HOSPITAL FINANCE: IS THERE LIGHT AT THE END OF THE TUNNEL?
ARMDS
negr
supplied
No Light at the End of the Tunnel:
Hospitals Suffer Set Back in Decade-Old Medicaid
Rate Appeal Cases
by Paul R. Murphy, Esq., James A. Robertson, Esq. and Philip A. Besler, FHFMA, CPA .......... 6

The “Health Claims Authorization, Processing and Payment Act” – The Answer to Your Facility’s Claims Problems?
by Sonja Allen, J.D., AHC, Inc. ........................................................................................................ 11

Revenue Cycle KPIs Draw Crowd to Annual Joint Meeting
by John J. Dalton, FHFMA ........................................................................................................... 15

The November Quarterly Meeting:
Strategic Management Issues in Healthcare Financial Reimbursement, November 8th, 2005
by Rea Zagaglia and Lee Gordon ................................................................................................. 18

IT Committee of New Jersey HFMA:
Katrina & Disaster Recovery. What Did We Learn, and What Could We Do Better?
by Jack Tenerelli, CNE, CMP, Network+ .................................................................................... 22

Profit Visualization Tools
by Al Rottkamp .......................................................................................................................... 27

NJ HFMA Annual Financial Statements ............................................................................. 32-35

11th Annual NJ HFMA Winter Social .................................................................................. 36-38

CFO Member Spotlight: John Dellocono ........................................................................... 39

Member Spotlight: Marilyn Koczan
by James Yarsinsky, CPAM ........................................................................................................ 42
Who’s Who in the Chapter 2005-2006
NJHFMA Website ................. www.hfmanj.org

NJ HFMA Board Members
Philip Besler, FHFA, CPA .......... Besler Consulting
Susan D. Bonfield, Esq. ........... Deborah Heart & Lung Center
Garry J. DeLeuuwerk .................. Unaffiliated
Marilyn A. Koczan, FHFA, MPA, CPAM .... Meridian Health System
John S. Halperin .......................... Raritan Bay Medical Center
Anthony T. Orlando .................. Englewood Hospital & Medical Center
Robert C. Peterson, CPA ............ Hackettstown Regional Medical Center
John B. Reiss, Ph.D., J.D. ........... Saul Ewing LLP
Doreen Stevenson, CPA .......... Saint Peter’s University Hospital
Mary T. Taylor, FHFA, MBA ........ Southern Ocean County Hospital
Sean J. Hopkins – Ex-Officio ........ New Jersey Hospital Association

NJ HFMA Advisory Council
Richard C. Parker ..................... CBIZ KA Consulting Services, Inc.
Stella M. Visaggio, CPA ............. Hackettstown Regional Medical Center
Gabrielle P. Parseghian, FHFA ...... Unaffiliated
Michael J. Monahan, FHFA ........ Corner Corporation
Thomas G. Shanahan, FHFA, CPA .... Raritan Bay Medical Center

Advertising Policy/Annual Rates
The Garden State “FOCUS” reaches over 1,000 healthcare professionals in various fields. If you have a product or service you would like the healthcare financial industry to know about, please take advantage of this great opportunity!

Contact Joan Hendler at 609-921-8950 to place your ad or receive a copy of the Chapter’s advertising policy. The Publications Committee reserves the right to refuse any ad not consistent with the overall mission of the Chapter. Inclusion of an ad in this Newsmagazine does not infer endorsement of the product or service by the Healthcare Financial Management Association or the Publications Committee. Neither the Healthcare Financial Management Association nor the Publications Committee shall be responsible for slight variations in production quality of published advertisements. Effective July 2005 Rates for 6 bi-monthly issues are as follows:

<table>
<thead>
<tr>
<th>Display</th>
<th>Full Page</th>
<th>Half Page</th>
<th>Quarter Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Back Cover – Full Page Color</td>
<td>$4,600</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Inside Back &amp; Front Covers – Full Page, Color</td>
<td>$4,350</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>First Inside Ad – Full Page, Color</td>
<td>$4,250</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>First Inside Ad – Full Page, Black &amp; White</td>
<td>$3,150</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Inside Ad – Color</td>
<td>$3,150</td>
<td>$2,600</td>
<td>NA</td>
</tr>
<tr>
<td>Inside Ad – Black &amp; White</td>
<td>$1,950</td>
<td>$1,400</td>
<td>$825</td>
</tr>
<tr>
<td>Center Spread – 2 Full Pages, Color</td>
<td>$5,900</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Center Spread – 2 Full Pages, Black &amp; White</td>
<td>$3,800</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

Ads should be submitted as print ready (CMYK) PDF files along with hard copy. Payment must accompany the ad. Deadline dates are published for the Newsmagazine. Checks must be payable to the New Jersey Chapter - Healthcare Financial Management Association.

Deadline for Submission of Material

<table>
<thead>
<tr>
<th>Issue Date</th>
<th>Submission Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>January/February</td>
<td>December 15</td>
</tr>
<tr>
<td>March/April</td>
<td>February 15</td>
</tr>
<tr>
<td>May/June</td>
<td>April 15</td>
</tr>
<tr>
<td>July/August</td>
<td>June 15</td>
</tr>
<tr>
<td>September/October</td>
<td>August 15</td>
</tr>
<tr>
<td>November/December</td>
<td>October 15</td>
</tr>
</tbody>
</table>

Identification Statement
Garden State “FOCUS” (ISSN#1078-7038; USPS 003-208) is published bimonthly by the New Jersey Chapter of the Healthcare Financial Management Association, c/o Elizabeth G. Litten, Esq., Fox Rothschild LLP, 997 Lenox Drive, Building 3, Lawrenceville, NJ 08648-2311

Periodical postage paid at Trenton, NJ 08690. POSTMASTER: Send address change to Garden State “FOCUS” c/o Elizabeth G. Litten, Esq., Fox Rothschild LLP, 997 Lenox Drive, Building 3, Lawrenceville, NJ 08648-2311

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

Editorial Policy
Opinions expressed in articles or features are those of the author(s) and do not necessarily reflect the view of the New Jersey Chapter of the Healthcare Financial Management Association, or the Publications Committee. Questions regarding articles or features should be addressed to the author(s). The Healthcare Financial Management Association and Publications Committee assume no responsibility for the accuracy or content of any articles or features published in the Newsmagazine.

The Publications Committee reserves the right to accept or reject contributions whether solicited or not. All correspondence is assumed to be a release for publication unless otherwise indicated. All article submissions must be typed and double-spaced and provided on disk, if at all possible.

Send all correspondence to:
Elizabeth G. Litten, Esq.
Fox Rothschild LLP, 997 Lenox Drive
Building 3, Lawrenceville, NJ 08648-2311

Reprint Policy
The New Jersey Chapter of the HFMA will not reprint articles published in Garden State FOCUS Newsmagazine. Individuals wishing to obtain reprint authorization must obtain it directly from the author(s) of the article. The cover of the FOCUS may not be used in the reprint; however, the reprint may note that the article was published in a specific issue. The reprint may not imply endorsement by the HFMA, directly or indirectly.
The President’s View

Dear Fellow Members of HFMA:

The cover of this edition of the FOCUS shows a train slowing down as it takes a curve on a track in preparation of entering a dark tunnel. The tunnel reminds me of the current financial plight of healthcare organizations in New Jersey. The train represents the next wave of change that will slowly engulf all the resources of healthcare financial departments in New Jersey. The train has not arrived yet, but an examination of its cargo will be critical to the survival of your organization.

In my previous Presidents’ View, I mentioned that Medicaid is preparing to rebase sometime in late 2006. CMS has just announced their intention to utilize All Patient Diagnosis Related Groups or APR-DRGs within the upcoming year. Horizon is renegotiating with hospitals utilizing Medicare based APC payments. CMS will soon make public Medicare payment amounts submitted to hospitals and physicians on 20 common procedures. Let us not forget about utilizing the new ICD10 coding principals too. As you can see, the cargo on this train can be hazardous to the health and stability of both your financial operation, and the bottom line.

If you are the CFO, what are your options? If retiring early is not part of your current plans, then how are you possibly going to react to this train that will soon accelerate and bring your organization to its knees? The answer is education and expertise. The CFO may request any employee who is an expert in IT, Reimbursement, Coding and the Patient Revenue Cycle to join him at an internal task force. Of course, no one will show up. Now the CFO must expand his scope and invite all his financial management team and affected hospital departments to attend. As the CFO glances across the packed room at his task force attendees, a quick observation will soon become evident. As a healthcare organization, how can we possibly react and be ready for such an onslaught of reimbursement and operational changes? The cargo on this train will affect all aspects of financial reporting, pricing, coding, revenue and the gray hairs on everyone’s heads. The question that should be answered is: who will teach?

New groupers, new coding, self pay patients armed with prices, where will the expertise come from in your organization to react to these changes? Now that I have your attention, maybe we can try and figure out a possible solution. Since no organization can possibly have the expertise to handle all these changes, the CFO will need to look elsewhere for assistance. The present is the best time to seek out professional organizations, including HFMA and our local chapter. The time is NOW to drive the education process, get involved, demand expertise, and try to guarantee that your employees will be ready when the train arrives. The HFMA Chapter of NJ is here to assist, but we need everyone on board so the train makes it to the light at the end of the tunnel.

The education committee will be sponsoring a Medicare Cost Reporting Preparation session on April 12th and a PC training class on May 9th. Remember our annual golf outing is scheduled for May 11th at the Fiddlers Elbow Golf Club, and our June Quarterly Meeting, sponsored by our FACT committee, is planned for June 13th. Please avail yourself of our website at HFMANJ.org for further details.

Thank You

John Manzi
From the Editor...

Dear Readers:

Our New Jersey chapter (and the publications committee, specifically) is continuing its efforts to enhance the value of HFMA membership in New Jersey. The publications committee has begun several projects geared toward this goal: we have begun work on redesigning the New Jersey chapter’s website; we are highlighting the expertise of a particular New Jersey hospital Chief Financial Officer in each issue (the “CFO Member Spotlight”); and we are working to identify and explore the most recent and critical issues facing the hospital and health care industry.

The cover of this issue, depicting a train heading into a dark tunnel, was inspired by publications committee member Jim Robertson’s description of the hospital Medicaid rate appeal. A couple of months ago, Jim had described the case to the committee, feeling optimistic that the Appellate Division would rule in the hospitals’ favor. At that point, we discussed including an article in an upcoming issue, and depicting a train coming out of a tunnel (the “light” at the end of the proverbial tunnel). The recent court decision against the hospitals shifted the image of a train coming out of a dark tunnel to the image of a train heading into one. John Manzi’s President’s letter describes the cover as a symbol of movement into a dark fiscal atmosphere, but also as a call to examine the fiscal “cargo” on-board. As with the last issue’s “Help Wanted” cover, we are making an effort to use the cover as a means of highlighting content – and as a means of engaging our readers into current and relevant issues.

We also try to tap into the expertise of other HFMA chapter members, so that we can bring our New Jersey readers informative articles on issues faced by hospitals in other states, and with the longer-term goal of sharing New Jersey’s magazine and health care issues with other chapters. James Unland’s articles on the pricing/collections/charity care controversies facing tax-exempt hospitals in Illinois were an excellent example of how the issues affecting the industry elsewhere are relevant in New Jersey. The committee was especially pleased with Jim’s comments on the magazine copies we sent to thank him for his contribution:

“I must say – and I say this as a former Editor of our chapter’s ‘newsletter’ as well as ongoing Editor of the Journal of Health Care Finance – your magazine (calling it a ‘newsletter’ doesn’t do it justice!) is most impressive! We think of ourselves out here in the First Illinois Chapter as being pretty cool, but you guys have really raised the state-of-the-art with your publication!”

Thank you, article contributors (and advertisers and the many members who read the magazine on a regular basis), for your role in helping our committee produce a worthwhile magazine – and thank you, Jim Unland, for reminding us that the ongoing work is worth it.

Regards,

Elizabeth G. Litten, Editor
Our Decision Support System is a lot like the others . . .

**REVENUE RECOVERY**
An automated "data mining" service that identifies contract payment issues and revenue opportunities on patient accounting claims.

**VISION DECISION SUPPORT**
Web-based Oracle data warehouse with contract pricing, data visualization, and powerful reporting with drilldown to patient level data.

- AR Valuation
- Revenue Valuation
- Receivables Management
- Profitability Analysis
- Revenue Budgeting and Budget Monitoring

Only way different!

VISION® is the affordable way for any size hospital to obtain the latest web-based Decision Support and contract management technology—with no upfront costs. With VISION, you’ll have the ability to diagnose and treat your most challenging revenue cycle and profitability issues. What a concept!

