hfma™ new jersey chapter
healthcare financial management association

garden state focus
national excellence award winner

September/October 2011 • vol 58 • num 2

BE IN A POSITION OF STRENGTH℠

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

Scott Mariani, Partner, JD
Practice Leader, Healthcare Services Group
smariani@withum.com • 973.898.9494

focus •advertisers•

focus •features•

focus •points•

focus •cover•

Cover courtesy of Hermitage Press

Who's Who in the Chapter 2011-2012

Chapter Website .....www.hfmanj.org

Communications Committee

Anthony F. Consoli, Director ..... CBIZ Benefits & Insurance
Elizabeth G. Litten, Esq., Chair ..... Fox Rothschild LLP
Al Rottkamp, MBA, Vice Chair ..... Princeton Healthcare System/Aramark
Steve Aaron ..... ARC Group Associates
Mark Dougherty, FACHE ..... Energy Systems Group, LLC
Julius Green, CPA, JD ..... ParenteBeard LLC
Laura Hess, FHFMA ..... NJHFMA
John Manzi ..... Panacea Healthcare Solutions, LLC
Rhonda Maraziti ..... WithumSmith + Brown, P.C.
Nicole K. Martin, MPH, Esq. ..... Somerset Medical Center
William McCann ..... Healthfirst NY
David A. Mills ..... Deloitte Consulting
Amina Razanica ..... New Jersey Hospital Association
James A. Robertson, Esq. ..... McElroy, Deutsch, Mulvaney & Carpenter, LLP
Roger D. Sarao, CHFP ..... New Jersey Hospital Association

NJ HFMA Board Members

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

NJ HFMA Chapter Officers

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

NJ HFMA Advisory Council

Mary T. Taylor, MBA, FHFMA ..... Southern Ocean Medical Center
Brian P. Sherin, MBA, FHFMA ..... Besler Consulting
Joseph J. Dobosh, Jr., MBA ..... Children's Specialized Hospital
Cheryl H. Cohen, MBA, FHFMA ..... Pantheon Capital

Advertising Policy/Annual Rates

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

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

Display	Full Page	Half Page	Quarter Page
Back Cover – Full Page Color	$4,600	NA	NA
Inside Back & Front Covers – Full Page, Color	$4,350	NA	NA
First Inside Ad – Full Page, Color	$4,250	NA	NA
First Inside Ad – Full Page, Black & White	$3,450	NA	NA
Inside Ad – Color	$3,450	$2,600	NA
Inside Ad – Black & White	$2,150	$1,450	$875
Center Spread – 2 Full Pages, Color	$5,900	NA	NA
Center Spread – 2 Full Pages, Black & White	$3,800	NA	NA
NEW! Web Ads are available to our *FOCUS* advertisers – $250 for 3 months			

Ads should be submitted as print ready (CMYK) PDF files along with hard copy. Payment must accompany the ad. Deadline dates are published for the Newsmagazine. Checks must be payable to the New Jersey Chapter - Healthcare Financial Management Association.

DEADLINE FOR SUBMISSION OF MATERIAL

Issue Date	Submission Deadline
January/February	December 15
March/ April	February 15
May/June	April 15
July/August	June 15
September/October	August 15
November/December	October 15

IDENTIFICATION STATEMENT

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

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

OBJECTIVE

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

EDITORIAL POLICY

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

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

REPRINT POLICY

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

The President's View . . .

Mike Alwell

It's hard to believe that the summer slipped by so quickly and that we are now in the middle of the fall. There has been tremendous amount of activity since the last issue of the Focus was published.

In July the Managed Care Committee presented their first all day education session. Under the leadership of Kevin Joyce and Jill Squires, the committee chair and co-chair, the committee secured speakers that addressed a myriad of managed care issues including the identification of health reform models utilized by varying industry stakeholder groups, insights to strategic and operational issues related to reform, and key ways to assess your current readiness for addressing regulatory changes. The day capped off with a riveting payor/provider panel discussion. By all accounts, this meeting was a great success.

The Regulatory & Reimbursement session in September addressed the ***Shocking Truth About Healthcare Reform.*** Rich Rifenberg, Vicki Ozmore, and the entire committee presented a program that very nicely addressed the 2012 Medicare changes and the continued challenges of meeting regulatory requirements and its effect on providers. Speakers addressed the 2012 IPPS changes, budgeting and doing more with less in an era of healthcare reform, and healthcare reform's impact on DSH payments. Rolling all of this into a one day event with a speaker from Highmark was no small task. Great thanks to the Regulatory & Reimbursement Committee.

The Education Committee led by Maria Facciponti and Rita Romeu has been working diligently on collaborative webinars with the other HFMA Chapters in our region among other things. In September the committee presented a program to a number of the chapter's sponsors entitled ***"Getting the Most from your Trade Show Dollars"*** with a focus on what to expect as an exhibitor or sponsor at the Annual Institute. The Education Committee is in the midst of rolling out this year's Basic Financial Management program. This series of sessions will address a wide variety of topics while also preparing people to sit for the Certified Healthcare Financial Professional exam. This program is being coordinated by Eric Fishbein, this year's Certification Contact. I should note that Eric took (and passed) the new exam so that he would be in a position to effectively coach members who are looking to become certified.

Please be on the lookout for the NJ Chapter's next step into the21st Century. Tracy Davison-DiCanto is in the process of developing a Facebook page dedicated to the NJ HFMA Chapter. This will help to connect our organization to thousands of people.

The Membership Committee is in the final planning stages of a Shelton Award Recognition Dinner. Join us on November 17 in celebrating national recognition as the only HFMA chapter in 2010-11 to receive the esteemed Robert M. Shelton Award for 5 years of Sustained Excellence in service to members! See your e-mail or www.hfmanj.org to register.

Lastly, I would like to encourage everyone to get involved in the chapter. Your involvement makes for a much stronger association. Through your work on various committees, writing articles, or speaking at educational sessions you can also earn Founder's Points which can lead to you being invited to the Annual Institute at no cost.

Speaking of the Annual Institute…we will talk about that next time.

Michael Alwell

Believe to Achieve

From The Editor . . .

Elizabeth G. Litten

Dear Readers:

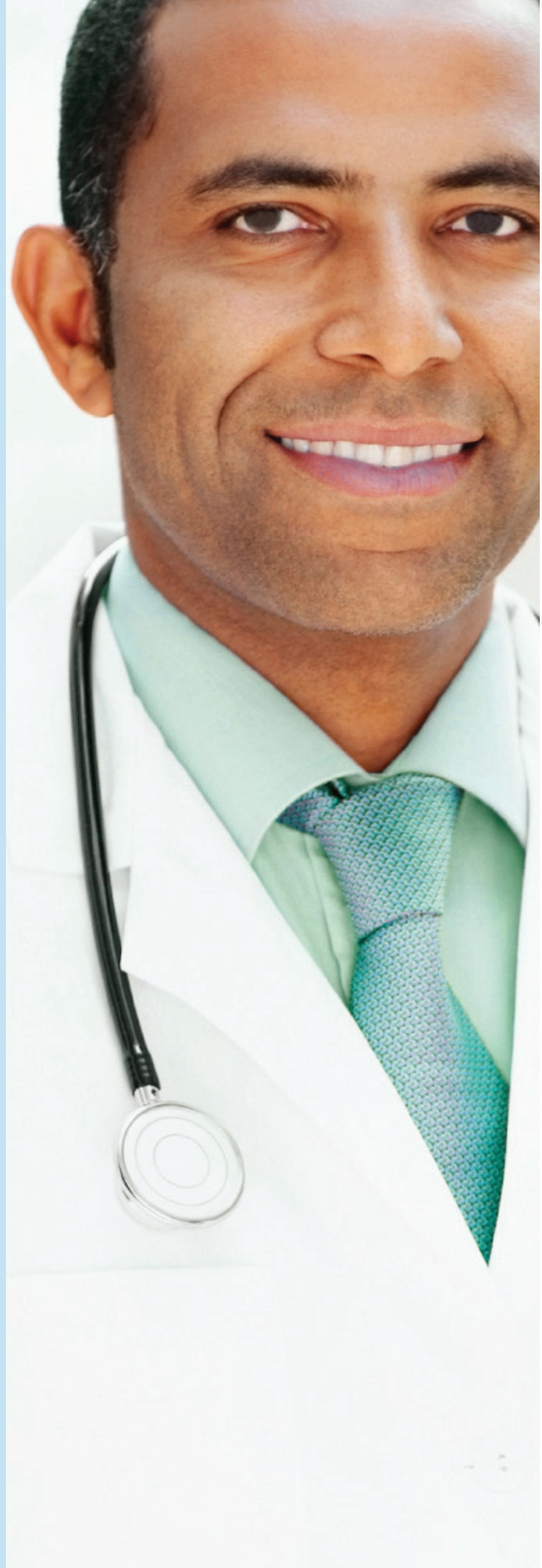
The health care landscape in New Jersey seems to shift and change more often than our coastline. This issue offers a glimpse of a few of the changes and challenges that may shift and build (or erode, depending on one's perspective) the shape of New Jersey health care for years to come. Will New Jersey patients be able to purchase medical marijuana from state-approved facilities? Will New Jersey's homeless population find a better alternative to hospital emergency rooms when simply seeking a place to stay overnight? How will New Jersey hospitals and employers deal with information hackers? Can a New Jersey-grown ACO model designed specifically for Medicaid patients living in a particular region save money and improve access, quality, and health outcomes (even as proponents of Medicare's proposed ACO model are few and far between)?

New Jersey has always enjoyed a varied landscape, and many of us agree that the variations and diversity of its topography, population, political viewpoints, and businesses are positive attributes. The variety of articles and topics submitted to and published in this magazine similarly contribute positively to this Chapter's communications. Please continue to keep the variety and interesting topics coming!

Regards,

Elizabeth G. Litten
Editor

PS – Editor's Note: *Al Rottkamp, my friend, faithful Committee Co-Chair, tireless Chapter website guru, and generally most-entertaining computer/tech whiz around, is NOT a lawyer, and despite the admitted profession of the editor, Al's article was not edited in a manner that would grant or imply that Al has either the authority or ability to practice law or render legal advice. Please see the Editorial Policy published on page 2 of this magazine for additional caveats and disclaimers. We love you, Al!*



Finally, a health plan worth smiling about.

Become a Healthfirst NJ provider and discover the difference. Call 1-866-889-2523.

- Competitive reimbursement for our physicians
- No written referrals needed for network specialists
- Dedicated Network Management Representatives

healthfirst NJ

1-866-889-2523 | healthfirstnj.org

HOW DOES YOUR BUILDING MEASURE UP ON ENERGY USAGE?

All over the state, facilities managers are wisely taking advantage of **FREE** Energy Benchmarking from *New Jersey's* ***Clean Energy*** *Program*.

Your report costs nothing. But what you learn is priceless. Your building's energy use is scored and tracked and you receive improvement plans that can save you money down the road.

But it gets even better! Organizations that have participated in energy benchmarking have, on average, reduced their energy consumption by 20%. Let us analyze your energy profile and guide you to cost-effective energy upgrades for your building.

FINANCIAL INCENTIVES AVAILABLE

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

To get your share, visit NJCleanEnergy.com/BENCHMARKING or call 866-NJSMART to speak to a representative.

BPU

New Jersey SmartStart BUILDINGS®

New Jersey's Clean Energy PROGRAM™ Your Power to Save njcleanenergy.com

Protecting Your Payroll from the Halloween Hackers

Al Rottkamp

by Al Rottkamp

From the early days of bartering, to transactions in the twenty-first century, money and information are the lifeblood of any business. Where our grandparents shopped locally, paid cash and shook hands to close the deal, today technology allows us to conduct business anywhere in the world, at any time. Signatures are a series of keystrokes. Payments for goods received, or services rendered, are routed through a bank account or credit card institution. In general, the law renders judgments based on contract law from judicial decisions and the Uniform Commercial Code.

The rise in hacker activity and recent court decisions concerning technology and banking underscore the need for increased security measures, account pattern analysis and contract scrutiny. Decisions in two recent cases are important because they are divergent and demonstrate that this area of the law is far from settled. In both Comerica Bank v. ExperiMetal Inc. (EMI) (June 2011) and Patco Construction Company v. Ocean Bank (Ocean) (May 2011), the court ruled in favor of the defendant. The Ocean case was disposed of through a motion for summary judgment.

The deciding factors in each case were 1) the Uniform Commercial Code, Article 4A, 2) the contract language, 3) the security measures in place at the time of the incident, and 4) the reasonable foreseeability of the occurrence as it relates to information security and applicable law.

The EMI case is the first major ACH/wire fraud incident to go to trial. At the heart of the case is whether the bank or the customer has final responsibility for fraud and security scams perpetrated on the customer. In less than 7 hours, hackers transferred $1.9M out of EMI's account at Comerica by way of 97 wire payment orders to accounts in the US, Scotland, Finland, Russia and Estonia. If the loss of the funds was not bad enough, EMI did not even have $1.9M in available funds, which triggered EMI's line of credit. Comerica managed to reverse all but $560,000 of the transfers into the EMI account. While Comerica did have several security methods in place, it did not have an automatic profiling system to flag unusual transfers. Comerica published its account authorization and security measures in the Service Agreement and the Master Agreement with EMI. Hackers were able to obtain the account authorization information from an EMI computer when an authorized EMI user fell prey to an email phishing scam and unwittingly disclosed the information. The court ruled that a "bank dealing fairly with its customer would have detected and/or stopped the fraudulent wire activity." In summary, an authorized EMI employee gave the hacker the account information by accident and the bank did not stop the unusual activity.

ACH, or Automated Clearing House, is a networked system banks use to transfer funds between accounts. Where wire transfers are relatively quick and irreversible, ACH transactions can take days and are reversible.

