collaboration /kəˌlabəˈrāshən/ Noun
1. The action of working with someone to produce or create something.
2. Something produced or created in this way.

- Pharmacy Benefit Savings Through Innovation and Collaboration
  see page 7
- Demand Side Management: Options in the Quest for Energy Efficiency
  see page 17
Scott Mariani, Partner and healthcare industry expert, knows how critical it is for hospitals and healthcare delivery systems to implement the right strategies for financial survival. His healthcare clients trust his advice and guidance, enabling them to focus on what matters most — providing quality patient care. Whether with tax, audit or consulting, helping his clients avoid fiscal trauma is Scott’s specialty.

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

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The President’s View . . .

Wow, it’s hard to believe this HFMA year and my term as President is coming to an end! Our Chapter leadership has surely “Stepped Up”. At our Leadership Retreat last June, our team, (which consisted of the Board and all Committee Chairs & Co-Chairs, and Laura Hess of course, 40 attended) came up with 4 areas to work on improving during the year:

Certification & Education programs
Future Leaders / Social Networking
Vendor Events
Member Recognition

Well, in these tough economic times, we were able to complete 3 out of 4 of these goals. Under the leadership of our Program Chair, Tracy Davison-DiCanto, the Education Committee created a subcommittee for Certification, led by Lindsey Colombo, to concentrate on a new education series to help members obtain their certification. This year we had over 50 attend, and 17 passed exams! Our Education hours increase by more than 1,200 hours or 7% thanks to the Committee Chairs & Co-Chairs and their members! Our Annual Institute in October had 2.5 days of education, with close to 500 attendees.

Our other new committee, Managed Care, has been a great success with executives from the payer and provider community collaborating together to improve health care processes. They had multiple roundtable discussions, and featured speakers from Horizon BCBS, Aetna and Qualicare presenting on ACO’s and Garfunkel Wild & Travis, P.C. and Aetna presenting on Out-of-Network issues. Their focus was “to create a constructive, open venue for honest discussions of relevant managed care issues, at a high level…” and thanks to Elizabeth Jennings and Joe Privitera they are accomplishing just that!

Mike Ruiz de Somocurcio “Stepped Up” and established our new Sponsorship Committee, to ensure we identify ways to recognize and provide value to our sponsors. I personally thank all of our sponsors for their continued support of our chapter, and encourage them to participate in this committee.

With the help of Mike Alwell, the Board approved a new policy for Member Recognition, which allows us to give back to our volunteers. For members who achieve awards for exceptional service, significantly contribute to the chapter winning a Yerger, achieve certification or earn any HFMA National Founders Awards, they will be given passes to our Annual Institute. See the article in this issue of FOCUS for more detail. The Board of Directors may now attend all Quarterly Education Sessions for free. Member satisfaction survey for the last 4 years went from 58% to 69% and now 71%. The Board is continuing to look for ways to give back to our members who “Step Up”!

As far as Future Leaders and Social Networking, we are still working on that one, although John Manzi and Dotti Lindstrom brought John Brault and Tracy Davison-DiCanto onto our Board as “Future Leaders/Associate Board Members” 5 & 6 years ago, and now they are both Officers, so I guess we are doing something right! The generational energy and ideas are raising the bar each year! The Membership Services & Networking committee had several events this year, combining education, membership opportunities with golf & bowling! Congratulations to all of them.

I encourage all of you to renew your membership today, take advantage of the benefits HFMA and the New Jersey Chapter have to offer. Continued education programs, learn and share best practices, networking opportunities, personal and professional growth! Get involved, you’ll soon have good friends for life!

I humbly thank the Officers, Mike Alwell, John Brault and Dave Weissel, all the Board Directors, NJHA and all the Committee Chairs, Co-Chairs and members for their ongoing spirit, support and for Stepping Up to make the New Jersey Chapter the best! Finally, we are fortunate to have Laura Hess on our team; she keeps us on a path to continued success.

I wish Mike Alwell, our incoming President, and his team continued success. The National Chair’s theme, (Greg Adams from NJ of course!) is “Believe to Achieve”, appropriate in this healthcare environment, do more with less! This year we not only have Greg at the National HFMA level, but also Cheryl Cohen as Regional Executive, Joe Dobosh & Sean Hopkins on the National Advisory Council (NAC), Rick Parker on the CAT team, Jeff Schaub and Stella Visaggio on the Principles and Practices Board; New Jersey is making a difference!

Respectfully,
Mary T. Taylor, MBA, FHFMA

Hot off the press and just in time: This year the New Jersey Chapter will receive the following awards:
The Robert M. Shelton Award for Sustained Excellence over 5 years (see the letter from the editor and on page 46 of this issue for the history of this prestigious award)
C. Henry Hottum Award for Educational Performance Improvement
John M. Stagl Silver Award for Excellence for Education
Bronze Award of Excellence for Membership Growth and Retention
Gold Award for Excellence for Certification
Helen M. Yerger Special Recognition Awards (4) for Individual Chapter
Helen M. Yerger Special Recognition Award for Multi-Chapter w/ Metro Philadelphia
Dear Readers:

The New Jersey health care world is surprisingly interconnected and talented. I am frequently surprised and delighted by the number of NJ HFMA members whose paths intersect mine and whose ideas and actions pave new paths. The late Robert M. Shelton, FHFMA, the very first New Jersey Chapter President back in 1955, was one of those people. A few of you may recall the *FOCUS* magazine article entitled “Flashback of 50 Years” published in April of 2000 written by Robert Shelton. He wrote about having been hired as Chief Accountant at Mercer Hospital in Trenton, New Jersey in August of 1949. His predecessor at the hospital was H. Burtis Skellenger, one of the 283 charter members of the American Association of Hospital Accountants. Before working at Mercer Hospital, Robert was assistant director of Opinion Research Corp. in Princeton and often passed Albert Einstein walking to work.

Fast forward eleven years and a month from April of 2000: a group email is circulated from Chapter President Mary Taylor that reads:

*WOW - I just received a phone call from our National Chair, Debora Kuchka-Craig! The HFMA committee met on the 25th, looked at all the data nationwide, and New Jersey has shown 5 Years of Sustained Excellence in service to members!*

*We are getting the Robert M. Shelton Award!! New Jersey is the only chapter receiving this award!! This is a great honor!*  

*Congratulations to everyone. Over the last 5 years, all committee chairs/co-chairs and members have truly shown just how great New Jersey is! The last 5 National themes, and New Jersey Presidents were:*

- **StepUp**
  - Mary Taylor, President
- **Making it Count**
  - Brian Sherin, President
- **Making Connections**
  - Joe Dobosh, President
- **Make a Difference**
  - Cheryl Cohen, President
- **Courage in Leadership**
  - Dotti Lindstrom, President

*We will receive the award at the HFMA ANI, June 26-29, 2011 in Florida.*

Congratulations, Mary, and thank you for your dedication this past year. Thank you, also, to our past Presidents, committee chairs, members, article contributors, path forgers, and thinkers. The Chapter’s success has been, and will continue to be, a true team effort.

Regards,

Elizabeth G. Litten  
Editor
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Pharmacy Benefit Savings Through Innovation and Collaboration

by Dexter Shurney, MD

ORGANIZATION
Vanderbilt University is a private research university and medical center with more than 41,000 members located in Nashville, Tennessee.

CHALLENGE
The University wanted a better handle on how its money was being spent and why certain drugs were included on the formulary used by its pharmacy benefit management (PBM) firm. In addition, the University sought the flexibility to customize its drug formulary and to self-direct its pharmacy benefits program to any extent desired. This self-directed model would afford the University more flexibility and decision-making authority with its pharmacy benefits program, provide transparent knowledge of the PBM’s pricing and revenue streams, and ultimately achieve added savings.

The University wanted to control its pharmacy benefit plan destiny, instead of the PBM determining how, and to what extent, savings were achieved.

In order to move in this direction, a key decision point was the selection of the appropriate PBM partner.

SOLUTION
The University employed a national consulting firm to solicit proposals from PBM firms to provide a prescription benefit program. The request for proposal targeted specific objectives, such as:

- Improve employee satisfaction
- Provide full pricing and revenue stream transparency
- Provide full pass-through pricing
- Retain no other revenue stream than a per member per month administrative fee
- Retain zero pharmacy network spread
- Support University-owned pharmacies
- Allow the University to self-direct its pharmacy benefit program
- Develop a collaborative business partnership with its PBM

As a result of this extensive process, the University selected Navitus Health Solutions as its new PBM and implemented its program on January 1, 2010.

The University, in collaboration with its new PBM, targeted a clinical and formulary strategy specific to its member population and promoted its in-house pharmacies, utilizing the following innovative solutions:

- **Direct Formulary Drug Product Selection.** Leveraging its extensive pharmaceutical expertise from its medical center and in-house pharmacies allows the University to drive formulary decisions, customize the formulary to its needs and garner more savings through formulary management.

- **Optimizing Affiliated Pharmacies.** The flexibility to use the University’s own pharmacies for retail, mail and specialty prescriptions with its self-insured health plan allows enhanced pricing and savings for the University and its members. Optimizing in-house pharmacy use is accomplished through plan designs that encourage members to use these pharmacies.

The University is fortunate to have access to pharmaceutical expertise—from medical centers and in-house pharmacies—that strengthen its ability to drive formulary decisions and customize its own formulary. This level of support enables it to leverage the expertise of its clinical staff and essentially develop its own, PBM-supported Formulary Committee. The University achieved control of its formulary by using the following approach:

1. The PBM’s Pharmacy & Therapeutics (P&T) Committee meets quarterly. The University’s Health Plan Medical Director participates in these meetings and experiences the due diligence that is involved with each formulary decision.

2. A team of clinical and other PBM staff compile and summarize the decisions made during the PBM’s P&T Committee meeting and customize the recommendations to the University.

continued on page 8
3. The University’s Formulary Review Committee meets. Chaired by the Medical Director, this Committee consists of three physicians, three pharmacists and two administrators from the University. The PBM summarizes items discussed and actions taken during its P&T Committee and answers any questions raised. The Committee reviews all of the PBM formulary decisions and considers the health, efficacy and economic ramifications specifically for the University.

4. The University’s Formulary Review Committee decides which formulary decisions to implement. With this scenario, the University and its PBM are able to make cost projections and recommend which drugs to discontinue, saving the University money.

An example of the University’s Formulary Review Committee in action is its decision in late 2010 to remove Nexium from its formulary. The Committee used the approach above and determined that there were lower-cost alternatives to Nexium that matched it in therapeutic value and effectiveness. The University thus communicated the change to providers and members, providing a 90-day window during which members could make the transition from Nexium to a covered alternative. This change provides cost savings for the University and its employees.

With this new approach, the University customized its formulary to its unique needs, leveraging the expertise of its staff and the PBM. It is assured first-hand that the make-up of the formulary has its best interests at heart.

In addition, the University’s chosen PBM does not have a vested interest in owning network pharmacy business and is able to assist the University in driving members to its own in-house pharmacies. This was not the case with its former PBM, because they were aligned with a pharmacy chain and sought to promote those pharmacies. The University optimized the use of its in-house pharmacies by:

- Implementing a tiered plan design. Copays for all levels of drugs are lower at in-house pharmacies, offering members a financial incentive to visit those pharmacies.
- Selecting a list of generic medications that are available for $1 a month and $3 for three months. These discounted copays are available only at in-house pharmacies. This program helped the University increase its generic utilization over 2008 by 9.2 percent (from 62.7 percent to 71.9 percent).

The Power to Connect

Balancing costs, care and operations

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• Utilizing the University’s affiliated pharmacies to provide mail order services and fill specialty prescriptions
• Customizing the member welcome letters and benefits booklet to communicate the above plan design

The University utilizes a variety of means to encourage members to visit in-house pharmacies and use generic drugs.

RESULTS
Through its new PBM partnership, the University now has ultimate control of its pharmacy benefits program. The University has achieved extraordinary savings using the benefit management strategy co-developed with its PBM. Cost savings to both the plan and its membership have been significant—without compromising patient care—as outlined below:
• 5.7 percent decrease in drug spend over 2008, or $2.3 million in savings. When trended, this decrease rolled the University’s drug spend back to 2007 costs.
• 18.2 percent decrease in member costs over 2008, or approximately $1.7 million in savings

The flexibility to make custom formulary changes that promote cost savings and make sense for the University, as well as the existence of the University’s Formulary Review Committee, have been a welcome change for staff. Everyone is on board with the new process. All parties involved understand the reasons for formulary placement and tiering of certain drugs. The University’s Formulary Review Committee is made aware of all activities that occur in the PBM’s P&T Committee and is provided explanation, if needed.