**HEALTH WARE CONCEPTS**
The New Way of Looking at Healthcare Decision Making
1.888.HWCSOFT  732.906.8863  www.hwcssoft.com
No Light At The End Of The Tunnel: Hospitals Suffer Set Back In Decade-Old Medicaid Rate Appeal Cases

by Paul R. Murphy, Esq., James A. Robertson, Esq. and Philip A. Besler, FHFMA, CPA

The New Jersey hospital industry has been fighting for the right to receive adequate Medicaid rates from the New Jersey Medicaid Program for over a decade. Hospitals have been consistently denied adequate reimbursement by the Division of Medical Assistance and Health Services (“DMAHS”) through its complete failure to recognize that the hospital industry has been providing inpatient hospital services to Medicaid fee-for-service beneficiaries at a substantial loss. New Jersey hospitals entered the long, dark tunnel of Medicaid rate appeals in 1995 and, as of February 17, 2006, there is less light at the end due to a decision of the Appellate Division of the Superior Court that rubber-stamped DMAHS’ conduct. A Petition for Certification to the New Jersey Supreme Court has been filed.

The Medicaid Rate Appeal Process

The Medicaid Program is a joint federal and state program designed to provide medical assistance to the indigent, disabled and elderly persons. 42 U.S.C.A. §1396 et seq. Under federal law, a State that wants to offer a Medicaid Program must submit a Medicaid State Plan for approval by the Secretary of the United States Department of Health and Human Services (the “Secretary”). The State Plan must include those elements described in 42 U.S.C.A. §1396a, including a process for hospitals to appeal the reimbursement rates established by the state for the hospitals’ provision of services to Medicaid beneficiaries.

DMAHS adopted a regulation, N.J.A.C. 10:52-9.1, that sets forth the hospital rate appeal mechanism for the New Jersey Medicaid Program. Under the appeal regulation, a hospital can appeal each year (sometimes referred to as a “rate year”) its diagnosis related group (“DRG”) rates established by DMAHS for that year for the hospital’s provision of inpatient services to Medicaid beneficiaries. The hospitals can seek additional reimbursement by demonstrating that either: (1) there is a calculation error in the rates established for the hospital for that year by DMAHS (“Calculation Error Appeal”); or (2) that the hospital has sustained a marginal loss in
providing inpatient services to Medicaid fee-for-service patients at the DRG rates established for the hospital for that year by DMAHS (“Marginal Loss Appeal”).

The Long and Tortured History of the Medicaid Rate Appeal Cases

The Courts are no strangers to the Medicaid rate appeal cases and in fact have been called upon on several occasions to keep DMAHS in check. The history of these cases essentially starts with the rate appeals filed by several hospitals for the 1995 rate years. The Appellate Division, in In re Zurbrugg Memorial Hosp., 349 N.J. Super. 27 (App. Div. 2002), reversed DMAHS’ arbitrary denial of those 1995 rate appeals on the prophetic grounds that the 1995 version of the Marginal Loss Regulation was “so flawed that compliance became a matter of chance rather than one that is carefully enunciated and systematic.” In an effort to resuscitate the procedural deficiencies in the 1995 version of the Marginal Loss Regulation, the Court remanded all of the 1995 rate appeals back to DMAHS for reconsideration in the hopes that an “interactive process” could take place between DMAHS and the hospitals which would remedy the deficiencies in the Marginal Loss Regulation.

Following the same process every year, DMAHS issued Medicaid rates to the hospitals in 1996, 1997 and 1998 which were appealed by the hospitals. Three years passed with no action by DMAHS, causing some of the hospitals to seek relief from the Appellate Division and leading to the Court’s decision in Hospital Center at Orange v. Guhl, 331 N.J. Super. 322 (App. Div. 2000). On July 9, 1999, the day before DMAHS’ appellate brief was due to be filed, and under pressure of the Guhl litigation, DMAHS issued final decisions denying the hospitals’ 1996, 1997 and 1998 rate appeals. Notwithstanding, the Court concluded that DMAHS had failed to satisfy its obligation to decide the Medicaid rate appeals within a reasonable amount of time in violation of the hospitals’ due process rights. DMAHS’ July 9, 1999 decisions were significant, however, because for the first time, DMAHS unexpectedly changed the “marginal loss” calculation in two material respects: (1) payments from the Hospital Relief Subsidy Fund (“HRSF”) and for Graduate Medical Education (“GME”) were added to the marginal revenue side of the marginal loss calculation; and (2) the Medicare Cost Report (“MCR”) was used solely, and to the exclusion of SHARE data or any other data source, to determine a hospital’s marginal costs.

DMAHS subsequently issued denials on the hospitals’ rate appeals for 1999, 2000 and 2001, and the hospitals filed requests for an administrative hearing for these years as well. Subsequently, all of the hospitals’ Medicaid rate appeals for rate years 1996-2001 were heard by Administrative Law Judge (“ALJ”) John R. Tassini, who found that DMAHS’ denial of the hospitals’ requests for rate increases under their Medicaid rate appeals was unreasonable because the DMAHS did not engage in the “interactive process” required by the Zurbrugg case for all Medicaid rate appeals and because it appeared that DMAHS had “promulgated no rule to describe use of SHARE, DSH, [or] HRSF . . . data, to calculate whether a hospital would sustain a marginal loss in providing inpatient services to Medicaid beneficiaries.” Accordingly, ALJ Tassini recommended that the cases be remanded back to DMAHS so that an “interactive process” could take place between the hospitals and DMAHS to come to some resolution on these issues.

Rather than engage in a meaningful discussion on the issues, on September 8, 2003, DMAHS, modified the ALJ’s decision and permitted itself to include in each hospital’s marginal loss calculation: (1) HRSF and other DSH payments; and (2) the use of the hospitals’ Medicaid inpatient cost data from each hospital’s MCR. The hospitals appealed DMAHS’ September 8th Final Agency Decision to the Appellate Division, which again remanded the cases back to DMAHS with instructions to engage in and complete an “interactive process” with the hospitals called for by the Zurbrugg case by no later than April 16, 2004.

The readers of this article will no doubt remember that DMAHS then sent the hospitals letters in February of 2004 requesting that all hospitals: (1) provide DMAHS any analysis that has been performed of the impact a change in volume of the hospitals’ services would have on the hospitals’ total costs, or any other analysis or study done of the incremental or marginal costs of delivering services at the hospitals; and (2) verify the accuracy of DMAHS’ cost and revenue data, which included total and allowable Medicaid inpatient costs from the hospitals’ MCR, total Medicaid DRG payments, GME payments, HRSF payments, and “other DSH,” i.e., Charity Care and Mental continued on page 9
Meet Breadth + Depth

Victoria McElarney, RN, MBA, CHE, CPC-H
Senior Manager

Vickie McElarney assists clients by bridging the gap between two very different worlds: clinical and financial. Vickie’s knowledge of the chargemaster gives her the ability to translate financial language into easily understood clinical terms. Vickie’s close interaction with department managers, as well as managers in finance and information systems departments, helps her uncover coding and operational solutions unique to each facility.

Vickie’s team of experienced clinical professionals are all Certified Professional Coders. Their approach to coding analysis results in identifying revenue opportunities while assuring billing compliance. To learn how Vickie can assist your organization, contact us today.
Health payments for the years for which the hospitals had rate appeals pending. At no time were the merits of including DSH funds in the marginal loss calculation debated, nor was the reasonableness of using SHARE cost data over MCR cost data discussed. Each hospital promptly responded to DMAHS’ letters in good faith.

It was no surprise then that on April 16, 2004, DMAHS issued Final Agency Decisions (“FADs”) on all of the hospitals’ Medicaid rate appeals, denying the hospitals’ request for Medicaid rate increases by loading HRSF, GME, Mental Health and Charity Care payments into the marginal loss calculation, and finding on unanimous, identical grounds that the hospitals “did not sustain a marginal loss for any of the rate periods in issue.” The hospitals then contested the conclusion in the Appellate Division of the Superior Court, leading to the Appellate Division’s decision on February 17, 2006.

The Appellate Division’s February 17, 2006 Decision

The Appellate Division issued its final decision on February 17, 2006 and it wasn’t good for the hospitals. The Court held that DMAHS did not act arbitrarily in including DSH revenues when calculating marginal loss, stating that whatever a hospital’s actual use of DSH payments may be, DMAHS is statutorily entitled to categorize DSH payments as a form of unallocated reimbursement for inpatient Medicaid care, and that such a categorization does not violate either express or implied legislative policies and is consistent with them.

The Court further found that DMAHS’ determination not to subtract the costs of indigent care that are unrelated to Medicaid inpatient treatment from DSH payments in determining marginal loss was also not arbitrary. The fact that DSH funds may have been used, in part, to provide inpatient and outpatient indigent care in addition to Medicaid-eligible inpatient fee-for-service care does not affect the conclusion that

it continues to be prudent for hospitals to file their rate appeals for the 2006 rate year as usual pending the outcome of the petition for certification.

DSH funds are Medicaid supplemental allotments and can be considered as a part of Medicaid inpatient rates by DMAHS.

Additionally, the Court held that the hospitals were not denied their administrative due process rights to fundamental fairness, finding that the Division’s common-sense interpretation of its Marginal Loss Regulation to permit the consideration of DSH funds as revenue in calculating marginal loss was expressed to the hospitals and has constituted the principal issue underlying all of the appeals. Thus, as the result of the appellate process, the Hospitals’ due process rights have been fully protected.

Finally, the Court found that the use of MCR data and the inclusion of DSH funds as revenue in marginal loss calculations did not constitute de facto rulemaking, because the Division’s construction of its own rule did not require it to engage in additional rulemaking in accordance with the APA, but rather constituted the interpretive process that occurred at the administrative level and culminated with the Court.

In support of its view, the Appellate Division noted that on July 5, 2005, DMAHS adopted amendments to the Marginal Loss Regulation, that explicitly counts all DSH payments as Medicaid “rate” payments in calculating whether a hospital is suffering a marginal loss in providing inpatient services to Medicaid fee-for-service beneficiaries and also purports to apply new rules retroactively to Calculation Error Appeals. This regulation is the subject of the separate appeal pending in the Appellate Division.

Future of Medicaid Rate Appeals

The Court’s decision and the amendments to the Marginal Loss Regulation raise significant obstacles to future Medicaid rate appeals. There is no question that the result reached by the Court is wholly unfair. Even more disturbing is the Court’s complete lack of courage to tackle the decade-long, state-wide crisis by refusing to hold DMAHS accountable for its conduct. Instead, the Court deferred to DMAHS.

On March 14, 2006, the hospitals filed their Petition for Certification with the New Jersey Supreme Court re-
questing that it review the Appellate Division’s February 17th decision in light of the important legal and public policy issues that are implicated by the case. We will be informing the hospital industry in a follow-up article of the outcome of the Supreme Court’s decision on the hospitals’ Petition for Certification. In the meantime it continues to be prudent for hospitals to file their rate appeals for the 2006 rate year as usual pending the outcome of the petition for certification.

In addition, the hospitals are considering their options relating to obtaining the long awaited rulings on the Calculation Error Appeals remanded to DMAHS in 2002.

About the Authors
Paul Murphy and James Robertson are Principals and Directors of Kalison, McBride, Jackson & Murphy, P.A., a 15-attorney boutique health care law firm located in Warren, New Jersey, representing health care providers throughout New Jersey, and specializing in reimbursement issues for the hospital industry. Philip A. Besler is the President and Chief Executive Officer of Besler Consulting, providers of financial and operational consulting services to healthcare organizations.
The “Health Claims Authorization, Processing and Payment Act” – The Answer to Your Facility’s Claims Problems?

by Sonja Allen, J.D., AHC, Inc.

The signing of the “Health Claims Authorization, Processing and Payment Act” marks the culmination of exhaustive efforts by health care advocates within the state of New Jersey. This claims denial bill saw various versions throughout numerous years of legislative process. The legislation (“S-2824”) was unanimously approved by the legislature on January 9, 2006 and expeditiously signed into law by Acting Governor Richard Codey just three days later. The legislation, due to become effective in July 2006 (180 days after enactment), is intended to inject uniformity and structure into a health care delivery system beleaguered by inadvertent loopholes and ambiguity, which before now precipitated confusion amongst providers, insurers and consumers of healthcare alike. Advocates of the bill hope that inefficiencies such as disorganized utilization management, sluggish claims processing and biased appeals procedures will be eradicated or greatly diminished as a result of the ratification of the legislation.

Utilization Review Management & Authorization of Health Care

Prior to the enactment of the “Health Claims Authorization, Processing and Payment Act,” managed care organizations were held to ambiguous “reasonableness” standards when it came to establishing time limits and procedures for evaluating the delivery of medical services for appropriateness, medical necessity and quality. The Act sets specific guidelines for the authorization of health care services delivered or proposed to be delivered to individuals enrolled in a health benefits plan. Encompassed in these guidelines is a new requirement that plans publicize information concerning utilization management and the processing and payment of claims on the Internet no later than 30 calendar days before the information takes effect. The information that must be posted includes, among other things, a description of the source of all clinical criteria guidelines used by the plan to determine medical necessity and a list of the documentation information required to be submitted with a claim for payment.

The new law further requires payers to respond to a provider’s request for authorization of health care services within the time periods stipulated to in the Act. The following deadlines are now part of the law: (1) For prior authorization of inpatient hospital services and health care services in an outpatient or other setting, a payer must communicate denial of a request or the limitation imposed on the requested service to the hospital within a time frame appropriate to the medical exigencies of the case but no later than 15 days following the time the request was made; (2) For authorization of concurrent hospital emergency department services, a payer must respond according to the exigencies of the case but no later than 24 hours following the time the request was made. In addition, payers will have additional time to process a request for authorization if the payer is unable to approve or deny the request within the prescribed timeframe because of the need for additional information. Providers will be required to respond to a request for additional information within 72 hours of the request.

