- American Hospital Association Releases Results of 2009 Schedule H Project
  see page 7
- Keys to Effective Denial Management
  see page 15
- Trends in Healthcare Philanthropy and the Use of Separate Foundations
  see page 38
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.

Scott Mariani, Partner, JD  
Practice Leader, Healthcare Services Group  
smariani@withum.com • 973.898.9494
American Hospital Association Releases Results of the 2009 Schedule H Project
by Scott J. Mariani, JD and Allison S. Kimowitz, CPA .............................................. 7

ICD-10 and EMR Impacts on an Organization
by Keith Fulmer, MHSA, PMP ................................................................. 12

Keys to Effective Denial Management
by Michael Sowinski ................................................................. 15

Time is Money: CMS Proposes 10-Year Look-Back Period for Returning Overpayments
by Cecylia K. Hahn ................................................................................................................................. 17

Mission Possible: Finding Capital for Stand-Alone Hospitals
by Anthony J. Taddey and Jason Beakas ................................................. 20

What’s New With Stark Law Enforcement?
by Gary W. Herschman, Anjana D. Patel and Matthew J. McKennan .................................................... 23

Patient’s “Meaningful Use” of Electronic Health Information Proposed as Core Measure for Provider Incentive Payments from Feds
by Elizabeth G. Litten ................................................................................................................................. 25

Making Sense of it All: Seeing though the Transparency
by Julie Kay ................................................................................................................................. 27

Your Healthcare Facility Can Benefit from Energy Deregulation Two Ways: “Reverse Auctions” and “Name Your Electricity Price”
by John A. Smith ................................................................................................................................. 29

Who Are the Industry’s Rising Star Leaders? ................................................................. 37

Trends in Healthcare Philanthropy and the Use of Separate Foundations
by Walter J. Dillingham, Jr., Leigh W. Weiss and John M. Lawson .................................................... 38

The Parade of Major Reported PHI Breaches Hits 400 – Theft is the Primary Type of Breach
by Michael J. Kline, Esq. ................................................................................................................................. 44
COMMUNICATIONS COMMITTEE

Anthony F. Consoli, Director ......................................................... CBIZ Benefits & Insurance
Elizabeth G. Litten, Esq., Chair ................................................... Fox Rothschild LLP
Al Rotkamp, MBA, Vice Chair .................................................... Princeton Healthcare System/Aramark
Steve Aaron .................................................................................. ARC Group Associates
Mark Dougherty, FACHE ............................................................... Energy Systems Group, LLC
Laura Hess, FHFMA ....................................................................... NJHFMA
John Manzi .................................................................................... Panacea Healthcare Solutions, LLC
Rhonda Maraziti ........................................................................... Somerset Medical Center
William McCann ........................................................................... Healthfirst
David A. Mills ............................................................................... Deloitte Consulting
Amina Razonica ............................................................................. New Jersey Hospital Association
James A. Robertson, Esq. ................................................................. McElroy Deutsch Mulvaney & Carpenter, LLP
Roger D. Sarao, CHFP ................................................................. New Jersey Hospital Association

NJ HFMA BOARD MEMBERS

Anthony F. Consoli ................................................................. CBIZ Benefits & Insurance
Laurie Grey .................................................................................. Princeton Healthcare System
Scott Mariani .................................................................................. WithumSmith + Brown, PC.
Darlene Mitchell .............................................................. Hunterdon Healthcare System
Michael Ruiz De Somocurcio – Associate Board Member ....................... Amerihealth
Roger Sarao, CHFP – Ex-Officio .................................................. New Jersey Hospital Association
Diana Sessions – Associate Board Member .........................................Accenture
Deborah E. Shapiro, MBA .......................................................... WFS Services
Stella Visaggio, FHFMA, CPA .................................................... Hackettstown Regional MC
Heather Weber ............................................................................... ParenteBeard
Dan Willis ....................................................................................... Children’s Specialized Hospital

NJ HFMA CHAPTER OFFICERS

President, Michael Alwell, FHFMA .............................................. Saint Michael’s Medical Center
President-Elect, John Brault, FHFMA ........................................... McBee Associates
Treasurer, David J. Wiessel ....................................................... Ernst & Young, LLP
Secretary, Tracy Davison-DiCanto, FHFMA, MBA ....................... Princeton Healthcare System

NEW JERSEY HOSPITAL ASSOCIATION

Heather Weber, FHFMA, CPA, MBA

ADVERTISING POLICY/ANNUAL RATES

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

Contact Laura Hess at 888-652-4362 to place your ad or receive a copy of the Chapter’s advertising policy. The Publications Committee reserves the right to refuse any ad not consistent with the overall mission of the Chapter. Inclusion of an ad in this Newsmagazine does not infer endorsement of the product or service by the Healthcare Financial Management Association or the Publications Committee. Neither the Healthcare Financial Management Association nor the Publications Committee shall be responsible for slight variations in production quality of published advertisements. Effective July 2006 Rates for 6 bi-monthly issues are as follows:

<table>
<thead>
<tr>
<th>Display</th>
<th>Full Page</th>
<th>Half Page</th>
<th>Quarter Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Back Cover – Full Page Color</td>
<td>$4,600</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Inside Back &amp; Front Covers – Full Page, Color</td>
<td>$4,350</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>First Inside Ad – Full Page, Color</td>
<td>$3,250</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>First Inside Ad – Full Page, Black &amp; White</td>
<td>$3,450</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Inside Ad – Color</td>
<td>$3,450</td>
<td>$2,600</td>
<td>NA</td>
</tr>
<tr>
<td>Inside Ad – Black &amp; White</td>
<td>$2,150</td>
<td>$1,450</td>
<td>$875</td>
</tr>
<tr>
<td>Center Spread – 2 Full Pages, Color</td>
<td>$5,900</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Center Spread – 2 Full Pages, Black &amp; White</td>
<td>$3,800</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

NEW! Web Ads are available to our FOCUS advertisers – $250 for 3 months

DEADLINE FOR SUBMISSION OF MATERIAL

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

EDITORIAL POLICY

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

The Communications Committee reserves the right to accept or reject contributions whether solicited or not. All correspondence is assumed to be a release for publication unless otherwise indicated. All article submissions must be typed, double-spaced, and submitted as a Microsoft Word document. Please email your submission to: Elizabeth G. Litten, Esq. elitten@foxrothschild.com

REPRINT POLICY

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

GARDEN STATE "FOCUS" (ISSN#1078-7038; USPS #003-208) is published bi-monthly by the New Jersey Chapter of the Healthcare Financial Management Association, c/o Elizabeth G. Litten, Esq., 997 Lenox Drive, Building 3, Lawrenceville, NJ 08648-2311

Periodical postage paid at Trenton, NJ 08650. POSTMASTER: Send address change to Garden State “FOCUS” c/o Laura A. Hess, FHFMA, Chapter Administrator, Healthcare Financial Management Association, NJ Chapter, P.O. Box 6422, Bridgewater, NJ 08807

OBJECTIVE

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

Who’s Who in the Chapter 2011-2012

Chapter Website: www.hfmanj.org

Who’s Who in the Chapter 2011-2012

Chapter Website: www.hfmanj.org
There has certainly been quite a lot of activity within the chapter over the past couple of months. January saw the beginning of the Basic Financial Management Series. This six week, evening program was designed to provide members with a deeper understanding of various aspects of healthcare finance (Contract Management, Disbursements, Budgeting and Forecasting, and Revenue Cycle) while at the same time preparing the attendees to sit for the HFMA Certification exam. What made this program truly unique was the fact that attendees were given the opportunity to attend the sessions at their choice of a northern or southern New Jersey facility with the locations connected via video-conference thanks to ARMDS.

On February 21st the New Jersey chapter sponsored a webinar entitled Keys to an Effective Denial Management Strategy. This program was presented in collaboration with the Pennsylvania HFMA Chapters as part of a regional webinar series. The program was very well received and was attended by more than 175 people in New Jersey and Pennsylvania.

February was also the month for our annual Medicare Cost Report Preparation Course and Medicare Hot Topics Update. This was another very successful program that received high ratings from all who attended.

In collaboration with the Health Information Management Association, the CARE (Compliance, Audit, Risk, and Ethics) Forum presented their annual educational session, Compliance Challenges for Today, Tomorrow and Beyond: Staying Ahead While Implementing Reform, on March 13th. This program drew close to 200 people, the largest attendance in at least the last four years. I have to give all of the credit for the tremendous success of this program to the quality of the agenda and all of the hard work and planning that went into it on the parts of Mike McKeever, Nadinia Davis and the entire CARE Committee with Ellen Shakespeare, Mary Sottile, and NJHIMA.

I’m also very happy to report that a recent HFMA member satisfaction survey showed that 69% of the respondents were highly satisfied with the value of their membership. The survey did identify that there is a need to provide additional programs and activities in south New Jersey, provide some additional focus on Revenue Cycle, and make some improvements to Chapter communications.

I had mentioned in my first President’s View letter that “…to show excellence to the membership the chapter must listen to its members and respond to their needs…” I can promise that the board began to address all of these recommendations as soon as the survey results became available.

The FACT (Finance, Accounting, Capital, and Tax) Forum has already planned two half day education sessions for the end of April focusing on HealthCare Reform and Other Hot Topics. One session will be presented at the Barnabas Health Corporate Offices in West Orange, and the second will be in south Jersey at AtlantiCare in Egg Harbor Township.

The new Revenue Integrity Forum will be holding a day long education session on revenue cycle management issues in June. The program will address topics such as ICD-10 implementation, facility E&M charging, Cardiology and Interventional Radiology Cost, Quality & Reimbursement, and much more. The day will end with a quiz show complete with prizes for the lucky winners.

In response to feedback from the survey, the Board is also already looking into possible improvements to the Chapter’s website and the on-line version of the Garden State Focus as well as increasing the use of social networking (yes, the chapter already has a LinkedIn Group and a FaceBook page).

Enjoy the spring. I hope to see everyone on May 10th at the NJ HFMA Golf Outing.

Michael Alwell
Dear Readers:

New Jersey and most of the northeast has experienced a mild winter, but the longer days and flowering trees are just as welcome as they are after a cold, snowy winter. The arrival of spring reminds me that a new Chapter year will soon be upon us, providing us with another opportunity to celebrate Chapter successes and assess opportunities for improvement. In particular, Chapter President Mike Alwell’s letter notes that we are looking to make improvements to our Chapter communications and website.

Please know that the Communications Committee reviews the results of the member satisfaction survey very closely, and we want to make sure our readers (some of you – and you know who you are – did not respond to the survey) have the opportunity to provide feedback as to how we can improve our communications with you. Of the 154 Chapter members who responded to the survey, 35 members submitted specific comments as to how the Chapter can improve. Several of the commenters submitted multiple comments, such that there were approximately 45 or so individual suggestions related to possible improvements. Only 1 of these comments related to the website (a commenter stated it is not as user-friendly as it could be), and only 1 related to FOCUS (the comment was that it should be sent electronically).

An additional 17 commenters offered “other” comments for the Chapter. Only 3 of these “other” comments were negative or suggested improvements, and the other 14 comments were positive or very positive. Two of the positive comments related specifically to communications: one member noted that “the chapter is doing a great job communicating”, and another stated, “I do like to get the e-mails that keep me aware of what is going on in health care. Thank you for that.”

Still, the Communications Committee is constantly looking into ways to improve, and we welcome your feedback on the following specific questions:

1. Do you view the mailed copy of the FOCUS magazine as:
   (i) a key member benefit;
   (ii) an incidental (nice or OK, but not necessary) member benefit;
   (iii) of no benefit to you as a member; or
   (iv) an annoyance.

2. Should the Chapter make the magazine available only on the Chapter website, and discontinue sending printed copies of the magazine? Should the Chapter email digital copies of the magazine?

Please email Laura Hess at hfmanj@aol.com with your answers and any other comments you may have regarding FOCUS and our website.

Regards,

Elizabeth G. Litten
Editor
VIE Healthcare’s Certified Hospital Expense Reduction Training

- Learn The Best-Practices In Expense Reduction
- We Teach Proven Hospital Expense Reduction Strategies That Will Achieve Documented Results
- Discover The Trends And New Opportunities In Hospital Expense Reduction That Your Organization Should Be Learning
- Invest In The One Area Which Can Improve Your Hospital’s Bottom Line Immediately - Expense Reduction

VIE Healthcare has created the only program available to hospitals who want their employees to learn the very valuable skill of Expense Reduction.

VIE’s Next “Learn from your Location” Training begins on May 7th through May 18th.

SPECIAL LIMITED TIME OFFER: Enroll 5 hospital employees and receive 1 at no cost. Enrollment by April 30, 2012
Offer Code FOCUS

Visit us at www.C-HERS.com to receive a free information packet or call Denise Bisogno at 732-359-7646 Ext 500

[Image of people with pens and darts]
New Jersey’s Clean Energy Program offers an extensive collection of comprehensive initiatives that make energy efficiency more accessible than ever. You’ll save up front through sizeable financial incentives and down the line with dramatically reduced utility bills.

**Financial Incentives Available**

With generous incentives from NJ SmartStart Buildings, we were easily able to afford the replacement of our inefficient, outdated lighting with high efficiency options that have drastically reduced our electric bills.

*Energy Smart. Bottom Line Brilliant!*
The American Hospital Association ("AHA"), with the assistance of Ernst & Young, LLP, undertook a project to analyze the different ways hospitals are serving their communities based upon recent tax return filings. When the Internal Revenue Service ("IRS") revised the Federal Form 990 starting with 2008 tax returns, they included Supplemental Schedule H, Hospitals. This schedule serves to report a hospital’s benefit to the community through both reporting financial information based upon costs and answering questions with narrative responses. Schedule H allows a hospital to “tell its story”. The IRS granted hospitals transitional relief in the first year of the new Form 990, making only Part V, Facility Information, mandatory to complete. However, for 2009 tax returns, all licensed tax-exempt hospitals were required to complete all six parts of Schedule H.

Responding Hospitals and Systems, by Size, Location and Type

A total of 571 Schedule Hs were utilized in the project; 477 individual hospitals and 94 healthcare systems (“systems”). The information was gathered in two phases; one for calendar year taxpayers and one for fiscal year taxpayers. During phase one, 349 Schedule Hs were collected and 222 Schedule Hs were collected in the second phase. The 94 system responses represented approximately 400 hospitals. Thus, the results of the project represent approximately 900 hospitals or 30 percent of the total hospitals that are required to complete Form 990, Schedule H annually. These hospitals and systems are representative of thirty-five different states throughout the United States.

Data was gathered on all six parts of the Schedule H and the results were divided into different segments. Systems were separated from individual hospitals due to the fact that certain system hospitals may fall into different categories. Single hospitals were categorized by size (small, medium or large) based on total hospital expense, location (urban/suburban or rural) based on zip code and hospital type (general medical/surgical, children’s, teaching or critical access) based on the facility response.

For purposes of this project, the single hospitals were categorized by size as follows:

- a small hospital had less than $100 million of total hospital expenses;
- a medium hospital had $100 million to $299 million of total hospital expenses;
- a large hospital had $300 million or more of total hospital expenses;

Using the size category criteria outlined above, the 477 individual hospitals were categorized as follows:

- 172 small hospitals
- 185 medium hospitals
- 120 large hospitals

The Results

On average, overall, the participating hospitals and systems report 11.3 percent of their total annual expense as a benefit to the community. The 11.3 percent is comprised of the following categories: 8.4 percent represents total charity care, means-tested government programs and other benefits; 2.4 percent represents Medicare shortfall; 0.4 percent represents bad debt expense attributable to charity care and 0.1 percent represents community building activities. For purposes of this project, benefits to the community include charity care, Medicaid underpayments, community health improvement programs, health research and education, subsidized services, bad debt

continued on page 9
Save the Date!

Annual NJ HFMA Golf Outing
May 10, 2012

Fiddler’s Elbow Country Club
Far Hills, NJ

Sponsorship opportunities are available.
Contact Laura Hess at NJHFMA@aol.com
expense attributable to charity care, Medicare shortfall, and community building activities.

