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

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To the membership of the New Jersey Chapter:

Hopefully by now everyone is starting to thaw out from the long, snowy winter we’ve had so far this year. At next year’s Annual Institute, snow shovels and bags of rock salt may be the giveaways if this trend keeps up!

As we were finalizing this edition of the Focus, the Physician Practice Forum was preparing for the committee’s inaugural education session on February 11th. Many thanks to Jennifer Shimek, Chair, Howard Lasner, Co-Chair, and Deborah Shapiro, Board Liaison, and the entire committee for all of their efforts. This forum has been of great interest to our membership since it was established earlier this fiscal year as the group discusses the many innovations that continue to develop in the complex physician-hospital relationship.

Please also mark your calendars for several upcoming events over the next few months:

- **March 3, 2014 – March 26, 2014**: CHFP Certification On-Line Workshop. This program will consist of eight one-hour webinars to prepare for the HFMA CHFP certification exam. Christoph Stauder, a past president of the Oregon HFMA chapter, has led similar programs in other parts of the country with participants experiencing improved exam pass rates.
- **March 11, 2014**: Fifty Shades of Compliance or Working in the Grey Zone. Presented by the CARE Forum, Lisa Hartman, Chair, Dara Quinn, Co-Chair, and Erica Waller, Board Liaison.
- **April 22, 2014** (South / PM session) and **April 24, 2014** (North / AM session): The FACT committee’s annual North-South sessions (free to members) will cover topics including the health care exchanges, disaster recovery and capital financing. The FACT committee is led by Megan Byrne, Chair, Karen Henderson, Co-Chair, and Scott Mariani, Board Liaison.
- **May 6, 2014**: 2014 Golf Classic. The Chapter’s annual golf and networking event will be held at Fiddler’s Elbow in Bedminster Township, NJ. Please join us for golf, cocktails and dinner. Sponsorship opportunities are available (please contact Laura Hess at njhfma@aol.com).

More information for each event can be located on the Chapter’s website, http://www.hfmanj.org.

It’s also the time in our Chapter’s fiscal year where we start looking ahead to next year – identifying our next group of committee leaders, board members and officers, planning for next year’s Annual Institute and other ways to continue to improve and grow our Chapter. Volunteers are always welcome, please reach out to any Board member or Committee chair if you are interested.

Please stay connected and involved with our Chapter. I look forward to seeing you at an upcoming event.
Dear Readers,

Please do not hold the cover photo against me. I promise that the cover of the next issue will NOT involve snow or ice or anything resembling cold weather. We are all ready for the spring thaw and outdoor activities that do not involve shoveling, slipping, or shivering!

Once again, the articles in this issue cover a wide range of topics pertaining to the health care industry in New Jersey, and the Communications Committee and I hope you find them informative and engaging. In addition, this issue includes a new feature. We have included the “Editorial Calendar” for 2014 (check out the colorful pages near the back of the issue) to highlight topics that will be covered in upcoming issues. The list of topics is not exhaustive and we will accept article submissions for inclusion (space permitting) even if the topic is not one listed on the Calendar, but our goal is to give readers, article contributors, and advertisers a glimpse of the content we are seeking and featuring for each issue.

For the Summer issue, we will focus on data privacy developments, employer clinics, direct contracting between employers and providers, and New Jersey budget issues. I welcome your submissions, as well as your ideas for topics you would like to see addressed in articles that are not included on the Editorial Calendar. Communications Committee member Rhonda Maraziti of WithumSmith + Brown, P.C. did a fantastic job creating this new Editorial Calendar – thank you! The quality of this magazine, the Chapter’s educational programs, and committee activities depends on the volunteer efforts of talented Chapter members like Rhonda and so many of you who work to make membership in HFMA worthwhile.

Last, but certainly not least, I want to draw your attention to our renovated website. Check it out at www.hfmanj.org and let us know what you think!

Regards and happy reading,

Elizabeth G. Litten
Editor
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Top 10 New Year’s Resolutions for Hospital CFOs

by Lewis D. Bivona Jr., CPA, AFE

It appears that 2014 will bring another year of challenges to the hospital industry. Fifteen states have exchanges up and running on their own without the problems being experienced at the Federal level. The federal government, that has set up jointly managed or direct exchanges is old news, and deeply troubled by IT and other issues. The panacea of affordable care for all is doubtful in that it is anticipated that most younger eligible are shying away from the exchanges while, as expected, those older and patients with health issues are flocking towards the plans.

The most dangerous concern for all providers is the apparent trend to select lower coverage plans which do little or nothing to protect individuals from financial devastation (high deductibles, co-pays, coinsurance and limited networks). These issues reemphasize the necessity of hospitals to operate in the most cost effective and diligent manner possible. Nothing is off the table when it comes to managing costs, whether it is human capital, provider, utilities, pharmaceuticals or supplies. There is a great degree of uncertainty in the industry, fueled by concerns over the ability of developing ACOs to control costs, the impending taxation of healthcare benefits, the roll out of ICD10, whether state exchanges will limit uncompensated care or just add to it, increased enforcement actions by OIG and RAC auditors, new Medicaid Integrity contractors gearing up for intensive audits, bond covenant defaults, lack of capital for projects and erosion of the bottom line.

As a hospital CFO, what are the things you should be thinking about and doing, going into 2014? The following is a list of Top 10 New Year’s Resolutions every hospital CFO should be making in order to move forward on a positive note in 2014:

1. Bundled payments are déjà vu all over again, as I predicted last year. With the advent of ACOs and challenges of affordable care, hospitals should be preparing, more than ever, to bundle hospital based physician costs (hospitalists, anesthesia, emergency, pathology, radiology, NPPs, social workers and employed physicians) into your rates if you have not done that already. Under healthcare reform, more people than ever will start to show up at your facility but not with the best insurance coverage; efficiency and cost controls will drive you toward profitability since most of these new patients will be eligible for Medicaid expanded benefits it will be a strain on hospitals; with or without expansion the ACA reduces DSH payments, beware! Procedure demand will be up on an outpatient basis since pent up demand from 2013 will finally materialize as Exchanges start to come online; don’t forget to price your procedures to be competitive with free standing facilities, if possible. Monitoring patient status of insurance payments will also be critical since Obamacare allows a 90 day grace period to pay which could result in retroactive denials for approved services if payments are in default; AHA has researched whether or not hospitals could pay premiums in these instances, and there seems to be no prohibition although CMS is not wild about the idea, but it might pay to do it on a case by case basis. Lastly, look out for changes in plan offerings as employers move to different offerings (HDHPs and HASs) that can have a detrimental impact to your cash flow by forcing employees into higher deductible plans.

2. Have you created medical homes? Medical homes are clearly going to be the key driver of managing healthcare costs under reform, even though it has had a dismal start. Do your homework on how to adapt your institution to be profitable in the new healthcare environment, including aligning with payors or other HMOs to develop co-branded products. If you have not aligned with your physicians yet, you better get busy because medical homes will be driving volumes of both inpatient and outpatient services well into the future! By all means, don’t forget to factor in nurse practitioners and other complementary care extenders into your plans to combat the anticipated physician shortage. continued on page 8
NOW is the Best Time in History for Hospitals to Invest in Cogeneration.

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Also, don’t forget to fix your contracts with payors before changing your business model or service offerings. Equally important, don’t forget to factor in risk sharing and performance criteria into your contracts and make certain it is crystal clear how the savings are divvied up.

3. Just like last year, quality at your hospital will continue to be a paramount for reimbursement. Payment reform is rewarding facilities that can do the right things and measure them; the shared savings programs sponsored by Medicare are proof of that! Healthcare acquired infections begin in FY 2015 so it is not too early to start lowering your rates now; hospitals that are in the lowest quartile for medical errors and serious infections will be paid 99% of the IPPS rates. Quality also focuses on lowering readmission rates, those that don’t will suffer up to a 2% decrease to their payment; don’t forget that in addition to the current readmission tracking (heart attack, pneumonia, and heart failure), CMS will be adding COPD and knee surgery to the list effective FY 2015. More and more patient centered outcomes will be in the sights of the healthcare reform law. Don’t rely on the government or payors to measure your quality, be prepared to support your activities and outcomes; remember how many reports have been issued in the past that have erroneous measurement data that needed to be refuted? Also, don’t forget that patients will be asked to give feedback on their care which has no bearing, per se, on the real clinical outcome. Remember, even NJ Medicaid is rolling out quality incentive plans; if you can’t measure your successes, someone else will tell you how you performed, and this option is not preferred.

4. When in doubt, don’t layoff! Retask department heads, managers and line staff to be agents of change. A lot needs to be done with new system implementations for ACO participation and risk sharing deals, ICD-10 roll out, infection control, discharge planning, meaningful use measurements, and readmission avoidance and not to mention the criteria relating to the “two midnight rule”. Staff involvement guarantees better buy-in and roll out of action plans that they are invested in, not those by fiat. Don’t forget about your nurses and NPs. Under reform there will be more of a demand for...
them than in the past; older seasoned nurses might just give up and retire if you are not attentive to their wellbeing.

