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  see page 7

• Mobile Phones in Hospital Settings:  
  A Serious Threat to Infection Control Practices  
  see page 15
Scott Mariani, Partner and healthcare industry expert, knows how critical it is for hospitals and healthcare delivery systems to implement the right strategies for financial survival. His healthcare clients trust his advice and guidance, enabling them to focus on what matters most — providing quality patient care. Whether with tax, audit or consulting, helping his clients avoid fiscal trauma is Scott’s specialty.

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It is amazing to think that another year has passed.

Last May when the board and committee chairs met to set the course for the upcoming year, the focus was to continue to provide exceptional value to the membership and to have the New Jersey Chapter recognized by HFMA National as a chapter worthy of the Robert M. Shelton Award for Sustained Excellence over a 5 year period. Shortly after that meeting we got word that New Jersey had been selected to be the 2011 Shelton Award recipient. While this was tremendous news, the announcement did not dampen the enthusiasm and drive that the chapter leaders had to make the 2011-2012 chapter year even better than the past.

The 2011 Annual Institute was the most successful that the chapter has ever had with 577 attendees, a Tricky Tray charity auction containing gifts worth more than $10,000, and a vendor fair of more than 50 exhibitors.

Over the past year, under the leadership of Lisa Hartman, Michael DiFranco, and Scott Mariani, we have seen the Finance, Accounting, Capital & Tax (FACT) Committee produce two full day educational sessions and two half day sessions, drawing more than 330 attendees.

The annual March Compliance, Audit, Risk & Ethics (CARE) Committee education session, coordinated by Mike McKeever and Nadinia Davis, had the best turnout ever for a March program with almost 200 people in attendance. At the request of a number of attorneys that were in the room, the NJ Chapter will be applying for NJ Continuing Legal Education (CLE) credits for the session and will look to become a regular provider of CLEs.

Kevin Joyce and Jill Squires, with the rest of the Managed Care Committee, also presented two full day educational programs this past year; one in July 2011 and the second in May 2012. For a committee that was formalized less than two years ago, it has come together beautifully to meet the needs of the members.

The Revenue Integrity Committee that was established in June of 2011 by Lindsey Colombo and Vickie McElarney, has been a great success and hosted an educational session in June which qualified for the traditional accounting and finance CPEs, as well as AAPC credit.

In total, the NJ Chapter provided more than 21,000 hours of continuing education this past year equating to more than 18 hours per member, the largest numbers the chapter has ever seen.

Erica Waller and the Member Services and Networking (MSN) Committee provided a number of social and networking events including what was fondly called the “Shelton Dinner,” a dinner that was open to all members as a way to celebrate the Chapter’s National recognition. Through the efforts of the MSN Committee, the chapter also saw a significant growth in membership. At April 30, 2012, the NJ Chapter officially had 1,201 members and a retention rate of 90.6%. These are the highest levels that NJ has ever seen.

The 2012 NJ HFMA Golf Outing turned out to be another great success. We all had concerns that the bad weather from earlier in the week was going to continue resulting in a cold, wet day. We were lucky that the clouds parted early in the morning and everyone was able to enjoy the day. The wind even gave some of us something to blame for the occasional hook or slice. We all have to thank Dotti Lindstrom for the work that goes into coordinating the outing year after year, and for whatever pull that she has with Mother Nature.

This year also saw the appointment of Cheryl Cohen to the HFMA National Chapter Advancement Team and Joe Lemaire to the National Policies & Practices Board. I offer my congratulations to both.

As I turn the gavel over to John Brault for the start of the new chapter year, I have to thank him, Dave Wiessel, and Tracy Davison-Dicanto, along with the Board of Directors, the Advisory Council, and the Chairs and Co-Chairs of each committee for such a successful year. I sincerely believe that the success of the NJ HFMA can be directly attributed to the hard work and commitment of all of the chapter leaders.

I also need to thank Greg Adams for his support throughout the year and congratulate him on an incredible job as the HFMA National Chair. And I would certainly be remiss if I didn’t thank Laura Hess for her time and commitment to the association. Laura has always been there for me or any member in need, day or night.

To quote Mary Taylor “Get involved, you’ll soon have good friends for life!” No truer words have been spoken.

Respectfully yours,

Michael Alwell
Dear New Jersey Chapter Members, Leaders, Sponsors, and Visitors,

I am humbled that you have selected me to serve you and the entire membership of the New Jersey Chapter as your President. I may be biased, but I strongly believe that The New Jersey Chapter is the greatest chapter in the nation. Last year we were recognized as such by the national organization. Under the leadership of Dotti Lindstrom, Cheryl Cohen, Joe Dobosh, Brian Sherin, and Mary Taylor the chapter was awarded the Robert M. Shelton award, named after the first president of our chapter. The award, recognizing five consecutive years of providing excellent service to our membership, is a fitting tribute to the leadership of not only those individuals I mentioned, but also a reflection of the leadership, dedication, and hard work of the countless volunteers within the chapter, all who contribute with the singular goal of making the membership experience excellent. As Mike Alwell passes the torch to me, the bar has been raised yet again.

Greg Adams, a former NJ Chapter President and great friend of the chapter, completed his term as the HFMA National Chair at the end of May. His theme for the year, “Believe to Achieve” served as a rallying cry for the board. Under Mike’s leadership, the chapter did not suffer a letdown following the Shelton honor; in fact the NJ Chapter provided 21,207 member hours of education, an increase of almost 10% over the prior year. In a market where health system consolidations are occurring all around us, budgets are being slashed, and time seems not to exist, we as a chapter have continued to show the value of this great organization to the industry. Our membership increased by nearly 5% eclipsing the 1,200 mark. Perennial recipients of awards for membership retention and growth, provision of education, innovative programming, and inter-organization collaboration, the NJ Chapter, our volunteers, and our members have set the bar high for the leaders that will follow, of whom I am just one. Despite our past successes, I can attest to the commitment of our current chapter leadership, the board of directors, the chairs and co-chairs of committees, and the membership of our various committees, to continue to push our chapter forward in service to our members.

Incoming chairman of the national organization Ralph Lawson has chosen “Leadership Matters” as his theme for the upcoming year. When I sit back and reflect on the theme, I can’t help but think about the overwhelming need for leadership within our industry. Strong leadership is a necessity in the face of change. It can be said that no other industry today has experienced change in the way that ours has, but let me take this one step further and propose that perhaps no other industry is in greater need of change then the healthcare industry today. We are in a fortunate position, as I scan our membership roster; I see a list full of leaders. I am excited to serve you, our industry’s leaders, through the year. I hope that those of you who are new to the chapter or are newly active within the chapter will find the benefit of sharing your leadership with us and assist us in our support of the membership.

At our chapter leadership retreat held in May, with the spirit of the Chairman’s theme in mind, the leadership team embarked on a strategic planning process that would result in a five year strategic plan for the chapter. With support from Rick Wagner, a member of the HFMA National Chapter Advancement Team and board member from the Colorado Chapter (this year’s Shelton award winning chapter), the team completed a comprehensive SWOT analysis. Despite our history of success, the team identified three areas of focus and an aggressive schedule of implementation that should result in significant improvement to the member experience.

Through data collected from member satisfaction surveys, it was clear that the chapter needed to do a better job of communicating with our membership. This focus on communication will take on a number of forms this year. You may have already noticed changes that were implemented to our weekly HFMA Pulse communications which have been made significantly more smart-phone friendly as well as now including the upcoming week’s committee schedule. The communications committee is exploring the addition of news clips as well, which will provide our members with local industry news from a variety of sources, in one place. We also are looking at improvements to our website and changes to the NJHFMA Focus magazine, exploring various new media formats that will make the information contained on the site and in the magazine more accessible to our membership.

The acquisition of physician practices, the establishment of joint venture relationship, and the overall integration of delivery systems continues to accelerate in our market place, our organization must continue to focus on these new entities, models for
delivery, and professional competencies. In order to ensure our membership is provided with the same great education opportunities that we provide for other healthcare finance modalities, we will be creating a physician practice committee and education development task force. This team will help to assess the educational needs of the demographic and develop recommendations for chapter action.

Perhaps most importantly, the leadership team has recognized a need for transparency. To this end, you will find a copy of the strategic plan published in this edition of FOCUS and on the website. We will also be providing summaries of board minutes in the FOCUS magazine, beginning with the minutes from our chapter leadership retreat. The nominating committee for the chapter, responsible for identifying the future leaders of the chapter, will also be infusing its process with transparency. We, as a leadership team, feel that it is critical for members interested in volunteering to take on a leadership role be made completely aware of the opportunities within the chapter, so that we can facilitate their involvement.

I am excited by the opportunities facing the chapter over the course of the upcoming year. This year’s Annual Institute is going to have something for everyone. We’re packing 21 hours of education into the 2 ½ day event. Rudy Giuliani will keynote an incredible education agenda. We will be holding the first annual CFO Cup golf tournament during the Wednesday of the institute. Additionally, we will be looking to expand the networking opportunities and the time available to spend among our sponsors and exhibitors. You will find more on the 36th Annual Institute later in this issue of the Focus.

I would be remiss to conclude this letter without saying thank you to those who have committed to making this year the most recent “Best Year Ever” for the NJ Chapter. Thank you to the volunteer leaders of the chapter whose countless hours of work and dedication to our chapter are critical to making the member experience the best in the country. Thank you to the provider organizations that recognize the value of HFMA and support us through encouraging the involvement of their employees. Thank you especially to our corporate sponsors, without whose financial support, the chapter could not provide the high level education offerings that have made us so successful. Most importantly, thank you to the membership for your continued participation in the organization and for the way you challenge the leadership team to constantly improve your experience with our chapter.

Welcome to a new year. Please let me know what I can do to help make your experience with the New Jersey Chapter of the Healthcare Financial Management Association the best possible!

John M. Brault, MHA, FHFMA

... and a note to sum the year up

Mike,

Thank you for your commitment and the dedication of your time to the Chapter. You did a terrific job of leading a great group of people all of whom stepped up and contributed in countless ways.

Often people ask why we put such effort into the NJ HFMA. The answer seems obvious – we believe in the purpose of the organization and the value it brings to our peers in terms of education and networking. However, when such great results are achieved, as we have seen once again this year, and the membership has gained as a result, the reward is that in itself.

Congratulations and thanks!!!

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

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Early Summer 2012

Six Things Hospitals Need to Know About Replacing Pagers With Smartphones

Paging: The End of an Era

by Chris Heim

Pagers have been an essential part of healthcare communications for a long time due to their ability to provide reliable communications at a low cost. When pagers emerged on the healthcare scene, they fundamentally changed the way doctors, nurses, and administrators could be notified that a critical message or anxious patient awaited them. Carrying a pager or “beeper” became a status symbol. Then slowly, the technology began to offer new capabilities, such as two-way information exchange. Throughout, pagers ensured message delivery in accordance with industry requirements. In most cases, they promised a cost-effective solution and featured onsite and wide-area options so the right people could be reached at all times. Life was good.

But then the ugly truth began to emerge. IT teams saw escalating costs due to the need for backup equipment. They wasted hours configuring devices and trying to verify whether messages were sent and received when doctors reported they did not see a particular communication. The lack of an audit trail for messages led to accountability issues. Pagers were assigned to individuals but never used (or lost), eating away at thin hospital IT budgets for unnecessary equipment and services.

And then there was the aging infrastructure: paging terminals and transmitters on life support themselves that began to have questionable reliability and failures. Repairs led to extended downtime as IT teams struggled to repair old equipment. Additionally, coverage for wide-area pagers started to go downhill as paging companies retired towers in concert with shrinking revenues. A lot of people started crossing their fingers and living with reduced performance.

Going forward, pagers will still have a place in hospital communications. But there is now a better solution that allows a large percentage of the user population of doctors, nurses, and administrators to consolidate to a single device. In fact, chances are good that these devices are already commonplace at your hospital.

Enter the Smartphone Dragon

Seemingly out of nowhere, smartphones such as the iPhone®, BlackBerry®, Android™, and others have burst onto the communications scene with a vengeance. Physicians, nurses, and administrators love them. Medical students receive them upon entry to school. Even 10-year-olds carry them around. They're superphones, merging the power of a cell phone with the capabilities of computers.

Unlike pagers before them, these devices transcend social and job-related boundaries. They're the communications device for the masses—and seemingly every physician. More importantly, they're everywhere. Hospitals are no exception. According to Manhattan Research, an estimated 63 percent of physicians currently use smartphones, with that number expected to reach 81 percent by 2012.¹

With the unmatched capabilities of smartphones—not just in person-to-person communications, but also in data retrieval for anything from drug interactions to receiving EKG results—their popularity is understandable. Users in hospitals are passionate about these devices and now request all communications, including code calls, to be sent to their smartphone. They wish to shed their tool belt of onsite and wide-area pagers and cell phones, preferring to simplify their lives and communications with a single, all-encompassing smartphone.

Although the clinical and administrative communities at many hospitals seem to be leading a grassroots campaign to ubiquitously adopt smartphones, IT teams have legitimate concerns. With so many brands of phones and service providers, how can protocols and devices be managed? What about reliability of message delivery?

Six Things Hospitals Need to Know About Replacing Pagers With Smartphones

Making the decision to replace pagers with smartphones is certainly a weighty consideration. Lives are at stake. The continued on page 8
technology has to ensure speedy delivery of the message. Every time. No exceptions. Following are important items to evaluate as you determine the right path for your organization.

1. Smartphone use is exploding exponentially in hospitals and this trend is not going away

   The fact is, smartphones are here to stay, and their users are highly loyal. Many physicians and other hospital staff members carry smartphones in addition to their onsite or wide-area pagers. However, they’re eager to consolidate to a single device and no longer wish to deal with pagers. It is important for IT teams to evaluate their options for incorporating smartphones into their communications strategy for all messages, including non-urgent updates and critical codes. Ultimately, a staff that is satisfied with their communications technology is one that will stick around. Attempts to ignore the growing smartphone trend will likely be futile.

2. SMS (text) via a smartphone service provider’s Web site is not suitable for mission-critical communications

   If you’re using a smartphone service provider’s Web site to send time-sensitive communications, your patient care may be suffering. For one, you likely have to visit multiple Web sites when a critical message needs to be deployed to cover the various plans spanning your user group. This wastes a lot of time and can be prone to error because people are often switching from one provider to another. Messages sent from service providers’ sites are also ‘fire and forget,’ meaning you have no centralized audit trail of communications to track message delivery, receipt, and response. Likewise, the built-in logic you have in place for escalating a message to the next most appropriate person cannot be carried out in the event the primary contact is unavailable. Overall, having backend communications systems that do not integrate means your process is rife with inefficiency and cause for serious concern.

3. An integrated messaging system is essential, especially when it comes to SMS

   One positive of most paging systems today is that they are integrated with contact center solutions such as operator consoles to facilitate code calls and other staff communications. When evaluating a move to smartphones and SMS, a system that ties in seamlessly to your existing or planned communications infrastructure is essential. Any messaging system that operates on a stand-alone basis and does not "talk" with related applications means that the process will become lengthened and more prone to errors that jeopardize patient safety. For today’s messaging systems to truly work in an environment where clinicians and other staff members
are highly mobile, you need to bring your contact center’s operator consoles, Web-based (or speech-based) employee directory, and on-call scheduling systems into harmony. A messaging system sitting in isolation is excess baggage for your IT team and hampers smooth information flow when it comes to effective staff communications using SMS.

4. The world of smartphones is heterogeneous – it’s impossible to just support one brand

Everyone has an opinion about which smartphone works best. Likewise, new smartphones are becoming available all the time, meaning the most popular one today may not be in vogue two years from now. Assuming your staff carries several brands of smartphones, the technology you put in place on the backend needs to be capable of supporting the diverse needs and devices of your user community. It also has to be able to accomplish this without causing extra strain on your IT staff. Additional IT considerations include the ability of smartphones to leverage wireless local-area networks (WLANs) down the road.