In addition, driving use of its own pharmacies for retail, mail and specialty prescriptions allows for enhanced pricing and savings for the University. The increased use of these pharmacies helps lower costs through deeper discounts and use of generic alternatives. Promoting use of University pharmacies through plan design encourages participants to use these pharmacies and contributes toward additional member cost savings. In addition, members can visit pharmacies close to their work locations, adding to the convenience of filling prescriptions.

Vanderbilt University now directs its own pharmacy benefit destiny. The transparent, full pass-through PBM business model has enabled the University to control its pharmacy benefit plan at any level desired and to achieve remarkable savings. The University has experienced negative trend, a decrease in drug spend and member costs, and an increase in generic utilization. These outcomes provide a true example of savings through collaboration and innovation.

About the author
Dr. Dexter Shurney, MD, MBA, MPH is the Medical Director for the Employee Health Plan for Vanderbilt University and Medical Center and also holds a faculty appointment as Assistant Professor Vanderbilt School of Medicine, Division of Internal Medicine and Public Health. He has an extensive background in health care management and policy and has distinguished himself as a leader in his profession in numerous ways. In addition to serving on several boards, Dr. Shurney was named to Chair Tennessee Gov. Phil Bredesen’s Diabetes Prevention and Health Improvement Board in 2007. He also serves as the Executive Director for the National Association of Managed Care Physicians Center on Preventive Health. Dr. Shurney is board-certified in general preventive medicine and public health.

•People Watching•

Congratulations to our very own Tony Consoli for his participation in the 15th Annual Jersey Shore Relay Marathon! Tony and his team raised over $2300 for the Special Olympics.

Following is Tony’s description of the event:
OK, I am sure you’re all wondering how our group of 5 “older” and slightly out of shape gentlemen did. The final results show that we finished at 3:54:09 in 228th place! Not world record stuff but, to keep everything in perspective, take a look at my crew in the picture. We beat our goal (under 4 hours) but did not count on the weather. Very cold, rainy and mostly running on boardwalks from Seaside Heights to Asbury Park - i.e. completely exposed to the winds coming off the ocean. I ran my segment between Sea Girt and Belmar dead into a 30+ mile per hour head wind - lots of fun! 6.2 miles in 42 minutes. I’m still in pain. The beer at the end was worth it - not a great training technique but definitely needed!

Congratulations again to Tony and his team!
Do patients, providers and health plans share common goals for the health care system? Do some of these goals represent the noblest aspirations of the Healing Professions that transcend other goals? If we all agree, at least in principle, that one primary goal for the health care system is to deliver the highest quality health care in the most efficient and appropriate manner – then we certainly have more interests in confluence than in conflict. We, therefore, should be able to focus on the best method of achieving this goal, and use this plan of action to minimize areas of conflict.

My Aetna colleagues and I not only think this is possible – we are already working with key provider groups across the country to jointly achieve these goals.

Aetna Medicare has been building care management capability for several years, and now provides dedicated care management to more than 18 percent of our Medicare members, including leading programs in care of advanced or terminal illness (e.g., the Aetna Compassionate CareSM program) (Krakauer, R, Spettell, C, Reisman, L, Wade, M: “Opportunities to improve the Quality of Care for Advanced Illness: An Aetna pilot program shows how it can be done”, Health Affairs, 2009; 28(5):1357-59). The Compassionate Care program was designed to provide support to members with advanced illness and to their families, and to help patients access optimal care. At the same time, the program has resulted in a reduction in acute care and other utilization, exclusive of denials, sufficient to be a major contributor to the success of our Medicare Advantage program. While this program and our other care management activities have proved beneficial to our members, we knew that these efforts would be more effective delivered in collaboration with physicians and other providers.

In 2007, we began working with certain provider groups to help improve the quality of care delivered to their patients/our Medicare members. We agreed to provide payment to provider groups that demonstrated improvement in the quality of care they delivered to the group Medicare members diagnosed with chronic illnesses. We also agreed mutually on quality measurements, including accepted process measures, that were compared to Aetna’s own managed level for the market. In addition, we provided dedicated Aetna case managers to some provider groups. These Aetna case managers work solely with one provider group and, preferably, were embedded on-site in the provider group’s offices. These dedicated Aetna case managers work more directly with the provider group’s physicians and staff, using information in Aetna’s systems to deliver care management services. For example, these dedicated Aetna case managers have access to “Care Considerations,” which indicate potential gaps in care determined by analysis of claims and other data by ActiveHealth Management’s CareEngine technology (ActiveHealth is an independent subsidiary of Aetna).

These Aetna case managers worked closely with the provider groups and they were dedicated to our mutual goals of improving the quality of care delivered to our Medicare members. This dedicated care management arrangement changed the nature of our relationship with the involved provider groups to that of true collaboration.

After nearly four years, we now have 47 such arrangements with provider groups, and some of these provider groups are located in the state of New Jersey. Collectively, those provider groups that have had sufficient membership for at least one year are showing an average of 10 percent fewer acute days (exclusive of denials) than our extant levels for their respective regions – levels already significantly below unmanaged Medicare. In addition, those provider groups that have met quality targets have received additional payments to reflect the work completed to improve the quality of care. Indeed, some of our longest standing and best performing provider groups show more than 50 percent fewer acute days than unmanaged Medicare for their region, as reported in a publication of the Commonwealth Fund (Hostetter, M: “Case Study: Aetna’s Embedded Case Managers seek to Strengthen Primary Care, Quality Matters”, August/September 2010, pp. 6-10).
Essentially, these provider groups represent a structure very similar to Accountable Care Organizations (ACOs) and are already in operation and producing good results – in some cases better than many might have thought possible. Aetna supports federal efforts to further the development of ACOs, and we believe that a successful federal ACO strategy would:

• reward providers that improve quality by assuring patients receive fully coordinated care in both inpatient and outpatient settings and improve patient adherence to treatment plans and prescription drug regimens;

• assure ACOs improve the efficiency of care while consistently meeting quality measures; and

• empower the participation of a wide variety of health care providers across both fee-for-service and Medicare Advantage models.

As federal regulations around ACOs are finalized, we will continue to aggressively seek to grow our already successful program in our Medicare Advantage product to the benefit or our provider partners, Aetna, and most importantly, our Medicare members/patients.

continued on page 23

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From ACA to ZPIC …
A Sampling of Audit Alphabet Soup

by Mary Ditri, Theresa Edelstein, MPH, LNHA, and Roger Sarao, CHFP, MPA

With an increased number of government contractors actively engaged to identify improper payment of Medicare and Medicaid dollars, providers are challenged with managing the maze of requirements and audits facing them. The alphabet soup of MICs and MIPs, PERMs and RACs can be overwhelming to an organization. The sampling of questions that follow will be sure to have you craving more.

• Does the Patient Protection and Affordable Care Act (ACA) have anything to do with Medicaid in New Jersey?

Yes! The ACA required the expansion of the Recovery Audit Contractor (RAC) Program to Medicaid, effective December 31, 2010. It amends Section 1902(a)(42) of the Social Security Act requiring states to establish programs to contract with Recovery Audit Contractors to audit payments to Medicaid providers. New Jersey has selected HMS as its Medicaid RAC and has submitted a state plan amendment to the Centers for Medicare and Medicaid Services Regional Office. CMS has delayed a publication date of the final rules and effective date. As of the date of this writing, no new date has been announced.

• What is the MIP?

The MIP is the Medicaid Integrity Program and is the federally contracted audit program under which Medicaid Integrity Contractors (MICs) operate.

• I've heard IPRO referred to as a MIC. How does that differ from a MIP?

In 2009, IPRO was awarded a Medicaid Integrity Program (MIP) Task Order by CMS, charged with auditing Medicaid claims to identify potential overpayments. As a Medicaid Integrity audit contractor (MIC), IPRO will perform Medicaid audits for CMS Regions I and II. New Jersey is a part of Region II, along with New York, Puerto Rico and the Virgin Islands. The first wave of MIP audits began in New Jersey in April 2010. Additional audit letters have been sent every few months since, with the most recent round occurring in April. To date, more than 20 New Jersey providers have been audited under the MIP. The focus has been primarily on acute care hospitals, however at least two psychiatric hospitals have been audited at the time of this writing. Resources are available at http://www.cms.gov/MedicaidIntegrityProgram.

• What else do MICs do?

There are three types of MICs – Audit, Review and Education – in each of five jurisdictions throughout the country. Generally, Audit MICs ensure that paid claims were for services provided and properly documented; for services billed properly, using correct and appropriate procedure codes; for covered services; and paid according to federal and state laws, regulations and policies. Audits will identify overpayments and are conducted post-payment for fee-for-service, cost reporting and managed care. Review MICs help identify high-risk areas and potential vulnerabilities, while providing leads to audit MICs based on their findings. And finally, Education MICs use the findings from the other two MICs to identify areas for education.

• We were asked for an FD-197 on our claims – what is that?

On the books since 1997, the Patient Certification Regulation (10:49-9.9 – Patient’s (beneficiary certification) has

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required providers to keep a beneficiary certification form on file (the “FD-197” form) in case the state requested it as part of an audit. The form requires all providers to obtain the signature of the Medicaid patient for all services rendered, after the services have been provided but before the claim is submitted for payment. In general terms, the individual is authorizing the release of information and payment request based on the fact that the service(s) covered by a claim has/have been received, requesting payment for those services made on his or her behalf and authorizing any holder of medical or other information to release to New Jersey Medicaid or New Jersey FamilyCare any information needed for the claim or any related claim. If a signed form was not on file for each service, the reimbursement was subject to recoupment. Although Medicaid never asked a provider to supply this form as part of any audit, IPRO was asking for it as part of required documentation for the MIP audits. Because most providers were not familiar with the regulation and could not supply the form, a significant number of claims were at risk for being denied.

- Are providers still required to provide the completed FD-197 as part of the MIP audit process?

The New Jersey Hospital Association engaged in a robust advocacy effort with state and federal officials to remove the requirement. In March, CMS announced that it was no longer requiring IPRO to have New Jersey hospitals provide a completed FD-197 form as part of the MIP audit process. The change applied to ongoing as well as subsequent audits, although the state regulations do still require hospitals to complete the forms. The Division of Medical Assistance and Health Services (DMAHS) is reviewing this regulatory requirement.

- How do I know if my organization is subject to an audit?

Any Medicaid provider may be audited, including fee-for-service providers, institutional and non-institutional, as well as managed care entities. CMS works to ensure that audits are not duplicative and they will not interfere with other law enforcement investigations.

- What is PERM?

PERM stands for Payment Error Rate Measure. Established by the Improper Payments Information Act of 2002; Public Law 107-300, CMS uses a 17-state rotation, with each group reviewed once every three years, evaluating a per-state sample of 500 fee-for-service claims pulled from all claims paid. New Jersey was in the FY2010 rotation. For that measurement, New Jersey providers were
reviewed for the time period of Oct. 1, 2009 through Sept. 30, 2010. Only organizations that provided services for the sample of claims pulled were contacted. They had 60 days to submit the requested record, with reminder phone calls and written requests received during that timeframe. Additional information is available at www.cms.hhs.gov/PERM/.

• **What is the difference between Utilization, DRG Validation and Quality-of-Care Reviews?**

Permedion, An HMS Company, is conducting utilization and quality of care reviews as well as Diagnosis Related Group (DRG) validation of inpatient hospital medical services provided and billed for Medicaid fee-for-service beneficiaries. **Utilization reviews** are conducted through both retrospective and concurrent medical record review of hospital discharges. Services are evaluated for medical necessity and correct billing. **DRG reviews** look at the coding of diagnoses and procedures along with other medical record information to assure accurate payment to the hospital. Readmissions to the same hospital within seven days is assessed to determine whether the two stays should be combined or whether there were any quality of care issues that caused the readmission. **Quality-of-Care reviews** are performed of the medical record to determine if standards of care were met and whether there were any hospital-acquired conditions.