5. Do not scrimp on compliance activities! While the 2014 OIG Workplan will not roll out until on or about the time this is published, it will probably be 2013’s on steroids. Make compliance a strategic initiative and ingrain it in your organizational culture. With the increased scrutiny that hospitals will be receiving by all governmental payors, you cannot afford to side step good business and governance practices. Compliance and internal controls will be a key ally in saving your hospital from embarrassing press articles and, even worse, monetary recoupments and fines. Don’t forget, there are many new payors (COOPs, new medical payors, new exchanges) that the government will be auditing to make sure they are not wasting tax money; this requires even more diligence on billing staff to assure that billing and reimbursement activities are accurate.

6. Pay attention to revenue cycle coding, including the impending change to ICD-10. Many providers still have not prioritized preparation activities for ICD-10, thinking that those changes would be pushed back one more time; not so. CMS announced in its “Final Rule” that it will be October 1, 2014 for real! Those that are not ready will suffer financially. ICD-10 preparation cannot be put off any longer since system testing and educating billers, coders, staff and physicians will be required. The new code sets are 5 times larger than ICD-9 so they should not be taken lightly. Also, coding and mapping tests should be completed as the government auditors will be all over errors as coding fraud.

7. IPPS increases are not going to make up for the overall increase in your costs of business unless you think you can hold your costs to less than one percent. Standardize physician preference items if you have not already done so. It would also not hurt to standardize treatment regimens, but don’t attempt to do it without provider buy-in. Hospitals and providers on the left coast are way ahead of us in paring down costs particularly in the pharmaceutical area. There are great companies out there that can help to benchmark your supply spend and ferret out the best deals without sacrificing quality. Some hospitals are also sending patients home with medicines to prevent inappropriate readmissions. Watch out for expensive new biologics which could easily blow away other savings initiatives. Cutting costs while still providing quality care will become much easier in a shared savings environment!

8. Technology will become more prevalent with health applications that are being deployed by your institution or related health partners. Evaluate security safeguards and make sure to incorporate these strategies into your risk management program. As data is being shared with more partners in the continuum of care, more opportunity for errors can arise.

9. Consider the possibility of a merger with another hospital for strategic reasons including the ability to manage patients through a large network, which is the heart of accountable care. M&A activity is expected to peak in 2014 and stand-alone hospitals will find that it is harder to achieve economies of scale that will be required under healthcare reform. Review of data supports that hospital systems typically perform 3-4% points higher than unaffiliated hospitals. Other benefits of mergers or affiliations include ease of medical staff management, better negotiating positions with payors, and enhanced access to capital.

10. High touch not only includes patient quality items. Remember your hospitals mission and continue outreach activities in the community; remember that community services count on your 5500 Form! Patient loyalty is as important to future revenues as any other activity.

Remember that success rarely comes to those who wait… it comes to those that do! Use these tips wisely to propel your organization forward in 2014!

About the Author

Lewis D. Bivona, Jr., CPA, AFE, has over 36 years of experience in the healthcare industry. Lew can be contacted at ldbcpa@verizon.net. He assists clients with risk positioning and medical home formation related to healthcare reform, payer contractual negotiations, payment dispute resolutions, litigation support and healthcare compliance matters.
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Ambiguities Sow Confusion Concerning Enhanced Payments to Medicaid Primary Care Providers under the ACA

Leonardo M. Tamburello

Increased Medicaid beneficiary access to primary care services is one of the signature ambitions of the Affordable Care Act. Section 1202 of the Healthcare Education and Reconciliation Act of 2010 (the “Statute”) attempts to achieve this goal by increasing payments to qualified primary care providers for selected primary care services provided in 2013 and 2014.1

Eligibility & Administrative Requirements

To qualify for these so-called “Enhanced Payments,” providers must self-attest that: (1) they are Board-certified and specialize in family medicine, general internal medicine, pediatric medicine, or any subspecialty within those designations recognized by the American Board of Medical Specialties, the American Osteopathic Association, or the American Board of Physician Specialties; or (2) at least 60 percent of their paid Medicaid claims for the prior calendar year were for eligible E&M or vaccine administration services as defined by the Statute. (“Qualified Services”).2 Qualified Services performed by non-physician practitioners (such as advanced practice nurses, nurse midwives and physician assistants) count towards this 60 percent threshold, provided that they were provided under the personal supervision of an eligible physician who accepts professional and legal liability for the services provided by the non-physician practitioner.3

Of course, reimbursement (including Enhanced Payments) is appropriate only where providers have delivered services in accordance with their managed care contract and Medicaid requirements. Consequently, in the event of an audit which requires setoff or recoupment, the Enhanced Payments related to ineligible services would also be subject to repayment.4 At the moment, Enhanced Payments have been authorized for Qualified Services performed in 2013 and 2014, but CMS has indicated a willingness to extend Enhanced Payments indefinitely, assuming Congressional funding materializes.5 Services through a federally-qualified health clinic (FQHC), rural health clinic (RHC), or performed for clients in standalone non-Medicaid programs such as Children’s Health Insurance Program (CHIP), are not eligible for Enhanced Payments.6

Though Enhanced Payments are funded exclusively by the federal government, CMS has given individual states and managed care organizations (“MCOs”), prepaid inpatient health plans, and prepaid ambulatory health plans broad discretion in their administration.7 For example, the Enhanced Payments may be made as “either add-ons to existing rates or as lump sum payments,” made no less than quarterly.8 This has led to varying (and sometimes inconsistent) approaches among states and MCOs. It has also confusion among providers and their employees. Although CMS issued rulemaking guidance which makes clear that MCOs are “required by regulation and contract to ensure that eligible primary care providers receive the appropriate rate increase for primary care services rendered,”9 it did not specifically define the term “provider” in this context.

Nonetheless, some MCOs have stepped in and defined that term to exclusively mean “rendering provider.”10 This definition completely disregards the fact that the “rendering provider” may be an employee of a group provider; that the group provider is most likely the contracting party with the MCO; and in most cases there is an employment contract between the group provider and the rendering physician which addresses the manner in which reimbursement for professional services is treated.

Unwarranted MCO Requirements Create Confusion

Horizon NJ Health, (“Horizon”) has taken the position that “[r]he enhanced payment[s] must ultimately be paid to continued on page 12
continued from page 11

the physician rendering the service so the individual physician, not the group practice, is receiving the benefit of the enhanced rate.” To this end, HNJH requires groups providers sign a “Group Attestation” in which they

Certify that all ACA authorized enhanced reimbursement amounts may be paid to the group’s Tax Identification Number, and the group, as required under the ACA, will distribute individual payments to the rendering provider in the group.

Neither Horizon, CMS, nor New Jersey Medicaid have publicly identified any basis in the ACA or the Final Rule to support the position that all Enhanced Payments must be made to rendering physician employee of a group practice, despite the Group Attestation’s clear mandate to that effect. Indeed, there is no legal requirement for such action, either in the ACA or the regulations implementing the Enhanced Payments. Moreover, neither the Statute nor the implementing regulations discuss the most common group employer scenario whereby a group provider employs the rendering physician through a contract contains a provision which assigns all revenue generated by their professional activities to the group.

The closest that the regulations come to addressing this point is a statement concerning salaried county-employed physicians, saying that “[i]f, as a condition of employment, the physician agrees to accept a fixed salary amount then we expect an appropriate adjustment to the salary to reflect the increase in payment.” There is absolutely no discussion of how this “appropriate adjustment” should be calculated or what effect terms of an existing employment contract might have on the situation. Into this vacuum, Horizon has invented the Group Attestation language above and interjected itself into a private contract between the group employer and its individual physician employees.

Both federal and state regulators are aware of group attestations such as Horizon’s. Nonetheless, CMS appears content not to intervene, so long as the MCOs themselves do not retain any of the Enhanced Payments. Similarly, New Jersey Medicaid seemingly does not find Horizon’s requested Group Attestation objectionable or problematic.

Perils of Signing the “Group Attestation”

Despite the regulatory indifference to Horizon’s unfounded demand that group providers sign a sworn statement that they will pay all Enhanced Payment amounts to rendering physician employees, signing the Group Attestation has potentially perilous consequences far beyond the obvious one of depriving the group provider of the increased funding to which it is entitled under the ACA. Group providers who sign Horizon’s attestation may face a recoupment or setoff from the payer, in addition to potential exposure under the False Claims Act if a future audit determines that the Enhanced Payments were not passed down to the rendering physicians.

Moreover, requiring that the rendering physician receives the Enhanced Payment does nothing to advance the Statute’s stated goal of enhancing Medicaid beneficiary access to primary care services. In contrast, depriving a primary care group of the ACA’s financial benefits encourages the hiring of fewer, not more, doctors; because all medical practices must be owned by licensed physicians, Horizon’s attestation encourages owners of primary care providers to act as the rendering physicians themselves, rather than using salaried physicians or non-physician practitioners to increase access. Thus, the Group Attestation may have the complete opposite effect from that intended under the ACA by curtailing (rather than expanding) Medicaid beneficiary access to primary care services.

Requiring that Enhanced Payments be made to rendering physicians also fails to recognize the entrepreneurial risk taken by physicians who form group practices that provide primary care services to Medicaid beneficiaries; it also deprives them of obtaining any relief from the loans or personal guarantees they have assumed in doing so.

