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MASS MEDIA

MA - RI Chapter
Healthcare Financial Management Association

Managed Care

The following Medal of Honor Award recipients were honored at the Annual Social and Awards Night on May 28th: Peter Leone, McDermott, Will & Emery; James Sullivan, Deloitte & Touche LLP; Daniel Phillips, Phillips DiPisa; Lawrence Martin; Carolyn Jacoby Gabbay, Nixon Peabody LLP; Edward Kennedy, Jr., Medical Bureau/ ROI; Gail Schlesinger, Caritas Christi Health Care System; and Lawrence McManus, St. Joseph's Hospital & Medical Center.

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MASS MEDIA

HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION

Managed Care

Newsletter Committe

Roberta Zysman, *Executive Director*
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Reigning in the Healthcare Cost Trend:

Is Massachusetts up for the Challenge? …Are you?

June 20, 2008

Well over 200 people attended an educational session, "Reigning in the Healthcare Cost Trend: Is Massachusetts up for the Challenge? ...Are you?", developed by the Chapter's Managed Care Committee. Program Coordinators for this year's event were John Minichiello of Health Alliance With Physicians, Inc. and Richard Wichmann of PricewaterhouseCoopers, LLP, assisted by the other member volunteers of the Managed Care Committee.

The healthcare cost trend is of critical concern in Massachusetts. The educational program promoted discussion on initiatives and strategies directed at the balance of cost containment with service access and quality improvement. The subjects were timely and the speakers offered unique and varying viewpoints on these complex issues.

A thorough federal and local legislative market update, given by Alexandra Calcagno and Bob Gibbons, kicked off the morning. Subsequent morning presentation topics included "The Commonwealth Responds to the Pressures to Contain Healthcare Costs" with speakers Melissa Boudreault, Katharine London, and Dr. Marylou Buyse, and "BCBSMA's Alternative Quality Contract" with Blue Cross Blue Shield of Massachusetts Senior Vice President for Health Care Management, Patrick Gilligan. The middle of the day featured a luncheon and presentation from Guy D'Andrea who spoke about the return on investment of pay for performance provider contracts. Wrapping up the day was a lively panel discussion moderated by Nancy Turnbull entitled "Is Massachusetts Doing Enough To Contain Healthcare Costs?". Panelists included Alan Hinkle, MD, Rich Parker, MD, John Chessare, MD, Delia Vetter, and Mark Hulse. A drawing for Red Sox tickets courtesy of PricewaterhouseCoopers, LLP ended the informative and enjoyable day.

The wonderful registration volunteers!

Rosemary Rotty receives her CHFP certificate from Chapter President Marvin Berkowitz.

Managed Care Co-Chairs John Minichiello (left) and Richard Wichmann (right) with speakers Melissa Boudreault and Katherine London.

Afternoon panelists: Rich Parker, MD, Nancy Turnball (moderator), Allen Hinkle, MD, Delia Vetter, John Chessare, MD, and Mark Hulse.

President's Message

As I begin my year as President of the Massachusetts-Rhode Island HFMA chapter I want to express my gratitude to my predecessor Kathleen Maher for the Chapter's achievements and successes during the 2007-2008 year. The quality of the chapter's educational programs was evidenced by the high attendance and the positive feedback submitted in our program surveys. Recognition of the chapter's successes also came from HFMA National through 2 awards made at this year's Annual National Institute (ANI): membership growth and retention and for excellence in certification.

I also want to acknowledge the great contributions made to the chapter by Jim Heffernan, Immediate Past President of the chapter as he leaves the Board of Directors where he has served with great distinction since 1997. Jim provided visionary leadership in guiding the chapter through the consolidation with the Rhode Island chapter and the corporate reorganization of the chapter. The overall quality of the chapter improved greatly under Jim's leadership.

The chapter also benefited from the involvement of the following directors who departed the board at the end of the 2007-2008 year: Joe Capezza, Rich Silveria, Rick Markello, Phil Geissinger and Bob DeVey. I thank them for their contributions and wish them well in their future endeavors.

I also want to welcome the new directors who have joined the board for the 2008-2009 year: Dennis Chalke, David Dillon, Tim Hogan and Rosemary Rotty. I look forward to working with them on several new program initiatives during the year ahead.

The HFMA National theme for this year is "Making Connections". Certainly the chapter's educational and social networking activities offer numerous opportunities for our members to make new as well as strengthen existing connections within HFMA. Taking advantage of HFMA activities will also promote connections beyond HFMA to other individuals and health care organizations that will benefit members in their career.

Upcoming social activities include the annual golf tournament on August 7 in Juniper Hill Golf Club in Northborough Massachusetts. Previous tournaments have attracted more than 200 attendees and have been very enjoyable events.

The chapter's corporate sponsors provide great support to HFMA activities and are an integral part of the chapter's success over the years. I want to thank our sponsors for their continued support. Our sponsors will be individually acknowledged during the August golf tournament. New sponsors for the 2008-2009 year will also be acknowledged in the next issue of Mass Media due out in October.

On September 19 our educational programs resume with the "New To Healthcare" program at Simmons College. This program provides an excellent orientation to health care finance for individuals within your organization who are new to the world of health care.

I want to encourage all members to attend this year's educational programs and to promote these programs through participation on one of the educational committees. I personally discovered that the benefits of HFMA membership increased significantly when I joined a committee. Committees play a major role through organization of educational programs as well as through the submission of articles to the Mass Media journal. Chapter committees cover a wide range of issues and I encourage you to consider joining one of the committees. I also encourage committees to submit two or more articles on the topics they address this year to Mass Media. The combination of programs and Mass Media articles ensure that educational material is widely disseminated to our members.

Thank you to all of the chapter's members for their ongoing support. Again I look forward to meeting and working with you during the year ahead. Please reference the chapter's website at www.masshfma.org for additional information. Please also feel free to direct any questions and concerns to my attention at president@masshfma.org.

Regards,

Marvin M. Berkowitz

Marvin Berkowitz
President, HFMA Massachusetts-Rhode Island Chapter

The Devil is in the Details – *the 2008 Form 990 Instructions*

By: Jeanne M. Schuster, Executive Director
Ernst & Young LLP

They say the "Devil is in the Details"[1] and with the instructions to the "new" Form 990,[2] they really mean it. First, there is a substantial amount of "details" – over 300 pages to the instructions. It might be the perfect solution for insomnia.

A few of the surprises: the definition of "key" employees,[3] another complex definition for determining who is an "independent" board member,[4] and, some flexibility in disclosing your organization's FIN 48 footnote.[5]

Definition of "Key" Employee

In the "old" Form 990, the filing organization was required to provide compensation information for the organization's trustees, officers and "key" employees. "Key" employees were individuals with responsibilities similar to an officer, but, without the title of "officer." For example, an organization may not have a Chief Financial Officer. If the job duties of the Senior Vice President of Finance were similar to those of a Chief Financial Officer, the Senior Vice President of Finance would be considered a "key" employee and the compensation of the Senior Vice President of Finance would need to be disclosed. The "old" Form 990 went beyond the "C" suite of officers (CEO, COO, and, CFO). It considered individuals with control over the organization's activities or finances to be "key" employees. So, many healthcare organizations needed to evaluate whether other individuals, such as the head of the medical staff, the top facilities

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Current and Future Issues Affecting Graduate

Speaker and program coordinator, Chris Francazio.