While the language of the Act does not specify by what means the payer must communicate a request for additional information, the payer and provider consequences for noncompliance of these guidelines are quite clear. If a payer fails to respond to an authorization request within the appropriate timeframe, the request will be deemed approved and the payer will be responsible for payment of covered services. If a provider fails to respond to a payer’s request for additional information within 72 hours, the provider’s request for authorization will be deemed withdrawn. The bottom-line consideration for providers, however, is the fact that a payer cannot deny reimbursement to a provider for covered services on the grounds of medical necessity if services are authorized prior to the delivery of such services or if the payer fails to respond to a request for authorization within the appropriate timeframe prior to the delivery of services.

While the disclosure and authority of the physician and physician assistants continue on page 12...
ization requirements outlined above should help illuminate utilization review and quality management and remove such procedures from the sole discretion of the plan, providers must take an anticipatory approach to ensuring reimbursement as opposed to attacking ensuing denial issues on a reactive basis arising from a denial, delay or benefit reduction. The result should be the flow of communication between plan and provider thereby better ensuring the best possible coordinated care for the patient. When providers are prospectively armed with such information, they tend to be placed in a better position to plan for the delivery of health care to their patients and obtain necessary authorizations and certifications. However, to reduce the financial risk involved in rendering necessary care without knowledge of whether such services are reimbursable, the key is to not only have such information readily available, but to make sound decisions based upon that information and implement such information into the provider's internal procedures.

Upon the initiation of any claim, the utilization review information required to be disclosed should be made a part of the record so that all staff modules invested in the revenue cycle of that claim may implement them appropriately. Denial avoidance and increased revenue at an accelerated rate are goals best achieved if they are at the forefront of the initial stages of the revenue cycle. A standardized and uniform process for staff at all levels of claim engagement is crucial to reducing potential delays and denials down the line. In light of S-2824's enactment, providers will want to update billing protocols accordingly, educate the staff to these important changes and make the implementation as seamless as possible by perhaps introducing templates, form letters and the like.

In order to take full advantage of the attention being shown to the issue of utilization review management, providers should initiate dialogue with their major payers immediately and review current contracts to evaluate how the issues are treated in such agreements. Furthermore, providers should be prepared to challenge any health benefits plan that does not meet the disclosure requirements of S-2824. Doing so will in the very least put the plan on notice that the facility is fully cognizant of the requirements of the new law and the organization will proficiently monitor the plan's compliance under these provisions.

Prompt Payment

The prompt payment of health benefits claims until now was yet another area of the health care delivery system fraught with technicalities and escape mechanisms advantageous to the payer wishing to circumvent timely payment requirements. The law required that all electronically submitted claims be paid within 30 days and all paper claims be paid within 40 days unless they required some undefined “special treatment” that would prevent timely payment. Fortunately, the “Health Claims Authorization, Processing and Payment Act” removes the “special treatment” loophole from the law which encumbered the health care delivery system with undue financial burden. Simply stated, clarity of the obligations to pay claims in a timely manner will translate into less financial risk for providers.

The new law clarifies that payers must notify the provider by electronic means within 30 days of receiving an electronic claim, or notify the provider in writing within 40 days of receiving the claim by other means, that the claim is deficient, in dispute or fraudulent. Furthermore, if an electronic claim cannot be adjudicated because of missing codes, the payer must electronically notify the provider within 7 days of that determination and request any information required to complete adjudication of the claim. The law also increases the late payment penalty from 10% per annum to 12% per annum.

One of the provisions most favorable to providers is the stipulation that payers cannot delay payment of a claim while seeking coordination of benefits unless there is “good cause.” S-2824 explains that “good cause” may only exist if the payer’s record already indicates other coverage. When a health benefits plan attempts to delay payment of a claim to pursue coordination of benefits information from the patient, staff members would be justified in demanding details from the health plan regarding the other coverage the patient supposedly has benefits under. If the plan is not able to provide such details, it should be reminded that, under the law, a routine request to determine whether coordination of benefits exists does not constitute good cause and, thus, the claim must be processed according to statutory prompt payment deadlines and will be subject to late payment penalties.

Refund/Underpayment Requests

Pursuant to S-2824, providers in many instances have 18 months from the date of first payment to seek additional reimbursement from a payer or covered person. Similarly, health benefits plans are now held to a strict deadline in seeking reimbursement for the overpayment of a claim from a provider. Providers are in turn afforded a specific amount of time to appeal an overpayment request. However, while these requirements will be quite effective in evening the playing field among payers and providers in the health care arena, providers should be wary of the fact that, once all provider appeal rights have been exhausted, a payer is allowed under the law to collect a refund by offsetting the refund amount against other claims. In such instances, payers are required to submit an explanation in writing to the provider detailing how the overpayment will be reconciled.
But, it is yet to be seen whether this provision will do more to make matters worse for providers where the optimal goal would be to eliminate the offsetting option altogether. This practice can easily develop into an accounting nightmare placing the provider at a distinct disadvantage. Nevertheless, to prepare for the changes reflected in the law, providers may wish to adjust protocols to ensure that refund requests are promptly addressed and to ensure that a contract management system is in place that accurately identifies underpayments.

Appeals
The new law further empowers the health care providers faced with carrier decisions to deny, reduce or terminate a patient's benefits by establishing a provider's right to avail itself of the Department of Banking and Insurance's Independent Health Care Appeals Program which offers an independent medical necessity review of denied claims. Importantly, the provider must be acting on the patient's behalf and with the covered person's consent. Prior to receiving services, a patient may sign a consent form authorizing the provider to appeal a claims determination. This consent is valid for all stages of the carrier’s appeals process and the Independent Health Care Appeals Program. Keep in mind, however, that there is an application processing fee of $25 that attaches to each request for review submitted to the Department of Banking and Insurance under this program. Therefore, one key consideration is whether it is cost effective to introduce this element into the facility's denial management system on an all-inclusive basis, or whether it makes more business sense to exercise this appeals option on a more selective case basis. In any case, providers want to take action now to develop the appropriate consent forms and introduce these documents into the patient admissions protocols as soon as possible so that all appeals options are reserved.

The new law also requires health benefits plans to establish an internal appeals mechanism to resolve disputes raised by both contracted and non-contracted providers. Providers must initiate appeals or on or before the 90th calendar day following receipt of a determination and carriers have 30 calendar days following receipt of the appeal to conduct the review and notify the provider of the determination. Also new is the provider's ability to seek arbitration in some instances of adverse determinations. For instance, if a carrier does not respond to an appeal within the statutory time constraints, or if the provider receives an adverse determination altogether, the provider may seek binding arbitration on any amount in dispute that is at least $1,000.

Conclusion
The “Health Claims Authorization, Processing and Payment Act” represents a laudable effort by lawmakers and health care advocates to better equip providers with a means to avoid the intense rigors of navigating the so-called “health insurance bureaucracy.” Hopefully, its passage will allow providers to center their focus on the paramount function of providing care to patients. While the overall effectiveness of this legislation is yet to be revealed and the impact of the law may draw new light once the Department of Banking and Insurance puts regulations in place in answer to the Act's provisions, providers can be optimistic that the right steps are being taken to create uniform standards that payers, providers and consumers can accept. While laying the foundation necessary to remove the inefficiencies in the health care delivery system, the new law is providing a setting more conducive to meeting the patient's health care needs.

About the Author
Sonja Allen, J.D. is a Managing Attorney specializing in legal research at AHC, Inc. (www.ahcinc.com). She is a graduate of the University of Virginia with a Bachelor of Arts in both Government and Sociology. She received her Juris Doctorate from Howard University School of Law. Sonja can be reached at sallen@ahcinc.com.
At Amper...
we focus on your needs, build trust and guarantee your success.

Amper’s Healthcare Services Group is committed to helping our hospital, ambulatory surgery center and physician clients meet the challenges of today's healthcare environment.

Michael J. McLafferty
CPA, MBA, CHFP, FACMPE

Lewis D. Bivona
CPA

Maureen A. Doherty
CPC, CPC-H

Georgina Y. Mendoza
MHA

(732) 287-1000
With Offices Throughout the New Jersey/ New York Metropolitan Area
www.amper.com/industries/healthcare.asp

Amper, Politzerer & Mattia
CERTIFIED PUBLIC ACCOUNTANTS and CONSULTANTS
Blessed with surprisingly Spring-like weather, the 17th Annual Joint Meeting of the New Jersey Chapters of the American Association of Healthcare Administrative Management and the Healthcare Financial Management Association drew more than 240 registrants to the Woodbridge Hilton on January 10 for an all-day seminar that featured a broad array of topics ranging from Revenue Cycle Key Performance Indicators (KPIs) to employee recruitment and retention. This meeting marked the tenth anniversary of the Blizzard of 1996, when 30˝ of snow shut down the entire state, and caused the meeting to be postponed for the only time in its history.

KPIs as Keynote

David C. Hammer, FHFMA, Vice President, Revenue Cycle Solutions for McKesson Provider Technologies, Fort Lauderdale, Florida, led off by addressing “How Do You Know Where You’re going If You Don’t Know Where You’ve Been?” Mr. Hammer has more than 22 years of revenue cycle experience in a variety of positions with leading not-for-profit and proprietary health systems, Big Four accounting firms, information systems vendors, and health care A/R management companies. He authored the cover story in the July 2005 issue of HFM, “Performance is Reality: is your revenue cycle holding up?”

Mr. Hammer emphasized the need for key performance measures (KPIs) that go beyond receivables, cash and A/R days and provide a more complete picture of revenue cycle performance against industry benchmarks and hospital goals. KPIs are useful in identifying and managing trends rather than focusing on single period results. They maintain a record of performance and tell a story. KPIs enable hospitals to benchmark performance against goals as well as industry best practices.

He defines three separate levels of KPIs:

- Level 1 indicators are those that are of most interest to senior executives and the Finance Committee of the Board, and include such items as cash collections, gross and net accounts receivable (A/R), percentage of third party A/R aged more than 90 days, cash as a fraction of net revenue and the cost-to-collect percentage;
- The six Level 2 indicators are of most interest to the key executives with revenue cycle responsibility, and include net A/R days, allowance for doubtful accounts, bad debt and charity care as a fraction of gross revenue, denials as a fraction of gross revenue, cash as a fraction of cash goal, and point-of-service collections as a fraction of goal; and
- The Level 3 indicators are useful to the revenue cycle operations management team for analyzing results and explaining variances, and include the clean claims throughput percentage, collection agency netback percentage, net revenue, complaints to administration and total open accounts.

KPIs are helpful in enacting positive changes in the revenue cycle. Stakeholders must understand the processes that generate the KPIs, and continuously adapt them as needed to enhance performance. KPIs also help to develop a culture of accountability and reward.

Mr. Hammer used graphs to illustrate how KPIs are tracked over time.

Drilling Down

Mr. Hammer then took the audience through a set of KPIs for each functional area that included KPI standards as well as “best practice” process indicators, including:

- Patient Access/Registration – patient waiting times, registrations completed per registrar, data quality measures
- Financial Counseling – collection of patient-pay balances, screening of uninsured patients for financial assistance
- Health Information Management – charts coded per coder, chart delinquency rate, chart retrieval time, transcription backlog
- Charge Entry/Revenue Protection – Late charges as % of total charges, continued on page 16

continued on page 16
lost charges as % of total charges, CDM incorrect/missing HCPCS/CPT-4 codes
• Billing/Claim Submission – HIPAA compliant electronic claim submission rate %, final billed backlog, Medicare supplemental billing turnaround, Medicare RTP denials rate
• Third Party and Guarantor Follow-up – insurance A/R > 90 days, bad debt write-offs as % of gross revenue, cost-to-collect, patient cash as a % of net revenue
• Cashiering/Refunds – HIPAA compliant electronic payment posting %, transaction posting backlog, credit balance A/R days
• Denials – overall denials rate, clinical denials rate, technical denials rate, appeals overturned rate
• Customer Service – correspondence backlog, walk-in patients’ wait time, automatic call distribution (ACD) average hold time, ACD abandoned calls %, ACD % of calls resolved in < 5 minutes
• Collections/Outsourcing Vendors – bad debt netback %, bad debt fee rate, legal collections fee rate

Mr. Hammer concluded by noting that “Having the numbers alone is not enough. When coupled with a good understanding of industry standards and the process management skills needed to achieve them, your numbers can tell a story of financial wellness, complete with key indicators that are trended across time. You’re not likely to know where you’re going unless you know where you’ve been.”

MMA Section 1011
Stuart Schiffman, Assistant Vice President, Patient Business Services for Virtua Health, presided over a panel of experts who discussed what is involved in obtaining reimbursement for services provided to undocumented aliens who use hospital Emergency Rooms. The panelists included Rosanna Dovgala, Armanti Financial Services, Rita Romeu, ARMDS, and Ricardo Torres, Self-Pay Solutions.

