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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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Hello everyone:
As my term as President of the Chapter winds down, I wanted to sum up this past fiscal year and highlight some of our accomplishments and continued challenges as we move into our 2015 fiscal year. We recently completed six submissions for HFMA’s National “Yerger” Awards – these are chapter recognition awards for improving and innovating the organization. The submissions are a great reflection of the Chapter’s activities over the course of the year:

• **Financial turnaround:** As noted in the October 2013 Focus, the Chapter incurred a significant loss in the prior fiscal year. There are several drivers of the Chapter’s income and expenses, the challenging health care and economic environment impacts attendance at the Chapter’s education and other events and it impacts our ability to raise sponsorship funding. The Board of the Chapter has been and continues to aggressively monitor the fiscal year 2013-2014 budget and actual results in order to stabilize the financial outcome for this fiscal year, and future years. Please support us in our efforts as we continue to seek out ways to reduce costs and grow our revenue base.

• **2014 Annual Institute:** The Institute continues to be our signature education and networking event, always a highlight for our Chapter year. The year-long effort to plan, organize and manage the activities that go into the Institute require a tremendous amount of effort and, again, I would like to thank all of the chairs, co-chairs and volunteers participating on the Institute 2013 Committee, Education Committee and Membership Services/Networking Committee. Planning for the 2014 Institute is well underway and I’m sure it will be a great program.

• **Physician Practice Issues Forum:** A new forum for the Chapter that was added this fiscal year, the Physician Practice forum was an immediate success with great participation in the quarterly discussions from the over 70 members of the forum and a successful bi-monthly education event in February. The intent of this forum was to provide a peer network for the evolving dynamics in physician-hospital relationships, an area that continues to challenge the industry.

• **North-South education programs:** Each year we attempt to implement ways to reach our membership with additional venues for our education programs and forum meetings. The Chapter has had success with conference calls, webinars, multi-site video conferencing, and multiple-location education events. We know everyone seems to get busier each year so we will continue to work on this challenge in a practical, cost-effective manner.

• **Pulse communications:** The weekly Pulse communication was revamped over a year ago during fiscal year 2013 to provide a concise update on the upcoming Chapter activities and also provide a source for New Jersey health care industry news. It’s a great reminder for upcoming events and the news clips provide very timely updates.

• **Collaboration with Make-A-Wish:** As communicated in the previous edition of Focus, in connection with the 2013 Institute we raised over $11,800 for Make-A-Wish New Jersey, enough to provide two children with their wishes. Thank you again to all who contributed and supported this great organization. Make-A-Wish was again selected as the beneficiary for the 2014 Institute – it is a great fit for our organization and the industry as a whole.

Thank you to all the writers and reviewers of the Yerger submissions, for writing them and more importantly for putting forth the effort to make the Chapter better: Heather Weber, Dan Willis, Mike McKeever, Jennifer Shimek, Megan Byrne, Rhonda Maraziti, Tony Consoli, Mike Alwell, Lisa Hartman, Mary Taylor, Tracy Davison-DiCanto, and Brian Sherin. All of the Chapter Committee Chairs, Co-Chairs and Committee members contributed greatly to our efforts this year.

My deepest thanks to the Board of the NJ Chapter for all of your effort and support throughout this fiscal year. A special mention goes to Tony Consoli and Deborah Shapiro, completing their second two-year term on the Board, and to Brian Sherin, completing his four-year term on the Advisory Council after many years of dedication to the Chapter as a Board member, Officer and President of the Chapter. And thank you to Laura Hess, our Chapter Administrator, for all your effort (and patience).

I wish Tracy Davison-DiCanto, and all of the Officers for fiscal year 2015, the best of luck and continued success for the Chapter.

And as always, please stay connected and involved with our Chapter. I look forward to seeing you at an upcoming event.

Dave Wiessel
In Memoriam

Harvey A. Holzberg, FACHE (1938-2014)
Semper Fi!

In March, New Jersey healthcare lost a giant. Born the same year as Superman, Harvey Holzberg was an unstoppable man of steel when striving to reach an objective. An indifferent student in high school, Harvey enlisted in the Marines after graduation. When asked in later life his reasons for joining, Harvey responded: “The recruiter said Semper Fi and, being from Brooklyn, I thought he said 75 and I needed the money.”

After four years in the U.S. Marine Corps, he earned a bachelor’s degree from NYU and an MBA from Baruch College of CCNY while working in personnel at Montefiore Hospital, Brooklyn Jewish Hospital and the Methodist Hospital of Brooklyn. Harvey then joined Lutheran Medical Center and embarked on a remarkable career that transformed healthcare wherever he landed. In 15 years at Lutheran, his accomplishments included developing the Sunset Park Family Health Center, the largest of its kind in the country.

When he was recruited across the Hudson in 1983 to serve as President and CEO of Jersey City Medical Center, rumors flew that the healthcare equivalent of Lee Iacocca was moving to the Garden State. For once, the rumors had it right. Harvey Holzberg converted the Medical Center from a failing city-owned hospital to a thriving, financially sound, not-for-profit institution. While there, he launched the Family Health Center, a federally-qualified health center (FQHC) offering a full range of health services to more than 20,000 patients a year.

In 1989, he agreed to take on the dual challenge of transforming a struggling hospital and helping to transform a decaying inner city: New Brunswick. Harvey and the team he led are largely credited with transforming Middlesex General Hospital into the Robert Wood Johnson University Hospital that we know today. He knew that you had to think bigger than what was before you, not be daunted by what you couldn’t do but committed to getting it done. During more than 17 years as its leader, his accomplishments included:

• Obtained Level I Trauma Center designation for Robert Wood Johnson University Hospital;
• Implemented heart, kidney and pancreas transplant programs, and other innovative surgical specialty programs;
• Completed affiliations with Hamilton Hospital, Rahway Hospital and Children’s Specialized Hospital;
• Co-founded the Cancer Institute of New Jersey, the first and only National Cancer Institute-designated comprehensive cancer center in the state;
• Built the Bristol-Myers Squibb Children’s Hospital;
• Created the New Brunswick Health Sciences Technology High School;
• Strengthened the Hospital’s clinical, academic and educational relationships with the UMDNJ - Robert Wood Johnson Medical School, and developed relations with Rutgers including the Rutgers College of Nursing and the Ernest Mario School of Pharmacy.

Love him or hate him, everyone has a Harvey story. Visionary leader, tireless advocate, fierce opponent, dogged in his pursuit of excellence. Current CEO Steve Jones tells the story about how Harvey went to the State in the morning with Judy Burgis, Senior Vice President, Planning, at his side and came home with a Level 1 trauma center designation. Judy explained that “no” was never the last answer, only the first so that Harvey could figure out where people’s cards were and then he would systematically strip them away to attain his objective.

Amy Mansue, Children’s CEO, says of Harvey: “There wasn’t a funeral, a Shiva or a wedding that Harvey missed when you were in his circle. I remember standing in line with him for over an hour in the pouring rain at a viewing for an employee who had lost her husband in a car accident. When I suggested that he could go ahead, he just laughed and said that he would then miss the time with me. He never thought offering his sympathy was more important than someone else’s.”

Here’s my Harvey story. I chaired the Planning Committee Chair of the Board at Children’s Specialized Hospital when we affiliated with the RWJ Health System. We convened a half-day strategic planning retreat to determine how best to achieve synergies from the affiliation. Moving our acute rehab beds to New Brunswick made great sense, but the licensing and certificate of need obstacles to transferring beds across county lines were formidable. Undaunted, Harvey speed dialed Steve Jones: “Steve, you know the Magyar Bank property that we’re looking to acquire? Put Children’s name on it. We’re moving the acute rehab beds to New Brunswick.” Six years later, the PSE&G Children’s Specialized Hospital opened its doors, completing New Jersey’s Pediatric Center of Excellence alongside the Child Health Institute and the Bristol-Myers Squibb Children’s Hospital.

Over 40+ years of involvement in New Jersey Healthcare, I’ve had the opportunity to work with dozens of brilliant leaders who worked tirelessly to improve the access to, and the quality of, health care for New Jersey residents. None have had a more profoundly positive effect on New Jersey healthcare than did Harvey Holzberg. Rest in peace, dear colleague. You certainly made a difference!

John Dalton, FHFMA
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Two-Midnight Rule: What We Need to Know

by Amina Razanica

Due in part to the rapid growth in recent years of long-stay “observation” cases, the financial burden on Medicare beneficiaries has become significant. The Center for Medicare and Medicaid Services (CMS) has been paying attention to the alarming increase in observation cases, particularly as they create higher out-of-pocket costs for Medicare patients. The impact is compounded for certain patients, since the time spent under observation status does not count toward the three-day inpatient stay requirement for admission to a skilled nursing facility.

In an attempt to address these concerns, CMS issued the fiscal year (FY) 2014 inpatient prospective payment system (PPS) final rule (CMS-1599-F) that contained a new set of regulations limiting the use of observation status. These regulations introduced the “Two-Midnight” rule with the intention of improving the integrity of inpatient admissions to acute care hospitals, critical access hospitals (CAHs), long term care hospitals and inpatient psychiatric facilities. The final rule provided instructions on when and how an inpatient admission should be ordered and certified and also reiterated the importance of proper medical record documentation.

Generally Appropriate and Generally Inappropriate Services for Medicare Part A Payment

According to CMS, under the Two-Midnight rule it is generally appropriate for a hospital to receive Medicare Part A (inpatient hospital and SNF) payment if the ordering physician expects a patient’s surgical procedure, diagnostic test or other treatment to require a hospital stay lasting at least two midnights and, based on this expectation, admits the patient as an inpatient stay. If the physician expects to keep the patient in the hospital only a limited period of time that does not exceed two midnights for surgical procedures, diagnostic tests or other treatments, inpatient hospital payment under Medicare Part A is generally inappropriate and such services should be submitted for Part B (hospital outpatient and physician) payment.

CMS listed the following exceptions to this rule:

• If unforeseen circumstances result in a shorter stay than the initial expectation of two midnights (such as death, transfer, departure against medical advice, unforeseen recovery and election of hospice care), CMS will consider the stay appropriate for Part A hospital inpatient payment. The medical record must contain all documentation relevant to the physician’s expectation and any unforeseen interruptions in care.

• In addition, there may be cases when the physician may have an expectation of a hospital stay shorter than two midnights for which admission may be appropriate. These cases include medically necessary procedures on the inpatient-only list and other circumstances (such as mechanical ventilation and other cases approved by CMS and outlined in a subregulatory guidance). Again, the medical record must contain all relevant documentation.

Documentation Requirement

An inpatient admission must be supported by an inpatient admission order, physician certification, progress notes and other clinical documentation in the medical record. Reviews of inpatient admissions will focus on documentation requirements, and hospitals should ensure that staff is trained to collect and verify the completeness of the following documents:

• An inpatient admission order, which must be obtained at admission. It must be supported by progress notes and must be provided by a physician or qualified practitioner who is:
  a. licensed by the State to admit inpatients, and who has admitting privileges to specific facilities granted by the hospital; and
  b. knowledgeable of the patient’s plan of care, hospital course, and current condition at the time of admission.

• A physician certification of medical necessity, which must be completed, signed, dated and documented before the discharge takes place. Certification begins with an admission order and must contain:
  a. an order authentication (certifying the physician’s signature or countersignature);
  b. reason for inpatient services, including diagnosis, admission assessment and plan of care;

continued on page 8
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continued from page 6

c. estimated length of stay;
d. plans for post hospital care; and
e. for inpatient CAH services, certification by the physician that the patient may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to CAH.

• **Additional documentation** to support an inpatient admission. The physician’s certification in the medical record must be adequate to justify that hospital services in an inpatient setting were reasonable and necessary. This documentation can be a part of the progress notes and discharge plan and must include:
  a. patient history and comorbidities;
  b. severity of signs and symptoms;
  c. risk of adverse events; and
d. current medical needs requiring inpatient care.

**Presumption: Selection of Claims for Review**

The FY 2014 inpatient PPS final rule described two related but different medical review processes – the “Two-Midnight” presumption and the “Two-Midnight” benchmark. Both will be considered during patient status reviews.

When conducting patient status reviews, Medicare Administrative Contractors (MACs) will be looking for whether the requirements for inpatient admission were met, whether the requirements for inpatient certification were met, and whether an inpatient admission is generally appropriate for Medicare Part A payment under the provisions of the FY 2015 inpatient PPS final rule.

CMS instructed MACs not to review claims that meet the presumption rule: if a claim shows that two or more midnights have occurred after the formal inpatient admission began, the contractor will presume – for claims selection purposes – that the inpatient admission was appropriate and the claim will not be selected for medical review.