Michael Rosenblatt, MD, spoke on the future of undergraduate medical education, and the resulting considerations for academic medical centers.

Research & Education Committee Co-Chair, Joel Gardiner of Deloitte & Touche LLP, with speaker Terence Flotte, MD, and Lisa Beittel, Associate to Dr. Flotte.

and Undergraduate Medical Education

May 16, 2008

Members and non-members gathered on May 16th at the Doubletree in Westborough, Massachusetts for Current and Future Issues Affecting Graduate and Undergraduate Medical Education, a program presented by the Research & Education Committee. This half day program helped attendees gain a perspective on what is happening with undergraduate medical education and potential impacts on Graduate Medical Education in the future. The program offered many insights on the latest regulatory trends and their associated impacts, the impact of regulatory issues on operations and finances, and leading practice financial measurement approaches to GME financial measurement and performance metrics. In addition, attendees received the "inside scoop" from the American Association of Medical Colleges.

The Research & Education Committee would like to thank the days' esteemed speakers: Karen Fisher, JD, American Association of Medical Colleges; Michael Rosenblatt, MD, Tufts University School of Medicine; Terence Flotte, MD, University of Massachusetts School of Medicine; Kip Perlstein; Deloitte Consulting; Chris Francazio, Hinckley, Allen & Snyder; and J. Mark Waxman, Foley & Lardner. Their presentations and insight made for a wonderful program.

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person, the person in charge of Information Technology, and, the leader of nursing, were "key" employees. The old definition worked just fine for most healthcare entities.

The draft Instructions to the new 2008 Form 990 released on April 7, 2008 define "key" employees as persons with overall responsibilities for the organization as a whole, **as well as certain persons who manage or have authority to control 5% or more of the organization's activities, assets, income, expenses, capital expenditures, operating budget, or compensation for employees** if the individual's compensation exceeds $150,000 (Emphasis added).[6] As an example of the devil in the details, there is a potential inconsistency in the definition of "key" employee. While the Highlights to the Instructions state that "key" employees are those who control "more than 5%," Part VII of the Instructions states that "key" employees are those who control "5% or more."[7]

Now, 990 filers will need to review numerous additional job descriptions in light of the new, more expansive definition. While the $150,000 threshold for compensation should assist in narrowing the positions to be reported and evaluated, we all know that threshold amounts in the Form 990 are not necessarily inflation adjusted, or adjusted often enough to keep pace with economic changes. So, while $150,000 sounds like a fairly large amount today – who knows whether $150,000 will be the equivalent of $50,000 in another decade.

Complex Definition of an "Independent" Board Member

In two separate places, the new form requires the filing organization to state the number of "independent" voting members of the governing body. A trustee is 'independent" according to the Instructions released on April 7, 2008 only if four factors are met **throughout** the tax year:

1. The individual is not compensated as an officer or other employee (with an exception for those who are part of a religious organization and have taken a vow of poverty).
2. The individual did not receive total compensation exceeding $10,000 from the filing entity or from related organizations as an independent contractor. However, total compensation does not include expense reimbursements.
3. The individual did not receive "material financial benefits" from the organization or a related organization. A transaction in excess of $50,000 is **automatically** a material financial benefit.
4. The individual does not have a **family member** that received compensation or other material financial benefits from the organization or a related organization.

In addition, an individual will **not** lack independence solely because the individual is a major contributor (i.e. donor) to the filing organization. And, any benefits received in the ordinary course of the organization performing its exempt purpose are excluded.

One difficulty of the above test is the definition

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of "material financial benefit." Those of us from Massachusetts may recall that Massachusetts used the "material financial benefit" terminology in its proposed "Act to Promote the Financial Integrity of Public Charities." Feedback on that Act expressed reservations about what did and did not constitute a material financial benefit. Jamie Katz, formerly of the Massachusetts Public Charities Division of the Attorney General's office, the principal proponent of the legislation, consistently stated that some of the terms will be flushed out in Guidelines and this was one of the terms the Guidelines were expected to cover.[8] And, he frequently said, "if a charity is lucky enough to have the President of Staples sitting on its board, it will not be considered a material financial benefit that the organization buys its office supplies from Staples." We always thought this example, while helpful, still left a lot of "grey" area. Similarly, new Form 990 Instructions provide very little detail about these independence-destructing "material financial benefits."

Disclosure of the filing organization's FIN 48 footnote

FIN 48 requires organizations to disclose "uncertain" income tax liabilities. Explanatory guidance clarifies that it applies to tax exempt organizations as well as taxable organizations. Many exempt healthcare organizations are spending significant time and effort to document whether there is a material impact on their financial statements from this accounting pronouncement.

The new Form 990 requires exempt organizations that are audited to disclose their FIN 48 footnote in the Form 990 Schedule D. When the form was first released, there was significant commentary on situations where an exempt organization may be part of consolidated financial statements and dis-

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closure of the FIN 48 information might be detailing uncertainty in tax issues of a taxable affiliate rather than the exempt organization filing the Form 990. Thus, a possible misinterpretation could occur that the reader might believe the disclosure was applicable to uncertainty in the taxes of the exempt organization. The Instructions provide helpful guidance on a remedy for this potential confusion. The Instructions state that the exempt organization may use some summarization to provide the part of the FIN 48 footnote that applies to the filing organization. The Instructions state:

Any portion of the FIN 48 footnote that addresses only the filing organization's liability must be provided verbatim. The filing organization may summarize that portion, if any, of the footnote that applies to the liability of multiple organizations including the organization (for example, as a member of a group with consolidated financial statements), to describe the filing organization's share of the liability.

Summary

No one will disagree that the Instructions to the new Form 990 are lengthy. They also contain some good news and some traps for the unwary on specific areas of the form. Filers need to understand the intricacies of these Instructions because – the devil is in the details. ❑

(Endnotes)

1 This common phrase is viewed as either a variant of a phrase attributed to Gustave Flaubert (1821-1880) "God is in the details" or attributed to merely Anonymous.

2 Return of Organization Exempt From Income Tax is commonly referred to by its form number, Form 990. The form and its instructions are available at the IRS website: www.irs.gov.

3 2008 Form 990 Core (Parts VII) Instructions - Draft April 7, 2008, page 2 of 14.

4 2008 Form 990 Core (Parts VI) Instructions - Draft April 7, 2008, pages 1 and 2 of 9.