• **Do the Recovery Audit Contractor programs apply to Medicare only?**

Initially, the permanent Recovery Audit Contractor program which began in 2009 only applied to Medicare. As mentioned earlier, the RAC program will expand to Medicaid in the near future. Under the Medicare RAC Program, the contractors detect incorrect fee-for-service payments by Medicare so that actions can be taken to recoup funds and proactively prevent future improper payments. The RAC for Region A, which includes New Jersey, is Diversified Collection Services, Inc. Additional information is available at www.cms.hhs.gov/rac.

• **I understand ZPICs replaced PSCs – is that true?**

Yes - the Zone Program Integrity Contractors (ZPICs) were put in place to replace the Program Safety Contractors (PSCs). Under the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), CMS was required to take a number of steps intended to streamline the claims processing and review process. Seven ZPIC zones were created to target high risk areas or “hot spots” for fraud and to focus on fraud detection, deterrence and prevention. Contractors are responsible for investigation, case development, administrative solutions and referral to law enforcement. ZPICs work with the Medicare Audit Contractors and Fiscal Intermediaries to recoup payments.

Stir in this “soup” reviews by the Medicaid Fraud Division, Office of Medicaid Inspector General – Office of the State Comptroller, the U.S. Attorney’s office unit for healthcare and government fraud, along with the federal Office of the Inspector General (OIG), and you have a recipe that calls for attention to detail.

So what is the bottom line? As providers are served a hefty ladle of Audit Alphabet Soup, it calls for clear, effective processes to remain compliant, prepare for the audit process and manage the day-to-day interactions with all the government auditing agencies involved.

**About the authors**

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Demand Side Management: Options in the Quest for Energy Efficiency

by Michael Fischette

New Jersey Hospitals in Peril

The crisis gripping New Jersey’s hospitals is no secret. In fact, the problem is identified simply by one overriding factor: Hospitals face ever-growing demands in caring for patients, and their revenues can’t keep pace. Specifically, Medicare and Medicaid have put hospitals on life support. Together they make up nearly half of all hospital revenues in New Jersey, dictating payments that fail to cover costs. The Kaiser Family Foundation, a national foundation committed to sound health policy, ranks New Jersey 50th (second lowest in the nation) in terms of healthcare expenditures to hospitals. Caring for the uninsured and underinsured is another challenge. Recently, hospitals spent more than $1.3 billion treating these needy patients, and only received $715 million back from the state. So it’s not a surprise that Standard & Poor’s has downgraded the credit rating of many New Jersey hospitals and predicts the state will experience additional hospital closures due to its harsh marketplace.

This financial crunch comes at a time when hospitals must also plan on future investments in infrastructure. “Hospitals are struggling right now. Many are just above the break-even point and a third of New Jersey’s hospitals are in the red,” said Sean Hopkins, senior vice president for health economics at the New Jersey Hospital Association. “Healthcare reform is coming down the pike and the state budget is as tight as it can be. Anything that continues to erode hospital balance sheets and diminish cash reserves will not help.”

Redesigning Energy Usage

With the momentum for Energy Efficiency (EE) mounting, saving energy, or generating “megawatts”, is cheaper and cleaner than consuming megawatts. EE is about using fewer energy sources to obtain the same services. This is a about aging infrastructure, it’s not about doing with less (i.e. shutting lights off when you leave the room). The real savings comes from replacing inefficient equipment with new state of the art equipment. However, the greenest energy is the energy not used in the first place. Reducing energy consumption - or the demand for energy - reduces the total amount of required power generation capacity and the corresponding carbon and other harmful greenhouse gas emissions it produces.

Hospitals account for 4% of all energy consumed in the US and can achieve a 60% reduction in energy utility use by redesigning the way they use energy. This translates into savings of about $730,000 annually for a newly constructed, code-compliant hospital, according to a study released at the CleanMed conference. It can also prevent approximately 7,800 tons of carbon emissions per year. These strategies include heat recovery, high efficiency lighting, daylighting, in-room environment tempering, vacancy air control, combined heat & power and thermal energy storage. The study finds that this approach can be implemented for less than 3% of the total project’s cost, which is expected to be recouped through energy savings and utility incentives within the first 5 to 8 years of a building’s life.

Not unexpectedly, power generation systems and transportation also remain prime markets for EE investments. Systems that utilize the excess heat generated by power plants (combined heat and power systems) promise an annual potential market size greater than $50 billion per year, while the potential for recycled energy development exceeds $100 billion per year.

Trends in Demand Side Management

In the US, experts estimate that EE investments can save between $170 billion and $932 billion per year in energy expenses right now, rising to a savings of $900 billion by 2020 and $3.9 trillion by 2030. By 2020, EE savings could total $1.2 trillion based on an investment of $520 billion through 2020. This would effectively eliminate about 23% of projected energy consumption as compared to any “business as usual” scenario.

Demand Side Management (DSM) strategies take advantage of opportunities to increase the efficiency of energy service delivery. Currently, these opportunities are not being fully taken advantage of in the marketplace. DSM includes conservation programs that target reducing energy use and improving the efficiency of equipment, buildings and industrial processes. DSM also includes load management programs that redistribute energy demand to spread it more
evenly throughout the day. By tracking electricity consumption effectively, facilities are able to identify and react to obvious inefficiencies.

The benefits of DSM are both endless and priceless. DSM has both economic and environmental advantages:

- Reduces customer energy bills
- Stimulates economic development
- Creates long-term jobs that benefit the economy
- Increases the competitiveness of local enterprises
- Can reduce maintenance and equipment replacement costs
- Reduces local air pollution
- Reduces emissions that contribute global environmental problems
- Enhances national security by easing dependence on foreign energy sources
- Can increase the comfort and quality of work spaces, increasing worker productivity
- Can create market transformations with long-term results.

### Financing Efficiency

Unfortunately, the institutional market is currently capital-constrained and unable to afford even high-return efficiency investments, let alone basic capital improvements. It is these entities, who lack their own capital equipment budget, that particularly need outside financing.

The current economic environment obviously contributes to the hospital sector’s reluctance to address infrastructure improvements. Probably the most successful EE program in the state is PSE&G’s Carbon Abatement program which has provided funding to some New Jersey hospitals for purposes of reducing energy consumption. Currently, PSE&G has funded 20 EE projects at hospitals, with another 23 facilities on a waiting list. This program is so successful in part because of the overwhelming need and also due to the program’s design, which is to combine a grant and zero-interest loan to implement the energy efficient projects. We can only hope to see more programs like this.

Our firm has participated in many of these projects with first-hand knowledge of the successes. Initially, customers receive an investment grade audit of their hospital campus. The audit results will determine the potential savings derived through a variety of measures and technologies: HVAC, humidification, building envelope, motors, lighting and other energy consuming equipment. The measures identified by the audit with a simple payback of 15 years or less will be targeted for retrofit opportunities. Projects with a 15-year payback will receive an incentive to reduce payback to 8 years. Projects with a payback of 5 years will receive an incentive that will reduce the payback to 2 years. PSE&G will pay the total cost of the measures upon completion of the project and successful completion of a final inspection. Customers will repay their share over a three-year period on their PSE&G bill.

Additionally, Energy Performance Contracting is a collective solution that looks to make use of this wasted money and adds a financial element that enables hospitals to upgrade their buildings with modern, reliable and energy efficient technologies without the need for up-front capital. Improvements, upgrades or retrofit work are funded by the projected energy savings which can be guaranteed by the Energy Services Company (ESCO) installing them. The key benefit of Energy Performance Contracting is that if the ESCO doesn’t deliver on the required savings, they pay the difference and if they exceed the target saving, the customer takes the surplus. This means that all operational and financial risk is transferred to the ESCO. It’s an innovative solution that ensures that while energy targets are delivered, the building owner’s funding and risk issues are overcome. But more than a funding model, it is a program that includes practical, engineered EE measures that are implemented in buildings to deliver real energy savings. ESCOs have been instrumental in reducing utility expenses of up to 30% for their customers.

### Hospitals account for 4% of all energy consumed in the US and can achieve a 60% reduction in energy utility use by redesigning the way they use energy.

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### Third-Party Ownership & Selling Assets

Early in 2012, the University Medical Center of Princeton is due to be replaced by a $447 million new state-of-the-art facility, the University Medical Center of Princeton at Plainsboro (UMCPP), located just 2.5 miles from the center of Princeton. Designed by a team of internationally renowned architects and consultants, the new 636,000 square foot hospital will incorporate the latest green building technologies.

Among its green features is an efficient on-site central energy plant that has the capacity to supply the facility with 100 percent of its heating, cooling and power. The project was developed by an independently-owned energy company (“the company”) that will also own, operate and maintain the plant. The planning and construction of this plan and construction of this plant created an innovative model for securing financial support and operating campus energy systems that can be replicated on similar projects throughout the country.

To accomplish this, the company decided to outsource the financing, design, construction, ownership, operation and
maintenance of its energy operations. After careful review and assessment, it was determined that the new hospital would benefit from a combined cooling, heating and power (CCHP) plant that supplies electricity while producing steam for heating and sterilization, and chilled water for air conditioning. A long term energy services agreement established that the company would provide electric and thermal energy to the hospital through a collateralized investment. This forward-thinking outsourcing decision freed up capital that would otherwise be required to finance the energy plant. The additional capital would allow the hospital to invest in what it knows best: delivering exceptional health care services. Primarily it allowed the hospital to concentrate on what it does best: healthcare.

Alternative funding was a key component of the project’s economics that made it feasible. A significant grant from PSE&G provided funding directly to Princeton Health Care System (PHCS) for EE upgrades for the new central plant and hospital HVAC systems. The project also received commitments for a $1.9 million Clean Energy Solutions American Recovery and Reinvestment Act Combined Heat and Power Program grant administered by the New Jersey Board of Public Utilities and the New Jersey Economic Development Authority (NJEDA), a $3 million Clean Energy Solutions Capital Investment (CESCI) Fund no-interest direct loan and a $2 million CESCI grant from the NJEDA. The CCHP plant will have an estimated payback of less than five years with annual savings of hundreds of thousands of dollars.

The environmental benefits of the plant are equally substantial, eliminating 18.1 million lb of annual carbon emissions. The CCHP is 70 to 73 percent efficient versus 30 to 35 percent from a traditional power plant. Every source of energy is used to the highest extent possible, benefiting both the hospital and the environment. The New Jersey Hospital Association also applauds the plant as a model for hospitals seeking to improve operational efficiency. The plant is already delivering steam and chilled water for construction heating and cooling.

Outsourcing its energy center allows PHCS to focus on its core mission of providing healthcare while delivering a cost-effective operation that benefits the surrounding community and the environment. Creative third-party financing partnerships and innovative engineer/procure/construct solutions eliminate barriers for large-scale facilities interested in reducing costs while fostering environmental stewardship.

**The Other Side of the Meter**

Managing how an organization purchases its energy resources is called “Supply Side Management.” For an energy management strategy to be completely effective in an era of highly volatile energy prices, procurement strategies need to be examined closely. But without DSM programs, these energy and peak demand savings would not occur or would materialize only after significant delay, and in any case could not be relied upon, forcing utilities to construct expensive back-up capacity therefore causing higher rates. DSM programs can reduce electricity use and peak demand by approximately 20 to 40 percent. While it might seem desirable for a power utility to improve its load factor and postpone costly capacity expansion, in practice utility companies tend to be unenthusiastic towards load shifting and DSM in general. This is because they foresee a reduction of electricity and power demand, and consequently a reduction in sales and revenues.

**The Case for Smart Grid Technology**

The strong technological advancements in smart meters and demand response technologies coupled with strong public policy and monetary incentives for the deployment of cutting-edge renewable energy generation and EE measures have resulted in a strong trend towards a more localized, comprehensive, and customer-driven approach to electricity generation, energy delivery, and load management for electricity end-users.

This trend is fueling the proliferation of small, but smart microgrids at entities with campus-like settings such as universities and military bases. Hospitals are also particularly well suited for smart microgrids because they operate 24 hours a day, seven days a week, require reliable and uninterrupted power supply, and can utilize waste heat for use in the hospital, and often have a multi-building campus layout. Hospitals that take full advantage of smart microgrid technology will save substantially on their energy costs compared to competing hospitals that stay on the old course and remain at the mercy of the local distribution utilities and the often volatile energy commodities market.

A smart microgrid is simply a modernized, small-scale, localized version of the older and outdated and large centralized electricity system serving electricity customers today. Unlike the traditional large power grid approach, under the smart microgrid approach, the energy consumer, not the utility, generates and controls all, or a portion, of its electricity needs in the most cost effective manner possible for the benefit of the energy consumer.

