Healthcare Reform: Are We Just Skimming the Surface?

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Scott Mariani, Partner and healthcare industry expert, knows how critical it is for hospitals and healthcare delivery systems to implement the right strategies for financial survival. His healthcare clients trust his advice and guidance, enabling them to focus on what matters most—providing quality patient care. Whether with tax, audit or consulting, helping his clients avoid fiscal trauma is Scott’s specialty.

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IDENTIFICATION STATEMENT

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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.

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The President's View . . .

This year is certainly moving along quickly! Our Compliance, Audit, Risk and Ethics Forum (CARE) in conjunction with the NJ Health Information Management Association held their annual meeting titled “Winds of Change: Government Initiatives & Greater Accountability” on March 8th. The committee did a fantastic job pulling together topics and speakers to discuss PPACA, False Claims Act, NJ HITECH (New Jersey’s Regional Extension Center), Meaningful Use, RAC, MIC, ZPIC, ICD-10…it’s like learning a new language! Thank you to the committee chairs, Darlene Mitchell and Michael McKeever!

The education committee, in particular Cheryl Cohen, worked with NJHA to co-sponsor an event on March 24th – “Stepping Up to the New Era: The Implications of Reform on Capital, Strategic and Physician Planning”. With the uncertain impact of healthcare reform, this program was designed to help put things in perspective by focusing on key strategic planning issues, financially and operationally. The program was such a success, they will be planning more in the near future. Keep your eye on both www.HFMANJ.org and www.NJHA.com web sites for details!

Due to the efforts of Lindsey Colombo, the Board of Directors approved yet another new committee this month: “Revenue Integrity”. The purpose of the committee is to provide a forum for members to discuss charging issues, share and develop best practices as they relate to revenue integrity, and develop and maintain a close working relationship with the Patient Financial Services, Patient Access and CARE committees to discuss issues of mutual concerns. Lindsey Colombo and Vickie McElarney will co-chair this committee. Their first conference call, to see if there was any interest, had over 35 people on the call! Thanks to Lindsey for identifying this need for our members!

The communications committee has outdone themselves again with this issue of Garden State FOCUS. This issue is packed full of information on Health Care Reform, as we strive to keep our members educated in the ever changing regulations. Joanne Vaul, Board Director and Chair of our local sub-committee on this topic, has been appointed Chair of our new Regional Committee LINK (Local Information NetworK). This includes the 4 chapters in Pennsylvania and New Jersey, and is the result of a request from National HFMA to “provide local perspective on the impact of PPACA and HCERA, input and comment on HFMA’s positions and strategies for providers, payers, employers and communities”. Joanne also worked to ensure our chapter submitted comments to CMS regarding the Value-Based Purchasing Program. Thanks Joanne!

I thank all the Board members, committee chairs & co-chairs and their members for “Stepping Up” and keeping our members well informed!

Other upcoming events include:
April 26th – Women in Healthcare: Real Women, Real Issues, Real Solutions
May 12th – The Chapter’s Annual Golf Outing at Fiddler’s Elbow – Don’t miss it!

Respectfully,

Mary T. Taylor, MBA, FHFMA
Dear Readers:

The theme of this issue (hey, we need a theme to go with the cover picture!) is “Health Care Reform: Are We Skimming the Surface?” It is not hard to find summaries of, commentaries on, and challenges to the Patient Protection and Affordable Care Act (“PPACA”) and its companion Health Care and Education Reconciliation Act (“HCERA”), but it can be challenging to dive below the surface and into the depths of what reform will mean in practical (both finance and delivery) terms. One of the goals of the Communications Committee is to provide a bit more depth, substance, and targeted focus on current issues, including health care reform, affecting the health care industry.

Many of you have come to appreciate the articles submitted by fellow HFMA-NJ member John Dalton as much as I do. John’s articles are relevant and intelligent, thorough and data-oriented. When you read John’s PPACA article, you will agree that it definitely does not “skim the surface.” John focuses on addressing hospital-acquired infections as a key means of cost-reduction and quality-improvement, the two sides of the health care reform coin. The comment letter submitted by this Chapter to the proposed rules published by the Centers for Medicare & Medicaid Services (“CMS”) on the Hospital Value Based Purchasing Program (published in this issue) also shows that our members are closely watching and analyzing the reimbursement and operational changes that lie ahead for the health care industry. Joanne Vaul, co-author of the Chapter’s comments, did an outstanding job analyzing the proposed rules and the comments submitted by other hospital organizations. John, Joanne, and Chapter President Mary Taylor are good examples of members willing to dive down and resurface with pearls of information that can benefit the entire Chapter.

We will publish more information in the next issue about another HFMA development that may benefit Chapter members. The recent creation of the Local Information NetworK (or “LINK”) by National HFMA will provide an interface with National’s Health Reform Advisory Committee and will allow for local comment on potential HFMA services.

Regards,

Elizabeth G. Litten
Editor
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U.S. District Court Judge Roger Vinson, in the U.S. District Court for the Northern District of Florida, became the first judge to strike down the entire health care reform act entitled the Patient Protection and Affordable Care Act. Previously, a portion of the act had been ruled unconstitutional by U.S. District Court Judge Henry Hudson in Virginia but the ruling by Judge Vinson found that the unconstitutional provisions of the act could not be separated from the remainder of the law and, thus, the entire act must be invalidated.

The decision published on January 31, 2011, the style and case number of which are State of Florida v. U.S. Department of Health and Human Services, 10-cv-00091, found that the portion of the act that mandates that people procure minimum insurance coverage beginning in 2014 is unconstitutional because that provision exceeds the power of Congress under the Commerce Clause of the Constitution. The judge reasoned that the Commerce Clause could not be invoked because the act attempts to regulate inactivity, the failure to obtain insurance, rather than an activity which engages in interstate commerce. That is to say, Judge Vinson ruled that Congress has erroneously attempted to invoke the Commerce Clause to justify a law compelling nearly all Americans to purchase insurance or to pay a fine, not because of some interstate commercial activity in which they are engaged, but because of their failure to act to have insurance.

The states filing the suit had argued that a person’s refusal to buy health insurance does not amount to economic activity and that, in the absence of such activity, Congress lacked the power to regulate that inactivity under the Commerce Clause. The government’s response to that argument was that since virtually everyone will need health care at some point and since hospitals are required to treat emergent patients regardless of their ability to pay, the decision to not obtain insurance is, in effect, an economic decision as to how and when a person will pay for care. That is, the government argued, people who elect not to purchase insurance are choosing to pay later either out of their pocket or by passing the cost on to health care providers, the government or the people who do elect to purchase insurance. That election, the government asserted, has a substantial impact not only on the insurance market but upon the health care industry and, therefore, Congress is entitled to regulate it.

In rejecting that argument, Judge Vinson found the government’s reasoning “is without logical limitations.” He stated: “Every person throughout the course of his or her life makes hundreds and even thousands of decisions that involve the same general thought process that the defendants maintain is ‘economic activity.’”

The ruling is particularly notable because twenty-six states joined in the Florida case filed by the Florida Attorney General Bill McCollum. Interestingly, however, Judge Vinson rejected many of the claims of these states. The states had asserted that the expansion of Medicaid, which the law provided would begin in 2014, constituted an unconstitutional infringement upon the sovereignty of the states. Judge Vinson rejected that claim on the grounds that the states had the option to decline to participate in the Medicaid program.

Rather, it was the individual mandate provisions of the act that he found objectionable. In declining to limit his ruling only to the individual mandate provisions as Judge Hudson had done in Virginia, Judge Vinson opined that the individual mandate provisions requiring individuals to obtain insurance
continued from page 7

or pay a fine were the “keystone or lynchpin” of the act and that those provisions and the remaining provisions of the law “are all inextricably bound together in purpose and must stand or fall as a single unit.” In describing the law as a “finely crafted watch,” he observed that the individual mandate provision is “one essential piece” which “is defective and must be removed.” He went on to state that “There are simply too many moving parts for me to try and dissect out . . . the able-to-stand-alone from the unable-to-stand-alone.”

The government also argued that Congress was justified in requiring individuals to purchase insurance under the clause of the Constitution which empowers Congress to make all laws “necessary and proper” to carry out the powers enumerated for Congress by the Constitution. The argument was that the individual mandate was essential to many other provisions of the act. For example, without the individual mandate, the provisions of the act prohibiting insurers from denying insurance or charging higher rates on account of pre-existing conditions would be meaningless because people could wait until they became ill to purchase insurance, thereby imposing unsustainable financial burdens upon insurance companies. Vinson deflected that argument by stating: “Rather than being used to implement or facilitate enforcement of the Act’s insurance industry reforms, the individual mandate is actually being used as the means to avoid the adverse consequences of the Act itself. He went on to write: “under such a rationale, the more harm the statute does, the more power Congress could assume for itself under the Necessary and Proper Clause.”

Not surprisingly, the decision has left health care providers, governmental officials and insurers wondering where the law stands. Also not surprisingly, there is widespread disagreement as to the answer to that question. The lawyers for several of the plaintiffs confidently assert that the twenty-six states which are parties to the suit are no longer subject to any of the law’s provisions. Administration officials, on the other hand, are proceeding with implementation of the provisions of the act which take effect immediately as if the decision had not been rendered. Among the provisions which have already gone into effect are those which prohibit states from tightening their eligibility standards for Medicaid, a tempting target for financially strapped states. Many other provisions of the act do not take effect for several years. The individual mandate, the primary focus of Judge Vinson’s ruling, does not take effect until 2014. Other provisions, such as the requirement that states establish insurance exchanges with federal subsidies, do not take effect for several years.
Stanford Law School professor David Engstrom has weighed in by arguing that the decision does not prevent the implementation of the act. “The issue that the court has ruled on has been specifically contradicted by two other district courts,” he said.