In the Ocean case, hackers initiated a series of withdrawals from the Patco account at Ocean over several days. Of the $588,851 withdrawn, Ocean Bank blocked $243,406 of the transfers. Ocean Bank had several security measures in place through the Jack Henry software system, which provides multifactor authentication, low dollar limits, challenge questions and similar fraud prevention measures. A premium version of the software included email notifications and "Out of Band" procedures. The Out of Band authorization check step was a phone call confirming the electronic requests. The court reviewed security measures and FFIEC Bank Guidance. The court found that there was no evidence of a security breach on the Ocean computers, but the hackers knew the Patco usernames, passwords and challenge answers. A remnant of the Zeus/Zbot malware was found on a Patco computer. Ocean's security procedures were more than commercially reasonable and exceed the recommendations set in the FFIEC Guidance. The court ruled that Patco bore the risk based on contract language and mutual agreement to the security measures implemented. The court admitted there is a relatively small body of applicable case law interpreting UCC Article 4A, and stated that the Bank's security procedures in May 2009 were not optimal. However, after reviewing all of the facts and applicable law, the court ruled in favor of Ocean Bank.

Although the decisions are divergent, there is commonality between the cases. Both Comerica and Ocean Bank had implemented an Internet security system. In the Ocean case, the security implementation is well documented. Ironically, there is little if any discussion concerning security on the consumer side. There was no evidence presented about computer login procedures, antivirus or antimalware software

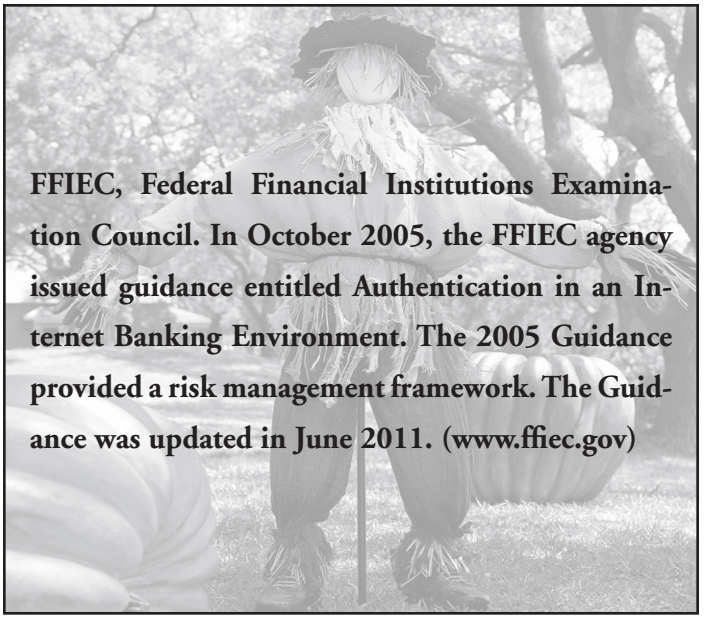
continued on page 8

continued from page 7

being present or absent. When each customer realized there was a significant problem, there is no documentation that either EMI or Patco contacted the FBI, state police or a crime lab for assistance. In both cases, the court considered "good faith" actions and the quality of those actions. (The "good faith" standard is sometimes referred to as the '"warm heart, empty head" standard.)

Foreseeability is a critical concept in information security and negligence law. With respect to information security, it is foreseeable that hackers will continue to 1) attack financial institutions for monetary gain, 2) attack military platforms (e.g., StuxNet Virus) and 3) create more powerful malware every year. Therefore, it is imperative that all parties, companies and individuals, implement security measures, login credentialing, encryption, automatic operating system (OS) updates for computers and mobile devices, and automatic antivirus and antimalware scans and updates. Vigilance is equally as important. In the EMI case above, an authorized user fell prey to an email phishing scam. Expenses for that mistake include legal representation, expert consultants and missed opportunities. It could have cost them another $500,000 if the decision was not in their favor.

In these types of lawsuits, liability always turns on whether the bank owed a duty to protect the customer. Absent a specific obligation or waiver, the duty may arise if the harm is foreseeable by the bank. An institution can be held liable for enabling, allowing or not preventing an opportunistic event, if that event is foreseeable. Have you ever left your keys in the car or your house unlocked? Courts have even denied a duty based on absence of foreseeability, even where the defendant's conduct created a risk of harm (Herrera V Quality Pontiac). Foreseeability is what a reasonable person would foresee under the circumstances.



Whether you are the owner of a small company, or the CFO of a university or healthcare system, it behooves you and your organization to implement strong security measures and update them frequently, educate your staff on scams and review your bank agreements quarterly with counsel.

After all, any reasonable person would expect you to take those steps. The reasonable person would expect you to!

About the author

Al Rottkamp is a member of the HFMA NJ chapter, the Association for the Advancement of Medical Instrumentation (AAMI) and the Information Systems Audit and Control Association (ISACA). He holds an MBA and MS in Biomedical Engineering. As an employee of Aramark Clinical Technology Services, he is the Director of Medical Technology Management, Princeton Healthcare System. He can be reached at ajcr123@aol.com.

CLIENT-FOCUSED SOLUTIONS

Meeting the unique needs of each client

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

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

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

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

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

Custom consulting services that meet your needs.

Jeffrey Silvershein *Vice President - Principal*
212.594.6669
JeffreySilvershein@McBeeAssociates.com

HEALTH CARE FINANCIAL AND MANAGEMENT CONSULTANTS

McBee Associates, Inc.

Breaking the Readmission Cycle with the Homeless: One at a Time

Patricia A. Furci

by Patricia A. Furci, RN, MA, Esq.

Reprinted with permission from RACmonitor

Recently, I was asked to see "Joe," a 76 year old homeless patient, for a possible guardianship, when I discovered that he had been admitted to the Hospital as an inpatient over 11 times in the past 5 months. Not only was this a guardianship issue, but one of breaking his cycle of the revolving door of readmissions.

I started by reviewing his prior admissions and compared those with his current admission. There was no distinction. He came in for his longstanding cardiac problem when he had no where to go. He usually slept in cars that he would find left unlocked. If there were no cars "available," Joe would come to the Emergency Department where he knew he would get admitted for his cardiac problem.

After consulting with the Case Management staff, the Physicians, the temporary guardian, the court-appointed attorney and the Judge, we were able to put together a plan for Joe. We decided to assist him in becoming Medicaid eligible even though we knew it would extend his hospital stay.

After a few short weeks, Joe became Medicaid eligible. The Case Management staff quickly found a bed in a nearby long term care facility and Joe left the hospital to seek his new home and start a new life. In his follow-up with the Court, sporting a new haircut and clothes, Joe told the Judge that it was good to have people care for him and that it wasn't that bad in the long term care facility after all.

The Judge dismissed the case and wished Joe much luck as he enjoyed his new life.

Getting everyone involved in the overall goal, halting the readmission cycle, is imperative. This includes the Court. The temporary guardian and court-appointed attorney need to be focused on assisting the Hospital in getting the patient benefits, so he can attain proper placement.

Although it took a few short weeks to get the Medicaid benefits for Joe, it was worth the wait. The revolving door of readmissions for Joe has ceased and he is finally getting the care he deserves.

As noted by Cheryl Clark in her article of July 18, 2011, "20% of the Homeless Hospitalized 3 Times in Last Year" in Healthleaders Media, she notes that one in five homeless visited the emergency department or was hospitalized over three times in the last year, and nearly 40% had no health coverage such as Medicaid. I guess Ms. Clark knew Joe.

Although it took a few short weeks to get the Medicaid benefits for Joe, it was worth the wait. The revolving door of readmissions for Joe has ceased and he is finally getting the care he deserves.

I know we will not see Joe again soon, but there are others still caught in the revolving door. We just need to catch them, even if it is one at a time.

About the author

Patricia is currently a Principal in the Firm of Furci Associates, LLC. and also acts as In-House Counsel at Robert Wood Johnson University Hospital in New Brunswick and at Palisades Medical Center, North Bergen, New Jersey. She is a graduate of Seton Hall School of Law where she concentrated in Health Law. Patricia can be reached at PatriciaFurci@yahoo.com.

Norris McLaughlin & Marcus, P.A.
ATTORNEYS AT LAW

MERITAS LAW FIRMS WORLDWIDE

Environmental Law

Hospitals and other businesses in New Jersey, New York, Pennsylvania and throughout the nation are subject to a web of federal, state and local environmental and safety legislation and regulation that is constantly expanding in scope and complexity. Our Environmental Law Group, working closely with our Health Care Law Group, provides a wide range of counseling and litigation services in this challenging area which include, but are not limited to:

- Representation in administrative and judicial proceedings before state and federal courts and agencies, including NJDEP, NYSDEC, PADEP, EPA, OSHA, and the Corps of Engineers
- Participation in property transactions involving New Jersey's Industrial Site Recovery Act ("ISRA"), Site Remediation Reform Act ("SRRA") or Pennsylvania's Act 2, which may include investigating contamination, working with environmental consultants on a remediation plan, preparing and filing proper forms with the state, and drafting environmental provisions to be included in agreements and disclosure documents
- Serving as special environmental counsel in tender offers, mergers and acquisitions, asset transfers and real estate transactions
- Litigating matters arising out of the generation, storage, discharge or release of hazardous substances, including representation under CERCLA
- Obtaining necessary environmental permits and approvals for medical, solid or hazardous waste storage, transportation, and disposal

If you would like to discuss our Environmental Law Group and how it may assist you, please call J. Anthony Manger, Chair of our Health Care Law Group, or Edward A. Hogan, Chair of our Environmental Law Group.

Norris McLaughlin & Marcus Environmental Law Group

Edward A. Hogan
Martha N. Donovan
Walter G. Reinhard
John F. Lushis, Jr.
Robert Mahoney
Timothy J. Siegfried
Scott B. Allinson
Charles F. Smith, Jr.
David C. Roberts
Margaret Raymond-Flood
Christopher Stevenson
John A. Jakub
Jeffrey M. Casaletto
William J. Beneduce
Stephanie A. Kobal

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

Bridgewater, NJ • New York, NY • Allentown, PA

P: (908) 722-0700 • F: (908) 722-0755

A full-service law firm serving the health care community for over 50 years.

Update on Implementation of the New Jersey Compassionate Use Medical Marijuana Act

Nicole DiMaria

by Nicole DiMaria , Esq.

This is a follow-up to previous articles published in the May/June 2010, September/October 2010, and January/February 2011 issues of the Garden State Focus.

It has been almost two years since the passage of New Jersey's medical marijuana law, the New Jersey Compassionate Use Medical Marijuana Act (the "Act"), and New Jersey still does not have a functioning medical marijuana program. After several months of uncertainty with respect to whether the program would go forward, the six alternative treatment centers (ATCs) that were recently licensed by the Department of Health and Senior Services (DHSS) to grow and/or dispense marijuana under the Act now have the go-ahead to finalize their preparations for operation. Despite all the hurdles along the way, patient access to medical marijuana may now be in sight.

The following provides an overview of developments with respect to the Act' s implementation since January, 2011.

Changes to DHSS Regulations: The DHSS released its proposed regulations to implement the Act on October 6, 2010 (the "Proposed Rule").[1] In response to a resolution passed by the New Jersey Legislature on December 13, 2010 – which declared portions of the Proposed Rule to be inconsistent with the Act – the DHSS issued revised proposed regulations on February 22, 2011 (the "Revised Proposal").[2] The following is an overview of the Revised Proposal's key changes to the Proposed Rule:

- Six ATCs will be licensed to both grow and dispense medical marijuana; the Proposed Rule had allowed for four ATCs to dispense, while only permitting the re maining two ATCs to grow marijuana.
- ATC satellite dispensing locations, which were permitted in the Proposed Rule, are now prohibited.
- Home delivery of medical marijuana, which was permitted under the Proposed Rule, is now prohibited.
- The prerequisite that a patient's condition be "resistant to conventional medical therapy" in order for the patient to be treated with medical marijuana is now only proposed to apply to the following conditions: seizure disorder, including epilepsy; intractable skeletal muscular spasticity; or glaucoma; the Proposed Rule had initially made this a prerequisite with respect to all medical conditions.

Selection of ATCs

In spite of the fact that the DHSS had not, and has not yet still, issued a final rule implementing the Act, the DHSS proceeded with its ATC licensure process and accepted ATC licensure applications January 17, 2011 through February 14, 2011. On March, 21, 2011, the DHSS announced its selection of the following six ATCs:[3]

- Breakwater Alternative Treatment Center Corp., Central Region, to be located in Manalapan, Monmouth County.
- Compassionate Care Centers of America Foundation Inc., Central Region, to be located in New Brunswick, Middlesex County.
- Compassionate Care Foundation Inc., Southern Region, to be located in Bellmawr, Camden County.
- Compassionate Sciences, Inc., Southern Region, to be located in either Burlington or Camden County.
- Foundation Harmony, Northern Region, to be located in Secaucus, Hudson County.
- Greenleaf Compassion Center, Northern Region, to be located in Montclair, Essex County.

