahsys.org (973) 656-6949</td>
<td>Call for information</td>
</tr>
<tr>
<td>Corporate Compliance/Ethics</td>
<td>B.J. Welsh/bjwelsh@rbmc.org (732) 324-6062</td>
<td>Nancy Graham/ngraham@beslerconsulting.com (732) 392-8243</td>
<td>First Thursday of the Month to face meetings, 9:00 am</td>
</tr>
<tr>
<td>Education</td>
<td>Scott Bestler/sbesler@beslerconsulting.com (732) 839-1219</td>
<td>Caitlin Zulla/czulla@md-x.com (201) 444-9900</td>
<td>First Friday of each month 9:00 am</td>
</tr>
<tr>
<td>FACT (Finance, Accounting, Capital &amp; Taxes)</td>
<td>Julius Green/jgreen@parentenet.com (215) 972-2352</td>
<td>Heather L. Weber/hweber@parentenet.com (215) 557-2016</td>
<td>First Wednesday of each Month 8:30 am</td>
</tr>
<tr>
<td>Future Leader</td>
<td>John Brault/john.brault@ehmc.com (201) 894-3099</td>
<td>Tracy Davison/tracy_davison@horizonnjhealth.com (809) 538-0700 x5313</td>
<td>Fourth Wednesday of each Month 8:00 am</td>
</tr>
<tr>
<td>Information Technology</td>
<td>Diane Tobin/dianetobin@earthlink.net 908-526-0250</td>
<td>Rich Mushock/richard.mushock@henryjaustin.org 609-278-5938</td>
<td>Third Thursday of each month 9:00 am</td>
</tr>
<tr>
<td>Institute 2006</td>
<td>Michael Alwell/mike.alwell@ahsys.org (973) 656-6949</td>
<td>Michael Friedberg/mfriedberg@beslerconsulting.com (732) 392-8318</td>
<td>Second Tuesday of each Month 8:00 am</td>
</tr>
<tr>
<td>Membership Services/Directory</td>
<td>Lynn Kahn/lkahn@beslerconsulting.com (732) 392-8241</td>
<td>Deborah Shapiro/dshapiro@wfs-services.com 201-617-7100</td>
<td>Third Wednesday of each Month 9:00 am</td>
</tr>
<tr>
<td>Patient Access</td>
<td>Gaye Werblin/gwerblin@centrastate.com (732) 294-2866</td>
<td>Maria Wence/wencem@lourdesnet.org (856) 757-3676</td>
<td>Second Thursday of each Month 9:30 am</td>
</tr>
<tr>
<td>Patient Financial Services</td>
<td>Laurie Grey/laurie.grey@princetonhcs.orgAnne Goodwill-Pritchett/agoodwillpritchett@humed.com 609-620-8383</td>
<td></td>
<td>Second Friday of each Month 10:00 am</td>
</tr>
<tr>
<td>Proaction</td>
<td>Rea Zagaglia/Rzagaglia@nmhnj.org 973-578-8943</td>
<td>Lee Gordon/Lgordon@humed.com 201-996-3373</td>
<td>Second Thursday of each Month 9:00 am</td>
</tr>
<tr>
<td>Publications</td>
<td>Elizabeth Litten/ELitten@foxrothschild.com 609-896-3600</td>
<td>Joan Hendler/joanhh@remexinc.com (609) 921-8950</td>
<td>First Thursday of each month 9:15 am</td>
</tr>
<tr>
<td>Social</td>
<td>John Brault/john.brault@ehmc.com (201) 894-3099</td>
<td>JaneAnn Sheehan/janeannsheehan@comcast.net (908) 654-8416</td>
<td>One Thursday approximately every month. Call for info.</td>
</tr>
</tbody>
</table>