It is notable that Judge Vinson declined to grant the plaintiffs’ request for an injunction to prohibit the law from being implemented while the case is appealed. He opined that an injunction was unnecessary because of a “long-standing presumption” that the government complies with decisions of this nature.

On February 17, 2011, the government filed a motion before Judge Vinson requesting that he clarify his ruling. Specifically, the government requested that Judge Vinson clarify whether his earlier decision relieves the plaintiff states from complying with the act during the pendency of an appeal from the decision. Several states, such as Alaska and Wisconsin, have taken the position that the law no longer applies in the states which were plaintiffs in the lawsuit. Other states, such as Ohio, have stopped short of asserting that the law is dead in their state. The federal government, in its motion for clarification, noted that the decision “potentially implicates hundreds of provisions of the act and, if it were interpreted to apply to programs currently in effect, duties currently in force, taxes currently being collected, and tax credits that may be owed at this time or in the near future, would create substantial uncertainty.”

On March 3, 2011, Judge Vinson issued an order staying the effect of his order. The stay was conditioned, however, upon the Justice Department pursuing an expedited appeal, which Judge Vinson ordered be accomplished within seven days. This ruling is, in effect, a suspension of his order pending appeal. Vinson was obviously irritated by the speed at which the administration was moving as he noted that it had been more than a month since his initial order and the government had not yet filed its notice of appeal.

Thus far, the judicial decisions regarding the new law have followed a predictable philosophical divide reflecting the partisan views of those who appointed the judges who have decided the cases. Both of the decisions finding the law to be over-reaching and exceeding the authority of Congress have been rendered by judges appointed by Republican presidents (Vinson by President Reagan and Hudson by President George W. Bush), thereby reflecting a more limited role of the federal government under the Commerce Clause and the Necessary and Proper Clause. On the other hand, the three decisions rejecting challenges to the law have been rendered by judges appointed by President Clinton, reflecting a view of more expansive powers of the federal government under these clauses.

Ultimately, the validity of the law will be determined by the U.S. Supreme Court. Judge Vinson recognized this in his order of March 3 when he noted: “It is likely that the Courts of Appeal will also reach divergent results and that, as most court watchers predict, the Supreme Court may eventually split on this issue as well.” What is not clear is whether the Supreme Court will wait for the case to come through the U.S. Circuit Courts in the normal course of appeals or whether the Supreme Court will yield to those who are urging it to exercise some sort of extraordinary procedure in order to hear the case on an expedited basis. The answer to that question should become clearer during the next few months. In the interim, it appears that the federal government will proceed as if the act is valid while some states will ignore it and proceed as if the Florida decision by Judge Vinson has rendered the act null and void.

The lawyers for several of the plaintiffs confidently assert that the twenty-six states which are parties to the suit are no longer subject to any of the law’s provisions. Administration officials, on the other hand, are proceeding with implementation of the provisions of the act which take effect immediately as if the decision had not been rendered.

About the author
Bill Potter received a Bachelor of Arts degree from Brown University and a Juris Doctorate from the University of Michigan Law School. He is also a graduate of the Air War College. During his long and successful career, he served as US Air Force Legal Advisor, Astronauts Memorial Foundation Director, Melbourne/Palm Bay Area Chamber of Commerce Chairman, Brevard Economic Development Council Chairman, city attorney for Melbourne, Indialantic, and Melbourne Village, Florida, Florida Institute of Technology Board of Trustees Chairman and held many other board positions. He is recipient of the Outstanding Community Service Award in 1971 and 1991, Air Force Commendation Medal, Air Force Achievement Medal, Air Force Meritorious Service Medal, and NATO Medal. He currently serves as a Treasurer of Holmes Regional Medical Center/Palm Bay Community Hospital, Palm Bay, Florida. He can be reached at wlpott@yahoo.com.
Can Patient Protection Produce Affordable Care?

by John J. Dalton, FHFMA

At the one year anniversary of the passage of the Patient Protection and Affordable Care Act (PPACA), the health care reform debate continues to rage, with legal challenges to the constitutionality of its individual mandate and Republican attempts to repeal the Act. Meanwhile, several important provisions of the Act have already been implemented, and hospitals are scrambling to meet the challenges that PPACA poses. Chief among their concerns is finding ways to produce the $155 billion in cost savings over the next ten years that the American Hospital Association agreed to in July 2009. For most hospitals, the cost of providing services to Medicare beneficiaries exceeds the payment received, so further cuts to Medicare payment rates pose a potential threat to financial viability. No margin, no mission.

Can patient protection produce affordable care? In this author’s opinion, the Act’s patient protection provisions can fundamentally change the way that patient care is delivered in America’s hospitals and, by the end of the ten-year implementation period, result in a more streamlined delivery system that produces higher quality, more affordable care for all Americans.

Quality – the New Imperative

At last October’s Annual Institute, HFMA Chair Debora Kuchka-Craig, FHFMA, described the paradigm shifts that hospitals face as health care reform changes economic incentives. Among other factors, she stated that quality would now drive payment, resulting in a new value proposition based on published quality and cost metrics. She suggested three key strategies for transformation in the reform era:

1. Transform care to increase quality and reduce cost;
2. Understand, manage and mitigate risk; and
3. Become more customer-centric.

Ms. Kuchka-Craig urged attendees to focus on measures or metrics that impact reputation (such as comparisons on quality and outcomes) and payment, citing Medicare’s rules on hospital-acquired conditions and readmissions. While recognizing that finance professionals are often uncomfortable tackling clinical care issues, she challenged members to “Step Up and make it happen,” citing Colin Powell’s rule: “Once the information is in the 40% to 70% range, go with your gut. Don’t wait until you have enough facts to be 100% sure, because by then it is almost always too late.”

What are the relevant facts?

Since October 2008, Medicare has stopped paying for certain hospital-acquired conditions, and PPACA authorizes the Secretary of Health and Human Services (HHS) to conduct a study and further expand that policy.

Beginning in 2012, Medicaid’s federal match will no longer pay for these conditions, and Medicare will begin penalizing hospitals for excessive rates of avoidable hospital readmissions.

Beginning in 2015, hospitals in the top 25th percentile of rates of hospital acquired conditions will be subject to a Medicare payment penalty, and the list of applicable conditions subject to scrutiny for excessive readmissions will be expanded.

When President Obama held a summit meeting of key stakeholders in July 2009, he asked each to contribute to reforming American health care. The American Hospital Association (AHA) agreed to absorb $155 billion in cost reductions over the next ten years. That’s an average of $15.5 billion per year, enough to cause any chief financial officer some sleepless nights. With most hospitals already losing money on Medicare, where can savings of this magnitude be found?

Healthcare-Associated Infections – a $31 Billion Issue

In March 2009, the Centers for Disease Control and Prevention (CDC) issued a paper, “The Direct Medical Costs of Healthcare-Associated Infections in U.S. Hospitals and the

The CDC estimated that overall annual direct medical costs of HAIs to U.S. hospitals ranged from $28.4 to $33.8 billion in 2007 dollars.
Benefits of Prevention.” A healthcare-associated infection (HAI) is one contracted by a hospital patient that is not associated with the admitting diagnosis. Authored by economist R. Douglas Scott II, the report used results from published medical and economic literature to provide a range of estimates for the annual direct hospital cost of treating HAIs in the United States. Applying Consumer Price Index (CPI) adjustments to account for the rate of inflation in hospital resource prices, the CDC estimated that overall annual direct medical costs of HAIs to U.S. hospitals ranged from $28.4 to $33.8 billion in 2007 dollars. Had the CPI for inpatient hospital services been used, the range would be $35.7 to $45 billion. Taking the mid-point of the estimated range using the CPI for all urban consumers, HAIs are a $31 billion issue.

The CDC analysis was based on the estimated number of infections incurred during 2002. Data were analyzed for surgical site infections (SSIs), central line-associated bloodstream infections (CLABsIs), ventilator-associated pneumonias (VAPs), catheter-associated urinary-tract infections (CAUTIs), and Clostridium difficile-associated disease (CDI). Cost estimates for each were inferred from published studies and combined with annual HAI incidence estimates from the National Nosocomial Infection Surveillance System (NNIS). The analysis did not include Methicillin resistant Staphylococcus aureus (MRSA) infections.

The CDC analysis found that 1.7 million HAIs occurred in 2002, resulting in an estimated 99,000 deaths. In human terms, one out of every 20 inpatients admitted to an acute care hospital during 2002 acquired an HAI, and one out of every 20 patients who acquired an HAI died.

After adjusting for the range of effectiveness of possible infection control interventions, the CDC analysis states that the benefits of prevention range from a low of $5.7 to $6.8 billion (20 percent of infections preventable) to a high of $20.0 to $23.4 billion (70 percent of infections preventable). Clearly, preventing HAIs provides the greatest potential for fulfilling the AHA’s $155 billion pledge. A 50 percent reduction in HAIs could produce $15.5 billion per year in cost savings.

This potential for cost reduction is easy to say, but difficult to attain. Can hospitals reach these goals? Recent studies provide some clues.