The Medicare Modernization Act includes funding of $250 million per year for four years beginning October 1, 2005. There is a total of $5.2 million available for New Jersey providers to reimburse them for health services provided to certain undocumented aliens. CMC has designated Trailblazer Health Enterprises to handle the enrollment and claim submission process. Claims are submitted and payments made on a quarterly basis. Funding is spread throughout the federal fiscal year, and prorated if claims made exceed funding available. Claim submissions must be made within 180 days of the end of each federal fiscal quarter.

Hospitals have two options for receiving payment:
1. The hospital may submit for payment based on hospital and physician services; or
2. The hospital may submit for payment based on hospital charges only, and the physician then is responsible for submitting charges separately.

Covered services begin when the hospital’s EMTALA obligation begins, and continues until the individual is stabilized (i.e., the patient’s emergency medical condition has been resolved). Providers must submit claims for payment on a service-by-service basis, and Medicare rules are used to calculate the payment amount due for hospital services up to the point of stabilization.

HIPAA, JCAHO, Recruiting and Retention
Joe Carr, Vice President and Chief Information Officer at the New Jersey Hospital Association, returned to moderate a panel of experts to discuss “When do we get beyond the 837? Countdown to the 835, 270 and more.”

Panelists updated the audience on the status of the various transaction and code set initiatives, noting that the 837 as implemented still falls short of what payors need today since it is based on ten year old specifications. To make a long story short, the paperless business office remains more of a dream than a long awaited reality.

Laureen Rimmer, Manager at Besler Consulting, provided attendees with some eye-opening insights into the revised JCAHO Accreditation Survey process. The combination of unannounced surveys with the new tracer methodology represents the most radical change to the accreditation process since its inception. The focus of the new accreditation process is on safe, quality patient care – a state of continuous readiness where hospitals are 100% compliant 100% of the time. The paradigm has shifted from survey preparation to analysis and improvement of operational systems. Ms. Rimmer walked the audience through the tracer methodology, which follows care delivered to patients in the hospital during the survey, along with illustrative examples.

The final two afternoon sessions dealt with employee recruitment and retention. Ken Krueger, President of Executive Health Search, discussed successful methods for recruiting professional staff, and was followed by Marilyn Koczan, Vice President, Patient Financial Services at Meridian Health, who described Meridian’s innovative employee incentive plan that has significantly improved employee retention rates.

About the Author
John J. Dalton, FHFMA, is Senior Advisor to the Revenue Cycle practice at Besler Consulting in Princeton, NJ. A former Chapter President and National Board member, Mr. Dalton was HFMA’s 2001 Morgan Award winner for lifetime achievement in healthcare financial management.
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.

Our tax services to health care clients include:

- Advice and counsel regarding tax exemption issues.
- Representing clients in tax-exempt financing.
- Structuring transactions with physicians or business entities.
- Obtaining Private Letter Rulings from the IRS.
- Providing IRS audit assistance.
- Representing clients in tax-related litigation or administrative proceedings.
- Advice and assistance regarding “intermediate sanctions” and “excess benefit transactions” under the Internal Revenue Code.
John Manzi, President for the NJ Chapter of the HFMA, welcomed members to the Fall Quarterly Meeting sponsored by the ProAction Committee.

The morning session speakers spoke about various changes to reimbursement in the Healthcare community. Steve Frankenbach, Senior Manager with Deloitte & Touche began the morning program by giving a “Medicare Update” on the Final Regulations for both Inpatient and Outpatient services. Mr. Frankenbach began his presentation on healthcare issues caused by Hurricane Katrina and the reimbursement of crisis services for Medicare and Medicaid patients who have been transferred to facilities not certified to participate in the Medicare and Medicaid programs. Steve also mentioned the Senate Finance Committee approved a bill on October 25, 2005 resulting in a $10 billion Medicare & Medicaid savings over five years. The IRF 75% rules will be frozen at 50% through June 2007, with a permanent moratorium on self-referral, and pay for performance initiatives. The post acute care transfer methodology will be increased from the current 30 to 182 DRGs and is estimated to cost $780 million in 2006. CMS is revising the number of Coronary DRG’s from 9 to 12. Payment add-ons for new Technology will include the dollars for facilities impacted by the Katrina Crisis and two new items which include Endovascular Graft repair of the Thoracic Aorta and the insertion or replacement of dual array rechargeable neurostimulator pulse generator. The Outpatient Final Rule would add 10 APC’s requiring massive coding changes. Payment for Observation services were enhanced with the creation of two new billing codes.

The morning program also presented a panel discussion on the possible affects of Consumer Health Plans/Health Saving Accounts on reimbursement. Ms. Annette Catino, President & CEO of Qualcare, Inc., started off this session. Ms. Catino gave an overview of defining Consumer Drive Healthcare. Ms. Catino stated Managed Care will be taking on a different environment, probably because the consumer will be in the decision maker position for much of the process. Ms. Marilyn Koczcan VP, PFS at Meridian Health System (MHS) in NJ, stated, at Meridian they have already developed a process of tracking both payer & employer adoption of the Health Savings Account (HSA) program. They are setting up education and program needs via the web. Ms. Koczcan made a big point on the need for education in the Patient Accounts and Patient Access Services area. She impressed upon the need for a price guide and the creation of “up front pricing” for the most frequented services rendered. Marilyn lastly stated credit machines were at every possible point of service. John Sindoni, Sr. VP, Human Resourc
Resources also from Meridian, expanded on the Consumer Driven Health Plans discussion from an employee’s point of view. He stated that Meridian contributes dollars to “their” HSA by matching contributions up to specified levels. John noted that the plan included a traditional health coverage component, with no deduction from the HSA, no out-of-pocket cost, and the unused dollars would roll over year to year. Vince Costantino, VP Human Resources at Raritan Bay Medical Center (RBMC) stated that RBMC was getting started with the employee/consumer choice, that it could create competition, in addition to raising awareness of their costs of health care. Lastly, Mr. Peter A. Hutton, General Manager for Corporate Synergies Group, stated that healthcare facilities need to prepare by bringing together a Revenue Cycle group within the system from an operational perspective. Mr. Hutton stated a key concern is learning to recognize the difference in plan codes, having the ability to understand the extent of coverage, and the prior approval and authorization processes. Peter gave a heads-up, on possible “Sticker-Shock” in how much remains unpaid, and how much is available in the patient’s HSA account. If a debit card technology is used, will the provider have the right equipment to handle the transaction and will the provider have the right processes to collect unpaid balances.

In the afternoon session, Anjana D Patel, Esq., Sills, Cummis, & Gross, P.C. gave a synopsis on Gainsharing arrangements between facilities and physicians. Could these arrangements be on the rise? Ms. Patel stated the reasons for gainsharing under the Medicare Program. Hospitals receive a fixed fee including medical denials without regard to their actual costs, but physicians are reimbursed on separate fee schedules, and have no incentive to minimize hospital costs and hospital denials. This process is a way to align the dissimilar economic interests of hospitals and physicians. In January 2001, the OIG approved a gainsharing arrangement with physicians. A hospital can propose to enter into a one-year contract with cardiologists or cardiac surgeons to pay 50% of the cost savings directly attributable to the physician’s changes in practice. The hospital should attempt to minimize the physicians’ incentive to “steer” more costly patients to other hospitals, and any physician responsible for a significant change from historical measures, will be terminated from the arrangement. Lastly, the OIG has not opened the floodgates to all gainsharing arrangements. These will be approved on a case-by-case basis. In October 7, 2005 testimony given to Congress, OIG stated that they are looking for 3 basic safeguards; Accountability, Quality Controls, and Controls on Referral Patterns.

Stuart Presser who is a Vice President from the Greater New York Hospital Association followed with an update on the Medicare Recovery Audit Contractor Initiative (RAC). Mr. Presser stated a pilot program is under way, under the Section 306 of the Medicare Modernization Act, to demonstrate the use of recovery audit contractors in “identifying underpayments and recovering overpayments made under Parts A and B.” CMS has chosen California, Florida and New York to pilot this program because these states have the highest per capita Medicare expenditures. RAC’s may review and issue recoupment demands for claims up to 4 years old. RAC has been provided with Parts A and B claims data back to FY 2001; database and potential recoupment periods will be updated on a rolling basis. RAC may look for duplicate payments, coding errors, fiscal intermediary errors, lack of medical necessity and other overpayments. CMS must review and approve RAC audit and recovery protocols. The major concerns of this initiative were the structure of contingency fees, which could encourage RAC’s to look for overpayments only. They could recover overpayments up to 4 years from the date if initial adjudication but hospitals are limited to 60 days to recover DRG underpayments. And lastly, overpayments identified by RAC will result in adjustments to the hospitals, PS&R and open cost reports.

continued on page 20
charge adjustments. He stressed that it is the obligation of hospitals to notify DMAHS 30 days prior to any changes made to the hospital’s charge structure. Mr. Guhl also stated the moratorium of Hospital Based Offsite Clinics is used to verify data of new or relocating providers of hospital based, offsite clinic services. DMAHS is also actively designing a web-based enhancement to the eligibility verification system, which will be free to providers and will include HMO verification numbers. Lastly, Mr. Guhl presented proposed regulations provided that hospitals who do not contract with all of the Medicaid HMO’s forfeit Hospital Relief Subsidy Funding, and the HMOs would lose auto assignment premium revenue.

About the Authors
Rea Zagaglia is a Chargemaster Coordinator at Newton Memorial Hospital and Co-Chairman for the Reimbursement, Pro/Action, and Managed Care Committee. rzagaglia@nmhnj.org

Lee Gordon is Budget/Reimbursement Manager at Hackensack University Medical Center and Co-Chairman for the Reimbursement, Pro/Action, and Managed Care Committee. He can be reached at lgordon@humed.com
Our last presenter for our program was John Guhl, CFO for the NJ Department of Human Services; Division of Medical Assistance and Health Services, who gave his annual NJ Medicaid Hospital Update. As part of the Inpatient Hospital Reimbursement Update, 3M has extended their support of the current Grouper software to October 2006. Rebasings of the current system will be reflective of current hospital care practices and will be budget neutral. It is anticipated that the implementation of the new methodology and rates will be completed by October 2006 with the vendor beginning the process by December 2006. Mr. Guhl also mentioned that the Outpatient Cost-to-Charge Ratios for hospitals will be modified based on projected 2006 charge adjustments. He stressed that it is the obligation of hospitals to notify DMAHS 30 days prior to any changes made to the hospital’s charge structure. Mr. Guhl also stated the moratorium of Hospital Based Offsite Clinics is used to verify data of new or relocating providers of hospital based, offsite clinic services. DMAHS is also actively designing a web-based enhancement to the eligibility verification system, which will be free to providers and will include HMO verification numbers. Lastly, Mr. Guhl presented proposed regulations provided that hospitals who do not contract with all of the Medicaid HMO’s forfeit Hospital Relief Subsidy Funding, and the HMOs would lose auto assignment premium revenue.

About the Authors

Rea Zagaglia is a Chargemaster Coordinator at Newton Memorial Hospital and Co-Chairman for the Reimbursement, Pro/Action, and Managed Care Committee. rzagaglia@nmhnj.org

Lee Gordon is Budget/Reimbursement Manager at Hackensack University Medical Center and Co-Chairman for the Reimbursement, Pro/Action, and Managed Care Committee. He can be reached at lgordon@humed.com

Our Health Law Group serves a broad range of health care providers, including hospitals managed care networks, trade associations, physicians and medical groups, nursing homes, assisted living facilities, home health agencies, rehabilitation hospitals, ambulatory care centers, outpatient rehabilitation facilities, and other specialized health care businesses.

For a free copy of our newsletter, please contact Pam Crook at 215.299.2076 or e-mail pcrook@foxrothschild.com.
Enhancing your bottom line...

Improving your performance

Our people hold the key.

revenue enhancement & recovery

governmental reimbursement & compliance services

medicaid assessment & enrollment services

charge process review & management

CBIZ KA CONSULTING

www.kaconsults.com

50 Millstone Road | Building 200, Suite 230 | East Windsor, NJ 08520 | (609) 918-0990
At the writing of this article, the 2005 hurricane season is drawing to a close. Good riddance! It was definitely one for the record books. Here are some stats:

First storm: June 8 (Arlene)
Total tropical depressions: 28
Total named storms: 26 (Record)
Total Hurricanes: 13 (Record)
Major Hurricanes (Category 3+): 7
Total Damages: Estimated over 100 Billion (Mostly Katrina)
Confirmed Fatalities: 2,806+ (Mostly Katrina)

As the statistics show, the one name that will be remembered is Katrina. It has brought a whole new meaning to disaster recovery.

It was overwhelming to witness the tragedy of Katrina’s aftermath unfolding on T.V. It was truly hard to believe that this was actually happening in the United States, and that the people we were watching were our neighbors.

The dire situation in New Orleans is a valuable lesson in preparedness. The lack of planning and preparation on the federal, state and local levels was truly disheartening. However, in all fairness, who expected an entire city to be underwater? Yes, they were warned that it was possible; but, no one really thought that it was going to occur. Well it did. We witnessed first-hand the results of what takes place when we are not ready for things to go wrong. Take away authority, like we saw in the streets of that city, and it’s every man or woman for him or herself. It did not take long for a mob rule mentality to prevail.