5 2008 Schedule D (Form 990) Instructions - Draft April 7, 2008, page 10 of 11.

6 2008 Form 990 Core (Highlights and General) Instructions – Draft April 7, 2008, pages 2 – 3 of 16 and 2008 Form 990 Core (Parts VII) Instructions - Draft April 7, 2008, page 2 of 14.

7 Compare 2008 Form 990 Core (Highlights and General) Instructions – Draft April 7, 2008, pages 2 – 3 of 16 with 2008 Form 990 Core (Parts VII) Instructions - Draft April 7, 2008, page 2 of 14.

8 Subsequent versions of the Act eliminated the term "material financial benefit" and instead used the federal concept of "excess benefit transaction" from Section 4958 of the Internal Revenue Code.

About the Authors

Jeanne M. Schuster is an executive director at Ernst & Young, LLP, concentrating in tax-exempt organizations. Her experience with tax-exempt organizations includes representation during IRS and state audits, including IRS CEP examinations, mergers and reorganizations of exempt and taxable corporations, applications for exempt status, unrelated business income tax, employment tax, information reporting and sales tax issues. Ms. Schuster received her B.A. degree in accounting from Bentley College, her J.D. degree from the New England School of Law and her LL.M. degree from Boston University School of Law. Ms. Schuster is an active longtime member of HFMA Masschsuetts-Rhode Island Chapter, currently serving on the Board of Directors.

Draconian Cost-Control Measures:

The Inevitable Response to Failed Market Forces?

Leanne Berge, Vice President, Strategic Planning and Business Development
Network Health

Much has already been written about the cost crisis facing the health care market today. We all know that the rate of cost increases for health care purchasers cannot be tolerated — either by the public or private purchasers of health insurance. Much has also already been written about the threat the health care cost crisis poses to Massachusetts' incipient health care reform initiative. The state's financial crunch is both a product of the under-projected popularity of its subsidized program, Commonwealth Care, as well as the continued medical cost trend that has remained largely unabated over the last decade. Though there has been some limited evidence of a trend slowdown, the harsh reality is that under any analysis, the public programs simply will not have sufficient funding to cover all eligible recipients with the comprehensive benefits that are covered today without additional revenue, or alternatively, without draconian shorter-term

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cost controls that reduce the cost trend. For now, neither the public nor the private sector seems prepared to move to the third alternative — reduce coverage and benefits for its citizens.

"Objectionable" cost control measures? Depends on whose "ox is being gored!"

Not surprisingly, the many proposed cost-control measures are rarely endorsed by all stakeholders in the health insurance market — unlike the relatively easy consensus that coalesced over Chapter 58 (Massachusetts' health care reform law) that enabled the launching of the Commonwealth's historic health reform. For a cost-control effort to be most effective, it inevitably means taking skin off someone else's nose. This is true of most of the following top-ten cost-control measures:

1. Shine a light, through public hearings, on the profit margins of the largest (not-for-profit) hospital systems

2. Require similar public hearings to challenge the profit margins of the (not-for-profit) health plans and their perceived excessive reserves

3. Publicize rate differentials among providers for services

4. Push patients to low-cost providers by imposing tiered or closed-panel networks based upon "efficiency" measures

5. Change reimbursement mechanisms to penalize inefficient providers and eliminate payments for quality deficiencies

6. Tighten restrictions on expansion of new facilities and technologies

7. Return to tight utilization management tools

8. Mandate adoption of health information technology without paying for it

9. Ban gifts of any kind from pharmaceutical companies to doctors

10. Finally, mandate government rate-setting — either for providers or insurers or both. This may begin with publicly funded programs and Medicaid managed care organization (MMCO) contracts but could spread to commercial arrangements as well.

Other than the last proposal, which remains a threat (or a promise, depending on one's point of view), the other nine actions are either already in motion or about to be enacted (or expanded) by the time this article is printed. The implicit message is that if these measures don't make a dent this year, rate regulation will be next year's remedy.

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Massachusetts State Senate President Therese Murray has blazed the trail with a bill that is currently winding its way through the legislative process, but most legislative-watchers believe the key provisions will remain substantially intact. Included in the various bills is a provision requiring the Division of Insurance to hold public hearings to examine the components of all major health plans' increased premium costs. Similarly, Murray's bill imposes public hearings through the Health Quality and Cost Council to examine increases in provider charges. The Council is already causing a stir with its plans to publicize comparative costs on the Web for medical services across providers and health plans. The Massachusetts Hospital Association and others have raised concerns over the timing and the methodology of the planned public disclosure, but the real concern on the part of some of the richer hospitals may be that the public will not tolerate the vast cost differentials that exist among providers, and that disclosure may be the first step on a slippery slope toward government rate regulation.

Murray's bill also includes longer-term remedies with such aggressive measures as a mandate for physician and hospital adoption of health information technology, despite the cost barriers to adoption for many physicians in solo and small practices. And, if any provision has been criticized by multiple groups, it might be the bill's ban on pharmaceutical gifts and increased disclosure requirements. In an effort to stem rising pharmacy cost trends, which like medical costs have not been linked with better outcomes, this provision targets the sacred cow of the pharmaceutical industry/physician relationship; certainly draconian in many parties' eyes, yet for others, an important action to combat an unholy alliance. Murray's bill and others also expand and strengthen the determination of need (DON) program by adding regulatory authority to approve outpatient services and establishing a sunset provision for past approvals for MRI, PET, and other

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services. The proposals also make it harder to add beds in satellite locations. And, finally, under the category of unpopular measures, the Senate bill would prohibit third-party payers from knowingly paying for services that resulted from one of the listed "never events," and providers are prohibited from billing the patients for services arising from one of these events. Shortly before this article was submitted, Massachusetts' Executive Office of Health and Human Services announced a similar policy prohibiting payments for a long list of "never events" that will be applied to all state public health programs and included in the state's contracts with MCOs.

The "offensive" cost-control measures are also appearing in the commercial health insurance sector, with changes in reimbursement (e.g., a return to risk contracts and capitation, as trumpeted by the new Blue Cross Blue Shield of Massachusetts reimbursement model) and tiered networks based upon black-box formulations of efficient provider performance. This latter effort to expand the Group Insurance Commission (GIC) tiered network product by some of the state's major health plans has become the subject of litigation by the Massachusetts Medical Society, which hopes to be more successful in its legal battle against the insurers than it has been in its pubic battle to date.

Is there really excess money in the system, and if so, where is it?

The answer to that question very much depends on who one asks. Each player in the market continues the predictable practice of pointing to the other guy. But, it is hard to deny that for some players in the local health care industry, the profits or reserves are significantly out of balance relative to other players in the system. According to the Department of Health Care Finance and Policy public reports, for 12 months ending in September 30, 2007, there have been record bottom-lines reported by some hospitals. One Boston hospital reported almost a 14% margin, with earnings of almost $355 million; another reported a 10% surplus and $112 million in earnings. There were others west of Boston with earnings above $60 and $70 million for the year. The widening gap between the haves and the have-nots is no secret. Neither can it be explained as reflective of the difference in services provided or populations served. Moreover, the magnitude of the variation of practice and costs in just one small state points to an immense opportunity to reduce costs; an opportunity that to date has been seriously overlooked. And, this article would of course be incomplete if it omitted reference to the huge profits and reserves of the most powerful health insurers, not to mention the controversial salaries and benefits of their executives.