Reducing HAIs

A number of initiatives directed at reducing HAIs have been underway for several years with varying results. Most recently, on March 1, the CDC reported that central line-associated bloodstream infections declined by 58 percent in U.S. hospital intensive care units between 2001 and 2009, representing up to 27,000 lives saved and $1.8 billion in health care costs avoided. In New Jersey, 39 hospitals participating in the “On the CUSP: Stop BSI” effort surpassed the national average by reducing the incidence of bloodstream infections 81 percent over the last two years. The New Jersey Hospital Association’s Institute for Quality and Patient Safety partnered with the Johns Hopkins Quality and Safety Research Group, the U.S. Agency for Healthcare Research and Quality, the American Hospital Association’s Health Research & Educational Trust and the Michigan Hospital Association’s Keystone Center for this highly successful program.

Medicare’s focus on avoidable readmissions is well-placed. In February, the Pennsylvania Health Care Cost Containment Council (PHC4) released its report, “The Impact of Healthcare Related Infections in Pennsylvania, 2009.” Based on data reported to PHC4, patients who acquired an HAI were nearly five times more likely to be readmitted within 30 days. Among all patients who contracted an HAI, 29.8 percent were readmitted within 30 days for an infection or complication. Of those patients who did not contract an HAI, only 6.2 percent were readmitted within the same timeframe for the same reasons. Other key findings of PHC4 included:

- Patients with an HAI were five times more likely to die. The mortality rate for patients who acquired an HAI was 9.4 percent, while the mortality rate for patients without an HAI was 1.8 percent.
- On average, patients with an HAI stayed 16.7 days longer than those with no HAI (21.6 days vs. 4.9 days).
- In 2009, 10,721 Medicare beneficiaries aged 65 and older contracted an HAI during their hospital stay. PHC4 estimated that Medicare paid an average of $20,471 for these cases compared with an average of $6,615 for hospitalizations without an HAI, a difference of $13,856.

The CDC analysis found that 1.7 million HAIs occurred in 2002, resulting in an estimated 99,000 deaths. In human terms, one out of every 20 inpatients admitted to an acute care hospital during 2002 acquired an HAI, and one out of every 20 patients who acquired an HAI died.
A new study by Craig A. Umscheid, MD, MSCE, assistant professor of medicine and epidemiology and director of the Center for Evidence-Based Practice at the University of Pennsylvania, confirms that up to 70 percent of certain cases of HAI s may be preventable with current evidence-based strategies. Published in the February 2011 issue of Infection Control and Hospital Epidemiology it covered CLABSIs, VAP, SSIs and CAUTIs.

Clearly, sound infection prevention practices will be a major key to prospering under health care reform. These include:

- Following best practice protocols for central line and urinary catheter insertion, preventing ventilator-associated pneumonia and surgical site infections, etc.;
- Monitoring hand washing, the single most effective way of minimizing the risk of spreading infection; and
- Implementing an environment of care that safeguards patients, staff and visitors from virulent pathogens.

Is a 50% reduction in HAI s attainable? On December 2, 2010, the Institute for Healthcare Improvement (IHI) held a webcast, “Finding the Will to Bend the Cost Curve.” During the webcast, I posed that question to Jeffrey D. Sellberg, MHA, Executive Vice President and COO. His response: “Absolutely!”

**Bottom Line - What’s It All Worth?**

If the CDC’s estimates are correct, significant reductions in HAI s can produce millions of dollars in annual cost savings for most hospitals. Let’s quantify the range of potential savings for a hospital with 10,000 annual inpatient admissions. The $31 billion in added medical costs for 1.7 million HAI s is an average of $18,235 per HAI. Adjusting that amount to 2011 dollars is a 6.21% increase to $19,368. The remaining arithmetic is straightforward:

1. HAIs occur in 5% of admissions: 10,000 X 0.05 = 500 HAIs;
2. Preventing 20% of these HAIs at $19,368/HAI = $1,936,800 saved;
3. Preventing 70% of these HAIs at $19,368/HAI = $6,778,800 saved.

Equally important are the deaths avoided (5 deaths at a 20% reduction in HAIs; 17.5 deaths at a 70% reduction). While the results will vary depending on a given hospital’s service mix and infection prevention program, there aren’t many areas that have such a positive potential effect on operating margin.

Added benefits of reducing HAIs include:

- Shorter average length of stay. The PHC4 data indicated that patients...
with an HAI stayed in the hospital an average of 16.7 days longer. Preventing 100 HAIIs per year reduces bed and staffing need by 1,670 patient days. For a hospital with 10,000 annual admissions, that’s a 0.167 day drop in average length of stay.

- Less stress on nursing staff, a chronically scarce resource. Since patients with HAIIs require intensive nursing care, the nursing hours freed up by reducing HAIIs are substantial.

- Reduced exposure to negligence claims. Some plaintiffs attorneys have labeled HAI litigation as the next “asbestos,” and use “never event” language to bolster their allegations of negligence in HAI cases.

Save money while saving lives and better utilizing scarce clinical resources. That’s a compelling value proposition. PPA-CA’s patient protection provisions present both a threat and an opportunity. Patient protection can produce affordable care, and I am optimistic that leading edge hospitals will grasp that opportunity, and not merely survive, but thrive under health care reform.

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**About the author**

John Dalton, FHFMA, is Senior Partner at Staph Solutions LLC, Senior Advisor to Besler Consulting, and a Past President of the New Jersey Chapter. He served on the National Board of Directors and was the 2001 recipient of the Frederick C. Morgan award for lifetime achievement in healthcare financial management. From 1974-77 he served as Project Manager for design and implementation of New Jersey’s first rate setting and cost reporting system (SHARE) and the conceptual design of the all-payor DRG system that became the model for Medicare’s Inpatient Prospective Payment System. In 1985, he served on an American team assessing health care delivery in the Kingdom of Saudi Arabia. As part of an HFMA delegation to Russia in 2008, he spoke on “U.S. Health Quality Indicators” at the National Research Institute of Public Health of the Russian Academy of Medical Sciences in Moscow. He serves as a Trustee of the St. Joseph’s Healthcare System, an Honorary Trustee of Children’s Specialized Hospital, and can be reached with comments at john@staphsolutionsllc.com.

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**Meet Some New Members!**

<table>
<thead>
<tr>
<th>Who is your employer, and what is your position?</th>
<th>Pat Jones</th>
<th>Al LoBiondo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newton Memorial Hospital, Patient Access – Quality Improvement.</td>
<td>Medesco, LLC an energy services company of which I am a principal. I am also president of AJ LoBiondo Associates, a health care expense management and national accounts consulting firm.</td>
<td></td>
</tr>
</tbody>
</table>

| What was your first job as a teen? | Baby sitting. | Stock clerk at a bookstore chain. |

| What do you like best about your work responsibilities? | Interacting with staff & patients. | Having the freedom for creativity to design and implement innovative strategies in areas where my health care clients can realize high returns on investment. |

| A job I would enjoy doing without pay is... | Teaching crafts. | Coaching or mentoring, especially young people with disabilities. |

| My favorite place is... | Home. | Any place warm, where there is sun, sea and a challenging golf course. |

| I will not eat... | Olives. | Stuffed cabbage. |

| If I’m not at work, you will find me... | Making cards. | Health club, coaching, golf course or watching football. |
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:

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VIA ELECTRONIC SUBMISSION

RE: Comments on Notice of Proposed Rule Making (NPRM) by Centers for Medicare and Medicaid Services (CMS) – Medicare Programs; Hospital Inpatient Value Based Purchasing Program (CMS-3239-P), published January 11, 2011

Dear Dr. Berwick:

The New Jersey Chapter of the Healthcare Financial Management Association (HFMA-NJ) appreciates the opportunity to comment on the above-referenced rule proposal concerning the Hospital Inpatient Value Based Purchasing (hereinafter, “NPRM”). HFMA-NJ’s 1,100-plus members include many New Jersey hospital Chief Financial Officers and a wide range of professionals providing financial, operational, legal, technical, and other services to healthcare entities.

New Jersey is a densely-populated state containing 72 licensed acute care hospitals, many of which were built in the early part of the 20th century and have an aging infrastructure. Many New Jersey hospitals have struggled financially. Nine hospitals have closed since 2007, and six have filed for bankruptcy since 2007. Many hospitals have postponed capital purchases to avoid bankruptcy. In addition, New Jersey hospitals have an obligation above and beyond federal EMTALA requirements to treat uninsured and underinsured patients, even though reimbursement from the State for charity care has sharply declined over the past several years. As such, HFMA-NJ is particularly interested in the NPRM and the financial implications related to the Inpatient Hospital Value Based Purchasing Program in New Jersey.

HFMA-NJ supports many of the comments submitted by associations and organizations such as the American Hospital Association (AHA) and the New Jersey Hospital Association (NJHA) and has attempted to focus these comments on issues not already raised by these other associations and organizations so as to avoid redundancy and to bring to light items of particular concern to our New Jersey members.

1. Appropriate Measures of Efficiency for future VBP calculations

We recommend that any payment based on efficiency standards should be excluded from the VBP program. Efficiency measurements are not sufficiently sophisticated to address all of the various elements impacting cost, particularly items such as: regional regulatory requirements, and geographic differences in processes, expectations, law, unionization, and patient severity of illness should be considered. All of these items need to be thoroughly researched and addressed prior to the development of any proposal to add efficiency into the payment calculation. Any inefficiencies result in significant financial consequences to the provider by their very existence so this would likely yield no significant change; the potential benefit of any
such proposal will be outweighed by the risk associated with potential methodological flaws.

2. **Performance Score Methodology**

The design of the proposed program is desirable because it is understandable. The linear nature of the adjustments and the equal weighting of the various elements within a given domain keep the methodology straightforward. However, there is no evidence supporting that it is equitable or that the result of implementing the methodology will have the desired outcome of transforming the healthcare payment system to be value driven rather than volume driven. We recommend that additional research be conducted to support the structure of the methodology and to evaluate the impact of its implementation.