Delay of Implementation of Act; Subsequent "Green Light"

Although marijuana possession/distribution remains illegal under Federal Law, the U.S. Department of Justice issued a memorandum to United States Attorneys on October 19, 2009 directing that they should not focus their federal enforcement resources in their States on "individuals whose actions are in clear and unambiguous compliance with existing state laws providing for the medical use of marijuana."[4] While

this memorandum gave comfort to patients and others acting in compliance with State medical marijuana laws, letters issued in April, 2011 from U.S. Attorney John Walsh and others sparked uncertainty with respect to the Federal Government's enforcement intentions, as they indicated the Department of Justice's commitment to enforce the Federal Controlled Substance Act, in spite of the legality of the use of medical marijuana under State law.[5] In response, Governor Christie stated in mid-June that he would not permit the medical marijuana program to go forward until he received clarification regarding the Department of Justice's enforcement policy, particularly with respect to the potential prosecution of State employees who administer the Act.[6]

On July 19, 2011, Governor Christie gave the Act the green light, announcing that he had instructed the Commissioner of DHHS to move forward as expeditiously as possible to implement the medical marijuana program.[7] He stated that, although there was no assurance that those who operate in compliance with the Act will not be prosecuted under Federal Law, he did not believe that Federal enforcement resources would be directed at such individuals, particularly in light of the restrictive nature of New Jersey's program.[8] He acknowledged there was a risk in allowing the program to go forward, but as he explained: "I'm taking that risk because I believe that the need to provide compassionate pain relief to these citizens of our State outweighs the risk that we are taking in moving forward with the program as it is set up."[9]

What Now?

As of the writing of this article, DHSS has still not fully implemented the physician and patient medical marijuana registry, which is necessary for the program's operation. As interested patients and providers await the grand opening of the six ATCs, they should inform themselves with respect to any administrative "hoops" they will have to jump through to qualify for participation.

Even assuming, however, that the program will be fully functioning in a relatively short time, patients and providers should expect fits and starts. Not only is the Act uncharted territory for New Jersey, it is essentially uncharted territory for the entire country. The Act stands apart from other similar State laws, as it is widely regarded as the most restrictive of any existing State medical marijuana program. Therefore, while New Jersey can feed off of other States' wisdom with respect to their programs, New Jersey's experience will undoubtedly be unique. We can most certainly expect additional hiccups along the way.

About the Author

Nicole DiMaria, Esq. is Counsel at Wolff & Samson PC, located in West Orange. Nicole is a member of the firm's Health Care and Hospital, and Corporate and Securities Groups, representing health care professionals, physician groups, health care and hospital systems, ambulatory care facilities, medical device and pharmaceutical companies, and other health-related entities. Nicole provides both health care corporate and regulatory counseling, advising clients on matters such as Federal Stark and Anti-Kickback Law compliance, HIPAA/HITECH compliance, Medicare/Medicaid reimbursement, state licensing, and state health care/professional regulatory compliance. Nicole can be reached at NDIMARIA@wolffsamson.com.

---

[1] 42 N.J. Reg. 2668(a) (Nov. 15, 2010).

[2] 43 N.J. Reg. 340(a) (Feb. 22, 2011).

[3] New Jersey Department of Health and Senior Services Press Release, *New Jersey Department of Health and Senior Services Announces Licensing of Six Nonprofit Alternative Treatment Centers for Medicinal Marijuana Program,* March 21, 2011, available at http://nj.gov/cgi-bin/dhss/njnewsline/view_article.pl?id=3681.

[4] See U.S. Department of Justice Memorandum, *Investigations and Prosecutions in States Authorizing the Medical Use of Marijuana,* Oct. 19, 2009, available at http://www.justice.gov/opa/documents/medical-marijuana.pdf.; see also David Johnston and Neil A. Lewis, *Obama Administration to Stop Raids on Medical Marijuana Dispensers,* The New York Times, March 18, 2009, available at http://www.nytimes.com/2009/03/19/us/19holder.html.

[5] Transcript of New Jersey Governor Christie's Opening Remarks at the July 19, 2011 Press Conference on New Jersey's Medical Marijuana Program, available at http://www.state.nj.us/health/med_marijuana_cc.shtml.

[6] Ginger Gibson and Susan K. Livio, *Gov. Christie to delay implementing N.J.'s medical marijuana law,* The Star Ledger, June 16, 2011, available at http://www.nj.com/news/index.ssf/2011/06/christie_to_delay_implementing.html.

[7] Transcript of New Jersey Governor Christie's Opening Remarks at the July 19, 2011 Press Conference on New Jersey's Medical Marijuana Program, available at http://www.state.nj.us/health/med_marijuana_cc.shtml.

[8] *Id.*

[9] *Id.*

Empowering Patients

by Dr. David Taylor

Dr. David Taylor

The recent advertising campaign launched by The Agency for Healthcare Research and Quality (AHRQ), aimed at getting patients to become more informed about the options available to them before they choose a treatment for their particular illness, shows how important it is to be an educated patient. In this way, patients are empowered to become partners with their physicians, adopting a "teamwork" approach that leads to more successful medical outcomes.

This system is especially beneficial when it comes to the treatment of prostate cancer. Men in the United States have a 1 in 6 lifetime risk of prostate cancer, and nearly a quarter of a million new cases of prostate cancer are diagnosed each year, according to the American Cancer Society. Prostate cancer is the second leading cause of cancer death in American men.

There are currently seven options for treating prostate cancer. The specific choice of therapy, either alone or in combination with other modalities, is dependent on the cell type and extent of the cancer as well as the age and health of the patient. These include surgery, radiation, active surveillance, hormonal therapy, chemotherapy, biologic therapy, and high-intensity focused ultrasound.

Surgery: Patients in good health can be offered surgery as a treatment option for prostate cancer. Removal of the prostate can be accomplished minimally invasively with either a small incision or laparoscopically with the aid of the daVinci robot. It usually requires only an overnight stay in the hospital but carries the risks associated with any surgery.

Radiation therapy: Radiation therapy is a cancer treatment that uses high-energy radiation to kill cancer cells or keep them from growing. External beam radiation therapy (EBRT) involves a series of daily outpatient treatments to accurately deliver radiation to the prostate. The latest advances in EBRT – intensity-modulated radiation therapy and image-guided radiation therapy – make it possible to focus treatment more precisely. This improves cure rates and minimizes the damage to the surrounding tissues. Internal radiation, also known as brachytherapy, is the implantation of radioactive sources directly into the prostate.

Active Surveillance: Active surveillance requires periodic monitoring of the PSA and digital rectal exam with the understanding there is a risk of disease progression. Through active monitoring and repeat biopsies, this risk is minimized.

Hormone therapy: Hormone therapy treatment removes hormones or blocks their action to stop cancer cells from growing because in prostate cancer, male sex hormones can cause prostate cancer to grow. Drugs, surgery or other hormones are used to reduce the production of these hormones.

Chemotherapy: Chemotherapy uses drugs to stop the growth of cancer cells, either by killing the cells or stopping them from dividing. These drugs can either be taken by mouth or injection.

Biologic therapy: Biologic therapy uses the patient's own immune system to boost, direct, or restore the body's natural defenses against cancer. Sometimes this treatment is also called biotherapy or immunotherapy. This novel approach was recently approved by the FDA, but only for more advanced disease.

High-intensity focused ultrasound: High-intensity focused ultrasound uses high-energy sound waves to destroy cancer cells. To treat prostate cancer, a probe is used to make the sound waves. This treatment is still considered investigational in the United States.

Patients may also want to think about taking part in a clinical trial. Clinical trials are part of the cancer research process and are done to find out if new cancer treatments are safe and effective, or better than the standard treatment.

The AHRQ campaign urges patients and physicians to work together to come to the best conclusion about patient care. A well-informed patient and a physician who presents the pros and cons of all treatment options produce the best patient outcomes. All parties benefit when patients are knowledgeable about and take control of their health care.

About the author

Dr. David Taylor is President and Chairman of the New Jersey Patient Care and Access Coalition. He is a member of Garden State Urology and practices in Morristown, NJ.

You Need Answers On How Healthcare Reform Will Impact Your Revenue.

THE CBIZ Healthcare Reform Toolkit

Insight Not Guesswork.

CBIZ's Healthcare Reform Toolkit is:

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

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

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

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

For additional information please contact CBIZ KA Consulting Services at 609-918-0990 or email us at HCRToolkit@CBIZ.com.

CBIZ®

CBIZ KA Consulting Services, LLC 609-918-0990 www.kaconsults.com

Complying with Federal and State Employee Screening Requirements

by Jim Hoffman

Jim Hoffman

INTRODUCTION AND BACKGROUND

Since authorized by Congress in 1977, the Centers for Medicare and Medicaid Services (CMS) has had the authority to exclude certain individuals, entities and corporations ("persons") from the Medicare and Medicaid programs. The exclusion program has been strengthened by further legislation and regulations in subsequent years. The purpose of this authority is to allow CMS to uncover, penalize and deter fraud and abuse within these programs. Organizations that receive payments from Medicare or Medicaid are prohibited from employing or contracting with persons that have been excluded, under penalty of fines and repayments.

An individual or organization may be excluded for many reasons, including convictions related to program-related crimes, patient abuse and controlled substances. In addition, entities controlled by a sanctioned individual and individuals controlling a sanctioned entity may be excluded. Exclusion periods range from temporary (e.g. when related to license expiration), to mandatory periods of one to five years for specific offenses, to permanent exclusion due to multiple violations. Once excluded, a person must apply for reinstatement, which is not automatically granted at the end of the exclusion period.

Employing or contracting with an excluded person can result in a Civil Monetary Penalty of $10,000 per offense when the employer "knew or should have known" of the violation. In addition, where the excluded person provided services that were billed to Medicare or Medicaid directly or indirectly, CMS will seek repayment penalties upon discovery of the violation. CMS has stated that penalties will be lower when the violation is self-reported.

The proposed 2012 Federal budget projects $40 billion in savings over ten years due to reductions of fraud and abuse in Medicare and Medicaid, and provides for hundreds of millions of dollars in funding to further the fraud detection and enforcement effort. It is clear that fraud reduction will continue to be a focus of CMS, and it anticipated that even greater emphasis on the exclusion program will be one result.

DATA SOURCES

Once a person is excluded from Medicare and Medicaid, their name and the details of the exclusion are maintained by the Department of Health & Human Services Office of Inspector General (HHS OIG) on the List of Excluded Individuals/Entities (LEIE). An online system allows providers to search the list. The list is also available in a downloadable format so that providers may automate the screening process, if desired.

The Federal government also provides other lists that a provider may wish to search. The General Services Administration maintains the Excluded Parties List System (EPLS), which lists individuals excluded from contracting with any agency of the Federal government (including, but not limited to, Medicare and Medicaid) for a variety of reasons. The U.S. Treasury Department maintains the Specially Designated Nationals List (SDN), which includes persons connected to sanctioned countries, terrorism and narcotics trafficking. U.S. individuals, companies and organizations are generally prohibited from dealing with individuals and companies that are listed on the SDN.

In addition to Federal data sources, many state Medicaid programs and licensing agencies provide websites and lists that allow a provider to determine if state-specific sanctions exist, and to confirm that their employees, providers, contractors and vendors are properly licensed for their type of work. Many of the government entities that maintain these lists share the data with one another, but it may take months for the data on one list to migrate to the other lists. Therefore, it is important from a compliance perspective to check all lists on a regular basis in order to identify and address issues as soon as possible.

BEST PRACTICES

While the exclusion regulations do not mandate the frequency at which the exclusion lists should be checked, CMS has signaled its take on best practices in other ways. The fact that the LEIE is updated on a monthly basis is an indication

that a monthly check may be warranted. More importantly, in a letter to State Medicaid Directors in January 2009, CMS required states to advise Medicaid program providers to check the HHS OIG exclusion list on a monthly basis. Both the New Jersey and New York Medicaid programs have instructed providers to screen employees and vendors on a monthly basis, along with checks of state-specific databases. While other guidance from CMS suggests that the lists should be checked "periodically," a monthly check is in the best interest of providers and may, in fact, be mandatory depending upon the provider's location. In addition, any new employees should be screened as part of the hiring process.

AN AUTOMATED SOLUTION IS NEEDED

With significant penalties likely to result from a provider's employment of an excluded person, regular screening of employees and vendors is an important compliance measure that must be taken. However, given that multiple lists must be searched, it can require significant effort to perform this work manually. In addition, matches can be missed due to misspellings, abbreviations, nicknames, etc. Finally, the lists can generate a large number of false positive matches that require manual follow up, and effectively tracking and documenting the results of these follow up activities can be tedious, time-consuming and error-prone.

Fortunately, software solutions are available in the market to assist the provider. These tools may contain proprietary logic to improve matching accuracy and reduce false positives, and by automating the process, they allow frequent searches of the appropriate databases with minimal effort. They also provide the documentation to demonstrate that the provider is fulfilling its obligation to determine if any of their employees or vendors are on the exclusion lists, potentially reducing the amount of fines and repayments.

CONCLUSION

In 2010, the HHS OIG settled more than twenty cases related to employment of excluded individuals. Most of the settlements were for amounts over $100,000. Given the potential for significant fines, penalties and adverse publicity, it is critical that providers have an effective process in place to screen employees on a regular basis.

About the author

Jim Hoffman brings over twenty years of technology and operations experience to his position as Chief Technology Officer of BESLER Consulting. Prior to joining the firm, Most recently, he was President and General Manager of Accuro Revenue Management for MedAssets. Prior to the acquisition of Accuro Healthcare by MedAssets, he served as President and Chief Operating Officer of the Accuro Revenue Management business unit, and Chief Operating Officer of Innovative Health Solutions, acquired by Accuro from Besler Consulting in 2005. His prior experience includes technology development in the healthcare, finance, telecommunications and entertainment industries. Jim is a graduate of the University of Virginia. He can be reached at JHoffman@Besler.com.