Charity Care, Means-Tested Programs, and Other Benefits

Schedule H, Part I, Financial Assistance and Certain Other Community Benefits at Cost was analyzed for all participants. The information shows that the 8.4 percent was the overall average of expenses attributable to “community benefit” under the definition adopted by the IRS and reported on each hospital's respective Schedule H, Part I. The 8.4 percent is comprised of the following: 5.7 percent represents charity care, unreimbursed Medicaid, and other unreimbursed costs from means-tested government programs; 0.5 percent represents community health improvement; 0.8 percent represents health professions education; 0.8 percent represents subsidized health services; 0.3 percent represents medical research and 0.3 percent represents cash and in-kind contributions to community groups.

The average of expenses attributable to “community benefit” under the definition adopted by the IRS and reported on each hospital's respective Schedule H, Part I was further reported by hospital size. The report shows that small hospitals reported an average community benefit percentage of 7.3 percent, medium hospitals reported 8.0 percent, large hospitals reported 9.8 percent and systems reported 9.3 percent; respectively. The hospital size categories and respective community benefit categories which total to these percentages are as follows:

Small Hospitals

The 7.3 percent is comprised of the following: 5.7 percent represents charity care, unreimbursed Medicaid, and other unreimbursed costs from means-tested government programs; 0.3 percent represents community health improvement; 0.2 percent represents health professions education; 1.0 percent represents subsidized health services; 0.3 percent represents medical research and 0.1 percent represents cash and in-kind contributions to community groups.

Medium Hospitals

The 8.0 percent is comprised of the following: 5.8 percent represents charity care, unreimbursed Medicaid, and other unreimbursed costs from means-tested government programs; 0.5 percent represents community health improvement; 0.6 percent represents health professions education; 0.9 percent represents subsidized health services; 0.1 percent represents medical research and 0.1 (approx, rounded down) percent represents cash and in-kind contributions to community groups.

Large Hospitals

The 9.8 percent is comprised of the following: 5.7 percent represents charity care, unreimbursed Medicaid, and other unreimbursed costs from means-tested government programs; 0.5 percent represents community health improvement; 1.6 percent represents health professions education; 0.7 percent represents subsidized health services; 0.9 percent represents medical research and 0.4 percent represents cash and in-kind contributions to community groups.

Systems

The 9.3 percent is comprised of the following: 5.8 percent represents charity care, unreimbursed Medicaid, and other unreimbursed costs from means-tested government programs; 0.5 percent represents community health improvement; 1.2 percent represents health professions education; 0.7 percent represents subsidized health services; 0.5 percent represents medical research and 0.6 percent represents cash and in-kind contributions to community groups.

Federal Poverty Guidelines to Determine Free and Discounted Care

Hospitals frequently utilize Federal Poverty Guidelines (“FPG”) issued annually by the Department of Health and Human Services to determine free and discounted care to their patients. The results indicated that 96 percent of hospitals in each size and location categories use FPG to determine eligibility for free care, with 99 percent of large hospitals utilizing them. The data also shows that 88 percent of hospitals in each of the size and location categories use FPG to determine eligibility for discounted care.

Bad Debt Expense

Estimates of bad debt expense attributable to charity care were completed by greater than 70 percent of the participants. The average bad debt expense attributable to charity care reported was 0.4 percent of total expenses or approximately $1.6 million per participant. A majority of hospitals and systems reported that a portion of their bad debt expense would qualify as a benefit to the community.

Under the Patient Protection and Affordable Care Act enacted on March 23, 2010, the IRS must review the Form 990, Schedule H for every filing tax-exempt hospital at least once every three years.
as charity care if these individuals provided certain necessary financial information.

Medicare Surplus and Shortfall

More than 75 percent of the respondents reported a Medicare reimbursement shortfall. Shortfall is when the Federal government reimburses hospitals at less than their costs for treating Medicare-qualifying patients. Of the respondents reporting a shortfall, 27 percent of them reported having a shortfall greater than six percent of their total expenses.

Both bad debt and Medicare shortfall (or surplus) are reported in Part III of Schedule H. In this part of Schedule H the IRS also asks hospitals to describe why bad debt and Medicare shortfall constitutes community benefit. Most hospitals participating in the AHA project described their rationale for inclusion. Reasons given included:

- Under IRS Revenue Ruling 69-545, the promotion of health is evident when a hospital serves patients with Medicare and other government health benefits.
- Hospitals are lessening the burden on the government by providing medical assistance to individuals eligible for Medicare. Under the recently issued IRS Notice 2011-20, this act of treating patients under Medicare was deemed a charitable purpose.

Community Building Activities

The participating hospitals and systems indicated that they spend only 0.1 percent of their total expenses on community building activities. These activities include, but are not limited to, making cash or in-kind donations to programs addressing health problems or participation on the state Board of Health, universities and schools, regional health departments and community relations committees in the community.

Summary

The project report is useful as it shows information based upon the initial complete filing of Form 990, Schedule H. We must remember that this information is based upon only 900 of approximately 2,900 not-for-profit hospitals nationwide; approximately thirty percent. Therefore, this information and the averages reported herein may vary from those hospitals who elected not to participate. In addition to the project results, the IRS instructions are a good, comprehensive starting point when preparing your organization’s Schedule H. Please note that as Schedule H is still in the early stages of development, there are still many gray areas with respect to whether a hospital program, department or activity may be considered “community benefit” for purposes of Form 990, Schedule H.

Under the Patient Protection and Affordable Care Act enacted on March 23, 2010, the IRS must review the Form 990, Schedule H for every filing tax-exempt hospital at least once every three years. In addition, the Secretary of the Treasury must report the comparative levels of the charity care for these hospitals annually to Congress and complete a Congressional study every five years to report the trends over this time period. As a result, further guidance from the IRS and the Department of Treasury in the future with respect to Schedule H and community benefit is likely.

About the authors

Scott J. Mariani, JD, is a Partner at WithumSmith+Brown, Certified Public Accountants and Consultants, and is also a Practice Leader of the firm’s Healthcare Services Group. Scott can be reached at smariani@withum.com.

Allison S. Kimowitz, CPA, is a Senior Accountant at WithumSmith+Brown, Certified Public Accountants and Consultants, and is a member of the firm’s Healthcare Services Group. Allison can be reached at akimowitz@withum.com.

Don't let your HFMA membership lapse!
Be sure to renew at www.hfma.org.
To assist our health care facilities clients who may be experiencing severe financial pressure, members of the Norris McLaughlin & Marcus Health Care and Creditors’ Rights & Bankruptcy Practice Groups formed a team to help financially troubled health care facilities. Services provided by the Group include:

- Serve as counsel and health care consultants to troubled health care facilities and institutions considering filing for reorganization or liquidation under the federal Bankruptcy Code or state insolvency laws

- Provide advice and counsel to entities seeking to take over targets which are financially troubled health care facilities and institutions

- Analyze and advise new venture capital groups involving the takeover and mergers of financially troubled health care facilities and institutions

- Serve as regulatory and litigation counsel, and regulatory consultants, to hospitals and their affiliated corporations, hospital medical staffs and medical staff members, nursing homes and other long-term care facilities, professional practices and other providers of health care services

- Assist health care facilities that are the target of federal program fraud investigations, whistle-blower actions, and other federal and state compliance actions which may involve emergent criminal and civil defense support

- Accept appointments by the Bankruptcy Judges in the District of New Jersey, the Commissioner of the New Jersey Department of Health and Senior Services, and New Jersey Chancery Judges to serve as Trustees, Assignees for the Benefit of Creditors, Rehabilitators for New Jersey and New York health care facilities and institutions

Financially Troubled Health Care Facilities Group

J. Anthony Manger
Gary N. Marks
Ira S. Novak
Sandra Jarva Weiss

Matthew R. Sorrentino
Bruce J. Wisotsky
Morris S. Bauer
Larry K. Lesnik

Please visit our web site for more information on our Health Care Law Group
www.nmmlaw.com

New Jersey • New York • Pennsylvania
P: (908) 722-0700 • F: (908) 722-0755

A full-service law firm serving the health care community for over 50 years.
We are in the midst of unprecedented change in the healthcare industry. The entire healthcare coding structure and logic is changing from ICD-9 to ICD-10 and so must every financial, clinical and operational IT system that touches these codes. Additionally, the federal government has paid more than $3 billion to U.S. hospitals and doctors’ offices in the process of switching to electronic medical records (EMR). While both proponents and critics agree that ICD-10 and EMRs will ultimately lead to improved patient care, there is far less concurrence on the timetable, approach and estimated budgets for these large projects.

Perhaps the most heated debate centers around timing of ICD-10 implementation efforts. The recent announcement by Centers for Medicare & Medicaid Services (CMS) that the date for ICD-10 implementation will be postponed beyond Oct. 1, 2013, has prompted a number of unintended consequences. Waiting until a new date has been identified, if one is identified, will further strain resources and timing. A Healthcare Information and Management Systems Society (HIMSS) member survey suggests that any delay in the implementation of ICD-10 could result in additional provider costs. Examples of these costs include maintaining two separate systems, retaining the services of consultants for longer than anticipated and re-training staff. That is on top of multi-million dollar financial investments that have been budgeted to meet the ICD-10 deadline.1 Delaying progress and disbanding project teams will result in lost tribal knowledge, talent and jobs as they look for other opportunities within the market. This will further strain the talent pool when the new date is set and once again healthcare organizations are racing toward the same deadline. ICD-10 implementation will still be the same volume of work, regardless of a delayed deadline, and is still expected to take 18+ months. HIMSS urges maintaining the existing deadline of October 1, 2013 for most providers. Delaying the inevitable may give facilities a cushion – which can be critical for those hospitals who haven’t even completed an ICD-10 readiness assessment of primary functional areas like IT, revenue cycle, operations. However, there is still a drain on talented professionals and experienced consulting partners. Waiting will only make those resources more scarce.

While competing priorities – like meaningful use for EMR – may take focus away from beginning the ICD-10 implementation process, experts agree that healthcare organizations need to have the assessment process under way. Without an assessment, organizations cannot budget accordingly, and the cost is higher than many may think. In a 2011 survey by HealthLeaders Media,2 32 percent of healthcare organization who had completed a financial assessment expected to spend up to $1 million to prepare, while just 9 percent estimated a cost between $1.1 million and $5 million. Fast-forwarding to the present, 19 percent of respondents to the recent HIMSS Leadership Survey said their organization had already spent more than $1 million on the conversion to ICD-10.

Not only is there varied and eye-opening speculation on the total cost of implementation, but the amount of employee training and IT systems to be remediated can be staggering. A comprehensive ICD-10 readiness assessment3 on a 293-bed hospital in Pueblo, CO, helped the CEO identify the length of time, budget and amount of resources required for the implementation preparation and “go live” phases. The medical center had initially identified six IT systems that would be impacted in addition to the planned Meditech 6.0 upgrade. The hospital also was planning for the training needs of their coding, clinical documentation improvement (CDI), health information management (HIM), as well as billing and medical staff. In actuality, the readiness assessment conducted by an outside vendor revealed that 27 IT systems would be impacted in addition to the planned MediTech 6.0 upgrade. The hospital was planning for the training needs of their coding, clinical documentation improvement (CDI), health information management (HIM), as well as billing and medical staff. In actuality, the readiness assessment conducted by an outside vendor revealed that 27 IT systems would require remediation and testing. Additionally 35,000 personnel hours – including 15,000 education hours – would be required. The conversion would directly impact 1,084 of the hospital’s employees and physicians, including the human resources department, trauma registry, and diabetes and wound care clinics, many of which were never anticipated in the hospital’s initial estimate.

While the 2015 implementation deadline for EMR holds solid, there are varied approaches suggested by industry consulting firms. Several best practices, commonly seen include:

- **Analyze and redesign workflows** Organizations will need to realign and standardize procedures across the organization to accommodate the new technology. It is vital
to evaluate bad processes and correct them prior to implementation to avoid simply proliferating and automating bad processes.

• **Provide multiple and varied training opportunities** An effective training plan will ensure maximum utilization once the EMR system is up and running. While a formal training plan is the first step, a refined training plan based on the roles of each user group offers a specific perspective on real-life, day-to-day activities.

• **Identify and train super users** Super users act like “personal trainers” and complete rounds with physicians, as well as station themselves at each patient unit, to assist with questions or system procedures.

The proliferation of EMRs and implementation efforts for ICD-10 will no doubt continue, but at what pace? A survey by the American Hospital Association (AHA) found that 35 percent of U.S. hospitals are using electronic health records, up from 16 percent in 2009, and 85 percent have said they intend to apply for incentive payments for using the technology by 2015. Many large providers, hybrids and academic medical centers are well on their way to meeting the current ICD-10 deadline of Oct. 1, 2013, and have significant investment made in both permanent and temporary staffing to support these projects. Also, many vendors are working hard to get their systems ready for ICD-10 and have established plans to complete prior to October 2013. However, it is human nature for people to use all the time they have available to complete a task or project. Hopefully, organizations will heed warnings from experts like HIMSS and the American Health Information Management Association (AHIMA) and continue working toward the October 2013 deadline.

**About the author**
Keith Fulmer has more than 20 years’ experience in Information Technology and Consulting. He has successfully integrated Kforce Clinical Research and Health Information Management operations within Kforce Inc.’s Health and Life Sciences division. His ICD-10 experience includes establishing the Kforce ICD-10 Consulting Practice as well as defining and developing the ICD-10 Assessment and Implementation methodology. Keith serves on the Board of Directors for a local Healthcare Services company and holds a Master of Health Services Administration. He is also certified through the Project Management Institute as a Project Management Professional (PMP). Fulmer can be reached at HealthcareSolutions@kforce.com. For more information, please visit www.kforce.com/Healthcare-Solutions.

**Footnotes**
2Minich-Pourshadi, K. ICD-10 Puts Revenue at Risk, Health-Leaders Media, July 2011

THE CBIZ Healthcare Reform Toolkit
Insight Not Guesswork.

CBIZ's Healthcare Reform Toolkit is:

**Comprehensive** The Toolkit provides 13 financial impacts for your hospital including DSH, Quality Indicators, Readmissions and others.

**Flexible** The Toolkit lets you modify assumptions and manipulate your own data to arrive at the answers you need.

**Progressive** The Toolkit updates your Healthcare Reform financial impact as additional regulations and legislation are announced.

You need to quantify the financial impact of the new initiatives in order to understand how Healthcare Reform will affect your facility. By using the Toolkit, you can perform the financial modeling necessary to develop your facility's Healthcare Reform implementation strategy.

For additional information please contact CBIZ KA Consulting Services at 609-918-0990 or email us at HCRToolkit@CBIZ.com.
Estimates show denied claims represent over 13% of gross revenue for providers nationwide. Some studies suggest that over 90% of those denials were preventable and nearly 70% could be overturned. An additional 6% of gross revenue was lost to underpayments. These numbers are staggering when you combine lost revenue as a result with the high cost associated with resolving these denials.

To face this challenge, providers must have an effective strategy in place to identify denials, manage their resolution and analyze root cause to facilitate prevention of future denials. Some keys to an effective denial management strategy include:

1) Capturing all remittance information necessary for denial management

A primary source of denial information is the payer remittance advice (RA). Many providers focus on payment posting from the RA and neglect to capture all of the information critical for effective denial management. For denial follow-up, it is important to capture and categorize all payer reason and remark codes.

2) Paying attention to payers who provide hard copy remittance reports

To maximize collections, providers must manage denials for 100% of their payer mix. Payers who cannot provide electronic remittance advice (ERAs) typically represent around 15% of total revenue, and many providers feel that the cost of capturing denial information from a hard copy remittance report is just too high to chase such a low percentage of revenue. A simple cost/benefit analysis will likely reveal that the cost of capturing denial information from a hard copy remittance report is easily outweighed by the denial recovery opportunity, and the opportunity to identify and prevent future denials.

3) Identifying and managing underpayments

If your denial management process does not identify and manage underpayments, you may be losing up to 6% of your annual gross revenue. Managing underpayments is frequently overlooked as part of a denials management strategy. First, you can qualify partial payment denials from remittances by looking for specific reason codes to identify charge-level denials. Second, it is critical to identify payment variances by comparing remittance paid amount to the expected payment amount. This can be challenging if HIS systems, contract management systems and denial management systems don’t work well together, however, this problem is easily and clearly worth resolving given the amount of revenue at stake.