3. **Appeals Process Structure and Timeline** (qualification and timeframes)

We recommend that there be a formal process for appeals, and that be designed and publicy available prior to implementation of the VBP program. Specific items that are subject to appeal, conditions for appeal and a vehicle to support rapid appeal resolution should all be included in the language.

Thank you for your consideration of these comments. Please do not hesitate to contact either Joanne Vaul (jvaul@cbiz.com) or me should you have questions.

Respectfully Submitted,

**Mary T. Taylor**

Mary T. Taylor, MBA, FHFMA  
President, NJ HFMA

Joanne Vaul  
Chair, Sub-Committee on HealthCare Reform, NJ HFMA

**Note to Readers:** The AHA and NJHA VBP comment letters can be accessed at the following link: [http://www.hfmanj.org/vbp.page](http://www.hfmanj.org/vbp.page)
Health Care System Building and Networking

In the current health care environment, system building and networking are essential to success...maybe even to survival. Health care institutions may need to find merger partners. Physicians and physician organizations may benefit from strategic alliances with other health care organizations. Other entities in the health care field may be looking for joint venture partners.

Yet, system building and networking raise complex legal issues. Anti-trust concerns are thorny. Tax and tax-exemption issues abound. And the business aspects of negotiating such arrangements are far from easy.

Norris McLaughlin & Marcus' health care attorneys are among the most experienced in assisting clients in navigating these difficult waters. Our health care attorneys have handled some of the largest health care mergers and have been involved with the development of some of our region's most successful health care networks. Norris McLaughlin attorneys have also successfully dealt with some of the most sophisticated business, tax and anti-trust issues in system and network development.

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Preparing for ICD-10: The Cost of Change

by Denny Roberge

Providers and executives at every healthcare facility in the United States are aware that their coding will change forever on October 1, 2013. That is the deadline set by the Department of Health and Human Services for implementation of the ICD-10-CM/PCS Coding System for all covered entities. Make no mistake: the transition from ICD-9 to ICD-10 will be no small feat. Following is advice to help hospital executives begin to plan accordingly.

Be Prepared

With ICD-9, providers have become accustomed to a rudimentary code structure, but ICD-10 will expand that structure and create a more detailed and complex system. In fact, while ICD-9 consists of about 14,000 diagnosis codes, ICD-10 contains almost 70,000 and in terms of procedural coding, the code set will increase from around 4,000 to 87,000 codes. Selecting the correct codes has always been important for proper billing and reimbursement and ICD-10 undeniably will complicate this task. Healthcare organizations that are not already planning for this change have underestimated the time and effort it requires and the consequences of not being prepared.

Look at Current Processes

There are many issues hospitals should already be addressing in preparation for the future changes. The first task is to take a long, hard look at current processes. Determine where the excess resides in the system, eliminate the overlaps and decide if the system’s proverbial belts are as tight as they possibly can be. Decide if money will be better spent on technology or on staff. Perhaps outsourcing is a sensible option, especially considering the need for expert assistance in comparison to the cost of attracting and retaining such expert talent.

Manage Audits & Documentation Proactively

Next, hospitals should be sure to have a process in place for handling Medicare and Medicaid RAC, commercial payor, and other government audits, because instead of going away, audits will become more robust in the future. The challenges of ICD-10 create an opportunity for auditors and they will identify systems that are not prepared. Audit tracking software that assists in managing audits and prospectively identifies risks should already be in place. Documentation is an “Achilles Heel” for many hospitals and deficiencies require immediate process improvement and training focus. Providers need to know when errors are being made and held accountable. Current internal and payer audits provide insight into exposure and deficiencies that cannot be ignored. Hospitals should be prepared to fix these issues now or be forced to pay money back and face penalties – and no hospital executive wants that to happen.

Adopt Best Practices

Hospitals also need to be adopting best practices all along the revenue cycle. Charge capture audits are not a waste of time because money is being left on the table every day and it is important to capture any and all potential lost revenue. Having a denials management process in place is also important because every time a claim is denied, in addition to the lost revenue itself, the rework is also expensive. Hospitals should also look at their pre-service models to make sure they are as efficient as possible.

Correct Deficiencies

Finally, hospitals should perform a gap analysis and if deficiencies are identified, the time to correct those deficiencies is now. It will also be critical to evaluate systems and staff to ensure the right tools are being used by the right people. Taking a hard look at partnerships with regard to coding, transcription and collections can also be helpful.

Plan for Training

When ICD-10 is finally adopted, users will notice many fundamental differences. Numerous professional organizations and websites explain the differences and provide examples regarding the specificity and structural changes continue on page 33
Aligning Physicians and Hospitals

by Kate Lovrien & Luke Peterson

Healthcare and payment reforms, new structural models and myriad market forces have increased the pressure on the physician-hospital relationship, but forging stronger partnerships is a key element of future success.

As illustrated by Exhibit 1, there are three major elements required for full physician-hospital alignment, composing the “Physician-Hospital Alignment Triangle”:

- Clinical Activity Alignment
  The correlation of the patient care approach, expectations of quality and service, and consolidation of activity in the diagnosis, treatment and rehabilitation of a patient
- Economic Alignment
  The correlation of physician and hospital financial returns
- Alignment of Purpose
  The correlation of vision, values and energies; creating a shared belief in a single vision/mission, a common culture and an active involvement in the future direction of the organizations

To study alignment in a systematic way, we developed the Physician-Hospital Alignment Diagnostic, a quantitative tool that allows hospitals to test their specific situation and alignment against others across the country.

Taking a sample of 40 hospitals shows some interesting results:

- The total alignment score is measured by adding the scores of the three types of alignment. With a maximum possible full alignment score of 150, the sample scores range from 59 to 106. The mean score is 81.
  - Clinical activity alignment scores range from 19 to 38 of a possible 50 points with a mean score of 27
  - Economic alignment scores range from 12 to 36 of a possible 50 points with a mean score of 27
  - Alignment of purpose scores range from 17 to 36 of a possible 50 points with a mean score of 27
- Urgency of alignment is a factor of the market, hospital, and competitive factors. The measure of Urgency ranges from 22 to 39 of a possible 50 points with a mean score of 30.

These scores, which are similar to other hospitals in the database, show the variability of alignment and that many hospitals have significant opportunity for greater alignment in multiple areas.

Strategies to Improve Physician-Hospital Alignment

There are 20 distinct strategies in four categories (business services, contracts, structured communications and employment) that hospitals can use to strengthen the three forms of alignment. (See Exhibit 2 on next page.)

Moreover, each of these strategies impacts different parts of the Physician-Hospital Alignment Triangle. As such, the appropriate strategy needs to be used for a given situation when trying to achieve a given type of alignment. In general, hospitals wanting to align physicians should consider strategies based on the connections outlined in Exhibit 3 on next page:

EXHIBIT 1: Physician-Hospital Alignment Triangle
alignment in clinical activity and economic areas. (See Exhibit 4.) Moreover, market indicators suggest that the urgency of creating stronger physician alignment is lower than average.

Further investigation of Hospital A shows that the hospital’s administration has been actively working to create a common vision with its physicians. This common vision has led to direct physician leadership in setting the strategic course of Hospital A. However, while Hospital A has kept up with the national trends, it has not been overly aggressive at using the tools that might advance clinical activity or economic alignment. For instance the Hospital A does not employ any physicians, does not pay ER call pay, and has only a very limited number of other contractual and business service activities with its physicians. Given the relatively weaker alignment within clinical activity and economic areas, Hospital A has embarked on a program to maximize alignment in these two areas.

**Conclusion**

Strengthening physician relationships is a key component of hospital and health system success. With the increasing integration of the physician into the hospital and health system organizations, it is important to create stronger alignment in all three areas. For more information, visit www.PhysicianHospitalAlignment.com.

**About the Authors**

Kate Lovrien is a senior manager and Luke Peterson a partner with Kurt Salmon’s healthcare strategy group, and the two are co-authors of www.PhysicianHospitalAlignment.com. They have focused their careers on advising community and regional referral hospitals and healthcare systems on the strategic positioning including physician-hospital alignment, health system organizational structures, and continuum of care coordination. They can be reached at Kate.Lovrien@kurtsalmon.com and Luke.Peterson@kurtsalmon.com.

**Footnote**

1The 40 hospitals were chosen to provide a cross section of the typical community hospital in the U.S. today. These hospitals all depend heavily on a private practice medical staff, are located in urban and suburban markets and range from 150 to over 500 beds. These hospitals represent typically high-quality, successful organizations.
The HFMA Peer Review process is a rigorous product and service evaluation program that significantly reduces risk and expands your purchasing options. Here are five reasons you should start your next purchasing process with HFMA Peer-Reviewed products and services:

**Reviewers whose opinions matter**

HFMA Peer Review process is based on evaluations conducted by your fellow CFOs – healthcare professionals whose needs and concerns are similar to your own. No one is more qualified to cut through inflated marketing claims. The HFMA Peer Reviewed designation is your assurance that a product or service has proven its quality, value and ROI in healthcare environments like yours.

**The due diligence you'd conduct if you had the time**

HFMA conducts a far more rigorous due diligence process than your time and resources allow. A thorough, 11-step screening process evaluates products and services against HFMA’s high standards for effectiveness, quality, price, value and customer support. The process includes extensive surveys of current customers, as well as organizations that considered but ultimately decided not to purchase the product or service. The Peer Review team leaves no stone unturned during the evaluation process.