5. Smartphone applications should offer an improved audit trail

Intelligent smartphone applications are capable of providing an audit trail that includes a log of messages sent, received, and read. This is crucial to comply with Joint Commission requirements. These logs are a safety net to prove what happened and when—especially who was contacted. Unlike most pagers, smartphones also allow users to respond with their availability. Messages can be sent back that confirm a smartphone has received the message, the message has been read, and the message has been acknowledged by the recipient. All of this is captured in an audit trail to ensure accountability.

6. Redundancy and escalation are critical

There is no getting around the fact that messages sent in hospitals absolutely must reach their intended recipients instantaneously. A code STEMI message has to reach the right team members to minimize the door-to-balloon time for the patient. This means IT teams have to establish multiple paths to get messages through to recipients in the event that high communications traffic is straining bandwidth or coverage dead spots occur. Establishing redundant communication paths through overlapping access points helps ensure smartphone communications reach the right person. In addition to an attention to infrastructure, the ‘if, then’ business rules of your hospital should be incorporated so that messages are automatically escalated to the appropriate person if the initial contact cannot be reached on either a primary or secondary device.

Conclusion

Today’s smartphones are truly changing the way everyone communicates. They have made inroads into hospitals worldwide as the device of choice for many physicians, nurses, and administrators. Effective use of smartphones should simplify messaging not only for staff members, but also for the IT teams who support them.

Smartphones also offer benefits over pagers in the ways they can be extended in medical situations beyond person-to-person critical messaging. They can be used for workflow activities such as receiving lab results, initiating notifications, managing schedules, managing alarms from clinical and security systems, performing client-to-client messaging, and providing information look-ups. In the end, patient care and safety will be heightened by more efficient staff communications, and the staffs themselves will be more satisfied with their jobs. As you consider making the switch from pagers to smartphones, make sure you evaluate how your strategy encompasses each of these six items. This will help you create a rock-solid messaging foundation for your organization.

About the Author

Chris Heim is the President of Amcom Software and can be reached at cheim@amcomsoft.com. Under Heim’s leadership, Amcom has grown aggressively and quadrupled in size. Amcom Software’s unified communications technologies include solutions for contact centers, emergency management, mobile event notification, and messaging. The company’s products are used by leading organizations in healthcare, hospitality, education, business, and government.”

About Amcom Software

Amcom Software connects people to each other and to the data they need. This helps organizations save lives with communications that are faster, more accurate, and more efficient. Amcom Software’s unified communications technologies include solutions for contact centers, emergency management, mobile event notification, and messaging. The company’s products are used by leading organizations in healthcare, hospitality, education, business, and government. By continually developing its industry-leading technologies, Amcom Software has rapidly grown and solidified its market leadership.

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Mobile Phones in Hospital Settings: A Serious Threat to Infection Control Practices

Health professionals need to help raise awareness about the health risks of using an unclean cell phone

by Dr. Abhinav Singh and Dr. Bharathi Purohit

The global system for mobile telecommunication was established in 1982 in Europe with a view of providing an improved communications network. The first use of mobile phones in India was in 1995; today there are 287 million mobile phone users in India, which accounts for 85 percent of all telecommunication users. Today, mobile phones have become one of the most indispensable accessories of professional and social life. Although they are usually stored in bags or pockets, mobile phones are handled frequently and held close to the face.

Hospital-acquired infections affect more than 25 percent of admitted patients in developing countries. In U.S. hospitals, they cause 1.7 million infections per year and are associated with approximately 100,000 deaths. It is estimated that one third of these infections could be prevented by adhering to standard infection control guidelines.

Germ Prone

Increasing functionality and affordable prices for cell phones and smart phones have resulted in a global reliance on staying connected. Cell phones are now commonplace, whether it be the dinner table, the kitchen, a restaurant, the gym, or even the bathroom. These factors and the heat generated by cell phones contribute to harboring bacteria on the device at alarming levels. When we consider a cell phone’s daily contact with the face, mouth, ears, and hands, the dire health risks of using germ-infested mobile devices are obvious.

Unlike our hands, which are easily sterilized using hand sanitizers made available readily across all hospitals and medical facilities, our mobile phones are cumbersome to clean. And, we rarely make an effort to sanitize them. As a result, these devices carry a variety of bacteria. Cell phones are used often in hospitals by patients, visitors, and health care workers. Also, travelers who go to low-income countries where potable water and good sanitation are limited are exposed to the risk of contracting infections because these individuals carry phones, and the potential of such accessories to spread bacterial infection is not yet clear.

Bacterial Infections in Health Care Workers and Corporate Users

A study was conducted in Southern India to determine whether mobile phones of healthcare workers (HCWs) and corporate users harbor micro-organisms. Swabs collected from mobile phones were inoculated in solid and liquid media and incubated aerobically. Growth was identified as per standard microbiological procedures.

Antibiotic susceptibility was determined for Staphylococcus aureus. A questionnaire was used for data collection on awareness of mobile phone use. Of 51 HCWs and 36 corporate mobile phones sampled, only five (6 percent) showed no growth.

Pathogens isolated from HCW samples included S. aureus (methicillin-sensitive S. aureus, methicillin-resistant S. aureus), Escherichia coli, Klebsiella pneumoniae, and Pseudomonas aeruginosa. Coagulase-negative Staphylococci also were isolated. Among corporate isolates, 29 percent were pathogenic. Polymicrobial growth was detected in 71 percent of HCW mobile phones and 78 percent of corporate mobile phones. Only 12 percent of HCWs used disinfectants to wipe their mobile phones. Therefore, it was concluded that mobile phones serve as a ready surface for colonization of nosocomial agents, indicating the importance of hand hygiene to prevent cross-transmission.

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The first study of bacterial contamination of mobile phones was conducted in a teaching hospital in Turkey with a bed capacity of 200 and one intensive care unit. One-fifth of the cellular telephones examined in a study conducted in New York were found to harbor pathogenic microorganisms. Health care workers’ mobile phones provide a reservoir of bacteria known to cause nosocomial infections. UK National Health Service restrictions on the utilization of mobile phones within hospitals have been relaxed; however, utilization of these devices by inpatients and the risk of cross-contamination are currently unknown.

Demographics and characteristics of mobile phone utilization by inpatients and phone surface microbial contamination were examined by Brady et al. One hundred and two out of 145 (70.3 percent) inpatients who completed a questionnaire detailing their opinions and utilization of mobile phones also provided their mobile phones for bacteriological analysis and comparative bacteriological swabs from their nasal cavities; 92.4 percent of patients supported utilization of mobile phones by inpatients; indeed, 24.5 percent of patients stated that mobile phones were vital to their inpatient stay.

Patients in younger age categories were more likely to possess a mobile phone both inside and outside hospital (p < 0.01), but there was no gender association. Eighty-six out of 102 (84.3 percent) patients’ mobile phone swabs were positive for microbial contamination. Twelve phones (11.8 percent) grew bacteria known to cause nosocomial infection. Seven phone (6.9 percent) and 32 nasal swabs (31.4 percent) demonstrated Staphylococcus aureus contamination. MSSA/MRSA contamination of phones was associated with concomitant nasal colonization. Patient utilization of mobile phones in the clinical setting was popular and common.

A cross-sectional study was conducted in Turkey to determine bacterial colonization on the mobile phones used by patients, patients’ companions, visitors, and health care workers. Significantly higher rates of pathogens (39.6 percent versus 20.6 percent, respectively; P = .02) were found in mobile phones of patients’ (n = 48) versus the health care workers (n = 12). There also were more multidrug pathogens in the patients’ mobile phones, including methicillin-resistant Staphylococcus aureus, extended-spectrum β-lactamase-producing Escherichia coli, Klebsiella spp, high-level aminoglycoside-resistant Enterococcus spp, and carbapenem-resistant Acinetobacter baumannii. Findings suggest that mobile phones of patients, patients’ companions, and visitors represent higher risk for nosocomial pathogen colonization than those of HCWs. Specific infection control measures may be required for this threat.

In Nigeria, there has been an increase in the use of mobile phones among the general population, and the use of phones is common in certain areas of the environment where the percentage presence of bacteria is likely high, such as in hospitals, in animal slaughter areas, and in toilets. A study was conducted to determine whether mobile phones could play a role in the spread of bacterial pathogens and to prove possible control or preventive measures that could be instituted to avoid this likely vehicle of infection. In this study, 62 percent of 400 mobile phones from all of the study groups were found to be contaminated by bacterial agents.

Isolation of bacterial agents from electronic devices such as hand-held computers and personal digital assistants has shown these devices to be possible modes of transmission of nosocomial pathogens. In a study conducted in Queen Elizabeth Hospital in Barbados, West Indies, more than 40 percent of mobile phones of 266 medical staff and students were culture positive. Ulger, et al. reported that 94.5 percent of 200 health care workers and their mobile phones were contaminated with various microorganisms, including nosocomial pathogens, in a study conducted in New York and Israel.

Nosocomial infection is an important problem in all modern hospitals. As early as 1861, Semmelweis demonstrated that bacteria were transmitted to patients by the contaminated hands of health care workers. Hospital operating rooms and intensive care units are the workplaces that need the highest hygiene standards, both for the personnel working there and the equipment used by them. Rusin, et al. had documented both gram-positive and gram-negative bacteria in hand-to-mouth transfer during casual activities. This implies that mobile phones may serve as vehicles of transmission of diseases such as diarrhoea, pneumonia, boils, and abscesses. A study was conducted in Turkey to determine the contamination rate of health care workers’ mobile phones and hands in operating rooms and ICUs. These results showed that HCWs’ hands and their mobile phones were contaminated with various types of microorganisms.
Dental Clinics

A cross-sectional study was conducted in India to determine the level and type of bacterial contamination of the mobile phones of dental personnel involved in direct patient care and to determine the usefulness of cleaning with 70 percent isopropyl alcohol for decontamination. Dental faculty and trainees in an Indian dental school were asked to participate in a study in which a questionnaire was administered concerning patterns of mobile phone use and disinfection. Swabs from mobile phones of the participants were taken using moist sterile swabs and plated on blood agar plates. The bacteria isolated were identified by biochemical tests. Eighteen percent of the participants (n=9) reported using their phones while attending patients. Nearly 64 percent (n=32) used their mobiles for checking time, and 64 percent (n=42) reported never cleaning their phones. In total, 50 mobile phones were cultured for microorganisms: 98 percent (n=49) were culture-positive, and 34 percent (n=17) grew potentially pathogenic bacteria. There was significant reduction in the mean number of colony-forming units after decontamination with alcohol (p<0.001). The bacterial load was reduced by around 87 percent.

The results of this study show that mobile phones may act as an important source of nosocomial pathogens in the dental setting. Therefore, it is important for dental school administrators to encourage higher compliance with handwashing practices and routine surface disinfection through framing of strict protocols to reduce the chances of occurrence of nosocomial infections.16

Researchers conducted a pilot study to estimate the prevalence and type of microorganisms isolated from the mobile phones of 80 health care workers at a Thai hospital before and after alcohol cleansing. The surface of the phone’s keypad, mouthpiece, and earpiece was swabbed, and the phone was cleaned with a 70 percent alcohol pad. A second culture swab of the keypad, mouthpiece, and earpiece was obtained one minute later. The researchers reported that 38 participants (47.5 percent) had exposure to multidrug-resistant bacteria at enrollment in the study, and there was an average of two cases per house staff with multidrug-resistant bacteria. Three mobile phones (3.8 percent) had cultures positive for Acinetobacter spp. before alcohol cleaning. After alcohol cleansing, no microorganisms were detected. Overall hand hygiene compliance was 39 percent before touching a patient, 29.4 percent before a clean/aseptic procedure, and 47.5 percent after touching a patient’s surrounding.

Although previous reports identified health care workers’ mobile phones as a reservoir for various multidrug-resistant bacteria, none had shown that alcohol cleansing can reduce the detection of bacteria on mobile phones.17

Creating a Policy

What we need is a sound and feasible policy with respect to mobile phone usage in hospital settings. Today mobile phones are important devices for both the professional and social lives of their users. However, restrictions on the use of mobile phones in certain areas of the environment where the percentage of bacteria present is likely high (such as in hospitals, dental clinics, lecture theatres, canteens, business centers, toilets, and other such places) are difficult and thus not a practical solution.

Users of mobile phone hence need to be advised to use antibacterial wipes to make their mobile phones germ free at all times. Also advocated is strict adherence to infection control and precautions such as hand washing and good hygienic practice among the users of mobile phones, to prevent the possibility of phones as vehicles of transmission of both hospital and community-acquired bacterial diseases.

Conclusion

Health professionals, from microbiologists, epidemiologists, doctors, and dentists to behavioral scientists and occupational health and safety consultants, need to take note of how and where we are using our cell phones, draft new guidelines and prevention tips, and help raise awareness about the health risks of using an unclean cell phone. However, we recommend that patients and doctors be educated by clear guidelines and advised on inpatient mobile phone etiquette, regular cleaning of phones, hand hygiene, and advised not to share phones or related equipment with other inpatients in order to prevent transmission of bacteria.

Cell phones are now an extension of a person’s lifestyle, accompanying them everywhere. Everyone should clean their cell phones -- but especially doctors, dentists, and nurses, whose hygiene impacts patients’ well-being.

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“But in the world nothing can be said to be certain except death and taxes.”

Benjamin Franklin may need to amend his famous quotation to include the certainty of reimbursement uncertainty for health-care providers. Considering the size and scope of Medicaid and Medicare, the threat of reimbursement-rate cuts for these programs can be particularly problematic for hospitals as they seek financial stability and plan for future capital projects.

What’s Happening?

States still face a long and rocky recovery as 30 states have projected budget shortfalls totaling $49 billion for the next fiscal year, according to the Center on Budget and Policy Priorities. Medicaid is a large component of a state’s expenditures—averaging 13% of state budgets nationwide—and it’s becoming even larger. Standard & Poor’s Healthcare Economic Composite Index indicates that the average per capita cost of health-care services covered by Medicaid rose 5.28% in 2011. As a result, Medicaid is a common target for states’ budget balancing efforts, leaving many hospitals with an uncertain future.

Medicare reimbursement rates are susceptible to cuts as well. In March, Congressmen Paul Ryan’s budget passed by the U.S. House of Representatives proposes to cut Medicare spending by $205 billion in part by privatizing the system. Although this budget will likely be rejected by the Senate, it at least evidences that Medicare cuts are part of the budget-balancing discussion.

Hospitals are often getting pulled in both directions. Even as reimbursement rates are being cut, Medicaid is becoming more prevalent as a payor source. The Medicaid expansion mandated by the Patient Protection and Affordable Care Act, commonly called the Affordable Care Act (ACA), is scheduled to take effect Jan. 1, 2014 and is projected to move an additional 16 million people to Medicaid. Although this increased coverage will “federalize Medicaid,” meaning the federal government will bear a majority of the extra costs, the Congressional Budget Office projects that states will still see a 2.8% increase in Medicaid cost due to the expanded enrollment.

Legal challenges are fueling the ambiguity. Several lawsuits have been filed in an attempt to block, or at least delay, scheduled cuts to Medicaid reimbursement. In late February, the U.S. Supreme Court decided to forego a ruling on a lengthy legal battle between California and health-care providers protesting cuts in Medicaid reimbursement rates. A similar federal lawsuit filed by the Arizona Hospital and Healthcare Association in an attempt to block a 5% cut in Medicaid hospital payment was recently dropped. A decision by the Supreme Court on the ACA’s constitutionality is expected this summer.