REFERENCES

HHIS OIG Exclusion Program
http://oig.hhs.gov/fraud/exclusions.asp

HHS OIG Special Advisory Bulletin - The Effect of Exclusion from Participation in Federal Health Care Programs
http://oig.hhs.gov/fraud/alerts/effect_of_exclusion.asp

CMS Comments Re: Self-Disclosure
http://oig.hhs.gov/publications/docs/press/2010/asc_cmp.pdf

GSA Excluded Parties List System
https://www.epls.gov/

US Treasury SDN Information
http://www.treasury.gov/resource-center/sanctions/SDN-List/Pages/default.aspx

CMS State Medicaid Director Letter re: Screening for Excluded Employees
http://www.dmas.virginia.gov/downloads/pdfs/pr-SMD_09_001.pdf

New Jersey Medicaid Newsletter re: Monthly Screening
https://www.njmmis.com/downloadDocuments/20-22.pdf

New York Medicaid Newsletter re: Monthly Employee Screening
http://www.health.state.ny.us/health_care/medicaid/program/update/2010/2010-04.htm#rem

2010 Civil Monetary Penalties Case Archive:
http://oig.hhs.gov/fraud/enforcement/cmp/false_claims.asp

How to Approach Healthcare Food and Nutrition Services

by Lynne Jacoby and Brian Berger

Lynne Jacoby

Brian Berger

In this challenging economic climate, it has never been more important for healthcare institutions to implement programs that improve quality care, reduce costs and actively promote a healthy life style throughout an institution's departments. This article will demonstrate the processes needed to develop a successful program for one specific department, Food and Nutritional Services ("FANS"). Improving a healthcare institution's FANS department should include both quality improvement and cost reduction – they are not mutually exclusive. To achieve this success, the program must be built from a food industry operational perspective, which is different from the way foodservice has been operated within the healthcare industry in the past. All healthcare administrators deserve to know exactly what they are paying for when it comes to their foodservice program. Transparency, shared financial risk, cost guarantees, stabilized bills, and minimizing of waste should be expected. Hospital food quality and service should be on par with the offerings found in a retail setting, and the operations should be run with the same level of efficiency needed for a retail business to be profitable. To achieve these goals, healthcare institutions need to utilize operational experts from the food industry as opposed to solely relying on their outsourced foodservice company, GPO or healthcare consultancies who do not specialize in the food industry.

Do you know what your food program really should cost? Does your food program reflect your hospital's mission?

Challenges in the Healthcare Industry

To no one's surprise, hospitals have especially felt the effects of the credit crunch, as many borrow to fund day-to-day operations, longer-term facility improvements and technology purchases. As payment to hospitals traditionally lag behind care delivery, hospitals often use debt to meet operating expenses. Healthcare financing experts warn that hospital credit lines will continue to be called in as financial covenants become harder to maintain.

It is also expected that Medicare and Medicaid funding will continue to be significantly reduced. Philanthropic donations are down and unemployment is still at record highs with no end in sight. Unemployment has resulted in loss of insurance for many Americans, which in turn has reduced the number of elective surgeries. Elective admissions could represent only 9 or 10 percent of a hospital's admissions and yet often represent 25 percent or more to the hospitals bottom line.

Due to these and other policy and economic issues, healthcare institutions are operating in a new environment, one where they need to scrutinize and reassess carefully the costs and benefits of all programs and services. Unfortunately, there is no quick fix to the external environment. The good news (yes, there is some) is that these external pressures have motivated healthcare leaders to rethink the way many of their services perform. By assessing services in a nontraditional manner, hospitals have achieved reduced costs and increased quality of internal programs. One service area that has historically not been a priority for healthcare administrators is FANS, but it is an area where cost reductions and service improvements may have significant implications.

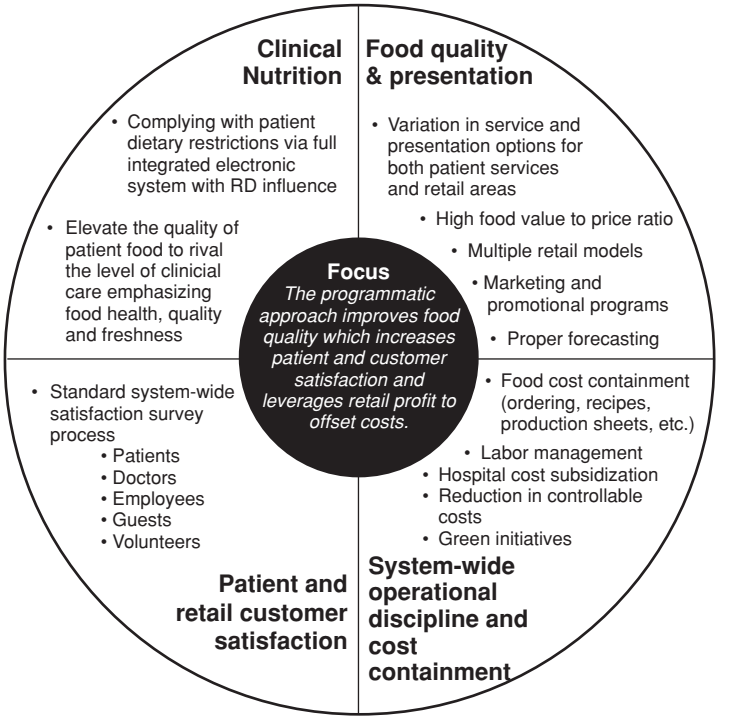
Healthcare institutions are demanding more from not only their in-house department heads but also from the outsourced vendors with whom they partner. In an outsourced arrangement, the hospital is looking for a true partnership where both risks and rewards are shared. Without this type of relationship, it is difficult to achieve efficiencies, cost reductions, process improvements and a higher quality product.

Current State of FANS

Healthcare Administrators historically do not have a level of expertise in FANS, as their backgrounds are typically not in food operations. For instance, how many administrators can walk into their kitchen and know if they require 30 or 50 employees to operate the food program at a high standard?

Therefore, administrators must trust that their operator, either in-house or outsourced, is meeting the institutions mission, financial and quality expectations. Realistically, this is often not the case. In an outsourced setting, it is typical that the contractual structure places all of the financial risk on the hospital, not the contractor. Contractors do not have the pressure to operate as efficiently as a retail operator, because the hospital is solely responsible for the costs. Financial reporting is often lacking and non-transparent. In an in-sourced setting, the cost and quality level is typically dependent on the competency of the food service director. Without access to the programs and standards the outsourced providers have built (i.e. standardized recipes ensuring diets are correct and food allergy issues are prevented, as well as forecasting and production tools), food service directors are routinely on their own to build a successful program. In larger hospital systems, food service directors often communicate to share best practices, however, in practicality, uniform programs are rarely found in an in-sourced system. Additionally, quality and cost of service can not only vary from one healthcare Institution to another in the same system, but from one segment of foodservice to another in the same institution (i.e. retail cafeteria vs. patient care).

A leading-edge FANS program

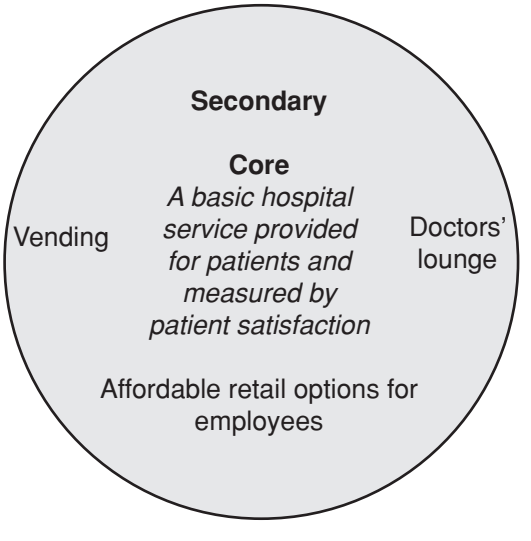


Evolution of FANS

The way that the general public views food today is significantly different that it was even a decade ago. We as a culture are much more discerning in what we eat. Our awareness of the nutritional content and the source of our food significantly influences our meal selections. Food service in a healthcare institution has an impact on virtually everyone that comes through the doors, including the patients, employees, visitors, and vendors; yet, the quality of the program rarely meets the standards of the food purchased in the retail world, despite the quality of the food program having a direct reflection on the perception of the institution.

One significant evolution in the food program of institutions is changing from a department focus to a system-wide programmatic focus, resulting in improved food quality, increased satisfaction, heightened emphasis on healthy eating and leveraging retail revenues to offset costs, as seen below.

A traditional FANS department



What can be gained by a successful FANS Assessment?

Many healthcare institutions will bring in a healthcare consulting generalist to look for savings and efficiencies throughout many departments within a hospital or utilize a GPO to conduct similar assessments. However, these companies typically assess the food department from a benchmarking perspective which many times results in cutting service or quality to achieve financial savings. To achieve cost savings with an increase in quality, process improvements and/or contractual structure changes are needed and require the expertise of foodservice industry experts. A successful assessment completed by advisors from the foodservice industry, accompanied with a hospital specific implementation strategy, should result in significant savings (routinely 10 to 40

continued on page 20

continued from page 19

percent). A successful assessment may also provide an opportunity to receive capital expenditure dollars from third parties for renovations and program changes (i.e. moving from cook-chill to a room service model). Implemented changes have a high impact on everyone who steps foot in the hospital.

How to start – step by step assessment method

In an outsourced or in-sourced program, the hospital needs to first determine the "true" revenue potential from retail outlets and the "true" total cost for all services provided. Once the financial picture is understood, the hospital may then develop the strategy for accountability - using metrics, contract structure (in an outsourced program), incentives, guarantees and other methods to firmly place the financial risk and responsibility on the contractor or in-sourced department leaders.

The diagnostic assessment conducted should include a review of the contract (if applicable), historical financial data, patient satisfaction scores and the operational systems. The following services, as applicable to each institution, should be included in the assessment: cafeteria, vending, catering, physician's lounges, patient service, fixed expense trays (i.e. ER meals, observation meals, guest trays, etc.) and third party providers (i.e. franchised outlets such as a Starbucks kiosk). Specifically, the following should be conducted:

- Contractual Best Practice Evaluation – assess existing contracts (if appli-cable) and benchmark them to industry standards (Food and Nutrition, Vending, Contract Dining, Healthcare).
- Financial Analysis – review historical cost data in areas such as revenues, total costs (labor, product, direct, fees), rebates and participation levels.
- Operational Assessment – conduct management interviews and an on-site assessment of existing operations in all areas covered by the service. Improve cost trans--parency by linking financial plans to operational plans and activities; challenge existing financial plans to identify and release unsupported balances; centralize budget contingencies to better manage scope and wasteful spending.

Ways to sustain your program changes

After the assessment is complete and the process improvement strategy is implemented, the institution must monitor the program to ensure long term success. In an outsourced setting, the administrative needs should be minimal if an appropriate contract is signed. The outsourced company should be held accountable for providing the necessary information in a real-time manner which allows the hospital to know what their food program cost will be on a monthly and annual basis – no surprise bills! The hospital, on their part, must assist the contractor in controlling the variable expenses (i.e. catering, floorstocks, etc.). Approval processes and communication channels should be leveraged to control costs in these areas; the outsourced company should be held contractually to methods for informing the hospital of these costs and providing the necessary back-up data on how the charges are calculated. In an in-sourced setting, the procedures should be the same, but the accountability is placed on the department leadership. In summary, sustaining the cost benefits of the new system should include:

- Improving financial awareness and establishing clear accountability and ownership of cost throughout FANS.
- Sustaining identified savings by recommending a robust set of cost management processes, tools and capabilities (e.g. budgeting, reporting, plan delivery monitoring) or a new contractual arrangement (when appropriate).
- Developing hospital ownership to monitor this process.

In conclusion

The importance of the FANS department's role in today's healthcare institutions is greater than ever. Controlling the increasing and variable cost of the department is extremely relevant with the economic pressures the industry is facing, but just as important (if not more) is having a program that promotes health and reinforces the mission and brand of the institution. There are challenges to either option for this department, outsourced or in-sourced, but these challenges can be overcome if the right strategy and operational system is implemented.

About the Authors

Lynne Jacoby and Brian Berger are the Principals of JBH Advisory Group, a food service consulting firm which specializes in macro-level food and beverage consulting. Prior to starting JBH, Ms. Jacoby and Mr. Berger ran the Global Food & Beverage Practice at PricewaterhouseCoopers, which Ms. Jacoby created. Both Ms. Jacoby and Mr. Berger have extensive careers in food service within and outside of the healthcare industry. Lynne and Brian can be reached at lynne.jacoby@jbhadvisorygroup.com and brian.berger@jbhadvisorygroup.com, respectively.

About their Company

JBH Advisory Group is based in New York City and is a unique advisory group offering a results-driven methodology to assist Healthcare clients in yielding long term financial and service improvements to their Food and Nutrition Services (FANS) programs. JBH consultants have assisted in over 100 hospitals in the last 18 months, realizing a reduction in total FANS costs ranging from 13 to 30 percent, with the average savings of 26 percent as a result of their services.

New Jersey Provider Overpayments and Escheat: Whose Money Is It, Anyway?

Jason Dalal

by Jason Dalal

It is September 1, 2011 and you are a health care provider receiving a notice from a licensed New Jersey insurance carrier requesting reimbursement for an alleged overpayment made to you on January 15, 2008 for service you provided to a patient insured by the carrier. Do you have to reimburse the carrier for the overpayment? If the carrier need not be reimbursed, are you compelled to surrender the overpayment to the State of New Jersey under its escheat law? This article will address each of these questions and provide a clear framework for dealing with an overpayment in accordance with New Jersey law.

Do you have to reimburse the carrier for overpayment?

In the situation described above, the answer would be no. Pursuant to the Health Claims Authorization, Processing and Payment Act ("HCAPPA"), no payer[1] shall seek reimbursement for overpayment of a claim previously paid later than 18 months after the date the first payment on the claim was made, except when a payer suspects fraud or a pattern of inappropriate billing practice. HCAPPA applies to all efforts initially made by the payer to recoup an alleged overpayment on or after the date the HCAPPA became effective, July 11, 2006, regardless of the date of delivery of the health care service(s) for which the claim was submitted, or the date on which the claim was paid.[2] Guidance from the State of New Jersey suggests that HCAPPA was intended to apply to a broad range of health care payers and services.[3]

Do you have to reimburse the State of New Jersey for overpayment?