But perhaps there is something in which all interested parties can agree — that there is an opportunity to do better — voluntarily and in keeping with the not-for-profit missions of the health care providers who lead in this market. If we recognize that there are non-draconian, short-term, and effective alternatives that are within our control, yet are still untapped, we may be able to avoid untenable scenarios and fulfill our vision for our citizens. Then we will have the time we need to implement real and sustainable improvements in our health care system with measures that improve quality and deliver on the promise of our business. ❑

About the Authors

Leanne Berge is the vice president of strategic planning and business development at Network Health (Medford, Mass.), a managed care organization that serves more than 160,000 members through its MassHealth plan, **Network Health Together,** and its Commonwealth Care plan, **Network Health Forward**. Ms. Berge provides leadership for Network Health's new business lines and oversees Network Health's relationship with state government and regulatory agencies. Ms. Berge also leads strategic planning and corporate compliance activities for Network Health. Prior to joining Network Health, Ms. Berge served as principal of Berge Healthcare Strategies and previously served as senior vice president of network services for Harvard Pilgrim Health Care.

Outsourcing an EMR System—

Service Level Agreements and Other Contractual Concepts You Need To Know To Reduce Your Risk

By: Allan P. Weeks, Esq., Attorney
Law Office of Allan Page Weeks

Introduction

There are two different functional configurations of an Electronic Medical Record ("EMR") computerized system ("EMR System") that will be offered by a company (the "Vendor") to a healthcare provider organization, large or small, that is acquiring such a system (the "Buyer"): (1) The entire system of software, hardware, telecommunications equipment and associated databases will reside on the Buyer's site (collectively, "On-Site EMR System," which may be referred to by Vendors as the "Client/Server" model); or (2) nearly all or a portion of the EMR System will reside on the Vendor's site (collectively, "Outsourced EMR System").

The Buyer who is considering an Outsourced EMR System will need to select one of the following operating structures: (1) On-Site EMR System: the Vendor or, less frequently, a third party hosts

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the EMR software (i.e., operate and maintain the server(s) on which the licensed EMR software will reside) that is distributed by the Vendor, along with a few associated services that a Vendor also may provide, such as software and telecommunications support or (2) Outsourced EMR System: the Buyer transfers most or perhaps all of the responsibility for the operation and support of the Outsourced EMR System to the Vendor, with the exception of the computers and communications equipment at the Buyer's site, under an Information Technology ("IT") services model called an "Application Service Provider" ("ASP"), now often referred to as "Software as a Service" ("SaaS"). (For purposes of this article, the ASP and SaaS outsourcing services models will be referred to as either "ASP Services" or an "ASP Structure.")

This article first describes the differences between an On-site System and an Outsourced System and then focuses on how those distinctions are reflected in the outsourcing contracts between the Buyer and the Vendor(s). This article does not analyze the other legal and transaction issues that would be raised in the EMR software license and other agreements that will accompany a contract for those two EMR Systems models. To some extent, the topic of this article is based on the author's observation that buyers of computerized systems, such as an EMR System, that involve remote access via the Internet, a Virtual Private Network (or VPN, a communication network tunneled through another network, and dedicated for a specific network) or otherwise often are not aware of the complexity of the contracts and contract negotiations that accompany implementation of those outsourcing services.

Structural Differences Between an On-Site EMR System and an Outsourced EMR System

Both the On-Site EMR System and the Outsourced EMR System basically will deliver the same data processing, associated IT services and output to the Buyer's end-users and, in turn, its patients. However, as is the case with most IT transactions, the manner in which the IT products and services are to be utilized dictates the content of an IT contract and many of its deal-specific provisions.

On-Site EMR System: When a Buyer is considering which EMR System to acquire, an often compelling distinction between the on-site computer system and one that is outsourced is that with an On-Site EMR System, the Buyer retains full control of work flow, internal communications, data (especially the patient records) and the use and support of the EMR System. Because the software, databases, hardware and most of the telecommunications equipment will reside on the Buyer's site, for the most part, this transaction uses the types of contracts that are familiar to most buyers of IT products and services: There will be a software license, software maintenance services agreement and the contract used to purchase and support any new hardware, often a purchase order.

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However, depending on the amount of new computer and telecommunications equipment that needs to be installed for the EMR System, and unless the Buyer has an IT staff with sufficient experience and depth, another contract may be needed for the installation and acceptance testing of the software/hardware and any software development or customization services necessary to satisfy the Buyer's special requirements. The Vendor or a third party can be hired to perform those tasks. (Note that the third party often has a reseller or agency relationship with the Vendor.) After the On-Site EMR System is placed into use, it will operate and be supported like most other IT products that reside at the Buyer's site.

Outsourced EMR System: There are two distinct characteristics of an IT outsourcing structure: (i) The EMR System has changed from being a product acquired and operated by the Buyer to a service that is provided to the Buyer by the Vendor; and (ii) this shift results in the loss of some or, potentially, all of the Buyer's direct operational control of that computer system.

- Hosting Services: The term "hosted services" usually refers to a software licensing and operational structure by which the EMR software, which has been licensed to the Buyer by the Vendor, will reside on a server that is operated by (i) the Vendor at its site or (ii) less typically, a third party at its site. Either of those options will provide the Buyer's end-users with remote access to the EMR software and any associated software for the purpose of processing the medical records and performing the Buyer's other requirements that utilize that EMR software. In addition, when the Vendor is the hosting entity, the Hosting Services agreement will require the Vendor to provide software maintenance (including software updates) and other

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support services. Except for this outsourced portion of the EMR System, the use of, and access to, the rest of the EMR System that remains on the Buyer's site would be expected to be the same as with an On-Site EMR System. To the extent that any component other than the EMR software is in the possession of the Vendor, the structure will be moving towards the below-described ASP Services model.

- ASP Services: When the Buyer obtains the Vendor's services via an ASP Services model, the responsibility for the operation and maintenance of virtually all of components of the EMR System actually or figuratively will be transferred to the site of the ASP Services Vendor. That transfer will include the EMR software and other associated software, telecommunications equipment and servers, patient records and any other associated data/information that is necessary to support the portion of the Buyer's healthcare services that is managed by the EMR System; and all of those components of the EMR System will be under the Vendor's control and accessed electronically by end-users in the Buyer's offices. (Of course, the Buyer's end-users will exert some control over the data processing and related activities via that remote access.)