The Pursuit of Financing

Despite the doubt regarding the future of these two major payor sources, many hospitals do not have the luxury of delaying needed capital projects. When pursuing financing for these capital projects, there are steps that providers can take to mitigate the risk of Medicare and Medicaid reimbursement rate cuts. Additionally, lenders are not ignorant to the risk of potential cuts, so being able to articulate a plan for possible Medicaid cuts will improve the chances of obtaining financing.

First, any lender or government agency providing credit enhancement wants to be convinced that hospital management has a grasp on the state and national legislative landscape. Hospital leadership should be able to discuss how the hospital has been impacted by past changes to the law and what future changes are currently being discussed. Government agencies or investors working with hospitals across the country may not be knowledgeable of the reimbursement outlook for a specific market or state, so they will be looking to the hospital to provide this information. Demonstrating that the hospital has a pulse on the developments impacting reimbursement and has been able to navigate reimbursement changes in the past is a key indicator of the strength of the management team when assessing a hospital’s credit worthiness.

While the traditional underwriting metrics of financial performance, market-population analysis, and local reputation still exist and will need to be examined, lenders and agencies will also expect a sensitivity analysis detailing the impact of possible Medicare or Medicaid rate cuts. If a feasibility study is being completed in conjunction with the proposed
financing, it will likely include an examination of sensitivity relative to admission declines, interest rate increases and other major variables. Assuming a project has a Medicaid or Medicare census, a separate sensitivity analysis should be completed detailing the impact of various percentage cuts for reimbursement rates. The results may be surprising. According to Fitch’s sensitivity analysis of all the hospitals it rates, each percentage point cut in Medicare reimbursement rates reduces operating margin by 40 basis points on average.

As with all potential underwriting risks, an obvious mitigation to the risk of reduced reimbursement rates is to decrease the project size and resulting funding request. Project size is often the first topic of discussion with potential investors and agencies. Project costs are commonly compared to benchmarks based on per-square-foot construction costs or to similar hospitals that recently have been constructed. Considering their qualms with the health-care industry, investors have reduced the targeted leverage points and are now seeking lower loan-to-value ratios. Therefore, an organization should expect construction costs to be heavily scrutinized, especially with reimbursement-rate cuts looming on the horizon, when pursuing financing.

The Pursuit of Consistency

Lenders and agencies will likely ask to review a hospital’s strategic plan to ensure there is a response for industry changes, including reimbursement cuts. A plan that successfully addresses the risk of reimbursement cuts should largely focus on expense-control tactics that a hospital may employ. Be aware that, when compared to the actual financial performance of a hospital’s completed financing, expense projections often are understated in the feasibility study while revenue and cash projections are mostly accurate.

Ross Manson, principal at Eide Bailly, a CPA firm dedicated to audit and consulting services, has observed this trend during his 17 years of working with hospital management teams. According to Ross, a hospital needs to make a concerted effort to keep a sharp eye on expenses post-financing even though its balance sheet may be flush with cash.

“When a hospital is pursuing financing for a planned capital project, expenses are often carefully scrutinized by several parties whether it is the hospital’s board of directors, a rating agency or potential lenders and investors,” Manson said. “The true test for hospital management is to maintain the same expense discipline in the post-closing years when there is not quite as much third-party oversight.”

While a hospital’s revenue base is at the mercy of many external factors, including the local economy, legislative changes and the patient base, a hospital has more direct control over expenses. If it has a plan in place to continue monitoring expenses on an ongoing basis, the hospital can mitigate one of the few variables that can be controlled. This allows room for more fluctuations in the other assumptions contained in a feasibility study, including reimbursement rates.

This is indeed a challenging time for health-care organizations; however, by focusing on a few select items that can be directly controlled, a hospital may better prepare to brave the storm of reimbursement rate cuts. Understanding the political landscape, performing a sensitivity analysis, sizing the project appropriately and exhibiting expense discipline will lead to a higher rate of success when pursuing financing. In a world of uncertainties, the key is to focus on what is certain.

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### Meet A New Member!

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Compliance Challenges for Today, Tomorrow and Beyond: Staying Ahead While Implementing Reform
NJ HFMA CARE Forum Meeting
March 13, 2012

By Michael P. McKeever, CPA, CHRC

Every year as we plan the March NJ HFMA Compliance, Audit, Risk and Ethics (CARE) Forum Meeting with our counterparts at NJHIMA the one unspoken concern is the weather, which can be unpredictable during that time of the year and which can adversely affect the turnout for the meeting. But since this was the winter that wasn’t, we really hadn’t have worried. The meeting on March 13 drew close to 200 participants, including for the first time in anyone’s memory a group of college students, who along with their instructor came to learn what’s new in healthcare compliance. The program, which was titled Compliance Challenges for Today, Tomorrow and Beyond: Staying Ahead While Implementing Reform, was well received by the audience, based on the feedback received. And for the first time, in response to requests from members, the Chapter has applied to the New Jersey Board on Continuing Legal Education to grant Continuing Legal Education (CLE) credits for the day’s sessions. We are currently awaiting a response from the Board.

Morning Sessions – Hot Topics in Compliance

The morning started off with the New Jersey Hospital Association’s Regulatory Update, which was followed by the first session titled Hot Topics in Compliance, during which Kelly Sauders from Deloitte & Touche and Bret Bissey from UMD-NJ focused on current government initiatives that compliance professionals deal with on a daily basis. Of interest was the fact that the government’s return on investment for compliance activities has been increasing, as more and larger settlements continue to justify the resources applied to healthcare investigations. It is anticipated that the RAC program overpayment collections will for 2012 will approach $1.6 billion, which is double the $800 million collected during 2011. They talked about recently enhanced government activities, such as data mining of provider information, which is also beginning to occur at the state level. Another initiative discussed was the OIG’s compliance reviews, which include an onsite audit of claims that could last from six to eight weeks. A copy of the questionnaire used by the OIG as an element of these reviews was made available online to participants. And they reported that a stronger linkage is being formed with the state Medicaid agencies, as they are beginning to share more information with CMS and a separate Medicaid RAC program is underway. Increased focus on medical necessity was discussed, along with the reports of a recent settlement related to the inappropriate admission of patients for gamma knife treatments. Kelly and Bret left the audience with the knowledge that the government is expecting providers to self police their own practices, as well as the importance of establishing a culture of compliance if you are to weather the increased enforcement activity through the constantly changing healthcare environment.

Cyber Insurance: Should It Be Part of Your Risk Program?

The next session focused on the emerging risks to providers from the loss of information used in providing care to our clients. Tony Consoli and Damian Caracciolo from CBIZ Insurance Services explained that while data loss can come from malicious means, such as hacking or theft of a computer, or non-malicious circumstances, such as accidental disclosure or a computer glitch, the end result is the same and must be ameliorated. Additional risks to data security can come from cloud computing and increased sharing of information with vendors and business partners. They reported on the results of various studies that show the extent of the problem as well as the numerous ways an entity can lose valuable information about their clients. One of these studies found that 69% of data breeches were not discovered by the entity itself, and that 87% of these breeches could have been avoided through
reasonable processes and controls. Common problems seem to be an overreliance on Intrusion Detection Software (IDS), insufficient management of system patches, and not using encryption on devices that contain sensitive data. In response to these risks, they suggested a proactive process, which included raising awareness throughout the organization, talking to IT staff about data security, assessing and testing potential vulnerabilities and preparing for the possibility of having a data breach that will be reportable under the HITECH Act. The various federal regulations related to data security were discussed, including HIPAA, HITECH and the Red Flag Rules. Currently 48 of the states require some form of notification when there is unauthorized access to customer information, which compounds the problems resulting from a large scale breach. Finally, the presenters explained the financial costs of a reportable breach, and what to look for if you decide to purchase cyber insurance coverage for your entity.

Health Information Exchanges
The next speaker was Colleen Woods, the New Jersey Health IT Coordinator who works for the Governor’s Office and who reported on the status of Health Information Exchanges in the state. Colleen spoke of the important role that information technology will play in the transformation of the healthcare delivery system. She gave examples from studies that showed improvement in the delivery of care when electronic health records (EHR’s) are used. Currently healthcare is 12 years behind other industries in the adoption of information technology. Between 60% and 70% of all New Jersey providers’ records are still paper based, and the primary methods for exchanging clinical information are the telephone and fax. The status of the various initiatives to establish Health Information Exchanges throughout the state was provided, along with information on the percentage of physician practices by state that were planning to apply for Meaningful Use Incentives, which are payments from CMS for the implementation of EHR’s. New Jersey is below the national average in this category. Examples of the uses of EHR’s were discussed, including improved medication administration, immediate availability of public health information such as immunization records, and the timely reporting of diagnostic information. Statistics and survey results on the use of EHR’s by New Jersey providers were reported, as well as the amount of incentive payments received to date. Colleen also shared the New Jersey HIT’s areas of focus as we move towards a fully integrated health information network.

Afternoon Sessions – Compliance’s Role in the Changing Healthcare Landscape
After lunch there was a panel discussion focusing on compliance’s role in the coming changes to our healthcare delivery system, such as the development of Accountable Care Organizations (ACO’s), new physician practice alignment strategies, joint ventures and the co-management of service lines. The panelists were Gary Herschman, an attorney from Sills Cummins & Gross, P.C., Tom Flynn, Chief Compliance Officer, Hackensack University Medical Center, Frank Goldstein, Vice President for Physician Services, Meridian Health and Lloyd F. George, CPA. Gary began the discussion with a discussion of the operational aspects of an ACO. The types of individuals and entities that can form an ACO were reviewed, as well as the requirements to notify beneficiaries and to post public notice of the formation. The arrangement must be for 3 years, and CMS can terminate the arrangement for cause, but only after a specified administrative process. Examples of the shared savings calculations under both an at-risk and no risk model were presented. ACO’s must meet 33 quality measures to qualify for the shared savings. The ACO must be a legal entity under applicable law, and must include in its governance at least one beneficiary who is independent of the other trustees and the entity itself. The ACO must have a conflict of interest process, as well as a Compliance Officer, who cannot by regulation also be legal counsel. The regulations allow for waivers from the Anti-Kickback and Stark requirements. Various methods of distributing the savings were also explained.

The discussion then turned to the various hospital/physician alignment models that are being utilized. Although there are various hybrids, six basic models were described in detail: the outright acquisition of a physician practice by a hospital; employment of the physicians and leasing of other assets and staff; employment of the physicians, purchase of the ancillary services and the leasing of other assets and staff; the purchase of ancillary services and the employment of a physician as Medical Director; the purchase of ancillary services and the leasing of all other assets and staff, including the physicians under personal service agreements; and leasing of all assets and staff. Other strategies, such as joint ventures and the co-management of service lines were also discussed. A rule of thumb is that the higher the level of integration, the more likely the relationship will be viewed as a legitimate business arrangement. Also, employment models lower the risk related to Stark and Anti-Kickback regulations. But in all these arrangements, the transactions should be at fair market value.

Lloyd then presented an overview of the valuation process. He explained the two premises under which a valuation could be performed, which are going concern and liquidation, as well as the standards of value, which are fair value, investor value and fair market value. The relationship of fair market value to the Stark and Anti-Kickback regulations was explained and a working definition of fair market value was provided. The three valuation approaches, market, cost and
the income approach, were described in detail. Finally, some pitfalls to consider when establishing the fair market value of a transaction were explained. The panelists then had a lively discussion of compliance's role in the various delivery models being implemented and envisioned.

**Using Analytics for Improving Your Compliance Program**

Next Barbara Piascik and Greg Krantz from MedAnalyt-ics spoke about the use of data analysis to improve the performance of compliance programs. They explained current industry trends and how payers are using provider data to identify areas of non-compliance. Providers need an improved understanding of their own data, in order to proactively respond to coding and billing anomalies. The difference between reporting, which shows what happened, how often, when it happened and the financial impact of the problem, and analytics, which helps prioritize issues, identifies the root cause and responsible party, and helps frame a response was explained. They then explained the steps necessary to implement a program of data analytics, which include an inventory of current systems and reports and the creation of a team of stakeholders who can determine the uses of the data and what metrics should be measured. Emphasized was the need to establish analytics as the source of information across the entity, which they aptly named the “Single Source of Truth”. Certain operational issues were discussed, including the potential for analyzing too much information, how often certain elements need to be measured, who will be receiving the information, is there time for sufficient review of the data before it is disseminated, and will the information be useful to promote appropriate action. The speakers then lead the audience through the process by which data analytics can assess the risk of billing and coding errors. Examples of dashboards showing financial, operational and compliance information were presented. In concluding, the speakers reminded the participants of the importance of keeping up with industry trends, the potential costs of non-compliance, and the importance of having in-sight into their own data.

**Compliance as Help Desk**

The final session of the day, titled “Compliance as Help Desk, True Tales from NJ Hospital Compliance Officers”, was hopefully as much fun for the audience as it was for the presenters. Michael McKeever from UMDNJ acted as host, with Lisa Hartman from Princeton Healthcare System, Angela Melillo from Saint Peters University Hospital and Darlene Mitchell from Hunterdon Healthcare System as the panel of healthcare compliance experts. Prior to the session, members of the CARE Forum were asked to submit their strangest and most troublesome compliance issues for discussion by the panel. Anonymity was assured, and if there were funny issues they were willing to share all the better. Interspersed between discussions about HIPAA, sexual harassment and billing issues were calls received by a Compliance Officer complaining that the entity’s sprinklers were watering the sidewalk instead of the grass and the food was better in one cafeteria than in the other. Under the heading of all other duties as required, one Compliance Officer reported receiving a call when the heat wasn’t working, while another received a complaint about the operation of an ATM that was in the lobby. And then there was the caller who thought that the deduction on their pay stub for FIT went to pay for the employee fitness center, not realizing that it was their federal income tax deduction. And one Compliance Officer reported receiving a call from someone looking for the Complaint Department, which is easily understood, as Compliance often receives calls that no one else knows how to answer. One member reported receiving a call that there were pigeons trapped between a fence and an air conditioning unit. And yes, thanks to the Compliance Officer, those pigeons were freed without harm. And of course Compliance Officers often receive calls about legal and human resources issues, as well as quality of care concerns. But the final issue included in the presentation was this author’s personal favorite. The caller complained that the garbage truck emptied the dumpster during the employee’s shift change and it smelled bad.

**Summary**

Based on feedback the March Meeting surpassed the participants’ expectations. The sessions included up to date compliance and operational information that brought added value to both compliance professionals and other interested parties. The day’s event was planned by a committee that consisted of Angela Melillo, BJ Welsh, Dara Quinn, Darlene Mitchell, Lisa Hartman, Michael McKeever, Nadinia Davis and Tom Flynn, all members of the CARE Forum, and Ellen Shakespeare and Mary Sottile from NJHIMA. Their hard work and dedication was essential to the successful program presented that day.

**About the Author**

Michael McKeever is currently the Director, Compliance Special Projects, Audit and Process Improvement at UMDNJ. He has over 25 years experience in healthcare compliance, audit and finance in acute care hospitals, long term care settings, ambulatory surgery centers, physician practices and recently in a health sciences university. He was intricately involved in the nation’s first Voluntary Disclosure to the Office of Inspector General of the Department of Health and Human Services, as well as a successful Advisory Opinion Request. A graduate of Rider College, he is a member of the AICPA, NJSCPA, HFMA and HCCA. He is a Certified Public Accountant, and is also certified in Healthcare Research Compliance. Mike can be reached at mckeevmp@umdnj.edu.
Early Summer 2012

Strategic Plan For Service Quality And Growth
June 2012 – 2017

EXECUTIVE SUMMARY
The HFMA New Jersey Chapter has developed a strategic plan for program years 2012-2017 providing the following:

Long Term (Five Years)
• Consistently provide excellent member service as measured by the Member Satisfaction Survey, Chapter Balanced Score Card, DCMS, and ultimately repeat as a recipient of the Robert M. Shelton award for sustained excellence in member service.
• Incorporate the Chapter Balanced Scorecard into the Strategic Plan.
• Promote certification as a means to enhance career opportunities.
• Promote the value of HFMA membership to current members, employers and prospective members.
• Respond in a proactive nature, to new and proposed state and federal regulatory issues.
• Promote transparency within the Chapter leadership structure that results in a culture of accessibility between Chapter leadership and the membership.