The benefits of a smart microgrid approach for hospitals are numerous. A smart microgrid at a hospital site can integrate all on-site renewable generation resources, DSM technologies, heat recovery, and usage with all of the hospital buildings to meet the exact energy needs of the hospital through real time energy management. This will allow the hospital to maximize energy savings through sophisticated load profiling techniques.

A smart microgrid can save money by allowing the hospital to procure power in real-time at significantly lower costs, while using on-site renewable generation to hedge peak power

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Focus 19

May/June 2011
CBIZ's Healthcare Reform Toolkit is:

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continued from page 19

costs, sell in the day-ahead market, and produce Renewable Energy Credits (RECs) for sale. Additionally, they can reuse the waste heat energy that is produced during on-site renewable and traditional electricity generation for heating buildings, hot water, sterilization, cooling and refrigeration. Smart microgrids also make it possible to get the most from renewable generation because they have the flexibility to integrate on-site fuel cell, small wind, solar photovoltaic (PV), solar hot water and geothermal heat pumps in an integrated manner.

Other Success in Hospital DSM

With the chillers nearing their end of useful life, Robert Wood Johnson University Hospital in New Brunswick enrolled in PSE&G’s Carbon Abatement Program after receiving a detailed analysis and load profile modeling to determine the optimal chiller plant and site chilled water system configuration based on energy efficiency, life cycle cost, and existing space constraints. In order to qualify for the PSE&G program, the chiller plant was required to have an ROI of less than 15 years based on energy savings and demand reduction.

Specifically, engineers generated a load profile model of the central chilled water system to determine the hospital’s peak load and recommend the optimal chiller sizing and configuration based on existing space constraints. Energy savings methods were identified in the chilled water distribution by bypassing all secondary building pumps and replacing all of the three-way valves at each of the air handlers and replace them with high-performance two way control valves. The new chiller plant and chilled water site temperature differential ECMs will reduce the hospital’s electrical demand (kW) for the chiller plant by 23% and reduced the electrical consumption (kWh) by 43%. This improvement project has an annual energy savings of $398,000 with a payback of less than 9 years. The hospital is also considering a new CHP plant independent of PSE&G financing.

PSE&G’s program also funded an investment grade energy audit for the University of Medicine & Dentistry in Newark, resulting in a comprehensive list of energy conservation measures (ECMs). This $3.6 million project’s addition of a steam-driven chiller, resulted in approximately $416,000 in annual energy savings with a payback of less than 9 years.

Cooper University Hospital in Camden recently implemented ECMs surrounding their central power plant via PSE&G’s program. The $3.9 million in ECMs included boiler, chiller, heat recovery, motor and controls upgrades that will save Cooper Hospital approximately $370,000 a year in energy costs with a payback of 9.5 years.

New Attitudes and Performance-Based Conservation

Implementing DSM strategies inevitably requires the commitment and behavioral buy-in of hospital teams. This “greening of healthcare” is an attitude that is paramount to reinforcing the mindset of saving energy dollars. Often easier said than done, the entire workforce and environment can be conditioned to switch off lights and pay attention to often energy-deficient areas like kitchens, thereby maximizing the “greening” movement.

In Ontario, Canada, for example, many hospitals are participating in a web-based building performance management system, a system which is now one of the largest performance-based databases in North America. The hospitals use the system to benchmark their energy and water use, set targets based on high-energy performing facilities, determine their conservation potential and monitor their monthly energy and water savings.

Performance-based conservation complements and enhances more prescriptive DSM programs. It harvests the considerable potential for low cost, high total resource cost (TRC) savings resulting from operational improvements, recommissioning of building systems, and upgraded controls and automation. By continuously monitoring and reporting on actual energy use and savings achieved, it helps verify that prescriptive measures are properly installed and operated and specifically realize the estimated savings upon which prescriptive incentives are calculated. Such targeted, timely and accessible information can align and integrate the efforts of all the players involved in building performance, including managers, operators, contractors and designers, enabling them to work together towards higher standards of EE.

Conclusion

Energy efficiency strategies are cost-efficient and bring substantial financial savings. EE is a rare investment, generating its own economy. EE actions can improve the well being and comfort of end-users. EE actions are win/win solutions with positive impacts for all actors involved: local authorities, end-users, producers and suppliers. EE improvements can slow the growth in energy consumption, save consumers money and fund capital expenses for energy infrastructure. As New Jersey hospitals prioritize their commitment to patient care, they must educate and innovate to survive in an economy that yearns for EE. By implementing EE technologies, identifying alternative financing and developing best practices, hospitals must rise to the challenge to stay afloat.

About the author

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Focus 21
The New Jersey HFMA has been actively involved in discussing and reviewing the healthcare reform legislation and related regulations for the past year. Recently, the National HFMA has requested that each Region form a LINK committee(s) to provide HFMA with local feedback on various topics and issues associated with reform. LINK will serve as an ongoing chapter/ regional committee to:

- Provide input and counsel to management in the development of HFMA’s perspectives on key provisions of the new Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010 (HCERA).
- Provide a special focus on ramifications and response strategies for providers, payers, employers and their communities.
- Provide input and comments on HFMA’s positions regarding the evolving regulations related to implementation of these provisions.
- Comment on potential services HFMA would offer to help members and others deal with these issues.

In Region Three (comprised of 4 Pennsylvania Chapters and the New Jersey Chapter), the decision was made that this support to HFMA would be provided at the regional level. Since the New Jersey Chapter already has an established group working on reform related issues, the decision was made that this group would provide the foundation for the initiative. The specific process will be as follows:

- Establish the regional committee, to include providers - CFOs, CEOs, CMOs, and revenue cycle executives. All current New Jersey Reform Committee members are encouraged to continue to participate in the process via this LINK Committee.
- HFMA will periodically forward a discussion guide summarizing the issue(s) along with any relevant legislation or regulations and a list of questions and comments.
- Upon receipt of the package, the LINK Committee Chair will poll committee members to determine the interest level in responding based upon the impact to the local providers and the community. It is expected that the Committee will respond to at least three to four requests per year.
- LINK Committee gathers and summarizes input and responds back to HFMA staff.
- LINK Committee is asked to provide an aggregate view of the ideas developed at the local level. This is where the value-add will be in terms of understanding the impact to the local communities. While proposed changes will have some similar impacts on all organizations, it is anticipated there will be different impacts based on size, geography, and communities served.
- Staff will compile the responses and submit to the HFMA Health Reform Advisory Committee.
- Upon completion of a response by the Health Reform Advisory Committee, the summary of HFMA’s position will be provided back to the LINK Committee members and chapter presidents.

We anticipate that the first issue that will be handled through the LINK Committee process will be the ACO Regulation responses. We encourage any provider based members wishing to participate in the LINK Committee to reach out to the HFMA – New Jersey Chapter President, Mike Alwell at malwell@smmcnj.org or the Committee Chair, Joanne Vaul at jvaul@cbiz.com to get involved.
NJ HFMA Establishes a New Revenue Integrity Committee

NJ HFMA is committed to meeting the needs of its membership and providing opportunities for continued growth and sharing of information. The concept of Revenue Integrity has been written about extensively in our professional publications lately. In line with this trend a relatively “new” position and/or department of Revenue Integrity has begun to spring up in many area hospitals. It is a function that many of us perform under a variety of existing job titles; yet few truly understand all the behind the scenes work required to contribute to the financial success of our healthcare organizations.

Are you looking for a forum to discuss charging issues, revenue leakage and best practice scenarios that relate to revenue integrity which will contribute to the financial success of your organization? If so, please join our new committee, the Revenue Integrity Committee. The committee will meet on the Fourth Tuesday of most months, from 9:00 – 11:00 AM. Meetings will be held in the Board Room at NJHA, with the exception of the September and November meetings which will be held at Raritan Bay Medical Center. Please confirm meeting dates with the committee chairs prior to attending. If you are unable to attend in person, please call in at 1-888-290-0578 and use the pass code – 88128109.

This committee has been developed to establish a forum for networking and information sharing regarding issues that are not discussed in detail at any of the other forums, for example, implementing charge reconciliation processes. Our committee will be dedicated to gaining an understanding of the multitude of governmental and state regulations and how to operationalize them to ensure accurate and compliant charge capture. The byproduct of this success will enhance the Patient Accounting Department’s productivity and empower the revenue generating ancillary departments to maintain accountability in providing a steady revenue stream.

We will work closely with the Patient Financial Services, Patient Access and CARE committees to discuss issues of mutual concerns. Our committee will work towards developing relationships with government agencies, third party payors and the NJHA to voice opinions on legislation and regulations affecting revenue integrity.

About the Author
Dr. Randall Krakauer serves as Aetna’s National Medical Director, Medicare. Dr. Krakauer graduated from Albany Medical College in 1972 and is Board Certified in Internal Medicine and Rheumatology. He received training in Internal Medicine at the University of Minnesota Hospitals and in Rheumatology at the National Institutes of Health and Massachusetts General Hospital/Harvard Medical School, and received an MBA from Rutgers. He is a fellow of the American College of Physicians and the American College of Rheumatology and Professor of Medicine at Seton Hall University Graduate School of Medicine. He is past chairman of the American College of Managed Care Medicine.

Dr. Krakauer has more than 30 years of experience in medicine and medical management, has held senior medical management positions in several major organizations. He is responsible for medical management planning and implementation nationally for Aetna Medicare members, including program development and administration. Dr. Krakauer can be reached at Krakauer-MDR@AETNA.com.
I recently read an article that stated, “ACOs have been compared to the elusive unicorn: everyone seems to know what it looks like, but no one has actually seen one.” How can we determine if our healthcare system is ready to form an ACO? Are we actually ready to move forward on this initiative?

In theory, an ACO is a network of doctors and hospitals that shares responsibility for providing care to patients, bringing together the different component parts of care for the patient – primary care, specialists, hospitals, home health care, etc. – ensuring that all of the parts work well together. There are three essential characteristics of ACOs:

1. The ability to provide and manage with patients the continuum of care across different institutional settings, including at least ambulatory and inpatient hospital care and possibly post acute care;
2. The capability of prospectively planning budgets and resource needs; and
3. Sufficient size to support comprehensive, valid, and reliable performance measurement.

With these points in mind, a healthcare system should be asking itself some very strategic questions if considering the formation of an ACO:

✅ Do we want to invest in developing an ACO structure now or do we want to wait to see how others attempts fare? It is easy to take a wait and see attitude, but you risk being left behind as your competitors make great strides before you even start the race. If you don’t have the human capital to support this task, consider outsourcing to a company with a history of people that have been involved in developing managed healthcare entities.

✅ Do we have the clinical capacity to manage risks? If your organization is not used to treatment protocols, best practices, coordinated care modules (i.e., full risk cardiac, obstetrical, orthopedic, primary care) that cover all care in a bundled payment, then you may not be ready to embrace something as difficult as full risk coverage for all care.

✅ Do we have the data to understand our own community needs and the cost related to those needs? Clearly, if you have not implemented electronic health records (EHR) capabilities between the hospital and all potential stakeholders, then you potentially do not have a major tool to manage unnecessary utilization of resources.

✅ Do you have good relationships with your physicians and allied healthcare professionals that will allow you to drive waste out of your processes of care? If you have ten different companies providing sutures to your facility, you are probably not ready. Take a look at other areas where you may have failed to develop consensus for what is good for patient outcomes and for costs of the facility such as pacemakers, replacement knees and hips, drug formularies, etc. and figure out why they failed; if your competitors have done the same drill and can say affirmatively that they have solved these problems, they are way in front of your capability.

✅ Do we have strong relationships with insurers and other payors? Healthcare entities that can demonstrate that they have actively worked with these payors have an obvious leg up on the competition in that the payors can assist you in developing cost and quality benchmarks that you would be difficult to do alone; payors also can be your greatest ally in that they have a vested interest in helping the best institutions to survive so that they can provide care to their members.

✅ Do we have any experience in running wellness campaigns? Without this type of experience, you may not be able to involve or incentivize your covered population to become active participants in managing their own health care which can ultimately raise costs.