✔ Mark Your Calendar

- April 18, 2007 all day Medicare Cost Report Preparation Course Woodbridge Hilton
- April 18, 2007 6 pm Golf Warm-Up and Clinic Hyatt Hills Golf Complex
- May 8, 2007 all day “Hands On” PC Training Course NJHA
- May 10, 2007 all day Annual Golf Outing Fiddler’s Elbow CC
- May 23, 2007 all day Ladies Golf Outing (not for ladies only!) Pine Barrons Golf Course
- June 14, 2007 all day Quarterly Meeting – F.A.C.T. Committee Woodbridge Hilton
- October 10-12, 2007 NJHFMA Annual Institute Trump Taj Mahal, Atlantic City
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THE INAUGURAL MEMBER RECOGNITION DINNER

Friday, March 9, 2007
6:00PM – 10:00PM

Bridgewater Marriott
700 Commons Way
Bridgewater, NJ

Marcy Slachman
Nabila Mahmud
Roger Sarao and his fiance Amanda
Susie Hoffman and Dotti Lindstrom

John Brault & his guest
Olga & Pete Allan

Mike Serluco and John Manzi
Where did he get that shirt?!

Mr & Mrs. Ray Tigol

John Brault & his guest

Olga Barone-Allan & Karen Johnson

Nabila Mahmud

Marcy Slachman

Kevin Chmura, Rick Parker, & George Kelley
Certified Members & Founders Awards Presentation

A Special Thank You to the Following Sponsors:

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Accolades also go to Jim Pender, JaneAnn Sheehan and the Social committee for their tireless effort in making this event so successful, and to Tara O’Neill for all her help with her graphic design expertise!

Our New CHFPs: Stella Visaggio, Jeff Grizzetti, Brian Gaughan & BJ Welsh

Our New Fellows (FHFMA):
Lindsey Colombo,
Maria Facciponti (not pictured)
and Joe Davi (not pictured)

Our Muncie Gold Award Recipients:
Joe Samples & Phil Besler
(not pictured)

Our Reeves Silver Award Recipient:
Lisa Hartman

2006 Medal of Honor Recipients:
Roger Sarao, Stella Visaggio, John Manzi, & Dotti Lindstrom (not pictured)

Our Reeves Silver Award Recipient:
Kevin Pleasant, Mary Taylor, Karen Johnson, Lindsey Colombo, Bob Peterson, Elizabeth Litten, Mike Alwell (not pictured), & Lynn Kahn (not pictured)

The Follmer Bronze Awardees:
National Yerger Awards

“Governance Compliance”
Compliance Committee: BJ Welsh & Lisa Hartman,
Co-Chairs and John Reiss, author

“At least the hat matches!”

“CFO Spotlight Initiative”
Publications Committee: Elizabeth Litten &
Joan Hendler, Co-Chairs

2004-2005 Past President, Rick Parker - Reminiscing about last year’s awards dinner!

“Institute Networking Function”
Social Committee: Karen Johnson & JaneAnn Sheehan,
Co-Chairs, with John Manzi

“2005 Annual Institute”
Institute Committee: Caitlin Zulla and
Olga Barone-Allan, Co-Chairs
If you’d like to be able to respond positively to the above questions, you should learn about Hamilton Cavanaugh & Associates’ distinct retirement program, Aspire. New pension legislation and upcoming 403(b) regulations will pose additional challenges for your retirement programs. Aspire can provide you with a complete solution to meet these new challenges. Key program components are:

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- “Unbundled” platform that provides plan sponsors maximum flexibility
- Written due diligence procedures that assure fiduciary compliance
- “Best-in-Class” mutual funds and service providers chosen from the dynamic due diligence process
- Availability of brokerage window that can be utilized to customize a plan sponsor’s program
- Comprehensive enrollment, education and advisory services
- 100 percent expense and fee disclosure to plan sponsors and participants
- Interactive web site that can be personalized with an organization’s logo as well as relevant program forms and documents.

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Gene Korjeski
ekorjeski@parentenet.com
570.820.0101

Julius Green
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215.972.2352

Ben Jarmul
bjarmul@parentenet.com
215.972.2337

Steve Repko
srepko@parentenet.com
215.972.2195

In Memory of
Michael Wojciehowski

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NJ HFMA members extend their deepest sympathy to his family.
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Scott Mariani, JD 973.898.9494
Leo D’Orazio, MBA, CHE 732.828.1614

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