**An impartial review process**

No matter how thorough your own due diligence process, it’s difficult to get an impartial review of products or services you’re considering. Vendor websites, literature and references are obviously biased to emphasize the positives, and discussions with your network of colleagues might not uncover product limitations, drawbacks or service problems. The HFMA Peer Review process challenges those claims. If a product or service doesn’t deliver, it won’t earn HFMA Peer Reviewed designation.

**A better list of candidates**

In today’s rapidly changing marketplace, it’s challenging and time consuming to keep up with all the product and service options available. Moreover, you may be understandably reluctant to consider an unknown vendor, especially for a critical purchase. You may go back to the same vendors over and over simply because you’re unaware of better alternatives or don’t have time to check them out. Because HFMA’s Peer Reviewed products and services have been so thoroughly vetted, you can consider new sources with confidence and widen your purchasing horizons safely.

**Assurance of continued service and support**

HFMA Peer Reviewed status is not a once-and-you’re-done designation. HFMA conducts an annual re-evaluation of Peer Reviewed products and services to ensure that they continue to meet the rigorous standards that secured initial approval. This is additional assurance of the vendor’s long-term commitment to quality, effectiveness and customer support.

**The bottom line**

HFMA’s Peer Review designation helps ensure that a product or service will do what it claims to do and will provide a solid ROI. It also documents that the vendor has demonstrated expertise in the healthcare industry and a strong reputation for integrity. For Gregg Beeg, CFO of Central Michigan Hospital in Mount Pleasant, Michigan, and HFMA Fellow, the HFMA Peer Reviewed credential carries tremendous weight in vendor comparisons. “It is exceptional the quality of the organizations that are granted and approved through the Peer Review process,” he says. He calls the HFMA Peer Reviewed designation “a gold star benchmark that all of us in the healthcare industry can use.”

Reduce risk and save time by starting your next purchasing process using HFMA’s list of Peer Reviewed products and services. You’ll find the complete list on the HFMA website at http://www.hfma.org/Marketplace/Peer-Review-Products-and-Services/HFMA-Peer-Review/.

**About the author**

*Jeff Evarts is a Healthcare Finance Specialist with First American Healthcare Finance, a Peer Reviewed service. He can be reached at jeff.evarts@faef.com.*
CBIZ’s Healthcare Reform Toolkit is:

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**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.
Deadlines Work

by Robert Wilson

As I sit here writing this column against the deadline, I’m reminded of my days as a young advertising copywriter when I occasionally needed a deadline as motivation to finish a boring project. The deadline did more than motivate me to finish -- more often than not, it was what finally stimulated enough creative thinking to move me forward -- in other words, it motivated me to think outside of the box.

“Thinking outside of the box.” Boy, has that phrase become overused. People are so often telling us that we need to think outside of the box that it has fallen into the realm of cliche. Never the less it is still true. Sometimes, however, we need to be put into a box first before we can think outside of it. A deadline is just such a box.

I used to believe that the more freedom I had, the more creative I could be. But it doesn’t necessarily work that way. Ingenuity needs to be motivated by something, and if the desire to achieve isn’t there, then an uncomfortable boundary may work.

Have you ever watched a man or a woman with one leg running a marathon or competing in downhill snow skiing? I have, and every time I’m deeply impressed because I have both of my legs and I can’t do either one. I used to wonder why they were able to do so much more than me when I was the one born with the greater advantage. Now I can see that the difference is that they were challenged by a boundary and I wasn’t. Some of them might even argue that they were the ones born with the greater advantage. Being unable to walk made them uncomfortable, and conquering their disability became a powerful motivating factor. They had to get out of that box!

Think of creativity as a prisoner trying to bust out of jail. When your resources and opportunities are limited you must become innovative. A good illustration of this is the World War II movie The Great Escape. It is an amazing tale of ingenuity. Men with little to work with escape from a German POW camp. In addition to digging three tunnels without shovels, they made hand drawn traveling documents and identification papers that looked authentic enough to pass for ones made on a printing press. Now that was a box to get out of!

I have enjoyed working for myself most of my adult life. People frequently tell me they wish they could be self-employed like I am. They say things like, “If I could just get one client then I could quit my job.” My response is always the same, “Until you quit your job, you are never going to find that first client. There is nothing like the deadline of a rent or mortgage payment staring you down at the end of the month to motivate you to get out and look for clients.”

Everyone works under some kind of deadline. They force us to prioritize our responsibilities; they limit procrastination; and they help us achieve our work-related goals. But, we often lack them in our private lives. We are not given deadlines to accomplish our most important personal goals and without those boundaries procrastination can creep in and destroy our best intentions. The trick is to impose a deadline on yourself. But it has to have some teeth to work.

Here’s how to do it: Write down your goal. Then set a reasonable date in which you can achieve it. Next, go to your bank or attorney and set up an escrow account. Now add the teeth – put into the account an amount of money that will hurt to lose: $1,000... $10,000... $100,000... you decide! Set it up so that if you haven’t achieved your goal by the deadline then the funds go to a favorite charity... or make it even more motivating: let the funds go to your worst enemy!

Not ready to try that? Then try the buddy system. Pair up with a friend and each of you take responsibility to follow up on the other one. You can get together once a week and check on each other’s progress. If goals aren’t being met, then nag each other into the UnComfort Zone!

About the Author
Robert Evans Wilson, Jr. is an author, speaker and humorist. He works with companies that want to be more competitive and with people who want to think like innovators. For more information on Robert’s programs please visit www.jumpstartyourmeeting.com.
February 24, 2011, St. Paul, MN – Medical Learning, Inc. (MedLearn) and Panacea Healthcare Solutions, LLC (Panacea) today announced completion of a transaction that merges the entities into a parent company named Panacea Healthcare Solutions, Inc.

MedLearn is a nationally recognized healthcare publishing and consulting firm specializing in all aspects of coding, compliance, reimbursement and revenue cycle. Panacea is a financial consulting and software development company specializing in hospital coding, compliance, reimbursement and revenue cycle systems and services.

Michael Rogge, who founded Medical Learning, Inc. in 1991, will remain as the Chairman and President. Frederick Stodolak, formerly chief executive officer of Panacea Healthcare Solutions, will have the same title in the new entity.

“We have worked with Panacea for almost two years now and have had great success,” said Rogge. “From the start we have seen the great synergy between our companies. MedLearn’s thought leadership together with the financial consulting and web-based technology expertise of Panacea position us as the leading source for consulting and software solutions for healthcare organizations.

“We are very excited about the talent and technology we have pulled together as a result of this transaction and believe our business model is progressive and responsive to the needs of healthcare providers in this ever demanding environment,” said Stodolak. “Over the next year we will leverage our vast knowledgebase by expanding our news and information, publishing and educational services reach through advanced media technology and to offer our expanding client base alternative web-based revenue cycle, reimbursement, spend management solutions and decision support solutions.”

The company’s headquarters will reside in St. Paul, Minnesota and will maintain additional offices in New Jersey, Florida, California and Arizona. Panacea Healthcare Solutions, Inc. will continue to utilize the widely recognized MedLearn name in conjunction with its publishing and consulting services under the Panacea banner.

About Medical Learning, Inc.
MedLearn is the nation’s most respected authority on medical coding, compliance and reimbursement. Founded in 1991, MedLearn helps leading healthcare organizations to confidently meet their revenue and compliance obligations. MedLearn’s variety of products and services includes publications, consulting services, seminars and customized learning and assessments. More information is available at www.medlearn.com.

About Panacea Healthcare Solutions
Panacea Healthcare Solutions, LLC, (www.panaceaushealthsolutions.com) with offices in Florida, Arizona and New Jersey, provides expert coding, compliance, and financial advice and information technology to improve bottom line performance to healthcare providers, and other clients. Panacea’s areas of expertise include Coding, Compliance, Finance and Reimbursement and Revenue Cycle Consulting and Systems.
Successful completion of HFMA's certification program leads to the professional designation of Certified Healthcare Financial Professional (CHFP) and ultimately to Fellow of the Healthcare Financial Management Association (FHFMA). Achieving these designations helps to prepare healthcare finance professionals for increasingly responsible positions in the healthcare industry and demonstrates your dedication to your professional development. HFMA's CHFP certification is intended for mid-level healthcare professionals with a minimum of 3-5 years experience.

As of January 2011, the eligibility requirements to become a CHFP are as follows:
- Active regular or advanced HFMA membership
- The Title Manager and above or equivalent
- The successful completion of one comprehensive certification exam

Also new for 2011, the CHFP preparation and study material are available online:
- Free Sample Exam – http://www.hfma.org/samplecertificationexam
- Self Study Materials – http://www.hfma.org/certificationselfstudy
- Exam Registration – http://www.hfma.org/chfpexamregistration

To learn more about becoming certified visit: www.hfma.org/certification

To review FAQs about the program changes, visit: www.hfma.org/certificationFAQ

New Jersey Chapter’s commitment to our membership

The NJ Chapter is encouraging members to become a Certified Healthcare Financial Professionals and ultimately Fellows in HFMA by reducing the financial burden associated with these designations. Therefore, the NJHFMA Board of Directors will reimburse NJ Chapter members for applicable certification related expenses including the application fees and fees related to NJHFMA-sponsored certification exam study courses. Expenses related to the purchase of study materials from HFMA national will be excluded from reimbursement.

Congratulations to our Newly Certified Members!