4) Considering how denied accounts are assigned to follow-up staff

Too often the focus on resolving EVERY denial results in chasing hundreds of low-balance denials while sacrificing valuable resources who could be working on resolving collectible denials. Make sure follow-up assignments are reasonable. If a follow-up work queue has 2,000 denied accounts in it, the likelihood of staff always working on the most important account will be pretty low, and the likelihood of timely follow-up on all 2,000 denied claims is even lower. There are always exceptions that require judgment, however, consider filtering follow-up work queues to include a smaller number of high priority accounts. Also, consider setting a threshold (based on cost to collect or other defined criteria) for automating low-balance write-offs on denials, eliminating those accounts from work queues.

5) Automating or streamlining follow-up activity

Efficiency is the key to maximizing recoveries. Follow-up staff should have tools to save them time, allowing them to work and resolve more accounts. Some examples:

- Payer-specific appeal letter templates that can be auto-filled with account-level information like Patient Name, PCN, MRN, DOS, Denial Reason Codes, etc.
- Write-off authorization tools to streamline the request and approval process
- Canned follow-up actions and notes to prevent staff from wasting valuable time typing the same thing over and over again
- Quick access to view and/or print the EOB and the denied claim
- Automated alerts that notify users when a prior follow-up action has not resolved the denial within the designated period of time

6) Tracking and analyzing the outcome of denial follow-up

Make sure the outcome of each resolved denial is clearly identified. Analyze outcomes and educate staff to evaluate processes that historically have not been successful.

continued on page 16
continued from page 15

ing denials. If sending the same appeal letter to the same payer for the same denial reason on 100 different claims has not overturned any denials, consider creating a new follow-up plan for that denial reason.

7) Identifying root cause and focusing on prevention

Increasing denial recovery rate is good. Decreasing initial denial rate is better! The key to prevention is in identifying the root cause. When providers understand root cause, they can make business decisions to facilitate prevention. Studies suggest that almost 80% of denials are Patient Access errors, but if the cause is unknown, staff may not be solving the right problem. It is worth the effort to evaluate and assign root cause to denials which includes identifying trends and taking steps to prevent future denials.

8) Setting and tracking financial and operational performance goals

Dashboard-style reporting tools are very helpful to communicate performance metrics throughout the organization and to manage performance. Important denial performance metrics include: initial denial rate, recoveries on denials and underpayments, rate of appeals overturned, monthly denial trends by payer and error type, denial outcomes by payer and error type.

These tips are some of the keys to a comprehensive and effective denials management strategy. Combining these eight tactics with a strong denial management solution like Emdeon Denial Manager will simplify execution of this strategy. Emdeon Denial Manager optimizes efficiencies in each of these areas to help you reduce your collection costs and A/R days, while improving your recoveries and cash flow.

About the Author

Michael Sowinski is an Account Executive for Institutional and Large Providers with Emdeon. He can be reached at: msowinski@emdeon.com.

Emdeon is a leading provider of revenue and payment cycle management and clinical information exchange solutions, connecting payers, providers and patients in the U.S. healthcare system. Interested in learning more about these eight strategies for effective denial management or finding out where the industry is headed with Denial Management applications? Find out more information by visiting Emdeon online at www.emdeon.com/denial-manager/.

Source for all statistics in article: The Healthcare Advisory Board
Time is Money: CMS Proposes 10-Year Look-Back Period for Returning Overpayments

By Cecylia K. Hahn

By now, most everyone is aware of Section 6402(a) of the Affordable Care Act (“ACA”), which was signed into legislation on March 23, 2010, requiring that an overpayment be reported and returned by the later of (1) the date which is 60 days after the date on which the overpayment was identified; or (2) the date any corresponding cost report is due, if applicable. On February 16, 2012, the Centers for Medicare & Medicaid Services (“CMS”) proposed new rules to implement this requirement. The new rules will expand the power of CMS to recover overpayments, contributing to paying for the expensive ACA, while simultaneously costing providers millions of dollars in cost-reporting expenses.

What is an overpayment?

An “overpayment” means “any funds that a person receives or retains under [Medicare] to which the person, after applicable reconciliation, is not entitled . . . .” Examples of overpayments include:

1. Medicare payments for non-covered services;
2. Medicare payments in excess of the allowable amount for an identified covered service;
3. Errors and non-reimbursable expenditures in cost reports;
4. Duplicate payments; and
5. Receipt of Medicare payment when another payer has the primary responsibility for payment.

Overpayment may also result from Medicare’s overestimating payments for services. Medicare may overestimate payments to providers throughout the cost year with the expectation that those overpayments will be returned upon reconciliation.

What are the requirements for reporting and returning overpayments?

A person who has received an overpayment must return the overpayment to the Secretary and inform of the reason for the overpayment. This requirement will be implemented through the existing voluntary refund process. Providers will report overpayments using an appropriate form from a Medicare contractor, an intermediary. The purpose of the form is to identify the claim to CMS. Additionally, the provider is burdened with the requirement to inform CMS of the following information:

1. How the error was discovered;
2. A description of the corrective action plan implemented to ensure the error does not occur again;
3. The reason for the refund;
4. Whether the provider has a corporate integrity agreement (“CIA”) with the OIG or is under the OIG Self-Disclosure Protocol;
5. The timeframe and the total amount of refund for the period during which the problem existed that caused the refund;
6. Medicare claim control number, as appropriate;
7. Medicare National Provider Identification (“NPI”) number; and
8. If a statistical sample was used to determine the overpayment amount, description of the statistically valid methodology used to determine the overpayment.

Of course, along with satisfying the onerous reporting requirement, the provider must submit a refund in the amount of the overpayment. The slew of requirements will render reporting and returning of overpayments, which should be a simple and uncomplicated accounting task, a form of art.

What does “identified” mean?

The proposed regulations attempt to clarify the statute which does not define when an overpayment is “identified.” Under

continued on page 19
Successful solutions produce a significant return on investment, fit within the client’s culture, and provide long-term benefits. McBee Associates’ creates custom solutions that address the unique needs of your facility. Our world-class consulting team carefully balances the need for both short-term fixes and long-term solutions. Create a strong foundation of financial health with our full-service consulting services, including:

- **Revenue Cycle Enhancement**—Improve billing efficiency and accuracy with the help of our knowledgeable health care finance professionals.

- **Denial Management**—Recoup revenue associated with denied claims and reduce denial rates with our successful appeals process and root-cause analysis.

- **Revenue Recovery**—Identify underpayments and recover lost revenue with our proven Revenue Data Mining services.

- **Regulatory Compliance**—Strengthen internal compliance initiatives and reduce risk with the help of our expert consulting team.

*Custom consulting services that meet your needs.*

**Jeffrey Silvershein**  *Vice President - Principal*
212.594.6669  
JeffreySilvershein@McBeeAssociates.com
CMS’ proposal, a person has “identified” an overpayment if the person has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the overpayment. CMS believes defining “identification” in this way gives providers an incentive to exercise reasonable diligence to determine whether an overpayment exists.

CMS has provided examples of when a provider might act in reckless disregard or deliberate ignorance. In some cases, a provider may receive information concerning a potential overpayment that creates an obligation to make a reasonable inquiry to determine whether an overpayment exists. Failure to conduct such inquiry could result in the provider knowingly retaining an overpayment. A provider may be required to make a reasonable inquiry when, for example:

1. A provider receives an anonymous tip of an overpayment from a compliance telephone hotline;
2. In reviewing records, a provider determines a service was improperly coded, resulting in an increased reimbursement;
3. A provider learns a patient died prior to the service date on a claim submitted for payment;
4. A provider learns an unlicensed or excluded individual provided a service;
5. An internal audit reveals overpayment(s);
6. A provider learns an unlicensed or excluded individual provided a service;
7. A provider receives, for no apparent reason, a significant increase in Medicare revenue.

If reasonable inquiry reveals that an overpayment has been received, the 60-day clock begins to run from that revelation. There is no further guidance as to how long a provider may take to conduct the reasonable inquiry. Thus, the meaning of “identified” remains elusive.

**Is it possible to extend the time to return an overpayment?**

The 60-day deadline to return an overpayment can be extended if the provider will suffer a financial hardship. Financial hardship exists when the total amount of outstanding overpayments is 10 percent or greater than the total Medicare payments made for the cost reporting period: (1) covered by the most recently submitted cost report, or (2) for the previous calendar year for a non-cost-report provider.

However, provider beware: failure to report or return an overpayment may give rise to liability under the False Claims Act and the Civil Monetary Penalties Law.

**Provider beware:** failure to report or return an overpayment may give rise to liability under the False Claims Act and the Civil Monetary Penalties Law.

**What is the look-back period?**

The proposed regulations extend the look-back period for reporting overpayments from 4 years to 10 years. However, not surprisingly, the proposal is silent as to whether the new 10-year look-back period begins immediately or whether it will be applied prospectively. Expect the proposed look-back period to be applied from the date the regulations are adopted. After all, all is fair in love, war, and regulating Medicare.

Comments to the proposed rules must be received by 5 p.m. on April 16, 2012.

**About the Author**

Cecylia K. Hahn is an associate with the health care practice of McElroy, Deutsch, Mulvaney & Carpenter, LLP, a 300-attorney firm with ten offices in New Jersey, New York, Connecticut, Massachusetts, Pennsylvania, Delaware, and Colorado. As of July 1, 2011, Kalison, McBride, Jackson & Robertson, P.C. has consolidated its health care practice with McElroy, Deutsch, Mulvaney & Carpenter, LLP.

**Footnotes**

1. 42 C.F.R. § 414.303.
2. Id. at § 401.305.
3. Id. at § 401.607. Amounts included in an approved, existing repayment schedule are excluded from the calculation pertaining to financial hardship. Id.
4. Id. at § 401.305(g).
Mission Possible: Finding Capital for Stand-Alone Hospitals

By Anthony J. Taddey and Jason Beakas

Your mission, should you choose to accept it, is to find capital to renovate or replace your aging hospital at an affordable cost. As a stand-alone hospital that doesn’t rely on taxes, how hard can it be in 2012?

Let’s find out. Median-ratios reports issued at the end of 2011 for nonprofit hospitals and health systems by the “Big Three” credit rating agencies—Standard & Poor’s, Fitch Ratings and Moody’s Investor Service—indicate how industry and economic pressures are affecting the credit ratings of hospitals. These median ratios, by offering a snapshot of the finances of all rated hospitals in their individual portfolios, help in the comparison of credits across rating categories and are used to predict future sector performance.

What Lies Ahead?

Year-end median reports pointed to an overall improvement in performance for hospitals and health systems, but predicted challenging conditions for 2012. The Big Three warned of the growing pressures on the nonprofit health-care sector with a still weak economy, selective credit markets, health-care reform uncertainties, low patient volumes and the increasing number of uninsured/underinsured patients along with decreased reimbursement rates. These serious external threats continue to apply pressure on a hospital’s bottom line while patients increasingly expect state-of-the-art facilities and services that provide quality and value.

On the positive side, due to a waning supply of higher rated, investment-grade debt over the past three years, health-care investors have moved down the credit spectrum in search of higher yields. Health-care investors’ increased risk tolerance is evident by the narrowing spread between BBB and A-rated 30-year bonds as investors search for higher returns. For example, the spread between Healthcare Baa/BBB and A/A 30-year offerings was 151 basis points in January 2009. However, as of January 2012, that spread has dropped by 53.6% to just 70 basis points. This has created an opportunity for lower rated, stand-alone hospitals to reduce their cost of capital to levels that more closely match their higher rated brethren. This landscape also requires a growing list of alternative capital-funding options, which low- to noninvestment-grade, stand-alone hospitals can use to revamp their aging plants or refinance existing higher cost debt.

Mission Possible for BBB or Below

Hospital leaders—particularly those of stand-alone, investment and noninvestment-grade facilities—need to be aware of what financing options are available to them in order to choose the best way to fund construction, renovations and new technologies and care-delivery methods. In addition to obtaining a debt rating, hospitals can consider the following routes to access long-term, fixed-rate capital:

Government-Sponsored Options

• The U.S. Department of Housing and Urban Development’s FHA Sec. 242 Mortgage Insurance offers 100% nonrecourse debt at fixed-interest rates. The maximum term is 25 years after construction completion and loan-to-value is capped at 90%, which in some cases allows the loan to cover the entire actual project cost. Average operating margins must be positive and the average debt-service-coverage ratio must be equal to or greater than 1.25 for the previous three years.

• The U.S. Department of Agriculture offers two programs for rural hospitals—the Business & Industry Program (B&I) for communities of 50,000 or less and the Community and Facilities Program (CF) for communities of 20,000 or less. The B&I program offers a maximum term of 25 years and is best suited for projects of $10 million or less with the size of the loan guarantee varying between 60%-80% depending on the loan size. The CF program provides direct and guaranteed loans
(up to 90%) with a maximum term of 40 years. For both programs, the guarantee is generally issued upon construction completion.

- The **New Markets Tax Credit Program (NMTCP)** through the U.S. Department of the Treasury may be used to finance capital projects for the health-care sector. NMTCP attracts investment capital to eligible low-income communities—rural or urban—by providing investors with a tax credit against their federal income tax return in exchange for making equity payments in Community Development Entities (CDEs). The tax credit, which totals 39% of the original investment amount, is claimed over a period of seven years. The CDE will then make two loans to the borrower at below market rates, which require interest-only payments for the first seven years. Amortization on the loans begins after that initial period. The borrower pays no fees and most banks will treat investor-provided equity as project equity, reducing the amount of equity a non-profit borrower needs to contribute to finance the project. Additionally, many states offer state tax credits in conjunction with the federal program.

**FHA Sec. 242 in Action**

Electra Memorial Hospital is a critical access hospital in northwest Texas. Challenged by a tight credit market and rural location Electra and its lender turned to the FHA Sec. 242 program to significantly renovate its 45-year-old facility and build a new wing of private rooms. As a result of the FHA mortgage insurance credit enhancement, Electra is expected to increase patient volume revenues through enhanced patient care and added services at AA-rated equivalent cost of capital.

**Commercial Options**

All nonprofit hospitals and governmentally owned hospitals can issue **revenue (or cash-flow supported) bonds**, which are generally ratable depending on their underlying credit characteristics. Additionally, many governmentally owned hospitals can issue **general-obligation (or tax-supported) bonds**, which also may be rated. These long-term, fixed-rate bonds are underwritten by a broker/dealer in a primary offering. Depending on market conditions and other available financing options, the hospital has the ability to use additional credit enhancement to further reduce its borrowing.

---

**Health-Care Interest Rates**

The tightening spread over the past three years shows that investors have moved down the credit spectrum in search for higher returns. At the same time, it illustrates a waning supply of higher rated credit due to a growing list of alternative funding options.

---

continued on page 22
• A floating-rate index note may be a more preferable option than a fixed-rate bond. Basically, the index floater is a variable-rate bond with an initial index-floater mode or period (typically three to seven years) during which the bond pays an interest rate equal to a short-term index plus a fixed-credit spread. The bond can be a public offering or privately placed directly with a bank and is subject to renewal risk at the expiration of its initial term.

• Private placement, a common alternative today, is when tax-exempt bonds are privately placed with a bank or multiple banks or with a large bond fund. These bonds are negotiated with a select group of investors and disclosure requirements can sometimes be minimized and covenants made more flexible. If the private placements are deemed "bank qualified," banks can deduct 80% of their costs and can pass along the savings to borrowers by means of a reduced interest rate. However, only $10 million in tax-exempt bonds can be designated as bank-qualified by a debt issuer in a year.

• The Federal Home Loan Bank (FHLB) letter-of-credit wrap gives a borrower the means to enhance taxable debt issuances with a FHLB’s AA+ rating when an FHLB member bank provides the underlying LOC. This means smaller local banks could provide organizations access to investment-grade credit enhancement usually available only from larger banks. Nonprofits should still investigate FHLB LOCs because tax-exempt debt is not providing the cost break it has in the past. Also, taxable bonds require fewer upfront closing costs and fewer restrictions on the use of bond proceeds.

Private Placement in Action
Fulton County Health Center, a small hospital in northwestern Ohio, has grown to include several specialty units, several medical clinics and a senior-living facility. FCHC, in good financial standing, faced an expiring LOC with a bank. A 5-year variable-rate direct purchase structure was selected. The new issue was a refunding of the earlier bonds plus cost of issuance. The transaction addressed the upcoming LOC expiration and removed the credit renewal risk during the 5-year term.