In addition, by signing Horizon’s Group Attestation, a group provider could be potentially creating an ambiguity concerning terms of employment with their contracted employee physicians as to whether the Enhanced Payments should be treated differently from other revenue generated by employee physicians, which is typically assigned to the group. It may be argued that by signing the Group Attestation, the group provider is expressing agreement or intent that Enhanced Payments should be treated differently from all other forms of remuneration, (i.e., given to the rendering physician). Potentially, this may create unnecessary disputes between group employer and employee physicians over entitlement to the Enhanced Payments, particularly if the employee-physician’s employment contract predates the Statute’s enactment and/or does not specifically address the issue of Enhanced Payments or compensation under the ACA.

Risk Avoidance and Mitigation Strategies

Providers should think carefully and consult with experienced healthcare counsel before signing any attestation or amendments to their provider agreement addressing the disposition of Enhanced Payments under the ACA. If they decide to do so, it should be with a full understanding that they could be creating an expectation that the entire Enhanced Payment will be turned over to the rendering physicians, and that if they fail to do that, there are unpredictable and potentially serious consequences that may follow. In
appropriate circumstances, a group provider may consider an attestation that pursuant to the employment contract between the itself and its rendering employee physicians, the latter have assigned all rights to reimbursement for professional services to the former, which includes that related to the Enhanced Payment.

Given the dearth of regulatory leadership and lack of explicit authority to address the common situation where a group provider employs salaried physicians whose employment contracts provide for the assignment to the group of all remuneration received as a result of professional activities, prudence suggests that some portion of the Enhanced Payments should be shared with the salaried employed physicians (and other non-physician professionals) who provided Qualified Services which led to the Enhanced Payment through direct or deferred compensation. In addition, the remainder of the Enhanced Payment should be used by the group practice to further the Statute's stated goal of increasing access to primary care services for Medicaid beneficiaries. This can take a variety of forms including the purchasing of new equipment, hiring new employees, expanding office hours, or retiring debt related to the operation of the practice. In the event of an audit, clear documentation evidencing the disposition of the Enhanced Payment should be maintained in accordance with the group’s document retention practices.

Summary

While Enhanced Payments under the ACA are powerful incentives for primary care providers to expand their Medicaid services, providers should nevertheless act cautiously and insure full eligibility and compliance with CMS directives as well as contractual requirements. Anytime a signed attestation is requested, a provider should carefully scrutinize the representations it contains, and consider consulting with experienced healthcare counsel for specialized advice. As discussed above, the basis for the Group Attestation appears dubious at best and could lead to serious compliance issues including setoff and recoupment, as well as exposure and civil monetary penalties under the False Claims Act.

Endnotes

7. 77 Fed. Reg. at 66671 and 66680.
8. 77 Fed. Reg. at 66679.
13. 77 Fed. Reg. 6669-66701
17. 42 C.F.R. 405.370.

About the author

Mr. Tamburello is of counsel in the Healthcare Practice Group at McElroy, Deutsch, Mulvaney & Carpenter, LLP in Morristown. He concentrates his practice on the representation of healthcare providers in a variety of litigation and dispute resolution contexts including medical malpractice defense, compliance, audits, fraud and abuse, and privacy and information security.

•Certification Corner•

It’s all at your desktop!

While skillset required to become board certified in healthcare financial management remains robust, the process to become certified has never been easier. HFMA offers an online exam study materials and most recently online exam proctoring. The NJ chapter is now also offering an online CHFP exam preparation course during the month of March. For more details on the CHFP exam, visit the certification section at www.hfma.org. Information related to the NJ Chapter’s program or certification in general can be direction co-chair: Eric Fishbein at eric.fishbein@connolly.com

Remember, the NJ Chapter will reimburse members who successfully pass the CHFP exam for the cost of the exam as well as preparation materials.

Congratulations to the NJ Chapters newest certified member: Christopher Ault, CHFP!
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Hospitals are Discovering Why Now is a Great Time to Look at Cogeneration!

by Paul Errigo

There has never been a better time than right now for hospitals in NJ and NY to take a serious look at Cogeneration.

Cogeneration represents one of the most effective approaches to energy cost reduction, because it produces two types of energy at once – Electric Power and Thermal Energy. In addition to the significant benefit of reducing a hospital’s energy costs by 40-60%, it also serves as an energy backup system; it reduces the risk of power outages, and minimizes the extra cost charged by utilities for electricity during peak-use periods (demand charges). Right now in NY and NJ, government incentives can pay for up to 50% of project costs.

What is CHP?

Cogeneration, also known as Combined Heat & Power (CHP), is the simultaneous production of electricity and heat from a single fuel source – most commonly Natural Gas. When traditional utility power plants burn fuel to produce electricity, they also produce tremendous amounts of heat. This heat can represent approximately 70% of the energy content of the fuel used, and is lost as it is vented into the atmosphere.

With cogeneration, you generate the electricity on site, capture the waste heat, and utilize it for a variety of thermal applications. Cogeneration captures waste heat and then converts it into usable energy that can then be available to augment existing boilers and chillers for heating and cooling, domestic hot water or steam, and sterilization. This captured energy comes at no cost to the hospital because it is a natural bi-product of the electricity produced.

Hospitals Are Strong CHP Candidates

According to the US Dept. of Energy, “Hospitals are ideal candidates for combined heat and power (CHP) systems because hospitals function 365 days a year, 24/7, and they require round-the-clock energy. CHP systems enable hospitals to reduce energy costs, improve environmental performance, and increase energy reliability. Resources saved are often redirected to improve patient care.”

For hospitals the benefits of cogeneration are numerous:
- Reduced energy bills (40-60% on average) allowing a ROI of 5-10 years, and under a five year ROI in many cases with government incentives. Incentives often pay for up to 50% of the project.
- Redundancy - Additional Standby/backup power supply.
- Physical hedge against rising utility charges.
- Improved carbon footprint & longer life of boiler equipment.

CHP Benefits
Lower Energy Costs
In New York, New Jersey, and most of the northeast, hospitals pay an average of $0.16 per kWh. A CHP system can continued on page 16
operate in the range of $0.04 - $0.06 cents per kWh, so the savings are significant.

**Increased Reliability**

With CHP, hospitals get lower, more predictable energy bills. Total system energy is improved when power is produced onsite through a CHP system. By enabling hospitals to supply their own power, CHP systems provide a hedge against the rising cost of electricity.

The following are a few case studies and examples of systems completed or in process, and demonstrate what an impact a CHP system can have on a hospital’s bottom line:

- The Methodist Hospital (Houston, TX) in 2008 built a 4.6 MW system that uses turbine technology with a heat recovery steam generator and 2800-ton, steam chiller.
- Weill Cornell Medical Center (New York, NY) installed the same year a 7.5-MW CHP system that meets all of its base electric load and nearly 70% of its peak demand thereby allowing an 80% cut in its utility electricity purchase. One third of the hospital’s steam demand is met by a heat recovery boiler.
- NYU Langone’s new CHP system will use turbines and a heat recovery system to meet the steam needs of all of the buildings and taking it off ConEd’s expensive steam loop. When the system is fully operational in 2018 the hospital estimates it will save $17 million per year.

**Federal, State and Utility Incentives:** Under pressure from their Public Service Commissions, many utilities are changing their tariffs to promote CHP. Given that hospitals never disconnect from the grid when using Cogeneration, with a CHP system the “standby” rates utilities charge is key. States such as New York and New Jersey offer millions in grant monies to support CHP installs, and the federal government gives a 10% Investment Tax Credit and accelerated 5-year depreciation.

**More Reliable Emergency Power**

Hospitals must perform critical, life-saving functions even when a widespread disaster interrupts their supply of electricity from the grid. CHP can be designed to maintain cricial
life-support systems, operate independently of the grid during emergencies, and is capable of black start (which is the ability to come online without relying on external energy sources). Because they are already up and running, CHP systems can offer a more seamless, reliable power alternative than traditional emergency generators.

**CHP’s Role in Superstorm Sandy**

There are numerous stories of how CHP systems proved reliable during Superstorm Sandy for hospitals and other facilities. According to an article written by the Association to Save Energy, “The immense benefit of CHP was wonderfully demonstrated during Hurricane Sandy where many facilities with CHP kept the lights and heat on during and after the storm,” Houston Advanced Research Center’s Gavin Dillingham said in a recent newsletter. Such facilities included housing complexes, as well as university and hospital campuses.

CHP systems enabled buildings, hospitals, and entire campuses to retain full heat and power – even after losing grid-supplied electricity. This not only enabled these facilities to maintain critical operations during and after the storm, but also relieved the storm-stressed grid as electric utilities struggled to restore services.

Along with other hospitals in the tri-state region, South Oaks Hospital on Long Island drew full power from its CHP plant during Hurricane Sandy. Seeing the impending emergency, South Oaks engineers proactively isolated the 350,000 square foot facility, which includes an acute psychiatric hospital, nursing home, and an assisted living center, in the early evening on Oct. 28. The hospital’s 1.3 megawatt CHP plant provided full power until the electric grid stabilized. [http://www.ase.org/resources/chp-kept-schools-hospitals-running-amid-hurricane-sandy](http://www.ase.org/resources/chp-kept-schools-hospitals-running-amid-hurricane-sandy)

**Think You Can’t Afford CHP?**

Many hospitals are faced with financial challenges or the fact that they are a not-for-profit organization and cannot take advantage of the tax incentives that increase CHP affordability. Some may also have a more pressing need or priority for their capital.