Mid Term (2-3 Years)
• Update the Chapter Marketing Plan to continue to build the membership base, retain existing members and expand the reach of the Chapter, further promoting the value of HFMA membership to individuals and employers.
• Modify the annual Chapter Planning Meeting placing a greater emphasis on the Strategic Plan and the identification and development of Chapter goals which directly benefit the membership, and ensuring their successful implementation during the year.
• Enhance the appearance and content of the Chapter’s Garden State FOCUS news magazine, while exploring electronic, social, and mobile media vehicles.
• Promote the member recognition program in order to show value to our membership
• Promote increased utilization of the Chapter website by making members aware of the content on the website and increasing the efficiency of content available through reduction of “clicks”.

Short Term (Current Chapter Year)
• Continue the Leadership Training Retreat for Committee Chairs and Board members with an increased emphasis on planning.
• Engage active feedback from the Chapter’s membership in developing strong in-depth educational programs on timely topics.
• Evaluate educational programs targeted to payer and non-hospital membership in the Chapter.
• Evaluate the educational sessions offered to the membership and attract wider participation.
• Explore mechanisms to make the content on the Chapter website easy to access and use.
• Create transparency in the nominating process through alternative methods for elections and nominations.
• Promote HFMA’s 2012-2013 theme “Leadership Matters”.

CHAPTER MISSION
To provide members with opportunities for professional growth through sound educational programs, information sharing among peers, certification and networking, while influencing healthcare legislation, operational practices, and accounting policies, in conjunction with establishing and promoting the highest standard of professional and ethical conduct.

CHAPTER VISION
To be an indispensable resource for healthcare finance professionals in the state of New Jersey and to provide educational and networking opportunities to individuals and organizations that seek to attain excellence in healthcare financial management.

CHAPTER VALUES
The New Jersey Chapter is guided by the following values:
• Service to the membership is the highest priority.
• Excellence is the standard for all that is done.
• Teamwork is essential to the success of the Chapter.
• Creativity and innovation are to be encouraged.
• The Chapter will act in a financially responsible manner.
• Respect and dignity will define how individuals are treated.
• Active Member participation and volunteerism will be encouraged and supported.
• Contributions will be recognized for all levels of service.
• Encouragement for continued education and member certification.

PLANNING AND DATA GATHERING PROCESS
• Perform program content and speaker evaluations from all educational sessions, including quarterly Chapter meetings, educational sessions and the Chapter’s Annual Institute.
• Reviewed results of Annual Member Satisfaction Survey performed by National for CY 2011 & CY 201.
• The Strategic planning committee, comprised of the officers to the board, advisory council and chairs of Education, Membership, and Institute Committees, met in January, to begin the process of planning, as well as identifying opportunities for the up-coming 2013 Chapter year.

• Performed a Chapter wide SWOT analysis, facilitated by the Chapter Advancement Team, on April 19, 2012 (Chapter Mini-LTC).

• Requested and incorporated input from the Chapter Board of Directors, Advisory committee, Education, Membership, and Institute Committee Chairs with regard to revisions to the Strategic Plan and Chapter goals for the coming year.

• Completed a 2012-2013 planning meeting with all Board members and Committee Chairs on April 20, 2012, resulting in short and long term goals and a CY 2013 action plan.

EXTERNAL ASSESSMENT

The New Jersey Chapter solicits member’s input through a variety of mechanisms on a regular basis at various times during the year. Program assessments are conducted at all educational sessions and at the Annual Institute. An overall Chapter survey is sent to 100% of the membership annually. A survey specific to Chapter committee chairs is also completed semi-annually. The information gained from these and other sources is utilized in developing the Chapter’s Strategic Plan. The current external assessment for the New Jersey Chapter includes the following observations with regard to the healthcare industry in New Jersey:

• Consolidation – The creation of multi-hospital systems has resulted in fewer jobs and a reduction in membership from traditional sources, attributable to hospital closures and bankruptcies, and also may introduce out-of-area executives which may have differing views of HFMA through experience at other Chapters.

• Expense Reductions – Pressures to reduce provider costs has resulted in the reduction of available provider dollars that are dedicated to education and professional development.

• Economy – The economic downturn that began in 2008 continues to impact the New Jersey healthcare market in the form of hospital closures and bankruptcies. Correspondingly, this has led to an increase in the number of unemployed and uninsured populations further impacting healthcare facilities and staff. It is anticipated that this will affect the Chapter’s ability to attract and retain members as well as efforts to engage members in volunteer roles and their ability to participate in educational opportunities.

• Limited Flexible Time – The reduction in staffing has increased the workload for industry professionals, affecting both attendance at Chapter sponsored events and their ability to volunteer to serve the Chapter.

• Competition with other Education Programs – There are many other professional and commercial organizations that attract our members with educational programs that compete with similar programs sponsored by the Chapter.

• Legislative Changes & State Budget – The political and financial climate in the state of New Jersey results in additional pressures on healthcare providers and associated financial and clinical professionals. The New Jersey Hospital Association actively participates at the HFMA, NJ Chapter Board level, and informs the entire membership on current and critical issues affecting the healthcare environment.

• Free Standing Competition – Recent increases in this segment of the market has added pressure to the hospital providers. Hospitals are feeling the impact of the shift to non-hospital, free standing centers to their volumes and “bottom lines.

• Affordable Care Act – As providers comply with PPACA and other elements of health care reform, new delivery systems and financing mechanisms are being developed resulting in organizations that look and function in a markedly different way from Organizations in the recent past. The Chapter must be ready and willing to respond to the needs of those organizations and the individuals within them or risk losing them to other competing organizations.

INTERNAL ASSESSMENT

In October 2011, HFMA National sent out a survey to a sample of 950 Chapter members. The response rate was 16%. On April 19, 2012, a Chapter Advancement Team facilitated SWOT analysis was performed. The following is a summary of the responses:

STRENGTHS

• Chapter Meetings and Educational Programs – 95% of the respondents indicated that they were satisfied or very satisfied with the quality of the speakers and programs sponsored by the Chapter.

• Networking – The Chapter provides numerous networking functions throughout the year. The Chapter survey indicates that the members are pleased with the level of networking opportunities.

• Financial Stability – The strength of our financial position affords us the ability to subsidize high quality programs and networking events. It also provides us with the opportunity to support our membership by offering scholarships for higher education to member dependents.

• Member Recognition – The strength of our Chapter is in the dedication and participation of our volunteers. We will continue to implement and enhance the level of

continued on page 24
continued from page 23

member recognition since we must rely on the continued active involvement of the membership.

• **Diversity in Leadership** – The Chapter will continue to have two, Associate Board members who will sit on the Board of Directors and participate in a non-voting position. This program began in the 2006/07 Chapter year. The present board constitution is representative of our membership, with representation from PFS, Compliance, Managed Care, Reimbursement, General Finance/Accounting, Senior Financial Executives, Payors, and Vendors. This diversity is a strength for our Chapter and a major contributor to our success.

• **Website (www.hfmanj.org)** – The website continues to be developed as an additional means of communication, and a valued resource for upcoming events. The Job Bank, which includes a listing of current employment opportunities for our members throughout our catchment area, is the most highly utilized page on the site.

**WEAKNESSES**

• Lack of Active Participation from Senior Financial Executives (SFE) As financial pressures increase in the industry, the SFEs find it increasingly difficult to actively participate and have asked for programs specifically geared to their needs. Program attendance is largely comprised of the technical and mid level financial management staff and vendors. The Chapter must endeavor to show value to these individuals in order to ensure continued participation from their subordinates and to support the value provided to our sponsors.

• **Policies and Procedures** – The Chapter continues to develop and revise policies and procedures. Existing policies and procedures will be reviewed annually, with new policies added, as necessary, to provide improved structure and guidance to the organization and its leaders. HFMA’s nature as a volunteer organization makes knowledge transfer to new leaders difficult. Documented policies that are easily accessible, and explained on a regular basis to the volunteer leadership team are critical to the operation of the Chapter.

• **Committee Involvement/Succession Planning** – With expanding professional and personal commitments, it has become increasingly difficult to secure active committee members and chairpersons. Although, many members sign up for committee membership, meeting participation is low even with the increased flexibility of being able to participate via conference lines. This impacts the ability to cultivate future Chapter leaders. While the Chapter has experienced success through the advent of the associate board member position, new methods for engaging membership must be explored to ensure continued Chapter success.

• **Communication and Website (www.hfmanj.org)** – Both a strength and a weakness, our website must be a continued focus of our strategic plan. As technologies change and new communication vehicles such as social media sites and mobile applications become part of the main stream, the Chapter must continue to reevaluate our methods of communicating with the membership.

• **Provider Attendance at Chapter’s Educational Sessions** – The attendance at all educational meetings is in need of greater provider participation. While the Chapter recognizes the contribution of its vendor members, the input and expertise of the provider community is integral to our mission. The location of Chapter Programs was identified in the membership survey as a concern with no specific recommendation. Each year, during the planning of education sessions, consideration of other locations will be explored. Programs for engaging providers will also be explored and developed, with emphasis on emerging Healthcare Finance positions resulting from the Affordable Care Act. The Chapter will explore the possibility of increasing attendance by offering educational credits that will be accepted by other organizations (AAPC, NJ Continuing Legal Education, etc.).

**CHAPTER GOALS AND OBJECTIVES**

**Goals for Service to Members**

• Continue and expand upon current caliber of educational programs and collaborative educational efforts with other organizations such as AHENJ, AAHAM, MGMA, HIMS, NJHA, HCCA, HMMS-NJ and other other HFMA Chapters.

• Expand Senior Financial Executive involvement in Chapter Programs. Explore creation of SFE “Champion” positions within the Chapter.

• Experiment with different pricing schemes, meeting structures, meeting locations and meeting content to determine what is most attractive and beneficial to the membership.

• Seek and receive input from the Chapter’s membership on educational topics via surveys.

• Continue an ongoing recognition program for certified members, Chapter Chairs and members/committees who volunteer above and beyond.

• Update the Chapter certification coaching courses for members interested in certification while ensuring that the value of certification is promoted to the membership.

• Expand upon the networking opportunities offered to the membership.

• Promote members to “Make Connections” through their volunteer efforts within and outside of HFMA.

**Goals for Education**

• Review national programming, national CAT best practice educational projects and Chapter leader topic surveys for use within the Chapter.

• Develop a leadership orientation program, separate from the annual leadership retreat. This will allow for focused
training of volunteers while providing significant time for the development of the short term strategic plan at the Chapter retreat.

- Provide more educational sessions geared towards State and Federal regulatory changes.
- Provide more education programs early in the Chapter year so as to reduce the pressure on volunteers in the last quarter of the year.
- Expand the variety of locations for educational sessions throughout the state, exploring new technologies that could allow for satellite locations and remote attendance.
- Achieve the Gold award for education.
- Achieve the Hotm award for education improvement.

Goals for Quality of Service

- Update and regularly maintain Web site calendar for educational and social events.
- Improve upon committee structure and succession planning to ensure that the Chapter is being proactive and adequately addressing the various needs of the membership.
- Continue to publish the Garden State ‘FOCUS’ news magazine while exploring new media vehicles for educating members.
- Improve upon the Chapter member survey process and create avenues to improve feedback by alerting the membership of the survey timing and its importance to the Chapter’s continued improvement.
- Under the guidance of the sponsorship committee, identify innovative ways for driving value to our sponsors.
- Explore the creation of a physician practice financial management committee serving those financial managers working with and for newly formed healthcare delivery structures, physician practices, etc.

Goals for Chapter Growth

- Follow-up with all non-members who attend any Chapter program/event to encourage them to become HFMA members.
- Engage all members expressing an interest in volunteering within the Chapter to take on a roll within our committees.
- Continue discussions with vendors and reciprocating organizations to provide hotlinks to HFMANJ.org and HFMA National website from their website.
- Reach out to area colleges and universities to encourage faculty and students to become members.
- Encourage existing members to participate in the National ‘Member-Get-a-Member’ campaign.
- Increase membership via educational sessions whereby the cost of the program will be applied to the HFMA membership.
- Through “new member” breakfast/lunch during full day meetings, recruit individuals for participation on committees.
- Encourage registrants for the Chapter Annual Institute to commit to volunteerism.

<table>
<thead>
<tr>
<th>Action Item</th>
<th>Responsible Party</th>
<th>Initial Report Due to the Board</th>
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</thead>
<tbody>
<tr>
<td>Identify methods for nomination and election within other Chapters</td>
<td>John Brault</td>
<td>April 2012</td>
</tr>
<tr>
<td>Develop 12 Month Rolling Education Calendar</td>
<td>Heather Weber/Mike McKeever</td>
<td>June 2012</td>
</tr>
<tr>
<td>Update Marketing Plan</td>
<td>Maria Facciponte/Tracy Dicanto</td>
<td>June 2012</td>
</tr>
<tr>
<td>Review Effectiveness and Purpose of weekly PULSE communications</td>
<td>Elizabeth Litten/Al Rotcamp/David Wiesell</td>
<td>June 2012</td>
</tr>
<tr>
<td>New Member Identification</td>
<td>Kevin Margolis</td>
<td>July 2012</td>
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<tr>
<td>Create a Board Meeting recap to be published in the FOCUS and PULSE</td>
<td>Heather Weber</td>
<td>July 2012</td>
</tr>
<tr>
<td>Develop a more transparent process for nomination and elections</td>
<td>John Brault/Michael Alwell</td>
<td>July 2012</td>
</tr>
<tr>
<td>Create webinar process</td>
<td>Brian Herdman/Tony Consoli</td>
<td>July 2012</td>
</tr>
<tr>
<td>Solicit Testimonials from Committee Membership</td>
<td>All Committee Chairs</td>
<td>July 2012</td>
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<tr>
<td>Volunteer Recruitment Plan</td>
<td>All Committee Chairs</td>
<td>July 2012</td>
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<tr>
<td>Physician Practice Committee Development Task Force</td>
<td>John Brault</td>
<td>July 2012</td>
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<tr>
<td>Mentorship Program</td>
<td>Tim Bialek</td>
<td>August 2012</td>
</tr>
<tr>
<td>Identify viable options for publishing the FOCUS (ie. HTML, Kindle, Mobile App)</td>
<td>Al Rotcamp/Elizabeth Litten/Laura Hess</td>
<td>August 2012</td>
</tr>
<tr>
<td>Chapter-Wide Volunteer Recruitment Program</td>
<td>Nominating Committee</td>
<td>August 2012</td>
</tr>
<tr>
<td>Student Member Recruitment Program</td>
<td>Tim Bialek</td>
<td>August 2012</td>
</tr>
<tr>
<td>CFO Outreach</td>
<td>Joe Dobosh/Stella Visaggio</td>
<td>September 2012</td>
</tr>
<tr>
<td>Identify opportunities for redesigning the Chapter website</td>
<td>Tony Consoli/Laura Hess</td>
<td>November 2012</td>
</tr>
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</table>
•Certification Corner•

For those individuals who are considering taking CHFP exam, you should be aware that the NJ Chapter of HFMA is fully supportive of your efforts. Beyond professional recognition, the NJ Chapter offers the following benefits to its certified members:

• Name badge ribbons at all meetings and events noting “CHFP” or “FHFMA”.
• Reduced registration (25% discount) rate at all Chapter functions with the exception of all golf outings, the New Jersey Annual Institute, and social events.
• Recognition at quarterly meetings
• A complimentary Day Pass to the NJ Annual Institute
• Presentation of certification pins at the New Jersey Institute.
• Publication of the accomplishment in FOCUS

Congratulations to the NJ Chapter’s newest fellow: Michael J. McLafferty, FHFMA

Becoming a Fellow of HFMA requires tremendous dedication to HFMA and the healthcare finance industry and includes:

• Publication of the accomplishment in FOCUS
• Being a CHFP and maintaining the designation through ongoing participation in professional development activities,
• Being a regular or advanced member in HFMA for at least five years,
• Completing 120 college credits, and
• Volunteering in healthcare finance

Questions on becoming a CHFP? Visit the certification page on hfmanj.org or contact Eric Fishbein at 860-674-0717 or efishbein@presscott.com
Has the Medicare Cost Report Become Relevant Again?

by Scott Besler

In the present environment, as hospitals compete for business, whether it is for patients or physicians or third party payors, the Medicare Cost Report is becoming a useful benchmark for senior leadership.