Despite mixed reviews from the Big Three for the healthcare sector in 2012, credit spreads have narrowed and options exist for stand-alone hospitals, such as Electra Memorial and Fulton County, to continue to finance their growth. A good understanding of all the options will help you obtain the required financing at reasonable terms to complete your mission.

About the Authors
Anthony J. Taddey is a managing director with Lancaster Pollard and the regional manager of its Los Angeles office. He can be reached at ataddey@lancasterpollard.com. Jason Beakas is an associate with Lancaster Pollard in Columbus. He can be reached at jbeakas@lancasterpollard.com.


Certification Corner
NJ HFMA recently completed its annual 6 week Basic Financial Management Series. This series was an opportunity not only for those who were new to the healthcare industry to gain exposure to nearly all areas of healthcare finance, but served as a review class for those HFMA members interested in taking the certification exam. Thirty individuals registered for this series, which took place at ARMDS’ offices in Burlington and Bloomfield.

Thank you to those individuals who so generously volunteered their time to teach the various course modules and share their expertise with the participants. This year, Tracy Davison-Dicanto, Rita Romeu, Steven Frankenbach, Cheryl Cohen, Maria Facciponti and George Kelley all presented.

If you were unable to attend the series, but are interested in learning more about the certification process, please review the newly updated certification page at http://www.hfmanj.org/Certification3.page or contact the chapter’s Certification Chairperson: Eric Fishbein at efishbein@presscott.com
The federal Stark law continues to be a powerful weapon in the government’s quest to combat Medicare fraud and abuse. In just the last year, the government recovered a record-breaking $4.1 billion from its health care fraud prevention and enforcement efforts. Many of these cases are easy targets from the government’s perspective because they involve Stark law violations that are easier to prove under Stark’s strict liability standard of proof. This article highlights several recent Stark law enforcement actions and provides practical recommendations for compliance in light of the ever-increasing government enforcement activity.

Halifax Hospital Medical Center – DOJ Intervenes
This whistleblower case was originally brought by an employee of the hospital in charge of physician services. In late 2011, the government partially intervened in the lawsuit alleging that the hospital made improper payments to three neurosurgeons and six oncologists that were above fair market value, not commercially reasonable and took into account the volume or value of referrals, all in violation of the Stark law. Specifically, the government focused on the payment by the hospital to the physicians of improper incentive compensation in the form of “bonus pools” that were based on a percentage of the hospital’s operating margin for a particular service line.

Thus, according to the government, the more referrals the physicians made, the higher the profits of the hospital and the physicians. By sharing the profits (which presumably included the technical component of the services) with the physicians, the hospital allegedly violated the Stark law.

Tuomey Healthcare System – Federal Appeals Court Decision Expected Soon
In July 2011, a federal court entered a $45 million judgment against Tuomey Healthcare System (“Tuomey”), following a jury verdict finding that Tuomey violated the Stark law. The allegedly improper financial relationships involved part-time employment agreements entered into between wholly-owned subsidiaries of Tuomey and certain specialist physicians on its medical staff. Under the arrangements, a local gastroenterology group and local orthopedists agreed to perform outpatient procedures exclusively at Tuomey for 10 years.

Tuomey agreed to pay the physicians a base salary which was “tiered” based on collections of services personally performed, plus a bonus totaling 80% of collections and 5.6% of collections for meeting certain quality measures. The total compensation, including salary and benefits, was approximately 19% higher than the professional fee collections for the physicians’ professional services. In tape-recorded conversations, Tuomey executives stated that the payments were considered “phantom ownership” in an outpatient surgical center aimed at sharing revenue “with those people who might otherwise, frankly go out and compete” with the hospital.

On appeal to the Fourth Circuit, Tuomey argues that the arrangements do not violate the Stark law because the physicians were paid only for personally performed professional services. The government argues that the financial relationships did not meet the requirements of the indirect compensation exception to the Stark law because the payments took into account the volume or value of the physicians’ referrals. Oral argument on the appeal occurred in January 2012 (which included both substantive and procedural arguments), and the Fourth Circuit’s decision is expected this Spring.

This case is important because if the government’s position is adopted by the Fourth Circuit, certain compensation structures based on personally performed services (which previously were
thought not to implicate the Stark law) could fall directly within the law’s restrictions. For example, compensation based on the professional component of services, such as a methodology that takes into account patient encounters, collections, or wRVUs, could implicate the Stark law. Further, the government’s arguments could call into question compensation arrangements whereby physicians are paid in excess of their personally performed collections.

**Select Medical Corporation – $7.5M LTAC Settlement**

In September 2011, Select Medical Corporation (“Select”), the owner and operator of 110 long-term care acute care hospitals, agreed to pay $7.5 million to settle alleged violations of the Stark law and the False Claims Act. The lawsuit was initially filed by a former employee, who worked in various capacities for the company over a span of five years, including as regional director for provider relations in Ohio.

The government joined the lawsuit which alleged that Select paid several physicians for “sham” medical directorships under which the physicians did not perform any duties and which were based on referrals. The government will pay the whistleblower nearly $1.4 million from the settlement proceeds, and Select will pay the whistleblower’s attorneys’ fees and costs.

**Cayuga Medical Center – $3.5M Hospital Settlement**

In January 2012, Cayuga Medical Center in Ithaca, New York, agreed to pay $3.5 million to settle alleged violations of the Stark law and the False Claims Act. The lawsuit was initially filed by a plastic surgeon who alleged that the hospital recruited physicians (including himself) in violation of the Stark law by failing to update its physician recruitment contracts following the 2004 amendments to the Stark law, and for certain expenses that were no longer permitted in light of the regulatory changes (because they went beyond the actual incremental costs attributable to the recruited physicians).

Significantly, the hospital had in effect signed physician recruitment contracts, but it failed to update them in light of changes to the Stark law. Once it discovered this oversight, it self-disclosed to the government, but it failed to self-disclose all of the non-compliant arrangements, including the ones subject to the whistleblower’s lawsuit. This case is important because it demonstrates how easily hospital-physician arrangements can fall into the non-compliance trap if hospitals are not vigilant in monitoring their physician arrangements in light of the ever-increasingly complex and changing regulatory landscape.

**Conclusion**

The Halifax and Tuomey cases discussed above are significant because they may be indicative of an evolving area of focus by the government with respect to different types of physician incentive or bonus compensation structures that the government is alleging are tied to the volume or value of the physician referrals. The Select Medical and Cayuga cases are equally important because they demonstrate again how easily a hospital-physician compensation arrangement can violate the Stark law. All of these cases show how Stark law violations are easy targets to the federal government’s enforcement efforts, and how whistleblowers frequently include insiders such as hospital management, employees, and physicians.

**Practical Recommendations.**

Health care providers can and should take pro-active steps to avoid falling into the Stark law non-compliance trap, such as:

1. All arrangements with referring physicians should comply with a relevant exception to the Stark law. Compliance with the Stark Law requires, among other things, that arrangements are in writing and signed, and contain terms that are commercially reasonable and fair-market value. At a minimum, “fair market value” should be supported by a thorough and reasoned internal analysis, and for higher dollar and complex arrangements, a valuation from an independent and reputable health care valuation firm.

2. Hospitals should conduct periodic audits of their arrangements with physicians (personal services, physician recruitment, etc.) to confirm compliance with the Stark law. All arrangements with physicians should be reviewed every few years to ensure that the services are still being provided at the same level, and that the terms are still fair-market value and commercially reasonable. In addition, arrangements should be reviewed in light of applicable regulatory amendments, recent settlements, and case law developments.

3. Finally, to protect against the increasing prevalence of whistleblowers, hospitals should implement robust “whistle-blower avoidance” strategies as part of their compliance programs to promote the internal identification and reporting of compliance and billing issues. Employees should be favorably recognized for reporting on all such matters, and all reported issues should be fully investigated and corrective actions should be taken where appropriate. These steps should be fully documented and should decrease the risk that employees will report improprieties to the government or initiate whistleblower lawsuits.

**About the authors**

Gary W. Herschman is Chair of the Health Care Practice Group at Sills Cummis & Gross P.C. and may be reached at g herschman@sillscum mis.com. Anjana D. Patel is Co-Chair of the Health Care Practice Group and may be reached at apatel@sillscum mis.com and Matthew J. McKenna is an Associate in the Health Care Practice Group and may be reached at mmckenna@sillscum mis.com. The views and opinions expressed in this article are those of the authors and do not necessarily reflect those of Sills Cummis & Gross P.C.
Patient’s “Meaningful Use” of Electronic Health Information Proposed as Core Measure for Provider Incentive Payments from Feds

by Elizabeth G. Litten

The Centers for Medicare & Medicaid Services (CMS) recently published proposed rules setting forth the “Stage 2” criteria that eligible providers (EPs), eligible hospitals (EHs), and critical access hospitals (CAHs) (referred to herein collectively as “providers”) would be required to meet, in order to qualify for Medicare and/or Medicaid incentive payments for the use of electronic health records (EHRs) (“Stage 2 Proposal”). The Stage 2 Proposal is a small-font, acronym-laden, tediously-detailed 131-page document that modifies and expands upon the criteria included in the “Stage 1” final rule published on July 28, 2010. It is likely to be of interest primarily to providers concerned with receiving or continuing to receive added payments from CMS for adopting and “meaningfully using” EHR.

The Stage 2 Proposal is not, at first glance, particularly relevant reading for those of us generally interested in issues involving the privacy and security of personal information -- or even those of us more specifically interested in the privacy and security of protected health information (PHI). Still, two new provisions caught my attention because they measure the meaningful use required for provider incentive payments not simply on the providers’ use of EHR, but on their patients’ use of it.

One provision of the Stage 2 Proposal would require a provider to give at least 50% of its patients the ability to “view online, download, and transmit" their health information ("timely” meaning within 4 business days after the provider receives it) (and subject to the provider’s discretion to withhold certain information). Moreover, it would require that more than 10% of those patients (or their authorized representatives) actually view, download or transmit the information to a third party. There’s an exception for providers that conduct a majority (more than 50%) of their patient encounters in a county that doesn’t have 50% or more of “its housing units with 4Mbps broadband availability as per the most recent information available from the FCC” (phew!) as of the first day of the applicable EHR reporting period.

Another provision would require a provider to use “secure electronic messaging to communicate with patients on relevant health information” and would require the provider to show that more than 10% of the provider’s patients seen during the reporting period actually sent secure messages (presumably, to the provider, though the language is not precise) using the “electronic messaging function of Certified EHR Technology.” According to CMS:

> Over 43,000 providers have received $3.1 billion to help make the transition to electronic health records; the number of hospitals using EHRs has more than doubled in the last two years from 16 to 35 percent between 2009 and 2011; and 85 percent of hospitals now report that by 2015 they intend to take advantage of the incentive payments.

The Stage 2 Proposal will incentivize providers to continue this trend toward meaningful use of EHRs, but is also likely to result in providers’ efforts to induce to their patients to become EHR users.

Perhaps patients are ready, willing and able to communicate with providers via email and to download and forward their PHI. According to AARP, the aging baby boomer generation is apparently embracing electronic media and social networking at an unprecedented rate, and it is this segment of the population that is most likely to require health care services.

Two new provisions in the Stage 2 “meaningful use” criteria measure the meaningful use required for provider incentive payments based not simply on the providers’ use of EHR, but on their patients’ use of it.

Footnotes

1 https://www.cms.gov/EHRIncentivePrograms/60_RegulationsNotices.asp
3 http://www.aarpinternational.org/resourcelibrary/resourcelibrary_show.htm?doc_id=1630777
### New Members

<table>
<thead>
<tr>
<th>Name</th>
<th>Company/Position</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sheila Archibald</strong></td>
<td>Princeton HealthCare System Supervisor</td>
<td>(609) 620-8392 <a href="mailto:sarchibald@princetonhcs.org">sarchibald@princetonhcs.org</a></td>
</tr>
<tr>
<td><strong>Angela Cocuzza</strong></td>
<td>Meridian Health Manager Patient Accounts</td>
<td>(732) 897-7906 <a href="mailto:acocuzza@meridianhealth.com">acocuzza@meridianhealth.com</a></td>
</tr>
<tr>
<td><strong>Lynne Hofstaedt</strong></td>
<td>University Medical Center of Princeton Manager HIM</td>
<td>(609)498-74268 <a href="mailto:lhofstaedt@princetonhcs.org">lhofstaedt@princetonhcs.org</a></td>
</tr>
<tr>
<td><strong>Amy Marques</strong></td>
<td>St. Michael's Medical Center Director of Revenue Cycle</td>
<td>(973) 877-2419 <a href="mailto:amarques@smmmc.org">amarques@smmmc.org</a></td>
</tr>
<tr>
<td><strong>Michael J. Nudo</strong></td>
<td>MedLink Computer Sciences V.P. Marketing and Sales</td>
<td>(732) 762-7405 <a href="mailto:mjnudo@medlinkcs.com">mjnudo@medlinkcs.com</a></td>
</tr>
<tr>
<td><strong>Michael Setteducati</strong></td>
<td>Aergo Solutions President</td>
<td>(732) 917-7111 <a href="mailto:mike@aergo.com">mike@aergo.com</a></td>
</tr>
<tr>
<td><strong>Patricia Woods</strong></td>
<td>Princeton HealthCare System Supervisor Managed Care</td>
<td>(609) 620-8333 <a href="mailto:pwoods@princetonhcs.org">pwoods@princetonhcs.org</a></td>
</tr>
<tr>
<td><strong>Daniel G. Bryson</strong></td>
<td>ARMDS Assistant Manager</td>
<td>(609) 342-2000 <a href="mailto:dbryson@armds.com">dbryson@armds.com</a></td>
</tr>
<tr>
<td><strong>Lauren Irwin-Szostak</strong></td>
<td>Business Processes Redefined President</td>
<td>(800) 470-6622 <a href="mailto:lauren@bprllc.com">lauren@bprllc.com</a></td>
</tr>
<tr>
<td><strong>Jenna Andrusisian</strong></td>
<td>Atlantic Health System Financial Analyst</td>
<td>(908) 522-2847 <a href="mailto:jenna.andrusisian@atlantichealth.org">jenna.andrusisian@atlantichealth.org</a></td>
</tr>
<tr>
<td><strong>Nancy A. Christie</strong></td>
<td>CentraState Medical Center Charge Master Analyst</td>
<td>(732) 294-7064 <a href="mailto:nchristie@centrastate.com">nchristie@centrastate.com</a></td>
</tr>
<tr>
<td><strong>Lloyd F. George, CPA</strong></td>
<td>Lloyd F. George CPA, LLC Principal</td>
<td>(609) 799-5863 <a href="mailto:Lloyd.George@LFGCPA.com">Lloyd.George@LFGCPA.com</a></td>
</tr>
<tr>
<td><strong>Lynne M. Wiese</strong></td>
<td>Technosoft Corporation Director Provider RCM</td>
<td>(609) 936-7224 <a href="mailto:lwchange@msn.com">lwchange@msn.com</a></td>
</tr>
<tr>
<td><strong>Teresa Edge</strong></td>
<td>Capital Health System Supervisor</td>
<td>(609) 815-7825 <a href="mailto:tedge@capitalhealth.org">tedge@capitalhealth.org</a></td>
</tr>
<tr>
<td><strong>Janice A. Klama</strong></td>
<td>Capital Health System Supervisor</td>
<td>(609) 394-6000 <a href="mailto:jklama@chsnnj.org">jklama@chsnnj.org</a></td>
</tr>
<tr>
<td><strong>Allan Gregory</strong></td>
<td>Robert Half International</td>
<td>(732) 596-2174 <a href="mailto:allan.gregory@rhi.com">allan.gregory@rhi.com</a></td>
</tr>
<tr>
<td><strong>Jakahra Williams</strong></td>
<td>Capital Health System Supervisor</td>
<td>(609) 537-7001 <a href="mailto:jwilliams@capitalhealth.org">jwilliams@capitalhealth.org</a></td>
</tr>
<tr>
<td><strong>Peter DiCanto, Jr.</strong></td>
<td>Horizon Blue Cross Blue Shield of New Jersey Informatics Manager</td>
<td>(609) 718-9366 <a href="mailto:Peter_DiCanto@horizonnjhealth.com">Peter_DiCanto@horizonnjhealth.com</a></td>
</tr>
<tr>
<td><strong>Ian S. Katz</strong></td>
<td>Horizon NJ Health Hospital Account Executive</td>
<td>(609) 718-9421 <a href="mailto:ikatz@horizonnjhealth.com">ikatz@horizonnjhealth.com</a></td>
</tr>
<tr>
<td><strong>Eyo Effiong</strong></td>
<td></td>
<td>(864) 569-6024 <a href="mailto:effiong_eyo@yahoo.com">effiong_eyo@yahoo.com</a></td>
</tr>
<tr>
<td><strong>John Santuoso</strong></td>
<td>Kelly Financial Resources Senior Business Development Manager</td>
<td>(201) 804-6941 <a href="mailto:santuja@kellyservices.com">santuja@kellyservices.com</a></td>
</tr>
<tr>
<td><strong>Eva J. Goldenberg</strong></td>
<td>Atlantic Health System, Inc. Corporate Compliance Officer and Internal Audit</td>
<td>(973) 660-3143 <a href="mailto:eva.goldenberg@atlantichc.org">eva.goldenberg@atlantichc.org</a></td>
</tr>
<tr>
<td><strong>Ryan P. Lodge</strong></td>
<td>BESLER Consulting Junior Consultant</td>
<td>(732) 392-8314 <a href="mailto:lodgeryan@gmail.com">lodgeryan@gmail.com</a></td>
</tr>
<tr>
<td><strong>David S. Barmak, Esq.</strong></td>
<td>Law Offices of David S. Barmak, LLC Attorney</td>
<td>(609) 454-5351 <a href="mailto:david@barmak.com">david@barmak.com</a></td>
</tr>
<tr>
<td><strong>Linda Lederman</strong></td>
<td>UnitedHealthcare Vice President of Contracting</td>
<td>(732) 623-1330 <a href="mailto:Linda_Lederman@uhc.com">Linda_Lederman@uhc.com</a></td>
</tr>
<tr>
<td><strong>Scott Stark</strong></td>
<td>J &amp; S Stark Billing &amp; Consulting, Inc.</td>
<td>(732) 440-1459 <a href="mailto:ssstark@justark.com">ssstark@justark.com</a></td>
</tr>
<tr>
<td><strong>Shelby Johnson</strong></td>
<td>C &amp; H Collections Director, Sales</td>
<td>(856) 356-4848 <a href="mailto:shelby.johnson@chcollects.com">shelby.johnson@chcollects.com</a></td>
</tr>
<tr>
<td><strong>Mario Salvati</strong></td>
<td>Shriners Hospital Director of Fiscal Services</td>
<td>(215) 430-4040 <a href="mailto:mmsalvati@shrinenet.org">mmsalvati@shrinenet.org</a></td>
</tr>
<tr>
<td><strong>Peter Tarricone</strong></td>
<td>Wells Fargo Senior Vice President</td>
<td>(973) 437-2425 <a href="mailto:peter.tarricone@wellsfargo.com">peter.tarricone@wellsfargo.com</a></td>
</tr>
</tbody>
</table>
“Transparency,” according to the Kernerman English Multilingual Dictionary is the full, accurate and timely disclosure of information. As it relates to healthcare, transparency is the ability to provide meaningful information to patients regarding the cost and quality of the services they receive. Specifically, patients are becoming savvier regarding their out of pocket costs because they have to pay a larger piece of the pie.