A Power Purchase Agreement (PPA) can provide hospitals all the benefits of CHP with ZERO CAPITAL ($0) required, and ZERO ($0) operating & maintenance costs.

A PPA provides an investment into a hospital by installing, owning, & operating a CHP system at no cost in exchange for an agreement by the hospital to purchase all the energy the system produces at an agreed upon discount off the lowest secured utility rate. The hospital continued on page 18
in turn gets an on-site power source and improves its bottom line by reducing the cost of electricity, heat, hot water, and cooling.

The hospital only pays for the energy they need and would otherwise purchase from the grid at a discounted rate that is GUARANTEED. Savings and terms typically vary from 5 to 15% and from 5 to 15 years.

In addition to monetary gains, CHP enables you to position your hospital as a green facility and environmentally responsible. Some companies who offer a PPA may also include any additional equipment that will benefit the cogeneration system; i.e. an absorption chillers, boiler, cooling tower, etc.

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About the Author
Paul Errigo is a Partner and the Director of Business Development at GREENCROWN Energy (GCE), a turnkey developer of Cogeneration Systems & Power Purchase Agreements. He is a member of HFMA and a frequent speaker on Cogeneration (CHP) for a variety of industries. GCE is an official partner with the US Dept. of Energy and the EPA’s Combined Heat & Power Partnership. They are members of NJ’s Clean Energy Program, The Association of Energy Engineers, and the NJ Chapter of the US Green Building Council. GCE also provides related energy conservation measures such as Energy Supply Cost Reduction, Special Case Resource (Backup Generator Revenue), & HVAC/R Efficiency Restoration.

Paul can be reached at perrigo@greencrownenergy.com

mark your calendar . . .

<table>
<thead>
<tr>
<th>Date</th>
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<th>Event Description</th>
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<tr>
<td>March 11, 2014</td>
<td>Woodbridge Hilton</td>
<td>all day Education Series: Fifty Shades of Compliance or Working in the Grey Zone Compliance, Audit, Risk &amp; Ethics</td>
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<td>April 22, 2014</td>
<td>Woodbridge Hilton</td>
<td>half day FACT Committee South Education Session</td>
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<td>April 24, 2014</td>
<td>Woodbridge Hilton</td>
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<td>Doubletree Tinton Falls</td>
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<td>July 16, 2014</td>
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<td>all day Education Series: Managed Care</td>
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PLEASE NOTE: NJ HFMA offers a discount for those members who wish to attend Chapter events and who are currently seeking employment. For more information or to take advantage of this discount contact Laura Hess at NJHFMA@aol.com or 888-652-4362. The policy may be viewed at: http://hfmanj.orbius.com/public/assets/A02-Unemployed-Discount/file_168.pdf
•Who’s Who in NJ Chapter Committees•

2013-2014 Chapter Committees and Scheduled Meeting Dates

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

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

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<tr>
<th>COMMITTEE</th>
<th>CHAIRMAN/EMAIL/PHONE</th>
<th>CO-CHAIR/EMAIL/PHONE</th>
<th>SCHEDULED MEETING DATES/TIME</th>
<th>MEETING LOCATION</th>
<th>BOARD LIASON</th>
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<tbody>
<tr>
<td>CARE (Compliance, Audit, Risk, &amp; Ethics)</td>
<td>Lisa Hartman <a href="mailto:hartman@princetonhcs.org">hartman@princetonhcs.org</a> (609) 953-7140</td>
<td>Dana Quin <a href="mailto:DQuin@cranpointhealth.org">DQuin@cranpointhealth.org</a> (201) 821-8705</td>
<td>First Thursday of the month (888) 269-3831 9:00 AM</td>
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<td>Erica Waller <a href="mailto:ewaller@princetonhcs.org">ewaller@princetonhcs.org</a> (609) 620-8335</td>
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<td>Al Rothkamp <a href="mailto:ar123@earthlink.net">ar123@earthlink.net</a> (609) 584-6508</td>
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<td>Cheryl Cohen <a href="mailto:Cheryl.H.Cohen@weiljafargo.com">Cheryl.H.Cohen@weiljafargo.com</a> (609) 259-3363</td>
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<td>Karen Henderson <a href="mailto:KHenderson@withum.com">KHenderson@withum.com</a> (973) 532-8879</td>
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<td>Jennifer Vanegas <a href="mailto:jvanegas@harf.com">jvanegas@harf.com</a> (581) 643-3377</td>
<td>Fourth Thursday of each month (888) 290-0578 8:00 AM</td>
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<td>Tracy Dawson-DiCanto <a href="mailto:tdawson-dicanto@princetonhcs.org">tdawson-dicanto@princetonhcs.org</a></td>
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<td>New Jersey Hospital Association Board Room</td>
<td>Kevin Joyce <a href="mailto:kjoyce@qualicarenc.com">kjoyce@qualicarenc.com</a> (732) 562-7823</td>
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<td>Jennifer Barr &amp; Tim Blaik &amp; Maria Facciponti <a href="mailto:Jbarr@hackensackums.org">Jbarr@hackensackums.org</a> / <a href="mailto:Tblaik@somerset-healthcare.com">Tblaik@somerset-healthcare.com</a> / <a href="mailto:MFacciponti@adremarka.com">MFacciponti@adremarka.com</a> (556) 996-3376 / (908) 243-8640 / (973) 614-9100</td>
<td>Call for meeting arrangements (888) 269-3831</td>
<td>Locations alternate by month - please contact the chairs</td>
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<tr>
<td>Patient Access Services</td>
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<td>Dana Derrick <a href="mailto:dderrick@poh.org">dderrick@poh.org</a> (908) 667-6870</td>
<td>8/19, 10/11, 12/13, 2/14/13, 4/11/13 (888) 269-3831 9:30 AM</td>
<td>CBZ KA Consulting offices in East Windsor, NJ</td>
<td>Deborah Shapiro <a href="mailto:dshapiro@cbiz-services.com">dshapiro@cbiz-services.com</a> (201) 617-7100</td>
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<td>Patient Financial Services</td>
<td>Steven Stadtmueller <a href="mailto:stadtmueller@vanderh-jp.com">stadtmueller@vanderh-jp.com</a> (732) 779-1771 Ext. 146</td>
<td>Kathleen Yencko <a href="mailto:kyencko@aphfeycorp.com">kyencko@aphfeycorp.com</a> (303) 226-1905</td>
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<tr>
<td>Physician Practice Issues Form</td>
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<td>Howard Lainer <a href="mailto:Harold.Lainer@elonmc.com">Harold.Lainer@elonmc.com</a> (201) 606-2136</td>
<td>9/11, 11/14, 1/14/13, 2/13/13, 3/12, 5/8 (888) 287-5336 9:00 AM</td>
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<td>First Wednesday except Jan which is 1/8 (888) 269-3842 9:00 AM</td>
<td>New Jersey Hospital Association</td>
<td>Steven Bilysky <a href="mailto:sbilyski@causecogas.com">sbilyski@causecogas.com</a> (303) 672-9896</td>
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On an annual basis, the leaders of the Chapters of HFMA that comprise “Region III” come together for the Fall President’s Meeting. This meeting enables the chapter leaders to work closely together, to provide feedback to the National HFMA leadership, and to share ideas for better programs and opportunities for our members. This year the Region III Fall President’s Meeting was held on September 12-14 in Burlington Vermont near the shores of Lake Champlain.

The meeting participants included the President and President-Elect of each Chapter, the Regional Executive and Regional Executive-Elect (past Chapter Presidents who volunteer to assist with Regional coordination efforts), HFMA Board member Melinda Hancock and HFMA Director of Chapter Relations Eileen Crow, as well as certain other officers of some Chapters. The Fall President’s Meeting allows us to come together as a Region to discuss leading practices for the administration of our Chapters, including areas such as education, member satisfaction and engagement, communication with members, certification and succession planning.

We also were provided with information related to the National HFMA organization. Several items of interest included:

- HFMA’s goal to continue to convene with the three groups that are central to the health care industry: hospitals, physicians and payers, especially as integration and blending within the groups continues to evolve.
- HFMA’s strategic plan to provide more thought leadership and point of view solutions for issues facing the industry.
- Plans to provide more resources and tools to the membership to support individual career development.

Many topics were discussed amongst the group over the course of the multi-day meeting. One in particular led to what hopefully will be a very successful education program. The leaders from the Chapters spoke about various views regarding CHFP certification and ways to enhance the level of certified members in each Chapter. Chapters in the Region plan to participate in a webinar education series hosted across the Chapters which will prepare participants for the certification exam. Early interest and enrollment in this program has been tremendous and hopefully it will lead to several new certified members.

Other areas of discussion involved different approaches to improve the education programs sponsored by each Chapter. Each Chapter shared success stories and ideas for providing more value to their membership through education programs. Other administrative aspects of leading a Chapter were discussed with the goal of providing innovative solutions that other Chapters could replicate.

Additionally, we were informed of planned updates on the National level to the annual Leadership Training Conference (“LTC”). Each year new Chapter officers and others with membership, education and publication roles from across the country meet for several days to learn more about their roles, ways to improve their Chapter, and HFMA in general. The planning committee for the upcoming 2014 LTC has taken steps to revamp aspects of the agenda and format of the LTC program in order to allow for more open discussion across the Chapters and enhanced idea sharing.