Overpayments may implicate the New Jersey Uniform Unclaimed Property Act (the "Property Act").[4,5] The Property Act states that a credit balance, customer overpayment, security deposit, refund, credit memorandum, unused ticker or similar instrument that occurs or is issued in the ordinary course of business which remains unclaimed by the owner for more than three years after becoming payable or distributable is presumed abandoned.[6] The Property Act goes on to state that a person holding such abandoned property that is subject to custody[7] shall report the abandoned property to the Treasurer of the State of New Jersey.

Not more than 120 days nor less than 60 days before filing a report with the Treasurer, the holder of the abandoned property must send by certified mail, with return receipt requested, written notice to the apparent owner at the last known address informing the owner that the holder is in possession of the property subject to the Property Act if: (i) the holder has in its records an address for the apparent owner which the holder's records do not disclose to be accurate; (ii) the claim of the apparent owner is not barred by the statute of limitations; and (iii) the property has a value of $50 or more.[8]

So who do I pay? Co-Existence of HCAPPA and the Property Act

The New Jersey Unclaimed Property Administration (the "UPA") had informally addressed the interplay between HCAPPA and the Property Act in 2007 upon the inquiry of several hospitals. The chief question to be answered was: who had a right to the overpayment following the 18 month time limit? While the issue was never referred to the New Jersey Attorney General's office (and thus no guidance was ever formally or publicly issued), the UPA took the position that while the Property Act would not operate in a manner so as to cause providers to subject these payments to escheat to the State (or to return the overpayments to carriers) after the enactment of HCAPPA, it would still continue in force post-HCAPPA as between the provider and the patient. HCAPPA vests the payment in the provider following the 18-month period, but only to the extent that payment is not rightfully owed back to the patient.

Thus, while you may not be required to surrender the overpayment to New Jersey or a carrier under the circumstances described above (because more than 18 months have passed since the date of the overpayment and the overpayment has vested in you as the provider), you may be required to relinquish the overpayment, or a portion of it, to the patient.

continued on page 22

continued from page 21

The Importance of Categorizing Carrier Payments

Providers must be very careful to document how carrier payments (and overpayments) are applied to individual patient accounts, and must clearly identify whether the payment creates a "credit balance" on a patient's account. In situations where the patient has paid more than a copay, coinsurance or deductible, the provider must carefully document whether the patient is entitled to a refund or credit upon the provider's receipt of payment from the carrier.

The UPA often audits providers, and it will expect the provider to affirmatively demonstrate that a post-HCAPPA overpayment did not generate a credit that should have been attributed and repaid to the patient. Where patient accounts are affected, the Property Act continues to apply after the 18 month time limitation (namely, the provider will be required to follow the required Property Act procedures to locate the patient and make the payment to the patient and/or turn the payment over to the UPA).

The Risk of Repayment

There is some risk in simply proceeding with repayment. Voluntary repayment of a substantial number of claims, even when there is no suggestion of wrongdoing on the part of the provider, can trigger an audit of the provider's billing practices by the payer. A billing problem that results in overpayments over a period of months or years could be suggestive of an unacceptable level of carelessness in the provider's billing practices. If the audit reveals other undisclosed billing problems, the payer could avail itself of remedies to recover the payments, such as withholding future payments, and could refer the matter to the authorities. Therefore, prior to proceeding with repayment, the holder of the abandoned property should undertake an internal review of its own practices to determine if it was negligent in its handling of the abandoned property and consult with a legal expert.

About the author

Jason Dalal is a corporate law associate at the law firm of Fox Rothschild LLP. He can be reached at JDalal@foxrothschild.com.

---

[1]Payer" means a "carrier" or any agent thereof who is doing business in the State of New Jersey and is under a contractual obligation to pay claims. "Carrier" means an insurance company, health service corporation, hospital service corporation, medical service corporation or health maintenance organization authorized to issue "health benefits plans" in the State of New Jersey. "Health benefits plan" means a hospital and medical expense insurance policy; health service corporation contract; hospital service corporation contract; medical service corporation contract; health maintenance organization subscriber contract; or other plan for medical care delivered or issued for delivery in this State. For purposes of this act, health benefits plan shall not include one or more, or any combination of, the following: coverage only for accident, or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; stop loss or excess risk insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; coverage for Medicaid services pursuant to a contract with the State; and any other similar insurance coverage, as specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Health benefits plans shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and such other similar, limited benefits as are specified in federal regulations. Health benefits plan shall not include hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health benefits plan maintained by the same plan sponsor, and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor.

[2]N.J.S.A. 17B:30-48 et seq.

[3]DOBI Bulletin No. 06-16 available at: http://www.state.nj.us/dobi/bulletins/blt06_16.pdf

[4]N.J. Stat. Ann. §46:30B-1.

[5]Overpayments may instead implicate the Patient Protection and Affordable Care Act (the "PPACA") signed by President Obama on March 23, 2010, pursuant to which any person receiving an overpayment made by Medicare or Medicaid must report and return identified overpayments to the affected party and notify the affected party to whom the overpayment was returned in writing of the reason for the overpayment. The PPACA does not identify when a particular claim is deemed to be identified. Historically, albeit in a self-disclosure context, the Office of the Inspector General has taken the position that an overpayment is not identified until a provider has conducted an internal investigation of the potential overpayment. A provider's obligation to repay an overpayment can also be found in the Medicare program regulations. Providers have to repay when "at fault" as to the claim that triggered the overpayment. An overpayment that is discovered subsequent to the third calendar year following the year in which payment was made will not be recoverable by Medicare so long as the provider was without fault. A provider is considered without fault if it exercised reasonable care in billing for, and accepting payment. "Reasonable care" is defined by the Medicare regulations as the provider making full disclosure of all material facts related to the claim and the provider had a reasonable basis for assuming that the payment was correct on the basis of the information available to the provider, or if the provider had reason to question the payment, the provider promptly brought the question to the carrier's attention. Please see the *Medicare Financial Management Manual* for more information.

[6]N.J. Stat. Ann. §46:30B-42.

[7]The requirements for custody are set forth at N.J. Stat. Ann. §46:30B-10.

[8]N.J. Stat. Ann. §46:30B-50.

•Who's Who in NJ Chapter Committees•

2011-2012 Chapter Committees and Scheduled Meeting Dates

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

PLEASE NOTE THAT THIS IS A PRELIMINARY LIST – CONFIRM MEETINGS WTH COMMITTEE CHAIRS BEFORE ATTENDING.

COMMITTEE	CHAIRMAN/EMAIL/ PHONE	CO-CHAIR/EMAIL/ PHONE	SCHEDULED MEETING DATES*/TIMES	MEETING LOCATION	BOARD LIAISON
CARE (Compliance, Audit, Risk & Ethics)	Michael McKeever mckeeverm@deborah.org 609-893-1200 ext 5201	Nadinia Davis Nadinia.Davis@mountainsidehosp.com 973-429-6801	First Thursday of the Month (888) 269-3831 9:00 AM Attendee Code: 5952498	Meeting in person at Deloitte & Touche, Princeton, NJ for Oct., Jan., Apr. and July Balance are calls. Please call to confirm	Darlene Mitchell mitchell.darlene@hunterdonhealthcare.org 908-237-7059
Communications	Elizabeth Litten ELitten@foxrothschild.com 609-896-3600	Al Rottkamp ajcr123@aol.com 609-584-6508	First Thursday of each month (888) 269-3831 9:15 AM Attendee Code: 7844155	Fox Rothschild offices 997 Lenox Dr Bldg 3 Lawrenceville, NJ	Tony Consoli aconsoli@cbiz.com 732-794-2662
Education	Maria Facciponti mfacciponti@armds.com 973-614-9100	Rita Romeu romeur@armds.com 973-614-9100	First Friday of each month (888) 269-3831 8:30 AM Attendee Code: 7363742	Conference calls with in-person quarterly meetings. Call for more info.	Tracy Davison-DiCanto tdavison-dicanto@princetonhcs.org 609-620-8471
Certification (Sub-committee of Education)	Eric S. Fishbein efishbein@presscott.com 609-677-7888		First Friday of each month (888) 269-3831 8:30 AM Attendee Code: 7363742	Conference calls with in-person quarterly meetings. Call for info.	Tracy Davison-DiCanto tdavison-dicanto@princetonhcs.org 609-620-8471
FACT (Finance, Accounting, Capital & Taxes)	Lisa Hartman lhartman@princetonhcs.org 609-430-7789	Michael DiFranco mike.difranco@gt.com 215-814-1757	Second Wednesday of each Month (888) 269-3831 8:00 AM Attendee Code: 8730600	To alternate between in person and conference calls; locations TBD	Scott Mariani smariani@withum.com 973-898-9494 x420
Institute 2011	Howard Krain hkrain@microsoft.com 908-377-5020	Dan Willis DWillis@childrens-specialized.org 908-301-5458	Fourth Thursday of each Month (888) 290-0578 8:00 AM Attendee Code: 8788393	Conference calls with in-person meetings. Call for more information.	Mike Alwell malwell@smmcnj.org 973-877-2853
LINK (Local Information NetworKs)	Elizabeth Litten ELitten@foxrothschild.com 609-896-3600	Dennis Scotti discotti@presscott.com 732-238-3188	As needed. (888) 290-0578 Attendee Code: 9654515		Mike Alwell malwell@smmcnj.org 973-877-2853
Managed Care	Kevin Joyce kjoyce@qualcareinc.com 732-562-7823	Jill Squires jill.squiers@ehmc.com 201 894-3099	6/16, 7/21, 9/15, 10/20, 12/15 9-11:00 AM No conference calling	New Jersey Hospital Association Board Room	Stella Visaggio svisaggi@hrmcnj.org 908-850-6928
Membership Services/ Networking	Erica Waller Ewaller@princetonhcs.org 609-620-8335	David Kaminski dkaminski@trinitas.org 908-994-8114	Call for meeting arrangements (888) 269-3831 Attendee Code: 5495569	Locations alternate by month - please contact the chairs	Deborah Shapiro dshapiro@wfs-services.com 201-617-7100
Patient Access Services	William Hunt whunt@humed.com 201-996-2897	Diana Sessions Diana.Sessions23@gmail.com 770-330-1259	Second Thursday of each Month (888) 269-3831 9:30 AM Attendee Code: 8942192	CBIZ KA Consulting offices in East Windsor, NJ	Laurie Grey lgrey@princetonhcs.org 609-620-8383
Patient Financial Services	Josette Portalatin jportal@valleyhealth.com 201- 291-6017	Steven Stadtmauer sstadtmauer@csandw-llp.com 973-778-1771 Ext. 146	Second Friday of each Month (888) 290-0578 10:00 AM Attendee Code: 6748634	New Jersey Hospital Association Board Room	Jay Picerno jpicerno@sbhcs.com 973-322-4102
Regulatory & Reimbursement	Rich Rifenburg rifenburgr@deborah.org 609-893-6611 x5794	Vickie Ozmore vicki.ozmore@atlanticare.org 609-677-7171	Third Tuesday of each Month (888) 269-3831 9:00 AM Attendee Code: 9169098	Locations alternate by month - please contact the chairs	Heather Weber hweber@parentenet.com 215-557-2016
Revenue Integrity	Lindsey Colombo lcolombo@rbmc.org 732-324-6031	Vickie McElarney Victoria.McElarney@rwjuh.edu 732-418-8423	First Wednesday of each Month (888) 290-0578 9:00 AM Attendee Code: 8128109	Alternates Raritan Bay MC and New Jersey Hospital Association Board Room	Steven Bilsky sbilsky@causeycpas.com 303-672-9896
Sponsorship	Michael Ruiz de Somocurcio Michael.RuizdeSomocurcio@amerihealth.com 732-726-6709		Second Thursday of each Month (888) 290-0578 8:30 AM Attendee Code: 8451888	Conference calls	Michael Ruiz de Somocurcio Michael.RuizdeSomocurcio@amerihealth.com 732-726-6709

Does The New Jersey False Claims Act Live Up To Higher Federal Standards? Not Yet

James A. Robertson

John W. Kaveney

by James A. Robertson, Esq. and John W. Kaveney, Esq.

New Jersey hospitals are well aware of the Federal and New Jersey False Claims Acts and their significant penalties. Everyone has heard of the million dollar settlements with healthcare entities from across the country relating to their alleged false and fraudulent claims. These lawsuits, and the federal government's general mission to identify and prosecute fraud, show no sign of slowing down as the United States Department of Justice ("USDOJ") recovered a record $3 billion in false claims' cases in fiscal year 2010. Since 1986, the USDOJ has now recovered more than $27 billion through false and fraudulent claim lawsuits and settlements. Through various legislations over the past several years, the Federal False Claims Act has been refined and strengthened to provide the government and the public with an even more potent tool to combat healthcare fraud.

As a result, the Office of Inspector General ("OIG") of the United States Department of Health & Human Services ("DHHS") now seeks to ensure that each State's false claims statute similarly reflects the modified and strengthened language contained in the Federal False Claims Act. The primary means of accomplishing this goal is through an incentive program adopted by the Social Security Act. Should New Jersey choose to adopt these revisions, there will be an even greater incentive and urgency for hospitals and other healthcare entities to ensure false or fraudulent claims are not submitted and that proper audit and oversight programs are in place to avoid the broad liability and significant penalties of these statutes.