Medicare Cost Report Defined

Providers that participate in the Medicare program must submit an annual Medicare Cost Report (MCR) to their Medicare Administrative Contractor (MAC) also known as their Fiscal Intermediary (FI). The MCR is a rather large financial report of various data. The MCR includes certain data related to patient statistics (e.g., visits, discharges, and days), provider’s total gross and net revenue, and expenses. A provider’s payer mix (i.e., amount of Medicare and Medicaid, as well as commercial and private third party payer, patients) is also included and is an important part of the MCR. This data is submitted and separated by hospital services. The MCR determines each provider’s total costs and charges that are associated with all patients, and allocates a portion of these costs and charges to Medicare patients. The amount is then compared to the payments received by the provider from Medicare and a settlement is then calculated. From this streamlined perspective, the MCR has been compared to a tax return.


The MCR is divided into worksheets which allow for the correct submission and flow of the report and also make it easy to compare data elements among providers and between cost reporting years.

Below is a brief description of the most common worksheets.

There may be other worksheets that a hospital is required to submit due to the type of services provided. For example, providers that offer renal services will have to complete the I series worksheets, and those that offer provider-based services for Hospice and Home Health will need to submit the H and J series worksheets, respectively.

Worksheet S-10

The Centers for Medicare and Medicaid Services (CMS) has made several changes to the Hospital Cost Report data system, and the new CMS-2552-10, after having a few minor snags, is in full use. Of the many changes, no worksheet has

<table>
<thead>
<tr>
<th>Worksheet</th>
<th>Description</th>
<th>Purpose/Goal</th>
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<tbody>
<tr>
<td>S Series</td>
<td>Statistical data</td>
<td>To properly report statistics related to payer</td>
</tr>
<tr>
<td>A Series</td>
<td>Proper classification of expenses by cost center</td>
<td>To report allowable Medicare costs by cost center or department</td>
</tr>
<tr>
<td>B Series</td>
<td>Matching of costs to revenue by utilization of a step-down approach</td>
<td>Allocation of overhead costs</td>
</tr>
<tr>
<td>C Series</td>
<td>Matching of cost to revenue – gross revenue by cost center or department</td>
<td>Calculation of cost-to-charge ratios</td>
</tr>
<tr>
<td>D Series</td>
<td>Calculation of Medicare share of hospital cost</td>
<td>Determine a hospital’s portion of Medicare cost</td>
</tr>
<tr>
<td>E Series</td>
<td>Calculation of Medicare settlement</td>
<td>Determine amount owed by or owed to the Medicare program</td>
</tr>
<tr>
<td>G Series</td>
<td>Hospitals Financial Statements</td>
<td>Report the financial statements into the cost report software</td>
</tr>
</tbody>
</table>
seen more change than worksheet S-10 – Hospital Uncompensated and Indigent Care Data.

The purpose of worksheet S-10 is to provide charges and payments for uncompensated care and indigent care and to calculate the associated cost for providing patient care services for which the hospital is not compensated. Hospitals will utilize several data elements, including but not limited to the following:

- Uncompensated Care Policies;
- Bad debt listing by write-off date applicable to cost reporting period;
- Charity care listing based on service date with the cost reporting period;
- Medicaid traditional and managed care listing including patient charges and payments; and
- Documentation to support Disproportionate share (DSH) or supplemental payments for Medicaid (State subsidy funding)

There are three major components of worksheet S-10:

- **Uncompensated Care** – Listed as charity care but also the bad debt which would include both non-Medicare bad debt and non-reimbursable Medicare bad debt.

*Note: Uncompensated care does not include courtesy allowances or discounts given to patients.*

- **Charity Care** – Includes all health services at the hospital where it was demonstrated that the patient is unable to pay. Charity care results from a hospital’s policy to provide all or a portion of services free of charge to patients who meet certain financial criteria.

*Note: For Medicare purposes, charity care is not reimbursable and unpaid amounts associated with charity care are not considered as an allowable Medicare bad debt.*

- **Bad Debt** – This is the provision for actual or expected uncollectible accounts. Bad debts that would be included are those that are non-Medicare patients and those that are non-reimbursable Medicare Bad Debt.

*Note: Bad debts are normally reported as an expense and not as a reduction from revenue. Therefore the gross charges that result in bad debts will remain in net revenue.*

The importance of the calculation of your hospital’s DSH payments will change beginning in federal fiscal year 2014. At a recent session at the American Health Lawyers conference on Medicare and Medicaid Issues, members of CMS and the United States Department of Health and Human Services (HHS) would not commit that worksheet S-10 would be the sole source of calculating the uncompensated care portion of the 2014 DSH payments. It was stated here that both CMS and HHS are currently reviewing and listening to comments from the provider community regarding this calculation and that it was too early to say what could and should be used. CMS also stated that they are aware of many different sources for uncompensated care and would need to evaluate each before any final determination is decided. The 2552-10 version of worksheet S-10 has changed from the previous year. These changes could impact the amount of uncompensated care applied to the new DSH calculation, as it is currently one of the controllable variables in future DSH calculations, and should be reviewed before submission.

**Conclusion**

The MCR continues to play a critical role in the determination of Medicare reimbursement to hospitals and health systems. In the present environment the staff at many hospitals is challenged to allocate their time and resources toward the preparation and thorough review of the MCR. Preparation of this report is or should be a year-long process that involves not only financial staff but clinical and other departments as well. The employees completing your cost report need to invest their time by implementing policies and creating procedures for cost report data accumulation and preparation. This may involve time that staff is borrowing from time spent focusing on future issues for the hospital. Historically, the cost report is seen as a retrospective report; however, with the appropriate understanding and review, this report can assist management in future budgeting, decision support and strategic planning. As we have mentioned the MCR preparation is a yearlong process and a hospital should assure that a formal cost report preparation process is in place. Hospitals should maintain a cost report inventory that includes status and deadlines as time management plays a key role. A hospital should also keep a log of their Medicare cost report reserves and estimated settlement amounts, in addition to understanding the open appeal items for the hospital.

The United States Supreme Court recently heard cases challenging the constitutionality of certain provisions of the Patient Protection and Affordable Care Act, leaving the fate of the healthcare reform law in question. If the act’s individual mandate is struck down by the Court, it is uncertain what portions of the law, if any (including the DSH changes), will survive.

The provider community has withstood similar changes to the cost reporting requirements in the past. The use and importance of cost report data for Medicare Inpatient and Outpatient Prospective Payment Systems, will continue to be an
important piece of hospitals’ future plans. Hospital leadership needs to be aware of various re-opening and appeal processes. For many hospitals, having a proactive plan in place can result in witnessing increased revenue through corrected payments, which has helped them to meet their fiscal responsibilities and their social missions.

About the Author
Scott Besler, Senior Manager, has over twenty (20) years of progressively responsible experience in preparation and review of Medicare Cost Reports. Scott has been responsible for a myriad of areas relating to healthcare facility reimbursement while working at BESLER. He is a member of both the New Jersey and Philadelphia HFMA Chapters and their respective Reimbursement Committees. He, along with the staff of BESLER Consulting, has hosted several industry seminars related to cost report preparation and is a regular contributor to HFMA. Scott can be reached at sbesler@besler.com.

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(610) 692-1525  
William.Bieljeski@wellsfargo.com
The NJ Chapter of HFMA held their annual leadership retreat on Thursday and Friday April 19th and 20, 2012 in Weehawken, New Jersey. This two day event was an opportunity for board members and committee chairs to come together and strategize on how to improve our chapter for the upcoming year. After winning the Shelton Award for five years of sustained excellence and growth, the chapter is faced with a challenge of “what next”. This meeting was an opportunity to discuss what should be accomplished this upcoming year to ensure that NJHFMA is meeting the needs and expectations of the full membership.

The meeting was facilitated by two national CAT (Chapter Advancement Team) leaders Kent Thompson and Rick Wagner. A SWOT (Strengths, Weaknesses, Opportunities and Threats) analysis was completed by all the board members and committee chairs attending the retreat, which helped identify the major strengths and threats of the chapter and what our major opportunities for the chapter in the future could be.

Time was also spent discussing the results from the membership survey. We want to thank all the members that took the time to fill out the membership survey for the chapter. This is the only way we are able to assess what the membership finds beneficial and suggestions for opportunities to help enhance what we offer or could be offering. The NJHFMA Leadership takes these recommendations and comments seriously.

The five main areas that the NJHFMA leadership has identified to focus on in the upcoming year include:

1. **Improving Communications** both within the leadership group and out to all the members. There is quite a bit of communication at this time but it was agreed that maybe that is not getting read by the whole group and we need to review all forms of communication to see if we need any changes.

2. **Organization Perception** – that is what the perception of the organization is as it relates to the exclusivity? Do the members know how they can volunteer for leadership positions and is the election process as open as it should be in today’s internet society?

3. **Value Proposition** – What is the value HFMA offers its members and those we would like to be members and are we communicating that effectively?

4. **Membership Recruitment** – This area needs to be reviewed annually to see that we are reaching all areas. With the changing healthcare system we have seen a raise in the number of staff working at Hospitals but at physician groups owned by them. We need to be reaching out to this group and others as the systems change to offer them education and other benefits related to HFMA.

5. **Education** – the NJ Chapter has excellent education events and has recently added more education on the revenue cycle. Every year this needs to be reviewed for content, location, cost and how the subjects are reaching new members.

The group was energized and everyone was assigned tasks around these initiatives to ensure that ideas discussed will be implemented. There are positive changes being discussed around how information is delivered, meeting more member’s needs, and transparency in leadership. The NJHFMA Leadership hopes you will see positive changes coming out based on our updated strategic plan. We look forward to another successful year and for everyone that wants to get more involved, to please join us. You can contact any board member or committee chair and they assist you in selecting a forum or committee that will be most advantageous to you. This year’s National HFMA slogan is “Leadership Matters”, which is very true for our Chapter and we are looking for more members to get involved and become the Leaders of NJHFMA of tomorrow and help shape our chapter for the future.

**About the Author:**
Heather Weber is the incoming Secretary of the NJHFMA Board. She has been a Board member for the past several years and co-chair of the FACT committee before that. She is an audit partner at ParenteBeard, LLC specializing in Healthcare and Employee Benefit Plans and has over eighteen years experience in the New Jersey Healthcare Industry. She is also a member of the AICPA, NJCPA, and EWNJ. Heather can be reached at Heather.weber@parentebeard.com.
### Who's Who in NJ Chapter Committees

**2012-2013 Chapter Committees and Scheduled Meeting Dates**

*NOTE: Committees have use of the NJ HFMA Conference Call line.*

If the committee uses the conference call line, their respective attendee codes are listed with the meeting date information below.

PLEASE NOTE THAT THIS IS A PRELIMINARY LIST - CONFIRM MEETINGS WITH COMMITTEE CHAIRS BEFORE ATTENDING.