The “Two-Midnight” benchmark “clock” starts after registration and initial triaging activities are conducted and once the hospital care begins. This may include observation care, or care received in the emergency department, operating room or other treatment areas. Excessive wait times should be excluded from the count, as an inpatient admission does not begin until the inpatient order and formal admission occurs.

CMS was also clear that Medicare payment was not permissible for care provided due to inconveniences (e.g., a family’s money and time needed to care for the patient at home or travel to a physician’s office). MACs will be instructed to look through claims for evidence of systematic abuse or gaming, including unnecessary delays in the provision of care to qualify for the presumption. CMS will instruct MACs to identify such claims through probe reviews and through other CMS data sources, such as the results of the Comprehensive Error Rate Testing (CERT) program, the First-Look Analysis for Hospital Outlier Monitoring program, and the Program for Evaluating Payment Patterns Electronic Report (PEPPER).

**Probe & Educate Audit Process**

So far, MACs have been performing prepayment patient status reviews on a sample of 10 claims (for small hospitals) and 25 claims (for large hospitals) with dates of admission on or after Oct. 1, 2013 but before Sept. 30, 2014. MACs will conduct patient status reviews using a “Probe & Educate” strategy for claims submitted by acute care inpatient hospital facilities, long term-care hospitals, and inpatient psychiatric facilities. CMS also revealed that MACs may conduct a limited number of additional reviews if they suspect trends of abuse, gaming or delays in care for the purpose of avoiding the Probe & Educate audits. If it is found that hospitals are non-compliant with the “Two-Midnight” policy, they will receive education and additional corrective action as necessary.

To complete the Probe & Educate process by Sept. 30, 2014, MACs will ask for a majority of the additional documentation requests by June 2014. Appeal rights remain intact during the Probe & Educate process.

CMS will not conduct post-payment patient status reviews for claims with admission dates of October 1, 2013 through October 1, 2014.

**How Can Hospitals Succeed Under the Two-Midnight Rule?**

CMS periodically issues updates to its educational materials and guidance documents on the “Two-Midnight” rule, and hospitals are expected to take part in open-door forums to clarify issues they face. Hospitals should pay particular attention in educating their staff to know:

- the latest rules so they can make the appropriate inpatient admission decisions;
- observation stays regulations and how to document, code, and bill observation stays;
- what is necessary for appropriate supportive physician documentation; and
- what to expect from MAC audits.

CMS also updates its Frequently Asked Questions (FAQs) and other materials regarding the “Two-Midnight” policy and the related Probe & Educate process on its main website, [www.cms.gov](http://www.cms.gov). Providers are strongly encouraged to check the site frequently as the audit process continues.

Hospitals and hospital systems, as well as their trade associations, have spoken out against the policies as
currently written. Following months of consultation with New Jersey Hospital Association’s senior leadership, many member hospitals from the state and the American Hospital Association (AHA), Sens. Menendez (D-N.J) and Deb Fischer (R-Neb.) formally introduced “The Two-Midnight Rule Coordination and Improvement Act of 2014”. The proposal requires CMS to develop criteria for a short inpatient hospital stay that accounts for medical necessity and delays enforcement of the rule to the earlier of Oct. 1, 2015 or when the agency develops criteria defining short inpatient stay. The proposal also calls for developed criteria to be used for establishing payment methodology as a part of the FY 2015 Medicare hospital inpatient prospective payment system. This would allow the continuation of the Probe and Educate audit process but would not expand the number of claims for review per hospital. AHA has urged hospitals, hospital systems, and trade associations across country to co-sponsor the bill so the provision can be included in the March 31 physician payment fix legislative package.

In addition, both NJHA and AHA continue to encourage members of the N.J. Congressional Delegation to co-sponsor H.R. 3698, the “Two-Midnight Rule Delay Act”. Although different from Sen. Menendez’s legislation, co-sponsorship of H.R.3698 will send a strong message to CMS and congressional leaders regarding concern about the “Two-Midnight” policy. NJHA remains actively involved in the issue and will continue to work with the Senator, N.J. state delegation and CMS on the resolution.

The new regulations by CMS are meant to clarify the difference between hospital inpatient and outpatient stays, and consequently reduce the financial burden of Medicare beneficiaries. Although the time requirements under the “Two-Midnight” rule complicates decision making, medical factors and physician judgment remain core components in the decision to admit the patient as an inpatient or place the patient under observation. The industry is in agreement that the FY 2014 inpatient PPS final rule contains many unanswered questions, and is actively seeking clarifications as the Probe & Educate audit process continues.

About the author
Amina Razanica, MBA, is currently a Sr. Financial Analyst at the New Jersey Hospital Association where she performs economic modeling and financial impact analysis for the association’s members on state and federal healthcare issues, performance metrics, and industry trends. Amina can be reached at arazanica@njha.com.
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New Generation of the Poison Ivy Vaccine in Clinical Study

by Robert E. Coifman, MD, Cathy F. Yang, Ph.D., and Sarah Klosek

Medical research and education are thriving in New Jersey, with Rowan University as just one example of an institution were both are occurring with exciting results. The University recently announced $5 million in funding for the Rowan University Venture Fund to support early stage research. Earlier this year, the University received a $3.05 million grant from the Robert Wood Johnson Foundation to develop new health care delivery education and research programs. Additionally, US News & World Report has named Rowan University School of Osteopathic Medicine as one of the country's best medical schools for geriatric medical education. The impact of robust medical research and education opportunities available in New Jersey is demonstrated by the results of the collaborative efforts of New Jersey allergist, Dr. Robert Coifman, and Rowan University Professor of Chemistry, Dr. Cathy Yang.

In the summer of 2008, a 30 year old tree trimmer came to the Millville office of allergist Dr. Robert Coifman, seeking allergy management for recurrent severe poison ivy. He was unable to avoid it in the course of his work, and for the past several summers he needed continuous treatment with high doses of prednisone.

There had been commercial poison ivy vaccines from the 1950's into the 1980's but in the late 1980's they were all been pulled from the market because of inability to demonstrate predictable effectiveness in studies the FDA directed by Congress to require for continued licensure of allergy vaccines that had been approved before effectiveness testing was required.

While the old vaccines did not help enough patients enough of the time to pass the FDA's effectiveness test, they had definitely helped some patients, and they had never been shown to produce dangerous side effects. It seemed to Dr. Coifman that the risks of treatment with a home-made vaccine made from fresh poison ivy leaves would be less than the risks of taking high doses of prednisone for six months or more of every year, so he offered to try to make one. The patient gave his consent. Dr. Coifman then contacted Rowan Chemistry Prof. Cathy Yang to ask if she'd be interested in working together to make a poison ivy allergy vaccine, and she said yes. Dr. Coifman and his staff harvested fresh poison ivy leaves from a farm owned by one of his employees, and Prof. Yang and her associates turned it into their first generation allergy vaccine. Together they developed a quantitative poison ivy allergy patch test, with which they can measure sensitivity before treatment, measure response to treatment, and track response to treatment over time.

The allergens in poison ivy are a family of four similar chemicals called urushiol, collectively referred to as poison ivy urushiol. Poison ivy urushiol is not soluble in water but it will dissolve in vegetable oils, and in previous poison ivy vaccines it had been dissolved and injected in sterile corn or olive oil.

Vegetable oils are extremely difficult to sterilize if they are accidentally contaminated. Because of this, vaccines of poison ivy urushiol dissolved in vegetable oils had been manufactured in closed, totally germ-free production lines. It would be costly to set up a sterile, germ-free production line for the small quantities of vaccine needed for early phase clinical trials, and it would be both costly and difficult to modify the vaccine preparation process in a closed production line to make the changes they knew, and they'd want to make, as they learned from ongoing experience. Coifman and Yang therefore decided to make vaccines by dissolving and injecting poison ivy urushiol in small volumes of ethyl alcohol (ethanol). Ethanol stings more than vegetable oil on injection but it's self-sterilizing, which made it possible to both make the vaccine, and modify the vaccine preparation process, using clean but not sterile technique in ordinary chemistry laboratory work-space.

Allergy vaccines can be designed to do either or both of two things. One is to produce desensitization, a temporary ability to tolerate the offending allergen that develops as the dose of vaccine is increased to a level shown to be effective, and that lasts as long as treatment is continued. Treatment should be daily, or no farther apart than every two to three days, with the maximum dosing interval needed to maintain the desensitized state depending on the allergy and the vaccine. Readers may have read or heard about clinical trials of desensitization for peanut and other food allergies, which have not produced perfect results, but have helped many patients with severe allergies to those foods.

The ideal goal of treatment with an allergy vaccine is to induce durable immunologic tolerance, which is as being continued on page 12
on a biological email OK-list. The immune system learns in the process of immunization to accept and tolerate the target allergen in the same way that a healthy immune system tolerates one's own tissues, identifying it as fine line without need for continuing vaccine treatment. Once durable immunologic tolerance is achieved, it typically lasts for months to years without need for ongoing treatment.

The most effective previously reported approach to durable induction of immunologic tolerance to poison ivy previously reported in response to poison ivy vaccines was in guinea pigs, not humans. A chemically modified poison ivy urushiol vaccine injected in corn oil produced partial tolerance, persisting one to two months after treatment. The tree-trimmer who was the first patient treated with Coifman and Yang's poison ivy vaccine developed complete clinical tolerance (no reaction to the same workplace exposures that had previously required months of continuous high dose prednisone) and became 100 times less sensitive by quantitative patch test. He retained both his clinical protection and his patch test response nine months after treatment, but lost clinical protection and his patch test sensitivity returned to his pre-treatment 14 months after treatment. (At that time he changed his occupation for reasons other than poison ivy allergy, so he was not interested in re-treatment.)

Three other highly allergic patients also responded complete clinical responses to treatment, with 22 to 5000 times reduction in patch test sensitivity. In one, clinical and patch test protection were present at 9 months but lost by 12 months. The patient who became 5000 times less sensitive was still clinically protected, and remained 1250 times less sensitive than before treatment at four years. The third patient was lost to follow-up after 3 months. In terms of the amount of allergen needed compared to the weight of the patient, our vaccine in ethanol was 200 times as effective as the best previously reported poison ivy vaccine in corn oil.

However, our initial vaccine did not induce tolerance in patients who were less sensitive before beginning treatment and it also lost potency more quickly than we would like, despite refrigeration. It was also so dilute that we could not inject larger doses without injecting unacceptably large volumes of ethanol.

Prof. Yang designed a procedure to make a much more concentrated, purified and stable poison ivy urushiol vaccine, also in ethanol. It induced tolerance as well as the original. Dr. Coifman, who was mildly allergic to poison ivy before treatment, kept increasing his own dose of the purified vaccine to see if by increasing dose he could induce tolerance in himself, as a mildly allergic patient. He succeeded, but only at a high enough dose to produce hives lasting three months. Dr. Coifman did not have known contact with poison ivy to learn if he had clinical protection, but he was protected by patch test at 3 months and lost that protection by 6 months.

The reduced effectiveness of the purified vaccine suggested that something useful was lost in the purification process.

With a third vaccine, a mix of vaccine formulae #1 and #2, Dr. Coifman again induced tolerance in himself, this time at a dose whose only side effect was a temporary increase in the level of certain allergic cells in the blood. Dr. Yang then produced a 4th vaccine, as concentrated and as stable as purified vaccine #2, but containing everything present in her more effective but less stable vaccines #1 and #3. The first patient to receive this vaccine is currently being treated.

Coifman and Yang believe they understand why their poison ivy vaccines in ethanol work better than previous vaccines in vegetable oil. They believe the same mechanism can be adapted to vaccines for protein allergens, and have done very preliminary experiments to adapt the method to peanut. As they acquire more data on the safety and effectiveness of their poison ivy vaccines, they hope that they'll be able to interest a vaccine manufacturer in licensing their technology for commercial use. They are also generating candidate peanut allergy vaccines for animal trials. Hopes are that they will confirm their theory about how and why their ethanol-based vaccine works in animal models as well.

About the Authors

Dr. Robert Coifman is a physician who treats patients through his solo practice - Allergy & Asthma of South Jersey. He is certified by the American Board of Pediatrics and the American Board of Allergy & Immunology. He is a fellow of the American Academy of Allergy, Asthma & Immunology, and the American College of Allergy, Asthma & Immunology, and he has served as a national scientific committee chairman and as a member of the national meeting continuing medical education program faculty for each of these two societies. Dr. Coifman can be reached at recoifman@gmail.com.

Dr. Catherine Yang is a professor in the Chemistry and Biochemistry Department at Rowan University. Dr. Yang's research includes drug discovery and development for indications such as cancer, diabetes, and allergies. During her tenure at Rowan, Dr. Yang received many academic awards including the Cottrell College Award of Research Corporation, the National Institute of Health AREA Grant Award, the Innovative Research Award of National Applied Chemical Laboratory, the National Science Foundation MRI Grant Award, and the Sigma Xi National Academy of Sciences Grants-in-Aid of Research. Dr. Yang can be reached at yang@rowan.edu.