Let’s face it, providers today are confronted with a number of challenges within the industry including increased number of uninsured patients, employers shifting more of the financial risk to the employee, larger co-pays, co-insurance and deductibles. Additionally, costs continue to escalate and bad-debt is on the rise.

As most healthcare providers know, presenting specific information about a patient’s out of pocket liability can be very complex. There are multiple complex considerations including the charge description master (CDM) or list pricing, payor reimbursement rates or contracts, eligibility and benefit information. Not to mention determining the service and related components that the patient is receiving (i.e. hip replacement, tonsillectomy, colonoscopy, etc.) The financial clearance process has become more important than ever to secure payment and reduce the risk of insurance and identity fraud.

Providers, payors as well as consumers (formerly known as patients) all have specific needs when it comes to transparency. Providers are expected offer a fully transparent out-of-pocket liability estimate for their patients. But patients also expect their payor to provide this information. Unfortunately, it can be difficult for both in this mixed up healthcare reimbursement model. As many as 36 states have enacted legislation that requires information regarding quality and cost be made available to the consumer. Web sites such as NJ Hospital Care Compare and NJ Hospital Price Compare attempt to make information available to consumers to make decisions about where they receive their healthcare and how much they will have to pay for it.

With this new focus on transparency in healthcare, providers are uniquely positioned to serve their population. By embracing the opportunity to educate the patient providers are better equipped to identify alternative payment sources and accelerate the cash collection process while improving overall patient satisfaction.

In one particular provider’s case, implementing a pre-service financial clearance process yielding tremendous benefits both to the provider as well as the consumer.

Collecting the patient’s portion of the charges is more important than ever in the current economy. A few techniques and tools can make the job easier for patient financial services staff members. Even if you have a good patient estimating tool, communicating with patients about their out-of-pocket liability can be much more challenging than it used to be, especially if your staff is not equipped to ask for money. Historically, healthcare providers have avoided the process of asking for payment before services are rendered. Further, Patient Access staff members have not been equipped with the appropriate tools and techniques to execute a pre-service collection program. To better address the challenges we face as an industry today, we must be prepared to implement a successful pre-service collection program.

What You Should Do

What makes a pre-service collection program successful? First, you need to establish a clear financial policy that both patients and staff understand. The policy should clearly define

continued on page 28
whether prepayment is a request or a requirement and determine what conditions might be an exception. The key is to provide options that benefit both patients and the healthcare provider to prevent policy exceptions. Second, there must be support from the Board of Directors as well as the senior executive team. Without support from the top down, a plan is sure to fail. There should be no policy exceptions regardless of a patient’s relationship to the executive team. Staff expectations should be clearly defined and supported so that there is no question regarding the execution of the policy. Once you have clearly defined the expectations, a comprehensive training program should be developed to ensure that staff members are equipped with the appropriate techniques. In many cases, the skill sets required of Patient Access staff do not include asking patients for money. Even individuals who have excellent customer service and clerical skills may be unwilling and/or unable to ask for money from your patients. Although pre-service collection techniques should employ a soft approach, consider teaming up with your collection agency to apply some of the training techniques used in their programs.

Specific scripting should be developed for every possible scenario. Consider questions that begin with why, when, what, who, and how. Avoid questions that require only yes or no answers to allow patients to provide additional insight into their particular situation. One of the most effective techniques in scripting is the “pregnant pause.” Providing information about the patient’s financial obligation and then allowing the patient to respond before saying anything can be the most effective form of communication as it relates to point-of-service collections. Staff should also be allowed to customize the scripts to suit their personality. Practice makes perfect. Allow ample role-playing time as well as a certification process to ensure that your staff is comfortable in each of the defined scenarios and that an escalation process exists for certain situations. Last, once a program is implemented, continuous monitoring should be part of your process. In other words, measure everything that moves, including staff performance, customer satisfaction, collection success rates, and employee satisfaction. The result will give you a clear picture of the entire program from every angle of the process.

Benefits of Implementing a Pre-service Collection Program
Implementing a pre-service collection program not only can result in increased point-of-service collections, but also may improve customer satisfaction. Consumers today want to be involved in the financial decision-making process of receiving health care. They want to be able to plan for these expenses and avoid unpleasant surprises after services have been provided. A pre-service collection program coupled with training and clear processes can raise consumer awareness, improve collections, and avoid costs post-service.

Pre-service Collection Techniques
Here are a few tips for a successful pre-service collection effort:

- First, plan for solid, dependable collections by establishing a clear financial policy that patients and staff understand. Every successful business has such a policy. The key is to give adequate options to patients that benefit both the provider and the patient and control the urge to make policy exceptions on the spur of the moment.
- Use questions beginning with why, when, what, who, and how. This will allow patients to talk more, providing more insight into their situations and mindsets.
- Don’t let patients say “no.” Phrase questions so they require more than a yes/no response. For example, ask, “How will you be paying today?” Don’t ask, “Would you like to make a payment today?”
- Use motivational phrases to get patients to take a positive action. For example, ask, “Do you want to pay this bill today so you won’t have to be bothered with it in the future?”
- Phrase statements as questions. For example, ask, “Paying your bill today will allow you to focus on getting better and not worry about the bill, won’t it?”
- Practice, practice, practice. Identify the various collections scenarios that the collections coordinator is likely to encounter, and plan appropriately using strategies similar to those outlined above. Role-play the situations during staff meetings so that staff members fully understand the policies and those responsible for collections are prepared when patients raise questions or concerns.

About the Author
Julie Kay is vice president, revenue cycle solutions strategy at MedAssets. She can be reached at jkay@medassets.com.
Your Healthcare Facility Can Benefit from Energy Deregulation

Two Ways: “Reverse Auctions” and “Name Your Electricity Price”

by John A. Smith

Energy deregulation has eliminated many government rules and regulations that stifled competition in the energy industry, the same way competition was suppressed in the telecommunications industry. Now healthcare facilities in deregulated states can choose to receive their electric supply from their local utility company or from a qualified, third-party electric supplier known as a Retail Electric Provider (REP).

In New Jersey, there are four local electric utility companies: PSE&G, JCP&L, Rockland Electric and Atlantic City Electric. Energy deregulation here has spawned a variety of third-party electric suppliers that are state-licensed and regulated by the New Jersey Board of Public Utilities (NJBPU). All of them would like to win your business. Many states, including NJ, NY, PA, DE, MD, MA, NH, CT, OH, IL, TX and others, have opened their markets to third-party energy suppliers.

Under the traditional energy delivery system, a network of power plants produces electric energy to be released into the grid. Local utility companies like PSE&G and JCP&L purchase this energy in large blocks to be provided to the customer. These utilities are required to purchase their power at a fixed moment in time, regardless of market conditions. Conversely, competitive energy suppliers are able to analyze a wide array of market conditions, and use this intelligence as a basis to purchase their power strategically. The net result is that REPs like Hudson Energy, Suez, or Hess Corporation can purchase energy from the grid to resell it to the customer at a lower price per Kilowatt than the local utility is currently offering.

Visit any local utility’s website to find the NJ “Energy Choice Program”

It provides more information about deregulation and billing. The following is excerpted from Atlantic City Electric’s website:

**Atlantic City Electric Supports Energy Choice**

Whether you choose to stay with Atlantic City Electric as your electricity supplier, or choose another supplier, we will continue to provide reliable energy delivery and service.

**The Choice Is Yours**

The restructuring of the electric utility industry allows you to select the electricity supplier that fits your needs. If you don’t choose a supplier, Atlantic City Electric buys electricity for you and charges you according to rates approved by the New Jersey Board of Public Utilities. This is called “Basic Generation Service” (BGS), and the cost for this appears under the “Supply Charges” in the Electric Delivery Charges portion of your bill (customer bills are broken down to indicate charges for “supply”, the actual electricity, and “delivery”, the process of getting that electricity to end users). Atlantic City Electric continues to deliver the electricity to all customers whether or not they choose another supplier.

**Your Facility Can Save Money by Leveraging the Power of Reverse Auctions**

Healthcare facilities are some of the highest consumers of electricity in the commercial space, according to the US Department of Energy. Today these facilities can shop around for the lowest cost per kilowatt-hour (Kwh) since this is a commodity price that changes every day according to market conditions.

Online Reverse Electricity Auctions represent a relatively seamless way to procure electricity at the lowest cost. Natural
gas commodity prices are a leading indicator for electricity/Kwh prices, and they are at a 10+ year low. This fact has helped many 3rd party suppliers to win new customers. Government agencies, commercial and industrial facilities utilize electricity auctions to ensure they get the lowest Kwh price on the market from a third-party electric supplier.

### How Reverse Auctions Work

There is a simple way for healthcare facilities to procure competitive bids for electricity without using the traditional “paper bid” Request for Proposal (RFP), brokers, or other time-and-budget-consuming methods. Online reverse auctions for hospitals, nursing homes and other health care facilities are becoming a popular way to procure electricity and save a substantial amount of time and money. A reverse electric auction is the opposite of eBay. For example, a starting bid can be $0.98 per Kwh and then the alternative electric suppliers can keep bidding the price down.

There are only a few good platforms in this online reverse auction space. The best of breed platforms provide an easy online process to procure the lowest electricity price. They may use remote independent consultants who can assist healthcare facilities, at no charge, to audit their past usage, forecast future demand, create a bidding profile for electric suppliers and establish a reverse rate with which to begin an auction.

Prior to an auction, the healthcare facility should request that the folks running the online reverse auction platform provide indicative price quotes from these suppliers. This document should provide annual dollars saved and the percentage of savings. This may help a facility narrow the field to the top three suppliers most likely to win their electric supply in a reverse auction. The facility can then schedule an auction for a future specified time. Most auctions occur within a compact time window; as short as five minutes or up to thirty minutes long is the norm. During a typical auction, if any supplier enters a bid in the last few minutes this may trigger an extension to the auction. This prevents a supplier from waiting until the last few seconds to place a low (but not their lowest) bid.

### Your Facility Can Name Your Electricity Price

There is also a platform which enables your healthcare facility to name its own electricity price per Kwh. This is much like Priceline.com or a put option to buy a stock for 5% less than the current asking price. The customer chooses a fixed price that stays active online until the prospective client cancels the order, or one of the suppliers agrees to meet that price. The result is a cost effective solution for a facility currently in a term contract with an alternative electric supplier.

For example, a hospital may have a current contracted price of $0.082 from a supplier like Hudson Energy locked in until February, 2013. The hospital would be willing to extend or move the contact to another supplier on that future date if they could procure a $0.078 per Kwh fixed price. That’s when the “name your price” platform really makes sense. Perhaps at today’s prices none of the suppliers can meet your desired target price, but a month from now the spot market may go down enough for one supplier to match that price and still profit from you as a new client.

The range of electricity supply options and the degree of competition made possible by deregulation have created new opportunities for healthcare facilities to significantly reduce a major operating cost. Your facility can win by using a reverse online auction or naming your own electricity price, bringing benefits to your bottom line today. To learn more call Mark Dougherty, Business Development Manager for Energy Systems Group. Mark serves on our HFMA-NJ Communications Committee, and he can be reached at 201-359-4162, or email mdougherty@energysystemsgroup.com.

### About the Author

John A. Smith is managing partner of Capable Communications and past president of Central Jersey Business Association. He is an independent energy, telecom and IT consultant working with many government agencies, healthcare facilities and other business entities on the topic of helping them reduce energy, communications and IT costs. John can be reached at email jsmith@capablecomm.com.
A Successful Marriage: Factors Both Sides should Consider when a Physician Practice is Acquired by a Hospital or Health System

We are a hospital considering the acquisition of a physician practice, and have quite a few candidates seeking to partner with us. What are some factors to consider regarding the process?

The current economic climate is making things tough in healthcare, let’s face it. Between healthcare reform changes, looming audits by regulatory oversight organizations, malpractice litigation and stiff competition in the marketplace, it is no wonder many physician practices are seeking opportunities with hospitals or healthcare systems for acquisition. Their hope is to find a good fit, thereby receiving subsidy from the hospital in terms of covering overhead costs and salaries, and also establishing a solid referral source for a continuous flow of new patients. The hospital, in turn, receives the specialized expertise or geographic location to fill a patient need, hopefully resulting in a new income stream. Successful physician-hospital alignment can and does happen, and assuming the proper due diligence has revealed a clean bill of health on both sides, the partnership should be looked at from three key perspectives, ensuring a good match for everyone involved.

1. **Strategy Fit.** In order to remain competitive and to serve the community as best it can, a hospital or healthcare system looking to acquire a practice might be seeking to fill a void whether in a service offering, geographic location, improved access to coverage, or to gain entrée to a different payment model, such as an ACO (accountable care organization). The doctors within a physician practice might be seeking access to more resources for growth, and/or to ensure he or she continues to practice in the area of medicine about which they are passionate. Both sides need to be up-front about their vision and expectations of what the union would bring to the table.