<table>
<thead>
<tr>
<th>COMMITTEE</th>
<th>CHAIRMAN/EMAIL/PHONE</th>
<th>CO-CHAIR/EMAIL/PHONE</th>
<th>SCHEDULED MEETING DATES/TIME</th>
<th>MEETING LOCATION</th>
<th>BOARD LIAISON</th>
</tr>
</thead>
<tbody>
<tr>
<td>CARE (Compliance, Audit, Risk, Ethics)</td>
<td>Nudinia Davis (973) 906-4076</td>
<td>Dana Quinn <a href="mailto:quind@umnj.edu">quind@umnj.edu</a> / (973) 922-8942</td>
<td>First Thursday of the Month (888) 269-3831 9:00 AM</td>
<td>Meeting in person at Deloitte &amp; Touche, Princeton, NJ for Oct., Jan., April and July Balance are calls. Please call to confirm</td>
<td>Darline Mitchell <a href="mailto:mitchell.darlene@hunterdonhealthcare.org">mitchell.darlene@hunterdonhealthcare.org</a> (908) 237-7059</td>
</tr>
<tr>
<td>Communications</td>
<td>Elizabeth Litten <a href="mailto:ELItten@rothschild.com">ELItten@rothschild.com</a> / (609) 984-3600</td>
<td>Al Rottkamp <a href="mailto:ajroc123@net.com">ajroc123@net.com</a> / (609) 854-6508</td>
<td>First Thursday of each month (888) 269-3831 9:15 AM</td>
<td>Attendee Code: 7461155 For Rothschild offices 997 Lenox Dr Bldg 3 Lawrenceville, NJ</td>
<td>Deborah Shapiro <a href="mailto:dshapiro@wthe-services.com">dshapiro@wthe-services.com</a> (201) 617-7100</td>
</tr>
<tr>
<td>Education</td>
<td>Mike McKever <a href="mailto:mckever@umnj.edu">mckever@umnj.edu</a> / (973) 972-8559</td>
<td>Mary Cronin &amp; Stacey Bignie <a href="mailto:Mrcrnin@bestconsulting.com">Mrcrnin@bestconsulting.com</a> / <a href="mailto:Stbigos@nja.com">Stbigos@nja.com</a> (732) 839-1217 / (609) 275-4017</td>
<td>First Friday of each month (888) 269-3831 8:30AM</td>
<td>Attendee Code: 7363742 Conference Calls</td>
<td>Michael Alwell <a href="mailto:mialwell@msn.com">mialwell@msn.com</a> (973) 877-2853</td>
</tr>
<tr>
<td>Certification (Sub-committee of Education)</td>
<td>Eric S. Fishbein <a href="mailto:elfishbein@presscott.com">elfishbein@presscott.com</a> / (908) 677-7888</td>
<td>Cheryl Cohen cochen@<a href="mailto:pantheon@comcast.net">pantheon@comcast.net</a> / (609) 259-3638</td>
<td>First Friday of each month (888) 269-3831 8:30AM</td>
<td>Attendee Code: 7363742 Conference Calls</td>
<td>Mike Alwell <a href="mailto:mialwell@msn.com">mialwell@msn.com</a> (973) 877-2853</td>
</tr>
<tr>
<td>FACT (Finance, Accounting, Capital &amp; Taxes)</td>
<td>Lisa Hartman <a href="mailto:lhartman@archarcharch.com">lhartman@archarcharch.com</a> / (609) 453-7140</td>
<td>Michael DiFranco &amp; Mark Lacorci <a href="mailto:Mike.difranco@gt.com">Mike.difranco@gt.com</a> / <a href="mailto:mark.lacorci@ParenteBeard.com">mark.lacorci@ParenteBeard.com</a> (215) 814-1757 / (908) 243-8640</td>
<td>Second Wednesday of each month (888) 269-3831 8:00 AM</td>
<td>Attendee Code: 8730600</td>
<td>Scott Mariani <a href="mailto:smariani@withum.com">smariani@withum.com</a> (973) 896-9494 x420</td>
</tr>
<tr>
<td>Institute 2012</td>
<td>Dan Willis <a href="mailto:dkwillis6@gmail.com">dkwillis6@gmail.com</a> / (908) 301-5458</td>
<td>Mike Ruiz de Somocurcio &amp; Erica Waller mruiz@<a href="mailto:desomocurcio@amenheimhealth.com">desomocurcio@amenheimhealth.com</a> / <a href="mailto:ewaller@archarcharch.com">ewaller@archarcharch.com</a> (908) 662-2459 &amp; (609) 620-8335</td>
<td>Fourth Thursday of each Month (888) 290-0578 8:00 AM</td>
<td>Attendee Code: 678393 Conference Calls</td>
<td>John Braull <a href="mailto:johnbraull@mcbmeassoclll.com">johnbraull@mcbmeassoclll.com</a> (973) 824-0960</td>
</tr>
<tr>
<td>Managed Care</td>
<td>Kevin Joyce <a href="mailto:kjjoyce@archarcharch.com">kjjoyce@archarcharch.com</a> / (732) 562-7823</td>
<td>Jill Squires <a href="mailto:jsquires@archarcharch.com">jsquires@archarcharch.com</a> / (201) 594-3089</td>
<td>9/6, 10/24, 12/12, 1/9/13, 3/6/13</td>
<td>Attendee Code: 2295500 No conference calling</td>
<td>New Jersey Hospital Association Board Room</td>
</tr>
<tr>
<td>Membership Services/Networking</td>
<td>Maria Facciotti <a href="mailto:mfacciotti@arcm.com">mfacciotti@arcm.com</a> / (973) 614-9100</td>
<td>Kevin Margolis &amp; Tim Bialek <a href="mailto:Kevin.margolis@amenheimhealth.com">Kevin.margolis@amenheimhealth.com</a> / <a href="mailto:tbialek@archarcharch.com">tbialek@archarcharch.com</a> (908) 662-2459 / (908) 243-8640</td>
<td>Call for meeting arrangements (888) 269-3821</td>
<td>Attendee Code: 5495669</td>
<td>Locations alternate by month - please contact the chairs</td>
</tr>
<tr>
<td>Patient Access Services</td>
<td>William Hunt <a href="mailto:whunt@hmuc.com">whunt@hmuc.com</a> / (908) 986-2097</td>
<td>Dara Derrick <a href="mailto:dderrick@archarch.org">dderrick@archarch.org</a> / (908) 650-6870</td>
<td>8/19, 10/11, 12/12, 2/14/13, 4/13/13</td>
<td>Attendee Code: 8942192</td>
<td>CBIZ KA Consulting offices in East Windsor, NJ</td>
</tr>
<tr>
<td>Patient Financial Services</td>
<td>Joepis Portolin <a href="mailto:jportiol@archarcharch.com">jportiol@archarcharch.com</a> / (201) 291-4017</td>
<td>Steven Stockmayer <a href="mailto:sstockmayer@ccnow-nj.com">sstockmayer@ccnow-nj.com</a> / (973) 779-1717 Ext. 146</td>
<td>Second Friday of each Month (888) 290-0578 10:00 AM</td>
<td>Attendee Code: 674634</td>
<td>New Jersey Hospital Association</td>
</tr>
<tr>
<td>Regulatory &amp; Reimbursement</td>
<td>Brian Herdman <a href="mailto:bherdman@cbiz.com">bherdman@cbiz.com</a> / (609) 918-0990</td>
<td>Charina Fanara <a href="mailto:cfanara@quadramed.com">cfanara@quadramed.com</a> / (732) 919-5208</td>
<td>Third Tuesday of each Month (888) 269-3831 9:00 AM</td>
<td>Attendee Code: 9169899</td>
<td>Monmouth Shores Corp. Park Meridian Conf. Room 1C 1350 Campus Pkwy, Neptune</td>
</tr>
<tr>
<td>Revenue Integrity</td>
<td>Vickie <a href="mailto:McClayreVictoria.McClayre@quayah.com">McClayreVictoria.McClayre@quayah.com</a> / (732) 418-4823</td>
<td>Nora Burdi <a href="mailto:NBurdi@valleymhealth.com">NBurdi@valleymhealth.com</a> / (201) 291-6384</td>
<td>First Wednesday except Jan which is 1/9 (888) 290-0578 8:30 AM</td>
<td>Attendee Code: 8128109</td>
<td>New Jersey Hospital Association</td>
</tr>
<tr>
<td>Sponsorship</td>
<td>Michael Ruiz de Somocurcio mruiz@<a href="mailto:desomocurcio@amenheimhealth.com">desomocurcio@amenheimhealth.com</a> / (732) 726-6709</td>
<td>Diana Sessions <a href="mailto:diana.sessions@archarcharch.com">diana.sessions@archarcharch.com</a> / (732) 330-1259</td>
<td>Second Thursday of each Month (888) 290-0578 8:30 AM</td>
<td>Attendee Code: 8451688</td>
<td>Conference calls</td>
</tr>
</tbody>
</table>

Early Summer 2012
Q. Can you please provide a brief background on the proposed regulations with respect to the new medical device excise tax that was introduced in the Patient Protection and Affordable Care Act ("PPACA")?

The Internal Revenue Service ("IRS") issued, on February 3, 2012, proposed regulations with respect to IRS Notice 2010-89 and the medical device excise tax which was enacted by Section 1405 of the PPACA. IRS Notice 2010-89, published with request for comment on December 27, 2010, introduced Internal Revenue Code §4191 which imposes a tax on all sales of taxable medical devices.

For all sales occurring after December 31, 2012, a 2.3% tax will be imposed on all sales of any taxable medical devices by the manufacturer, producer or importer of the medical device. The tax is expected to raise $20B over a ten year period. Section 201(h) of the Federal Food, Drug & Cosmetic Act defines a taxable medical device as any device intended for human use. Specifically, a medical device is an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent or other similar or related article, including any component, part, or accessory which is:

1. Recognized in the official National Formulary, or the United States Pharmacopeia, or any supplement to them; or
2. Intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment or prevention of disease in man or other animals; or
3. Intended to affect the structure or any function of the body of man or other animals, and which does not achieve its primary intended purposes through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of its primary intended purposes.
4. The Food and Drug Administration ("FDA") has classified approximately 1,700 different generic types of devices for which each is assigned to generally one of three regulatory classes based on the level of control necessary to assure the safety and effectiveness of the device. The three classes include Class I, general controls, Class II, special controls and Class III, pre-market approval. There are still a number of devices that remain unclassified and the FDA reserves the right to impose the tax on any medical device that is later determined should have been included in the complete list of taxable medical devices.

A. What is the definition of a manufacturer for purposes of the excise tax?

A manufacturer is defined, in IRS Publication 510, as any person who produces a taxable article from new or raw material, or from scrap, salvage or junk material, by processing or changing the form of an article or by combining or assembling two or more articles. If a person furnishes the materials and keeps title to those materials and to the finished article, they are considered to be the manufacturer even though another person actually manufactured the taxable article.

The manufacturer of the medical device is generally not permitted to charge the tax to the purchaser of the medical device; however, it is expected that manufacturers will increase the price charged for the medical device in order to offset their cost of the tax.

Q. Are there any medical devices that are exempt from the excise tax?

The tax will not apply to eyeglasses, contact lenses, hearing aids and any other medical device determined by the IRS to be of a type that is generally purchased by the general public at retail for individual use. This is known as the "retail exemption". The proposed regulations provide that, "A device is considered to be of a type generally purchased by the general public at retail for individual use if it is regularly available for purchase and used by individual consumers who are not medical professionals, and if the design of the device demonstrates that it is not primarily intended for use in a medical institution or office or by medical professionals. Whether a device is of a type described in the preceding sentence is evaluated based on all the relevant facts and circumstances".

Other exemptions from the tax include:

1. The Research Use Only Exemption will apply as long as the medical device is labeled as "Research Use Only" even if not listed with the Food and Drug Administration; and...
2. The Investigational Device Exemption applies to medical devices that are in circulation for investigational purposes only and not required to be listed with the FDA.

What types of additional items are addressed in the proposed regulations?

In addition to providing clarification on IRS Notice 2010-89 and the medical device excise tax section of the PPACA, particularly the types of medical devices that are exempt from the tax, the proposed regulations also provide a nonexclusive list of factors to be considered in determining whether the design of a device demonstrates that it is primarily intended for use in a medical institution or office, or by medical professionals, and therefore not intended for purchase and use by individual consumers. Some of these factors include:

1. Whether the device generally must be implanted, inserted, operated or otherwise administered by a medical professional;
2. Whether the cost to acquire, maintain and/or use the device requires an investment that an individual consumer generally cannot afford;
3. Whether the device is a Class III device under the FDA system of classification; and
4. Whether the device qualifies as durable medical equipment, prosthetics, orthotics or other supplies that are available exclusively through a rental arrangement under Medicare Part B rules and regulations.

Are there any instances when the excise tax could apply to hospitals?

There are several instances in which the excise tax could potentially apply to hospitals. For example, the proposed regulations address comments raised concerning the taxation of “convenience kits” which are defined in the proposed regulations as two or more different medical devices, or a combination of medical devices and other items, packaged together for the convenience of the user. Specific concerns were raised over the potential for double taxation when one or more taxable medical devices are included in a kit. However, the IRS determined, in the proposed regulations, that sales of kits are not excluded from the imposition of the medical device excise tax. This could potentially result in double-taxation of certain medical devices that are commonly included in kits. Under the proposed regulations, a kit is defined as a “taxable medical device” if the kit is listed as a device with the FDA pursuant to FDA requirements.

Other situations in which the excise could apply to hospitals include importing of medical devices from outside the United States, combination products and rental of durable medical equipment.

The proposed regulations also address many additional issues with respect to the tax including, but not limited to, dental instruments and equipment, sales by persons other than the manufacturer, associated devices and components of devices and various other definitions of terms used throughout.

At what point is a sale of a taxable medical device considered to be completed and how is the sales price determined?

The excise tax goes into effect when a sale takes place. That is, title to the medical device passes from the manufacturer to the purchaser. This would also include the lease of a medical device by a manufacturer. The excise tax is based on the sales price of the medical device. The sales price is defined as the total consideration paid for the device including money, services or other forms of payment.

How is the excise tax reported and paid?

The medical device excise tax is a tax on the manufacturer of the medical device. Excise taxes are required to be reported on Form 720, Quarterly Federal Excise Tax Return. This form must be filed on a quarterly basis and deposits of all tax due must be made electronically on a semi-monthly basis.

The Treasury will be holding a public hearing on May 16, 2012, at the Internal Revenue Service in Washington, D.C. The comment period with respect to the proposed regulations closed on May 7, 2012.

What should hospitals do in order to determine the potential applicability of the excise tax?

Hospitals should perform a self assessment to determine readiness for potential exposure to this tax as a manufacturer of taxable medical devices. Specifically, the most common instances in which the excise tax will apply to hospitals, as outlined above, are the assembly and provision of convenience kits, rental of durable medical equipment, importing of taxable medical devices from outside the United States, combination products and instances where a hospital completes the manufacturing process of an item following the purchase of that item. The proposed regulations include seven detailed examples of the applicability of the excise tax. Manufacturers of taxable medical devices have already begun to notify purchasers that the 2.3% excise tax will be passed on to purchasers of the devices. This could clearly apply to hospitals in the form of increased prices of medical devices as outlined earlier.

About the Author

Anthony J. Panico, CPA, MS, is a tax partner in the Morristown office of WithumSmith+Brown, CPAs, with a specialized focus on healthcare and not-for-profit clients. Tony can be reached at apanico@withum.com.
BESLER Consulting Announces
Jonathan Besler Promotion to President and Chief Executive Officer

(PRINCETON, NJ, May 24, 2012) – BESLER Consulting, a leading financial and operational consultancy to healthcare providers, is pleased to announce that Jonathan Besler has assumed the position of President and Chief Executive Officer.

Jonathan joined the firm in 2009 as Senior Director of Client Services for BESLER Consulting. In this role, he worked closely with the product line management to improve all business functions related to service delivery, client engagement, and new service development associated with the revenue cycle, compliance, reimbursement, hospital and physician coding/reimbursement and operational improvement.

“Jonathan has been key to the firm’s growth and development over the past few years. He has contributed his vision, energy, integrity and a continued commitment to serve our clients in the BESLER tradition,” according to Phil Besler, the firm’s Chairman of the Board. “As the firm continues to expand our product and service offerings and to grow geographically, Jon is ideally suited to take the helm at this time.”

Jonathan is a seasoned strategic financial services business leader who spent more than five years with PricewaterhouseCoopers, LLP in Boston before joining BESLER. His experience in client service, as well as his knowledge of auditing and related compliance requirements, will continue to complement the high level of expertise, professionalism and dedication that has established BESLER as a premier consultancy for more than twenty-five years.

Jonathan has a strong background in finance and accounting including financial analysis, analytical trends, research and regulatory compliance. He holds a Masters of Accountancy from Tulane University and is licensed as a CPA by the State of New Jersey.

About BESLER Consulting
BESLER Consulting was founded in 1986 as a financial and operational consultancy to America’s leading healthcare providers, and has been growing in our purpose “to improve the health of the healthcare community through unmatched solutions.” Today, BESLER Consulting provides consulting expertise in many areas including: revenue cycle management, reimbursement, coding, compliance, accreditation, clinical staffing and interim management in a variety of provider settings. BESLER Consulting has also developed the BVerifiedSM suite of cloud-based solutions to meet the increased need for hospitals to use their internal resources for many of the new regulatory compliance, revenue cycle and reimbursement functions.

BESLER Consulting provides value to our clients by exceeding their expectations for revenue integrity, reimbursement assurance, regulatory guidance and compliance, operational efficiencies, accreditation and licensure services and web-based solutions. This commitment is achieved through proven products, unmatched service and a dedicated team of highly qualified professionals. For more information visit us on the web at www.besler.com.

Panacea Announces Innovative Cloud-Based Coding, Compliance and Reimbursement System

Facilitates proactive identification of coding, compliance, quality and financial risk and opportunities

April 25, St. Paul, MN – Panacea Healthcare Solutions, Inc., a company specializing in Hospital Coding, Compliance, Reimbursement and Financial Systems and Services, today announced that in Las Vegas on April 29th at the Health Care Compliance Association’s Annual Compliance Institute, it will be introducing CLAIMSauditor.com as the industry’s most effective and easy-to-use cloud-based technology to assist healthcare providers to proactively identify coding, compliance, and quality of care issues and financial risks and opportunities. The Company announced that the system features an intuitive rules engine allowing coding specialists, revenue cycle experts, financial managers, quality professionals, compliance officers, and others to create customized rules within seconds or to select rules from an ever-increasing library to search multi-year inpatient and outpatient claims database to proactively identify risks and opportunities. The system also interfaces with MediReps ComplyTrack™, created specifically for the healthcare industry by Wolters Kluwer Law & Business a complete solution for managing enterprise risk and compliance featuring web-based workflow software, the most

Focus
comprehensive regulatory content in the industry, and support at every level by health care compliance experts.

Frederick Stodolak, CEO at Panacea stated, “We are very excited about our new system because for years our clients have wished for timely access to their own data in a way that gives them freedom to do their own data analysis, research and reporting without relying on their already burdened IT department. The system is extremely cost effective because the annual subscription fee can be shared among the HIM, Finance, Compliance, Quality and other department operating budgets and it immediately identifies new incremental net revenue opportunities and potential audit or reimbursement risks. Our beta sites and our own consultants have already added effective rules such as patient safety rules, lost charge rules, DRG under-coding rules, RAC and OIG rules and rules to evaluate risk related to potential changes in reimbursement for re-admission and hospital acquired conditions.”