  In contrast to Hosting Services, in an ASP Services model, the Buyer is only purchasing services from the Vendor. As a consequence, the software components of the EMR System do not necessarily have to be licensed to the Buyer, because the software neither resides at the Buyer's facility nor is under the Buyer's control. The exception to that licensing situation occurs when a "client" component of the EMR software, which enables the Buyer to communicate with the Outsourced EMR System, is distributed to the Buyer. In that case, use of the client software will be governed by a software license that probably will have to be agreed to by each end-user in the Buyer's organization before the EMR software can be accessed by an end-user. However, generally some type of license that establishes the conditions for on-line access to the EMR software is associated with the ASP Services model.

IT Contract Terms that are uniquely Applicable to Outsourcing Transactions

The contractual provisions discussed below address the fact that the responsibility for certain elements of the Buyer's EMR System and its related IT operations are no longer operated or controlled by the Buyer. In essence, these provisions describe the procedures that apply to the legal and operational relationship established by the Buyer and Vendor and, in addition, allocate various obligations and liabilities between the parties. It also is true that in many respects, an outsourcing relationship more closely resembles a partnership than a typical vendor/buyer relationship, which

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may affect how the resulting relationship is managed.

An example of how this different relationship is reflected in an outsourcing contract is demonstrated by the differences between the product warranty usually offered by a software vendor and the services warranty of an outsourcing services provider. When software is licensed directly to an end-user, the license generally states that the software will function in substantial conformity with the product's specifications or descriptive literature. If the software does not function as warranted, the accompanying remedy of repair/replace will only be available to the licensee for a stated period of time, e.g., ninety (90) days, after delivery of the software.

While there may be specific performance obligations placed on a provider of outsourced services, as further discussed below, a vendor's warranty for the performance of its services is less specific and is based on the application of a negligence standard to the services. However, the outsourcing vendor's services warranty will be in effect for the entire period during which the services are provided, not just the first ninety (90) days of the EMR software's operation.

The following discussion is about the specific provisions that mostly are found only in contracts for outsourced services. As a result of that limitation, this article will not address, e.g., confidentiality, indemnities for a third party's claims of infringement of its Intellectual Property rights, choice of law or other like provisions that routinely would be part of any IT transaction. Each of the below contract provisions is applicable in varying degrees to both Hosting Services and ASP Services.

- Ownership of Buyer's Data: If the Buyer's or its patients' data or information (collectively,

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"Data"), whether confidential or otherwise protected by laws and regulations (e.g., HIPAA), resides with the Vendor or a third party hired by the Vendor, the outsourcing contract must provide that (i) the Data is the property of the Buyer; (ii) the Vendor acquires no ownership rights in that Data or any output from the Vendor's services that includes, or is the result of, processing that Data, unless that output also includes the Vendor's proprietary data; (iii) the Buyer has the right, which may have some conditions placed on it, to demand the return of the Data within a time certain and in a form that is useable by the Buyer; and (iv) upon any termination of the outsourcing relationship, all of Data either is to be returned to the Buyer or destroyed, with an appropriate certification by the Vendor that such destruction has occurred.

- Security: At a minimum, the Buyer needs to engage in an investigation that is sufficient to assure the Buyer that the confidentiality and security obligations imposed by the outsourcing contract and applicable Federal and State laws/regulations on any Data under the control of the Vendor can be complied with by the Vendor. The investigation also should produce an understanding of the procedures that the Vendor will employ to back-up and store the Data and any output from the outsourced services, as well as the level of security that will be applied by the Vendor to both the Data and its other relevant obligations. Additionally, in today's insecure environment, the process of obtaining and maintaining the appropriate level of security should consider disaster contingency and business continuity planning, as well the Vendor's use of third parties to provide the outsourced services, which arrangements can result in security gaps and other operational problems. (Healthcare counsel should be consulted regarding several of those matters in this bullet, as they are beyond the scope of this Article.)
- Service Level Agreements ("SLA's"): As mentioned earlier, the warranty that the Vendor is likely to provide for its outsourcing services will be rather unspecific, but SLA's can close that gap by setting both standards for the Vendor's performance and remedies if the Vendor fails to meet those obligations. To be effective, however, the SLA's must include a schedule of liquidated damages that will be incurred by the Vendor if the SLA's are not met. SLA's can be complicated to formulate, require a good technical understanding of how the Vendor actually will provide its services and usually require the negotiation of another document. Those negotiations may be contentious, because the liquidated damages generally are taken off the top of the Vendor's revenue, unless other forms of compensation are agreed to, e.g., a credit towards future fees. Thus, the decision of a Buyer to seek SLA's for an outsourcing agreement depends on the nature and extent of

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the projected harm to that Buyer's operations and healthcare services if the Vendor fails to provide the minimum level of services that the Buyer needed, expected and has paid for.

- Termination of the Outsourcing Contract; Transition Services: Because a central part of the Buyer's operations and its core Data will be controlled by the Vendor, and although termination of the outsourcing relationship is one of the last things that the Buyer and Vendor will want to discuss during an outsourcing contract's evaluation and negotiation phases, the topic of termination is critical for outsourcing transactions. In addition, to prevent the Buyer's activities and healthcare services from being brought to a halt upon any termination of the outsourcing agreement, arrangements must be made, known as "transition services" to assure that the outsourced services will continue to be available to the Buyer after that termination, whether the termination is for cause or will naturally occur under the terms of the agreement. One way to resolve this potential problem is for the Vendor to agree to provide its services for a stated period of time after the event of termination occurs, provided that the Buyer continues to compensate the Vendor for its services.
- Bankruptcy of the Vendor: The dot.com bust, which resulted in the demise of many ASPs, made real the somewhat abstract consequences of an outsourcing provider declaring Bankruptcy or otherwise going out of business. The legal remedies for a Buyer may be more uncertain when ASP Services are involved than when Hosting Services are being provided, because under the Hosting Services model, the Buyer is the licensee of the EMR software and thereby may have certain rights to continue using that software. The inclusion of the Data

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ownership rights discussed earlier in this Section, also should improve the Buyer's rights in a Bankruptcy proceeding. Backing up the Data by the Buyer at its site will be helpful and, in addition, the Buyer can further enhance its position by negotiating for an archival copy of the EMR software to reside at its site, which copy would be updated by the Vendor in accordance with its software support services obligations under the EMR software license.

- Hosting Services or ASP Services Vendors' Use of Third Parties: Very early in the Vendor evaluation process, the Buyer must determine if any of the Vendors being considered plan to use the services of a third party data center or other like services provider to assume some or all of the Vendor's responsibility for the Hosting Services or ASP Services. The Buyer also should be concerned, and make appropriate modifications to its contract, even if the third party is only providing cage space in which the Vendor's server(s) will sit while being connected to that third party's communications equipment and services. The underlying concern in that situation is that third party's personnel may provide routine or emergency maintenance services to the Vendor's server(s) and other equipment, creating the possibility of access to the Buyer's confidential information by personnel who may not by covered by the appropriate non-disclosure agreements.