Background

New Jersey hospitals have historically been forced to ensure compliance with both the Federal and New Jersey False Claims Acts to avoid the extreme penalties associated with such violations. While there is no absolute requirement that state false claims acts mimic the Federal False Claims Act, section 1909 of the Social Security Act (the "Act"), which was adopted in 2005 as part of the Deficit Reduction Act, creates a financial incentive for States to enact false claims' statutes that meet a set criteria. That criteria includes requirements that: (1) the law establishes liability to the State for false or fraudulent claims; (2) the law's provisions are at least as effective in rewarding and facilitating qui tam actions for false or fraudulent claims; (3) the law requires filing a false claims action under seal for the first 60 days with review by the State Attorney General; and (4) the law contain a civil penalty at least as severe as the civil penalty authorized under the Federal False Claims Act.

In exchange, complying states receive an increased share of any amounts recovered pursuant to the individual state's false claims statute. Typically, a State can expect approximately an additional 10% share in any recovery from a false or fraudulent claim lawsuit or settlement. This additional revenue is a significant incentive for states, especially in a struggling economy where each state is doing everything it can to combat budget deficits and revenue shortfalls. New Jersey is no different as it struggles with a $29.7 billion budget, of which, $5 billion was allocated to the Department of Human Services. Thus, it is likely that New Jersey will make every effort to generate additional revenue through this federal incentive program.

The OIG has granted a two year grace period for compliance, which will end on March 31, 2013. Thereafter, a previously approved State will no longer qualify for the incentive unless its State False Claims Act has been: (1) amended and resubmitted to the OIG, and (2) either approved by the OIG or identified as under review.

The OIG's Review of State False Claims Acts

On March 21, 2011, the OIG issued a letter to the New Jersey Attorney General, Paula T. Dow, providing a review and critique of the New Jersey False Claims Act and its satisfaction, or lack thereof, with Section 1909 of the Act. This review

was performed upon the request of the State of New Jersey as part of a larger program offered by the OIG to assist states in ensuring compliance with section 1909 of the Act in light of recent amendments to the Federal False Claims Act. Approximately 26 of the 50 states requested a review by the OIG. Following review of the New Jersey False Claims Act, in consultation with the USDOJ, the OIG determined the New Jersey statute did not meet the requirements of section 1909 of the Act and thus requires amendment if New Jersey desires to receive the financial incentive after March 31, 2013.

Distinctions Between the Federal and New Jersey False Claims Acts

The inconsistencies between the present Federal False Claims Act and the New Jersey False Claims Act are due to the recent passage over the past few years of three key pieces of legislation. While most Americans are likely familiar with them, they may not have known each contained key revisions to the Federal False Claims Act. Specifically, these legislations are: (1) the Fraud Enforcement and Recovery Act of 2009 ("FERA") adopted May 20, 2009; (2) the Patient Protection and Affordable Care Act ("ACA") adopted March 23, 2010; and (3) the Dodd-Frank Wall Street Reform and Consumer Protection Act (the "Dodd-Frank Act") adopted July 21, 2010. Through these bills, the bases for liability and the rights of qui tam relators were expanded upon and more specifically defined.

The first required revision identified by the OIG amends the basis for liability. In 2009, FERA amended the actions upon which liability can be based and the definitions of such terms as "claim," "obligation" and "material." Most significantly, liability for "knowingly presenting, or causing to be presented, a false or fraudulent claim for payment or approval" no longer requires that the claim be made or presented to an officer or employee of the government. This revision significantly expands the scope of potential actions covered by the statute thereby increasing the possibility of a violation of the Federal False Claims Act. Moreover, FERA also expanded the scope of the definition of a "claim." The term now broadly encompasses requests or demands for money or property regardless of whether or not the United States has title to the money or property and includes requests or demands by third parties "if the money or property is to be spent or used on the Government's behalf or to advance a Government program or interest." Finally, FERA also provided the terms "obligation" and "material" with expansive definitions. Consequently, more claims will fall within the scrutiny of the Federal False Claims Act thereby increasing the potential for exposure by hospitals and other healthcare providers.

continued on page 26

continued from page 25

Contrastingly, the scope of the New Jersey False Claims Act's definition of liability is not as broad. It defines liability as, among other things, knowingly presenting or causing to be presented a false claim to the employees, officers or agents of the New Jersey or to any contractor, grantee or other recipient of New Jersey funds. Likewise, the New Jersey False Claims Act's definition of "claim" is not as expansive. It encompasses requests or demands for money, property or services made to any employee, officer or agent of New Jersey, or to any contractor, grantee or other recipient if the State provides any portion of the money, property or services requested or reimburses for any of the money, property or services, making it narrower than the Federal False Claims Act.

The OIG also identified necessary revisions to the qui tam aspects of the New Jersey False Claims Act to ensure full satisfaction with section 1909(b)(2) of the Act. A qui tam action is the mechanism by which private individuals can assist in the prosecution of false and fraudulent claims and receive a portion of any award or settlement resulting from that lawsuit. One revision concerns the right to relief by a whistleblower that is discharged, demoted, suspended, harassed or in any manner discriminated against. The Federal False Claims Act, through amendments in FERA and the Dodd-Frank Act, permits recovery of such relief whenever the whistleblower takes action "in furtherance of other efforts to stop 1 or more violations." The New Jersey False Claims Act, however, requires a more specific set of circumstances to entitle a whistleblower to relief: (1) a voluntary disclosure of information to the State or law enforcement agency, or other acts in furtherance of a false claims action, such as testimony for the government or assistance in filing an action. While similar, New Jersey's requirement for relief is not as broadly defined as in the federal statute and thus was identified by the OIG as an area requiring amendment to ensure greater facilitation of qui tam actions.

Another significant distinction identified by the OIG that will have a profound impact upon false claims actions in New Jersey concerns government intervention in qui tam actions. FERA amended the Federal False Claims Act to include a new paragraph, which states that if the government elects to intervene in a qui tam action, it "may file its own complaint or amend the complaint of a person who has brought an action . . . to clarify or add detail . . . and to add any additional claims with respect to which the [g]overnment contends it is entitled to relief." This means that once a qui tam action is filed, if the government ultimately decides to intervene, it would not be barred from amending and revising the original complaint to identify new claims or add new details because any such amendments would automatically relate back to the filing date of the original complaint. As a result, the government is not restricted by the statute of limitations. New Jersey presently has no similar statutory provision to allow for such amendments by the State upon intervention in a qui tam action.

The OIG also states that the New Jersey False Claims Act is less effective in rewarding and facilitating qui tam actions due to its broader rules for dismissals of such claims. Pursuant to an amendment by the ACA, courts are instructed to dismiss claims under the Federal False Claims Act, unless opposed by the government, if there was public disclosure of substantially the same allegations either through: (1) a criminal, civil or administrative proceeding in which the government is a party; (2) a federal report, hearing, audit or investigation; or (3) by the news media. However, the New Jersey False Claims Act does expressly permit the State of New Jersey the opportunity to oppose or block a dismissal and additionally requires dismissal in a broader context of circumstances. Thus, the OIG's requested amendment would provide greater protection of qui tam actions from dismissal by the courts.

One of the exceptions to the above rules for dismissal is where the individual bringing the claim is the "original source" of the information. While the Federal and New Jersey False Claims Acts previously had identical definitions for what constituted an "original source," the ACA has since broadened the definition in the Federal False Claims Act thereby creating a larger class of individuals whose qui tam actions would be protected from mandatory dismissal by the courts. The Federal False Claims Act now defines "original source" to include an individual who either: (1) voluntarily disclosed the information to the government prior to a public disclosure or (2) has independent knowledge of information that materially adds to the publicly disclosed allegations and that information is voluntarily discloses to the government prior to the filing of an action. New Jersey's False Claims Act maintains the prior federal definition of "original source," which includes an individual with direct and independent knowledge of the information, which he or she voluntarily provides to the State before filing an action based on that information. Thus, while the New Jersey statute requires independent knowledge and voluntary disclosure to the government, the federal statute only requires disclosure to the government prior to public disclosure or that the individual have some new material information. The New Jersey definition is therefore more restrictive and thus does not facilitate and reward qui tam actions to the same extent as the Federal False Claims Act.

Finally, the OIG criticized the New Jersey False Claims Act for limiting qui tam actions brought by present or former employees or agents of the State, or a political subdivision of the State, where the information relied upon is discovered in a civil, criminal or administrative investigation or audit

continued on page 28

•Focus on Finance•

IRS issues draft community health needs assessment guidelines

Q. The IRS recently released Notice 2011-52 which is applicable to tax-exempt hospitals, can you tell us about this Notice?

A. The Notice provides draft regulations, definitions and guidance relating to the new community health needs assessment requirements applicable to tax-exempt hospitals as outlined in the new Internal Revenue Code ("IRC") Section 501(r). Generally, a tax-exempt hospital must conduct a community health needs assessment and adopt an implementation strategy once every three years. In addition, the IRS has asked for public comments with respect to the draft regulations contained in this Notice.

Q. You note that IRC Section 501(r) is "new"; when was this created?

A. New IRC Section 501(r) was added to the Code by virtue of the Patient Protection and Affordable Care Act ("Affordable Care Act"), Pub. L. No. 111-148, 124 Stat. 119, enacted March 23, 2010.

Q. What is the effective date of the new IRC Section 501(r) community health needs assessment requirements?

A. The community health needs assessment requirements are effective for taxable years beginning after March 23, 2012. The community health needs assessment requirement initial "3 year window" started with tax years beginning after this date. This means that for calendar year tax-exempt hospitals they must conduct a community health needs assessment in a written report and adopt a written implementation strategy prior to December 31, 2013.

Q. Are there penalties for non-compliance?

A. Yes, IRC Section 4959 imposes a $50,000 excise tax on a hospital organization that fails to meet the community health needs assessment requirements for any taxable year. In addition this excise tax also results in a required disclosure on the hospital's annual information return, its Form 990, Return of Organization Exempt From Income Tax.

Q. What documentation does the Notice require in the community health needs assessment written report?

Scott Mariani

A. Treasury and IRS are requiring these written reports to include the following:

1. A description of the community served by the hospital facility and how it was determined.
2. A description of the process and methods used to conduct the assessment, including a description of the sources and dates of the data and other information used in the assessment and the analytical methods applied to identify community health needs.
3. A description of how the hospital organization took into account input from persons who represent the broad interests of the community served by the hospital facility, including a description of when and how the organization consulted with these persons.
4. A prioritized description of all of the community health needs identified through the CHNA, as well as a description of the process and criteria used in prioritizing such health needs.
5. A description of the existing health care facilities and other resources within the community available to meet the community health needs identified through the CHNA.

In addition to the above, Treasury and IRS have taken the position that a hospital has not conducted a community health needs assessment until the written report has been made "widely available." Widely available is defined to include posting the written report on the hospital's website. In certain limited narrowly defined instances another website can be utilized.

Q. What does the Notice require with respect to the written implementation strategy?

A. Treasury and IRS feel that that an implementation strategy will address a health need identified through a community health needs assessment for a particular hospital facility if the written implementation strategy plan either:

continued on page 28

continued from page 27

1. describes how the hospital facility plans to meet the health need; or
2. identifies the health need as one the hospital facility does not intend to meet and explains why the hospital facility does not intend to meet the health need.

In addition to the above, Treasury and IRS have taken the position that in most instances a hospital has generally not adopted a written implementation strategy until the plan has been adopted by either the governing body of the organization (e.g. Board of Trustees) or a committee of the governing body.

Q. Is the hospital organization required to make its written implementation strategy widely available to the general public similar to its community health needs assessment?

A. No, Treasury and IRS are not requiring this; however, they are requiring that the written implementation strategy be attached to the hospital's Form 990, Return of Organization Exempt From Income Tax; annually.

Q. If a hospital organization has multiple hospital facilities can it prepare one community health needs assessment written report and one written implementation strategy?

A. No, as currently drafted both Treasury and IRS are requiring a hospital organization to conduct a separate community health needs assessment and adopt a separate implementation strategy for each hospital facility it operates. This means that if one hospital legal entity is comprised of five separate hospital facilities or campuses, the hospital is required to prepare five separate community health needs assessment written reports and five separate implementation strategies, not combined reports for all five facilities. We do believe, however, that Treasury and IRS may change this requirement and allow one combined community health needs assessment written report and one combined written implementation strategy for multiple hospital facilities when final regulations are published.

Q. Any final thoughts?

A. Yes, stay tuned as changes to the draft regulations contained in Notice 2011-52 are likely. In addition, the creation, implementation and enforcement of IRC Section 501(r) is another example of the Treasury and IRS' continued focus on community benefit and a hospital fulfilling its charitable tax-exempt purposes and also making hospital's activities and operations more transparent to the general public.

About the author

Scott J. Mariani, JD, is a Partner in the Morristown office of WithumSmith+Brown, Certified Public Accountants and Consultants, and is also a Practice Leader for the firm's Healthcare Services Group. Scott specializes in providing tax advice to integrated healthcare delivery systems, hospitals, long-term care facilities, physician groups and other not-for-profit organizations. He can be reached at smariani@withum.com.

---

continued from page 26

that is within the scope of the individual's job description or duties. Thus, New Jersey does not permit qui tam actions by individuals that only were able to obtain the information about the fraud because of their job description or duties. The Federal False Claims Act contains no such limitation and thus is less restrictive upon qui tam actions.

Conclusion

New Jersey is consequently left in a position where it must strengthen its False Claims Act and broaden its protection of qui tam actions or face losing the significant financial incentive provided pursuant to section 1909 of the Act. While no action by the Legislature has been taken as of yet, it is likely the New Jersey Legislature will act to adopt these amendments prior to the OIG's deadline to ensure this additional stream of revenue in the future. If New Jersey chooses to enact these amendments into its False Claims Act, it will only further expand the scope of liability and the rights of those bringing qui tam actions thereby placing added pressure on New Jersey hospitals to continue being ever vigilant in their self-auditing and oversight programs to ensure false or fraudulent claims are not submitted to the state or federal government.