CLAIMSauditor.com can be licensed by hospitals directly and through the use of web service technology, while vendors can enhance the value of their current offering and data stream by integrating CLAIMSauditor.com to their customer base. Information about CLAIMSauditor.com can be found at www.PanaceaHealthSolutions.com and at the product website address.

**About Panacea**
Panacea Healthcare Solutions, Inc. provides coding, compliance, reimbursement and revenue solutions infused with intelligence and delivered through our consulting, software, publications and webcasts to more than 4,000 U.S. providers. Each one is rooted in Panacea’s extensive frontline experience in healthcare finance, coding and compliance.

Please contact Rebecca Stodolak, Chief Operating Officer, at rstodolak@panaceahealthsolutions.com with any questions.

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### mark your calendar • • •

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Location</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>July 17, 2012</strong></td>
<td>8:15-4pm</td>
<td>NJHA</td>
<td>The Conference on Professional and Personal Enrichment</td>
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<tr>
<td><strong>July 24, 2012</strong></td>
<td>9-3pm</td>
<td>NJHA</td>
<td>Capital Access in Post Reform Era</td>
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<tr>
<td><strong>August 9, 2012</strong></td>
<td>7:30 – 12:30pm</td>
<td>East Windsor Holiday Inn</td>
<td>Meaningful Use, Security and Privacy, The Cornerstone Of Health Information Technology</td>
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<tr>
<td><strong>August 16, 2012</strong></td>
<td>8:30-12:30pm</td>
<td>NJHA</td>
<td>Medicare 101</td>
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<tr>
<td><strong>September 11, 2012</strong></td>
<td>all day</td>
<td>Woodbridge Hilton</td>
<td>Bimonthly Meeting: Regulatory &amp; Reimbursement</td>
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<tr>
<td><strong>October 10, 2012</strong></td>
<td>11am</td>
<td>Galloway National</td>
<td>1st Annual CFO Cup Golf Tournament*</td>
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<tr>
<td><strong>October 10-12, 2012</strong></td>
<td></td>
<td>The Borgata, Atlantic City</td>
<td>Annual Institute</td>
</tr>
</tbody>
</table>

*Event open to Annual Institute Sponsors only.

**PLEASE NOTE:** NJ HFMA offers a discount for those members who wish to attend Chapter events and who are currently seeking employment. For more information or to take advantage of this discount contact Laura Hess at NJHFMA@aol.com or 888-652-4362. The policy may be viewed at: http://hfman.orbius.com/public.assets/A02-Unemployed-Discount/file_168.pdf
HFMA-NJ’s Publications Committee strives to bring New Jersey Chapter members timely and useful information in a convenient, accessible manner. Thus, this Job Bank Summary listing provides just the key components of each recently-posted position in an easy-to-read format, helping employers reach the most qualified pool of potential candidates, and helping our readers find the best new job opportunities. For more detailed information on any position and the most complete, up-to-date listing, go to HFMA-NJ’s Job Bank Online at www.hfmanj.org.

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

<table>
<thead>
<tr>
<th>Job Position and Organization</th>
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</tr>
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<tbody>
<tr>
<td>HEALTH INFORMATION MANAGEMENT DIRECTOR</td>
<td>Cooper University Hospital</td>
<td>Camden, NJ</td>
</tr>
<tr>
<td>DIRECTOR OF BUDGET &amp; REIMBURSEMENT</td>
<td>An award-winning midsize healthcare facility</td>
<td>Central NJ</td>
</tr>
<tr>
<td>CHIEF FINANCIAL OFFICER</td>
<td>Hunterdon Healthcare System</td>
<td>Flemington, NJ</td>
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<td>STRATEGIC FINANCIAL ANALYST</td>
<td>Holy Name MC</td>
<td>Teaneck, NJ</td>
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<td>RN DECISION SUPPORT ANALYST BUDGET/REIMB. DEPT.</td>
<td>CentraState Healthcare System</td>
<td>Freehold, NJ</td>
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<tr>
<td>RN CONSULTANT</td>
<td>CBIZ KA Consulting Services</td>
<td>East Windsor, NJ</td>
</tr>
<tr>
<td>EXEC. DIRECTOR OF THE OFFICE OF HEALTH CARE FINANCING</td>
<td>NJ State Dept. of Health &amp; Senior Services</td>
<td>Trenton, NJ</td>
</tr>
<tr>
<td>BUDGET ANALYST</td>
<td>Meridian Health</td>
<td>Neptune, NJ</td>
</tr>
<tr>
<td>ASSOCIATE DIRECTOR OF FINANCE</td>
<td>Children's Specialized Hospital</td>
<td>Mountainside, NJ</td>
</tr>
<tr>
<td>CONSULTING MANAGER</td>
<td>R. DeLuca Associates LLC</td>
<td>Hasbrouck Heights, NJ</td>
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<tr>
<td>SR. REIMBURSMENT ANALYST</td>
<td>St. Luke's University Health Network</td>
<td>Lehigh Valley, PA</td>
</tr>
<tr>
<td>HEALTHCARE CONSULTANT</td>
<td>NJ State Dept. of Health &amp; Senior Services</td>
<td>Trenton, NJ</td>
</tr>
<tr>
<td>ASSISTANT CONTROLLER</td>
<td>JFK Medical Center</td>
<td>Edison, NJ</td>
</tr>
</tbody>
</table>
Accumulating retirement savings to last a lifetime is an important financial goal for many Americans. Fixed annuities, which offer a guaranteed fixed rate of return and tax deferred earnings, as well as income that can last for life, can be an option for current and future retirees, depending on their circumstances.

When you purchase a fixed annuity, you receive a guarantee that your money will earn interest at a specified rate and that your return (the money paid back to you) will occur on a set schedule in fixed amounts. Guarantees and payment of lifetime income are contingent on the claims-paying ability of the issuing company.

Generally, there are two premium options: single premium (one lump-sum payment) or multiple premiums (payments made in installments). Payouts can begin immediately or at a future time, but they are usually scheduled for retirement and can last for your lifetime or another scheduled length of time. Retirees often favor immediate annuities, which begin to provide income at regular intervals as soon as a single lump-sum premium has been paid. Deferred annuities, often favored by those saving for retirement, accrue interest over time (the accumulation period) with the payout scheduled to begin at a future date. In both cases, earnings are tax deferred.

Favorable Tax Treatment

Because annuities help people save for retirement, they receive favorable tax treatment. Tax deferral allows your potential earnings to accrue compound interest without immediate taxation, which can add to the value of your savings. Unlike some qualified retirement plans, annuities are not subject to income or contribution limits. Annuity premiums that are not part of a qualified retirement plan are paid with after-tax dollars. Your principal contribution will not be taxed again, but interest earnings are taxable.

When you have fully recovered your initial premium, the remaining payouts are fully taxable. The tax benefits of fixed annuities do include a restriction: If withdrawals are made before age 59½, there may be a 10% Federal income tax penalty, in addition to any income taxes due. Furthermore, if you withdraw funds during the accumulation period, the issuing company may levy surrender charges.

Annuities offer no additional tax advantages when used to fund a qualified plan. It is important to keep in mind that fixed annuity contracts include rules, restrictions, and expenses that may vary by product and issuing company. In addition to surrender charges as mentioned, there may also be annual fees for management expenses, and upfront fees could include mortality and expense charges. Make sure you fully understand all options, restrictions, and expenses for your specific annuity.

Income for Life?

How much you receive from an annuity generally depends on your age when you begin to receive payments, the value of the contract, and the payout option elected (gender may also play a role). Once you own an annuity, you’ll need to select a payout option when you choose to annuitize, usually at retirement.

Most annuities offer a number of different payout choices. Here’s a brief overview of some basic options:

- **Life Only.** This option provides income for life and generally provides the largest benefit of all the options. You can receive payments monthly, quarterly, semi-annually, or annually.

- **Life with Term Certain.** With this option, you’ll receive income for life. If you die before a stipulated time (the term certain), usually 5, 10, 15, or 20 years, the payments then continue to a beneficiary for the remainder of the term certain.

- **Joint and Survivor Life.** Under this arrangement, two individuals receive annuity payments for both their lives. When one dies, the other continues to receive income, or some portion of it, for the remainder of his or her life.

- **Installment Refund Life.** With this option, if you die before you have received at least as much as your original premium payment(s), the balance will be paid out to a beneficiary in installments.

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**Unit Refund Life.** This option is similar to the installment refund life option, except that the beneficiary receives the balance in a lump sum.

**Payments for a Specified Period.** With this option, payments are made for a pre-specified term, generally ranging from one to 30 years, and then continue to a beneficiary if you die before the term ends.

Fixed annuities can be an important part of your overall savings and retirement income strategy, helping to meet diverse financial goals and objectives. If you are currently saving for retirement, a fixed annuity can help supplement your existing long-term vehicles, such as a 401(k) plan or an Individual Retirement Account (IRA). If you are a retiree, a fixed annuity can provide you with a regular income stream during your golden years. Remember, the time to plan for the future is now. Be sure to consult with your personal advisors for information according to your unique circumstances.

Note: Fixed annuities are neither insured nor guaranteed by the FDIC; they may decline in value if surrendered prior to maturity. Guarantees are based on the claims-paying ability of the issuing company.

The information contained in this newsletter is for general use, and while we believe all information to be reliable and accurate, it is important to remember individual situations may be entirely different. The information provided is not written or intended as tax, legal, or financial advice and may not be relied on for purposes of avoiding any Federal tax penalties. Individuals are encouraged to seek advice from their own tax or legal counsel. Individuals involved in the estate planning process should work with an estate planning team, including their own personal legal or tax counsel. Neither the information presented nor any opinion expressed constitutes a representation by us or a solicitation of the purchase or sale of any securities. This article is reprinted with permission from LIBERTY PUBLISHING, INC., BEVERLY, MA COPYRIGHT 2010.

About the Author
Mark McLafferty, MBA, is a financial representative with Emerald Financial Resources, a MassMutual Agency; courtesy of Massachusetts Mutual Life Insurance Company (MassMutual).

Mark can be reached at mmclafferty@financialguide.com.
“What have you done for me lately?” is not a question hospitals have historically had to answer. However, in recent years, community leaders and government officials have held tax-exempt entities, especially hospitals, to a “what have you done for the community?” standard to justify tax-exempt status. Nothing validates this point more than Schedule H of the revised Form 990. The Schedule H is part of the Form 990 required to be filed by tax-exempt entities. The Schedule H is specifically required to be completed by entities defined as a “hospital” that are required to file a Form 990 for the tax year in question.

The former Form 990 was not numerically driven. Community benefit and charity care were not based on actual numbers or percentages, but on an organization’s ability to articulate the “benefit” it provided to the community. The revised Form 990 contains more objective criteria and is numerically driven. The revised form is now shouting “here specifically is what I have done for you this year and why my organization deserves the tax exempt benefits conferred upon it.

The most fiercely debated portion of the revised Form 990 has been the section of Schedule H dealing with community benefit and financial assistance reporting. The benefit a hospital provides to its surrounding community is at the core of its tax exempt purpose. It is also the most difficult to measure and quantify, and can vary greatly by geographical location.

In the Schedule H debate there has been intensely contested dialogue regarding what should be included in the calculation of the community benefit and financial assistance provided and what should be excluded. There have been suggestions as to the amount of community benefit that is “expected” from each hospital. Other contested issues involve what is included in community benefit, how much benefit the hospital provides to the surrounding community and finally the amount and kind of financial assistance the hospital provides to uninsured and low income residents.

There have been various reports compiled on this topic. One of these reports, the Schedule H Benchmark Project (attached) prepared by Ernst & Young LLP (EY) for the American Hospital Association (AHA) contains information provided by over 570 hospitals as filed with the Internal Revenue Service (IRS).

A major difference between other reports, such as “Community Benefit Reporting” by the Catholic Health Association and the AHA study is the information included in the calculation of the community benefit percentage. Part of the Schedule H reporting debate relates to the carve-out of certain expenses hospitals incur. In the AHA study certain expenses like Medicare shortfall, bad debt expense attributable to charity care, and community building activities were included in the community benefit percentage while in other reports the community benefit percentages were lower because these components were omitted from the calculation. The AHA’s position is that these components should be reported, as they are a part of the benefit provided to the community.

The Report

The information for the Benchmark Report was taken from the 2009 Schedule H information provided by hospitals on their 2009 Form 990. 2009 was the first year the Schedule H was required to be filed with the Form 990. EY took the information provided by the hospitals and compiled it to produce the final report.

Beginning in 2011 EY and the AHA requested their clients and members, respectively, provide copies of their Schedule H’s to EY. The forms collected were then divided into calendar and fiscal year responses.

The study compiled the Schedule H’s of 571 hospitals, which, when adjusted for hospital systems included in the study, represents approximately 30% of all 2,900 not-for-profit hospitals. The Report contains several key findings that provide insight into actual percentages of community benefit and the factors used to reach the conclusions.

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Key Findings

The study found that exempt hospitals provided a broad range of programs benefitting the health of the communities they serve, as well as providing substantial financial assistance:

- Participating hospitals and systems reported an average 11.3% of their total annual expense as benefit to the community. Benefits to the community included charity care, Medicaid underpayments, community health improvement programs, health research and education, subsidized services, bad debt expense attributable to charity care, Medicare shortfall, and other community benefits and community-building activities.

- Exempt hospitals and systems reported an average 5.7% of their total annual expense as charity care, unreimbursed Medicaid, and other unreimbursed costs from means-tested programs.

- More than 88% of exempt hospitals in each of the size and location categories used federal poverty guidelines to determine eligibility for discounted care.

- More than 70% of responding exempt hospitals and systems entered estimates of bad debt expense attributable to charity care on their Schedule H submissions, averaging an additional 0.4% of total expenses or an average $1.6 million per respondent.

- More than 75% of participating exempt hospitals and systems had Medicare reimbursement shortfalls.

By its very definition, the Schedule H does not include all the tangible and intangible benefits of improving the communities’ health and well-being. Hospitals need to continue to tell their story regarding the benefits provided to the community. This information should be contained in the community benefit report that can be attached to the Form 990.

The Patient Protection and Affordable Care Act added section 501(r) to the Internal Revenue Code. Section 501(r) includes additional requirements a hospital must meet to continue to qualify for tax exemption. These additional requirements address a hospital’s financial assistance policy, policy relating to emergency medical care, billing and collections, and charges for medical care. Starting in 2012 501(r) requires hospitals to complete a community health needs assessment (CHNA).

Section 501(r)(3) requires a hospital organization to conduct a CHNA every three years and adopt an implementation strategy to meet the community health needs identified through such assessment. The CHNA must (1) take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health and (2) be made widely available to the public.

In addition to the quantitative data discussed above, Schedule H contains several questions dealing with a hospital’s financial assistance policies and CHNA’s in response to section 501(r), with the CHNA questions mandatory beginning with 2011 returns. It is likely the IRS will use a hospital’s answers to these questions to gauge its compliance with 501(r).

Conclusion

Objective information regarding community benefit and financial assistance are a part of a new, more detailed reporting regime. We are now in the era of a quantifiable “what have you done for me lately” reporting environment. No longer is it enough that a hospital has an emergency room, is open 24 hours a day and therefore is a benefit to the community. Now the community benefit is quantified, packaged and reported to the general public via the Form 990.

The AHA Report seems to provide a preview of what the IRS will likely discover when it completes its review of the 2009 Form 990 Schedule H reporting from the hospitals. This information may shape the future reporting obligations required by the IRS once their review has been completed. And, it is likely that the Schedule H information will be a major component used by regulators and legislators alike in analyzing and formulating requirements for maintaining tax-exempt status for hospitals.