Conclusion

Outsourcing contracts are operating agreements, although they often are not viewed that way. As such, they control the Vendor's data processing and other related services that need to be readily available to meet the Buyer's and its patients' needs over the term of the Buyer's outsourcing contract. Because of those obligations and the operational characteristics of outsourcing services, outsourcing transactions are quite different from an On-Site EMR System or other typical IT transactions, which are product-oriented and are completed when the product has been delivered and accepted, except for any on-going software/hardware support services,. Thus, the evaluation of outsourcing vendors and the drafting and negotiation of an outsourcing agreement requires the application of different business, technical and legal expertise to protect against signing an outsourcing contract that will be unfavorable to the Buyer. ❑

About the Author

Allan Weeks is an attorney who has specialized in Information Technology transactions for more than twenty years, focusing on IT contracts for Healthcare and Life Sciences organizations. Allan can be reached at 617-725-0222 or allan@aweekslaw.com and his website address is www.aweekslaw.com.

The Self Insurance Decision

By: Linda J. Guerra, MBA
Director, Provider and Payor Operations, Beth Israel Deaconess Physician Organization
and
Margaret J. Meehan, MBA
Director of Finance, MIT Medical

In today's heath care environment, more employers are choosing to self insure their employees' health insurance. Given the double digit premium increases over the past decade or so, many employers see self insuring as a way to contain costs. When self insurance first became a popular alternative to offering traditional health insurance coverage, only large companies had the resources and sophistication to self insure. However, today many smaller companies have joined the self insurance arena hoping to control a cost that can significantly impact their bottom line. According to a report by the Employee Benefit Research Institute (EBRI), in 2000 almost 50 million employees and their dependents receive benefits under a self insured plan, which at the time was about one third of the private employer based plans in the United States.[1]

The table on page 26 from the Department of Health and Human Services Medical Expenditure Panel Survey (MEPS) illustrates employers offering a self insured plan to their employees. The

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Table II.A.2.a(2005) Percent of private-sector establishments that offer health insurance that self-insure at least one plan by firm size and selected characteristics: United States, 2005

Characteristics	Total	Less than 100 employees	100-499 employees	500 or more employees	Less than 50 employees	50 or more employees
United States	32.7%	12.3%	30.3%	75.4%	12.3%	61.1%
Industry group **						
Agric. fish. forest.	17.8%	15.2%	15.9% *	81.2%	15.5%	34.3%
Mining and nat resources	37.3%	8.8%	44.1%	83.9%	8.1%	57.0%
Construction	18.2%	15.8%	33.3%	75.6%	15.6%	39.6%
Utilities and transp.	45.0%	17.1%	34.1%	85.3%	11.9%	73.7%
Wholesale trade	39.8%	12.0%	48.7%	83.1%	11.0%	82.2%
Finance and real estate	47.2%	7.7%	28.6%	83.9%	7.0%	75.5%
Retail trade	46.6%	11.2%	24.9%	82.4%	11.2%	70.1%
Professional services	28.7%	10.5%	28.4%	70.7%	10.6%	61.6%
Other services	28.4%	13.8%	28.9%	67.5%	14.0%	50.6%
Ownership						
For profit, incorporated	35.8%	12.0%	32.5%	81.4%	12.0%	65.2%
For profit, unincorporated	15.2%	10.5%	27.4%	48.7%	11.8%	54.4%
Nonprofit	31.6%	14.4%	25.0%	45.7%	15.3%	29.8%
Age of firm						
Less than 5 years	12.6%	10.6%	43.8%	42.1%	10.6%	33.6%
5-9 years	15.1%	12.0%	21.1% *	64.2%	12.7%	32.1%
10-19 years	15.1%	11.6%	25.2%	56.4%	11.7%	31.0%
20 or more years	33.1%	12.8%	30.2%	81.8%	12.8%	59.0%
Unknown	76.6%	10.5% *	42.7%	76.3%	13.5% *	77.1%
Multiemployer status						
2 or more locations	80.2%	12.8%	31.8%	79.7%	12.7%	85.4%
1 location only	12.8%	12.2%	28.2%	43.8%	12.2%	17.5%
Percent full time employees						
Less than 25%	30.5%	15.4%	20.1% *	60.6%	14.1%	50.3%
25-49 %	34.7%	10.0%	24.5%	78.4%	10.5%	81.6%
50-74 %	32.8%	13.8%	28.2%	78.8%	14.0%	80.6%
75% or more	32.4%	12.0%	32.7%	80.4%	12.0%	81.9%
Union presence						
No union employees	29.7%	11.3%	28.2%	74.6%	11.4%	59.7%
Has union employees	66.0%	20.6%	41.3%	91.2%	20.6%	91.7%
Unknown	74.0%	19.7%	34.0%	90.0%	20.1%	93.0%
Percent low wage employees						
50% or more low wage	37.7%	12.7%	27.6%	72.4%	13.2%	57.6%
Less than 50% low wage	31.3%	12.2%	31.4%	82.0%	12.1%	62.5%

Source: Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends, 2005 Medical Expenditure Panel Survey-Insurance Component.
Note: Definitions and descriptions of the methods used for this survey can be found in the Technical Appendix.
* Figure does not meet standard of reliability or precision.
** Definitions of industry groups and low-wage employees changed in 2000. These data are not comparable to IC data prior to 2000. See Technical Appendix.

full table can be found on the DHHS website at: http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2005/tia2a.pdf

Self insured health plans gained prominence after the passage of the Employer Retirement Income Security Act (ERISA) of 1974. This federal regulation governs the provisions of employer based pension and welfare plans including health insurance plans.[2] Since this is a federal regulation, it supersedes any state regulations. This is a critical component of self insurance, as this means that employers do not have to pay state premium taxes since the employer is not an insurance company, nor do employers need to follow state mandates that dictate certain aspects of health coverage. This allows large corporations with employees in multiple states to design a standardized plan for all employees without having to adhere to each state's health insurance mandates. The self insured employer can formulate their premium based on their true claims experience plus an administrative fee. Doing this also allows the employer to save the profit margin that insurers typically build into their premium.

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	Estimated Potential Cost Savings
Premium tax avoidance	2%
State mandates (assuming plan sponsor does not comply)	1%-2%
Float – claims paid retroactively versus premiums paid proactively	0.5%-1.5%
Savings from risk assumption	2%-6%
Total	5.5%-11.5%

Timing of employer payments is another advantage of self insured plans. Unlike fully insured plans where premiums are paid prospectively, under self insured plans claims are paid retrospectively after the services have occurred. This allows the employer to collect the employees' portion of the premium and all funds can be invested until claims are due, thus the employer can earn interest until payment for claims is needed. Employers will typically purchase stop-loss insurance to cover any large unexpected outlier claims such as transplant services.