2. **Financial Fit.** The financial impact of the union must be considered in two phases: 1) current value of the physician practice; and 2) projected value of the revenue generated by the practice for the acquiring hospital or system. This requires thoughtful and careful consideration, analysis and assessment of historical data, the economic climate, state of the industry, financial position of the business, geographic location, budgeting and forecasts and other complex and variable factors. High-level factors may include:
   - What is the current net revenue of the practice to be acquired?
   - Will the hospital or system have to make any substantial investments in the practice regarding equipment, additional staffing, etc?
   - Is there currently a strong collections process in place?
   - What happens with current accounts receivables? Will the hospital fold them into its own, or, with the practice, look to resolve?
   - Will current salaries be affected? Will there be a change in compensation structure, such as pay based on performance? Are any of the current physicians within a few years of retirement?
   - Will the current staff in the office be retained, or will there be cuts?

Leveraging the services of a professional who can provide an objective business valuation would be a prudent move to help answer many of these questions and more.

3. **Culture Fit.** With any business acquisition, the importance of a good culture fit is important. Will doctor-management personalities mesh or conflict? Does the hospital’s overarching vision for future growth and treatment of patients and personnel align with that of the doctors at the practice? What is the communication strategy between the hospital or system and the newly acquired physician practice? What are the expectations of the brand image to be portrayed to the community? These issues may seem minor compared to those of financial or strategic considerations, but they can be important in helping with staff morale and productivity. A story once heard involved a newly acquired
physician practice throwing a $12,000 holiday party for its staff, fully expecting the hospital to reimburse them for the expense, as it was a long-standing tradition to hold this elaborate function (ultimately the dispute led to sour feelings between the practice and the hospital). People enjoy working with - and doing business with - people they like. Cultural considerations can certainly influence the success of the integration process.

Ensuring the strength of physician-hospital alignment is crucial in the success of an acquisition. Similar to a marriage, it is important for both parties to identify the positives each can offer the other in order to make an effective partnership, and address those issues up front which could develop into larger problems later on. Taking the right steps now will pay off in the long term, hopefully resulting in a successful, life-long relationship.

About the author
Daniel J. Vitale, CPA, is the partner-in-charge of the Toms River, NJ, office of WithumSmith+Brown, Certified Public Accountants and Consultants. He is also the Co-Practice leader of the Firm’s Healthcare Services Group. Dan has over 35 years of professional experience in business consulting, mergers and acquisitions and general tax matters, specializing in healthcare. He can be reached at dvitale@withum.com.
HFMA-NJ's Publications Committee strives to bring New Jersey Chapter members timely and useful information in a convenient, accessible manner. Thus, this Job Bank Summary listing provides just the key components of each recently-posted position in an easy-to-read format, helping employers reach the most qualified pool of potential candidates, and helping our readers find the best new job opportunities. For more detailed information on any position and the most complete, up-to-date listing, go to HFMA-NJ’s Job Bank Online at www.hfmanj.org.

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

**Job Position and Organization**

<table>
<thead>
<tr>
<th>ASSISTANT CONTROLLER</th>
<th>FINANCIAL/CDM ANALYST</th>
</tr>
</thead>
<tbody>
<tr>
<td>JFK Medical Center</td>
<td>Atlantic Health System</td>
</tr>
<tr>
<td>Edison, NJ</td>
<td>Morristown, NJ</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SENIOR FINANCIAL ANALYST</th>
<th>DIRECTOR OF ACCOUNTING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chilton Hospital</td>
<td>Hunterdon Medical Center</td>
</tr>
<tr>
<td>Pompton Plains, NJ</td>
<td>Flemington, NJ</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SENIOR ACCOUNTANT</th>
<th>FINANCIAL ANALYST</th>
<th>DIRECTOR OF FINANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgem LLC</td>
<td>Surgem LLC</td>
<td>Somerset Medical Center</td>
</tr>
<tr>
<td>Oradell, NJ</td>
<td>Oradell, NJ</td>
<td>Somerville, NJ</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CONTROLLER</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Atlantic Health System</td>
<td></td>
</tr>
<tr>
<td>Morristown, NJ</td>
<td></td>
</tr>
</tbody>
</table>
Focus

Saving for retirement is a personal responsibility and a necessity. One tax-advantaged savings option is the Roth IRA. The Roth IRA has been available for more than a decade to taxpayers below certain income levels. Due to a change in the law that goes into effect in 2010, taxpayers at all income levels can now take advantage of the Roth IRA, as the income limit on conversions from traditional IRAs to Roth IRAs has been eliminated.

Many people are unsure as to how the Roth IRA might fit into their retirement plans. With this in mind, let’s take a closer look at this retirement savings vehicle.

Who Is Eligible?

At first glance, the primary advantage of a Roth IRA is that contributions and earnings can be withdrawn free of income taxes, as long as the withdrawal is a qualified distribution. Unlike a traditional, deductible Individual Retirement Account (IRA), contributions to a Roth IRA are made on an after-tax basis, and as a result, no income tax is due when distributions are taken.

In 2010, you are eligible to make a full contribution to a Roth IRA if your modified adjusted gross income (MAGI) does not exceed $105,000 for single taxpayers or $167,000 for married taxpayers filing jointly (contributions to a Roth IRA are phased out for single filers with AGIs between $105,000 and $120,000 and for joint filers with AGIs between $167,000 and $177,000). You can contribute to a Roth even if you are a participant in a qualified plan (such as a 401(k)) and whose AGI exceeds the expanded deductible IRA income limits ($56,000 to $66,000 for single tax-payers and $89,000 to $109,000 for married taxpayers filing jointly for 2010), without exceeding the income limits for a Roth IRA.

What Are the Benefits?

You’ll need to carefully analyze your unique situation to determine if there are any long-term benefits to using a Roth IRA as opposed to a traditional IRA. Essentially, the Roth IRA allows taxpayers to lock in a tax rate, whereas those with traditional IRAs will be unable to predict whether changes in the law or their own circumstances could push them into a higher tax bracket in retirement. Many retirees expect to owe less tax in retirement, since they no longer earn income from working; however, if you expect to be in a higher income tax bracket in retirement, the Roth IRA may be beneficial for you.

The Roth IRA also offers a savings vehicle for those who are participants in a qualified plan (such as a 401(k)) and whose AGI exceeds the expanded deductible IRA income limits ($56,000 to $66,000 for single tax-payers and $89,000 to $109,000 for married taxpayers filing jointly for 2010), without exceeding the income limits for a Roth IRA.

Should You Convert to a Roth?

Under the Tax Increase Prevention and Reconciliation Act of 2005 (TIPRA), the income limit for conversions from a traditional to a Roth IRA is eliminated in 2010, meaning that taxpayers at all income levels may now take advantage of the Roth IRA. Converting your traditional IRA into a Roth does come with a price, however. Any deferred income taxes from your traditional IRA (the one you will be converting) will be due in the tax year in which the conversion occurs. To make conversion more attractive in 2010, TIPRA also stipulates that a saver who converts in 2010 may choose to pay the tax owed immediately or spread the tax payment over 2011 and 2012. Income inclusion will, however, be accelerated if distributions are taken during these years. It is important to note that, under current law, tax rates are scheduled to increase in 2011.

In addition, taxpayers under age 59 1/2 will be subject to an early withdrawal Federal tax penalty of 10% if IRA funds are used to cover the taxes owed on the conversion. Therefore, if you are younger than age 59 1/2, you will need to pay this in-
come tax from out-of-pocket sources to avoid the 10% penalty tax.

If you're thinking about converting an existing IRA to a Roth, be sure you consider the following:
1) When you expect to need the IRA proceeds
2) Your ability to pay the income tax due in the year of conversion from an alternative source
3) Whether the additional tax incurred at the time of conversion will place you in a higher tax bracket, which could result in a greater than expected income tax liability
4) Whether or not converting will benefit your long-term bottom line

Other Considerations
In addition to tax-free withdrawals, a Roth IRA has two other important features: 1) there are no Internal Revenue Service (IRS) restrictions on when you must begin taking withdrawals (e.g., age 701/2 with traditional IRAs), and 2) you can continue to contribute to a Roth beyond age 701/2 if you have earned income and are within the applicable income limits. Over the long term, this can lead to the potential for additional savings, especially if you plan to work past age 701/2 or if you have other sources of retirement income and do not expect to rely heavily on your Roth IRA.

What's more, your Roth IRA beneficiary may continue to benefit from tax-free withdrawals over his or her life expectancy, as long as withdrawals commence before December 31st of the year after your death. (Note: If your beneficiary does not begin taking withdrawals by December 31st of the year after your death, the Roth IRA proceeds must be withdrawn by December 31st of the fifth anniversary of your death.)

The Roth IRA provides you with another retirement savings option. A thorough review of your overall retirement plan with your financial and tax advisors can help you determine how a Roth IRA might fit into your financial future.

The information provided is not written or intended as specific tax or legal advice and may not be relied on for the purposes of avoiding any Federal tax penalties. Individuals are encouraged to seek advice from their own tax or legal counsel.

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.

Save The Date!

2012 Annual Institute Charity Event
Join Us to Support the Make-A-Wish Foundation of New Jersey

Wednesday Evening, October 10, 2012
The Borgata Hotel Casino & Spa
Atlantic City, New Jersey
2011-2012 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/TIMES</th>
<th>MEETING LOCATION</th>
<th>BOARD LIAISON</th>
</tr>
</thead>
<tbody>
<tr>
<td>CARE (Compliance, Audit, Risk &amp; Ethics)</td>
<td>Michael McKeever <a href="mailto:mckeever@ideborah.org">mckeever@ideborah.org</a> 609-893-1200 9201</td>
<td>Nadinia Davis</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., Apr. and July Balance are calls. Please call to confirm.</td>
<td>Darlene Mitchell <a href="mailto:michael.darlene@hunterdonhealthcare.org">michael.darlene@hunterdonhealthcare.org</a> 908-237-7059</td>
</tr>
<tr>
<td>Communications</td>
<td>Elizabeth Litten <a href="mailto:ELitten@foxrothschild.com">ELitten@foxrothschild.com</a> 609-936-3600</td>
<td>Aij Rottkamp</td>
<td>First Thursday of each month (888) 269-3831 9:15 AM</td>
<td>Fox Rothschild offices 987 Lenox Dr Bldg 3 Lawrenceville, NJ</td>
<td>Tony Consoli <a href="mailto:aconsoli@cbiz.com">aconsoli@cbiz.com</a> 732-794-2662</td>
</tr>
<tr>
<td>Education</td>
<td>Maria Fascioponti mtaconcipontidarmds.com 973-614-9100</td>
<td>Rita Romeu</td>
<td>First Friday of each month (888) 269-3831 8:30 AM</td>
<td>Conference calls with in-person quarterly meetings. Call for more info.</td>
<td>Tracy Davison-DiCanto <a href="mailto:tdavison-dicanto@princethoncs.org">tdavison-dicanto@princethoncs.org</a> 609-620-8471</td>
</tr>
<tr>
<td>Certification (Sub-committee of Education)</td>
<td>Eric S. Fishbein <a href="mailto:efishbein@presscott.com">efishbein@presscott.com</a> 860-677-7888</td>
<td>Michael DiFranco</td>
<td>First Friday of each month (888) 269-3831 8:30 AM</td>
<td>Conference calls with in-person quarterly meetings. Call for info.</td>
<td>Scott Mariani <a href="mailto:smariani@withum.com">smariani@withum.com</a> 973-898-9494 x420</td>
</tr>
<tr>
<td>FACT (Finance, Accounting, Capital &amp; Taxes)</td>
<td>Lisa Hartman <a href="mailto:lhartman@princetonhons.org">lhartman@princetonhons.org</a> 609-430-7789</td>
<td>Michael DiFranco <a href="mailto:mike.difranco@gt.com">mike.difranco@gt.com</a> 215-814-1757</td>
<td>Second Wednesday of each Month (888) 269-3831 8:00 AM</td>
<td>To alternate between in person and conference calls; locations TBD</td>
<td>Scott Mariani <a href="mailto:smariani@withum.com">smariani@withum.com</a> 973-898-9494 x420</td>
</tr>
<tr>
<td>Institute 2011</td>
<td>Howard Krain <a href="mailto:hkrain@micromc.com">hkrain@micromc.com</a> 908-377-5020</td>
<td>Dan Willis</td>
<td>Fourth Thursday of each month (888) 269-3831 8:00 AM</td>
<td>Conference calls with in-person meetings. Call for more information.</td>
<td>Mike Atwell <a href="mailto:malwell@smmcnj.org">malwell@smmcnj.org</a> 973-877-2853</td>
</tr>
<tr>
<td>LINK (Local Information Networks)</td>
<td>Elizabeth Litten <a href="mailto:ELitten@foxrothschild.com">ELitten@foxrothschild.com</a> 609-996-3600</td>
<td>Dennis Scott</td>
<td>As needed. (888) 269-3831 9:00 AM</td>
<td>Call for info.</td>
<td>Mike Atwell <a href="mailto:malwell@smmcnj.org">malwell@smmcnj.org</a> 973-877-2853</td>
</tr>
<tr>
<td>Managed Care</td>
<td>Kevin Joyce <a href="mailto:kjjoe@dalcareairenc.com">kjjoe@dalcareairenc.com</a> 732-562-7823</td>
<td>Jill Squires</td>
<td>3/7, 4/4, 6/7, 7/11, 9/6, 10/24, 12/12 9:30-11:30 AM</td>
<td>No conference calling</td>
<td>New Jersey Hospital Association Board Room</td>
</tr>
<tr>
<td>Membership Services/Networking</td>
<td>Erica Waller <a href="mailto:Ewaller@princetonhons.org">Ewaller@princetonhons.org</a> 609-620-8335</td>
<td>Kevin Margolis</td>
<td>Call for meeting arrangements (888) 269-3831 9:00 AM</td>
<td>Locations alternate by month - please contact the chairs</td>
<td>Deborah Shapiro <a href="mailto:dshapiro@wfs-services.com">dshapiro@wfs-services.com</a> 201-617-7100</td>
</tr>
<tr>
<td>Patient Access Services</td>
<td>William Hunt <a href="mailto:whunt@humbered.com">whunt@humbered.com</a> 201-996-2897</td>
<td>Diana Sessions</td>
<td>Second Thursday of each Month (888) 269-3831 9:00 AM</td>
<td>CBIZ KA Consulting offices in East Windsor, NJ</td>
<td>Laurie Grey <a href="mailto:lgrey@princethoncs.org">lgrey@princethoncs.org</a> 609-620-8333</td>
</tr>
<tr>
<td>Patient Financial Services</td>
<td>Josette Portalatin <a href="mailto:jportalatin@valleyhealth.com">jportalatin@valleyhealth.com</a> 201-291-6017</td>
<td>Steven Stadtmauer</td>
<td>Second Friday of each Month (888) 269-3831 10:00 AM</td>
<td>New Jersey Hospital Association Board Room</td>
<td>Jay Picerno <a href="mailto:jpicerno@cbiz.com">jpicerno@cbiz.com</a> 973-332-4102</td>
</tr>
<tr>
<td>Regulatory &amp; Reimbursement</td>
<td>Rich Rifenburg <a href="mailto:rifenburg@ideborah.org">rifenburg@ideborah.org</a> 609-933-6811 x5794</td>
<td>Vicki Ozmore</td>
<td>Third Tuesday of each Month (888) 269-3831 9:00 AM</td>
<td>Locations alternate by month - please contact the chairs</td>
<td>Heather Weber <a href="mailto:hweben@parentenet.com">hweben@parentenet.com</a> 215-657-2016</td>
</tr>
<tr>
<td>Revenue Integrity</td>
<td>Lindsey Colombo <a href="mailto:lcolombo@hrmc.org">lcolombo@hrmc.org</a> 732-324-6031</td>
<td>Vicki McElaney</td>
<td>First Wednesday of each Month (888) 269-3831 9:00 AM</td>
<td>Alternates Raritan Bay MC and New Jersey Hospital Association Board Room</td>
<td>Steven Bilskey <a href="mailto:sbilskey@causeycpas.com">sbilskey@causeycpas.com</a> 303-672-9996</td>
</tr>
<tr>
<td>Sponsorship</td>
<td>Michael Ruiz de Somocurcio <a href="mailto:Michael.RuizdeSomocurcio@amerihc.com">Michael.RuizdeSomocurcio@amerihc.com</a> 732-726-6709</td>
<td></td>
<td>Second Thursday of each Month (888) 269-3831 8:30 AM</td>
<td>Conference calls</td>
<td>Michael Ruiz de Somocurcio <a href="mailto:Michael.RuizdeSomocurcio@amerihc.com">Michael.RuizdeSomocurcio@amerihc.com</a> 732-726-6709</td>
</tr>
</tbody>
</table>

*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.
Who Are the Industry’s Rising Star Leaders?