✅ Are we averse to hiring specialists to help us in difficult situations? Organizations that are morally opposed to hiring talent to build out skills they don’t have will fail. Hospitals will need to look for attorneys that are well versed in anti-kickback regulations as they evolve to incorporate the paradigms surrounding the PPACA and roll out of ACOs. Actuaries will need to be hired to project your demographics utilization trends and costs; they also serve as a reality check on projections received from payors. Benchmarking studies will need to be performed to assess organizational strengths and

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**Member Spotlight:**

**Liz Jennings**

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

**LIZ:** I’m a Jersey girl through and through, but you’d never know it to look at my family tree. I’m first generation American. My mom raised me as a single mom, working hard for every penny she earned so she could give me more opportunities than she had herself. She instilled in me a strong work ethic, and a deep gratitude for all the sacrifices she made on my behalf. As for my career path, I began working in the NJ market in the late eighties, at one of the original east coast HMOs: U.S. Healthcare, which was eventually acquired by Aetna. Managed care was a relatively new term in NJ at that time, and I remember many a meeting, explaining the overall concept to local employers and members. From there, I moved on to a start-up PPO called MasterCare as Director of Provider Relations. I was charged with developing the company’s provider network from the ground up, as well as overseeing whatever went along with it. The company went on to be acquired, where I moved to MD-X Solutions as the Director of Client Services. It’s here that I had my first real introduction to HFMA. In 2006, I joined MagnaCare and currently serve as Vice President of Network Management, digging in my heels for whatever’s in store for the healthcare industry.

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

**LIZ:** MagnaCare is a health plan management company which has provided solutions to self-insured private sector employers, providers, and governmental entities in the health, workers’ compensation, and no fault fields for over 20 years. Simply put, we manage self-insured health plans as well as a provider network of over 86,000 physician locations and 240 hospitals in the tri-state area. What MagnaCare does best is understand our clients’ unique needs by developing innovative and comprehensive solutions tailored to their specifications. This is especially critical with the advent of ACOs, where we believe there is a unique opportunity for the provider community to leverage their “brands” and deliver a “product” directly to their patients. Given MagnaCare’s current product and service offerings, we’re fully equipped and prepared to help transition providers into this ACO role. As a result, my own role at Magnacare is evolving in anticipation of these market changes. Where I previously oversaw the MagnaCare hospital network in both NY and NJ, I will now be focusing my efforts solely on the NJ marketplace, managing the full continuum of provider services, with the ultimate goal of strengthening our network and helping to better align provider/payer incentives.

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

**LIZ:** To be sure, there are challenges for all of us in healthcare, be it provider or payer. Although certainly not the most prevalent, one of the most frustrating challenges I face in my position is when I’m greeted with the mindset of “provider vs. payer”. In these circumstances, I believe it’s time to set the gloves aside, and work collaboratively in finding solutions to what ails us. If we can’t figure it out for ourselves, I certainly don’t want someone else to step in and figure it out for us.

That aside, one of the most amusing challenges I face is trying to explain my field to someone I’ve just met at a cocktail party or non-industry event. Responses usually fall into three categories: 1.) a blank stare, accompanied by a bland comment of “that’s interesting” or 2.) an hour debate over the perceived pitfalls of the American healthcare delivery system or 3.) someone who wants me to interpret their EOB.

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

**LIZ:** I don’t have any profound advice – just some basics. Listen. Learn. Gather and use as much information/data as possible when making difficult decisions. Don’t be afraid to get creative when trying to find a compromise. And keep in mind healthcare in this state is a tight knit community. Be professional and remember relationships, as well as your personal integrity, are important. Whatever you do, pick the path that allows you to sleep soundly when it’s time to rest your head on your pillow at the end of the day.

**FOCUS:** What are your hobbies and outside interests?

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**LIZ:** I’m much more of a generalist than a specialist. I love the outdoors, especially hiking and gardening, even entomology. But my all time favorite has got to be eating and drinking. Or better put, spending time with family and friends.

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

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**Certification Corner**

Becoming certified distinguishes you as a leader and role model in the healthcare finance community. It reflects a deep personal commitment and sense of accountability that inspires credibility and confidence in your professional knowledge as well as shows your dedication to high standards in the industry.

Congratulations from the Certification Committee to our Newly certified members:

- Patti Blaney, CHFP
- Jim Haddock, CHFP
- Kitty Tso, CHFP

visit www.hfma.org/productsandservices

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**Become CHFP Certified**

The CHFP Certification Program is Online January 2011

HFMA’s CHFP (Certified Healthcare Financial Professional) certification is intended for mid-level healthcare professionals with a minimum of 3-5 years experience. Becoming certified distinguishes you as a leader as well as a role model in the healthcare finance community. Earning the CHFP credential enhances your credibility, supports your professional development, demonstrates a high level of commitment to the field, and validates your skills and knowledge.

We’ve made the process of certification more convenient. Beginning January 2011 the requirements to becoming CHFP certified are:

- Active regular or advanced HFMA membership*
- The title Manager and above or equivalent
- The successful completion of one comprehensive certification exam

Also new for 2011, CHFP preparation and study materials will now be available online.

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

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

*The two year HFMA membership requirement has been dropped.
Recognizing (and Rewarding) the Volunteer in You

by Michael Alwell, FHFMA

How would you like to attend the New Jersey Annual Institute as a guest of the Chapter??

Now is the time to consider joining a committee, writing an article, or speaking at an HFMA function!

The Board of Directors believes that the key to a successful organization is to encourage member involvement and reward all of those volunteers that make a difference. To encourage member participation, the Board adopted a Member Reward and Recognition program last summer.

There are many ways that a member of the New Jersey Chapter can be recognized and earn awards:

New Jersey Chapter Achievement Awards

- Recipients of the President’s Award for exceptional service will receive complementary full registration to the NJ Annual Institute plus two night hotel stay.
- Those members who participate in Chapter activities and write or significantly contribute to winning Yerger applications will be rewarded with a day pass to the Annual Institute and a one night hotel stay.
- Members who receive the Chairman's Theme Award for outstanding committee participation will receive a day pass to the Institute.
- Anyone who becomes a Certified Healthcare Financial Professional (CHFP) or attains FHFMA status will also be recognized with a day pass to the Institute.

HFMA National Founders Merit Award Program

The easiest ways to earn Chapter recognition and a complementary day pass to the Annual Institute is to earn a Founders Award.

The Founders Award program is a personal incentive program designed to encourage, monitor, and recognize individual volunteer involvement in HFMA. The program provides an equitable way to translate activities into points. Over time, it will measure member involvement by looking at a collected number of points to determine how active an individual member is in HFMA.

The Founders Merit Award program was established in 1960 by HFMA to recognize the importance of individual members and the contributions they make to HFMA, on both the chapter and national levels. Points are accumulated according to the level of activity an individual holds, thereby encouraging members to participate in HFMA functions and to hold leadership roles within the organization.

The Awards

Four awards can be obtained based on the point system.

The Follmer Bronze Award is awarded to an individual who has earned 25 member points. The award is named after William G. Follmer, who established the American Association of Hospital Accountants (AAHA) (now HFMA).

The Reeves Silver Award is awarded to an individual who has earned 50 member points. This award honors Robert H. Reeves, an organizing member of AAHA who was elected its president in 1956.

The third award is presented to a member who has earned 75 member points. The Muncie Gold Award honors Fredrick T. Muncie, who was an organizing member of the AAHA and the first president of the association (1947-49).

A fourth award, the Founders Medal of Honor, was added in 1986 and is conferred by nomination of the member's Chapter Board of Directors. This award recognizes individuals who have been involved in the association for at least three years after earning the Muncie Gold Award, have provided significant service at the chapter and/or national level in at least two of those years, and remains members in good standing.

Those members who receive the Medal of Honor will be invited to attend the full NJ Annual Institute with one night hotel stay included!!

How can I earn points?

Members can earn points by: volunteering in a chapter or national committee; writing an article; mentoring a new member; speaking at an event; participating on a panel or participating in a chapter or national meeting in a volunteer role.

It is important to remember that although HFMA National and the chapters track these points, each member is responsible for reporting points earned to the chapter Founder’s Contact. We need your help to be sure that you receive Founders point credit that you deserve. Please review your HFMA National Founders points for the 2010-11 during the month of June. You will receive an email to alert you when the records are ready for review. Be sure to let Laura Hess know of any

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changes/additions to your Founders Merit Award points for the 2010-11 year by e-mail at NJHFMA@AOL.com. Please report any discrepancies by June 27, 2011.

You can view your Founders points on the HFMA National website 24/7. From www.hfma.org, enter your username and password and then click on Founder’s Points on the right. A list of your Founders Points will appear on the screen. Note: Any 2010-11 HFMA National points have already been posted to your database record.

For more information on how to join a committee please go to the Committee Page on the HFMANJ.org website (http://www.hfmanj.org/Chapter-committees.groups) or contact Laura Hess at (888) 652-4362.

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<td>Chairman’s Theme (Step-up) Award</td>
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The famous Chinese philosopher Lao-tzu said, “A journey of a thousand miles begins with a single step.” Don’t be afraid to take the first step to assure your future. Just make certain that you have good counsel and traveling companions that will keep you safe and on the right path.

About the author

Lewis D. Bivona, Jr, CPA, AFE, is a partner with WithumSmith+Brown, Certified Public Accountants and Consultants, and has over 32 years of experience in the healthcare industry. For more information on ACO readiness assessment, please feel free to contact Lew at lbivona@withum.com.
SFY2012: A Post Reform Budget

by Randy Minniear

Gov. Chris Christie is proposing a $29.4 billion budget for state fiscal year 2012, a 2.6 percent reduction over the current year budget. The budget proposal comes at a time when New Jersey faces a $10 billion structural deficit for the upcoming fiscal year, and the proposal reflects a reduction in total spending for the second consecutive year.

The budget blueprint focuses on cutting business taxes, revamping school aid and reforming pension and health benefits for public workers, as well as preserving critical healthcare funding during extremely difficult economic times. Most notably, the budget proposes increasing charity care funding by $10 million from $665 million to $675 million. The proposal also increases funding to Graduate Medical Education (GME) by $30 million from $60 million to $90 million and expands eligibility to all hospitals, with GME slots paid based on Medicare principles. In addition, the proposed budget maintains current funding levels for the Hospital Relief Subsidy Fund, the Health Care Stabilization Fund and the Mental Health Subsidy Fund.

However, while funding in areas that have traditionally been targeted for cuts are preserved or moderately increased, new areas of healthcare funding have fallen under scrutiny in the wake of the adoption of federal healthcare reform.

In his budget address, Gov. Christie said the state’s existing Medicaid program is unsustainable and that a “restructuring” is in order. This same sentiment is being expressed at the federal level, as Republicans in Congress recently faced the potential of a government shutdown over several key spending issues, including Medicaid. The state’s proposal for restructuring Medicaid calls for $300 million in savings in the 2012 budget through a Medicaid global waiver, which would give the state a budget-neutral lump sum of federal funding to support Medicaid, while providing the state greater flexibility to redesign the program. The waiver must win approval from the Centers for Medicare and Medicaid Services.

The Administration has offered little detail on how these savings will be achieved or what will be included in the state’s waiver request to the federal government, but the proposal has received increased attention from both the industry and the Legislature. The New Jersey Hospital Association (NJHA) has received the commitment of the Administration to participate as a key stakeholder in crafting the global waiver proposal. NJHA has been reviewing other states’ experiences with global waivers to identify potential provisions. Some of the guiding principles that NJHA will be pursuing in the global waiver effort will be ensuring alignment with federal initiatives, securing efficiencies through collaboration, focusing on primary care and aligning incentives across the provider continuum.

Along with the development of the global waiver, NJHA also is advocating for the restoration of cuts to post-acute providers. The budget proposal calls for a cut of nearly $4.6 million in matchable state dollars to provider rates for Special Care Nursing Facilities. These facilities care for some of the most critically ill patients including ventilator-dependent children and adults with HIV. In some instances these cuts could equate to the termination of these programs, leaving patients with nowhere to go other than the emergency room. Additionally, the budget proposal calls for $25 million in savings from a reduction of 2.5 percent in the nursing home reimbursement rate. These cuts will widen the gap between Medicaid payments and the cost of care for providing these services, making it likely that providers will have to consider reducing jobs and services.

The industry appreciates the Administration and Legislature’s commitment to the healthcare provider community. And there is much for the industry to be pleased with in the 2012 budget proposal. But there are certainly areas that need to be considered during the remaining months of the budget debate. Cuts to post-acute providers will only add strain on an industry that cares for our most vulnerable. And while a restructuring of Medicaid may be in order, it must be done thoughtfully and with provider input. As the nation and our state move deeper into the healthcare reform era, it is imperative that our state’s leaders allow the healthcare provider community to collaborate in shaping its own future.