Sarah Klocek is an associate with Fox Rothschild LLP and a member of the firm’s Intellectual Property Department. Sarah’s practice focuses on patent law in the chemical and pharmaceutical arts, including preparing and prosecuting patent applications; managing prosecution of foreign patent applications; conducting due diligence analyses; and preparing legal opinions. Sarah can be reached at sklocek@foxrothschild.com.
Interpreting Is No Joke!

by Lewis Bivona

Although Nelson Mandela was a great man, there is one thing for sure, most people will remember the phony sign language interpreter from his memorial service more than other things said and done that day. NBC News reported that the interpreter, identified as 34-year-old Thamsanqa Jantjie, had told Johannesburg’s Star newspaper he started hearing voices in his head and hallucinating, resulting in gestures that made no sense and outraged deaf persons around the world.

While some say that Mr. Jantjie was not even qualified will not be debated here today. The issue is for us hearing persons, who would have assumed that he was doing a good job, and was being understood by the deaf in attendance and watching worldwide. Furthermore, Mr. Jantjie was not just some free lancing interpreter, he had worked and was sourced through a bonafide interpreting agency for the event. Being married to an interpreter, I knew enough sign to know that what was being said was not being interpreted, but how would anyone else? The same could be said for medical personnel, physicians, nurses or other allied professionals in a medical setting; how can you tell what you are saying is being accurately conveyed and understood?

The Congressional Research Service report on the ADA (American’s With Disabilities Act) Title III, section 302, 42 U.S.C. §12182, provides generally that no individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation. In addition, this section provides that discrimination includes “a failure to make reasonable modifications in policies, practices, or procedures when such modifications are necessary to afford such goods, services, facilities, privileges, advantages, or accommodations to individuals with disabilities, unless the entity can demonstrate that making such modification would fundamentally alter the nature of such goods, services, facilities, privileges, advantages, or accommodations.” The definition of public accommodation specifically includes the “professional office of a health care professional” and hospitals. 42 U.S.C. §12181(7)(F).

While the ADA does give some leeway as to how and when you have to provide interpreting services, what is clear is that effective communication commensurate with the situation is required. The U.S. Department of Justice, Civil Rights Division, Disability Rights Section set out clear interpretations of their interpretation of the ADA was in the ADA Business Brief for Hospitals, some key tenants are:

- Hospitals must provide effective means of communication for patients, family members, and hospital visitors who are deaf or hard of hearing.
- The ADA applies to all hospital programs and services, such as emergency room care, inpatient and outpatient services, surgery, clinics, educational classes, and cafeteria and gift shop services. Wherever patients, their family members, companions, or members of the public are interacting with hospital staff, the hospital is obligated to provide effective communication.
- Exchanging written notes or pointing to items for purchase will likely be effective communication for brief and relatively simple face-to-face conversations, such as a visitor’s inquiry about a patient’s room number or a purchase in the gift shop or cafeteria.
- Written forms or information sheets may provide effective communication in situations where there is little call for interactive communication, such as providing billing and insurance information or filling out admission forms and medical history inquiries.
- For more complicated and interactive communications, such as a patient’s discussion of symptoms with medical personnel, a physician’s presentation of diagnosis and treatment options to patients or family members, or a group therapy session, it may be necessary to provide a qualified sign language interpreter or other interpreter.

The key takeaway from this guidance is that “effective communication” must occur. How does a hospital or physician practice know when effective communication is occurring, and how do you protect yourself from ADA violations? The ADA guidance on this principle is as follows:

What does it mean for communication to be “effective”? Simply put, “effective communication” means that whatever is written or spoken must be as clear and understandable to continued on page 14
people with disabilities as it is for people who do not have disabilities. This is important because some people have disabilities that affect how they communicate. (excerpted from the ADA Toolkit)

While requirements for physician offices are not quite as stringent as hospitals, they remain virtually the same. Let’s tackle the first things first, communication! Imagine you are in a foreign country where you need medical services, would you expect to have someone who is not only conversant in English but also understands what you are saying and accurately relays information both ways. Maybe you would not expect an interpreter for a sinus infection but you certainly would be insistent for a major issue. But even a sinus infection could be critical if the doctor wanted to prescribe something to you which has been allergic to you in the past.

So, how would you assess if communication is occurring? Just because an agency sent you an interpreter does not mean that they are situationally qualified. Some key questions would be:

How many years has the interpreter been working? This lets you know who is green versus experienced. Remember the Mandela Memorial, just because the hands are moving does not mean there is communication.

What fields has the interpreter provided services in and for how long? Educational, legal and commercial situations are quite different from medical.

Does the interpreter have a background in a medical environment or understand medical terminology? What situations have they interpreted, inpatient, outpatient, emergency, physician office, surgi-centers?

Consistency with patient? It is more important for a medical provider to know the patients history which supports not having a different interpreter every time a patient is seen; consistency is a best practice especially when treating a patient with multiple medical and/or complex issues.

How much insurance does the agency have for malpractice? If the agency hires freelance interpreters to fill their needs, do they have insurance? While hospitals and physicians are frequently looked at as deep pockets in lawsuits, it would be nice to know that you don’t solely own the liability of a contracted party without resources.

Impartiality is important particularly when staff provide interpreting services. To be qualified, an interpreter must be able to convey communications effectively, accurately, and impartially, and use any necessary specialized vocabulary.

The patient should feel comfortable with the interpreter. If there is not a melding with the interpreter, communication will not occur. If the patient requests a specific interpreter then the request should be honored. As mentioned earlier, the deaf patient may have established a relationship with an interpreter that understands their entire medical history; in this instance, to assure communication, these bonds should not be broken. Some interpreters may not be able to sign in a fashion that allows the patient to understand and vice versa. If there is no communicative common ground established understanding will not occur and you can easily open yourself up to a lawsuit.

Two New Jersey cases drive home the potential exposure that medical providers can face by not providing interpreters. The first case originated in Hudson County where a rheumatologist was sued by his former patient for not providing interpreting services for a patient who routinely asked him for the accommodation. The doctor’s position was that providing an interpreter essentially would cost more than he received from the patient for the visit, basically a financial hardship to the physician. Malpractice was never raised as an issue, only that the patient could not understand or effectively be involved in her prognosis and treatment. The award was for over $400,000, half of which was punitive in nature. Even though the patient and physician had communicated via notes and nothing untoward had happened, precedent in a previous legal case (Borngesser v. Jersey Shore Medical Center) was leveraged that indicated at key treatment junctures it would have been appropriate to provide an interpreter. Physicians have argued in other cases that providing such services pose a hardship on their practices, but these defenses are rarely successful, according to legal experts.

In a more recent case, a Burlington County nursing facility settled for undetermined amount plus the agreement that it will provide qualified sign language interpreters to deaf patients in the future. The case which was lodged through the NJ Division of Civil Rights alleged that the deaf patient was only offered interpreter twice during her stay there, relying solely on family interaction, lip reading and had written notes with caregivers. The other damning factor was that the patient did not understand treatment and procedures that had been ordered, or that they were even scheduled.

While an interpreter is not always required, as a hospital or physician can provide alternative communication methods, it is advised when complex issues, diagnoses or treatment plans are expected. In some instances notes, videos and other methods of communication are acceptable. There is considerable guidance provided in WikiLeaks Document Release http://wikileaks.org/wiki/CRS-97-826 report to
the Congressional Research Service entitled *Americans with Disabilities Act (ADA) Requirements Concerning the Provisions of Interpreters by Hospitals and Doctors.*

My accountant hat also tells me not to forget to tell you that healthcare providers can receive tax credits for up to 50% of eligible access expenditures (interpreters, video interpreter services, auxiliary aids, etc.) that are over $250 but less than $10,250, or more simply put, up to a $5000 per year credit. There are some limits. You must have under 30 FTEs, or less than $1 million dollars of annual revenue to qualify.

While the ADA and its requirements are not new, they certainly are becoming more relevant than ever. With the Affordable Care Act’s implementation and its expected deluge of new patients with rights that will be aggressively protected, it is more important than ever to make certain that, as a healthcare provider, you are meeting your obligations under the law. Remember that a best defense is a good offense. Apply common sense to your interpreter selections.

**About the Author**

Lewis Bivona is a CPA and President of Professional Medical Management Consultants. He has been an advisor and consultant to healthcare entities for over 36 years in insurance, ACO, MCO matters and compliance related issues. Lew has worked in hospital, surgi-center, health maintenance organizations, group practice and healthcare regulatory environments which provides his clients with a broad perspective to meet today’s complex financial and operational requirements. Lew can be reached at ldbcpa@gmail.com.

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The U.S. Treasury Department (“Department”), on February 10th, issued final regulations implementing the employer shared responsibility provisions of the Affordable Care Act (“ACA”). The final regulations provide transitional relief for large and mid-sized employers, including hospitals and physician practices, and address several other areas related to the employer shared responsibility provision of the ACA.

Background
Under the ACA and Internal Revenue Code (“IRC”) §4980H, an applicable large employer that, for a calendar month, fails to offer to at least 95% of its full-time employees health coverage that is both affordable and provides minimum value may be subject to a penalty if any of its full-time employees for that month purchase a qualified health plan through a state-based marketplace through the use of a premium tax credit or subsidy. An applicable large employer is defined as one that employed, during the preceding calendar year, an average of at least 50 full-time employees, including full-time equivalents.

Coverage under an employer-sponsored plan is deemed to be affordable for an employee as long as the employee’s required contribution toward the cost of single only health coverage does not exceed 9.5% of their household income. In order for employers to be able to determine household income, several safe harbors exist. For example, an applicable large employer is able to use an employee’s Form W-2, Box 1 wages as household income. Other safe harbors include hourly rates paid to employees or Federal poverty level. Coverage under an employer-sponsored plan provides minimum value as long as the plan’s share of the total allowed costs of benefits provided under the plan is at least 60% of those costs. A health plan meets this standard if it is designed to pay at least 60% of the total cost of medical services for a standard population.

The employer shared responsibility provision as originally drafted was set to be effective on January 1, 2014. Last summer, the IRS issued Notice 2013-45 delaying the effective date of this provision to January 1, 2015. The release of these final regulations provides further transitional relief for certain employers.

Definition of Full-Time Employee
For purposes of the employer shared responsibility provision, a full-time employee is defined in the final regulations as an employee, with respect to a calendar month, who is employed and provides an average of at least 30 hours of service per week, or 130 hours of service per month.

Transitional Relief
As noted earlier, the final regulations provide transitional relief for large and mid-sized employers. The Department has stated that this transitional relief was instituted to ensure a gradual phase-in of the employer shared responsibility provision and to assist employers that are subject to the provision.

Applicable large employers that have at least 50 but no more than 99 full-time employees, including full-time equivalents, have been granted an additional year until January 1, 2016 to comply with the employer shared responsibility provision. In addition, applicable large employers that have 100 or more full-time employees, including full-time equivalents, are still subject to the employer shared responsibility provision on January 1, 2015; however, they will only be required to offer health coverage that is affordable and provides minimum value to at least 70% of their full-time employees during 2015. This will increase to the 95% indicated above effective for the 2016 calendar year. The Department believes that this transitional relief will assist employers that, for example, may be currently offering coverage only to those employees that work an average of 35 hours per week or more but not yet to those employees that work an average of between 30 and 34 hours of service per week.

To qualify for the transitional relief, employers must provide appropriate certification as defined in the final regulations.

Types of Employees
The final regulations also address and provide clarification with respect to certain types of employees or occupations and whether or not these employees are considered full-time for purposes of the employer shared responsibility provision. The
Department provides the following in a Fact Sheet which summarizes the final regulations:

- Bona fide volunteers of government or tax-exempt entities, such as volunteer firefighters, will not be considered full-time employees.
- Teachers and other educational employees are to be treated as full-time even if their school is closed or operating on a limited schedule (e.g. summer).
- Seasonal employees with customary annual employment of six months or less generally will not be considered full-time employees.
- Service performed by students under federal or state-sponsored work-study programs will not be counted in determining whether or not they are full-time employees.
- Until further guidance is issued, employers of adjunct faculty are to use a method of crediting hours of service for those employees that is reasonable in the circumstances and consistent with the employer shared responsibility provision. The final regulations expressly allow crediting an adjunct faculty member with 2½ hours of service per week for each hour of teaching or classroom time as a reasonable method for this purpose.