HFMA’s Future Financial Leaders Award

HFMA’s Future Financial Leaders Award is an industry award that recognizes those who provide innovative and exemplary performance resulting in organizational performance improvement. Award winners are recognized for their ability to inspire individual and organizational excellence, create and attain a shared vision, and successfully manage change to achieve the organization’s strategic ends and successful performance. The Future Financial Leaders Award will be presented at ANI: The 2012 HFMA National Institute.

Eligibility
Mid-level healthcare managers in provider organizations.

Submission deadline

Future Financial Leaders Award nominees are evaluated based on their contributions in the following leadership areas:

- Leadership Skills and Behavior: Exercise appropriate leadership styles and behavior, employ critical thinking skills, and advocate for the organization and its values in the community and public policy arena.
- Organizational Climate and Culture: Foster a culture that values diversity, promotes teamwork, and engenders a commitment to the purpose and values of the organization.
- Communicating Vision: Establish and communicate a compelling vision for the organization that guides strategy formation and direction.
- Managing Change: Promote organizational development and continuous improvement, and use systems thinking to enact change in complex organizations.

Nomination Directives
In 500 words or less, please tell us about either one organizational initiative or an ongoing demonstration of leadership in which the nominee exemplified notable leadership. Make sure that you provide specific examples of how the nominee demonstrated leadership skills, fostered a culture promoting teamwork and commitment to the organization’s purpose, communicated a compelling organizational vision, and managed change.

- A brief summary of the initiative and how it was carried out or a brief summary of the demonstrated ongoing leadership
- The nominee’s role in the initiative and how the nominee influenced the concept and execution of the initiative or the nominee’s ongoing influence as an organizational leader
- The measurable effect of the initiative on the organization’s strategic and financial objectives or the measurable effect of the nominee’s ongoing leadership on the organization’s strategic and financial objectives
- Ways in which the nominee influenced others participating in the initiative or ways in which the nominee continues to inspire commitment to excellence from others
- Ways in which the nominee’s contribution was innovative or exceptional

Scoring
A panel of senior finance executives will review nominations and select award winners.

Selection process
A review panel comprised of recognized healthcare financial leaders select recipients based on the established criteria.

Presentation
The award will be presented at ANI. Award winners will be recognized in a special section in hfm magazine on ANI award recipients and announced in electronic communications including HFMA’s website, the Weekly News e-newsletter, the online news section of hfm magazine, and in a press release.

For questions or information, contact Joseph Abel, HFMA Professional Resources Director at (800) 252-4362, ext. 335 or jabel@hfma.org.
In the June 5, 2011 edition of *The New York Times*, a full-page ad framed in violet announced NYU Langone Medical Center’s philanthropic milestone: in less than four years, the Medical Center had raised an unprecedented $1 billion. This significant accomplishment helps to demonstrate how important philanthropy is to healthcare organizations as the industry goes through significant change.

Then, just two months later, on August 8, 2011, *The Wall Street Journal* published an article on a Moody’s assessment of the overall industry titled “Hospitals Put on Sick List.” The article discussed how not-for-profit hospital revenue is growing at its slowest rate in two decades, leading to an uptick in mergers.

With this in mind, philanthropic dollars will be even more crucial for hospitals as they seek to maximize their revenue base in these challenging times. As overall program revenues continue to shrink and the industry faces regulatory changes that are expected to occur over the next few years, healthcare organizations must seek to diversify their fundraising strategies and employ the best structures for reaching new donors.

William C. McGinley, President and CEO of the Association of Healthcare Philanthropy, commented: “Many of the larger healthcare systems have a long history of successful fundraising programs. The small and medium sized hospitals are starting to take steps to build out and diversify their fundraising strategies, which is crucial for their success.”

For 2010, the Report mentions that health-related organizations received an estimated 8% of charitable dollars, or $22.8 billion; in recent prior years this was approximately 6%. This represented a 1.3% increase from 2009 (a decline of 0.3% adjusted for inflation). The Report notes that these totals benefited from multimillion dollar gifts that supported research and treatments for certain diseases, as well as support of healthcare systems. Over the two year period (cumulative 2008-2010, inflation adjusted), donations related to health increased 4.1%, which was the second largest increase after International Affairs at 17%.

Also in June 2011, the Association for Healthcare Philanthropy (AHP) provided its *Annual Giving Report for 2010*. The Report showed that hospitals and healthcare systems raised more than $8.3 billion last year, which is an 8% increase from the prior year. This level translated into an additional $620 million in fundraising dollars. Figure 1 provides a view of a decade in annual giving for healthcare, which shows the recent years trending back up.

See Figure one on next page.
With fundraising on the rise for healthcare organizations, it’s important to identify the source of this funding in order to market to the appropriate demographic. As detailed in Figure 2, hospitals utilize a number of fundraising strategies with individual giving being a very important source of their fundraising.\(^{(2)}\)

**Figure 2: Funds Raised by Type of Fundraising Activity in Fiscal Year 2010**

<table>
<thead>
<tr>
<th>Type of Fundraising Activity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Fund</td>
<td>20.0%</td>
</tr>
<tr>
<td>Major Gifts</td>
<td>17.1%</td>
</tr>
<tr>
<td>Capital Campaign</td>
<td>15.4%</td>
</tr>
<tr>
<td>Special Events</td>
<td>14.8%</td>
</tr>
<tr>
<td>Grants</td>
<td>10.7%</td>
</tr>
<tr>
<td>Planned Giving</td>
<td>9.5%</td>
</tr>
<tr>
<td>Endowment Interest</td>
<td>4.9%</td>
</tr>
<tr>
<td>Memorial Gifts</td>
<td>3.8%</td>
</tr>
<tr>
<td>Other</td>
<td>3.8%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Association for Healthcare Philanthropy

These statistics make it clear that healthcare organizations need to focus on building and cultivating relationships with individual donors, while maintaining a diversified fundraising approach. And, it’s equally important to know who comprises the organization’s strongest donor base.

According to *The 2010 Study on High Net Worth Philanthropy*\(^{(3)}\) conducted by the Center on Philanthropy at Indiana University, high-net-worth families comprise approximately two thirds of individual donations (50% of all giving) annually. The study defines high-net-worth families as those with net worth of over $1 million or annual income of at least $200,000. For 2009, 70% of these families gave to healthcare organizations, compared to only 23% of families in the general population. Thus, the high-net-worth family may be the most valuable demographic for healthcare organizations to seek as potential and continuing donors.

**The use of Foundation Structures as a Fundraising Strategy**

One strategy that healthcare organizations have employed is to establish a separate fundraising foundation to lead their development efforts. Many other types of not-for-profits also use foundations, such as public colleges and membership organizations, just to name a few. There are a variety of reasons why a foundation structure can be beneficial to the healthcare organization:

**Increasing Trustee Opportunities:** a separate foundation creates additional board leadership and volunteer opportunities for trustees, who in turn can be substantial donors. Some foundations have been increasing their trustee membership.

**Maintaining Focus/Control:** this is a way to keep the fundraising, operations and administration in a separate area away from the core operations of the hospital. It enables the trustees to be focused on fundraising rather than the operations of the healthcare organization. In turn, it also allows the management and trustees of the hospital itself to focus on the complexities of running the day-to-day operations of the hospital and not the fundraising.

**Marketing:** this allows the hospital to have a more focused marketing and branding strategy. Many hospital foundations have separate web sites to highlight their upcoming special events as well as to communicate about different ways to give.

**Investing Endowment Funds:** some hospitals utilize this structure to manage their foundation funds separately as a long-term endowment, versus commingling all assets at the hospital.

**Limiting Liability:** the funds that are in a separate foundation may be protected from any hospital-related litigation. In addition, any trustees of the foundation may be viewed as separate from the hospital with respect to their liability exposure.

**Separating Finances:** this is a way to keep hospital finances separate from any fundraising efforts. For example, if the foundation is having a capital campaign, any significant inflows would impact the financials of the parent if they were not separate. Thus keeping the funds separate gives a better picture of the parent financials, and would not have implications for grants or government reimbursement rates.

**Borrowing:** it provides another separate pool of funds which can be used as collateral for loans.

\(^{(2)}\) Source: Association for Healthcare Philanthropy

\(^{(3)}\) The 2010 Study on High Net Worth Philanthropy, conducted by the Center on Philanthropy at Indiana University, high-net-worth families comprise approximately two thirds of individual donations (50% of all giving) annually. The study defines high-net-worth families as those with net worth of over $1 million or annual income of at least $200,000. For 2009, 70% of these families gave to healthcare organizations, compared to only 23% of families in the general population. Thus, the high-net-worth family may be the most valuable demographic for healthcare organizations to seek as potential and continuing donors.

**The use of Foundation Structures as a Fundraising Strategy**

One strategy that healthcare organizations have employed is to establish a separate fundraising foundation to lead their development efforts. Many other types of not-for-profits also use foundations, such as public colleges and membership organizations, just to name a few. There are a variety of reasons why a foundation structure can be beneficial to the healthcare organization:

**Increasing Trustee Opportunities:** a separate foundation creates additional board leadership and volunteer opportunities for trustees, who in turn can be substantial donors. Some foundations have been increasing their trustee membership.

**Maintaining Focus/Control:** this is a way to keep the fundraising, operations and administration in a separate area away from the core operations of the hospital. It enables the trustees to be focused on fundraising rather than the operations of the healthcare organization. In turn, it also allows the management and trustees of the hospital itself to focus on the complexities of running the day-to-day operations of the hospital and not the fundraising.

**Marketing:** this allows the hospital to have a more focused marketing and branding strategy. Many hospital foundations have separate web sites to highlight their upcoming special events as well as to communicate about different ways to give.

**Investing Endowment Funds:** some hospitals utilize this structure to manage their foundation funds separately as a long-term endowment, versus commingling all assets at the hospital.

**Limiting Liability:** the funds that are in a separate foundation may be protected from any hospital-related litigation. In addition, any trustees of the foundation may be viewed as separate from the hospital with respect to their liability exposure.

**Separating Finances:** this is a way to keep hospital finances separate from any fundraising efforts. For example, if the foundation is having a capital campaign, any significant inflows would impact the financials of the parent if they were not separate. Thus keeping the funds separate gives a better picture of the parent financials, and would not have implications for grants or government reimbursement rates.

**Borrowing:** it provides another separate pool of funds which can be used as collateral for loans.

\(^{(2)}\) Source: Association for Healthcare Philanthropy

\(^{(3)}\) The 2010 Study on High Net Worth Philanthropy, conducted by the Center on Philanthropy at Indiana University, high-net-worth families comprise approximately two thirds of individual donations (50% of all giving) annually. The study defines high-net-worth families as those with net worth of over $1 million or annual income of at least $200,000. For 2009, 70% of these families gave to healthcare organizations, compared to only 23% of families in the general population. Thus, the high-net-worth family may be the most valuable demographic for healthcare organizations to seek as potential and continuing donors.
continued from page 39

Providing Separate, Not Public Vehicles: separate 501(c)(3) organizations are often set up since donors prefer to give to a foundation versus an entity that is controlled by the local government.

Fulfilling a bequest: some hospitals have been set up where a separate foundation has been required. For example, one hospital foundation evolved from a bequest which stipulated that the monies needed to be in a separate endowment structure from the actual hospital.

Fundraising vehicle for foreign hospitals: Not-for-profit organizations based in other countries often use U.S. based foundations to help them raise funds for U.S. based donors. The funds are then funneled back to the parent organization.

We came across two situations where a not-for-profit organization actually closed its foundation. One organization closed it foundation to reduce costs, while the other closed its foundation due to board conflicts and overlap.

Research on the use of Healthcare Foundations

In order to get a better understanding of how healthcare organizations are using foundations to support their fundraising efforts, we conducted independent research of 57 healthcare organizations/foundations located in New York, New Jersey, and Pennsylvania. Research was conducted through interviews, tax return and recent form 990 reviews, and web site visits. We included total contributions, including government grants, and adjusted for transfers from their foundations.

Key Findings of Research:
• Over 70% of the hospitals had separate foundations
• A majority of these foundations were managed as long-term endowment structures
• Average hospital philanthropy is a small percentage of the budget at 2.9% (as % of overall hospital revenue)
• Wide range of board trustee size – with an average of 22 foundation trustees

The average donation size compared to total revenues was about 3.3% (2.9%, when adjusted for the large grant for one hospital). This measure is much lower than for other types of nonprofits. The size of the foundations ranged from $1.2 million to $340 million, and the total annual donations ranged from $124,000 to $310 million.

We found that 40, or 70%, of the healthcare organizations we reviewed had foundations. It was interesting to note that four of the largest hospitals in the metro New York area did not have separate foundations, including NYU Medical Center, Memorial Sloan Kettering, New York Presbyterian, and Montefiore Medical Center, which may indicate their already established tradition and history of giving.

Of these 40 organizations, 32, or 80%, manage their foundations as long-term endowment funds and thus tend to follow long-term balanced investment strategies. This may be due, at least in part, to the fact that some of these funds may be restricted monies. Eight organizations use their foundations as flow-throughs, where they keep the funds in cash and transfer them to the parent organization as needed. Some foundations maybe be invested too conservatively and may want to consider more robust investment plans if appropriate.

We also researched the number of foundation trustees for these foundations, which showed the range to be 5 to 87. Hackensack University Medical Center (NJ) had the greatest number of trustees at 87, which maximizes their board representation, but at the same probably requires the implementation of an executive committee. The average number of foundation trustees was 21. Larger organizations tended to have more trustees. At the same time, small organizations are considering expanding their boards as a way to be proactive with their fundraising.

Summary of Foundation Research Data

| Survey size: | 57 organizations |
| How many had separate 501(3)(c) foundations: | 40 or 70% |
| # Foundations using Long-term investment strategies: | 32 or 80% |
| # Foundations with flow-through foundations: | 8 or 20% |
| Range of giving rates (contributions /total revs): | 0.11% to 24% |
| Average giving rate: | 3.3% |
| Average giving rate (adjusted for a large grant): | 2.9% |
| Range of total donations: | $124k to $310MM |
| Range of long term foundation size ($MM): | $1.2MM to $340MM |
| Largest three foundations ($MM): | $340; $211; $133 |
| Range of # of Foundation Trustees: | 5 to 87 |
| Average # of Foundation Trustees: | 21 |

Susan Raymond, of Changing Our World, completed an earlier study of healthcare foundations that looked at 159 hospitals with affiliated foundations. Susan’s research showed that the use of hospital foundations began as more of a western U.S. phenomenon that has since moved east. Many of the western foundations had been formed over 25 years ago, and some had larger asset bases. California and Texas were home to some of the larger ones. They also tended to be associated with larger, metropolitan hospitals.
Investment Considerations for Hospital Foundations

While hospital foundations provide an effective fundraising tool, as with any long-term pool of assets, making sure the appropriate objectives, spending and liquidity requirements, and risk tolerance are defined and considered is of great importance. Creation or revision of an up-to-date investment policy statement codifies this work. Further steps related to asset allocation and the specific investment choices that comprise portfolio construction round out an effective and comprehensive investment program.

Each state has a legal and regulatory framework for its resident nonprofits that have investment implications. An example is New York’s Prudent Management of Institutional Funds Act (NYPMIFA), which has the specific requirement that all nonprofits adopt a written investment policy. These topics will be covered in greater detail in a future article.

**Conclusion**

Our research took a closer look at separate 501(3)(c) stand-alone healthcare foundations and reviewed how their parents utilize these structures as both a fundraising and long-term investment portfolio vehicle.