The Fall President’s Meeting also enhances the relationships amongst the Chapter leadership teams as we spend time in the formal meeting discussions and in other group activities. Ultimately, the Chapters within Region III and their membership benefit from this collaborative environment.
A Business Associate Agreement Dilemma: To Indemnify or Not to Indemnify – Ten Considerations

by Michael J. Kline, Esq.

Now that the Final Omnibus Rule under HIPAA, originally published on January 25, 2013, is in full force, covered entities (CEs) and their continuing business associates (BAs) should be examining their existing pre-Final Omnibus Rule HIPAA Business Associate Agreements (BAAs). While the “Effective Date” of the Final Omnibus Rule was March 26, 2013, most provisions did not go into effect until September 23, 2013. BAAs that were “already in effect” as of January 25, 2013, and were not otherwise renewed or modified from and after the March 26, 2013 Effective Date should be reviewed and modified no later than September 23, 2014, if necessary, to comply with the Final Omnibus Rule.

By this time, CEs and BAs should have become more sophisticated and cautious regarding the negotiation of, and entry into, a BAA. In this regard, a party (Party) to a BAA (or a Subcontractor Agreement (SCA), for that matter), whether a covered entity (CE), business associate (BA) or subcontractor (SC), may confront the question as to whether to agree to, demand, request, submit to, negotiate or permit, an indemnification provision (Provision) respecting the counterparty (Counterparty) under a BAA or SCA. On January 25, 2013, the U.S. Department of Health and Human Services published “Sample Business Associate Agreement Provisions,” which were silent on the matter of indemnification. Nonetheless, whether or not to include a Provision is often a major question for Parties to BAAs and SCAs.

1. A CE or BA may assert that it has a “standard form” of BAA that includes a Provision running solely for such Party’s benefit. The Counterparty may legitimately push back and demand that such Provision be removed, or at least that the BAA be revised to include a reciprocal Provision for its benefit. (A Party may also ask its Counterparty whether the Counterparty has ever previously executed a BAA or SCA that does not contain such a Provision.)

2. Before a Party agrees to any Provision whereby it is indemnifying the Counterparty, it should find out from its own insurance carrier whether such a Provision is permitted under such Party’s liability insurance policy or if agreeing to such a Provision will have any adverse impact on its insurance coverage. CEs and BAs may now have insurance that specifically covers security and privacy data breaches, including HIPAA breaches (collectively, Data Breaches), and that coverage in particular requires scrutiny regarding the impact of any Provisions.

3. If a Provision is to be included (and perhaps as a general rule even if there is no Provision), there should be a negation of potential third party beneficiary rights under the BAA or SCA. For example, HIPAA specifically excludes individual private rights of action for a breach of HIPAA – a Party does not want to run a risk of creating unintentionally a separate contractual private right of action in favor of a third party under a Provision.

4. A Party should endeavor to limit its own maximum dollar amount exposure for indemnification. For this reason alone, a Provision should be viewed as not “standard.”

5. A Party should endeavor to limit the time period for indemnification under the Provision. In this regard, HIPAA and state laws have specific time frames for notification of Data Breaches that should be considered with respect to the Provision.
6. If the BAA or SCA includes a Provision, a Party may desire to limit its monetary liability for any and all Breaches under the BAA or SCA solely to the indemnification obligations under the Provision.

7. A Party should consider expressly limiting its own monetary liability under the Provision to events directly and proximately caused by a material breach of the BAA and only to the extent that the material breach of such Party caused damages to the Counterparty. (“Standard” language often is written as “events arising out of or relating to a breach”, a much broader and less objective criterion.)

8. Where a BA or SC is a lawyer or law firm that is counsel (or another licensed person who has professional and ethical obligations separate from HIPAA, such as a physician) to a Counterparty, consider whether there are professional responsibilities of attorneys (or such other licensed person) respecting the negotiation of the Provision, including notifying the Counterparty that it should consider retaining separate counsel to advise it on the Provision (and other terms of the BAA such as item 10 below).

9. If a regulatory authority or court exacts a monetary penalty from a Party in connection with a Data Breach or such Party is found to have been involved in a HIPAA breach, the right to indemnification of such Party by the Counterparty under a Provision may be limited or not enforceable at all as a matter of public policy.

10. If a Provision is to be included, attention should be given to its impact on corollary matters, such as limitation on recovery of consequential, special, punitive and other damages and attorneys’ fees and legal expenses.

In light of the above and other potential considerations, careful thought should be given as to whether or not a Provision is appropriate in a specific case and merits what could become a serious and potentially irresolvable stumbling block to the underlying business relationship. In extreme cases, the matter of indemnification and its complexities and consequences could even result in termination of the business relationship between the Parties.

**About the Author**
Michael J. Kline, Esq., is a partner with Fox Rothschild LLP, based in its Princeton, NJ office, and is a past Chair of the firm’s Corporate Department. He concentrates his practice in the areas of corporate, securities, and health law, and frequently writes and speaks on topics such as corporate compliance, governance and business and nonprofit law and ethics. He is also a frequent contributor to the firm’s HIPAA, HITECH and Health Information Technology blog at http://hipaahealthlaw.foxrothschild.com
New Jersey Senate and Assembly Pass Legislation to Improve Trauma Response System

By Patricia C. McManus

Trauma systems have been shown to effectively coordinate trauma responses and reduce the risk of death due to injuries. Trauma systems have been defined as “comprehensive and coordinated statewide and local injury response network[s] that include all facilities with the capability to care for the injured”, wherein “trauma care delivery is organized through the entire spectrum of care delivery, from injury prevention to pre-hospital, hospital, and rehabilitative care delivery for injured persons.” See Model Trauma System Planning and Evaluation, U.S. Department of Health and Human Services, Health Resources and Services Administration, released February 2006, available at http://www.facs.org/trauma/tsepc/pdfs/mtspe.pdf.

Injury continues to be the leading cause of death for New Jersey citizens between the ages of 1 to 44 and results in more than 60,000 emergency department visits each year, costing over $2 billion. Though New Jersey has numerous trauma centers (10 in total, 3 designated as Level I and 7 designated as Level II), a 2008 report by the American College of Surgeons (“ACS”) found that New Jersey’s trauma system faced many challenges. Among other things, the ACS found that New Jersey had neither a central State agency tasked to oversee and ensure the coordination of the statewide trauma care system nor a mechanism to systematically collect data regarding various aspects of trauma care in the State.

Legislation aimed at improving New Jersey’s trauma system passed both the Senate and Assembly on January 13, 2014. Senate Bill 3027 (A4500) provides for the development and implementation of a State trauma system. The legislation notes the ACS’ recommendations that New Jersey provide for the:

- establishment of a statutorily authorized lead agency to oversee development of a formal trauma system, appointment of a designated leader to coordinate stakeholders involved in all aspects of providing trauma care in the development, maintenance, and ongoing evaluation of a formal State trauma system, the creation of an advisory body to formulate policies that address all aspects of patient care, and the development of prevention strategies to help control injury as part of a formal State trauma system.

[S3027, available at: http://www.njleg.state.nj.us/2012/Bills/S3500/3027_R1.PDF]

Pursuant to the legislation, the Department of Health will serve as the lead agency for the development of the State trauma system. The Commissioner of Health (the “Commissioner”) will appoint a State Trauma Medical Director to oversee various aspects of the system. The Medical Director, in collaboration with the State Trauma System Advisory Committee (“STSAC”), a committee established by the legislation, will oversee the development of the system plan and will be responsible for implementing, maintaining, and providing ongoing evaluation of the plan. The Medical Director will also ensure the participation of relevant stakeholders.

The STSAC is tasked with advising the Commissioner and the Medical Director on the development of the trauma system plan. The STSAC members will be appointed by the Governor and will include, but not be limited to:

- the medical director of each State-designated trauma center;
- the medical director of a State-certified burn treatment facility;
- the chairperson of the New Jersey Emergency Medical Services Council;
- the medical director of a rehabilitation facility in the State that treats patients with traumatic injuries;
- three representatives of pre-hospital care providers in the State, including an advanced life support provider as recommended by the State mobile intensive care advisory council, a volunteer basic life support provider as recommended by the New Jersey State First Aid Council, and a paid basic life support provider;

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• the New Jersey licensed physician chairperson of the New Jersey Chapter of the American College of Surgeons Committee on Trauma;
• a New Jersey licensed physician recommended by the New Jersey Chapter of the American College of Emergency Physicians;
• a New Jersey licensed nurse recommended by the New Jersey Chapter of the Emergency Nurses Association;
• one individual with expertise in the prevention of injury; and
• one medical director of the emergency department of a New Jersey hospital that is not a State-designated trauma center.