Congratulations to the following members for becoming certified healthcare financial professionals (CHFP):
- Rosemary Bain, CHFP
- James N. Cryan, CHFP
- Eric S. Fishbein, CHFP
- Pamela J. Gallagher, CHFP, CPA

Congratulations to the following member for obtaining the distinction of Fellow, FHFMA, in the Healthcare Financial Management Association:
- Tracy A Davison-DiCanto, FHFMA, MBA

For more information about the HFMA certification program go to http://www.hfmanj.org/Certification3.page or contact one of the members below:

Lindsey Colombo, FHFMA, MPA, Committee Chair
Work: (732) 324-6031
Email: lcolombo@rbmc.org

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Michael Alwell, FHFMA
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Email: malwell@smmcnj.org

Lisa R. Hartman, M.P.H - Education Committee Chair
Work: (609) 430-7789
Email: lhartman@princetonhcs.org
### 2010-2011 Chapter Committees and Scheduled Meeting Dates

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

The call in number is (888) 269-3831 for all but the PFS, Institute and Sponsorship Committees.

The call in number for PFS, Institute and Sponsorship Committees is (888) 290-0578.

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.**

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<th>COMMITTEE</th>
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<th>SCHEDULED MEETING DATES*/TIMES</th>
<th>MEETING LOCATION</th>
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<tr>
<td><strong>CARE (Compliance, Audit, Risk, &amp; Ethics)</strong></td>
<td>Darlene Mitchell <a href="mailto:mitchell.darlene@hunterdonhealthcare.org">mitchell.darlene@hunterdonhealthcare.org</a> 908-237-7059</td>
<td>Michael McKeever <a href="mailto:mckeeverm@deborah.org">mckeeverm@deborah.org</a> 609-893-1200 ext 5201</td>
<td>First Thursday of the Month 9:00 AM</td>
<td>Attendee Code: 5952498</td>
<td>Meeting in person at Deloitte &amp; Touche, Princeton, NJ for Oct., Jan., April and July Balance are calls. Please call to confirm</td>
</tr>
<tr>
<td>Communications</td>
<td>Elizabeth Litten ELittenfoxrothschild.com 609-896-3600</td>
<td>Al Rottkamp <a href="mailto:ajc123@as1.com">ajc123@as1.com</a> 609-596-6508</td>
<td>First Thursday of each month 9:15 AM</td>
<td>Attendee Code: 7844155</td>
<td>Conference Calls with in-person quarterly meetings.</td>
</tr>
<tr>
<td>Education &amp; Certification</td>
<td>Lisa Hartman <a href="mailto:lhartman@princetonhcs.org">lhartman@princetonhcs.org</a> 609-430-7789</td>
<td>Matt Glass <a href="mailto:Matthew.Glass@MSSB.com">Matthew.Glass@MSSB.com</a> 973-912-7714</td>
<td>First Friday of each month 8:30 AM</td>
<td>Attendee Code: 7363742</td>
<td>Call for info.</td>
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<tr>
<td>FACT (Finance, Accounting, Capital &amp; Taxes)</td>
<td>John Doll <a href="mailto:JohnDoll@verizon.net">JohnDoll@verizon.net</a> 732-915-5430</td>
<td>Adam Bavifard <a href="mailto:adam.bavifard@gmail.com">adam.bavifard@gmail.com</a> 609-596-3600</td>
<td>First Wednesday of each Month 8:30 AM</td>
<td>Attendee Code: 8730600</td>
<td>To alternate between in person and conference calls; locations TBD</td>
</tr>
<tr>
<td>Institute 2011</td>
<td>Howard Krain <a href="mailto:hrain@microsoft.com">hrain@microsoft.com</a> 908-377-5020</td>
<td>Dan Willis <a href="mailto:DWillis@childrens-specialized.org">DWillis@childrens-specialized.org</a> 908-301-5458</td>
<td>First Thursday of each Month* (See note above) 8:00 AM</td>
<td>Attendee Code: 8760933</td>
<td>WFS offices</td>
</tr>
<tr>
<td>Managed Care</td>
<td>Elizabeth Jennings <a href="mailto:EJennings@magnacare.com">EJennings@magnacare.com</a> 516-282-8233</td>
<td>Joe Privitera <a href="mailto:privitera@mail.holyname.org">privitera@mail.holyname.org</a> 201-833-7010</td>
<td>6/17, 7/20, 9/16, 10/13, 12/16 – 9-11:00 AM</td>
<td>Attendee Code: 6748634</td>
<td>New Jersey Hospital Association <a href="mailto:dkwillis6@gmail.com">dkwillis6@gmail.com</a> 908-301-5458</td>
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<tr>
<td>Membership Services/Networking</td>
<td>John Manzi <a href="mailto:jmanzi@panaceahsolutions.com">jmanzi@panaceahsolutions.com</a> 732-575-2520</td>
<td>Erica Waller <a href="mailto:Ewaller@princetonhcs.org">Ewaller@princetonhcs.org</a> 609-620-8335</td>
<td>Call for meeting arrangements</td>
<td>Attendee Code: 5493569</td>
<td>Locations alternate by month</td>
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<tr>
<td>Patient Access Services</td>
<td>William Hunt <a href="mailto:whunt@humed.com">whunt@humed.com</a> 201-996-2697</td>
<td>Diana Sessions <a href="mailto:dsession@wrjuh.edu">dsession@wrjuh.edu</a> 609-586-6465</td>
<td>Second Thursday of each Month 9:30 AM</td>
<td>Attendee Code: 8942192</td>
<td>CBIZ KA Consulting offices in East Windsor, NJ <a href="mailto:Igray@princetonhcs.org">Igray@princetonhcs.org</a> 609-620-8383</td>
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<tr>
<td>Patient Financial Services</td>
<td>Marilyn Koczan <a href="mailto:mkoczan@meridianhealth.com">mkoczan@meridianhealth.com</a> 732-897-7126</td>
<td>Josette Melillo <a href="mailto:jmellio@valleyhealth.com">jmellio@valleyhealth.com</a> 201-291-6017</td>
<td>Second Friday of each Month* (See note above) 10:00 AM</td>
<td>Attendee Code: 6748634</td>
<td>New Jersey Hospital Association <a href="mailto:Mcronin@beslerconsulting.com">Mcronin@beslerconsulting.com</a> 732-839-1217</td>
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<tr>
<td>Regulatory &amp; Reimbursement</td>
<td>Mike Sabo <a href="mailto:mike.sabo@dhshmmtbsys.com">mike.sabo@dhshmmtbsys.com</a> 732-722-7070</td>
<td>Scott Besler <a href="mailto:Sbesler@beslerconsulting.com">Sbesler@beslerconsulting.com</a> 732-839-1219</td>
<td>Third Tuesday of each Month 9:00 AM</td>
<td>Attendee Code: 9160808</td>
<td>Locations alternate by month</td>
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<tr>
<td>Sponsorship</td>
<td>Michael Ruiz de Somocurcio <a href="mailto:MichaelRuizdeSomocurcio@amerihealth.com">MichaelRuizdeSomocurcio@amerihealth.com</a> 732-726-6709</td>
<td></td>
<td>Second Thursday of each Month (See note above) 8:30 AM</td>
<td>Attendee Code: 8451888</td>
<td>Conference Calls</td>
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Ask the Ethics Guy®!
Five Easy Principles?
Principle No. 3: Respect Others (Part 2)

Keeping promises is a cornerstone of respect—for others and ourselves. What would our word be worth if we constantly broke it?

by Bruce Weinstein, Ph.D.

Thus far in our exploration of the five fundamental ethical or “life” principles, we have looked at:

- Do No Harm
- Make Things Better
- Respect Others (Part 1)

This week we continue unpacking the duty of respect for others by looking at the obligation to keep our promises.

Promises and Trustworthiness

You have just made plans to have dinner with a friend you have not seen in a while. Then another friend invites you to a party you would really love to attend, but to do so, you would have to break the engagement with your first friend. What should you do?

The obvious thing is to ask if you can bring your dinner date to the party. Let’s assume for the sake of argument that for some reason you can’t. It would not only be rude to cancel the dinner date, it would be unethical, because it would involve breaking a promise simply to indulge your own desires.

There are always extenuating circumstances that justify breaking a rule. If, for example, a parent is rushed to the emergency room an hour before the dinner date, we not only have a right to reschedule the dinner, but we have a moral obligation to do so. Our duty to our parent outweighs the duty to our friend. The example we’re considering, however, doesn’t involve a life-or-death decision.

One of the rules that keep relationships in working order is the rule of keeping our promises. After all, our word would be meaningless if we broke it on a regular basis. At the heart of this moral obligation is the concept of trust. We maintain the trust that people place in us by, among other things, keeping our promises. By keeping the date, you maintain your integrity, and you’ll feel better about yourself, even if you end up sacrificing what seems to be the more appealing opportunity. And who knows? You may end up enjoying the dinner after all.

Not for Professionals Only

Closely related to the concept of promise-keeping is fidelity, or loyalty. We get not only “fidelity,” but “confidentiality” (as well as “Fido,” the standard nickname for dogs, the most faithful of pets) from the Latin root fide. When we speak of a professional having a fiduciary responsibility to a client, we mean that the professional has an ethical obligation to be loyal to his or her

continued on page 28
When we speak of a professional having a fiduciary responsibility to a client, we mean that the professional has an ethical obligation to be loyal to his or her client. This duty is tied to the very notion of professionalism.

Promising-Keeping in Everyday Life

Now that we know the “why” of keeping promises, here are some simple ways we can apply this aspect of Life Principle No. 3 in our business and personal relationships:

1. Don’t make promises you can’t keep.

2. Keep the promises you make.

3. If you can’t keep a promise for a legitimate reason (which does not necessarily include something better coming along), be honest with the person to whom you made the pledge.

Next issue we’ll discuss Life Principle No. 4: Be Fair.