Further analysis shows that other types of not-for-profit organizations have benefitted from a using a stand-alone foundation strategy. Some examples include:

<table>
<thead>
<tr>
<th>Organization</th>
<th>Type of Foundation</th>
<th>Foundation Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diocese of Brooklyn</td>
<td>Religious</td>
<td>Alive in Hope Foundation</td>
</tr>
<tr>
<td>Buffalo Philharmonic Orchestra Society</td>
<td>Arts and Culture</td>
<td>Buffalo Philharmonic Orchestra Foundation</td>
</tr>
<tr>
<td>Farmingdale State College</td>
<td>Education</td>
<td>Farmingdale College Foundation</td>
</tr>
<tr>
<td>LIM College</td>
<td>Education</td>
<td>LIM Fashion Education Foundation</td>
</tr>
<tr>
<td>AHRC New York City</td>
<td>Social Services</td>
<td>AHRC NYC Foundation</td>
</tr>
<tr>
<td>Queens Public Library</td>
<td>Education</td>
<td>Queens Library Foundation</td>
</tr>
<tr>
<td>American Medical Association</td>
<td>Membership organization</td>
<td>American Medical Association Foundation</td>
</tr>
<tr>
<td>Phoenix House</td>
<td>Social Services</td>
<td>Phoenix House Foundation</td>
</tr>
<tr>
<td>Society for Human Resource Management</td>
<td>Membership organization</td>
<td>SHRM Foundation</td>
</tr>
</tbody>
</table>

The healthcare arena will continue to be impacted by both economic and regulatory forces. Philanthropic dollars will be even more important in the future, and separate foundations will be a key strategy for enhancing and managing a successful fundraising plan.

As Susan Holt, a healthcare fundraising consultant from Vision Philanthropy Group, Inc. said, "hospital philanthropy may only represent a small percentage of a hospital's overall budget but that additional funding helps a hospital move from good to great." Healthcare foundations plus well thought-out strategic plans will become even more important in the future.

**Foundation Profile**

Metro Hospital* in upstate New York is an example of how a healthcare organization has effectively utilized a separate hospital foundation to maximize both its fundraising plans and endowment management strategies. The Foundation for Metro Hospital, which was founded in 1983, strives to ensure quality health care in its community by raising, investing, and distributing funds that support the lifesaving work performed at Metro. It currently maintains a $12.4 million endowment, which it manages for long-term balanced growth.

The Foundation has a strong website page which includes a summary on ways to give and a calendar of upcoming events, along with comprehensive information on planned giving options. They include newsletters on their site, which focus on fundraising testimonials. They also expanded their number of trustees to 29.

Metro has raised $12.1 million over the past five years. During the difficult 2008 and 2009 years, they were able to maintain their peak fundraising dollars at $3.4 million for each year, which shows their commitment towards fundraising.

*continued on page 42*
Organization Profile:

<table>
<thead>
<tr>
<th>Healthcare organization</th>
<th>Metro Hospital, upstate New York</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foundation</td>
<td>The Foundation for Metro Hospital (separate 501(3)(c) organization)</td>
</tr>
<tr>
<td>Founded</td>
<td>1983</td>
</tr>
<tr>
<td>Staff</td>
<td>Six professionals</td>
</tr>
<tr>
<td>Board</td>
<td>29 board members, recently added five new members</td>
</tr>
<tr>
<td>Donor targets</td>
<td>Individuals, corporations, foundations</td>
</tr>
<tr>
<td>Ways to give</td>
<td>Annual appeal, special events, memorials, capital campaign, planned giving</td>
</tr>
<tr>
<td>Legacy society</td>
<td>Yes—“1885 Society”</td>
</tr>
<tr>
<td>Foundation funds raised in 2009</td>
<td>$3.4MM/6.3% of total revenues</td>
</tr>
<tr>
<td>Foundation fundraising trend</td>
<td>2009: $3.4MM; 2008: $3.4MM; 2007: $1.1MM; 2006: $1.5MM; 2005: $2.7MM</td>
</tr>
<tr>
<td>Website</td>
<td>”Make a Gift” and “The Foundation” tags; separate foundation page</td>
</tr>
<tr>
<td>Planned giving details</td>
<td>Stock, bequests, charitable gift annuity, pooled income fund, life insurance, real estate, endowments, retirement plans</td>
</tr>
<tr>
<td>Online giving</td>
<td>Yes</td>
</tr>
<tr>
<td>Social Media</td>
<td>Use emails, exploring other uses</td>
</tr>
<tr>
<td>Newsletter</td>
<td>Yes, highlighted benefits of charitable gift annuity</td>
</tr>
<tr>
<td>Capital Campaign</td>
<td>mentions capital projects</td>
</tr>
<tr>
<td>Public Relations</td>
<td>Their successful capital campaign was highlighted in the Chronicle of Philanthropy along with their relationship with their fundraising advisor, Community Counselling Service Co. (CCS)</td>
</tr>
<tr>
<td>Endowment assets</td>
<td>$12,400,000</td>
</tr>
<tr>
<td>Strategy</td>
<td>Long-term investment strategy</td>
</tr>
<tr>
<td>Policy Statement</td>
<td>Must follow NYPMIFA requirements</td>
</tr>
</tbody>
</table>

*fictional name used to preserve confidentiality*
Balancing costs, care and operations

Balancing the demands of patient care, rising costs and the need to run a successful business can be a struggle for healthcare organizations. The professionals in ParenteBeard’s Healthcare Services Group have decades of experience in providing financial and business advisory services to hospitals and healthcare systems, physician and medical group practices, dental practices and other provider institutions.

Because ParenteBeard’s practice is structured regionally, we provide our clients with a thorough understanding of healthcare issues in their regions.

It’s challenging to envision what the healthcare industry will look like tomorrow. ParenteBeard can provide you with a secure business foundation today to help you move confidently into the future.
The Parade of Major Reported PHI Breaches Hits 400 – Theft is the Primary Type of Breach

by Michael J. Kline, Esq.

Previous issues of this magazine have contained articles on the breaches of Protected Health Information (“PHI”) that have been reported on the U.S. Department of Health and Human Services (“HHS”) list (the “HHS List”) as breaches of unsecured PHI affecting 500 or more individuals (the “List Breaches”). On February 24, 2012, HHS posted number 400 in the ever-lengthening Parade of List Breaches.

As the first postings on the HHS List occurred on March 4, 2010, it took almost exactly two years to reach the 400 level, which means that an average of 200 postings of List Breaches have been occurring each year.

A closer look at the 400 List Breaches reveals that there are an appreciable number of repeat marchers in the parade. In some cases assumptions had to be made as to repeat marchers because the names of some covered entities on the HHS List were similar but not identical to others or appeared to be different divisions of the same covered entity.

Based on such assumptions (including counting multiple divisions as one covered entity), there were:

(i) 28 covered entities with two List Breaches,
(ii) 16 covered entities with three List Breaches and
(iii) 1 covered entity with four List Breaches.

Therefore, there were 337 separate covered entities that reported the total of 400 List Breaches. Of the total of 400 List Breaches, 223 of them attributed the cause or partial cause of the breach to be “Theft.” Of the 223 thefts reported, 93 of them were characterized as theft of a laptop. Therefore, it is not surprising that the 400th List Breach was reported by Triumph, LLC (“Triumph”) as a theft on December 13, 2011 of a laptop containing PHI that related to several of its North Carolina behavioral and psychiatric facilities and affected 2,000 individuals (the “Triumph Breach”).

While the facts of the Triumph Breach were not remarkable in themselves, the event is worthy of review as being a typical List Breach involving a theft of a laptop that contained PHI of several thousand individuals. A closer look at the Triumph Breach reveals that it was an event as to which Triumph appears to have been a victim with little ability to avoid the loss.

Triumph should be commended for having placed a HIPAA Breach Notification (the “Notification”) on its Web site and a prominent notice on its Home page in red with a link to the Notification and the following advice: “Please click here to read the public notice which may affect consumers receiving services from our Winston-Salem, Mocksville and King facilities.” Many covered entities have not prominently detailed List Breaches on their Web sites.

The Notification states that the Triumph Breach occurred on December 13, 2011 when three men entered the 2nd floor lobby of a Triumph facility. While two of them were distracting the receptionist, the third entered a hallway and stole a laptop computer from an office. Because the Notification does say that the laptop was password protected, one can reasonably conclude that there was not encryption of data on the laptop.

The information on the Triumph computer was reported in the Notification to have included names, dates of birth, medical record numbers, insurance/Medicaid numbers, billing codes and authorization status for services, but not social security numbers, diagnostic codes or specific financial information.

Although the HHS List states that 2,000 individuals were affected by the Triumph Breach, no reference to the number of affected individuals was contained in the Notification. Many covered entities that provide information on their Web sites as to List Breaches do disclose the number of affected individuals.

Additionally, while the Notification included contact information for questions about the Triumph Breach, no reference was made in the Notification as to the offering by Triumph of credit monitoring or other security services to affected individuals, as has been done for many other similar List Breaches. Perhaps the explanation for the latter omission is the following statement by Triumph in the Notification:
We believe the motive for the theft was for the computer not for the information stored on the computer. In light of this theft, we are examining our policies, procedures and protocols to safeguard against any future incidents.

Nonetheless, it is uncertain as to whether the PHI stored on the computer will be inappropriately accessed and used. Triumph was an unfortunate victim of a theft of PHI as many other providers have been. Nonetheless, the Triumph Breach is a reminder that, no matter how a List Breach is caused, it will be costly for the covered entity on many levels, and the ultimate extent of the adverse impact cannot be known with certainty.

Finally, while the Parade of List Breaches continues to grow, there are many more PHI data breaches involving fewer than 500 individuals that are occurring as well. It is likely more a question of when, rather than whether, a covered entity will suffer a PHI data breach.

About the Author
Michael J. Kline, Esq., is a partner with Fox Rothschild LLP, based in its Princeton, NJ office, and is a past Chair of the firm’s Corporate Department. He concentrates his practice in the areas of corporate, securities, and health law, and frequently writes and speaks on topics such as corporate compliance, governance and business and nonprofit law and ethics.

Footnotes
1The Internet link is http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule/breachttool.html.
2The blog series produced by lawyers at Fox Rothschild LLP relating to HIPAA/HITECH/HIT has followed a number of them, including Health Net, Henry Ford Health System, SAIC and University of Rochester Medical Center. Its Internet link is http://hipaahealthlaw.foxrothschild.com/articles/breaches/.
3The Internet link is http://www.triumphcares.com/Public-Notice.pdf.
4The Internet link is http://www.triumphcares.com/.

Focused.
Experienced.
Trusted.

Sun National Bank’s healthcare group offers a full spectrum of financing, treasury management and advisory solutions for hospitals, surgical centers and practices. Find out how we can build a healthy partnership and a strong future together.

Sun National Bank
Recognized by Forbes as one of America’s most trustworthy companies – 5 years running.
Advertiser Focus

Please consider supporting our sponsoring companies

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

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

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

ParenteBeard is the Mid Atlantic’s leading regional certified public accounting and consulting firm with over 1,200 employees serving middle market and small business clients across the region. The 170 partner firm has 24 offices located in Pennsylvania, New Jersey, New York, Maryland, Delaware and Texas. The firm is ranked among the Top 20 firms in the USA and is an independent member of Baker Tilly International. For more information, please visit ParenteBeard at www.parentebeard.com.

Liberty is a preferred hospital revenue cycle firm specializing in converting accounts receivable into cash and scrubbing accounts until they reach a zero balance. Established in 1989, Liberty has served over 100 clients in the New Jersey/New York metropolitan area. Our key staff have held various leadership positions in hospital patient accounting and revenue cycle functions and is recognized as a high quality, high service firm with a reputation for flawless account work. Call us at 973.872.1497 or visit us at www.libertybilling.com.

Founded in 1974, WS+B is one of the largest regional accounting and consulting firms in the mid-Atlantic area with office locations in New Jersey, New York, Pennsylvania and Maryland. With over 375 employees, the firm ranks among the top 35 CPA firms nationwide. WS+B services hundreds of health care providers in the areas of accounting & auditing, consulting, tax, corporate governance and risk management. Contact Scott Mariani at smariani@withum.com or 973.898.9494. www.withum.com

www.foxrothschild.com

Counted among the 200 largest law firms in the country, Fox Rothschild LLP is a full-service firm with offices in Pennsylvania, New Jersey, New York, Florida, California, Nevada and Delaware, providing a complete range of legal services to public and private businesses, entities, charitable, medical and educational institutions and individuals.

The Health Care Law Group at Norris McLaughlin & Marcus is one of the largest in New Jersey. We provide a variety of services to clients throughout the health care field, including highly specialized work in the regulatory areas governing the delivery of health care services under state and federal law. Our health care clients include hospitals and their affiliated corporations, hospital medical staffs, nursing homes and other long-term care facilities, joint venture groups, professional practices, and other providers of health care services. For more information, visit our web site at www.nmmlaw.com.

Panacea Healthcare Solutions, LLC with offices in Florida and New Jersey, provides expert financial and information technology services and systems to healthcare providers, payers, and software companies. Panacea’s areas of expertise include coding, compliance, finance, reimbursement and revenue cycle consulting and systems. These services include CDMauditor.com, RACauditor.com, LostRevenueRecovery.com, and hospital Zero Base Pricing consulting.

For more information, visit www.PanaceaHealthSolutions.com or contact Mike Kennedy at 1-866-926-5933 x702.

NJ SmartStart Buildings is the commercial and industrial component of the NJ Clean Energy Program, offering technical assistance, design support and financial incentives for energy-efficient equipment in new construction and retrofits in New Jersey.

Visit NJ SmartStart Buildings online at www.njsmartstartbuildings.com or call us toll free at 866-433-4479 for more information.
Fox Rothschild's Health Law Practice reflects an intimate knowledge of the special needs, circumstances and sensitivities of providers in the constantly changing world of health care. Because of our significant experience and comprehensive, proactive approach to issues, health care providers — including institutional, group and individual practices of all types and sizes — turn to us to successfully meet the challenges of their competitive, highly regulated environment.

After all, we’re not your ordinary health care attorneys.

RESPONDING TO AN INDUSTRY IN TRANSITION

Elizabeth G. Litten, Esq.
609.895.3320
elitten@foxrothschild.com
Princeton Pike Corporate Center
997 Lenox Drive, Building 3
Lawrenceville, NJ 08648-2311
www.foxrothschild.com
INTRODUCING
THE FIRST ANNUAL
NJ HFMA CFO CUP
GOLF TOURNAMENT

When:       Wednesday October 10, 2012
Where:      Galloway National Golf Club
            Galloway, NJ

Golf Digest recently named Galloway one of America’s best private golf clubs!

Schedule:  Registration and brunch:  11:00 AM
            NJHFMA CFO Cup Golf Tournament shotgun start  12:30 PM
            Reception at Galloway National Golf Club  Approx 5:30 PM

Awards:    One First Place Team Trophy – CFO Cup
            First & second place team players will also receive trophies
            Winners announced and trophies awarded on Wednesday night at Borgata during
            NJHFMA Institute function.

Scoring:   Combined team score of all four players utilizing a Callaway scoring system

Foursomes will be $3,500 and include complimentary registrations to the Institute. Each foursome will be required to include a minimum of 2 hospital executives. Participation in the tournament is reserved for providers and current sponsors of the NJ HFMA Annual Institute.

Save the Date!!!
Registration and more information will be released soon!

Contact John Brault at johnbrault@mcbeeassociates.com, or (973) 624-0980 x3617, with any questions.
Meet Rudy Giuliani.

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”.

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
Is your Employee and Vendor Screening Solution Meeting All Your Needs?

It’s time to look at the **BVerifiedSM - Screening and VerificationSM Solution!**

- Easy to Use
- Automated Solution
- Unlimited Users
- Economical Solution/Competitive Pricing
- All Federal and State Databases Included
- Verify Caregivers’ License Information
- Unlimited Screening with 24/7 Access
- Backed by a Company with Compliance Experts

*Screening goes beyond the point of initial hire – it must be done on a regular basis.*

Call BESLER Consulting - 877.4BESLER

www.besler.com/SanctionScreening.htm

---

BVerified is a service mark of Besler & Co., Inc. d/b/a BESLER Consulting