Specifically, the STSAC will analyze trauma-care data, design a system of trauma care with standards for pre-hospital triage and hospital-based care and policies and evaluate the system to ensure optimal coordination within the system. Within a year of the date of enactment of the legislation, the STSAC will submit a report to the Commissioner and the Medical Director which will set forth a comprehensive State trauma system plan. The plan must address:

(a) best practices and standards for all trauma care providers; (b) development and implementation of protocols for the stabilization and transfer of patients; (c) training requirements for acute care hospital personnel with respect to identifying, stabilizing, and arranging for the transfer of a patient whose condition is beyond the scope of the hospital's capabilities; (d) mandatory trauma triage practices to be performed by emergency medical service providers; [and] (e) any other issues that the STSAC determines to be appropriate for inclusion in the plan.

The STSAC will continue to prepare annual reports on its activities for the Commissioner and Medical Director, and will provide any recommendations to improve the State trauma system on an ongoing basis.

About the Author
Patricia McManus is an associate with Fox Rothschild LLP and a member of the firm's Corporate Department, practicing in the area of healthcare law. Patricia's practice focuses on transactional and regulatory matters for institutional healthcare clients, professional service corporations and healthcare-related businesses. Patricia can be reached at PMcManus@foxrothschild.com
**Focus on...New Jobs in New Jersey**

**JOB BANK SUMMARY LISTING**

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

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

**Job Position and Organization**

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<td>Hospital for Special Surgery, New York, NY</td>
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<td>ADMINISTRATIVE DIRECTOR, REVENUE CYCLE</td>
<td>Shore Medical Center, Somers Point, NJ</td>
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<td>SENIOR ACCOUNTANT</td>
<td>JFK Health System, Edison, NJ</td>
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<tr>
<td>ASSISTANT VICE PRESIDENT, PATIENT FINANCIAL SERVICES</td>
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<tr>
<td>SENIOR DIRECTOR OF REVENUE INTEGRITY</td>
<td>Geisinger Health System, Danville, PA</td>
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<tr>
<td>DIRECTOR BUDGET &amp; REIMBURSEMENT</td>
<td>Saint Peter's Healthcare System, New Brunswick, NJ</td>
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<td>DIRECTOR NETWORK CONTRACTING</td>
<td>AmeriHealth New Jersey, Cranbury, NJ</td>
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<tr>
<td>SENIOR ACCOUNTANT/ANALYST</td>
<td>St. Francis, Trenton, NJ</td>
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| DIRECTOR OF MANAGED CARE                                                                 | Nemours, Wilmington, Delaware                 |
| SENIOR VICE PRESIDENT/CFO                                                                | United Health Services, Inc. (UHS), Binghampton, New York |
| MANAGER OF PATIENT ACCOUNTING                                                            | Children’s Specialized Hospital, Mountainside, NJ |
| MANAGER, MANAGED CARE CONTRACTING                                                        | AtlantiCare, Pomona, NJ                       |
| CHIEF FINANCIAL OFFICER                                                                  | Crystal Run Healthcare ACO, mid-Hudson Valley and lower Catskill region, NY |
| SENIOR FINANCIAL REPORTING ANALYST                                                       | Capital Health System, Lawrenceville, NJ      |
| REVENUE CYCLE MANAGER                                                                    | Besler Consulting, Princeton, NJ              |
| DIRECTOR OF ACCOUNTING                                                                   | Catholic Charities, Diocese of Trenton        |
Aetna, Valley Preferred Sign Accountable Care Agreement

Aetna (NYSE: AET) and Valley Preferred, a preferred provider organization aligned with Lehigh Valley Health Network, today announced a new accountable care agreement that is designed to improve the quality of care and lower overall health care costs for members of fully insured Aetna commercial plans in Lehigh and Northampton counties.

The collaboration will offer area employers better health care options for their employees by:

• Creating a more coordinated patient experience;
• Saving employees money when they use providers aligned with Valley Preferred’s accountable care (ACO) network; and
• Improving health care outcomes.

Aetna will introduce fully insured health plans in the region that will use Valley Preferred’s community-based systems of care and its ACO network of highly respected physicians. Fully insured products will be offered for employers with two or more employees beginning April 1.

“Aetna is very pleased to announce this collaboration with Valley Preferred,” said Patrick Young, president of Aetna’s Pennsylvania, West Virginia and Delaware operations. “By forming accountable care relationships with hospital systems, we’re improving quality and making health care more affordable and efficient for our customers in Pennsylvania.” Aetna provides health benefits to more than 1.3 million people in Pennsylvania.

Aetna and Valley Preferred will offer a wide array of co-branded Aetna Whole Health plans, giving employers choices that enhance the membership experience through a collaborative team approach to the full spectrum of health care. The collaborative, accountable care approach is designed to improve quality and reduce overall health care costs.

“Valley Preferred is pleased to partner with Aetna in this collaborative effort to improve health care quality and value here in our home community,” said Dr. Jack A. Lenhart, executive director, Valley Preferred. “Valley Preferred’s ACO physicians, care coordination efforts and quality improvement programs, together with Aetna, will work to achieve measurable advancements in patient care and cost control for the employers and families of Lehigh and Northampton counties.”

Under the agreement, Valley Preferred has committed to quality and cost outcomes for Aetna members that see Valley Preferred ACO physicians. Members will benefit from Valley Preferred’s “Achieving Clinical Excellence,” a performance-based incentive program for physicians to improve quality, efficiency and patient care experiences.

Accountable care models drive focus on more coordinated care

ACOs are alliances of physicians, hospitals and other providers that coordinate care for their patients. In an ACO, providers assume responsibility for improving the quality of patient care and lowering costs through better coordination and preventive care. Aetna members in these plans will receive an enhanced level of coordinated care.

Aetna is working with health care organizations across the country to develop products and services that support value-driven, patient-centered care. Aetna’s solutions help all types of patients, regardless of payer. Information about Accountable Care Solutions from Aetna is available at www.aetnaacs.com.

About Aetna

Aetna is one of the nation’s leading diversified health care benefits companies, serving an estimated 44 million people with information and resources to help them make better informed decisions about their health care. Aetna offers a broad range of traditional, voluntary and consumer-directed health insurance products and related services, including medical, pharmacy, dental, behavioral health, group life and disability plans, and medical management capabilities, Medicaid health care management services, workers’ compensation administrative services and health information technology products and services. Aetna’s customers include employer groups, individuals, college students, part-time and hourly workers, health plans, health care providers, governmental units, government-sponsored plans, labor groups and expatriates. For more information, see www.aetna.com.

About Valley Preferred

Valley Preferred, a provider-owned, preferred provider organization aligned with Lehigh Valley Health Network, is dedicated to Achieving Clinical Excellence® through the development and implementation of innovative pro-
Atlantic Health System, Chilton, Complete Merger

MORRISTOWN, NJ – JANUARY 2, 2014 – Atlantic Health System and Chilton Hospital announced the completion of a merger which adds the Pompton Plains-based hospital and affiliated Chilton Health Network sites to one of the largest non-profit health care organizations in New Jersey.

As part of its addition to Atlantic Health System’s facilities, the hospital will now be known as Chilton Medical Center, a change which better reflects the breadth of its services.

The merger, which became effective on January 1, 2014, joins two organizations that have established themselves as leaders in health care, and allows them to build upon a history of successful collaboration — including clinical affiliations in obstetrics, cardiology and other specialties — to ensure both institutions remain at the forefront of medicine and technology.

Atlantic Health System currently owns and operates Morristown Medical Center, Overlook Medical Center in Summit, NJ and Newton Medical Center and Goryeb Children’s Hospital. As a member of the Chilton Health Network, Chilton has offered health care services and care providers in communities throughout Northwestern New Jersey.

“After more than a year since we began the merger process, it is with great honor that we welcome Chilton into Atlantic Health System,” said Joseph A. Trunfio, President and Chief Executive Officer of Atlantic Health System. “With the addition of Chilton, our organization continues to grow stronger and better able to serve our community.”

Following the merger, Chilton Medical Center will continue to serve as a licensed, acute care hospital while also offering its community easier access to the world-class services offered by other members of the Atlantic Health System.

“Chilton and Atlantic Health System are focused on enhancing the scope and breadth of health care services care available at Chilton while providing seamless access to the Atlantic Health System network of outstanding services,” said Dr. Deborah K. Zastocki, President, Chilton Medical Center. “After many years of successfully working together, we can now work as one, to not only fulfill the health needs of our region, but build stronger, healthier communities.”

Atlantic Health System employs more than 11,000 people throughout Morris, Union, and Sussex counties, and has 1,310 licensed beds, including those at the Atlantic Rehabilitation in Morristown. There are over 193,100 emergency visits each year, including Morristown, Overlook, Newton, and at Overlook Emergency Services, Union Campus. Located at the crossroads of Morris, Passaic and Sussex counties, Chilton Medical Center employs 1,400 people and has 260 licensed beds. Annually, it serves more than 160,000 patients across 33 communities.