Employers may elect to pay claims directly, but most engage a Third Party Administrator (TPA) to pay their health insurance claims. This requires the employer to pay an administrative fee to the TPA plus the cost of the claims. Companies that self insure are considered Administrative Services Only (ASO) accounts by the TPA. Allowing an experienced health plan to process and pay the claims eliminates the administrative burden for the employer and also reduces the number of staff needed to manage the plan internally.

Since there are many variables that impact the magnitude of cost savings, an average is difficult to calculate. However, here are some typical variables with associated cost savings provided by local actuaries:

Another potential impact on cost is the decision on whether to purchase stop loss insurance. It is difficult for any organization to predict whether the costs of catastrophic cases will cost more or less than the cost of the stop loss insurance premiums. Sometimes the financial value of that decision is not evident in one year, but must be evaluated over several years. In a population of any size, it's dif-

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Annual Social & Awards Night

May 28, 2008

Over 120 members and guests of the Massachusetts-Rhode Island Chapter of HFMA gathered on the evening of May 28th for our annual social and awards night. Attendees enjoyed a delightful evening of wine, food, and award presentations. The event was once again held at the Harvard Club located on the 38th floor of 100 Federal Street in Boston - a fabulous location with panoramic views of the city and harbor. Attendees were treated to a number of superb Spanish wines which complimented the outstanding four course dinner, prepared by Executive Chef Erik Lacross. The wines were introduced by Thomas Welch from United Liquors, a local wine expert, who carefully explained the origins and processing of each wine. Following dinner, Gold, Silver and Bronze Service Awards were presented by Kathleen Maher, President, HFMA MA-RI Chapter, to ten deserving chapter members. Also, eight chapter members were presented Medal of Honor Awards for their years of dedication and involvement in the Chapter.

The backdrop for the evening – the Harvard Club's fabulous harbor view.

A delightful evening was had by all, for which the Massachusetts – Rhode Island HFMA Chapter would like to thank Thomas Welch from United Liquors along with Executive Chef Erik Lacross and the entire staff of the Downtown Harvard Club for their hospitality this evening, and of course, our wonderful sponsors. A special thanks to Roger Boucher for organizing this enjoyable event. Our annual social and awards event is a wonderful opportunity to socialize, network, and take advantage of fine friends, fine food and fine wine. If you didn't have the opportunity to attend this year, don't miss this event in 2009!

2007-2008 HFMA MA-RI Chapter President Kathleen Maher, HBCS, hands over the gavel to incoming Chapter President Marvin Berkowitz, BHC Consulting, at the Annual Social and Awards Night. ...read more inside!

Silver Award recipients Helynne B. Winter, Sturdy Memorial Hospital, and Richard M. Wichmann, PricewaterhouseCoopers LLP, alongside Bronze Award recipient Jeffrey S. Dykens, Cape Cod Healthcare, Inc., and Gold Award recipient Marc A. Proto, Children's Hospital.

The evening was coordinated by Roger Boucher, Bank of America, pictured with his wife Maura.

Dottie Martin, Joe and wife Joy Clancy, and Larry Martin.

Music kept everyone entertained

Attendees socialize and network with fellow members.

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ficult to predict how many cases an organization will experience. However, the larger the organization, the more risk since the odds are higher that there will be high cost cases in a larger population. A peripheral benefit of stop loss insurance is the predictability of monthly expenses.

In industries where there is competition for a limited labor pool, employers may need to offer richer benefits packages. Cost savings could be eroded for the self insured employer that needs to include state mandated benefits even though they could choose not to under the self insured model. The eastern Massachusetts health care industry is an example, where there are many health care employers and what some perceive as the lack of qualified candidates.

Issues and Concerns Surrounding Self Insurance

Self insured employers face myriad issues and decisions related to benefit design, expense management and premium pricing.

Benefit Design

Benefit design is a key decision that must be made by self insured employers. The package of benefits available to employees and how those benefits are managed can significantly impact cost, access to care and, as previously mentioned, could impact the ability to recruit competitively. Because self insured employers assume the entire risk, the TPA may be willing to accommodate any plan benefit design changes or individual benefit exceptions requested by the employer. In effect, the employer can design its own managed care program and TPAs with the infrastructure flexibility to accommodate these requests may likely do so since the TPA bears no risk. The flipside of such flexibility is the potential for the employer to increase expenses when expensive benefit exceptions are made or the benefit package is enhanced.

Expense Management

Expense management under the self insured model presents a variety of challenges. Because risk assumption lies with the employer, there is the potential that the TPA may not be as aggressive as the entity might prefer when managing claims and identifying other payors, such as workers compensation, that could assume the liability. However, TPAs that also sell fully insured products are likely to utilize the same processes, procedures and systems employed for their fully insured business, so that the organization's claims pass through the same system edits, holds and criteria. Regardless of whether this is the case, self insured organizations would be well served to make sure these types of cases are consistently tracked and followed up upon.

Because self insured organizations pay the actual cost of claims, there could be significant monthly expense volatility caused by catastrophic cases and utilization and practice pattern changes. A few patients with major diseases such as cancer or cardiovascular disease and premature births can cost several hundred thousand dollars over

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their course of treatment, a significant portion of which may show up in one month. Typically there is room in budgets for outlying cases, but the number of these cases is difficult to predict. To mitigate this risk, some entities purchase stop loss insurance or may hold reserves to cover higher cost cases. In addition to mitigating risk through insurance and reserves, organizations, including those who are fully insured, are mitigating cost increases through higher cost sharing with health plan members, wellness and disease management programs, consumer directed health plans and incentives to seek care at the most cost effective sites. Such cost controlling programs and tools, as well as utilization management programs and referral and authorization requirements, may be part of the employer's contract with the TPA. The employer must decide what to offer versus what to purchase keeping in mind capacity, expertise and cost differentials.

Premium Pricing

Similar to companies that offer fully insured products to their employees, self insured organizations charge employees a set premium. Companies that offer fully insured products typically charge employees a portion of the premium charged by the insurance company. In contrast, self insured organizations must calculate a premium that covers the costs of expected medical and administrative services.

The following are some of the factors that impact cost and must be factored in to premium calculations:

People Specific Factors

- Age and gender. Generally speaking, females during childbearing age, people in middle age and premature infants are most expensive.
- Utilization patterns, either patient or provider driven.
- Catastrophic illness or major trauma can easily account for a major portion of total expense.
- Geographic location plays a role in whether patients receive care in a more expensive urban academic medical center versus a less expensive community hospital.

Insurance Plan/Program Specific Factors

- Benefit design may encourage selection by groups that tend to have specific demands best met by a specific plan.
- Medical and utilization management.

Carrier and Provider Specific Factors

- Network discount. The terms of the TPA's negotiated discounts with providers has a significant financial impact.
- Health care inflation driven by new technologies and practice patterns.
- Administrative costs charged to self insured entities.