There is a simple truism for any disaster (big or small): if you do not plan properly, a bad situation can get worse. The result will be greater losses in assets and in lives. If you have a plan but don’t test it, then there is no way of knowing that it will actually work, and no way to make any improvements. A lot can go wrong in a very short period of time causing an individual to become overwhelmed in an emergency situation and panic. Take that same emergency situation and the same individual, train him/her on what steps to take and who to call at the start of an incident, and you will see a different outcome. At a minimum, the emergency can be contained and brought under control more quickly. This can help to minimize any negative impact.

There are two terms that we should differentiate:

Business Continuity – Goal is to protect all company assets, to keep the business going during a disruption, and to restore it to an operational level quickly.

Disaster Recovery – Goal is more situation specific. It requires getting a specific department or site up and running. Disaster recovery is included in a business continuity plan, and is usually associated with IT.

Where have we heard the term “disaster recovery” before? If you said HIPAA, you are correct. The HIPAA Security Rule requires all covered entities to have a disaster recovery plan in place to protect patient information. Here is a quick review of the requirements:

**Standard:**
Contingency Plan

**Implementation Specifications:**
Data backup plan Required
Disaster recovery plan Required
Emergency mode operation plan Required
Testing and revision procedures Addressable
Applications and data criticality analysis Addressable

Preparing for any disaster, regardless of its size, should not be taken lightly. Even small incidents can result in lost data and equipment. Planning and preparation takes commitment from all levels of the organization in order for it to be effective.

When it comes to disaster planning, most people tend to think inside of their building, or even in their particular area
of the building. These events usually include fires, flooding and power outages. In fact these are the most likely situations, so it is extremely important to prepare for them. However, does your plan take into consideration what's going on outside of your building? What caused the flood in your basement? In the case of New Orleans, a breach in the levy system caused the whole city to be flooded. While your plan for a flood was a good one; it only dealt with an occurrence within your facility. However, with a flood like the one in New Orleans, you cannot get out and no one can get in.

What are some of the issues which you are now facing?

Communications: Can you get in touch with anyone on the outside to let them know your situation? If your phones are down can you use e-mail? Or are your data and voice coming in through the same point and that has been washed out because of the flooding? Hopefully there is cell phone service.

Power: Your generators and UPS devices have all kicked in as expected. Things are humming along nicely. But remember, the whole city is under water. How long will you need to rely on these backup devices? Do you know how long they will stay up? If not, do you know what systems are critical and need to be up and running? Do those critical systems rely on another system that has been labeled as not critical that will be shut down?

Food: Water, food and medicine: how long will these supplies last? Can you feed both your staff and patients? Do medicines need to be refrigerated? Directly outside your facility there are people desperate for your supplies. In the case of junkies and criminals who know that you are a source for their needs, how will you protect your medical supplies and your staff?

Let’s take it a step further. Can it get worse? You bet! Following the devastating tsunami of 2004, there were numerous discussions regarding these killer waves. One particular discussion went over the possibility of a volcano called Cumbre Vieja. It is located on the west coast of Africa. A strong enough eruption can cause a large landslide sending a giant wave towards North America that could affect the entire east coast.

Is the tsunami scenario likely to happen? Who knows! Should we be ready in the event that it does happen? Why not? What people tend to forget with natural disasters is that it’s not a matter of if, but a matter of when.

The point is that we should be prepared for these possible events, and especially those large enough to affect our lives in a significant way.

Things to consider beforehand:

Facilities

Investigate your area for what types of disasters might occur and plan for them.
– Consider location. Take a look around you. Do you see an ocean or mountains? In the case of Yosemite National Park being a large volcano or fault lines, what you’re looking for may be beneath you. Investigate what type of disasters could occur and plan for them.

– Weather conditions. Is your region prone to hurricanes, tornados or snow storms? Is your facility located in a flood area? This information can be used to plan where your data facilities should be located. In the case of the flood area, you definitely do not want your file servers in the basement.

– Ensure that all construction codes for your area are followed. There is a reason these codes exist.

– The above illustrations are also very important to consider for designing new facilities.

– Check insurance policies to see what your policy covers.

continued on page 24
Power

Generators and UPSs will not run forever. Also, remember that power is not only affected by disasters. Interruptions in power can be caused by simple human error.

- Create an inventory of all of your systems. Take that inventory and identify which systems are critical and need to stay up, and which can be shut down. In the event of a prolonged power disruption, you will want to shut down as many systems as possible to conserve energy.

- Look for any system dependencies. You may think that one of your systems is not important enough to keep going during an emergency, but in fact some of your critical systems may be dependent on it to be up and running to function properly themselves.

- Keep in mind that some systems may not start up after being shut down. This is especially true for older systems. Check your support contracts and make sure that they are up to date.

- At a minimum, check your backup power systems to make sure that they are working properly. In the case of a UPS, check that the battery can handle the load on it. Like any battery, it will weaken with age.

Communications

Stable communications are vital in any disaster situation. This includes both external and internal communications between staff members.

- Diversification is key here. Experts agree that you will need several methods to get your message out.

- Many companies have incorporated an emergency notification system or a calling tree where there is a predetermined list of persons to call in the event of an incident.

- Define the disaster. Someone should be able to define that there is actually a disaster occurring and have the authority to take the appropriate actions.

Water

Water became a major issue in New Orleans after Katrina. Stocking up is the easiest solution. However, bottled water takes up space. This may take a little creativity.

There is no way to prevent disasters from occurring. However, we can avoid the unnecessary loss of data, assets, and life by making the resources available to plan and test for disasters.

There is no way to prevent disasters from occurring. However, we can avoid the unnecessary loss of data, assets, and life by making the resources available to plan and test for disasters.

Evacuation

In the event of a Katrina like disaster, where the incident will last for weeks, ground transportation is impossible. Your supplies are running low, and you may have to consider evacuating patients and staff.

- Air and small flotation craft are your only options for accomplishing the job. It may be a good idea to identify areas (higher ground and rooftops) where these craft will be able to land.

- Partner with hospitals outside of your area that might not be affected by the same disaster to accept your patients.

- Ensure that procedures are in place to send patients to hospitals that can deal with their ailments.

- Remember, you will probably be taking in more patients.

Protect your data

The HIPAA Security Rule specifies that measures must be in place to protect and ensure the availability of electronic protected health information (EPHI).

- At a minimum, important data should be on a mirrored or RAID drive.

- Backup your data regularly and check to make sure that the backup actually occurred. The last part may sound like common sense, but network administrators may be extremely busy and just assume that the backups occurred as planned.

- Check the backup software to make sure there is actually data being backed up. Sometimes settings are changed unintentionally, and even though you have checked that the backups are being performed important data might not be getting backed-up.

- Do an occasional test restore of data. If you are backing up to tape, try to do a restore on another machine.

- Keep a copy of your data off-site.
Test, test, test

If you do not test your plan then there is no way of knowing that it will work.

- The worst time to test your plan is during a disaster. You need to periodically review and test.

- Include your facilities in any government sponsored mock-disaster plans. It will help you to better prepare, and you will get to know the first responders.

- Employees should be aware of any procedures that they need to follow in the event of an incident. They should also know who to call.

The purpose of this article was not to conjure up images of giant waves or crippling asteroids engulfing the cities of the United States. For the most part, we believe that these major catastrophic events will not happen. Unfortunately we have the same attitude towards the smaller, yet more likely incidents (a small fire in your data center, some flooding, a momentary power outage causing a file server to go down). Just because the hurricane season is over, it does not mean that you should let your guard down. There is no way to prevent disasters from occurring. However, we can avoid the unnecessary loss of data, assets, and life by making the resources available to plan and test for disasters.

About the author

*Jack Tenerelli is the network administrator for Besler Consulting in Princeton, NJ. Jack can be reach at jtenerelli@beslerconsulting.com for any questions you have about his article.

Save the Date!

Annual NJ HFMA Golf Outing

May 11, 2006

Fiddler’s Elbow Country Club
Far Hills, NJ
J.H. Cohn focuses on the significant issues facing the healthcare industry today—

- High costs of uninsured healthcare
- HIPAA and OIG compliance issues
- Rising costs of delivering excellent patient care

Offering an integrated approach while leveraging our depth of expertise, industry knowledge and skill, we provide you with cutting-edge solutions to increasingly complex issues.

J.H. Cohn blends the best advantages of both national and local accounting and consulting firms to provide a range of services, including:

- Accounting, Attestation and Tax Services
- Financial, Operational and Management Restructuring Services
- Managed Care Contract Reviews
- Sarbanes-Oxley Act Reviews

For more information contact Sam Garruto, Partner-in-Charge, Healthcare Services Group, at 973-403-7994 or sgarruto@jhcohn.com.
It was Monday morning and I just opened an email that read something like this: attached spreadsheet details revenue, volume, carrier and services provided. Please analyze and provide an Executive Summary for Tuesday’s Leadership review. I sipped my coffee and waited for the sheet to open. It was 27 columns wide and over 2000 rows deep! This was going to take hours to prepare and Leadership prefers summaries in a format that can be understood in 2 minutes, or less.

Therein lies the issue: I needed a software application that presents a summarized view of information from thousands of data cells, and within minutes allows the reader to identify the most profitable services. I have that application.

In this article we’ll look at the power of technology, key parameters we use to process data, information overload and software presentation and analysis tools.

Time Changes Everything

Before Microsoft, Intel and Apple, information was basically presented in 3 ways: 1) typed on a manual typewriter with hand drawn graphs, 2) on Blackboards, and 3) overhead projectors. Remember ‘white out’, drafting curves and colored chalk? We collected less data, so it was easy to assimilate that data into useful information. And there was time for discussion.

Now thirty years later we use laptop computers, Microsoft & Adobe software, White Boards, color printers and cell phones. We collect so much data we need ‘data mining’ programs, searching for patterns the human eye could miss. Documents, spreadsheets and photographs are emailed over the Internet. Although time is not compressed, the amount of time allotted for information processing has been significantly reduced. At times, we experience information overload.

Keys to Understanding

We process data by using perceptual aids, or keys. These keys are size, shape, position, color, texture, temperature, smell and sound. They are a part of everyday life and many are embedded in text, tables, graphs and pictures. They are printed on paper and generated on our computer screens.

Information overload occurs when the amount of data a person can process and act upon, in their environment during a defined period of time, is exceeded. To avoid information overload fighter pilots engage in cockpit management, sometimes turning off instruments that provide no valuable information in their decision making processes during maneuvers. To experience the overload effect, play one of the new X-box or Play Station games with your kids.

Analytical Tools

There are basically two different types of software tools currently in use; those that focus on graphically presented calculations and those focused on visualization. Scorecards and Dashboards are typical examples of graphically presented calculations.

Look at the Receivables Asset Behavior Dashboard in the HFMA Toolbox (www.hfma.org/resource/focus_areas/patient_financial_svcs/400435.pdf). Robertson and Raddemann present a 9 segment Dashboard using perceptual keys we discussed; position, color, size and shape. Each segment contains colored text and graphics. It’s a clean format for presenting performance metrics with 3 or 4 variables in isolated segments. It’s digestible due to its size and limited number of parameters, in segments. The format can be generated in Microsoft Office and distributed in several formats; 1) printed directly from Office software, 2) converted to an Adobe Acrobat format and printed, 3) as a Power Point presentation, 4) as Internet pages and 5) a combination of the above. The combination effect results from the reader viewing the document online and downloading the file for further use.

There are a number of other companies that offer software for producing scorecards and dashboards. The products range from Excel plug-in applications to server-based, enterprise-wide applications. Below are a few examples that resulted from a Google search (company - product): the list is not exhaustive or an endorsement:

- Business Objects Company - Crystal Xcelsius (www.xcelsius.com)
- Corda - CenterView Dashboard (www.corda.com)
- Dundas - Chart, Gauge and Diagram products (www.dundas.com)
- Information Builders – WebFOCUS (www.informationbuilders.com)
- IQUB Company - OLAP Browser Pro (www.iqub.com)
- Inxight - SmartDiscovery Server & VizServer (www.inxight.com)
- Visual Mining - NetCharts (www.visualmining.com)

Although you could pack more Excel type charts and graphs in a Scorecard or Dashboard configuration, or add

continued on page 29
Our services solve the profitability puzzle.

Our consulting team has the RIGHT health care experience to meet, and exceed, our clients’ expectations.

For over 30 years McBee Associates has delivered RESULTS. This accounts for our success in maintaining long-term relationships with clients.

Call today to put our expertise to work for you!

call Jeffrey Silvershein, Principal
(212) 594-6669
www.McBeeAssociates.com
Focus 29

more Dashboard pages, the reader would soon be overloaded; it’s too much information for that format.

To address the problem of visualizing information with large amounts of data, researchers in the field of Visual Information Sciences, have experimented with some interesting formats: 1) Geometric shapes; squares, cones & pyramids, and 2) Botanical Mapping; bare tree configurations and tree’s with flowering geometric shapes. Although the presentations are interesting, their utility is beyond the scope of this article. To learn more about different viewing formats, read the tutorial notes by Dr. Keith Andrews (http://www.iicm.edu/ivis/).