Other Provisions

Certain other provisions that were originally slated to take effect in 2014 that have already been delayed until 2015 still remain:

1. To help accommodate employers that will be subject to the employer shared responsibility provision for the first time, employers can determine whether they had at least 100 full-time employees, including full-time equivalents, in the previous year by reference to a period of at least six consecutive months; instead of a full year.
2. Employers with non-calendar year plans will not be subject to the employer shared responsibility provision until their plan year starts in 2015; not on January 1, 2015.
3. The policy that employers offer coverage to their full-time employees’ dependents will not apply in 2015 to employers that are taking steps to arrange for such coverage to begin in 2016.
4. On a one-time basis, in 2014 preparing for 2015, plans may use a measurement period of six months even with respect to a stability period - the time during which an employee with variable hours must be offered coverage - of up to 12 months.

The Department has stated that as these limited transition rules take effect, they will take into consideration whether or not it will be necessary to further extend any of them beyond 2015.

Conclusion

Although the enforcement of the employer shared responsibility provision for certain employers has been delayed, it is important for employers to consider the potential applicability of this provision in the future. It is estimated that 96% of employers are small businesses and have less than 50 employees thus exempting them from the employer shared responsibility provision. The Department has indicated that final regulations with respect to the employer reporting requirements associated with the employer shared responsibility provision under IRC §6055 and §6056 will be forthcoming from the Internal Revenue Service (“IRS”). In addition, the IRS has released a series of 46 questions and answers related to employer shared responsibility which can be accessed via the newsroom section of the IRS’ website (www.irs.gov): “Questions and Answers on- Employer Shared Responsibility Provisions Under the Affordable Care Act.”

About the Author

Anthony J. Panico, CPA, MS, is a partner with Withum Smith+Brown, Certified Public Accountants and Consultants. He is an active member of the firm’s Healthcare Services Group and Team Leader of the Healthcare Reform Advisory Team. Based in the Morristown, NJ office, Tony can be reached at apanico@withum.com.

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| April 22, 2014 | Woodbridge Hilton | half day | FACT Committee South Education Session |
| April 24, 2014 | Woodbridge Hilton | half day | FACT Committee North Education |
| April 29, 2014 | Doubletree Tinton Falls | all day | Annual Women’s Session |
| May 6, 2014 | Fiddler’s Elbow CC | all day | Annual Golf Outing |
| June 10, 2014 | Woodbridge Hilton | all day | Education Series: Revenue Integrity |
| July 16, 2014 | Woodbridge Hilton | all day | Education Series: Managed Care |

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**Who’s Who in NJ Chapter Committees**

**2013-2014 Chapter Committees and Scheduled Meeting Dates**

*NOTE: Committees have use of the NJ HFMA Conference Call line. If the committee uses the conference call line, their respective attendee codes are listed with the meeting date information below.*

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

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<tr>
<td>CARE (Compliance, Audit, Risk, &amp; Ethics)</td>
<td>Lisa Hartman <a href="mailto:hartman@princetonhcs.org">hartman@princetonhcs.org</a> (609) 933-7140</td>
<td>Dara Quinn <a href="mailto:Dara.Quinn@cranpointhealth.org">Dara.Quinn@cranpointhealth.org</a> (201) 821-8705</td>
<td>First Thursday of the Month (888) 269-3831 9:00 AM Attendee Code: 5952488</td>
<td>Meeting in person at Deloitte &amp; Touche, Princeton, NJ for Oct., Jan., April and July Balance are calls. Please call to confirm</td>
<td>Erica Waller <a href="mailto:ewaller@princetonhcs.org">ewaller@princetonhcs.org</a> (609) 620-8335</td>
</tr>
<tr>
<td>Communications</td>
<td>Elizabeth Litten <a href="mailto:ELitten@foxrothschild.com">ELitten@foxrothschild.com</a> (609) 896-3600</td>
<td>Al Rottkamp <a href="mailto:ajr1230@comcast.com">ajr1230@comcast.com</a> (609) 584-6508</td>
<td>First Thursday of each month (888) 269-3831 9:30 AM Attendee Code: 7844155</td>
<td>Fox Rothschild offices 897 Lincoln Dr Bldg 3 Lawrenceville, NJ</td>
<td>Stella Visaggio <a href="mailto:svisaggio@foxrothschild.com">svisaggio@foxrothschild.com</a> (908) 650-6508</td>
</tr>
<tr>
<td>Education</td>
<td>Mike McKeever <a href="mailto:mckeever@princetonhcs.org">mckeever@princetonhcs.org</a> (973) 972-6859</td>
<td>Mary Cronin &amp; Stacey Bigos <a href="mailto:Mcronin@beslerconsulting.com">Mcronin@beslerconsulting.com</a> / <a href="mailto:SBigos@gha.com">SBigos@gha.com</a> (732) 639-1217 / (609) 275-4017</td>
<td>First Friday of each month (888) 269-3831 10:00 AM Attendee Code: 7363742</td>
<td>Conference Calls</td>
<td>John Brait <a href="mailto:Brait@drathena.com">Brait@drathena.com</a> (973) 244-3536</td>
</tr>
<tr>
<td>Certification (Sub-committee of Education)</td>
<td>Eric S. Fishbein Eric <a href="mailto:Fishbein@connolly.com">Fishbein@connolly.com</a> (402) 423-1285</td>
<td>Cheryl Cohen <a href="mailto:Cheryl.N.Cohen@Wellsfargo.com">Cheryl.N.Cohen@Wellsfargo.com</a> (609) 259-3363</td>
<td>First Friday of each month (888) 269-3831 10:00 AM Attendee Code: 7363742</td>
<td>Conference Calls</td>
<td>Mike McKeever <a href="mailto:mckeever@princetonhcs.org">mckeever@princetonhcs.org</a> (973) 972-6859</td>
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<tr>
<td>FACT (Finance, Accounting, Capital &amp; Taxes)</td>
<td>Megan Byrne <a href="mailto:megan.bryne@ey.com">megan.bryne@ey.com</a> (732) 516-4969</td>
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<td>Second Wednesday of each Month (888) 269-3831 8:00 AM Attendee Code: 6730600</td>
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<td>Scott Maniani <a href="mailto:smamani@wellsfargo.com">smamani@wellsfargo.com</a> (973) 896-8944 x420</td>
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<td>Jennifer Vanegas <a href="mailto:jennifer.vanegas@hartf.org">jennifer.vanegas@hartf.org</a> (581) 643-3377</td>
<td>Fourth Thursday of each Month (888) 290-0578 8:00 AM Attendee Code: 5879383</td>
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<td>Tracy Dawson-DiCanto <a href="mailto:tdawson-dicanto@princetonhcs.org">tdawson-dicanto@princetonhcs.org</a></td>
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<td>Managed Care</td>
<td>Belinda Doyle Puglisi <a href="mailto:bpuglisi@childrens-specialized.org">bpuglisi@childrens-specialized.org</a> (908) 301-5458</td>
<td>John Brait <a href="mailto:Brait@drathena.com">Brait@drathena.com</a> (973) 244-3536</td>
<td>4/14 (Children's specialized Hospital) Mon. May 12 (1 hr Phone Conf ONLY) Weds, May 14* (9:30-11:30 AM) (888) 290-0549 2:00 PM Attendee Code: 7775069</td>
<td>New Jersey Hospital Association Board Room</td>
<td>Kevin Joyce <a href="mailto:kjoyce@qualicareinc.com">kjoyce@qualicareinc.com</a> (732) 562-7823</td>
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<td>Membership Services/ Networking</td>
<td>Kevin Margolis <a href="mailto:kevin.margolis@somersethospital.org">kevin.margolis@somersethospital.org</a> (609) 662-2422</td>
<td>Jennifer Barr &amp; Tim Blaik &amp; Maria Facciponti <a href="mailto:barr@touche.com">barr@touche.com</a>/ <a href="mailto:tblaik@somersethospital.org">tblaik@somersethospital.org</a> / <a href="mailto:Mfacciponti@drathena.com">Mfacciponti@drathena.com</a> (551) 998-3376 / (908) 203-6100 / (973) 614-9100</td>
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<td>Tony Consoli <a href="mailto:aconsoli@cbiz.com">aconsoli@cbiz.com</a> (732) 794-2662</td>
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<td>William Hunt <a href="mailto:whunt@humed.com">whunt@humed.com</a> (201) 996-2997</td>
<td>Dara Derrick <a href="mailto:dderrick@Voith.com">dderrick@Voith.com</a> (908) 850-6870</td>
<td>4/10/14 &amp; 5/9/14 (888) 269-3831 9:30 AM Attendee Code: 8942192</td>
<td>CBZK Consulting offices in East Windsor, NJ</td>
<td>Deborah Shapiro <a href="mailto:dshapiro@cbiz-services.com">dshapiro@cbiz-services.com</a> (201) 617-7100</td>
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<td>Patient Financial Services</td>
<td>Steven Stadtmann <a href="mailto:stadtmann@nsudw-ip.com">stadtmann@nsudw-ip.com</a> (973) 778-1771 Ext. 146</td>
<td>Kathleen Yenco <a href="mailto:kycsien@dgafonecorp.com">kycsien@dgafonecorp.com</a> (923) 226-1805</td>
<td>Second Friday of each Month (888) 290-0578 10:00 AM Attendee Code: 6746344</td>
<td>New Jersey Hospital Association Board Room</td>
<td>Joette Portalatin <a href="mailto:jportal@valleyhealth.com">jportal@valleyhealth.com</a> (201) 291-6017</td>
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<td>Physician Practice Issues Form</td>
<td>Jennifer Shimek <a href="mailto:Jennifer.Shimek@ralphema.com">Jennifer.Shimek@ralphema.com</a> (732) 516-4676</td>
<td>Howard Lasner <a href="mailto:Howard.Lasner@ehcns.com">Howard.Lasner@ehcns.com</a> (201) 689-2136</td>
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<td>Conference Calls Sept. &amp; Jan. meetings will also be in person</td>
<td>Deborah Shapiro <a href="mailto:dshapiro@cbiz-services.com">dshapiro@cbiz-services.com</a> (201) 617-7100</td>
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<td>Vicki Ozmore <a href="mailto:Vicki.Ozmore@atlanticare.org">Vicki.Ozmore@atlanticare.org</a> (609) 677-7171</td>
<td>Third Tuesday of each Month (888) 269-3831 9:00 AM Attendee Code: 9169926</td>
<td>Monmouth Shores Corps. Park Meridian Conf. Room 1C 1350 Campus Pkwy, Neptune</td>
<td>Rosemary Nuzzo <a href="mailto:rosemary.nuzzo@atlanticare.org">rosemary.nuzzo@atlanticare.org</a> (609) 363-2114</td>
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<td>Christine Puttermann <a href="mailto:aputtermann@princetonhcs.org">aputtermann@princetonhcs.org</a> (609) 620-8339</td>
<td>First Wednesday except Jan which is 1/8 (888) 269-3842 9:00 AM Attendee Code: 8667753</td>
<td>New Jersey Hospital Association</td>
<td>Steven Blisky <a href="mailto:sbilsky@causseycpecs.com">sbilsky@causseycpecs.com</a> (303) 672-9896</td>
</tr>
<tr>
<td>CPE Designation</td>
<td>Lew Bixova <a href="mailto:lcbixova@verizon.net">lcbixova@verizon.net</a></td>
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M&A Trends in Healthcare Today

by Joseph J. Perez, CPA

Healthcare mergers and acquisitions are becoming more popular in today’s economy. There were 426 such transactions at the national level through the first six months in 2013. If you are on the buy side of such a transaction you are probably aware of the potential advantages of going through with it, but there are also a number of potential pitfalls that should be considered.

Facts about recent transactions
Recent hospital consolidation activity shows that M&A activity is on the rise. In an American Hospital Association report prepared by FTI Consulting, M&A transactions have been shown to steadily increase. The number of transactions between 2009 and June 2013 rose from 36 in 2009 to 72 in 2012. For the first six months of 2013, 31 transactions have already taken place.

On a local level in New Jersey, over the past 24 months there were the following hospital sales:

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Acquirer</th>
<th>Amount</th>
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<tbody>
<tr>
<td>Meadowlands Hospital</td>
<td>Hudson Hospital OpCo</td>
<td>$43.5 Million</td>
</tr>
<tr>
<td>Christ Hospital</td>
<td>Hudson Hospital OpCo</td>
<td>$52.0 Million</td>
</tr>
<tr>
<td>Hoboken University Medical Center</td>
<td>Hackensack University Medical Center and Legacy Hospital Partners, Inc.</td>
<td>$190.0 Million</td>
</tr>
<tr>
<td>Mountainside Hospital</td>
<td>Hackensack University Medical Center and Legacy Hospital Partners, Inc.</td>
<td>$35.0 Million</td>
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</tbody>
</table>

All of the hospitals listed above are now being operated as either a for-profit corporation or a joint-venture between a not-for-profit and for-profit corporation. Similarly, they were all previously operated as not-for-profit organizations.