Several benefits resulting from the merger of Chilton and Atlantic Health System include:

- Significant clinical and economic efficiencies to lower the cost of health care while providing the highest quality services
- Expanded outpatient and preventive medicine services within the region
- Broader patient access to coordinated primary, pediatric and specialty care; clinical trials; and the most immediate access to specialized emergency care, including complex stroke care, the latest cardiac diagnostic and treatment interventions, and advanced neonatal care
- Expanded access to tertiary care through primary care physicians
- Shared best practices, evidence-based care and quality assurance activities within and across our medical staffs

Atlantic Health System, headquartered in Morristown, New Jersey, is one of the largest non-profit health care systems in New Jersey. It includes Morristown Medical Center in Morristown, NJ; Overlook Medical Center in Summit, NJ; Newton Medical Center in Newton, NJ; and Goryeb Children’s Hospital in Morristown, NJ, as well as Atlantic Rehabilitation I, Atlantic Home Care and Hospice, and its subsidiary, Atlantic Ambulance Corporation. Atlantic Health System is a clinical and academic affiliate of The Mount Sinai Hospital and the Icahn School of Medicine at Mount Sinai; a Major Clinical Affiliate of Rutgers Cancer Institute of New Jersey; part of Atlantic Accountable Care

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grams to improve health care delivery and value in the community. Valley Preferred’s corporate philosophy is reflected in its performance promise of Care Beyond the Coverage. Among these is Valley Preferred’s BeneFITSM Corporate Wellness program provided to employers to promote healthier lifestyles for company employees and a culture of wellness in the workplace. This includes providing a wellness assessment, health workshops and seminars, tobacco cessation resources, corporate health fairs and screenings, and disease management programs. Valley Preferred also offers BeneFIT consultation and the award-winning BeneFIT Toolkit, which is a step-by-step guide designed to assist companies with improving employee wellness. BeneFITSM Corporate Wellness is accredited by the National Committee for Quality Assurance (NCQA) for Wellness and Health Promotion. For more information, visit www.valleypreferred.com and www.benefitcorporatewellness.com.

Meet A New Member!

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<tr>
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<tr>
<td><strong>Who is your employer, and what is your position?</strong></td>
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<td><strong>What was your first job as a teen?</strong></td>
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<td><strong>What do you like best about your work responsibilities?</strong></td>
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<td><strong>A job I would enjoy doing without pay is...</strong></td>
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<td><strong>My favorite place is...</strong></td>
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Organization, one of the largest ACOs in the nation, and is a member of AllSpire Health Partners. For more information, please visit atlantichealth.org.

About Chilton Medical Center
Chilton Medical Center is a fully accredited, 260-bed, acute-care, community hospital. It is Five-Star Rated, the highest possible by Healthgrades, for Total Knee Replacement and Heart Failure, for three years in a row and two years in a row, respectively. Chilton is also named a Top Performer on Key Quality Measures by The Joint Commission for Heart Attack, Heart Failure, Pneumonia and Surgical Care. Chilton’s reputation in the community has been built on personalized care and many outstanding services including The MotherBaby Center, the Emergency Department, a Comprehensive Wound Healing/Hyperbaric Center and the Sleep Health Institute. The medical center has completed its $24 million modernization project, which includes the Cardiovascular Interventional Lab, The Breast Center, Total Joint Center, Cancer Center and Surgical Services. Chilton Medical Center is located at 97 West Parkway in Pompton Plains, NJ 07444. For more information about its facilities and services, or to find a doctor by name, specialty, or location, please visit atlantichealth.org/chilton or call 1-888-CHILTON.
In cooperation with the Metropolitan Philadelphia Chapter
38th Annual Institute of the New Jersey Chapter of HFMA

The Borgata Hotel, Casino & Spa
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If your company is interested in a *speaking opportunity* please don’t hesitate to let us know by March 31!!
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For more information please contact the Institute Committee

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Jennifer Vanegas – Jennifer.Vanegas@faef.com – (585) 643-3377
Tracy Davison-DiCanto – tdavison-dicanto@princetonhcs.org – (609) 529-9461
I would like to draw your attention to a letter the Chapter recently received from Make-A-Wish New Jersey. As those who were in attendance at the Annual Institute this past October may recall, the Wednesday evening fundraiser was for the benefit of the Make-A-Wish Foundation.

One of the more enjoyable things the Chapter President is required to do is to select the charity we will support at our Institute. Make-A-Wish Foundation New Jersey has been selected the past two years. I think everyone whose life has been impacted by their children, their nieces or nephews, or children of their friends and neighbors would agree: organizations like Make-A-Wish are critically important to children and their families when dealing with a serious medical condition. Whether it’s a trip to Disney World, tickets to the Superbowl, or transforming into Batman in order to save the city of San Francisco, the granted wish restores hope and provides joy for a child and family members who are coping with too much reality. So it was an easy choice!

This year we raised over $11,800 for Make-A-Wish New Jersey, enough to provide two children with their wishes.

I would like to share my thanks to all who contributed: our Institute sponsors who provided gifts for the auction, sponsors who provided cash contributions for Make-A-Wish, everyone who purchased auction tickets, and especially the NJ-HFMA Board and Committee members who were very generous in their organized group donations.

Please spend a few moments reading the letter from Make-A-Wish New Jersey which describes Brett and Aryaan and their wishes. Let us all hope that the wishes provide some comfort and memories for them and their families.
January 18, 2014

Mr. David Wiessel
New Jersey Healthcare Financial Management Association

On behalf of Make-A-Wish® New Jersey, I would like to thank you once again for your generous contribution through New Jersey Healthcare Financial Management Association’s Annual Institute. To date, your fundraising efforts have totaled $11,860.21 and have fully funded the wishes of the following wish children! It is my honor to tell you a little more about Brett, Aryaan and their wishes:

Brett is a 17-year-old boy, who was diagnosed with ARVD, a type of heart disease. Like most boys his age, he loves playing video games - especially God of War - and hanging out with his friends. Brett’s favorite movie is The Godfather and he likes to listen to rock music. He enjoys playing both soccer and football and his favorite athlete is Sebastian Janikowski. When Make-A-Wish volunteers visited with Brett and his family, they asked him that magical question, “If you could have one wish, what would it be?” He wished to have an online shopping spree because he and his dad are building a car! This winter, Brett’s wish will come true when he is able to buy some of the parts they need and spend some more quality time with his father.

Aryaan is a 7-year-old boy, who was diagnosed with Leukemia. He loves the color blue and playing with his Golden Doodle, Gracie. Like most boys his age, Aryaan enjoys soccer, playing with Legos and playing video games. His favorite show is Arthur and he loves to listen to One Direction. When our volunteers visited Aryaan and his family, they asked him that magical question, “If you could have one wish, what would it be?” Aryaan wished to go to the BMW factory because he has been fascinated with the car brand ever since he visited his family in India. This winter, his wish will come true when he and his family are whisked away to Munich, Germany! While there, they will have the opportunity to tour the BMW factory, as well as see cars being made and sight-see while in Munich, a historic and medieval city!

Your generous support is giving Brett and Aryaan the opportunity to create memories with their families that they will cherish forever.

Once again, thank you for helping us restore hope, strength and joy to the lives of wish children and for sharing the power of a wish®!

With warm wishes,

Kristina Maglietta
Director of External Events
Dear Fellow HFMA Members:

Each year the NJ Chapter awards an education scholarship to a member, member’s spouse or member’s dependent based on defined criteria. I am pleased to invite you to apply for this year’s 2014 HFMA Scholarship. The New Jersey Chapter of HFMA will award at least one scholarship of up to $3,000. You, your spouse or dependent may be eligible for the scholarship if you meet the following criteria:

- Member, in good standing, of the New Jersey Chapter for the last two years.
- Spouse or dependent of a member, in good standing, of the New Jersey Chapter, for the last two years.
- Enrolled in an accredited college, university, nursing school or other allied health professional school.

Preference will be given to applicants pursuing degrees in finance, accounting, healthcare administration or a healthcare related field of study. Tuition not paid by an employer or other scholarship will qualify for the HFMA scholarship.

We make our selection based on merit, academic achievement, civic and professional activities, course of study and content of your application and essay. We do not use income in our selection process. To apply, please submit a completed Scholarship Application no later than April 1, 2014. Members of the Board of Directors, Officers and Advisory Council and their spouses or dependents are not eligible for scholarships.

We will announce the recipients of the 2014 NJ HFMA Scholarship at our bi-monthly meeting on June 10, 2014. If you have any questions or wish to receive additional applications, please contact me at (973) 244-3536 or Laura Hess at njhfma@aol.com.

We look forward to receiving your application and wish you success in your academic endeavors.

Respectfully submitted,

John Brault

John Brault, FHFM
Chairperson, 2014 Scholarship Committee
NEW JERSEY HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION MEMBER’S ANNUAL SCHOLARSHIP APPLICATION

MEMBER INFORMATION

Member Name _______________________________
Member Address _______________________________
Membership # ________________________________
Years in HFMA ______ # Years in NJ Chapter ______
Member Employer ____________________________

APPLICANT INFORMATION

PART 1 - PERSONAL DATA

Applicant Name ______________________________
Address _____________________________________
Relationship to Member ___________ ______
College ______________________________
Course (s) to be taken __________________________

Matriculated Student YES ________ NO ______
Degree/Program Pursued ______________________________
Anticipated Graduation Date ______________________________
Major __________ Annual Tuition ______________
Amount of Employer Support ______________
Amount of Other Scholarships Awarded ______________

(DOCUMENTATION MUST BE PROVIDED SUPPORTING TUITION, EMPLOYER’S REIMBURSEMENT POLICY AND ENROLLMENT IN SCHOOL.)