The Visualization Solution

Dr. Ben Shneiderman first designed Treemaps in the 1990’s in the Human-Computer Interaction Lab (HCIL) at the University of Maryland. Treemaps represent a new way of thinking about, and presenting information from large amounts of data. This form of presentation utilizes size, shape, position and color to define data in user defined groups. (Their web site defines TreeMaps as space-constrained visualization of hierarchical structures.) You will not find the usual bar graphs and pie charts in this format. The software is downloadable for Commercial and Non-Commercial use. The Non-Commercial use applies to academic and evaluation by a single individual in a company or institution (www.cs.umd.edu/hcil/treemap/). The application is packed with several useful examples: census, elections, NBA, projects, etc.

Remember the project in the opening paragraph, analyze a large spreadsheet for the most profitable services rendered? I started the project with the above Treemap software. Let’s look at a relevant simplified example; two insurance carriers and seven services (DRG) codes. In the figure, carrier 1 is on the left side, carrier 2 is on the right side. Reimbursed service codes are indicated by numbers 1 through 7, for each carrier. The size of the square represents the volume of services rendered.

From the Figure 1 below:
1) The total block size of Carrier 1 on the left side, is larger than the total block size of Carrier 2. Therefore, there is a larger services volume associated with Carrier 1.
2) For Carrier 1, the largest volume is code 3, the smallest volume is code 7.
3) For Carrier 2, codes 2 & 6 have similar volumes, the smallest volume is with code 7.

At this point, I have insurance carrier and volume information, but I am unable to identify the most profitable service(s). Two powerful features of the software are difficult to demonstrate on a black & white printed page; dynamic coloring and text generated from rolling your mouse over the square.

For the example, I’ve coded 4 colors: black, dark grey, light grey and white to identify profit and loss. Black represents an unprofitable service, while white represents a profitable service. Now examine Figure 2 below. The most profitable service is immediately identifiable (Carrier 2 with code 5 is all white).

There are a two interesting observations from the map:
1) A large service volume does not guarantee profitability: Carrier 1, code 1.
2) A service may be poorly reimbursed by any carrier: Code 6.

The numbers utilized for the example are for illustrative purposes only and do not include expenses. The initial example developed for this article, but scaled down for publication clarity, examined 2 insurance carriers and 14 services; seven from radiology and seven from the laboratory. The data included gross & net revenue, volume and technology expenses for a hospital with 1 off-site location. Since the software offers both naming and filter controls, it was easy to answer the question ‘what is the most profitable service’?

To understand the full power of TreeMaps, visit Map of the Market, from SmartMoney (www.smartmoney.com/marketmap). It’s a dynamic map of sectors and stocks. Two windows will load and open: the legend and the map. In the legend window, click on gainers and 26 weeks. The map is divided into continued from page 27

continued on page 30
business market sectors: Healthcare, Financial, Technology, Utilities, Transport, etc. Color indicates financial performance; green, black and red. The size of the dynamic square or rectangle indicates the company size relative to the sector. Roll your mouse over a square and a pop-up appears providing more information. The SmartMoney applications are available for licensing, but the applications are primarily for stocks, bonds and mutual funds.

In the Middle

Between the HCIL Treemaps and the powerhouse SmartMoney Map of the Market application, are three other visual data analysis products, Panopticon from Panopticon Software (www.panopticon.com), OpenViz from Advanced Visual Systems (www.avs.com) and Honeycomb from the Hive Group (www.hivegroup.com).

All three technologies allow you to filter, zoom-in, control and manipulate your data; carrier, code, revenue, volume, etc from the figures in the example previously discussed. Each product has an ‘engine’ for communicating with spreadsheets and databases. The power, flexibility and scalability of these products allows them to run on Windows, Solaris and Linx platforms with Java, COM or .NET versions. All are impressive in their ability to visually present the results of the question ‘show me the profit centers’. More information is available on their web sites, but delegate the research to your IT department.

Panopticon, offers an Enterprise and a Professional version of their Treemap software, as well as the recent February 2006 release of a free downloadable Learning version. This scaled down free version is packed with three example datasets; stocks, sales and costs. Web site literature discusses a ‘drag & drop’ ability to create maps in minutes with the Professional versions.

OpenViz allows any type of data to be shown as interactive 2D and 3D presentations on the web or integrated into your existing technologies. Almost any type of chart or map can be rendered, including Treemaps. You purchase a basic core application and increase functionality by adding modules. It’s a large scale software application that requires development before deployment. Development time for a large healthcare system application may be 2 months.

Although Honeycomb, a commercial extension of Treemaps, appears to be a smaller application than the above product, the company prefers to spend a few weeks working with you on design, integration, and controls. The company’s white paper describes a healthcare map. In their example, each of the 300 cells depicted represent a physician in a sample hospital. Each cell size represents the physician’s admission rate, while the color shows the percentage of the physician’s patients using Medicaid. You can easily change the data and observe the results from ‘what-if’ scenarios.

A painfully common ‘what-if’ scenario is, what will be the financial impact to the organization ‘when’ Medicare, Medicaid and your primary carrier, change the reimbursement rates again? A visual analysis tool will graphically provide the answer in seconds.

Throughout the article, I have avoided discussing the cost of these programs and focused only on their value in visually identifying profitable services. Several factors govern the price of software: 1) number of copies, or licenses, 2) hardware, 3) customization, 4) support staff and 5) maintenance & upgrade costs. It’s important to recognize that obtaining data and presenting key performance indicators (KPI), has its own cost. So, while the cost of a single desktop copy of Crystal Xcelsius is inexpensive at less than $900, the cost of a fully developed Enterprise wide Map application may exceed $40,000.

Summary

I started with a visualization problem - to quickly identify profitable services from a large data source. We reviewed several important parameters in current analysis tools; size, shape, position, color and texture. Implied, but not stated, is the power of current technology to deliver documents, pictures and music, anytime and anywhere on our cell phones, PDA’s and music system’s. (iPod’s are great for music and Radiology Images).

We discussed the usefulness of Dashboards and Scorecards with colored text, charts and graphs. As an executive summary, they represent an effective format for presenting performance metrics. Nine major segments per page may be the optimum upper density threshold.

Visual data analysis tools offer another format for evaluating information. They aggregate your data and use filters to control size, shape, position and color to characterize that data. They are more expensive than spreadsheet tools, but their flexibility and power can help you quickly identify uncollected revenue, profitable services, and reducible expenses or solve complex reimbursement “what-if” scenarios.

About the author

Al Rottkamp is a member of the HFMA NJ chapter and the Institute of Internal Auditors. He holds an MBA and MS in Biomedical Engineering. As an employee of Professional Services, he is the Director of Clinical Engineering, Robert Wood Johnson University Hospital at Hamilton. Al can be reached at ajcr123@aol.com.
Diagnostic services. Operational solutions. When health care matters have the potential to hurt your bottom line, count on WithumSmith+Brown to handle them with unwavering dedication, and unparalleled expertise.

In today’s ever-changing health care industry, our clients are faced with numerous challenges and complex concerns. To navigate these complexities, our Health Care Services Group provides a variety of services—from internal audit and reimbursement consulting to tax compliance solutions to IRS and state audits. Beyond that, these specialists volunteer their time to work with key industry organizations and essential committees—all to take better care of your business.

Make a healthy decision and see your success begin at www.withum.com

Dan Vitale, CPA  732.341.8728  
Scott Mariani, JD  973.994.1616  
Leo D’Orazio, MBA, CHE  732.828.1614

Benchmarking & Valuations  
Corporate Compliance & Internal Audit Services  
Reimbursement Consulting  
Due Diligence, Financial Feasibility Studies & Operational Review Services  
IRS Audit Representation  
Tax Compliance & Consulting Services
HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION
NEW JERSEY CHAPTER

STATEMENTS OF FINANCIAL POSITION
AS OF MAY 31

<table>
<thead>
<tr>
<th>ASSETS</th>
<th>2005</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>CURRENT ASSETS:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>$ 190,235</td>
<td>$ 177,397</td>
</tr>
<tr>
<td>Receivables for program and other activities</td>
<td>21,203</td>
<td>5,779</td>
</tr>
<tr>
<td>Prepaid expenses</td>
<td>20,871</td>
<td>9,992</td>
</tr>
<tr>
<td>TOTAL CURRENT ASSETS</td>
<td>232,409</td>
<td>193,168</td>
</tr>
<tr>
<td>EQUIPMENT, NET</td>
<td>2,404</td>
<td>3,884</td>
</tr>
<tr>
<td>TOTAL ASSETS</td>
<td>$ 234,813</td>
<td>$ 197,052</td>
</tr>
</tbody>
</table>

LIABILITIES AND UNRESTRICTED NET ASSETS

| LIABILITIES: |
| Accounts payable and accrued liabilities | $ 87,983 | $ 23,013 |
| Accrued payroll and payroll taxes | 2,605 | 8,362 |
| Deferred revenue | -- | 18,575 |
| TOTAL LIABILITIES | 90,588 | 50,250 |
| UNRESTRICTED NET ASSETS | 144,226 | 146,802 |
| TOTAL LIABILITIES AND UNRESTRICTED NET ASSETS | $ 234,813 | $ 197,052 |

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Healthcare Financial Management Association, New Jersey Chapter as of May 31, 2005 and 2004, and the results of its activities and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

July 20, 2005
HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION  
NEW JERSEY CHAPTER  

STATEMENTS OF ACTIVITIES AND CHANGES IN UNRESTRICTED NET ASSETS  

<table>
<thead>
<tr>
<th>YEARS ENDED MAY 31</th>
<th>2005</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>REVENUES AND GAINS:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meetings and continuing education programs</td>
<td>$141,274</td>
<td>$150,903</td>
</tr>
<tr>
<td>Annual institute</td>
<td>152,675</td>
<td>157,103</td>
</tr>
<tr>
<td>Social outings and events</td>
<td>116,915</td>
<td>105,059</td>
</tr>
<tr>
<td>National rebate</td>
<td>22,526</td>
<td>21,640</td>
</tr>
<tr>
<td>Advertising</td>
<td>52,225</td>
<td>41,788</td>
</tr>
<tr>
<td>Interest income</td>
<td>1,860</td>
<td>446</td>
</tr>
<tr>
<td>Other income</td>
<td>307</td>
<td>182</td>
</tr>
<tr>
<td>TOTAL REVENUES AND GAINS</td>
<td>487,782</td>
<td>477,098</td>
</tr>
</tbody>
</table>

| EXPENSES: |      |      |
| Program services and scholarships | 356,590 | 346,314 |
| Membership services | 52,163 | 69,900 |
| Management and general | 68,696 | 76,838 |
| TOTAL EXPENSES | 480,449 | 493,052 |

| CHANGES IN UNRESTRICTED NET ASSETS | (2,577) | (17,954) |

| NET ASSETS, BEGINNING OF YEAR | 146,802 | 164,756 |
| NET ASSETS, END OF YEAR | $144,225 | $146,802 |

HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION  
NEW JERSEY CHAPTER  

STATEMENTS OF CASH FLOWS  

<table>
<thead>
<tr>
<th>YEARS ENDED MAY 31</th>
<th>2005</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>CASH FLOWS FROM (USED BY) OPERATING ACTIVITIES:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Changes in unrestricted net assets</td>
<td>$2,577</td>
<td>$17,954</td>
</tr>
<tr>
<td>Adjustments to reconcile changes in net assets to net cash from (used by) operating activities:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depreciation</td>
<td>1,480</td>
<td>1,480</td>
</tr>
<tr>
<td>(Increase) decrease in operating assets:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Receivables for program and other activities</td>
<td>(15,424)</td>
<td>2,661</td>
</tr>
<tr>
<td>Prepaid expenses</td>
<td>(10,979)</td>
<td>(9,935)</td>
</tr>
<tr>
<td>Increase (decrease) in operating liabilities:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts payable and accrued liabilities</td>
<td>64,970</td>
<td>11,506</td>
</tr>
<tr>
<td>Accrued payroll and payroll taxes</td>
<td>(2,857)</td>
<td>5,262</td>
</tr>
<tr>
<td>Deferred revenue</td>
<td>(18,975)</td>
<td>(11,826)</td>
</tr>
<tr>
<td>NET INCREASE (DECREASE) IN CASH</td>
<td>12,338</td>
<td>(15,806)</td>
</tr>
</tbody>
</table>

| CASH AND CASH EQUIVALENTS, BEGINNING OF YEAR | 177,397 | 193,203 |
| CASH AND CASH EQUIVALENTS, END OF YEAR | $160,235 | $177,397 |

"SEE ACCOMPANYING NOTES TO FINANCIAL STATEMENTS"
HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION
NEW JERSEY CHAPTER
NOTES TO FINANCIAL STATEMENTS
YEARS ENDED MAY 31, 2005 AND 2004

NOTE 1. ORGANIZATION AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

a. Organization
The Healthcare Financial Management Association, New Jersey Chapter (the "Chapter") is an association of individuals organized to improve financial management of healthcare institutions and related healthcare organizations.

b. Basis of Presentation
The accompanying financial statements are prepared on the accrual basis of accounting which reflects income when earned and expenses when incurred.

c. Cash and Cash Equivalents
Cash and cash equivalents include highly liquid short-term investments with original maturities of one year or less.

d. Equipment
Equipment is stated at cost. Depreciation expense is computed using the straight-line method over the estimated useful lives of the assets. When assets are retired or otherwise disposed of, the cost and related accumulated depreciation are removed from the accounts and any gain or loss is recognized in income for the period. The cost of maintenance and repairs is charged to expense as incurred.

e. Chapter Revenues
The Chapter provides various educational and professional programs primarily for its Members. The revenues generated from these programs are recorded on the accrual basis of accounting in the period in which the programs are provided.

f. Tax Status
The Chapter's financial activities are combined with the National Healthcare Financial Management Association for the purpose of filing Federal Form 990. The National Association is a tax-exempt entity as defined by Section 501(c)(6) of the Internal Revenue Code. Accordingly, no provision for Federal or State income taxes is required.

g. Use of Estimates
The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.
Healthcare Institutions: Avoid a Financial Flatline

Attend a free seminar that will explore the fiscal responsibilities and potential liabilities of key management and board members. The panelists will provide creative solutions to assure financial health.