About the author

James A. Robertson is a Partner and head of the health care practice at McElroy, Deutsch, Mulvaney & Carpenter, LLP, a 300-attorney firm with ten offices in New Jersey, New York, Connecticut, Massachusetts, Pennsylvania, Delaware, and Colorado. Mr. Robertson is also the former Managing Partner of Kalison, McBride, Jackson & Robertson, P.C., which, as of July 1, 2011, has consolidated its health care practice with McElroy, Deutsch, Mulvaney & Carpenter, LLP.

John W. Kaveney is an associate in the health care practice of McElroy, Deutsch, Mulvaney & Carpenter, LLP.

hfma™ new jersey chapter
healthcare financial management association

SAVE THE DATE

Education Series

NJ HFMA Finance Accounting Capital and Tax Committee Presents:

Are You Ready for Year End?

Finance, Accounting, Capital and Tax Issues and Updates for Your Organization

Tuesday, November 8th 2011

(New Meeting Date offering 7 CPEs)

Woodbridge Hilton

120 Wood Avenue South, Iselin, NJ08830
8:30 AM-4:30 PM

Morning Sessions

- **New Jersey Hospital Association Update**

- **Economic Forecast in Health Care**
  This session will provide an overview of the state of the economic forecast for the healthcare industry from both a national and state perspective, including a discussion of key statistical data and information in the areas of employment, operating margins, etc. The speakers will share observations on the challenges that New Jersey hospitals face in this ever-changing economic environment.

- **Current and Future State of the Capital Markets: Panel Discussion**
  This panel discussion will focus on capital market trends and effectively accessing capital, developing financing strategies, and tactics for capital decision making. It will include representatives from the rating agencies, capital planning, investment banking, and CFOs from New Jersey hospitals/health systems to provide their perspective on the current state of the capital markets and their systems strategic and financial planning goals and objectives.

Lunch

Afternoon Sessions

- **Audit/Accounting Update- Balance Sheet implications including Reserves**
  This session will discuss new and pending accounting and auditing pronouncements as well as a refresher on important industry items previously discussed. Topics will include FASB standards such as "Accounting for Leases" as well as new requirements of the Emerging Issues Task Force (EITF) related to malpractice reserves and allowance for bad debt. The speakers will provide practical recommendations from a provider perspective on how to prepare for these emerging pronouncements as well as what your auditors will be looking for at year-end.

- **The Continued Evolution of Audit Committees**
  This panel discussion will include insights from an audit committee board member, the vice president of compliance for one of the largest health care systems in the Northeast, an audit partner, and an IT specialist. The panel will share emerging trends and best practices on what health care organization audit committees are discussing and how finance department management teams play a role in these important topics.

- **Tax Update Hot Topics and Community Benefit Reporting**
  This session will provide an update on tax issues hospitals will be facing. Such topics will include a detailed discussion on the new requirements under Section 501(r), recent guidance on Community Health Needs Assessment requirements affecting hospitals as set forth in the Patient Protection and Affordable Care Act of 2010, and a discussion of the tax planning and the IRS's point of view around Accountable Care Organizations.

Member Spotlight:
William Hunt, CHAM, CPC

William Hunt

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

WILLIAM: I am Director of the Admission Services Center at Hackensack University Medical Center, and have over 33 years of experience in the Healthcare Finance/Access field. Twenty three of those years were spent in various Patient Financial Services (PFS) positions starting as an insurance verifier on the Inpatient side, then various systems analyst positions which led to holding several senior positions in both the Outpatient and Inpatient PFS areas within a couple of New York City hospitals. I currently hold certification as a Health Care Access Manager and as a Certified Professional Coder. I am a member of HFMA, NAHAM and the AAPC. I am currently the Chair for the Patient Access Committee of the New Jersey Chapter of HFMA.

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

WILLIAM: Hackensack University Medical Center is a hospital employer in which I enjoy and have the opportunity to work with. The leadership is forward thinking, patient focused, and patient quality driven. The Medical Center is an exciting place to work as something new is always underway. My duties here are to ensure for Elective & Urgent/Direct admissions, along with surgical services such as Cardiac Catheterization, Ambulatory Surgery and Endoscopy services, that insurance verification/benefit coverage and pre-authorizations are obtained when required. Upfront cash collection activity has been an integral part of the pre-service process here since 2001. It accelerated throughout the Medical Center with a standardized across-the-board policy and procedure implemented in 2003. This collection activity includes estimating a patient deductible, co-pay and co-insurance, if applicable. Where appropriate, we refer patients for supplemental or alternate insurance coverage such as Medicaid or Charity Care. All elective services are to be financially cleared three days prior to the procedure.

I am also responsible for the Pre-Admission Scheduling and Testing process. A pre-registration unit helps to ensure pre-service patient data capture and helps to prepare and enhance the patient day of service processing experience. Admissions also currently accepts the registration/financial activity of the Adult Emergency Department, on a transitional basis.

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

WILLIAM: Keeping up with the ever changing payer requirements to have a "clean claim" produced the "first time" and improving facility cash flow for services rendered.

One of the special challenges that any Access area has is our desire to provide outstanding customer service to the variety of people and internal/external customers we interact with.

FOCUS: What are your hobbies and outside interests?

WILLIAM: I enjoy the game of chess and I am a video gamer.

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

New Members

Maria E. Antunez
Hackensack University Medical Center
Patient Financial Services Supervisor
(201) 996-3487
mantunez@humed.com

Deepak R. Butani
Care for the Homeless
Chief Finance Officer
(201) 314-1236
Deepak.butani@yahoo.com

Victoria E. Brennan
PricewaterhouseCoopers
Senior Accountant
(973) 236-4720
victoria.e.brennan@us.pwc.com

Anna Costanza
Meridian Health System
Supervisor
(732) 532-2509
acostanza@meridianhealth.com

Kathleen Fay
Meridian Health System
Access Services Supervisor
(732) 775-5500
kfay@meridianhealth.com

Tammy Nigro
Meridian Health System
Supervisor
(732) 776-4347
tnigro@mericianhealth.com

Judith Rapolla
Bayshore Community Hospital
Superviser
(732) 497-1720
jrapolla@meridianhealth.com

Marianne Valerio
Jersey Shore Univ Med Center
Access Services Supervisor
(732) 776-4556
mvalerio@meridianhealth.com

Jeffrey Rafkin
(732) 212-0060
jrafkin@ppenet.com

Jenny Chu
Huron Consulting Group
Consultant
(312) 590-3670
jjlee@huronconsultinggroup.com

Robert Mores
Marsh USA Inc
Senior Vice President
(973) 401-5230
robert.mores@marsh.com

Thaddaeus Diggs
University of Medicine & Dentistry of NJ
Manager of Operations
(973) 972-0350
diggstl@umanj.edu

Lisa A. Holt
Horizon NJ Health
Accounts Receivable/Recovery Manager
(609) 718-9361
lisa_holt@horizonnjhealth.com

Joseph Bufano, Jr.
Inimeg Management Co., Inc
Medical Administration
(732) 541-2233
imci@comcast.net

Peggy Capece
Meridian Health Systems (OMC)
Supervisor
(732) 836-4037
mcapece@meridianhealth.com

Michael Castle
(908) 619-3730
mcastle30@gmail.com

Devyani Kaushik
Decision Support Analyst
(908) 252-4039
dkaushik@somerset-healthcare.com

Nanci D. Morris
Managing Director
(973) 635-2557
nanci.morris@ne-rc.com

Les Pasternack
PNC Bank
Healthcare Banking Mgr
les.pasternack@pnc.com

Kathy Hughes
Holy Name Medical Center
Accounting Supervisor
(201) 541-5957
k-hughes@holyname.org

Michael Welfeld
Medco Health
Director of Finance
(201) 269-6369
michael_welfeld@medco.com

Kathleen Latham Yenco
Gaffey & Associates
(201) 707-7023
key9489@a0l.com

E. Pachella
MedAssets
(201) 762-6831
epachella@medassets.com

Kokil Tandon
(212) 954-4872
kokiltandon@gmail.com

John Barker
Liberty Health
Corporate Director of Decision Support
(201) 770-3782
johnb1263@yahoo.com

Chet Pniewski
Health Care Mngmt Associates
Managed Care Coordinator
(732) 294-7055
cpniewsk@centrastate.com

Adjoa T. Twum
Presscott Associates
Consultant
(860) 677-7888
atwum@presscott.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

DIRECTOR OF FINANCE
Deborah Heart & Lung Center
Browns Mills, NJ

DIRECTOR OF FINANCE, FINANCIAL REPORTING
AtlantiCare
Egg Harbor Township

REVENUE CYCLE DIRECTOR
St. Francis Medical Center
Trenton, NJ

VICE PRESIDENT, REVENUE CYCLE
Kennedy Health System
Cherry Hill, NJ

SENIOR FINANCIAL ANALYST, MANAGED CARE
UMDNJ – New Jersey Medical School
Newark, NJ

MANAGER OF CORPORATE COMPLIANCE
Meridian Health System
Neptune, NJ

DIRECTOR OF MANAGED CARE
Holy Name Medical Center
Teaneck, NJ

ASSISTANT VICE PRESIDENT, FINANCE
Hospital for Special Surgery
New York, NY

BUSINESS MANAGER, CANCER GENOME INSTITUTE
Fox Chase Cancer Center
Philadelphia, PA

Can New Jersey Crack the Quality/Cost Code with its New Medicaid ACO Model?

by Elizabeth G. Litten

Elizabeth Litten

On a recent, quiet summer day, without fanfare, New Jersey Governor Chris Christie signed Senate Bill 2443 into law. This new law, P.L. 2011, c. 114 (the "Act"), makes New Jersey the first state in the country to establish a Medicaid Accountable Care Organization (or "ACO") Demonstration Project. The Medicaid ACO Demonstration Project will be overseen by the New Jersey Department of Human Services ("DHS") and must receive the support of the federal Centers for Medicare and Medicaid Services ("CMS") pursuant to a waiver request submitted in accordance with the Social Security Act. Once launched, New Jersey's Medicaid ACO project has the potential to improve much-needed primary care access and the quality of health care for the state's Medicaid population, while decreasing the cost of that care and, commensurately, the burden on New Jersey taxpayers.

New Jersey's Medicaid ACO project has the potential to improve much-needed primary care access and the quality of health care for the state's Medicaid population, while decreasing the cost of that care and, commensurately, the burden on New Jersey taxpayers.

Given the difficulty CMS has experienced in garnering support for its proposed ACO model[i], New Jersey's pending launch of ACO demonstration projects geared toward serving the Medicaid population is particularly note-worthy for its cross-industry support. Rarely (if ever) do the hospital industry, physician community, payer association, business community, church leader coalitions, patient advocates, and federally qualified health center ("FQHC") associations join together to support a health care payment reform initiative. Rarely (if ever) is this broad spectrum of stakeholder support greeted by support of the regulating agencies. Despite an expression of concern during a legislative hearing that the Medicaid ACO demonstration project was resonant of the Medicare Shared Savings Project described in Section 3022 of the Patient Protection and Affordable Care Act ("PPACA") and, thus, more aligned with "Obama-care" than with more conservative approaches to health care reform, the project was able to gain the necessary legislative and administration support to become law.

The next step toward launch of Medicaid ACOs will be the proposal, comment and response process, and adoption of regulations setting forth requirements for the "gainsharing plan" that each Medicaid ACO will submit to DHS for approval. The gainsharing plan, described in Section 5 of the Act, will contain required elements, but will essentially be the individual ACO's unique roadmap setting forth the manner in which it plans to improve access to primary and behavioral health care, improve health outcomes, and save money spent on inefficient or unnecessary care. The gainsharing plan will also include the ACO's projection as to the impact its plan (and the success of its plan) will have on participating hospitals, and will specify how savings will be shared with the state and within the ACO. The gainsharing plan must include specific information as to how patients will be protected and must include objective benchmarks for measuring quality of care, as well as subjective patient assessments of the patient's experience and satisfaction with the care rendered. Finally, the gainsharing plan is to be developed with community input and made available to members of the community served by the ACO.

Section 7 of the Act provides that each Medicaid ACO must submit a separate gainsharing plan for each Medicaid Managed Care Organization ("MCO") with which it contracts. The web page for the Division of Medical Assistance and Health Services ("DMAHS"), the division within DHS responsible

continued on page 34

continued from page 33

for administering the Medicaid program, describes the anticipated expansion of managed care program enrollment for New Jersey's Medicaid population:

New Jersey's State Fiscal Year (SFY) 2012 budget includes the initiative to move Medicaid fee-for-service clients into managed care plans offered by four participating HMOs. These changes were phased in beginning July 1, 2011 and include the aged, blind and disabled populations, as well as individuals who have both Medicare and Medicaid benefits. This initiative will remedy what has become a splintered program and will enable better care coordination, utilization management and cost savings.

Medicaid managed care in New Jersey is not new. In 1995, it was introduced to the Medicaid system to improve quality, health outcomes and contain costs for Medicaid and NJ FamilyCare clients. As the program grew in enrollment and scope, a fragmented approach to delivering services began to erode the advantages of a managed care system.

In April 2011, about 75% of all Medicaid and Children's Health Insurance Program (CHIP) clients were enrolled in a managed care plan, including over 100,000 individuals with complex medical needs. The SFY 2012 managed care enrollment initiative will result in nearly 92% of Medicaid enrollees being served through managed care.

What is the deadline for selecting and joining an HMO? NEW

July 1, 2011 Group - Approximately 45,000 individuals in the Aged, Blind or Disabled categories:

Clients received letters informing them to select a health plan by July 18, 2011.

"Ready to Enroll" packets soon followed.

October 1, 2011 Group - Approximately 110,000 individuals who receive both Medicare and Medicaid:

Clients received letters in spring 2011 informing them that they would need to select a health plan in fall 2011.