About the Author

Randy J. Minniear has managed the New Jersey Hospital Association’s state legislative advocacy efforts since 2004 as Senior Vice President for Government Relations and Policy. Before his service at NJHA, he worked as Director of Government Affairs at the Chemistry Council of New Jersey. He began his career in government relations work as Chief of Staff to former Senate President John O. Bennett.

Randy can be reached at rminniear@njha.com.
Ask the Ethics Guy®!
Five Easy Principles?
Principle 4: Be Fair (Part 1)

We can learn everything we need to know about the concept of fairness by looking at how some children behave at birthday parties

by Bruce Weinstein, Ph.D.

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

• Do No Harm
• Make Things Better
• Respect Others

For the next two issues we will examine Life Principle No. 4: Be Fair. What is fairness? Why is it so important? How can taking fairness seriously enrich our own lives?

Imagine you have a son, Larry, for whom you throw a birthday party one afternoon. Your sister brings her two boys, Curly and Moe, to the celebration. When Moe gets a bigger piece of birthday cake, Curly cries, “That’s not fair.” Seeing someone who appears no different than him get more cake strikes Curly as wrong, unjust, unfair.

If there’s a good reason to give Curly a smaller piece (say, for example, he is overweight), it’s justifiable and fair to cut different sized pieces of cake for the two boys. In fact, it’s not only fair, it would be wrong to do otherwise, since one boy deserves a smaller piece (hence the term “dessert,” or that which is deserved).

Now suppose that your sister explains to Curly why he’s getting a smaller piece, but this reason doesn’t placate the lad and he throws a temper tantrum. “All right, young man, now you won’t get any,” your sister tells him. “I’m taking you home, where you won’t get any cake. And because you’re acting so childishly, you won’t be allowed to watch TV for the rest of the weekend.”

Three Branches of Fairness

This response, of course, makes Curly even more upset, and his ratcheted-up tantrum is now justified. After all, he has been on the receiving end of a true injustice: Banishing him from the party and taking away his television privileges for so long seems, by any reasonable standard, an excessive punishment. It is, in short, unfair.

You feel so bad about the turn of events for Larry’s special day that you decide to make up for the interruption by having your spouse run out to get the latest child-friendly video game that all the kids will enjoy.

This story introduces us to three branches of the concept of fairness. Imagine a pie chart that represents justice, divided into three equal wedges. They represent, in no particular order:

• Distributive justice, which refers to how scarce resources are made available to a group of people with varying degrees of needs, desires, and other factors. Think of this in terms of who deserves a raise, and how much.
• Retributive justice, which refers to how we punish those who violate standards of behavior. What is fair punishment if an employee does something wrong? Should the fact that the employee happens to be the son or daughter of a close friend matter in deciding this?
• Rectificatory justice, which refers to how we rectify a situation in which a person or group of persons has been treated unfairly. When coming aboard as a new manager, how should you deal with an unjust situation created or ignored by your predecessor?

Let’s examine each in turn.

Distributive Justice

“You can’t always get what you want,” Mick Jagger sang in one of the Rolling Stones’ most famous songs, but many of us would beg to differ with his next assertion: “If you try sometime, you just might find you get what you need.” How many people do you know who are satisfied with their lot in
Do your colleagues, friends, and family members believe that their needs are being adequately met? Since we live in a world of scarcity, it is natural to want to know how we are to divide what there is among those who want or need it. Tom Beauchamp and James Childress identify the following as standards we might use to make such a decision:

1. To each person an equal share
2. To each person according to need
3. To each person according to effort
4. To each person according to contribution
5. To each person according to merit
6. To each person according to free-market exchange

One standard isn't necessarily better than another, as Beauchamp and Childress note. Context is everything. For a birthday party in which some children are on a restricted diet because of their weight, it would be wrong to employ standard No. 1. It would be just as wrong to use standard No. 5, because children have equal merit when it comes to getting cake (as opposed to advancing in a spelling bee or musical contest). In the context of a party, “To each according to need” seems like a better criterion to use in distributing cake and ice cream.

When it comes to giving out raises, it would seem that No. 4 or No. 5—contribution and merit—should be considered. But what about the person who puts out more effort than anyone else, yet accomplishes less? How much should effort count?

Even when it seems that a standard is apt, you may have to think again. Let’s say the resource in question is something far more scarce than ice cream or money, such as organs for transplant. No. 2—need—might seem obvious. Yet some argue that lifestyle choices that adversely affect one's health—deciding to smoke or failing to seek treatment for alcoholism, for example—should play a role in determining who should be given a transplant.

Obviously this is a complex issue and beyond the scope of this column to address thoroughly. The point is simply that of the six standards listed above for deciding who gets what (and there are other standards one can think of), no one standard applies to every situation. “One size fits all” might apply to baseball hats or mood rings but certainly not to how we realize the life principle of fairness.

Next issue, we will conclude our examination of this principle.

About the author

Dr. Bruce Weinstein is the public speaker and corporate consultant known as The Ethics Guy. His new book, Is It Still Cheating If I Don't Get Caught? (Macmillan/Roaring Brook Press) shows teens how to solve the ethical dilemmas they face. Follow Weinstein on Twitter at TheEthicsGuy. For more information, visit TheEthicsGuy.com.
## Who’s Who in NJ Chapter Committees

**2011-2012 Chapter Committees and Scheduled Meeting Dates**

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

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

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

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<th>COMMITTEE</th>
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<th>SCHEDULED MEETING DATES/TIMES</th>
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<tr>
<td>CARE (Compliance, Audit, Risk &amp; Ethics)</td>
<td>Michael McKeever <a href="mailto:mckeeverm@deborah.org">mckeeverm@deborah.org</a> 609-893-1200 ext. 5201</td>
<td>Nadinia Davis <a href="mailto:Nadinia.Davis@mountainsidehospital.com">Nadinia.Davis@mountainsidehospital.com</a> 973-429-6801</td>
<td>First Thursday of each Month (888) 269-3831 9:00 AM</td>
<td>Meeting in person at Deloitte &amp; Touche, Princeton, NJ for Oct., Jan., Apr. and July Balance are calls. Please call to confirm</td>
<td>Darlene Mitchell <a href="mailto:darlene@hunterdonhealthcare.org">darlene@hunterdonhealthcare.org</a> 908-237-7059</td>
</tr>
<tr>
<td>Communications</td>
<td>Elizabeth Litten <a href="mailto:ELitten@foxrothschild.com">ELitten@foxrothschild.com</a> 609-986-3600</td>
<td>Al Rottkamp <a href="mailto:acj123@aol.com">acj123@aol.com</a> 609-584-6538</td>
<td>First Thursday of each month (888) 269-3831 8:15 AM</td>
<td>Fax Rothschild offices 987 Lenox Dr Bldg 3 Lawrenceville, NJ</td>
<td>Tony Consoli <a href="mailto:anthony.f.consolli@marsh.com">anthony.f.consolli@marsh.com</a> 973-401-5223</td>
</tr>
<tr>
<td>Education</td>
<td>Matt Glass <a href="mailto:Matthew.Glass@morgangranstamley.milthernbarney.com">Matthew.Glass@morgangranstamley.milthernbarney.com</a> 973-912-7714</td>
<td>Maria Facciponti <a href="mailto:mfacciponti@armds.com">mfacciponti@armds.com</a> (973) 614-9100</td>
<td>First Friday of each month (888) 269-3831 2:00 PM</td>
<td>Conference calls with in-person quarterly meetings. Call for more info.</td>
<td>Tracy Davison-DiCanto <a href="mailto:tdavison-dicanto@princetonhcs.org">tdavison-dicanto@princetonhcs.org</a> 609-620-8471</td>
</tr>
<tr>
<td>Certification (Sub-committee of Education)</td>
<td>Eric S. Fishbein <a href="mailto:efishbein@presscott.com">efishbein@presscott.com</a> 609-430-7789</td>
<td></td>
<td>First Friday of each month (888) 269-3831 8:30 AM</td>
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<td>Dan Willis <a href="mailto:DWills@childrens-specialized.org">DWills@childrens-specialized.org</a> 908-301-5458</td>
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Where Are They Now?
Ray Kaden & Gene Arnone, founders of Kaden Arnone Associates

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

RAY KADEN: I attended Rutgers University, New Brunswick, graduating in 1966. I then went on to get my MBA at the Rutgers Graduate School of Business in Newark in 1967. At my first job at KPMG Peat Marwick, I was assigned to the new healthcare audit team learning hospital operations and finance and particularly the new Medicare and Medicaid reimbursement systems. I left KPMG in 1972 to become the CFO at CentraState Medical Center until 1977, which led to starting Kaden Arnone Associates in 1978 with Gene Arnone. Gene had been a Rate Analyst at the Department of Health in the mid seventies, so I had to meet with him regularly on our annual rate appeals. I found him a very sharp person, but reasonable in his approach. So, several years later when I was thinking of starting my own healthcare consulting firm, Gene was the person I called to see if he wanted to join me in this new venture.

Gene and I took second mortgages on our houses and put the money into the new company, never realizing the risk we were taking. Our first purchase was a Radio Shack computer on which Gene simulated the Department of Health’s SHARE rate-setting system and offered to prepare estimates of the hospitals’ 1979 rates for $500. Thirty hospitals contracted for the service, and when the DOH rates came out in December, 1979, the K & A rates for the hospitals were within pennies per day of the State’s calculations. After that, K & A became the “go to” place for all things financial and reimbursement related. Gene says that we responded to the industry, we tried to mold our company on its needs. Whatever the hospitals asked for, we sought to develop expertise in that area and meet their requirements.

Primarily because of Gene, we were a little ahead of the curve on computer capabilities. In the beginning, we did a lot of rate simulations, rate appeals, budget preparations, cost reports and analyses. He forced me to take some risks, and I like to think I provided some fiscal conservatism that a growing firm needs. As K & A added qualified staff like Fred Stodolak, Dave Rikkola, Sam Donio and Joanne Vaul, all of whom made significant contributions over the years to the healthcare industry, we then began to develop PC compatible software that the hospitals could use internally. We also developed expertise in new areas such as Certificate of Need financial feasibility studies, operational auditing, physician joint ventures, and even physician billing and healthcare credit and collection services.

By 1993, Kaden Arnone Inc. and its affiliate companies had eight Executive Directors, nearly 200 employees and over 100 clients primarily in New Jersey and the Middle Atlantic States.

In 1994, I left K&A to Gene Arnone and his younger partners. Over the next eight years, I worked part time on special projects for Johnson & Johnson (getting Medicare approval for the new coronary stent). Gene and I also went to Hungary on an assignment to help the Hungarian Government establish a DRG based reimbursement system for that country. I was also sent to Siberia on a USAID program to help several Russian companies develop western capitalist capabilities after so many years under a restrictive planned financial system. After you have been to Siberia, you realize that so many of the things we complain about in America are minor inconveniences.

Retirement doesn’t mean doing nothing; it is only an opportunity to do something different and interesting every day, without wearing a suit.

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continued from page 33

I think back to the start of my career at KPMG in 1967 and how they gave me the opportunity to develop my knowledge and skills in the healthcare industry. I’ve never regretted a minute of that journey.

Gene ArNONE: I was born and raised in Red Bank, New Jersey. After college I spent four years in the military in England. I started a career in healthcare because it was the only job available to me after the service while trying to support a wife and daughter. As Ray mentioned, I had been a Rate Analyst at the Department of Health when we met. With Ray I had the unique opportunity to have a unique partnership which lasted 20 years. I was then able to embark on a second career of service which brought great satisfaction and joy.

FOCUS: Please talk about your history in healthcare finance.

GENE ARNONE: I have had the privilege of working for the following organizations:

- New Jersey Department of Health – Rate Setting Analyst 1974 - 1976
- Controller Atlantic City Medical Center 1976 - 1978
- Medical Claims Processing 1986 - 1998
- Quadra Med Corp. 1997 - 1998

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

RAY KADEN: The biggest challenge in K & A was adding and training staff to meet the industry’s growing demands, while continuing to provide direct consulting services to clients who wanted either Gene or me to be on each engagement.