While the FTC is watching these transactions to maintain competition which is designed to keep prices down, consumers and regulators worry that the opposite will occur and prices will increase. For example, a hospital system made bigger through acquisition may have higher reimbursement rates from insurers for the same services than the acquired hospital. When the merged entity negotiates with the insurer, their goal is typically to align the insurer to the higher, not the lower, rate. This ultimately will get passed on to the consumer in the form of higher insurance premiums as the insurer seeks to maintain their margins.

C-suite executives continue to look for ways to fund future operations and secure financing to take these organizations into the future. Often times, this means turning to outside investors. As history has shown, these investors are seeing hospitals and healthcare organizations as targets that could generate investment returns. Changes in regulations are making these targets more lucrative as investments due to the potential increases in reimbursement through negotiating power and as a result of cost sharing plans.

What are the Key Considerations?
Have a strategy
To effectively evaluate a target, development of a clear strategy that emphasizes goals is essential to success. Starting with the goals, an organization can begin with the end in mind. So if for example, the goal is to generate profits to return to investors, then a strategy that results in a for-profit entity that has negotiating leverage with insurers and can successfully implement an “out of network” model to drive reimbursement up should be considered. It is important to note that this model will typically go against the interest of payors and ultimately consumers. Society has called for, and government has responded, to the economic need to reduce the overall cost of healthcare. If, for example, the goal is to support a not-for-profit organization remaining competitive by providing care to the community through enhanced technological and facility improvements, then a strategy that results in market evaluation and the organization’s ability to generate cash flow necessary to service the financing obligation of the expansion should be considered.
Assess strengths and weaknesses

Critical to the evaluation will be if the acquiring organization has the depth of management to go through with a transaction. On the buy side of a transaction, important questions to ask yourself are: Has the management team done this before? What were the outcomes of past transactions? Has the management team been successful with other strategic decisions? Have they worked with good consultants and advisors? All of these questions can give insight into the organization’s ability to achieve the goals or successfully implement a strategy. Identifying strategic strengths and weaknesses can be a good barometer of a positive outcome. Strategic strengths could include having sufficient financial resources or a strong financial position to support access to capital. Strategic weaknesses could include lack of knowledge of complexities of a business or accounting transaction.

Target screening

Proceeding to the target screening phase may be one of the simpler phases to undergo. A lot of the information needed to identify a target is readily available. Most states publish hospital quality reports which could be a good tool in identifying those hospitals that may be underperforming and may make a good target candidate. For example, the New Jersey Department of Health publishes “The Hospital Performance Report.” The report is designed for patients to make informed choices about the quality of the healthcare they receive. The data provides information that could be useful to both a buyer and a seller. For example, a seller that receives low scores for patient safety indicators and fails to improve may decide that they need to align themselves with a potential buyer. Similarly, New York State maintains an interactive website that allows users to measure and compare hospitals with each other and against state averages.

Due Diligence

Conducting due diligence is an intensive process that requires a great deal of information gathering and analysis. There are many complex issues that need to be resolved in any healthcare merger or acquisition. The scope of the due diligence process should address many of the complex accounting, tax, legal, operational, technology and human resource matters. Consideration of the accounting and tax aspects generally require a good consultant to get through the process. Analysis will generally include complex valuation of assets acquired and liabilities assumed requiring specialized skills not always readily available to the management team of the acquirer. Revenue models that attempt to assess quality of earnings need to consider the rapidly changing reimbursement environment.

Potential Concerns

The Patient Protection and Affordable Care Act (“PPACA”) is anticipated to expand health coverage to a larger group of individuals. While the Medicare fund is expected to receive some additional monies to assist in paying for expanded services, the expectation is that it will pay less in dollars for the same services. In other words, hospitals will have to provide more services to receive the same number of dollars. An increase in the volume of services provided naturally will cost the hospital more, so if the reimbursement is less, then revenue projections should take this into consideration.

Evaluations of the revenue projections, which are an essential part of the due diligence process, need to be considered with great care and with a good understanding of the impact of the PPACA. Demographic data of the primary and secondary service areas will also have to be factored into an analysis that predicts how the legislation will impact the future operations of both the acquiring and acquired entities. This can be done in a variety of ways but will involve a great deal of information gathering of economic and census data. A partner to assist in determining the feasibility of a deal is essential. Quality projections will involve a starting point that has been audited by an independent accounting firm and supportable assumptions related to how the entity records transactions in a summary of significant accounting policies and support for the future viability of the entity in the summary of significant demand assumptions.

Specific to a not-for-profit healthcare organization, of particular complexity is the accounting treatment of the transaction as a merger or an acquisition. A merger of two not-for-profit organizations would be required if the governing bodies of each cede control to create a new not-for-profit entity. The merger would be accounted for by applying the “carryover method” which requires combining the assets and liabilities of entities as of the merger date.

An acquisition by a not-for-profit entity is required if a transaction is structured in such a way that one of the entities is deemed to continue the activities of one or more of the other entities’ nonprofit activities. The purchase price will be allocated to the assets acquired and liabilities assumed in proportion to the fair market value (“FMV”) of the assets and liabilities. Goodwill will be recognized if the FMV of the net assets acquired exceeds the consideration transferred. An inherent contribution will be recognized if the FMV of the assets and liabilities exceeds the consideration transferred to the acquired entity.

Common Reasons for Merger and Acquisition Transactions

Many believe that small community hospitals and healthcare organizations cannot survive on their own because, in addition to administration costs of regulation and oversight, they cannot achieve sufficient economies of scale to continue as a viable
entity. Large health systems typically have a broader service reach, greater purchasing power and have negotiating leverage with third party health insurance payors. They also benefit from having lower administrative costs that can be spread over a larger revenue base than their smaller counterparts.

Other M&A transaction goals relate to expanding service offerings, potentially gaining higher margin services to offset other low margin services or uninsured patient services. Partnering with physicians who have a particular expertise in a higher margin service provides both direct and indirect financial benefits. Direct financial benefits to the organization come in the form of increased cash flow and profitability. Indirect benefits are in the form of improved reputation which may drive a higher volume of patients to the health system. Expanding through acquisition also gives a healthcare organization greater geographic strength to better serve a larger community. This is advantageous when regulatory bodies analyze community benefit statements of not-for-profit healthcare institutions.

Care coordination is also a big driver for M&A transactions. As Accountable Care Organizations ("ACOs") become more popular, hospitals and health systems will continue to create affiliations through M&A by buying up physician practices so that they have the primary and specialty care providers to provide a continuum of care. There are reimbursement incentives for those who successfully work the ACO model.

**Conclusion**

The process of merging or acquiring a healthcare entity is extremely complex. The PPACA and recent accounting changes have muddied the waters a bit. Successfully navigating through these transactions requires a strong management team, careful consideration of the deal structure and, finally, accounting and reporting for the transaction with the appropriate framework. Success generally can be achieved if both the acquirer and the target are forthcoming in the information exchange process and meaningful analysis of available data can be supported by tangible documentation. Equally important is the selection of a team to assist in some of the specialized areas of the transaction. Having the right partners to assist are essential to building success. Generally needed are financially strong partners to assist with securing financing, a reputable independent accounting firm to provide assurance on historical results and a consultant with the industry experience to analyze projected results and assess the viability of the entity into the future.

**About the Author**

Joseph J. Perez, CPA, is a partner with WithumSmith+Brown, PC, Certified Public Accountants and Consultants, based in the firm’s New Brunswick, NJ office, and has provided accounting, auditing, tax and consulting services to not-for-profit healthcare institutions for over a decade. He can be reached at jperez@withum.com.

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**Online Certification Series**

The March CHFP webinar has been a great success. More than 100 individuals across NJ and PA enrolled in the series.

For those who enrolled in the class, the Certification co-chairs welcome your feedback. Please let Cheryl Cohen (Cheryl.H.Cohen@Wellsfargo.com) or Eric Fishbein (eric.fishbein@connolly.com) know what worked well and what could be improved. Remember, there is no need to wait to sign up for the exam once you’ve completed the series and you feel you’re ready.

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**Continuing Education Requirements**

All current CHFPs and FHFMAs are required to complete 60 contact hours in eligible education programs every three years by May 31 of the “good through” year shown in your member record. The NJ Chapter hosts monthly educational events and HFMA national has webinars as well as live events— all of which provide numerous opportunities for members to fulfill these requirements.
Idaho Federal Court’s Antitrust Decision Demonstrates That While Efficiencies May Be Relevant, Market Power Still Controls

By Andrew F. McBride, III and Paul L. Croce


St. Luke’s operates seven hospitals throughout Idaho, as well as an emergency clinic in the town of Nampa. St. Luke’s employs or has entered into Professional Services Agreements (“PSA”) with approximately 500 physicians in numerous medical specialties throughout Idaho and eastern Oregon. Prior to the Saltzer transaction St. Luke’s employed no more than eight physicians practicing adult primary care services in the Nampa, Idaho vicinity.

Saltzer was the largest, independent, multispecialty physician group in Idaho, consisting of 41 physicians including 29 practicing in family medicine, internal medicine or pediatrics, 24 of which practiced in Nampa.

The affiliation between St. Luke’s and Saltzer began in December 2008 when the parties entered into a memorandum of understanding establishing an informal partnership designed to focus efforts around a series of joint initiatives aimed at improving access to quality medical care, enhancing coordination of services and streamlining the healthcare delivery model in the area.

In 2009, the parties began discussing a closer affiliation which came to fruition on December 31, 2012 when St. Luke’s acquired Saltzer’s intangible assets, personal property and equipment for an amount not to exceed $16,000,000. Additionally, Saltzer physicians entered into a five year PSA with St. Luke’s. While the PSA referenced a plan to implement quality based incentives, no specific incentives were built into the original PSA. However, the PSA was thereafter amended to provide for up to 20 percent of Saltzer’s compensation being tied to quality based initiatives.

Following the formation of the merged entity, suits were filed by the Federal Trade Commission as well as two of the merged entity’s competitors, who contended the acquisition would have anticompetitive effects. The merged entity relied upon the “efficiency defense” arguing that the acquisition was primarily intended to coordinate care and improve patient outcomes.

When analyzing the effects on competition the court noted that there was no dispute that the relevant product market was adult primary care services sold to commercially insured patients.

To determine the relevant geographic market the court employed the SSNIP test which evaluates whether all sellers in the proposed market could hypothetically impose a small but significant, non-transitory increase in price (generally 5 to 10 percent) and still make a profit, or whether the price hike would cause consumers to travel to adjacent areas where sellers offered lower prices.

Since the vast majority of health care consumers are not direct purchasers of health care, but rather purchasers of health insurance, the test examined the likely response of insurers to a hypothetical demand by all PCPs in a particular market for

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a SSNIP. If an insurer was likely to drop those PCPs from its network and direct its members to PCPs in adjacent regions, the adjacent regions would be considered as part of the geographic market. However, if the PCPs could successfully demand a SSNIP the relevant market would be limited to where those PCPs practice.

Based on testimony from members of Idaho’s largest insurer, Blue Cross of Idaho, regarding the necessity to provide access to PCPs in the direct community where its members reside, the court concluded that PCPs in Nampa could hypothetically impose a SSNIP. Thus, the court defined the relevant market as the Nampa community.

The court then examined the anticompetitive effects of the merger using the Herfindahl-Hirschman Index (“HHI”) which the FTC uses to determine whether an industry is considered highly concentrated or when potential mergers require investigation. An HHI ranges from zero to 10,000. Where an HHI exceeds 2500 that market is considered highly concentrated, and a merger that increases HHI by more than 200 points is presumed to enhance market power. Post-merger, the Nampa market had a HHI of 6,219 and an increase in HHI of 1,607. The merged entity would ultimately account for nearly 80 percent of primary care services in Nampa. Thus, the court found the acquisition to be presumptively anticompetitive under Section 7 of the Clayton Act.

In addition to the overall size of the merged entity, the court found significant that the acquisition was not only a merger of the two largest providers of primary care services, but also a merger of each of those providers’ closest substitutes. Accordingly, prior to the merger had either Saltzer or St. Luke’s attempted to use its leverage in the market to obtain higher levels of reimbursement an insurer could turn to the other for more competitive rates. However, post-merger if a health plan removed the merged entity from its plan it would be forced to choose from the third best option for its members, thereby significantly impacting the health plan’s ability to market its product to patients living in Nampa.

Finally, the court believed the merged entity could command increased reimbursement by billing ancillary services such as laboratory testing and diagnostic imaging, which had previously been conducted at the Saltzer offices, at higher “hospital-based” rates thereby increasing costs by 30 to 35 percent. Accordingly, the court found that the substantial market share of the merged entity would provide it with a dominant bargaining position over health plans in the Nampa market.