In conclusion, given the substantial savings that can be realized from self insuring, many large companies, and a fair number of smaller companies, are willing to take the risks involved in the hopes of gaining significant bottom line savings and slowing the rate of premium increase for employees. ❑

ENDNOTES:

1. Self-Insured Group Health Plans (n.d). Retrieved 3/25/08, from http://www.siia.org/i4a/pages/index.cfm?pageid=3339

2. Compliance Assistance. (n.d.). Retrieved March 25,2008, from http://www.dol.gov/ebsa/compliance_assistance.html

About the Author

Linda J. Guerra, MBA is the Director of Provider and Payor Operations at Beth Israel Deaconess Physician Organization in Boston, MA. Ms. Guerra has been a member of HFMA since 2002.

Margaret J. Meehan, MBA is the Director of Finance at MIT Medical in Cambridge, MA. Margaret has been a member of HFMA since 2001.

Second Annual Golf Tournament

June 3, 2008

On June 3rd, the Massachusetts-Rhode Island Chapter of HFMA held its Second Annual Golf Tournament at Agawam Hunt Club in Rumford, Rhode Island. It turned out to be a terrific day. Attendance increased from 52 last year to 79 players, with several guests joining for the luncheon. All the players unanimously voted to return next year. It is an old beautiful golf course!

David Dillon of Women & Infants Hospital and Jayne Kim of Phillips DiPisa & Associates were the friendly faces of the registration desk.

Prizes earned are as follow:

Gross

Mike Donahue

Dave Balsofiore

Dr. Rowland Barrett

Bob Pacheco

Net 1st

Michele Rhuork

Bill Ibbotson

Mike DeLeonardis

Larry Moyer

Net 2nd

Kevin Wert

Mark Stewart

Paul Fitzpatrick

Rich Nagle

Closest to the Pin

Sheryl Crowley

Dr. Rowland Barrett

Longest Drive

Barbara Lynett

John Krouskos

Barbara Lywett and Bill Gilbody pause on their way to the next hole.

Jerry Vitti, Ginny Moi, Susi Smith, and Scott Sugarman just after Ginny made a 30' putt.

Jim Heffernan stops to talk with Mike Connelly (front) and Wes Benbow. Possibly looking for a ride?!

Golfers and guest enjoying the luncheon.

A New One Day HFMA Program:

Health Care Finance For Not-For-Profit Board Members

On October 8, 2008 the Massachusetts-Rhode Island HFMA Chapter will initiate a new educational program designed for finance committee members of health care provider organizations, and their organization's CEO and CFO. The program will enable the new finance committee or board member to better understand the nature of health care finance and the obligations of a finance committee member.

The full day session will be designed and presented by Babson Executive Education and will be held at Babson College at the Babson Executive Conference Center. Topics addressed at this session will include a review of health care financial statements, financial statement analysis and also a presentation on financial strategy and its application to the health care industry. The session will utilize case studies and will rely on an interactive teaching approach to facilitate discussion and to provide a viable framework for the topics presented. The session will also allow time for networking and relationship building between all participants.

One reason for this program is to respond to the need expressed by HFMA members for a program to help them provide a better orientation for newly appointed members of their Finance Committees, particularly those who do not have a substantial health care background. The session will be led by Professor Jim Parrino, a faculty member of the Finance Department of Babson College. Professor Parrino has extensive experience designing and delivering high quality educational sessions for a variety of organizations. He has extensive background in working with board level groups.

The program will be held at the Babson Executive Conference Center, One Woodland Hill Drive, Wellesley, MA 02457. Additional information on this program will be distributed in the near future. Please direct any questions to Marvin Berkowitz at president@masshfma.org and also check our website at www.masshfma.org for updates and details about this program.

HFMA, Massachusetts-Rhode Island

Welcome New Members!

The following new members recently joined Massachusetts-Rhode Island Chapter of HFMA. We welcome you to the MA-RI Chapter and encourage you to take advantage of the many professional development, networking and information resources available to you at HFMA. Other HFMA members are a terrific resource for your everyday professional challenges – we encourage all members, current and new, to get involved with HFMA committees and social activities. And… use the Membership Directory – it's a great resource! We value your membership, so please send us feedback or questions on your HFMA experiences to admin@masshfma.org.

HFMA New Members - June 1, 2008 to June 30, 2008

Julie Bodde
Health New England

Peter Butler
Hayes Management Consulting, Inc.

Michael Farrell

Elizabeth Flaherty
Caritas Holy Family Hospital

Jennifer Groves
UMASS Memorial Health Care

Ethan Hope
Deloitte & Touche, LLP

Edith Joyce, CTP
Bank of America

Edward Keating
Brigham & Women's Hospital

Carl Lackstrom
Protiviti

Amy Lawton
Southcoast Ventures, Inc.

George Leehan
Massachusetts General Hospital

Lynette Leonard
Tufts Medical Center/Perot Systems

Sean Mcdonagh
Beacon Partners

Celeste Nigro
Beacon Partners

Laura Panza
Eclipsys Corporation

John Roch
Urban Medical Group

Christopher Shea
Walker Associates Inc

Louisa Soares
Signature Healthcare Brockton Hospital

Rene Weathers
Franciscan Hospital for Children

making connections

☆ ☆ ☆ RESERVE THESE DATES ☆ ☆ ☆

2008-2009

Program & Special Event Schedule

Date	Event	Location	Coordinator(s)
09-05-2008	New to Healthcare Seminar	Simmons College Boston, MA	Gerry O'Neill,FHFMA
10-08-2008	Health Care For Not-For-Profit Board Members	Babson Executive Conf. Ctr. Wellesley, MA	Marvin Berkowitz, FHFMA
10-10-2008	Accounting & Regulatory Technical Update	Doubletree Hotel Westborough, MA	Lee Ann Leahy
12-12-2008	Compliance Update	Doubletree Hotel Westborough, MA	Christopher Gingras and Garrett Gillespie
01-23-2009	Revenue Cycle Meeting	Gillette Stadium, Clubhouse Foxborough, MA	Karen Bowden and Beth O'Toole
02-13-2009	Enterprise Performance Management Seminar	Doubletree Hotel Westborough, MA	Gail Robbins
03-27-2009	Physician Practice Management/ Ambulatory Care Seminar	Doubletree Hotel Westborough, MA	Paul Breslin and Linda Burns
06-26-2009	Managed Care Meeting Westborough, MA	Doubletree Hotel Rick Wichmann	John Minichiello and

Education/Program Administration Committee, Co-Chairs: Gerard Vitti, gvitti@hfi-mass.com, and Catherine Robinson-Skeen, cskeen@saintsmedicalcenter.com

NOTE: Please keep in mind that the themes listed for the programs are general. The programs themselves address current issues pertaining to these themes.

Healthcare Financial Management Association

c/o Roberta Zysman, Executive Director
Beth Israel Deaconess Physician Organization, LLC
1135 Tremont Street, Ren-8
Boston, MA 02120.