The next biggest challenge was developing, challenging and keeping the quality staff that we had. In many cases, we hired young people fresh out of college. They were like sponges, soaking up knowledge and demanding responsibility. Several of them became our partners, and some are still providing important services in the successor company of K & A.

GENE ARNONE: I can recall a few special challenges over the years.

1) The Department of Health’s initiation of the first rate setting system in the country was a big one. New Jersey was second only to Maryland.

2) Atlantic City Medical Center was virtually in the grips of going bankrupt.

3) Kaden Arnone Associates and adjunct businesses were not exempt to all the risk and struggles of a new business.

4) QuadraMed’s transition to a publicly held corporation.

5) Other than that, just the challenges of healthcare over the last thirty years!

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

RAY KADEN: Starting and running the company takes a toll in the long run. I felt I had accomplished my life goals, and that it was a good time to walk away and ease back on my workload, enjoy my family and living. The company was in excellent hands.

GENE ARNONE: I think service is the end desire that most successful people gravitate towards and I was fortunate enough to have that opportunity at a relatively young age. Money is important in life yet when you have “enough” there are other things which provide even greater rewards.

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

RAY KADEN: I have been active as a member of several board level committees at Meridian Health System for the past 13 years. My experience has enabled me to give something back to the industry that has been so important and good to me my entire professional career.

GENE ARNONE: I have remained very active over the years. I have served in the following capacities:

- AtlantiCare Health System Board – Behavior Health Board, Medical Center Board and Chairman – Health Services Board – Captive Insurance Board and Chairman - overall tenure 1997 - present.

Retirement, just like work, is meaningful activity. It is just different, and something you don’t get paid for.
• Arc of Atlantic County – developmental disabilities – Board, Chairman and Emeritus - Capital Campaign Chairman and Residential Housing Initiatives, 1990- present.
• formed Arnone Associates and provide small business consulting services to a variety of closely held, family businesses.

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

RAY KADEN: I serve as the Treasurer and Chairman of the Finance Committee of the Homeowners Association where my wife, Rosemary, and I live. We have both been active as Disaster Services volunteers at the Red Cross. I’m also still active in the Rutgers Alumni Association and our local church. Our children, grandchildren, golf, exercise, and gardening also provide good R & R for the body and the mind. I am also mentoring my older daughter, Eileen, in starting her own wedding planning company.

GENE ARNONE: I love travel, golf, and sailing. I have the luxury of being semi-retired and spending 60% of my time pursuing family and avocations. My oldest daughter works in Meridian’s Foundation, ironically, with Ray’s daughter. My other daughter works for Abington Memorial Hospital in Pennsylvania, and my wife of 40 years, Cindy, works for AtlantiCare Hospice.

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

GENE ARNONE: Yes and No – what I’m doing today is something that has evolved over time. But in each chapter, I always worked backwards in accomplishing the next stage in my life. So from that standpoint, I have always known what I would eventually become.

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

RAY KADEN: It’s very hard, after working at 60 mph, to go to 25 mph. If you’re retiring from your career, you really need to find interests that both challenge your mind and keep your body fit. Retirement doesn’t mean doing nothing; it is only an opportunity to do something different and interesting every day, without wearing a suit.

GENE ARNONE: Always have something to look forward to do on Monday – it is very easy to leave somewhere when you have someplace better you’d like to go tomorrow. Retirement, just like work, is meaningful activity. It is just different, and something you don’t get paid for.

FOCUS: Thank you for taking the time out of your busy schedule to be interviewed for this edition of FOCUS.
CMS recently published highly anticipated proposed rules for the Medicare Shared Savings Program, a program that would establish Accountable Care Organizations for fee-for-service Medicare beneficiaries. For months, the health care industry has been guessing about how CMS would detail the Medicare Shared Savings Program, a feature of the Patient Protection and Affordable Care Act. How would Medicare beneficiaries be assigned? Can my institution form an ACO? How will CMS measure quality? What’s involved in becoming a Medicare ACO?

Although the proposed rules don’t answer all questions about the Medicare Shared Saving Program, they indeed make for informative reading. The rules themselves aren’t terribly lengthy and are contained in only 14 pages of the Federal Register, i.e., 76 FR 19640-19654. The comments, however, are another story, i.e., see 76 FR 19528-19640.

At this very moment and in the ensuing weeks and months, health care executives will be barraged with analyses, essays, articles, Power Point presentations, etc., all discussing and analyzing these proposed rules. In an attempt to avoid information overload, this article focuses on only one aspect of the proposed rules: Quality Assessment.

But before getting into the quality assessment details, a few fundamental components of the Medicare Shared Savings Program should be noted. First, the program applies to Medicare fee-for-service beneficiaries only. Second, it requires a 3 year commitment from the ACO. Third, all ACOs will be exposed to risk of financial losses based upon their performance.

Fourth, ACOs cannot obtain any shared savings distributions unless they achieve all quality standards (i.e., regardless of any economic savings that the ACO has achieved).

These domains are derived from and are intended to be consistent with other quality indicators used by CMS, e.g., the Physician Quality Reporting System (PQRS), EHR Incentive Program, and the Hospital Inpatient Quality Reporting Program. CMS justifies these choices of domains as consistent with other CMS programs. Accordingly, CMS suggests, enhanced operational efficiencies can be achieved and the quality reporting under the Medicare Shared Savings Program can be more easily scalable to accommodate more sophisticated quality measurement activities tied to more widespread use of EHR applications.

The specific quality assessment measures – there are 65 – are detailed in a 20 page table organized per domain. Each of the 65 quality measurements is linked to a specific method of data submission, e.g., such as claims data, survey data, a new “ACO GPRO” reporting process, and other specified data reporting methodologies (discussed below).

The “Patient/Care Giver Experience” domain is assessed by examining, via a survey methodology, the following variables: getting timely care, how well the doctor communicates, helpfulness and courteousness of office staff, patient rating of doctor, health promotion/education, shared decision making, and health/functional status.

DOMAINS AND MEASURES

CMS proposes that quality will be measured in terms of 5 “domains”:

1. Patient/Care Giver Experience
2. Care Coordination/Transitions
3. Patient safety
4. Preventative health
5. At-risk population/frail elderly health.
management, understanding one's self-care role, and other items). Claims data will be used to assess: discharges indicating short term complications (ketoacidosis, hyperosmolarity, coma), discharges for patients with uncontrolled diabetes, discharges for COPD, discharges for congestive heart failure, discharges for hypovolemia, discharges for bacterial pneumonia and UTI. Care coordination is also measured by the percent of all physicians meeting stage 1 of the HITECH meaningful use requirements and the percent of PCPs meeting that stage. In other words, the “meaningful use” requirement that 50% of PCPs must demonstrate meaningful EHR use prior to the second performance year is incorporated into this domain. Additional variables that are assessed in connection with the “Care Coordination/Information Systems” domain include the percent of PCPs using clinical decision support and using electronic prescriptions under the eRx Incentive Program. CMS will also be measuring patient registry use. The method of reporting measures pertaining to use of information systems will be through the new ACO GPRO data reporting tool.

Patient safety will be assessed based upon claims data or CDC National Health Safety Network data and will examine a range of “health care acquired conditions.”

Preventive Health will be measured by assessing the rates of flu vaccinations, pneumonia vaccinations, mammography screening, colorectal screening, cholesterol management, weight screening and follow-up, blood pressure measurement, tobacco use and tobacco cessation intervention, and depression screening. Data for all Preventive Health variables will be submitted via the ACO GPRO data submission tool.

Assessment of quality of care regarding the so-called “At Risk Population” domain focuses on certain at-risk categories: diabetes, heart failure, coronary artery disease, hypertension, and frail elderly. The data source for most of these variables will be the GPRO data submission tool.

At Risk for Diabetes. Quality of care regarding the at-risk population concerning diabetes will be assessed based upon the following variables: a diabetes “composite” measurement, percent of patients with diabetes mellitus ages 18-75 whose most recent hemoglobin A1c was less than 8% and whose most recent LDL cholesterol level was in control, tobacco use, aspirin use, and other clinical indicators.

At Risk for Heart Failure. Assessment of the population at-risk for heart failure will examine the percent of patients with a diagnosis of heart failure who: have a recorded assessment of left ventricular function (LVF); were hospitalized with LVF testing; have weight measure recorded, were provided patient education, who also have left ventricular systolic dysfunction (LVSD) and were prescribed a beta-blocker, who also have LVSD and were prescribed a ACE inhibitor or ARB therapy, and other clinical indicators.

At Risk for Coronary Artery Disease. Assessment of quality of care regarding patients with coronary artery disease (CAD) is based upon the following variables: adherence to scoring of a composite of items including oral antiplatelet therapy, cholesterol drug therapy, beta blocker therapy, LDL level and ACE or ARB therapy for patients with coronary artery disease and LVSD; percentage of patients with CAD that were prescribed oral antiplatelet therapy; percent of patients with CAD that were prescribed lipid lowering therapy based upon current guidelines, percent of patients with CAD that have had prior MI and were prescribed a beta blocker, and other clinical indicators.

At Risk for Hypertension. Assessment of quality of care rendered to those at risk based upon hypertension examines the percent of that high risk population with blood pressure under control and the percentage with high blood pressure with a documented plan for hypertension.

At Risk for COPD. Quality of care with respect to those at risk for COPD is examined by determining whether spirometry measurements are documented for COPD patients, whether the patient received smoking cessation counseling and the percent of COPD patients having an FEV1/FVC ratio of less than 70% who were prescribed an inhaled bronchodilator.

At Risk Frail Elderly. Quality of care provided to at-risk patients categorized as “frail elderly” is assessed by examining the percentage patients over 65 that have been screened for fall risk at least once within 12 months, of women having suffered a fracture who had either a bone density test or a prescription to treat osteoporosis within 6 months of the fracture, and the average percentage of monthly intervals in which Part D patients taking Warfarin do not receive an INR test.

DATA REPORTING AND RANDOM SAMPLING

As noted above, the proposed rules link, on an itemized basis, certain quality measures to certain data sources, such as claims data, survey data, the new ACO GPRO data collection tool and others.

Claims Data will play a significant, but not exclusive role in the quality measurement process. Advantages of using claims data are obvious – no burden. On the other hand, information about specific laboratory results, patients’ subjective opinions, IT utilization, etc., are not contained in claims data, therefore, CMS proposes (and will require) additional data reporting methodologies.

The ACO GPRO is described as a new data collection tool that is based upon an instrument currently used in the Physician Quality Reporting System (PQRS). According to
CMS, this was recently used in numerous large group practices and integrated delivery systems for an assigned population of patients in connection with the PQRS. The ACO GPRO tool is intended to allow ACOs to use existing IT to support data collection and provider feedback.

Measures to be reported via the ACO GPRO tool will be assessed pursuant to a sampling methodology. That is, with respect to each domain, CMS will draw a sample of 411 beneficiaries assigned to the ACO. If the ACO has fewer than 411 assigned beneficiaries, data regarding all beneficiaries will be analyzed. The process will be automated such that CMS will provide the ACO with a pre-populated instrument, reflecting beneficiary specific information, thus requiring the ACO to supplement that instrument with the reportable data. In subsequent years, expect to hear more about expanded and more automated quality measures and reporting that will be directly tied to EHR technology. CMS indicates that its ultimate intent is to create a web-based tool that would interface with EHR technology, permitting EHR data to directly populate the ACO GPRO data collection instrument.

CMS also refers to the use of survey instruments which do not appear to be developed at this time. Additionally, data will be submitted via an attestation of the ACO in some cases.

**Three Take-Away Points:**

There are three key compliance provisions worth highlighting:

1. As noted above, achieving compliance with CMS’s quality standards is a threshold issue for obtaining shared savings.
2. At least 50% of the ACO’s primary care physicians must be “meaningful EHR users” by the end of the initial year of the ACO’s existence. Otherwise, the quality performance standard will not be met and there can be no distribution of shared savings.
3. Quality standards for the initial year of an ACO’s existence will be met if the ACO’s data reporting is 100% complete and accurate for all quality measures. That is, CMS will not be measuring substantive quantity of care with respect to the initial year, rather, it will measure the reporting process only.

CMS also proposes that some current incentive programs will be integrated into the ACOs and others will not. For example, for ACOs that meet the quality performance standard under the shared savings program in the first performance period, those physicians eligible for participation in the PQRS incentive program will also be considered eligible for the PQRS incentive payment. Accordingly, data submission requirements under PQRS would thus be incorporated into the data submission requirements of the ACO.