About the Author

Felicia Tucker is a senior manager in Ernst & Young's LLP Exempt Organization Tax Services and the Provider Care Industry Sector. She has more than 14 years of experience in the tax-exempt organization sector and advises clients regarding exemption applications, unrelated business income tax planning and compliance as well as Internal Revenue Service exams, state and local tax issues, tax exempt bond issues and employment tax issues.

Felicia received her B.A. degree from Empire State College, her JD degree from Hofstra University School of Law and an LLM (Masters of Law - Tax) from The University of Alabama School of Law. Felicia can be reached at felicia.tucker@ey.com.
We are already working hard at planning the 2012 Institute!

This year’s institute will once again be held at The Borgata Hotel and Casino Spa in Atlantic City NJ. The conference will run from October 10th-October 12th. Here is what the institute committee has in store so far:

- Rudy Giuliani is confirmed as the Keynote Speaker – he will be speaking on “The National Healthcare Debate and the Need for Resolute Leadership” one month prior to the election
- The Make-A-Wish Foundation will be this year’s charity
- The Return of the C-Suite Golf outing at Galloway National Golf Club – Golf Digest recently named Galloway one of America’s best private golf clubs! (check out our really fancy logo below)

- 8 confirmed NJ Hospital and Health Plan CEO panelists
- One of the top Philadelphia and Jersey Shore cover bands will perform all your favorite hits on Thursday night at the MIXX
- A breakout session specifically designed for new members to maximize their chapter experience
- Exciting donations for our tricky tray event, including tickets for sporting events, gift cards, electronics
- A panel of CEO’s from each tri-state Hospital Association

- And of course, numerous breakout sessions designed around the topics that are extremely important to our jobs: ACO’s, Physician Integration, Reform, Medicare and Medicaid, Episodic Payments, ICD-10 and Revenue Cycle

Sponsors, we have also heard your feedback and have created numerous additional ways to interact with attendees and create value for your organizations

- Every Sponsor at the booth level and above will also receive a free quarter page ad for the Institute Edition of the Focus Magazine. This magazine will not just be viewable to attendees, but to our entire chapter membership
- A Sponsor Education lunch on Wednesday that serves to educate sponsors on what opportunities the chapter may offer
- The Make-A-Wish Foundation Charity Reception and awards from the CFO Cup event will be given in the Sponsor Exhibit Area on Wednesday evening.
- During the reception, every booth will contain a silent auction gift. We plan to do a quick overview of the item and what the exhibitor does and then pull the winner directly from the booth.
- We have changed our Floor Plan, combining all sponsor booths with the catering and dining tables as well as the bars.
- All breakfast and lunch will continue to be served in the exhibit area to provide additional face to face time with Institute attendees.
- A Thursday night networking reception at the Mixx to mingle with attendees

Be sure to mark your calendars, this will be an event not worth missing!

The Institute Committee
# 2012 Institute Agenda

**Wednesday, October 10, 2012**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>9:00</td>
<td>Conference Registration</td>
</tr>
<tr>
<td>9:00</td>
<td>CMS Washington Update</td>
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<tr>
<td>10:30</td>
<td><strong>BREAK</strong></td>
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<tr>
<td>11:00</td>
<td><strong>Healthcare Reform and Effect on DSH Payment</strong> Robert Grisius, NAVEOS - Healthcare Data Analytics</td>
</tr>
<tr>
<td>11:00</td>
<td><strong>Maintaining Compliance in the Recovery of Transfer DRG Payments</strong> Kathy Ruggieri &amp; Mary Devin, Besler Consulting</td>
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<tr>
<td>11:00</td>
<td><strong>How Big is Your Spreadsheet? Automating Data Can Reduce Your Reliance on Manual Processes and Improve Efficiency</strong> Steven F. Honeywell &amp; Margaret Dowling, University of Pennsylvania Health System &amp; PNC Healthcare</td>
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<tr>
<td>12:00</td>
<td><strong>Vendor Education Lunch</strong></td>
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<td>12:00</td>
<td><strong>LUNCH</strong></td>
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<tr>
<td>1:00</td>
<td>Healthcare Finance and Treasury in the New Market Environment Glen Wagner, Kaufmann, Hall &amp; Associates</td>
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<td>1:00</td>
<td>CDI and ACOs, Fine Tuning Your CDI Program to Support Successful ACOs Victor Freeman, J.A. Thomas &amp; Associates</td>
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<tr>
<td>1:00</td>
<td>Value Based Purchasing: Information Technology to Manage for Success Michael Troppe, Dell</td>
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<td>2:00</td>
<td><strong>Computer Assisted Coding (CAC), ICD-10 and the EHR: Evaluating the Benefits of Evolving Technology for Your Organization and Workforce</strong> Maryagnes Marek Medquist Inc</td>
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<tr>
<td>2:00</td>
<td>Aligning Investment Portfolio Decisions with Corporate Goals: A Case Study Al Pierre, SEI</td>
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<tr>
<td>2:00</td>
<td>Medicaid RAC Mark Anderson, Medicaid Fraud Division</td>
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<tr>
<td>3:00</td>
<td><strong>Managing Your Margins: Keys to Success for Clinical Margin Management</strong> Elyse Gellerman, MedAssets</td>
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<tr>
<td>3:00</td>
<td>Key Considerations for Insurers and Employers as they Gear Up for Participation in Health Insurance Exchange Price Waterhouse Coopers</td>
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<tr>
<td>4:00</td>
<td>Creating Environmental Sustainability in a Healthcare Setting Millbridge Healthcare Services, Inc.</td>
</tr>
<tr>
<td>4:00</td>
<td>Strategies for Optimizing Patient Access to Eliminate Misdiagnosing Undiscovered Eligibility as Self-Pay Janet Gorman &amp; Michael Sowinski, Emdeon</td>
</tr>
<tr>
<td>5:00</td>
<td><strong>New to HFMA/NJ Chapter</strong></td>
</tr>
<tr>
<td>6:00</td>
<td><strong>Tricky Tray Fundraiser benefiting The Make A Wish Foundation</strong></td>
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<tr>
<td>5:00</td>
<td><strong>Vendor Fair Open</strong></td>
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**Thursday October 11, 2012**

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<tr>
<td>7:00</td>
<td><strong>BREAKFAST</strong></td>
</tr>
<tr>
<td>8:00</td>
<td>Opening Remarks Joe Pfeifer - President and CEO of HFMA Ralph Lawson - Chairman of HFMA</td>
</tr>
<tr>
<td>9:00</td>
<td>The National Healthcare Debate and the Need for Resolute Leadership Rudy Giuliani</td>
</tr>
<tr>
<td>11:00</td>
<td><strong>General Session</strong></td>
</tr>
<tr>
<td>12:00</td>
<td>Getting Certified Lunch Cheryl Cohen &amp; Eric Fishbein</td>
</tr>
<tr>
<td>12:00</td>
<td>Region 3 Officer Lunch</td>
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<tr>
<td>12:00</td>
<td><strong>LUNCH</strong></td>
</tr>
<tr>
<td>1:00</td>
<td>How Leadership Matters to your Organization in a Time of Reform Panel of Hospital and Payer CEOs</td>
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<tr>
<td>2:30</td>
<td>Community Hospitals - Surviving and Thriving in Today's Complex Healthcare Environment Richard Lucas Seimens</td>
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<tr>
<td>2:30</td>
<td>Is Your Revenue Cycle an Asset to Patient Loyalty? Lincoln Fish &amp; Ted Bardson, Avadyne Health</td>
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<tr>
<td>2:30</td>
<td>Deriving Savings From Your Supply Chain: Hospital Spending Meets Patient Outcomes Kristian O'Meara, Bravo Solutions</td>
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<tr>
<td>5:00</td>
<td>Wine and Cheese Reception</td>
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<tr>
<td>6:00</td>
<td>President's Reception</td>
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<td>10:00</td>
<td>Late Night Cheese</td>
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**Friday October 12, 2012**

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<tr>
<td>9:00</td>
<td><strong>BREAKFAST</strong></td>
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<tr>
<td>9:00</td>
<td>Steve Adubato</td>
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<tr>
<td>10:00</td>
<td>Majority Leader Louis Greenwald</td>
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<tr>
<td>11:00</td>
<td>Hospital Associations of NJ, PA &amp; NY Panel</td>
</tr>
<tr>
<td>12:00</td>
<td>Awards, Raffles, Closing Remarks</td>
</tr>
</tbody>
</table>
The 2012 Annual Institute Committee is pleased to announce that Rudy Giuliani will deliver the keynote address on “The National Healthcare Debate and the Need for Resolute Leadership”.

Meet Rudy Giuliani.

Charity Event
MAKE A WISH
Make-A-Wish Foundation® of New Jersey

Golf Tournament
NJ-HMFA 1st Annual CFO Cup Golf Tournament

2012 NJ HFMA Annual Institute
October 10-12, 2012
The Borgata Hotel and Casino, Atlantic City, NJ
www.njhfmainstitute.org
Annual NJ HFMA Golf Outing
May 10, 2012
Fiddler’s Elbow Country Club

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Bubb, Grogan & Cocca LLP
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Med-Metrix

New Jersey Hospital Association
NJPR Hospital and Medical Support Services
Panacea Healthcare Solutions
Pantheon Capital
Pharmaceutical Review Service, LLC.
Robert Half International
RTR Financial Services
WithumSmith+Brown CPAs
Medical Debt: Attempts to Address a Complicated Problem Run Afool of the Law

by Patricia McManus

A recent study published by the Centers for Disease Control and Prevention’s National Center for Health Statistics (“NCHS”) found that from January through June of 2011, “1 in 5 persons was in a family having problems paying medical bills; 1 in 4 persons was in a family paying medical bills over time, and 1 in 10 persons was in a family that had medical bills they were unable to pay at all.” Based on the NCHS statistics, it comes as no surprise that medical debt is a troubling reality for many Americans. Medical debt can result from a variety of factors including being uninsured, being underinsured, or requiring emergency or prolonged health care. Whatever the cause, medical debt can create financial havoc, impact credit scores and the ability to refinance a home or obtain other loans, and create barriers to accessing care. Beyond that, individuals with medical debt often face harassing contact and other troubling (and sometimes illegal) practices by debt collectors.

Accordingly, medical debt and medical debt collection have become the focus of much attention by state and federal authorities, as well as media outlets. On March 12, 2012, the Medical Debt Responsibility Act (the “Act”) was introduced in Congress. If enacted, the Act would amend the Fair Credit Reporting Act, 15 U.S.C. 1681a, to require credit reporting agencies to remove paid or settled medical debt from credit reports within 45 days from the date of payment or settlement. States have responded by instituting hospital billing and fair pricing policies, strengthening laws requiring notice to patients about the availability of free or discounted care, and enacting strict debt collection policies, which can afford greater protections than the federal Fair Debt Collection Practices Act (“FDCPA”).

Despite advances in this area, troubling practices persist as hospitals and other providers struggle to meet their bottom-lines. The spotlight is on medical billing and collections after two high-profile cases revealed aggressive collections that are alleged to violate the FDCPA and other laws. Those cases, involving Accretive Health, Inc. (“Accretive”) and West Asset Management, Inc. (“West”), provide valuable lessons to hospitals and other providers looking to improve their billing and collection practices.

Accretive provides “revenue cycle management” and in 2010, contracted with the Minnesota-based non-profit healthcare system Fairview Health Services (“Fairview”) to provide services at Fairview’s hospitals. Earlier this year, Accretive’s practices related to both medical billing and medical bill collection came under fire by Minnesota Attorney General Lori Swanson, who claimed that Accretive instilled a “numbers driven” culture at Fairview, wherein Accretive employees encouraged Fairview personnel to demand payment of prior balances and pre-payment from patients, including emergency room patients, prior to the rendering of treatment. Additionally, Accretive is alleged to have created an electronic data system wherein a patient’s registration could not be completed until the patient advocate made an attempt at collection. If those collection attempts were unsuccessful, Accretive instructed hospital personnel to engage in bedside collections. Accretive rewarded the most aggressive collectors with financial and other rewards.

The Attorney General claims those practices “converted the hospital culture from that of a charitable organization to that of a collection agency.” As a legal matter, Accretive is alleged to have violated HIPAA, the FDCPA, Minnesota’s Health Records Act, Prevention of Consumer Fraud Act, Uniform Deceptive Trade Practices Act and debt collection laws, by among other things, violating patient privacy by mishandling patient data, engaging in deceptive practices to mask from patients its involvement with Fairview and other hospitals, and sending out collection notices that did not comply with Minnesota law. The Attorney General is seeking injunctive relief, statutory damages, an award to plaintiff of the costs of the action and reasonable attorneys fees to the State of Minnesota, and an order requiring Accretive to disclose to Minnesota patients the data that it has about them and information about where and how that data is stored and utilized.

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Accretive vehemently denies the Attorney General’s allegations and recently filed a motion to dismiss the First Amended Complaint. Reacting to intense public pressure, as well as sharp drops in its stock price, Accretive enlisted the assistance of a number of high-profile health policy figures, including former Secretary of the U.S. Department of Health and Human Services, Michael Leavitt, Former Senate Republican leader Bill Frist and former Senate Democratic leader Tom Daschle, to assist it in developing “national standards for health care providers’ financial interactions with patients.” According to Accretive’s news release of May 15, 2012, “[t]his process will create first-of-kind national standards for understanding expected charges, available resources, counseling, billing and payment procedures regardless of the ability to pay. An independent accreditation process will accompany the new standards, providing patients with assurance that they will be treated compassionately and fairly.”

West Asset Management, Inc.’s (“West”) debt collection practices also landed it in hot water recently. As a result of a suit filed by the United States, last year West and the United States entered into a Stipulated Final Judgment and Order for Permanent Injunction (the “Order”). The Order enjoins West from committing further violations of the FDCPA and the FTC Act and reads as a “what-not-to-do” list for any debt collection company. Specifically, the Order enjoins West from misrepresenting to consumers that West is a law firm and that its collectors are attorneys, stating that nonpayment of a debt could result in West taking legal action or seeking criminal prosecution, threatening actions that cannot legally be taken under applicable law, and communicating with consumers about their debt in a manner that is proscribed by law (including using profane and threatening language, calling at very early or late hours or calling an individual at their workplace). The FTC also assessed a $2.8 million civil penalty against West for violations of the FDCPA, and subjected West to intense monitoring to assure compliance with the law.

Hospitals and other healthcare providers should take the lessons of Accretive and West to heart. Billing and collections are a part of any business, but in the healthcare sector, particularly among non-profit healthcare providers, it is critical that providers balance their financial needs with patient rights and the letter of the law, and in the case of non-profits, their mission. From a risk management perspective, providers should review their billing and collections policies and their agreements with outside collections agencies. With the current trend in favor of consumer protection, providers
can anticipate some backlash related to their medical collection practices, particularly if the collections practices are aggressive or in any way outside the bounds of applicable law. Providers should take all consumer complaints seriously and investigate any allegations that staff or agents of the hospital or provider engaged to collect debts are acting in a harassing or untoward manner. Practices on the “borderline” should be reigned in to prevent the potential for claims or actions.

Medical debt is a complicated and multi-faceted problem, and providers must begin to look “outside the box” for solutions. Meaningful solutions to the dilemma of medical debt require the consideration of many factors including increased pricing transparency, improved communications between providers, patients, and payers, and increased access to care and adequate amounts of insurance, to name just a few items. Hospitals and other providers should consider the cases of Accretive and West as cautionary tales. Going forward, hospitals and other providers should attempt to fashion policies that can sustain their economic viability while treating individuals fairly and in a manner that will not compromise the physician-patient relationship or deter individuals from accessing care in the first place.

About the Author

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Footnotes


3Text of bill available at http://www.govtrack.us/congress/bills/112/s2149/text

4Unless otherwise noted, all information regarding the Accretive matter has been taken from the Complaint and related documents prepared by the Minnesota Attorney General and available at http://www.sagen.state.mn.us/.


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