While, based on the dominant market share alone, it is not surprising that the court ordered the divestiture of the acquisition, what is interesting is the court’s apparent willingness to consider St. Luke’s “efficiency defense,” i.e., that the merger will create efficiencies that will far outweigh any anticompetitive effects. This is significant because although there has been a trend by lower courts to recognize the defense, See, F.T.C. v. H.J. Heinz Co., 246 F. 3d 708, 720 (C.A.D.C. 2001), the United States Supreme Court has not sanctioned its use in a Section 7 case. See, F.T.C. v. Proctor & Gamble, Co., 386 U.S. 568, 580 (1967).

The court described the defense as requiring “convincing proof” of “significant” and “merger-specific” efficiencies. Merger-specific efficiencies are efficiencies that could not be achieved, or would not be achieved, absent the merger. Based on those requirements, the court found the defense to be unavailing, noting that where high market concentrations will result from the merger, the defense requires “proof of extraordinary efficiencies.”

St. Luke’s could not carry that burden because the facts demonstrated that employing physicians was one way, but not the only way, to put together a “unified and committed team of physicians” which would produce improved quality and generate efficiencies. Similarly, the court found that access to St. Luke’s electronic medical records system, which it contended would create significant efficiencies, did not need to be, and in fact was not, limited to physicians directly employed by St. Luke’s. Because the efficiencies which St. Luke’s contended were at the heart of the merger have been demonstrated with groups of independent physicians, those efficiencies could not be deemed to be merger-specific. Thus, St. Luke’s could not meet its burden of establishing the “efficiency defense.”

Nevertheless, the court acknowledged that the primary purpose of the merger was to improve patient outcomes, and noted that it believed that if left intact the acquisition would have indeed had the intended result. In fact, the court stated that “St. Luke’s is to be applauded for its efforts to improve the delivery of health care in the Treasure Valley.” Nevertheless, the court concluded that the potential for improved patient outcomes was outweighed by the potential anticompetitive effects and the acquisition therefore must be unwound.

While the case demonstrates the lower courts’ willingness to consider the “efficiency defense,” it highlights the high standard of proof needed to establish same. It further reminds us that the first, and most important consideration in a merger analysis, remains market power. There is no merger case thus far where efficiencies themselves have saved a merger that is prima facie unlawful.

About the Authors
Andrew F. McBride is a Partner in the health care practice at McElroy, Deutsch, Mulvaney & Carpenter LLP, with ten offices in New Jersey, New York, Connecticut, Massachusetts, Pennsylvania, Delaware, and Colorado. Paul L. Croce is an associate in the health care practice at McElroy, Deutsch, Mulvaney & Carpenter LLP.
The Power of Patient Empowerment

When you are an empowered patient, you become a vital member of your health care team.

by Dr. Anthony Perre

Enhanced communication creates greater trust, resulting in increased understanding and greater compliance with the treatment plan. Ultimately, getting answers to questions can make patients feel more in control of their health and can often lead to better health.

In fact, IHC cites several studies demonstrating that a clinician’s ability to explain, listen, empathize and collaborate with fellow team members can have a profound effect on biological and functional health outcomes. This expectation is the motivation behind the Patient Empowered Care® (PEC) model launched by Cancer Treatment Centers of America® (CTCA) in 2010. Under the PEC® model, multidisciplinary physicians and clinicians come together as one, appropriately named, “Empowerment Team.” Together, they develop and carry out individualized treatment plans tailored for each patient. Each Empowerment Team includes a medical oncologist, naturopathic clinician, registered dietitian, nurse care manager and clinic nurse, all dedicated to helping each patient fight cancer on their own terms. Patients may spend between two and three hours with their full health care team during every visit, depending on their individual needs, and rather than requiring the patient to move from department to department or clinician to clinician, the PEC team members come directly to the patient.

The role reversal from “Patient, the doctor will see you now” to “Doctor, the patient will see you now” helps patients feel comfortable and reduces angst caused by having to navigate between floors, buildings, and office addresses. The

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additional time and stress reductions allow for greater access to all team members, more responsive, personalized care, and, ultimately, for better patient understanding of their diagnosis and treatment plan.

The remarkable thing about patient empowerment is that it’s as simple as asking the right questions. And with a medical team that is ready to answer them, you’re already on your way to becoming empowered. Below are a few steps you can take to ensure communication between you and your health care team is effective.

- Bring a list of questions to each appointment.
- Don’t forget to ask about how significant aspects of life, such as family and career, may be affected.
- Ask about prescribed treatments—how they work, potential side effects, and how likely they are to be effective—and about how your treatment plan may affect your quality of life.

Don’t be afraid that any question is too basic; any topic that has an impact on your treatment and your life merits attention.
- Keep a notebook with you at all times to record any questions that come to mind so you can bring them to your doctor.
- Bring a friend or family member to your appointments. Two sets of ears are better than one!

About the author
Dr. Anthony Perre is the director of new patient intake and vice chief of administrative affairs at Cancer Treatment Centers of America in Philadelphia. He is a Hodgkin’s lymphoma survivor, husband and father of three.

New Members

<table>
<thead>
<tr>
<th>Jennifer R. Ferrang</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Vice President Sales, Northeast Region</td>
<td></td>
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<tr>
<td>732) 417-4732</td>
<td></td>
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<tr>
<td><a href="mailto:jennifer.ferrang@cardinalhealth.com">jennifer.ferrang@cardinalhealth.com</a></td>
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<td></td>
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<td>856) 773-3300</td>
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<td><a href="mailto:dwashburn@prnhs.net">dwashburn@prnhs.net</a></td>
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<td></td>
</tr>
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<td></td>
</tr>
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<td></td>
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<td>(215) 265-4065</td>
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<td><a href="mailto:rhaciski@grahamco.com">rhaciski@grahamco.com</a></td>
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<tr>
<th>Anthony Bissoondial</th>
<th>PRN Financial Services, LLC</th>
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<td>Vice President, Client Services</td>
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</tr>
<tr>
<td>732) 773-3300</td>
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<tr>
<td><a href="mailto:abissoondial@prnhs.net">abissoondial@prnhs.net</a></td>
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<th>Karen Thomsen</th>
<th>Jewish Home Family</th>
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<td>Medical Biller</td>
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<tr>
<td>201) 784-1414</td>
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<tr>
<td><a href="mailto:kthomsen@jewishhomefamily.org">kthomsen@jewishhomefamily.org</a></td>
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<th>Joel F. VandeVusse</th>
<th>Health Republic Insurance of New Jersey</th>
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<td>Chief Financial Officer</td>
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<tr>
<td>201) 308-8580</td>
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<tr>
<td><a href="mailto:jvandevusse@newjersey.health">jvandevusse@newjersey.health</a> republic.us</td>
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<th>Sean R. Callagy</th>
<th>Callagy Law</th>
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<td>President</td>
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<tr>
<td>201) 261-1700</td>
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<tr>
<td><a href="mailto:scallagy@callagylaw.com">scallagy@callagylaw.com</a></td>
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<th>Thomas LaGreca</th>
<th>Callagy Law</th>
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<tr>
<td>Team Lead Client Liaison</td>
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<tr>
<td>201) 485-9587</td>
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<tr>
<td><a href="mailto:tiagreca@callagylaw.com">tiagreca@callagylaw.com</a></td>
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<th>Robert Perry</th>
<th>Callagy Law</th>
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<td>Executive Director</td>
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<td>201) 261-1700</td>
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<td><a href="mailto:rperry@callagylaw.com">rperry@callagylaw.com</a></td>
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<th>Edwin M. Rubio</th>
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<td>Financial Analyst</td>
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<tr>
<td>201) 204-4292</td>
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<tr>
<td><a href="mailto:erubio@med-metrix.com">erubio@med-metrix.com</a></td>
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<th>Rajesh Chhabria</th>
<th>First Credit Services Inc.</th>
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<tr>
<td>Chief Executive Officer</td>
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<tr>
<td>732) 305-8301</td>
<td></td>
</tr>
<tr>
<td><a href="mailto:rchhabria@firstcreditonlin.com">rchhabria@firstcreditonlin.com</a></td>
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<th>Sam Blevines</th>
<th>Commerce Bank</th>
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<tr>
<td>Vice President/Account Executive</td>
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</tr>
<tr>
<td>(774) 992-7258</td>
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<tr>
<td><a href="mailto:sam.blevines@commercebank.com">sam.blevines@commercebank.com</a></td>
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<th>Gerard M. Coughlin</th>
<th>KPMG, LLC</th>
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<tr>
<td>Director</td>
<td></td>
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<tr>
<td>(203) 406-8083</td>
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<tr>
<td><a href="mailto:gcoughlin@kpmg.com">gcoughlin@kpmg.com</a></td>
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<th>Brian Weis</th>
<th>SR Healthcare</th>
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<td>Regional Manager - Northeast</td>
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<tr>
<td>(732) 239.3822</td>
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<tr>
<td><a href="mailto:brian.weis@spicarehealthcare.com">brian.weis@spicarehealthcare.com</a></td>
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<th>Sekhar V. Alluri</th>
<th>First Credit Services Inc.</th>
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<td>President/Account Executive</td>
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</tr>
<tr>
<td>802) 859-6768</td>
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<tr>
<td><a href="mailto:sekharalluri@gmail.com">sekharalluri@gmail.com</a></td>
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<th>Chris Thompson</th>
<th>GE Healthcare</th>
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<td>Sales</td>
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<tr>
<td>802) 859-6768</td>
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<td><a href="mailto:christophertompson@ge.com">christophertompson@ge.com</a></td>
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<th>Alan Kandel</th>
<th>A.M. Best</th>
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<tr>
<td>Business Development Manager</td>
<td></td>
</tr>
<tr>
<td>(908) 439-2200</td>
<td></td>
</tr>
<tr>
<td><a href="mailto:alan.kandel@ambest.com">alan.kandel@ambest.com</a></td>
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<tr>
<th>Joseph M. Dumont</th>
<th>University of Pennsylvania Health System</th>
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<tr>
<td>University of Pennsylvania Health System Analyst</td>
<td></td>
</tr>
<tr>
<td>(267) 414-2257</td>
<td></td>
</tr>
<tr>
<td><a href="mailto:jndumont@gmail.com">jndumont@gmail.com</a></td>
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Many physicians are partners, LLC members for S-Corp shareholders in their physician practices and receive a K-1 from the entity. In this edition of Focus on Finance, we’re going to discuss the K-1 in detail.

What is a Schedule K-1 form?

If you are an owner of a partnership, LLC or S-Corp that passes through income to its owners, in most cases you receive a K-1 form each year. The K-1 is prepared by the entity and distributed to its owners to report their portion of the income, loss and deductions. This information is used in the preparation of your personal income tax return.

What does pass-through mean?

Partnerships, S-Corporations and LLCs are called pass-through entities because they don’t pay taxes on their income. They pass the income to the owners and the owner’s pay the tax on their allocable share of the income.

What’s the difference between an S-Corp, LLC and partnership K-1 income?

As noted before, all are pass-through entities.

S-Corporation shareholders can only receive his/her percentage of profits based on his/her percentage of shares. S-Corp shareholders receive compensation through salary and pay employment taxes therefore the corporate net income reported on the K-1 is not subject to self-employment taxes.

Partners in a partnership are taxed on their pro-rata share of the net business profits based on their ownership percentage. If involved in running the partnership, in addition to paying income taxes partners must pay self-employment tax on that income.

Limited liability companies (LLC) can elect to be taxes as either a partnership (most common) or S Corporation. If filing as a partnership, LLC owners can decide to divide up the profits at whatever percentage they choose in the operating agreement despite their ownership percentages.

Income from K-1 to LLC members can be taxed as self-employment income or passive income. Passive income can be taxed at a higher 3.8% rate which we can explain offline if there are any questions.

How are the amounts on the K-1 determined?

They are based on the ownership share and profit & loss allocation percentage of each shareholder, partner and member. Keep in mind that the allocation of profits and losses to LLC members do not need to be equal to ownership shares (or units) if the LLC operating agreement provides otherwise and the entity is filing as a partnership.

Do I need to file Form K-1 or include when filing my tax return?

No, the entity is responsible for filing this form with the Internal Revenue Service and any applicable states. You use the data on the form to fill out portions of your personal income tax returns.

Why does my K-1 come late? Isn’t it supposed to be issued by January 31st?

One of the most common misconceptions about K-1s is that they are under the same January 31st deadline as most other tax documents such as W-2s, 1099s, and 1098s. They are not. For example, a 1120S K-1 for a calendar year S Corporation is technically due March 15th (the filing due date for the entity) but can file for a six month extension until September 15th. This can delay the receipt of your K-1. The same holds true for partnerships, LLCs estates and trusts which have an original due date of April 15th but can request a five month extension.

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continued from page 27

What do I do if I don’t receive my K-1 by April 15th?