About the author

Dr. Bruce Weinstein is the public speaker and corporate consultant known as The Ethics Guy. His new book, Is It Still Cheating If I Don’t Get Caught? (Macmillan/Roaring Brook Press) shows teens how to solve the ethical dilemmas they face. Follow Weinstein on Twitter at TheEthicsGuy. For more information, visit TheEthicsGuy.com.
What is the Disabled Access Tax Credit, and can my practice take advantage of the benefit?

The Disabled Access Tax Credit provides a tax incentive to eligible small businesses who make their businesses more accessible to people with disabilities. An eligible small business is one with either $1,000,000 or less in revenue or 30 or fewer full-time employees, so solo physicians or physician group practices who match these parameters can qualify. The expenditures must comply with the requirements under the Americans With Disabilities Act of 1990 and the tax credit amounts to 50% of those expenditures that exceed $250 but not over $10,250, thus a maximum credit of $5,000 per year. The credit is reported on Form 8826.

Eligible costs include providing accommodations to assist disabled individuals such as removal of architectural, communication or physical barriers, providing sign language interpreters, readers or taped texts, materials in an alternative format (ie: large print font or Braille) or the purchase or modification of adaptive equipment. A common purchase within the healthcare industry is power elevation exam tables that adjust to a height below 19” providing easier access for wheelchair bound individuals.

Taxpayers should exercise some caution when using the credit. While the IRS has not challenged many expenditures relating to architectural modifications, they have taken a tougher stance on the purchase of equipment. Several medical equipment companies have marketed their devices to healthcare providers using the credit as a benefit for purchasing their products. The companies state their equipment was designed to be accessible by disabled individuals and therefore meets the eligibility requirements. The IRS has stated the equipment must be for the primary purpose of complying with the applicable requirements under the Americans With Disabilities Act of 1990 and treating disabled patients that were otherwise turned away.

About the author
Jennifer R. Safeer, CPA, is a senior manager in the Toms River office of WithumSmith+Brown, Certified Public Accountants and Consultants. She can be reached at jsafeer@withum.com.
Where Are They Now?
Phil Besler

FOCUS: Please provide us with a short bio on yourself.

PHIL: I have been married to my wife, Carol, for 33 years. We have three children, Jennifer, Jonathan, and Brittany, and two grandchildren, Molly and Shail.

FOCUS: Please talk about your history in healthcare finance.

PHIL: I started out working for the Department of Human Services auditing nursing homes. I then moved over to the Department of Health in 1979, just prior to the implementation of the Chapter 83 System. I eventually advanced to the level of Chief of Hospital Ratesetting and left the Department in 1983 to work for Peat Marwick and Mitchell. A year later, in 1984, I started Besler and Morrisy with Jim Morrisy, who also worked for PM&M at the time. Our company was sold to E&W and I took a position with E&W. I left E&W in 1987 and created Besler Consulting. I have had that firm ever since.

FOCUS: Please discuss a few of the special challenges you faced in your positions.

PHIL: Change by far is the biggest challenge. Healthcare is constantly changing-operationally, new technologies, reimbursement methodologies, increased regulatory, monitoring, and of course a constantly decreasing financial pie. Change, however, is the lifeblood of a consulting firm. Without change consulting firms would see a decrease in business over time, as more and more people would learn to do the jobs consulting firms provide to their clients. New ideas would spread around the industry and once they become old ideas their value diminishes. So I instilled in my Firm that we should embrace change and see it as an opportunity rather than a problem. Adopting and embracing this attitude allowed us to grow our business, created a better work environment, and kept us on the forefront of new ideas.

FOCUS: What made you decide to make a change in your professional plans or to retire/semi-retire?

PHIL: There were three situations in my life that helped me consider early semi-retirement. First, my father was a WWII veteran so his teenage years and early adulthood were very difficult. After the war he worked 2 jobs to make ends meet. When he died at the age of 46, I was only 12. He never really got to enjoy life.

Second, I had two childhood friends die in their 40s. Considering that I lived on a small street in Trenton, two deaths were greater than a 20% death rate in my neighborhood.

Third, a friend of mine, who was 2 years older than me, died from cancer at the age of 55. I was on his emails for the last two years of his life. After reading his emails over an extended period, I thought about his wife and daughter and how he never got the opportunity to retire and enjoy the fruits of his labor or ever see his grandchildren.

FOCUS: Do you still spend time in professional pursuits or stay connected to the industry? If so, what is that you are doing in this regard?

PHIL: I maintain my CPA license and HFMA fellowship so I am always looking to acquire CPE credits. Also I stay in touch with my firm through emails, phone conferences and periodic meetings. As Chairman of Besler Consulting, I am involved in many of the high level decisions. I also do a lot of research on the changing issues and I am constantly on the lookout for new products, services and appeal issues that can benefit our clients. As I have 35 years in the healthcare industry and have never been accused of being shy, I have developed many contacts around the country so when employee talent becomes available, I help with the transition into our firm.

FOCUS: What are your other hobbies and outside interests and how much time do you spend on these?

PHIL: Next to my children and the greatest joy in my life, grandchildren, boating is by far my largest hobby. I put about 300 running hours a year on my boat. Taking it from New Jersey to Florida and back consumes about 4 weeks because it has to be done in weekly intervals for weather and activity reasons. During St. Patty’s week in Savannah, look for the Carolann2 behind the Hyatt on River St. The months of October and April you will find it in Charleston (my favorite city) at the Charleston City Marina and, of course, in the summer on beautiful LBI.

Water activities are next with swimming, scuba diving, snorkeling and water skiing. I also just learned to spear fish and lobster hunt from the great expert Steve Kirby (at least according to him).
I also try to do a lot of my own maintenance on my house, car and boat. I am learning a lot as I have “dock rat buddies” that are training me. I am also appreciating the opportunity to read a lot more books for enjoyment and education. Unfortunately, I am still a lousy golfer as I seem to have trouble focusing on that sport.

**FOCUS:** Did you ever think, all those years ago, that you would be doing what you are today?

**PHIL:** I always had the goal of retiring before the normal retirement age. As a workaholic, I knew keeping up that kind of pace would not be healthy. Although I loved my work and felt it challenging, I dreamt of the day that the pressure would be off and I could lead a healthier lifestyle. Now I get my 8 hours sleep most nights, eat healthy (we made our own garden and in Florida it grows faster than weeds) and take a lot of vitamins. I also have yearly checkups where I never seemed to have the time when I worked fulltime. I am also constantly on the move either doing physical labor or exercising for pleasure.

As for landing in Florida for seven months out of the year, that was a complete shock. Neither my wife nor I wanted to live in Florida for any extended period of time. We traveled the country for about 10 years looking for the ideal place. After all of that it ended up being Florida based on our criteria of: 1) easy flight back to NJ for family and friends, 2) warm through the winter, 3) accessible by my boat, 4) good boating environment, 5) theater, cultural events, 6) lots of activities, and 7) not a gated community. So we found a little spot called Ocean Ridge, which we affectionately refer to as Mayberry.

**FOCUS:** What advice can you give other professionals looking forward to retirement on some level or to pursuing a new career path?

**PHIL:** Enjoy life and don’t sweat the little things. During my career I put together a list of what is important to me and ranked them. Anytime life got tough, I would figure out where the problem existed within my ranking and deal with it at that level. Many people seem to focus on the negative because your attention is always drawn to problems. When this happened to me, I would look at all the positives and always determined the problem was minor in the full scheme of things. This is my ranking, but of course everyone is different:

Happy marriage
Happy children and grandchildren
Healthy family
Financially independent children
Friends
Satisfying employment/self employment

My advice is to create your own ranking and look at it regularly. If a change to a new job or retirement improves your focus then do it. If it lowers your quality of life then don’t do it. People considering retirement should go in different directions and have varied interests and activities. Find out what you like and don’t like by trying it.

My greatest fear when I got down to Florida is that I would be bored. Many people have gone back to work or moved back because after about a month of working on the house, they were bored. When I arrived in Florida I took community classes on making stained glass windows and performing small engine repair. I also joined a Scuba club, where I met the expert in the world on lemon sharks (Doc Gruber). Over the last 4 years I have been putting transmitters in lemon sharks and going over to Tiger Beach in the Bahamas and swimming with them. You will also end up swimming with 12 to 14 foot tiger sharks that show up uninvited, but they are hard to kick out of the group.

My point is to try a lot of things, you never know where it will lead you.

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

**PHIL:** It was my pleasure and if any of you are in LBI in the summer, Southeast Florida in the winter or Savannah for St. Patty’s week stop by and say hello.
CFO Spotlight:
Kevin Stagg, Christian Health Care Center

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

KEVIN: My background is fairly typical for a CFO. I have a Bachelor’s Degree in Business Administration from Iona College. I went to work for a public accounting firm out of school. My draw to the accounting profession was greatly influenced by parents. They were extremely hard-working individuals, which I was able to witness first hand when I worked for both of them in college. However, I was drawn to this profession because of my mother’s influence. She was a comptroller for a design firm and had a keen sense of business. Both parents knew I wanted to study business in college, and they encouraged me every step of the way. I have worked for several firms including Pannell, Kerr, and Foster; Touche Ross; and Ernst & Young. I also worked at Monmouth Medical Center for five years before I came to Christian Health Care Center (CHCC) in 1997.

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

KEVIN: I never imagined when I started in public accounting that I would end up working in health care. Initially, I was somewhat disappointed to be assigned to work on health-care accounts. I thought commercial accounts would be far more interesting and would have a better career path. Health care finance was not the most sophisticated department in the hospital, especially in the area of technology. However, once I got involved, it was easy to see the opportunities in the field. Today, I can’t imagine anything more interesting, complex, and challenging than health care.