PART 2 – EDUCATION BACKGROUND

Highest Level of Education Attained ______________________________
School ______________________________
GPA ______ Degree ______ Major __________

(YEAR DOCUMENTATION MUST BE PROVIDED DOCUMENTING GRADE POINT AVERAGE)

PART 3 – PROFESSIONAL CAREER

Employment History (List employment history as Attachment A.)

PART 4 – COMMUNITY AND PROFESSIONAL ACTIVITIES

Please describe your civic and professional activities and contributions to your community, profession, HFMA or other organization. (Please label as Attachment B.)

PART 5 - ESSAY

Matriculated Student YES ________ NO ______
Degree/Program Pursued ______________________________
Anticipated Graduation Date ______________________________
Major ____________ Annual Tuition ______________
Amount of Employer Support ______________
Amount of Other Scholarships Awarded ______________

(PLEASE SUBMIT AN ESSAY DESCRIBING YOUR EDUCATIONAL AND PROFESSIONAL GOALS AND HOW THIS SCHOLARSHIP WILL ASSIST YOU IN ACHIEVING SUCH GOALS. (PLEASE LABEL AS ATTACHMENT C.)

PART 6 - REFERENCES

Please furnish three formal reference letters (Please label as Attachment D.)

SIGNATURE ____________________________ DATE ___________

Please return completed package no later than April 1, 2014 to:
John Bruault, FHFMA
Chair Scholarship Committee, NJHFMA
Healthcare Financial Mgmt. Assoc. - NJ Chapter
PO Box 6422
Bridgewater, NJ 08807
A.

What updated information is now required with respect to the Federal Employer Identification Numbers?

Internal Revenue Service ("IRS") final regulations, published in the March 14, 2013 Federal Register, require taxpayers possessing an employer identification number ("EIN"), also known as Federal Employer Identification Numbers or FEIN, beginning January 1, 2014, to provide updated information to the IRS with respect to their EIN.

BACKGROUND

The EIN is a unique nine-digit number assigned by the IRS to taxpayers primarily for identification purposes. The EIN takes the form of XX-XXXXXXX. EINs are issued to employers, sole proprietors, partnerships, S and C corporations, tax-exempt organizations, estates, trusts, governmental agencies and other certain business entities. An EIN is the corporate equivalent of an individual social security number.

The IRS has determined that many EINs are issued to nominees that act on the behalf of the applicant but, subsequent to the application process, are no longer authorized to represent the applicant. Commonly, entities use nominees on their applications as responsible parties which prevents the IRS from gathering the appropriate information on an entity’s ownership. Nominees are generally authorized individuals who act on behalf of entities during the formation process on a temporary basis. By listing the appropriate responsible party, a taxpayer’s income and assets becomes much more transparent.

Form SS-4, Applicant for Employer Identification Number, requires the disclosure of the EIN applicant’s responsible party’s name and identifying number. According to the instructions to Form SS-4, a “Responsible Party” is, for entities with shares or interests traded on a public exchange, or which are registered with the Securities and Exchange Commission, (a) the principal officer, if the business is a corporation, (b) a general partner, if a partnership, (c) the owner of an entity that is disregarded as separate from its owner, or (d) a grantor, owner, or trustor, if a trust. For all other entities, a “responsible party” is the person who has a level of control over, or entitlement to, the funds or assets in the entity that, as a practical matter, enables the individual, directly or indirectly, to control, manage, or direct the entity and the disposition of its funds and assets. The ability to fund the entity or the entitlement to the property of the entity alone, however, without any corresponding authority to control, manage, or direct the entity (such as in the case of a minor child beneficiary), does not cause the individual to be a responsible party.

REPORTING

Under the final regulations issued, any taxpayer issued an EIN is required to provide the IRS with updated information including name and taxpayer identification number of the taxpayer’s responsible party through the filing of a Form 8822-B.

The Form must be filed within 60 days of the date of the change. In the event a taxpayer changed the identity of its responsible party prior to January 1, 2014, Form 8822-B can be used to report the most recent change but must be filed before March 1, 2014.

CONCLUSION

The regulations are effective January 1, 2014 and apply to all persons already possessing an EIN and those taxpayers who apply for one on or after January 1, 2014.

About the Authors

Karen L. Henderson, CPA, is a Tax Manager at WithumSmith+Brown, Certified Public Accountants and Consultants, and is a member of the firm’s Healthcare Services Group; Joseph Marmorato is a Staff Accountant. They can be reached at khenderson@withum.com or jmarmorato@withum.com.
“There is a single light of science, and to brighten it anywhere is to brighten it everywhere.”
- Isaac Asimov

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Tuesday, May 6, 2014
Fiddler’s Elbow Country Club
Bedminster Township, NJ
9:00 AM – Check In/Registration • AM Continental Breakfast
10:30 AM – AM Shotgun Start
3:30 PM – Cocktail Hour with Open Bar and Hors d’oeuvres (Golf Attire)

REGISTRATION INCLUDES
AM Continental Breakfast • Lunch will be served for all participants
• Refreshments & Snacks will be served on both courses
• Cocktail hour with open bar and hors d’oeuvres • Buffet Dinner & Prizes

FOR QUESTIONS, SPONSORSHIP OPPORTUNITIES
AND TO MAIL ENTRY FORM
Laura Hess, HFMA-NJ Chapter
PO Box 6422
Bridgewater, NJ 08807
888-NJC-HFMA / njhfma@aol.com

REGISTRATION FEE
Golf $375
Dinner only $125
Foursome and 2 Tees $1,750
(50% tee savings)

All corporate attendees are encouraged to upgrade their registration to include a tee sponsorship. We also offer other sponsorship opportunities for increased visibility for your organization. Please see hfmanj.org or contact Laura Hess for all opportunities and pricing.

REGISTRATION
• Please Register Online at www.hfmanj.org, where online payment is also available, but not required.
• Registrations will also be accepted by mail.
• Make checks payable to HFMA – NJ Chapter, and please mail at least 10 days prior to the event.
• Registrations must be received by April 28, 2014.
• Cancellations must be received by April 30, 2014.

For directions to Fidders Elbow Country Club, please see their website at www.fiddlerselbowcc.com.

SPIKELESS SHOES AND COLLARED SHIRTS REQUIRED • NO CARGO PANTS OR CARGO SHORTS

Name ___________________________ Phone # ___________________________ Golf/Dinner only $_______________
Address ___________________________ Email ___________________________

Player 2 Name ___________________________ Phone # ___________________________ Golf/Dinner only $_______________
Player 3 Name ___________________________ Phone # ___________________________ Golf/Dinner only $_______________
Player 4 Name ___________________________ Phone # ___________________________ Golf/Dinner only $_______________

Total $____________________________

In the case of inclement weather, please call the Chapter Hotline at 888-NJC-HFMA (888-652-4362), after 7AM, to check the status of the event.
**NJ HFMA Annual Golf Outing Sponsorship Opportunities**

**May 6, 2014**

*Be a part of a premier social & networking event for the Chapter! Last year we had over 150 attendees. This is a “can’t miss” event every year with visibility to C-level hospital management and great networking opportunities!*

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<th>Sponsorship Options</th>
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<td>Bag Tags, Meadow Course</td>
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<td>Bag Tags, River Course</td>
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<td>Cocktail Party Co-Sponsorships</td>
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<td>Putting Green</td>
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<td>Breakfast</td>
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<td>Corporate Tees &amp; Greens, each</td>
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<td><strong>Corporate Special: Foursome with 2 Tees</strong></td>
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<td>(50% tee savings)</td>
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<tr>
<td>First Hole, Meadow Course</td>
<td>$ 600</td>
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<tr>
<td>First Hole, River Course</td>
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Editorial Calendar 2014

Garden State Focus is the premier publication reaching over a thousand Healthcare Industry Executives who are the influencers and decision makers behind New Jersey’s prominent hospitals and healthcare systems, published and distributed 5x a year.

To advertise, please contact Laura Hess
888-652-4362   NJHFMA@aol.com

Topics listed are subject to change, in order to report on the most relevant issues in healthcare at that time.

Winter Issue—January/February    Deadline December 15
Topics: Hospital Resolutions and Trends in the New Year; Medicaid Primary Care Reimbursement.

Spring Issue—March/April     Deadline February 15
Topics: PPACA Updates; Patient billing/collections and high deductible plans; Third party premium payments for Exchange Plans; Developments in Cancer Care.

Summer Issue—May/June   Deadline April 15
Topics: Data/Privacy developments; Employer clinics; Direct contracting between employers and providers (network carve outs); State budget issues.

Fall Issue—September/October Deadline August 15
Special ANNUAL INSTITUTE Issue
Our biggest issue of the year! Bonus Distribution at HFMA-NJ’s 38th Annual Institute in Atlantic City, October 8-10, 2014!
Topics: Spotlighting issues and topics shared by the Institute presenters.

Holiday Issue—November/December Deadline October 15
Topics: Looking ahead to 2015; future trends in healthcare.
### Ad Rates 2014

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Frequency rates displayed below. Advertise in more issues for maximum exposure and better value!

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| Inside Front Cover—Full Page | $1,000.00 | $925.00 | $870.00 | SOLD
| Inside Back Cover—Full Page | $1,000.00 | $925.00 | $870.00 | SOLD
| First Inside Ad—Full Page *(Adjacent to President’s View)* | $ 950.00 | $ 875.00 | $ 850.00 |
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