You will have to file an extension to extend the filing deadline for your personal income tax return. Make note that the extension is only to extend the filing, not payment of any income taxes that may be due. You or your tax preparer will have to estimate the K-1 income to determine if there will be a resulting tax liability.

How am I supposed to estimate the K-1 income?

Contact the entity or accounting firm preparing the K-1 to see if they are able to provide any information to assist you in the tax planning. They should be able to give you a projected income or loss. Keep in mind this will be an estimate and not necessarily the actual result that will be reported on your K-1 but will hopefully eliminate any surprises when all is complete.

What does all this information on the K-1 mean?

Certain items from Schedule K-1 flow to other forms and schedules before making their way to page 1 of Form 1040. And the K-1 for partnerships/LLCs and S-Corporations have some slight differences. To keep things simple, we’re going to discuss the more common areas.

Information about the Shareholder

This section reports the shareholders name, social security number or federal identification number, address and ownership percentage. The ownership percentage is used to calculate the income/loss that is allocated to the shareholder.

Information about the Partner

Partnership returns provide more details than the S-Corporation in this section. Similar to the S-Corp, the partner or LLC member’s name, social security number or federal identification number, and address are reported. In addition to this information, the K-1 also provides information on the following:

Type of partner

A general partner is a partner who is personally liable for the partnership debts. A general partner is also commonly a managing partner, which means that this person is active in the day to day operations of the business. Any partner in a general partnership can act on behalf of the entire business without the knowledge or permission of the other partners, therefore all the partners are liable for their decisions. A general partnership is only comprised of general partners.

A limited partner is a partner in a limited partnership and has limited liability of partnership debts to the extent of their contributed capital or investment. A limited partnership is formed under state limited partnership laws and must have at least one general partner who will have unlimited liability. The limited partners do not take an active role in managing the business.

A member of a LLC is an owner of the company and are equivalent to partners in a partnership except they have limited liability for the debts of the business, unless they personally guarantee loans. The roles, obligations and rights of the LLC member is defined in the LLC operating agreement. LLCs can be member managed where all members participate in the decision making process or manager managed where the authority to make decisions is relinquished to a manager of the LLC. The manager can be a member or not. If the operating agreement specifies certain duties and rights to its members and managers, the members can use the operating agreement to impose personal liability on the managers.

Domestic or Foreign partner:

Partners are considered domestic unless they are a nonresident alien individual, foreign partnership, foreign corporation, foreign estate, foreign trust or foreign government.

Entity Type:

Indicates if the partner or LLC member is an individual, corporation, estate or trust, partnership, disregarded entity, foreign government or nominee.

Partners share of profit, loss, and capital:

Represents the partners or LLC members percentage share of the profit, loss and capital of the entity for the beginning and ending of the year.

Partner’s share of liabilities at year end:

Reports each partner or LLC member’s share of the entity’s liabilities.

- Non-recourse liabilities are those for which no partner or member bears the economic risk or loss. These types of loans are usually for property. If the borrower defaults, the issuer can seize the collateral but cannot seek out the borrower for any further compensation even if the collateral does not cover the full amount of the default.

- Qualified non-recourse liabilities are funds borrowed for the purchase or finance of real property and for which no partner or member is personally liable. The debt cannot be convertible and must be from a person who is regularly engaged in the business of lending money such as a bank. This is a special type of debt that allows you to be “at-risk” for income tax purposes even if you are not personally liable which we’ll touch upon later.
• Recourse liabilities are those for which the partner or member are personally liable and bear the economic risk or loss if the debt goes unpaid. In the event of default, the lender can not only confiscate or sell the collateral and property to cover the unpaid balance of the debt but can hold the borrowers responsible for the unpaid portion of the debt.

**Partner's capital account analysis:**
- Beginning capital account: capital balance as of the 1st day of the tax period.
- Capital contributed during the year: cash or other property contributed to the partnership during the tax period.
- Current year increase/decrease: current year profits and losses allocated for the current tax year minus deductions.
- Withdrawals and distributions: cash or FMV of property distributions received during the year.
- Ending capital account: capital balance as of the last day of the tax period. This represents the undistributed balance to the partner.

**Example:**
Partner St. Patty made an initial capital contribution of $50,000 to Lucky Leprechaun, LLC. He was then allocated $45,000 of net profits and received a cash distribution of $30,000. His ending capital balance of $65,000 is calculated as follows:

- **Beginning capital account:** $0
- **Capital contributed during the year:** $50,000
- **Current year increase/decrease:** 45,000
- **Withdrawals & distributions:** (30,000)
- **Ending capital account:** $65,000

**Ordinary business income (loss):** Owner’s allocable ordinary net income or loss from the business.

**Net rental real estate income (loss):** This income item is not included in the net ordinary business income/loss and represents income from rental real estate.

**Other net rental income (loss):** The same as above but is used to report rental income other than real estate.

**Guaranteed payments:** Represent payments made to a partner (or LLC member) to ensure the individual is compensated for certain contributions (service or goods) to the entity. They essentially function as a form of salary and are paid regardless of whether the entity makes a profit. This income is subject to self-employment tax.

**Portfolio Income:** Includes income not derived in the ordinary course of trade or business and includes interest income, ordinary dividends, annuities, royalties, or gain or loss on the sale of property that produces portfolio income. This is reflected in boxes 4 through 8 on the 1120S K-1 and 5 thru 9 on the 1065 K-1.

**Section 179 deduction:** Represents the immediate expense deduction taken for purchases of certain depreciable fixed assets during the year for use in its trade or business or certain rental activities.

**Other deductions and information:**
- **Contributions:** Cash contributed to charitable organization.
- **Investment interest expense:** Interest paid on property held for investment purposes.
- **Medical insurance:** Amounts paid during the year for insurance for you, your spouse and your dependents.
  - For partnerships and LLCs, these are included as guaranteed payments or distributions and deducted on the personal income tax return as self-employed health insurance deduction.
  - For more than 2% shareholders of S-Corps, the premiums should be included in the shareholders wages and reported on their W-2 (but not subject to FICA) and deducted on their personal income tax returns as self-employed health insurance deduction.
- **Pensions and IRAs:** Payments made on your behalf to an IRA, qualified plan and SEP or SIMPLE IRA plan.

**Self-employment earnings (loss):** Amount used to calculate general partner and LLC member self-employment tax; ordinary income plus guaranteed payments.

**Distributions:** Represents the cash received from the entity and may not be reflective of the taxable income. This amount is not taxable and is used in basis calculations for the individual owner.

**Q:** I’ve heard the terms “passive” and “non-passive” income. What does that mean?

**A:** Passive income is received with little or no effort required from you. It’s income from something that you do not actively or materially participate in. Some common examples are rental real estate properties, profits from business that you have little or no day to day role or responsibility or investment income.

Non-passive income is income earned from your direct effort and physical presence. Some examples would be wages, continued on page 30
self-employment income or income from a business that you materially participate in.

I own a business but don't work there every day. Is that considered passive or non-passive?

The IRS considers income as passive unless you materially participate in the income generating activity for which they have multiple tests. Passing any one of them proves your activity is non-passive. For example, you can qualify by participating for more than 500 hours in the year or 100 hours if none of your partners or co-workers put in more time. Note managing the business doesn't count if the business employs another manager to make similar decisions.

What about rental income?

Unless you are a real-estate professional, renting out property is always classified as passive income.

I received distributions that were significantly less than my income. Why am I taxed on the income and not the amount of cash I received?

This is the most common question and concern from our physician practice owners. Pass-through entities report the net income (loss) to its individual owners and the owners pay tax on that income regardless of the cash they received during the year. There are many differences that can result in this difference.

- Capital purchases
- Loan repayments
- Cash reserved for business operations

Quick talk about Basis:

Basis has many components and your Schedule K-1 isn't designed to tell you what you're your basis is. This is something that you or your tax preparer need to calculate year by year. There are three simple rules to keep in mind with regards to basis:

- You can't deduct losses in excess of your basis.
- If you have basis to deduct losses, the basis has to be "at-risk"
- If the basis is "at-risk", losses that are passive might be limited.

Basis begins with your initial investment in your ownership interest. Then it's adjusted as follows:

- Increase by share of all items of income and gain including tax-exempt income.
- Increase by cash or property contributions during the year.
- Decrease by withdrawals and distributions during the year.
- Decrease by share of all items of deduction including section 179, losses and non-deductible expenses (i.e.: meals & entertainment).

Partners, LLC Members and S Corp shareholders all increase their basis in their partnership or S-Corp interest by the cash and property contributed and by their share of income. Basis is decreased by distributions of cash or property and their share of losses.

Partners/LLC Members share of liabilities shown on the K-1 increase their basis. An S Corp shareholder, on the other hand, increases his basis only for loans he personally makes to the S-Corp. Third party loans made to the S-Corp, even if personally guaranteed by the shareholder, do not increase the shareholder's basis.

Tax Alert: Shareholder loans should be in writing, bear an interest rate and have commercial terms to avoid any challenge by the IRS in the event of an audit.

At-Risk:

If a loss is reported on the K-1, they can only be deducted to the extent the partner, LLC member or shareholder is at-risk. Or in simpler terms you're only allowed to deduct losses attributable to borrowed funds if you're on the hook for them. Losses not deductible in the current year are carried over indefinitely until the taxpayer's at-risk amount increases.

For shareholders, the at-risk amount is their basis plus personal loans to the S-Corp. Partners and LLC members will use their basis plus the partnership recourse and qualified non-recourse liabilities.

About the Author:

Jennifer Safeer, CPA, is a senior manager with Withum Smith+Brown, Certified Public Accountants and Consultants. Jenn has over 20 years of professional experience, working closely with physicians and physician group clients. Based in the firm's Toms River office, she can be reached at jsafeer@withum.com.
The professionals at WithumSmith+Brown, PC (WS+B), Certified Public Accountants and Consultants, are knee-deep in 1120s and 1040s right now, but will carve out a little time this busy tax season to help celebrate the firm's 40th anniversary on March 21. Incorporated in 1974, WS+B originally started with six employees in a small Milltown, NJ, office. With now over 500 staff members in 13 offices across six states, there is certainly much to celebrate.

“It has been an incredible journey, being a part of a thriving business that has grown in size and geographic reach over the past 40 years,” says Ivan Brown, CPA, one of the accounting firm’s three founding partners. “We have clients who have been with us since day one, and also have several staff members who have been with us for over 35 years. That is certainly testimony to the fact that we have achieved something special here at WS+B.”

By placing the objective to nurture a client-centric culture as its highest priority, the results have fostered the firm’s own success, having experienced consistent year-over-year revenue growth since its inception, with expected gross income to reach $100 million this fiscal year. WS+B is one of the largest accounting firms in the country, currently ranking #31 nationally and #6 in New Jersey.

“We certainly place client service as our number one priority, providing our clients with the proactive solutions, customized services, and expert advice that they have come to expect for the past four decades,” says Len Smith, CPA, the second of the three founders. “But just as important is our firm’s culture. We want our staff to learn and grow in their careers with us, and also have a little fun, too.” This philosophy has worked, with WS+B being honored annually for the past 10 years as one of the “Best Places to Work in New Jersey” and, for the first time this year, in New York City as well.

With corporate headquarters based in Princeton, NJ, the firm has additional offices in Morristown, New Brunswick, Paramus, Red Bank and Toms River, NJ; Newtown and Philadelphia, PA; New York City, NY; Silver Spring, MD; Aspen, CO; and Orlando and West Palm Beach, FL. WS+B is also a member of HLB International, a worldwide network of independent professional accounting firms and business advisors in over 100 countries.

WS+B has garnered a reputation within the accounting profession and local business communities as an innovative accounting firm, particularly when it comes to its marketing, advertising and social media efforts. Its viral videos such as the Flash Mob video created two years ago to help inaugurate its new New York City office, or the recent series of 40 video shorts celebrating the firm’s anniversary which are released one at a time on Instagram then pushed out to other social media channels, have been a big hit with all generations. WS+B also airs radio ads which sound atypical for an accounting firm, with one in particular spotlighting its culture with light-hearted humor and dance music, asking audiences to visit the firm’s website in order to “experience the Withum Way.”

“Our success and longevity afford us the ability to be a little more creative, to think outside the box, in terms of our marketing strategies,” states Bill Hagaman, CPA, WS+B’s managing partner and CEO. “The branding you see out in the marketplace reflects the heart of our firm, which is our dedicated, talented and loyal staff. One of our favorite mantras is ‘work hard-play hard,’ and our culture certainly lives up to that.”