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

KEVIN: To me, rising CFOs have to have a strong command of the financials, which frankly is the minimum requirement. However, I think it is vitally important that financial leaders have a strong understanding of operations and the strategic vision of the organization. CFOs need to understand operations in order to create processes to develop efficiencies in their respective industries, especially in the health-care field. I believe it is extremely important that rising CFOs be great teammates to other members of the organization. This will give the CFO the opportunity to be part of the team and play a significant role in developing the strategy and operational focus.

FOCUS: What are your hospital’s specifics – are you a single facility or part of a system? Do you have a religious affiliation? Please describe your location, demographics and the services offered at your hospital.

KEVIN: Christian Health Care Center is one of the premier mental health and elder-care organizations in New Jersey. We have a total of 522 beds in multiple programs. They include inpatient mental health, long-term care, post-acute care, behavior management, assisted living, independent senior living, medical adult day care, and extensive outpatient mental health services. Our organization will celebrate 100 years of service to the community this year. We were founded in 1911 by a group of deacons from the Reformed faith.

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

KEVIN: Like most health-care organizations, we grapple with changes in reimbursements, regulations, and insurance issues. In recent years, we made a concerted decision to move aggressively to grow our mental health and elder care product lines. We increased our inpatient mental health beds by 12, expanded mental health outpatient programs, and developed a post-acute care unit (PACU), in order to provide rehabilitation services, in our nursing home. Our census remains high, and we are looking to increase the number of beds in the PACU to accommodate demand. We are also in the process of securing local zoning approvals to construct 258 units of
independent senior housing, within a continuing care retirement community. It is an exciting project and definitely the most ambitious yet for CHCC. It is a natural extension of our 100-years history of meeting community needs.

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

KEVIN: CHCC has utilized a number of financing vehicles to expand its’ campus. We have utilized the traditional tax-exempt financing of selling bonds backed by the Center’s creditworthiness. Most recently, we have had a great deal of success with the variable tax-exempt financing, which is backed by a bank letter of credit. We also have utilized the equipment tax-exempt financing issued through the New Jersey Health Care Facilities Financing Authority.

FOCUS: What are your spare time activities?

KEVIN: Since when does a CFO have spare time? However, when I do I like to remain physically active. I run, cycle, ski, and play golf. My family enjoys being outside, and I have been able to share my passion for outdoor activities with my wife and three daughters.

FOCUS: What are your professional memberships?

KEVIN: I am a member of the American Institute of Certified Public Accountants, New Jersey Society of Certified Public Accountants and the New Jersey chapter of HFMA. I also participate in various post acute care associations throughout New Jersey. I am also active in various professional health care associations including the Health Care Association of NJ, LeadingAge New Jersey and New Jersey Hospital Association.

FOCUS: You are just told you have 30 minutes to pack - you are going to a sparsely populated island. What would you bring, besides food, clothes, hygiene products, etc?

KEVIN: I’m sure I would enjoy a short stay on a peaceful island, however, I would bring any device, electronic or otherwise, that would allow me to communicate with family and friends. I can’t imagine my life without that interaction.

associated with the new code set. When planning for the adoption of ICD-10, hospital executives should remember that all staff members who deal with coding, compliance, billing, and charge capture will need proper training in order for the implementation to be successful. There are very few FTEs in the organization that will not require ICD-10 related training. Even though training is expensive and it takes workers away from their primary job functions, in the long run, it is a mission-critical investment and every organization should have a multi-year budget and plan to successfully implement the new standard.

Invest to Assist with the Transition

In additional to staff training, systems will need to be updated to accommodate the changes associated with ICD-10, but system upgrades require time and testing – and upgrades cost money. However, just as it is important to invest in staff, it will be equally important to invest properly in the systems that support and mitigate risks associated with this transition.

Conclusion

If hospitals can identify deficiencies and correct them now, before ICD-10 arrives, they will be much better positioned for a successful transition. By taking the time to fix the known problems in advance, hospitals can also be ready for the unknown variables that will inevitably accompany the ICD-10 implementation.

About the author

Denny R. Roberge is Executive Director, Solution Strategy, for MedAssets. He is a recognized leader in bridging technology and the needs of the revenue cycle. Denny has designed and implemented numerous databases and systems that enhance and complete the revenue cycle continuum. His extensive experience within healthcare provider organizations includes: Concord Hospital, The New Hampshire Hospital Association’s Foundation for Healthy Communities, Tucker Alan Inc., and The Massachusetts General Hospital. Denny can be reached at droberge@medassets.com.

About MedAssets

MedAssets (NASDAQ: MDAS) partners with healthcare providers to improve financial strength by implementing spend management and revenue cycle management solutions that help control cost, improve margins and cash flow, increase regulatory compliance and optimize operational efficiency. MedAssets serves more than 180 health systems, 4,000 hospitals and 75,000 non-acute healthcare providers. For more information, go to www.medassets.com.
FOCUS: Please provide us with a short bio on yourself.

JOHN: I am currently a Vice President in Finance at Saint Barnabas Health Care System. I started my career as an auditor in Ernst & Young’s New Jersey Healthcare practice where I made some lifelong friends and learned a great deal about hospital finance through exposure to many facilities throughout the New Jersey region. After that I was fortunate to have had positions at Meridian Health and Health Ware Concepts.

I live in Fanwood, New Jersey with my lovely wife Grace, two beautiful children Macy and Tristan and my dog, Max.

I hold a degree in Accounting and Economics from University of Delaware and I am proud graduate of Saint Peter’s Prep in Jersey City.

FOCUS: Please talk about your employer and your duties there.

JOHN: I was very fortunate to join Saint Barnabas Health Care System (SBHCS) in June of 2010. SBHCS is New Jersey’s largest integrated health care delivery system. It includes six acute hospitals, two children’s hospitals, psychiatric facilities, ambulatory care centers, and numerous outpatient centers, home care and hospice. Over two million patients are treated each year by the staff of more than 18,000 employees (largest private employer in New Jersey) and 4,600 physicians (one-fifth of the state’s actively practicing physicians). Over the past several years we have continued to add services and technology to further our commitment to providing the highest quality of patient care and health education to the community and the region.

My responsibilities include revenue cycle management, financial operations and charge integrity.

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

JOHN: Being relatively new to SBHCS, my greatest challenge has been learning more about all of our facilities, systems and team members. Going forward my challenges will include standardization and building on the success of our site leaders as we further integrate our revenue cycle processes across the System.

FOCUS: What advice can you give other professionals that are interested in entering your line of work?

JOHN: In the words of a good friend and mentor, “Manage your risks and surround yourself with good people”. I would add, keep a positive outlook.

FOCUS: What are your hobbies and outside interests?

JOHN: I love spending time outside with my kids. We like to go for bike rides and I can’t say I have ever had a bad day at the beach. I also love skiing, reading and thanks to my very patient friend, I am finally learning to play the guitar.

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

JOHN: Thanks for listening – and come and see me at the FACT Committee Quarterly Seminar on June 14th.
•Focus on...New Jobs in New Jersey•

JOB BANK SUMMARY LISTING

HFMA-NJ’s Publications Committee strives to bring New Jersey Chapter members timely and useful information in a convenient, accessible manner. Thus, this Job Bank Summary listing provides just the key components of each recently-posted position in an easy-to-read format, helping employers reach the most qualified pool of potential candidates, and helping our readers find the best new job opportunities. For more detailed information on any position and the most complete, up-to-date listing, go to HFMA-NJ’s Job Bank Online at www.hfmanj.org.

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

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<th>Job Position and Organization</th>
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<tbody>
<tr>
<td>ENTERPRISE SOLUTIONS/SALES</td>
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<tr>
<td>Health Care Software</td>
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<tr>
<td>Wall Township, NJ</td>
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<tr>
<td>MANAGER/SENIOR ASSOCIATE</td>
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<tr>
<td>DGA Partners</td>
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<tr>
<td>Bala Cynwyd, PA</td>
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<tr>
<td>DIRECTOR PATIENT ACCOUNTS</td>
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<tr>
<td>AtlantiCare</td>
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<tr>
<td>Southeastern NJ</td>
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<tr>
<td></td>
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<tr>
<td>DENIALS MANAGEMENT SPECIALIST</td>
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<tr>
<td>Somerset Medical Center</td>
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<tr>
<td>Somerville, NJ</td>
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<tr>
<td>RISK MANAGEMENT MANAGER</td>
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<tr>
<td>Jersey Shore University MC</td>
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<tr>
<td>Neptune, NJ</td>
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mark your calendar . . .

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
<th>Location</th>
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<tbody>
<tr>
<td>April 26, 2011</td>
<td>Annual NJHFMA Women’s Session</td>
<td>DoubleTree Hotel</td>
</tr>
<tr>
<td></td>
<td>all day</td>
<td></td>
</tr>
<tr>
<td>May 12, 2011</td>
<td>Annual Golf Outing</td>
<td>Fiddler’s Elbow</td>
</tr>
<tr>
<td></td>
<td>all day</td>
<td>Country Club</td>
</tr>
<tr>
<td>June 14, 2011</td>
<td>Annual Institute</td>
<td>The Borgata</td>
</tr>
<tr>
<td></td>
<td>all day</td>
<td>Atlantic City</td>
</tr>
</tbody>
</table>

Pleasing note: NJ HFMA offers a discount for those members who wish to attend Chapter events and who are currently seeking employment. For more information or to take advantage of this discount contact Laura Hess at NJHFMA@aol.com or 888-652-4362. The policy may be viewed at: http://hfmanj.orbiius.com/public.assets/A02-Unemployed-Discount/file_168.pdf.
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March/April 2011

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