On the other hand, incentive payments under the EHR Incentive Program or the Electronic Prescribing Incentive Program will not be incorporated into the ACO shared savings program. Accordingly, eligible professionals who participate in those incentive programs could continue to do so independently according to the requirements of those programs.

**Conclusion**

CMS has attempted to fully explain its rationale for measuring quality of care under the recently published proposed ACO rules. Its goals are validity, reliability, efficiency and scalability, none of which can be argued. Additionally, CMS intends these measures to have a normative effect, that is, to actually improve quality of care.

From the perspective of ACO formation, perhaps the single fundamental element of the quality assessment methodologies is not the methodologies themselves but the ramifications of less than 100% compliance which is zero shared savings. Accordingly, ACOs in the planning stages must carefully study the technical details of these quality measurement components and must pay due attention to the implementation, process and financial requirements they impose.

**About the authors**

Andrew McBride and Barry Liss are partners of Kalison, McBride, Jackson & Robertson, P.C., a 14-attorney boutique health care law firm located in Warren, New Jersey, representing health care providers throughout New Jersey in a wide array of health law matters and specializing in ACO and IDS development including hospital based ACOs and the creation of ACO and IDS joint ventures between hospitals and physician entities. They can be reached at AMcBride@kmjrlaw.com and BLiss@kmjrlaw.com, respectively.

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1ACOs in “Track 1” assume risk in the third year; ACOs in “Track 2” assume risk in all three years.
2See 76 FR 19571 – 19591.
3This data collection tool is more fully described at 76 FR 19592-19594. For more information about the eRx incentive program, see 76 FR 19959-19600.
4E.g., foreign object retained after surgery, blood incompatibility, surgical site infection, etc.  See 76 FR 19577.
5The at-risk subcategory, “frail elderly,” is derived from the CMS-HCC Risk Adjustment Model. (See 76 FR 19607-19608).
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all day

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Hyatt Hills Golf
Summer Networking Golf
4:30

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Look hard at the changes within the nation’s healthcare industry, and you’ll see a growing number of business transactions between hospitals and their physicians. These can range from simple employment agreements to complex co-management agreements or compensation agreements related to multi-dimensional acquisition transactions. The common denominator between them is the need for a fair market valuation (FMV) by a qualified advisor.

Standards for FMV in a healthcare transaction have been well-defined by both valuation industry standards and governmental codification. However, many pitfalls and snares await those who are inexperienced with the FMV process. This article identifies ten common problems in determining physician compensation FMV, and how to avoid those traps.

Pitfall 1: Trying to pay superman or wonder woman
To support highly compensated physicians, compensation agreements sometimes define a work effort level (hours worked per week) that is in excess of what Superman or Wonder Woman could be expected to provide. While some physicians can sustain a 50-70 hour work week, requiring 60 hours per week over a full work year invites skepticism of the arrangement. If a physician holds multiple roles in a given institution, i.e. administrative and clinical functions, requiring 60 hours a week in a single role is bound to draw regulatory attention.

Excess effort requirements are also an invitation to the physician to compromise the integrity of the time reporting process needed to insure accurate documentation of work effort under the compensation arrangement. Either of these outcomes is undesirable and will make it difficult to both obtain a FMV opinion and to maintain time-keeping records that will withstand possible audit.

Pitfall 2: There’s a ghost in the house
Hospital physician employment agreements and professional services arrangements normally contain a specific list of duties and responsibilities for the position. Clinical services are easy to define, but administrative, supervisory and teaching (AS&T) services are more problematic. Too often the tasks listed are overly broad, too vague or unnecessarily esoteric and raise questions of substance and authenticity of the physician’s role under the arrangement.

To remove the “specter” of a padded scope of work, define the duties and responsibilities of the position to be consistent with organizational needs and expectations and also to be measurable for performance evaluation purposes.

Pitfall 3: Fruitless “cherry-picking”
Valuation advisors are required to apply three methodologies when determining the FMV of a transaction. These approaches—income, market and cost—rarely yield the same result in a given valuation. While there may be reasons to select one result over another (“well, we don’t want to pay too much for this practice” or “we really need to pay this physician top dollar to secure his services or loyalty”) the FMV usually is determined by considering the applicability of all of the methodologies and then applying judgment as to which one(s) are best reflective of FMV.

When the “best” outcome is used to justify a compensation level, the result can be a biased or indefensible value. Like kids picking and eating unripe cherries, hospital leaders that pursue this strategy are setting themselves up for a belly ache.

Pitfall 4: Trying to buy a cadillac at a chevrolet price
Physicians interested in serving in an administrative, teaching or supervisory (AS&T) role are often offered compensation at a rate below what they could earn for equivalent time in their clinical practice. This can deprive a hospital of the

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services of a physician who is important to a core mission program. FMV standards may allow a compensation level that will be more appealing to the physician.

In many instances, when the AS&T role is less than 50% of a physician's standard work week (defined as 40 hours), the FMV can be based on clinical benchmarks drawn from market-based data. Clinical compensation benchmarks for most specialties are higher than for administrative positions. Using clinical compensation benchmarks as the proxy for FMV in those situations is equitable for the physician while allowing the hospital to match his/her skills and experience to the position's requirements.

Pitfall 5: One size does not fit all situations

Compensation for on-call services provided by physicians is both a political and a financial issue for hospitals and their medical staff. Valuation of on-call services should be objective and consistent, yet meet all parties’ needs.

The bulk of on-call services in most hospitals is provided by physicians providing coverage from home while carrying a beeper. The FMV methodology most commonly used for these services involves the use of a discounted hourly rate derived from published benchmark data. The discounted rates range between 10% and 25% of the full hourly rate (annual compensation divided by 2080 hours) for the physician's clinical specialty.

The discounted rate selected should consider several factors: the importance of the call coverage to the hospitals operations, frequency of the required call coverage and the physician’s ability to generate professional fee income when called into hospital to provide services.

Pitfall 6: Treating quality differently from quantity

Compensating physicians for productivity has become standard practice in the health care industry. Productivity measures using wRVU’s (work Relative Value Units) are now commonly used to measure a physician’s work effort and can be used to support FMV remuneration—especially the base component of a compensation package.

Metrics for quality are more limited and must be carefully selected when being used in the FMV process. This is particularly true when quality is to serve as the basis for a performance-based incentive component of a physician's compensation package.

In determining the FMV of compensation for quality-based performance, several criteria need to be considered:
Pitfall 7: Fair but unreasonable!

Compensation FMV determinations often overlook or ignore the two separate, but interrelated, concepts of which it is composed: fair market value and commercial reasonableness.

Fair market value is the compensation that would be included in an arrangement that results from bona fide bargaining between well-informed parties to the arrangement who are not otherwise in a position to generate business for each other.

Commercial reasonableness requires that the arrangement would make commercial sense if entered into by other reasonable parties of similar size and scope of business interests.

As an example: A hospital may offer to compensate a cardiologist $200 per hour to serve as the medical director of the heart station (FMV), but it is not commercially reasonable for them to hire three medical directors for the heart station.

Compensation paid by a hospital to a physician(s) under the arrangement must meet both of these tests. Being both fair and reasonable is necessary to avoid unexpected consequences in the future.

Pitfall 8: Flying too close to the sun

FMV analyses for physician compensation purposes use nationally published data for determining market-based rates. This data is stratified into percentiles—usually the 25th, 50th, 75th and the 90th. As a rule of thumb, compensation paid to a physician should fall between the 25th and 75th percentile of the market. Compensation above the 75th, but below the 90th percentile range, can be supported under FMV if one or more of the following criteria are evidenced:

- The position and its requirements are unique to the market place
- The physician under consideration has qualifications, credentials and experience that can support the use of this standard
- There is a limited pool of qualified physician candidates available to fill the position

Setting a compensation level above the 90th percentile is ill-advised. Since it is likely to exceed the FMV threshold, it poses a significant risk of external review with the attendant justification issues. When extremely high compensation levels are required to obtain the services of a physician who meets the criteria above, the best approach is to structure the compensation package with a base component and an incentive component, both of which, if properly set, can be supported under FMV.

Pitfall 9: Treating a “rock star” like an opening act

A step above the highly-compensated physician are the handful of doctors who can only be termed medical rock stars. These high profile physicians exhibit extraordinary performance levels with broad and diverse responsibilities. They are unique to a regional, or even national, marketplace and can command a compensation package that far exceeds usual and customary FMV considerations. They generally hold positions in academic medical centers and/or large metropolitan centers. It is impossible to establish the FMV of such a rock star by using standard market data.

Thus, FMV efforts for these physicians are usually based largely on anecdotal information that has been sourced and thoroughly vetted by an independent party knowledgeable about physician compensation within the industry.

Since these physicians typically wear multiple hats, the FMV evaluation can be strengthened by dividing their roles or functions and valuing each component separately. Then, by aggregating the individual valuation results, a composite result can be used as a proxy for the FMV.

Pitfall 10: Putting the cart before the horse

The most frequent and, often, egregious FMV mistake hospitals make is consummating a physician transaction before the financial remuneration being offered is subjected to a FMV analysis. If a compensation package fails to meet FMV tests, the resulting need to revise, renegotiate or even renege on a deal can cause substantial consternation among the parties or even destroy an important business relationship.

A proposed transaction term sheet should be conditioned upon obtaining a satisfactory FMV opinion. This simple step provides a safeguard to the parties before the transaction is locked-in and the detailed documentation process begins. Another important step in this process is checking the final documentation for consistency with the term sheet to insure that they both agree for all items that could impact on FMV. In essence, there is no substitute for having an institutional protocol that provides a step-by-step process for completing a physician/ hospital business transaction. The protocol should clearly indicate when and how a FMV analysis is to be completed within the process.

Avoiding these pitfalls can take an organization a long way towards minimizing the risks associated with physician compensation and fair market value. To be sure these risks continued on page 44
really are minimized, hospitals should also take time to appro-
riately structure all arrangements up front. A short delay in
completing a transaction is far more tolerable than living un-
der a long-term, intrusive government compliance agreement.
Make sure that all details of the physician transaction are fully
and complete documented. In an audit, “I don’t remember” is
a poor substitute for proper documentation.

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HFMA’s New Jersey Chapter Receives National Excellence Award

Westchester – June 6, 2011 - The Healthcare Financial Management Association’s (HFMA) most prestigious chapter award, the Robert M. Shelton Award for Sustained Excellence, will be presented to the HFMA New Jersey Chapter on June 28 during the Annual Chapter Presidents’ Dinner at HFMA’s Annual National Institute in Orlando, Florida.

The Shelton Award is given in recognition of five years of sustained excellence in service to members. This year alone (2010-11) the New Jersey Chapter achieved a Silver Award for Education with 16.6 registrant hours per member; the Henry C. Hottum Award for Educational Performance Improvement, growing 100.7% over last year’s registrant hours; Gold Award of Excellence for Certification with 17 passed exams. The Chapter is also receiving a Bronze Award of Excellence for Membership and five Helen M. Yerger Special Recognition Awards.

In the past five years, the New Jersey Chapter has displayed year-over-year growth in education hours, member counts, and certified member counts. In that time, the Chapter has also earned:

- Five Hottum awards for educational performance improvement
- One gold and one silver award for certification excellence
- Two silver and one bronze award for education
- One gold and three bronze awards for membership growth and retention
- 21 Yerger Awards

“The New Jersey Chapter has done excellent work over the past five years, particularly in the area of education,” says HFMA President and CEO Richard L. Clarke, DHA, FHFMA. “The chapter is very deserving of this most prestigious award.”

About HFMA
The Healthcare Financial Management Association (HFMA) provides the resources healthcare organizations need to achieve sound fiscal health in order to provide excellent patient care. With over 36,000 members, HFMA is the nation’s leading membership organization of healthcare finance executives and leaders. HFMA helps its members achieve results by providing education, analysis, and guidance, and creating practical tools and solutions that optimize financial management. The organization is a respected and innovative thought leader on top trends and challenges facing the healthcare finance industry. From addressing capital access to improved patient care to technology advancement, HFMA is an indispensable resource on healthcare finance issues. www.hfma.org
The New Jersey Chapter of HFMA is pleased to announce its 35th Annual Institute at the Borgata Hotel, Casino and Spa, Atlantic City, NJ October 12 - 14, 2011

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