To honor the milestone date, each of WS+B’s offices hosted its own lunchtime festivities complete with cake, games and contests, enabling the staff to enjoy a quick breather in between tax returns. Other smaller events will be planned throughout the year with the 40-year theme. The firm also shared an email continued on page 32
message of gratitude to its clients the morning of the anniversary, which included a link to a special commemorative video. “To serve our clients is the very reason WithumSmith+Brown exists,” Hagaman explains, “but it’s our staff who make this firm thrive. We look forward to another 40 years of success.”

For more information about WithumSmith+Brown, please visit www.withum.com.

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**Focus on Industry**

**Morristown Technology Expert Carl A. Scalzo Signs Publishing Deal with Celebrity Press for New I.T. Book**

Carl A. Scalzo will team with CelebrityPress, a leading book publishing company, and several leading experts from the technology industry to release the new book, “The Business Owners Guide To I.T. and All Things Digital.”

Carl A. Scalzo, Founder and Chief Executive Officer of Online Computers and Communications, LLC, has joined a select group of leading I.T. experts from across North America to co-write the forthcoming book titled, *The Business Owners Guide To I.T. and All Things Digital: 20 Critical Facts Every Business Must Know To Maximize Their Company’s Efficiency, Security, Employee Productivity And Profits*. Nick Nanton, Esq. along with business partner, JW Dicks, Esq., the leading agents to Celebrity Experts® worldwide, recently signed a publishing deal with each of these authors to contribute their expertise to the book, which will be released under their CelebrityPress™ imprint.

Since founding Online Computers and Communications, LLC in 2012, Carl A. Scalzo has built a dedicated team of over 40 employees in two locations. Carl is responsible for the management, development, and strategic direction of the company’s technology systems and functions, while maintaining a strong, personal relationship with his clients, as well as his business partners and vendors.

Carl has more than 25 years of experience in strategic technology solutions for business and organizations throughout New York and New Jersey, Maryland, and Washington, D.C. CelebrityPress™ describes the book:

> For the past 60 years, the Digital World has been steadily infiltrating our lives. Like all epic changes, digital progress has touched us all. For those following the progress of the Information Age, the Digital World has moved us to a higher level of specialization and efficiency, while simultaneously allowing us a laser-focus on our activities.

> Spearheading the technical backup for Information Technology in the business world are specialists in computer systems and their applications. We highlight the CelebrityExperts® in this book who so diligently contribute to this process. These entrepreneurs develop and adapt computer systems to better organize and run our businesses. They have competed in the marketplace and achieved the success of surviving and thriving in the Digital Era that we enjoy – truly a feat in the competitive world of today.

> You too can readily benefit from these Celebrity-Experts®. These authors share their experiences to help you develop your business and avoid the errors they have made along the way. If you wish to succeed, it is far better to be guided by those that have made a successful trip rather than follow the advice of someone who has only read the map.

The royalties from this project will be given to Entrepreneur’s International Foundation, a not for profit organization dedicated to creating unique launch campaigns to raise money and awareness for charitable causes. The book is scheduled for release on Thursday, May 15th, 2014.

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*continued on page 34*
The Wild West of Data Breach Enforcement by the Feds

by Amy Purcell and Elizabeth Litten

Imagine you have completed your HIPAA risk assessment and implemented a robust privacy and security plan designed to meet each criteria of the Omnibus Rule. You think that, should you suffer a data breach involving protected health information as defined under HIPAA (PHI), you can show the Secretary of the Department of Health and Human Services (HHS) and its Office of Civil Rights (OCR), as well as media reporters and others, that you exercised due diligence and should not be penalized. Your expenditure of time and money will help ensure your compliance with federal law.

Unfortunately, however, HHS is not the only sheriff in town when it comes to data breach enforcement. In a formal administrative action, as well as two separate federal court actions, the Federal Trade Commission (FTC) has been battling LabMD for the past few years in a case that gets more interesting as the filings and rulings mount (In the Matter of LabMD, Inc., Docket No. 9357 before the FTC). LabMD’s CEO Michael Daugherty recently published a book on the dispute with a title analogizing the FTC to the devil, with the byline, “The Shocking Expose of the U.S. Government’s Surveillance and Overreach into Cybersecurity, Medicine, and Small Business.” Daugherty issued a press release in late January attributing the shutdown of operations of LabMD primarily to the FTC’s actions.

Among many other reasons, this case is interesting because of the dual jurisdiction of the FTC and HHS/OCR over breaches that involve individual health information.

On one hand, the HIPAA regulations detail a specific, fact-oriented process for determining whether an impermissible disclosure of PHI constitutes a breach under the law. The pre-Omnibus Rule breach analysis involved consideration of whether the impermissible disclosure posed a “significant risk of financial, reputational, or other harm” to the individual whose PHI was disclosed. The post-Omnibus Rule breach analysis presumes that an impermissible disclosure is a breach, unless a risk assessment that includes consideration of at least four specific factors demonstrates there was a “low probability” that the individual’s PHI was compromised.

In stark contrast to HIPAA, the FTC files enforcement actions based upon its decision that an entity’s data security practices are “unfair”, but it has not promulgated regulations or issued specific guidance as to how or when a determination of “unfairness” is made. Instead, the FTC routinely alleges that entities’ data security practices are “unfair” because they are not “reasonable” – two vague words that leave entities guessing about how to become FTC compliant.

In 2013, in an administrative action, LabMD challenged the FTC’s authority to institute these type of enforcement actions. LabMD argued, in part, that the FTC does not have the authority to bring actions under the “unfairness” prong of Section 5 of the FTC Act. LabMD further argued that there should only be one sheriff in town – not both HHS and the FTC. Not surprisingly, in January 2014, the FTC denied the motion to dismiss, finding that HIPAA requirements are “largely consistent with the data security duties” of the FTC under the FTC Act. The opinion speaks of “data security duties” and “requirements” of the FTC Act, but these “duties” and “requirements” are not spelled out (much less even mentioned) in the FTC Act. As a result, how can anyone arrive at the determination that the standards are consistent? Instead, entities that suffer a data security incident must comply with the detailed analysis under HIPAA, as well as the absence of any clear guidance under the FTC Act.

In a March 10, 2014 ruling, the administrative law judge ruled that he would permit LabMD to depose an FTC designee regarding consumers harmed by LabMD’s allegedly inadequate security practices. However, the judge also ruled that LabMD could not “inquire into why, or how, the factual bases of the allegations … justify the conclusion that [LabMD] violated the FTC Act.” So while the LabMD case may eventually provide some guidance as to the factual circumstances involved in an FTC determination that data security practices are “unfair” and

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have caused, or are likely to cause, consumer harm, the legal reasoning behind the FTC’s determinations is likely to remain a mystery.

In addition to the challenges mounted by LabMD, Wyndham Worldwide Corp., has also spent the past year contesting the FTC’s authority to pursue enforcement actions based upon companies’ alleged “unfair” or “unreasonable” data security practices. On Monday, April 7, 2014, the United States District Court for the District of New Jersey sided with the FTC and denied Wyndham’s motion to dismiss the FTC’s complaint. The Court found that Section 5 of the FTC Act permits the FTC to regulate data security, and that the FTC is not required to issue formal rules about what companies must do to implement “reasonable” data security practices.

These recent victories may cause the “other sheriff” – the FTC – to ramp up its efforts to regulate data security practices. Unfortunately, because it does not appear that the FTC will issue any guidance in the near future about what companies can do to ensure that their data security practices are reasonable, these companies must monitor closely the FTC’s actions, adjudications or other signals in an attempt to predict what the FTC views as data security best practices.

About the authors:
Amy Purcell is an associate in the Philadelphia office of Fox Rothschild LLP. Amy’s practice includes all aspects of commercial and business-related litigation. She represents clients in state and federal courts, as well as in arbitration forums, on a range of matters including those related to contractual disputes, alternative dispute resolution, misappropriation of trade secrets, false advertising. Amy also routinely represents clients in privacy and electronic data security matters on a national level by handling data security investigations and remediation efforts, as well as claims and lawsuits alleging violations of privacy. In that role, Amy assists clients in taking the necessary steps to protect themselves against data breaches, providing counsel concerning company-wide policies and programs to ensure compliance with state and federal laws, and advising clients on how to respond to data security breaches. She was instrumental in the creation of the firm’s Data Breach 411 iPhone app – which serves as a guide to quickly access data breach notifications rules from state to state – and is a frequent contributor to the firm’s Privacy Compliance & Data Security Blog (http://www.foxrothschild.com/blogs/dataSecurity.aspx). Amy can be reached at apurcell@foxrothschild.com.

Elizabeth G. Litten, Esq. is a partner with Fox Rothschild LLP, based in its Princeton, NJ office. As a regulatory attorney concentrating in health law, she provides advice to health care providers, health plans, and a variety of other companies that work in or with the health care industry. She is a frequent speaker on HIPAA compliance matters and a regular contributor to the firm’s HIPAA, HITECH and Health Information Technology blog (http://hipaahealthlaw.foxrothschild.com).

Carl A. Scalzo:
For more than two decades, he has assisted his clients in understanding how information technology can aid in furthering the success of their business. He has a deep understanding of the importance of business continuity, and how to further grow the success of a business or organization strictly through the use of technology.

With significant experience in financial fundraising software Blackbaud CRM, Carl has been responsible for the management of information systems and consulting services for many non-profit organizations. He was intimately involved in five of the largest Blackbaud CRM implementations throughout the country, and has been the Chair of the FTPI conference for the Federation system several times.

Carl is a regular presenter at conferences and trade shows. He has been featured in Newspapers such as The New Jersey Jewish News, and has received mentions in a number of volumes and other publications.

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In a “Legal Advisory” dated October 10, 2013 entitled “Potential Barriers to Hospital Subsidies for Health Insurance for Those in Need” (the “AHA Advisory”), the American Hospital Association (“AHA”) provided an analysis of whether it would be permissible for a hospital to purchase coverage on the federal Health Insurance Marketplace created by Patient Protection and Affordable Care Act or any state-based exchange (referred to in this article as the “Marketplace” or the “Exchange”) on behalf of a patient of the hospital. The AHA Advisory noted that an individual’s share of the cost of a premium might be prohibitive, even with a federal subsidy, and a number of hospitals and health systems had expressed interest in providing subsidies to be used toward the purchase of Exchange plans, rather than simply absorbing costs associated with providing episodic care to uninsured patients unable to pay for their care.

The AHA Advisory raised two potential legal barriers to a hospital’s subsidization or payment of premium for a plan purchased by an individual on an Exchange: the federal anti-kickback statute (“AKS”) and federal tax exemption requirements. With respect to whether the payment of premium would implicate the AKS, the AHA noted that key issues involved whether the agency charged with enforcement of the AKS, the United States Department of Health and Human Services (“HHS”), would view the Exchange itself or a plan offered on the Exchange to be a “federal health care program”; whether either the Exchange itself or services or items covered by an Exchange plan would be viewed by HHS as “services” or “items” that are “purchased” or “ordered” by the patient; and whether factors addressed in past Advisory Opinions issued by the Office of Inspector General (“OIG”) involving hospital subsidization of premiums or patient care arrangements would make it more or less likely that enforcement agencies would prosecute a particular premium payment arrangement.

In a letter dated October 30, 2013 from Kathleen Sebelius, the Secretary of HHS, to U.S. Representative Jim McDermott, Sebelius stated that HHS “does not consider” a plan offered on the Exchange or the Exchange itself to be a “federal health care program” subject to the AKS. She noted that HHS and OIG nonetheless have authority to oversee Exchange activities, and that additional “federal and state criminal or civil authorities” would apply to certain Exchange-related conduct.

On November 3, 2013, the Centers for Medicare & Medicaid Services (“CMS”) within HHS released a memo with the subject line “Third Party Payments of Premiums for Qualified Health Plans in the Marketplaces.” This memo states that “hospitals, other healthcare providers, and other commercial entities may be considering supporting premium payments and cost-sharing obligations with respect to qualified health plans purchased by patients” on the Exchange. The memo does not purport to prohibit the practice, but states that “hospitals, other healthcare providers, and other commercial entities may be considering supporting premium payments and cost-sharing obligations with respect to qualified health plans purchased by patients” on the Exchange. The memo concludes: “HHS discourages this practice and encourages issuers to reject such third party payments. HHS intends to monitor this practice and to take appropriate action, if necessary.” The memo does not indicate what type of “appropriate action” HHS might take.

In an interim final rule published on March 19, 2014 (“Interim Rule”), HHS makes a specific exception to its general discouragement of Exchange plan issuers’ acceptance of third-
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Footnotes
2Public Law 111-148, as amended by the Health Care and Education Reconciliation Act, Public Law 111-152 (collectively, PPACA)
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<td>Winter Issue—January/February</td>
<td>December 15</td>
<td>Hospital Resolutions and Trends in the New Year; Medicaid Primary Care Reimbursement.</td>
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<td>Spring Issue—March/April</td>
<td>February 15</td>
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