Intended for management, directors and officers of New Jersey healthcare institutions

Date: Thursday, June 8, 2006 - 8:30 a.m. to 2:00 p.m.

Place: Park Avenue Club, Florham Park, NJ

Panelists: Michael D. Sirota, Shareholder, Cole, Schotz, Meisel, Forman & Leonard, P.A.
Hal L. Baume, Partner, Fox Rothschild, LLP.
Margaret J. Davino, former General Counsel of St. Vincent’s, NY, and St. Joseph's, NJ
Warren J. Martin Jr., Principal, Porzio, Bromberg & Newman, P.C.

For more information, please call 973-889-4279.
11th ANNUAL NJ HFMA WINTER SOCIAL

by Laura Hess, FHFMA

On Saturday March 4th, 2006, 116 NJ HFMA Chapter members and guests joined together at the Bridgewater Marriott for the Chapter’s 11th Winter Social. This annual event offers an opportunity to honor the chapter’s immediate past president, as well as the award recipients of the past chapter year.

This year’s event began at 6PM with a lovely two hour cocktail reception, offering attendees an opportunity to catch up. At 8PM the doors to the ballroom opened to welcome the guests to dinner and the award festivities.

When guests were settled in, Dave Rikkola, George Kelley, Joe Samples, Karen Johnson, Sam Donio & John Manzi proceeded with their “roast” of the evening’s guest of honor, 2004-2005 NJ HFMA Chapter President, Rick Parker. The “roast” had guests chuckling with stories, video, and photos of Rick’s life as told by his closest friends and co-workers.

Rick had his opportunity to thank everyone later in the evening for their “kind” words, as well as for the framed Derek Jeter highlight photos and Billy Joel tickets! Rick also thanked his assistant, Marguerite McCluskey for all of her hard work during his leadership, as well as fellow past president, Tom Shanahan, for his guidance.

After a wonderful meal, John Manzi called upon Rick Parker to recognize the recipients of the national and Yerger awards received by the chapter under his leadership, as well as our Chapter Achievement Awards. The national awards were presented to Rick at the annual national ANI in June.
John Manzi then went on to recognize the chapter’s Founders Award recipients, and to thank all of the evening’s generous sponsors.

We gratefully acknowledge and thank the following:

**LEAD SPONSORS:**
- Besler Consulting
- MD-X Solutions
- CBIZ KA Consulting

**TABLE SPONSORS:**
- Besler Consulting
- Ernst & Young

**SUPPORTING SPONSORS:**
- CCS of New Jersey
- McBee Associates
- OSI
- Schachter Portnoy

Christine Rikkola, Rick Parker, Nancy Donio

Rich Mushock, Joan Hendler, Jane Ann Sheehan - Follmer Bronze Recipients

Joe Samples, Lisa Hartman, Phil Besler, Steve Bilsky, John Hailperin and Rita Romeu - National Award Recipients

Fatima Elias, Mary Taylor, Phil Besler & Mike Alwell - Newly certified members.
Rita Romeu was called upon next to recognize the NJ chapter members attaining their certification or fellowship status in the past year. Rita also took a moment to thank all the folks who have worked so hard to develop the chapter’s certification core exam study review course. These folks included: Jim Monahan, Mary Taylor, Maria Facciponti, Michael McLafferty, Rich Mushock, Kevin Brophy, and Mike Alwell.

After the conclusion of the awards ceremony, the evening continued on and closed with music, dancing and conversation.

On a final note, we would be remiss in not extending great thanks to Frank Kimchick, our annual winter social photographer, Tara O’Neill, who continually assists us in developing our brochures and invitations, our Social Committee for putting together this great event, and our chapter award winners themselves. It’s through our chapter volunteers, and their dedication, that we can look forward to another successful year. Thanks everyone!
FOCUS: CFO backgrounds are diverse, please tell us about yours. How did you get started? What is your education and professional background?

JOHN: How does that saying go, it’s not the destination that is ultimately important but the people you meet and life’s experiences along the way. Except for the very early years, most of my life has been spent here in New Jersey. I graduated from Monmouth University with a Bachelor of Science in Accounting and later completed my MBA from the same school.

My first decision after completing my undergraduate degree was to decide whether I wanted to go into public or private “corporate” accounting. The decision really wasn’t that difficult as I was fascinated with corporate America and wanted my career to progress into financial planning and ultimately a management position. As a result, I decided to take an accounting position with a large publishing firm in New York City. The publishing industry was very interesting and within less than two years I had moved into an accounting management position.

However, as I soon learned, opportunities in financial planning were very limited and the two hour commute door to door was becoming tedious. With that in mind, I took a financial planning position with a small computer manufacturer in Oceanport, New Jersey and later moved on to Digital Equipment Corporation, in Piscataway as a regional financial business manager. It was during those years that I really honed my skills in financial strategic planning that would serve me well throughout my career. As you can see, the first part of my career was not spent in Healthcare. I feel very strongly that a large part of my success in healthcare is attributable to my experience in other industries where the pressures to produce stockholder returns truly drive the decision making process.

I joined CentraState Healthcare System, then Freehold Area Hospital, back in 1989. During my tenure here I have held various financial management positions, which has been a terrific learning experience. In 1998, I was offered and accepted the position of Senior Vice president/CFO and have served in that capacity ever since.

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

JOHN: Honestly, the answer is no. Early on, my career aspirations were to obtain a highly responsible financial management position in for-profit corporate America. I had never even considered a career in healthcare, let alone working for a not-for-profit organization. Needless to say, my decision to enter the healthcare industry has not only been a tremendous experience but also fortuitous for me personally as well.

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

JOHN: As far as skills for "rising" CFO’s, it is very important to develop good people, communication and interpersonal skills. I am a firm believer that you are only as good as the people you work with and, therefore, the skills to identify and foster these work relationships are the keys to any successful individual and/or organization. It is also important to develop a strong relationship with the Medical Staff, especially Medical Staff leadership. I think it also goes without saying that the CFO now, more than ever, must embrace information technology as higher costs, consumerism and pay for performance will put added strain on achieving operational efficiency. Lastly, financial leaders need to be more strategic in nature and play an even larger role in the strategic planning process. Specifically, CFO’s should have the skills necessary to develop a strategic capital formation process that will support the long-term goals of the organization.

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.

JOHN: The System is a not-for-profit community healthcare organization in Freehold providing a wide range of services to residents of Monmouth County and central New Jersey. It includes a 271 bed acute-care medical center, a 123-bed skilled nursing facility, an 82-bed assisted living facility and a 330-unit lifecare retirement community. CentraState has over 2,000 employees

continued on page 40
For more information, contact Jeffrey G. Blumengold, CPA, FHFMA at 732.205.2011.

and offers a wide range of services to a diverse multicultural population. Western Monmouth County is a fast growing area in need of diverse healthcare services for all age categories. CentraState is a member of the Robert Wood Johnson Health Network, a Clinical research affiliate of the Cancer Institute of New Jersey and is affiliated with the UMDNJ-Robert Wood Johnson Medical School.

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

JOHN: Over the past few years, in response to community needs, CentraState has greatly broadened its services to include: expanded Maternity care and Special Care Nursery, Emergency Department, Cardiac Catheterization and Endovascular Lab, Health Awareness Center, Cardiology Services, Diabetes Care Program, Spine Center, Sleep Center, Computed Tomography and Magnetic Resonance Imaging, inpatient Psychiatric services and Oncology, Rehabilitation and Dialysis Unit, Radiation Therapy and Radio Surgery and Bariatric surgery. In addition, an expansion of the Emergency Department was just completed as well as the establishment on a new Family Practice Residence teaching program. CentraState is currently expanding and renovating its Lifecare retirement community and is developing a new 170,000 square foot ambulatory campus which will be attached to the main campus building.

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

JOHN: Throughout its history, CentraState has used a variety of financing mechanisms to fund its program development. For its large projects, CentraState has primarily used tax exempt and taxable financing through the New Jersey Healthcare Facility Finance and New Jersey Economic Development authorities. We have also used various capital and operating lease structures as well as commercial lending alternatives when appropriate.

FOCUS: What are your spare time activities?

JOHN: In regards to spare time, there is often not enough with three kids under the age of three. When I do have spare time I like to golf, take day trips with the family and enjoy some down time going to the theater or the movies. I hope as the children get older we will spend
INTERIM PLACEMENT:
LET SOMEONE ELSE DO THE FOOTWORK.
( LIKE US. )

Patient Financial Services is no walk in the park these days, especially when someone goes on vacation. Or takes a leave of absence. Or, worse, gets sick. And trying to find really qualified, pre-screened candidates on your own, well, let’s just say it’s a rough path to manage. That’s where we come in.

No one knows the interim placement needs of Patient Financial Services and the Revenue Cycle Management Department the way we do. We’re The PFS Resources Group, a BESLER Consulting affiliated company. We support your needs through interim staffing, recruiting and training services. And since we pre-screen and pre-qualify every candidate, we guarantee every placement! So let us do the footwork. All you have to do is call.

Relax, unwind. Call now. Let us walk in your shoes.

THE PFS RESOURCES GROUP
For All Your Interim Staffing Needs.

1.877.PFS.ASSIST  WWW.PFSRESOURCES.COM
Member Spotlight:
Marilyn Koczan

by James Yarsinsky, CPAM

Marilyn Koczan is married and has four sons. She started her career in 1975 as a staff accountant at Jersey Shore Medical Center and was promoted to increasingly responsible positions – Internal Auditor, Assistant Director of Finance, Director of Finance and Senior Director. After their merger to form Meridian Health in 1996 with Riverview Medical Center and Ocean Medical Center, Marilyn became a Corporate Director of Finance and then Vice President of Patient Financial Services.

FOCUS: Marilyn, please talk about your duties within the organization.

Marilyn: My corporate responsibilities include Patient Financial Services, Enterprise Scheduling, and Access Services. I am also a liaison with Corporate Compliance, Medical Records, Managed Care and Information Technology. In short, I am responsible for the Revenue Cycle.

FOCUS: Name a few of the special challenges you face in your position.

Marilyn: In addition to maintaining best practice benchmarks for all aspects of the revenue cycle, I also have close to 300 employees under my report. They must demonstrate excellent customer service and a thorough knowledge of their specific role in the revenue cycle.

FOCUS: Wow! That is a lot of employees. What greatest changes have you witnessed in patient financial services since you started your career?

Marilyn: The greatest change has been the automation of the revenue cycle and the complete integration of Access Services and Patient Financial Services, as well as the revenue impact of Medical Records, Compliance and Managed Care on the profitability and financial strength of the industry.

FOCUS: What advice can you give other patient accounting professionals that they can do to favorably impact patient financial services departments?

Marilyn: You must educate and keep your employees happy. Our profession has undergone so many changes that there is no substitute for a knowledgeable and stable workforce. Our most valuable resource is the people who work for us.

FOCUS: What are your hobbies and outside interests?

Marilyn: When my workday is complete, I am totally dedicated to my family (5 boys including hubby!). Balancing work and my personal life keeps me very happy and constantly busy. I also find time to exercise regularly which I believe is important to your mental as well as physical health.

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

About the Author
Jim Yarsinsky, CPAM is president of The PFS Resources Group, a BESLER Consulting affiliated company. He can be reached at 732/392-8300 or by jyarsinsky@pfsresources.com.
January 20, 2006

Centers for Medicare and Medicaid Services
US Department of Health and Human Services
Re: File Code CMS-0050-P

Dear Sir/Madam:


HFMA-NJ is an HFMA Chapter consisting of 1059 employees at New Jersey hospitals, integrated delivery systems, nursing homes, and other health care organizations. While we have not had the chance to thoroughly review the proposed rule and develop specific comments, an executive review by HFMA-NJ raised the following significant concern:

**FORMAT OPTIONS:** (p 55997 middle column item 6). The proposed rule, combined with the definition of electronic media that is contained in the original HIPAA transactions final rule* gives cause for much concern. The proposed rule suggests that 24 months after the effective date of the Claims Attachment Final Rule, health care providers will in some cases no longer be able to fax paper claims attachments to health plans. This is because many entities’ fax functionality allows incoming faxes to be received directly into computer systems, instead of onto paper.

Claims attachment faxing is commonly used between provider and payer organizations, especially for complex claims that are difficult and time-consuming to settle. We therefore ask that faxes from fax machines to computers be excluded from Section 162.1925 of the final rule. (Section 162.1925 is “Standards and Implementation specifications for the electronic health care claims attachment response transaction”)

Requiring providers to convert to using computer systems rather than fax machines to support settlement of all claims will place an immediate expensive and unfair burden on them. It will also complicate what is currently a very simple and secure process. Providers that lack the financial resources to completely implement computer systems should not be prohibited from faxing paper attachments just because some of their payers have had the resources to implement greater sophistication.

We look forward to your response to this comment.

Sincerely,

John Manzi, President

*Section 162.103 of 45 CFR Parts 160 and 162 Health Insurance Reform: Standards for Electronic Transactions; Announcement of Designated Standard Maintenance Organizations; Final Rule and Notice defines “Electronic media” to mean “the mode of electronic transmission. It includes the Internet (wide-open), Extranet (using Internet technology to link a business with information only accessible to collaborating parties), leased lines, dialup lines, private networks, and those transmissions that are physically moved from one location to another using magnetic tape, disk, or compact disk media.”
Now you have the power to establish and maintain your CDM prices based on actual costs with a simple click of your mouse – without spending hundreds of thousands of dollars on a cost accounting system. But there’s more. With the online Strategic Pricing Module – the latest addition to our acclaimed CDM FOCUS™ suite – you can establish prices with consideration given to payor contract terms and market area prices. Strategic Pricing also lets you calculate and perform net revenue impact analysis of alternative pricing scenarios so that you can assess the financial impact on your bottom line prior to implementation. Even with the assurance of compliance! So turn your computer into a practical, cost efficient, yet powerful tool for implementing a cost, market or payor contract rate-based Strategic Pricing system.

Register now for a free sample report at www.costbasedpricing.com
GET ON BOARD

* HFMA staff and volunteers determined that this product has met specific criteria developed under the HFMA Peer Review Process. HFMA does not endorse or guarantee the use of this product.
Combining leading technology, training and strategy

In today’s ever-changing healthcare environment, it’s more important than ever to effectively and appropriately manage accounts receivable. Let Remex ease the burden—our comprehensive Extended Business Office Services simplify and maximize your return without using valuable internal resources.

Remex specializes in the needs of hospitals, physician groups and other healthcare entities. Our team of associates are extensively trained and sensitive to regulatory requirements while retaining excellent relationships with patients. We provide every client an interactive web portal link, giving on-line access to individual accounts and statistical reports.

Combining the advantages of nation-wide licensing with our local expertise allows us to pursue accounts no matter where patients reside or move.

Let us prove that Remex’s collection process is better than the competition. Send us your outstanding accounts—even if you have previously sent them elsewhere for collection—and let us pursue them. We’ll demonstrate how our proven methodology, sophisticated technology and professional skill outpace your expectations.

Call us toll-free at (800) 562-5158, or e-mail us at: joanh@remexinc.com

www.remexinc.com
New Members

Craig Suchodolski
(732) 292-0840

Michael Chapman
Student
(212) 679-0549
michaelbodymaint@yahoo.com

Nancy Black
Bergen Regional Medical Center
Director of Patient Access
(201) 967-4105
nblack@bergenregional.com

Mark J. Picillo
Siemens Financial Services
VP Credit & Operations Manager
(732) 590-6625
mark.picillo@siemens.com

Peggy Chafart-Lema
Meridian Health System
Sr. Managed Care Analyst
(732) 751-3374
pchafart@meridianhealth.com

Kaaren Corallo
Meridian
Patient Accounts Supervisor
(732) 897-7160
kcorallo@meridianhealth.com

William R. Oster
WithumSmith+Brown
Manager
(973) 868-9494
boster@withum.com

Deborah L. Visconti
Ernst & Young, LLP
Senior Auditor
(732) 516-4481
deborah.gwin@ey.com

Maurice Short
Mckesson
Customer Service Specialist
(201) 407-4167
maurice.short@nyu.edu

Mirta Goldstein
(201) 770-3778

Michele Monani
MD-X Solutions, Inc.
Client Service
(201) 444-9900
mmonani@md-x.com

Cathy Suber
UMDNJ
Revenue Cycle Training Manager
(973) 972-9886
suberca@umdnj.edu

Lynn Chiantese
New Jersey Hospital Association
Jr. Financial Analyst
(609) 275-4029
lchiantese@njha.com

James Hannagan
St. Mary's Hospital
Controller
(973) 470-3454
hannaganj@smh-passaic.org

Boris Smolkin
Aptium Oncology
Financial Analyst
(908) 994-8757
Andre Vanterpool
Corporate Synergies Group
Benefits Consultant
(908) 433-8248
andrev@corpsyn.com

Jaime A. Garcia
Patient Financial Concepts, Inc.
(973) 566-9848
jgarica@pfconcepts.com

Daniel Rodriguez
Patient Financial Concepts, Inc.
(973) 566-9848
Drodriguez@pfconcepts.com

Victor Zamora
New Jersey Hospital Association
Manager, Economic Modeling
(609) 275-4017
vzamora@njha.com

B. Reese Rogatsz
New Jersey Hospital Association
Manager, Economic Modeling
(609) 275-4017
rrogatsz@njha.com

Mark Your Calendar

April 6, 2006
HFMA PA/NJ Joint Meeting - Capital Financial Planning Update
Holiday Inn Philadelphia Stadium Hotel

April 12, 2006
Preventing Medicare Cost Reports
Woobridge Hilton NJHA

May 9, 2006
PC Training Class - Intermediate Excel and Intro to Access
Fiddler’s Elbow CC Woodbridge Hilton

May 11, 2006
Annual Golf Outing

June 13, 2006
Quarterly Meeting - Finance, Accounting, Capital & Tax

October 11-13, 2006
NJHFMA Annual Institute
Borgata, Atlantic City
**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.]

<table>
<thead>
<tr>
<th>Job Position and Organization</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>SENIOR REIMBURSEMENT ANALYST</td>
<td>ACCOUNTANT</td>
</tr>
<tr>
<td>Solaris Health System</td>
<td>Meridian Health</td>
</tr>
<tr>
<td>DIRECTOR OF FINANCE</td>
<td>ADMISSIONS MANAGER</td>
</tr>
<tr>
<td>Bayonne Medical Center</td>
<td>Raritan Bay Medical Center</td>
</tr>
<tr>
<td>SENIOR INTERNAL AUDITOR</td>
<td>CORPORATE COMPLIANCE SPECIALTIST</td>
</tr>
<tr>
<td>Bayonne Medical Center</td>
<td>South Jersey Healthcare</td>
</tr>
<tr>
<td>ACCOUNTANT</td>
<td>DIRECTOR OF BUDGET &amp; REIMBURSEMENT</td>
</tr>
<tr>
<td>Holy Name Hospital</td>
<td>Bayonne Medical Center</td>
</tr>
<tr>
<td>ACCOUNTANT</td>
<td>STAFF ACCOUNTANT</td>
</tr>
<tr>
<td>Burdette Tomlin Memorial</td>
<td>South Jersey Healthcare</td>
</tr>
<tr>
<td>Hospital</td>
<td></td>
</tr>
<tr>
<td>DIRECTOR OF FINANCE</td>
<td>SENIOR ACCOUNTANT</td>
</tr>
<tr>
<td>Bayshore Community Health</td>
<td>Liberty Health</td>
</tr>
<tr>
<td>Services</td>
<td></td>
</tr>
<tr>
<td>SENIOR FINANCIAL ANALYST</td>
<td>MANAGER, CLINICAL CODING SERVICES</td>
</tr>
<tr>
<td>AtlantiCare Regional Medical</td>
<td>CBIZ KA Consulting Services</td>
</tr>
<tr>
<td>Center</td>
<td></td>
</tr>
</tbody>
</table>

---

March/April 2006
Since 1986, BESLER Consulting has been assisting healthcare providers in enhancing revenue, gaining operational efficiencies and achieving compliance. BESLER Consulting clients benefit from a team of highly experienced, dedicated professionals. They bring to each engagement in-depth knowledge in a wide range of financial, operational and compliance issues. Telephone 1.877.4BESLER • Web site Besslerconsulting.com

NJHA Corporate Services delivers the most cost-effective, efficient and valuable programs available to meet the challenges facing healthcare organizations today. With programs designed to deliver greater financial value and other significant advantages, our number one priority is creating the greatest value for healthcare organizations. Contact us at 888-221-2182 or www.njhacorporateservices.com.

Medical Billing Resources Inc. (MBR) has been providing receivable management programs to the healthcare industry for more than twenty years. Hospitals, Physician group practices, faculty practice organizations, and ambulance companies comprise our marketplace. Our highly flexible programs provide front-end system capabilities, back-office claims processing and management resources, processes designed to maximize cash from aged receivables, and support during system conversions. For information please visit our web-site at www.medicalbillingres.com, or contact Larry Frits at 973-429-8882 x7116.

Established in 1973, McBee Associates, Inc. one of the nation’s largest, independent health care consulting practices provides managerial and financial consulting services to health care organizations. The firm’s consultants maintain an extensive array of financial and managerial expertise, enabling them to resolve any financial challenge that faces a home health care provider today. Visit: www.mcbbeassociates.com

For over twenty-five years, CBIZ KA Consulting Services has provided customized financial solutions to healthcare providers. Our staff blends industry knowledge and practical experience to provide services in the fields of reimbursement optimization, Medicare and Medicaid recovery, managed care, decision support, benchmarking and clinical resource management. For information, visit www.kaconsults.com.

The Healthcare Employees Federal Credit Union (HEFCU) is a not-for-profit, federally insured, member owned financial cooperative offering a full range of deposit and loan products. It is a FREE employee benefit with no cost to you, the employer. HEFCU offers exclusive no-surcharges access to 2,000 ATM’s in NJ; 35 shared branches in NJ; internet lending with instant decision; and more! Find out why HEFCU has attracted 25,000 members from 250 employers throughout New Jersey over the last 20 years. Contact HEFCU at 1-800-624-3312 x5125 for more details or go to http://www.hefcu.com/. Visit their main office at 29 Emmons Drive, Suite C 40, Princeton NJ 08540.

Innovative Health Solutions is a leading provider of nationally recognized coding, compliance, reimbursement and decision support solutions serving more than 30% of the nation’s general acute care hospitals. Our bolt-on technology tools help our customers increase revenue, reduce expenses, enhance decision support, improve cash flow and ensure coding compliance. For more information, call 866.822.6700 or visit innovativehealthsolutions.com.

J.H. Cohn is among the top 15 largest accounting and consulting firm in the United States. Since 1919, the Firm has cultivated a reputation for honesty, integrity, technical excellence, and genuine concern for clients. To learn about J.H. Cohn and its life cycle approach to helping middle market business owners create, enhance, and preserve wealth, please call Jim Garruto, 973-403-7994 or visit www.jhcohn.com.

Visit us on the Web: www.hfmanj.org
If you worked on Wall Street, you’d have a detailed business continuity plan that would enable your organization to survive service interruptions. But healthcare information security is not just about data protection, it’s about the continuity of care in any situation – from a server outage to a natural disaster.

At CTG HealthCare Solutions, every service we deliver is fundamentally rooted in clinical process and focused on the mission of healthcare. Off-the-shelf, one-size-fits-most security solutions won’t do.

We bring you healthcare-specific solutions:

- CPOE and decision support
- Patient data access solutions with strong privacy protections
- Continuity of care during service interruptions without subjecting patients to unacceptable risk
- Compliance with regional health initiatives and federal, state and industry regulations
- The latest technological developments and security best practices

We use our in-depth knowledge of security, controls and contingency planning to build a comprehensive solution tailored to your unique healthcare needs.

For more information, contact NJHA's Guy Evans at 609-936-2204, gevans@njha.com.

**Healthcare Information Security. It’s not about protecting business. It’s about protecting people.**
These days, there’s one sure way to fortify your company. Put quality front and center.

That’s why so many companies turn to Ernst & Young. Our professionals aspire to operate with the highest integrity and professional excellence, striving always to do the right thing. They bring you years of experience in providing a range of sophisticated services based on financial, transaction, and risk management knowledge in our core services of audit, tax and corporate finance. So in this ever-changing economy the goal is always the same. To help you build on — and fortify — the company you worked so hard to create. ey.com

For more information contact:

Tom Griffith Assurance Services Partner (732) 516-4291 tom.griffith@ey.com
Roger Bjorkquist Assurance Services Partner (215) 448-5002 roger.bjorkquist@ey.com
Gary Horowitz Tax Services Principal (732) 516-4328 gary.horowitz@ey.com