Client "Ready to Enroll" packets are expected to be mailed the second week of August informing clients to select a health plan by **September 15, 2011**.[ii]

Thus, while Medicaid will have very little direct participation in the Medicaid ACOs, it will oversee the Medicaid ACOs by approving their initial applications for certification, as well as the gainsharing plans submitted by each Medicaid ACO for each Medicaid MCO that voluntarily seeks to participate in the Medicaid ACO. In overseeing the Medicaid ACO demonstration project, DHS and DMAHS will play a key role in ensuring that the health care needs of the Medicaid population are being met in a cost-effective, collaborative, and sustainable manner.

Perhaps the differences inherent in addressing cost and quality issues specific to the Medicaid population versus the cost and quality issues specific to other patient populations (including the non-Medicaid-eligible Medicare population) will prove key to cracking the quality/cost code essential to any ACO model. The work of Jeff Brenner, MD, the founder of the Camden Coalition of Healthcare Providers ("CCHP") and its Executive and Medical Director, was profiled last January in a *New Yorker* article by Atul Gawande.[iii] Dr. Brenner demonstrated that, in Camden, New Jersey, one of the nation's poorest cities, only one percent of the population accounted for 30 percent of medical costs, and that the leading cause of emergency department visits was primary care issues such as head colds, ear infections, sore throats, and asthma. Dr. Brenner quickly realized that improving primary care access and improving the coordination of care and communication among medical, behavioral, and social services providers was essential for improving quality and reducing cost. Some of these issues transcend the Medicaid population, but addressing them in the specific context of the Medicaid population, and creating a program that gives each ACO the flexibility to identify the needs and develop the solutions appropriate for the ACO's patient population, may prove key for creating successful ACO models in other contexts.

About the Author

Elizabeth G. Litten practices health law in the Princeton office of Fox Rothschild LLP. She is a frequent contributor to the firm's HIPAA, HITECH and Health Information Technology blog, which can be accessed at http://hipaahealthlaw.foxrothschild.com/. Elizabeth can be reached at ELitten@foxrothschild.com.

---

[i]CMS's proposed ACO regulations can be found at http://www.cms.gov/sharedsavingsprogram/. For an article describing national-level provider and legislator concerns with the proposed regulations, see http://www.pbs.org/newshour/rundown/2011/05/political-debate-heats-up-around-accountable-care-organizations.html

[2]http://www.state.nj.us/humanservices/dmahs/home/carve.html

[3]http://www.newyorker.com/reporting/2011/01/24/110124fa_fact_gawande

hfma™ new jersey chapter
healthcare financial management association

Chapter Internal Financial Review

In past years, the NJ Chapter of HFMA underwent an external audit of the chapter's financial statements which was conducted by an independent auditing firm. Although such an independent audit is not required by the national HFMA organization, it has been the practice of our chapter for many years. HFMA does require that each chapter conduct either an independent audit or the HFMA Internal Financial Review. The HFMA Internal Financial Review process and reporting was developed by HFMA and must be followed by any chapter opting for this approach instead of an independent audit. Pursuant to HFMA's requirements, the Internal Financial Review must be completed by an individual or individuals possessing the appropriate financial experience and who are not involved in the chapter's bookkeeping activity.

The purpose of the Internal Financial Review is to test and evaluate the chapter's fiscal integrity and operating guidelines. Furthermore, the review:

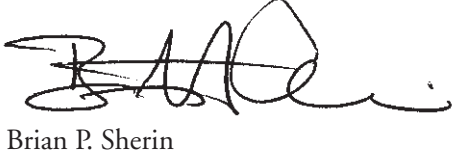
- Addresses whether the chapter's financial statements reasonably reflect its activities for the year.
- Considers whether an adequate level of documentation is maintained for the chapter's receipt and disbursement transactions in order to reconcile checking and saving account bank statement balances.
- Considers whether transaction approval guidelines are in place and are being observed.

During the 2010-2011 Chapter year, the Board of Directors considered the possibility of utilizing the HFMA Internal Financial Review process in lieu of an independent audit. There were two main considerations taken into account by the Board: 1) Would the Internal Financial Review be sufficient to evaluate the integrity of the chapter's financial practices and reporting?, and 2) What would be the cost savings in performing the Internal Financial Review as opposed to an external audit? After careful consideration, the Board decided that the Internal Financial Review option met the needs of the chapter and, in addition, provided considerable cost savings to the chapter. As a result, the Board opted to conduct the Internal Financial Review for the 2010-2011 Chapter year.

The Internal Financial Review was completed on a voluntary basis by a certified public accountant who is a member of the chapter. John Brault, Chapter Treasurer, provided the necessary documentation required for the Internal Financial Review. The completed Internal Financial Review questionnaire was provided to the chapter's Audit Committee of the Board of Directors. A meeting of the committee was held to discuss the completed Internal Financial Review questionnaire. At the conclusion of the discussion, the Audit Committee accepted the Internal Financial Review and approved the final financial statements.

The accompanying Balance Sheet and Profit & Loss Statement as of and for the year ended May 31, 2011 reflect the final financial statements for the NJ Chapter for the 2010-2011 chapter year. If you should have any questions, please feel free to reach out to any Board member for assistance.

Respectfully submitted,



Brian P. Sherin
2011-2012 Audit Committee Chair
NJ HFMA

40 New Jersey Chapter
Balance Sheet
As of May 31, 2011

	Total
ASSETS	
Current Assets	
Bank Accounts	
1000-00 TD Bank Checking	27,968.55
1021-00 TD Bank Money Market	160,049.36
1022-00 PNC Money Market - 0286	100,617.30
Total Bank Accounts	**$288,635.21**
Accounts Receivable	
1200-00 Accounts Receivable	16,942.50
Total Accounts Receivable	**$16,942.50**
Other Current Assets	
1275-00 Prepaid Expenses	6,999.40
Total Other Current Assets	**$6,999.40**
Total Current Assets	**$312,577.11**
Fixed Assets	
1300-00 Fixed Assets	4,380.00
Total Fixed Assets	**$4,380.00**
TOTAL ASSETS	**$316,957.11**
LIABILITIES AND EQUITY	
Liabilities	
Current Liabilities	
Accounts Payable	
2000-00 Accounts Payable	85,610.87
Total Accounts Payable	**$85,610.87**
Other Current Liabilities	
2100-00 Deferred Revenue	35,477.50
2200-00 Accrued Payroll	2,972.54
2250-00 Payroll Liabilities	1,353.03
Total Other Current Liabilities	**$39,803.07**
Total Current Liabilities	**$125,413.94**
Total Liabilities	**$125,413.94**
Equity	
3900-00 Retained Earnings	183,208.65
Net Income	8,334.52
Total Equity	**$191,543.17**
TOTAL LIABILITIES AND EQUITY	**$316,957.11**

Thursday, Jul 28, 2011 03:20:44 PM GMT-4 - Accrual Basis

40 New Jersey Chapter
Profit & Loss
June 2010 - May 2011

	Total
Income	
4000-00 Meeting Income	193,141.48
4100-00 Education Income	32,450.88
4200-00 Newsletter	43,629.95
4300-00 Golf Outing Income	62,560.00
4400-00 Social Events Income	1,950.00
4600-00 Dues Rebate from National	27,204.03
4650-00 Other Rebate	450.17
4700-00 Interest Income	944.68
4950-00 General Sponsorship	205,075.00
Total Income	**$567,406.19**
Expenses	
5000-00 Meetings Expenses	348,842.30
5100-00 Education	21,192.19
5200-00 Newsletter Expense	44,418.59
5300-00 Golf Outing Expenses	59,203.97
5400-00 Social Event Expenses	1,747.22
5600-00 Member Recognition	17,906.44
5800-00 Payroll Expense	48,769.39
5950-00 HFMA Web Site	6,157.50
5990-00 Other Travel and Expenses	77.10
6000-00 Office Supplies/Copying	291.71
6200-00 Postage	778.59
6300-00 Telephone	1,008.36
6400-00 Membership Fees NJHA	384.00
6500-00 Administrative Expenses	1,471.37
6600-00 Insurance	2,833.52
7000-00 Credit Cards	4,657.38
7500-00 Depreciation	4,332.04
7900-00 Provision for Bad Debts	-5,000.00
Total Expenses	**$559,071.67**
Net Operating Income	**$8,334.52**
Net Income	**$8,334.52**

Thursday, Jul 28, 2011 03:51:05 PM GMT-4 - Accrual Basis

40 New Jersey Chapter
Statement of Cash Flows
June 2010 - May 2011

	Total
OPERATING ACTIVITIES	
Net Income	8,334.52
Adjustments to reconcile Net Income to Net Cash provided by operations:	
1200-00 Accounts Receivable	-16,942.50
1250-00 Other Receivables	14,074.97
1260-00 Allowance For Doubtful Accts	-5,000.00
1275-00 Prepaid Expenses	9,529.82
1320-00 Fixed Assets:Accumulated Depreciation	4,248.04
2000-00 Accounts Payable	-4,424.72
2100-00 Deferred Revenue	17,527.50
Net cash provided by operating activities	**$27,347.63**
INVESTING ACTIVITIES	
1310-00 Fixed Assets:Video Equipment & Computer	-1,428.04
Net cash provided by investing activities	**$ -1,428.04**
Net cash increase for period	**$25,919.59**
Cash at beginning of period	262,715.62
Cash at end of period	**$288,635.21**

Thursday, Jul 28, 2011 03:55:41 PM GMT-4

Meet A New Member!

Maria Antunez	
Who is your employer, and what is your position?	Hackensack University MC - Patient Financial Services Training Instructor.
What was your first job as a teen?	Private Tutor.
What do you like best about your work responsibilities?	Finding solutions to problems, coaching people to become the best in their roles, achieving/exceeding challenging goals. I love a good challenge!
A job I would enjoy doing without pay is...	A Curator for museums or exhibits.
My favorite place is...	The Renaissance Faire in Tuxedo NY & Las Vegas.
I will not eat...	Snails, Ostrich Eggs, any Amphibian or Reptile.
If I'm not at work, you will find me...	At the movies, a show or a festival.

mark your calendar . . .

November 16, through January 25, 2012
TBD
6-9PM
Six Wednesdays
Basic Financial Management Education Series

November 8, 2011
Woodbridge Hilton
all day
Bimonthly Meeting: Finance, Accounting Capital & Tax

January 10, 2012
Woodbridge Hilton
all day
Bimonthly Meeting: PFS & PAS

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

Ask the Ethics Guy®!
Do I Have to Admit I'm Job-Hunting?

by Bruce Weinstein, Ph.D.

Bruce Weinstein

Be fair to yourself by seeing this as an opportunity for both you and the company to benefit.

Dear Ethics Guy: I try to be an honest person—and even think I succeed most of the time—but am I obligated to tell my boss the truth if he asks me whether I'm looking for a job? I told him I wasn't, but I actually am. I feel like I've maxed out here and there really isn't any great reason to stay.

Our ethical obligation to tell the truth does not mean that we have to answer every question we are asked. Only those with a right to be told the truth can demand a response to their questions. For example, if you are a doctor, and a patient asks you what her diagnosis is, you have a duty to tell her. If someone at a cocktail party later asks you what this patient's diagnosis is, you not only have a right not to disclose this information, you have a duty not to do so. (I am, of course, making several assumptions here: That the patient has decision-making capacity, that the person at the cocktail party is not involved in the patient's care, and so on.)

If your boss asks you who you are dating, what your religion is, or how you plan to vote, you have no ethical obligation to respond. I'm not saying that you ought to lie in these circumstances, but neither are you required to be forthcoming. Of course, there are legal as well as ethical concerns raised by these queries, which are beyond the scope of my expertise to address adequately. Suffice it to say that you should be truthful only when your boss has a genuine right to know the answer, and the question is not prompted by mere personal curiosity.

The question then becomes, "Does my boss have a genuine right to know that I'm considering moving on?" It depends in part on your circumstances: Let's say you give the requisite two weeks' notice. How drastic would the consequences of your leaving be for your clients? Is there someone else who could readily step in and take on your work without incurring too great a burden? You might also want to consider whether you are prepared to end a relationship that might be valuable to you in the future.

Whose Best Interests?

Let's assume for the sake of argument that your departure would put a temporary strain on the company's resources but that business will continue nevertheless, and that, as much as you would like to remain on good terms with the company, it is more important to you to be in a less stressful working environment or in one that may offer greater opportunity for your career. Let's also assume that even if your boss never made clear that he expects you to tell him about your desire to move on, the ethical principle of fairness suggests that your boss may very well be entitled to know about your wish to leave.

But that isn't the end of our analysis. After all, you might understandably fear retaliation from your boss if you are truthful now. How could it be the case, then, that ethics requires putting your company's interests above your own? Can loyalty truly require jeopardizing oneself? We are now at the heart of the matter.

continued on page 40

continued from page 39

It is inaccurate to look at an ethical problem—this one or any other—as a battle between the interests of one party and the interests of another, in which there is ultimately a victor and a loser. The ideal solution to any ethical conundrum takes into account the interests of everyone involved, and in most situations, it is indeed possible to find a way to honor all of those interests. One is rarely forced to choose between, say, protecting yourself or being fair to your employer.

Asking for What You Want

Once we step outside of the box and consider the ways in which we can take all of our ethical responsibilities into account, it becomes easier to find the best possible solution. You are at a crossroads in your professional life, and you might use this opportunity to explore with your boss what is bothering you and how your concerns could be addressed in a way that would be advantageous to you and the company.

Your boss may not understand fully—or at all—the nature of your discontent. If there is the slightest possibility that being upfront with him could resolve the impasse, it makes sense to be candid with him now. Everyone stands to benefit: you, your employer, and ultimately your clients.

When I started out in the working world, I used to listen to motivational tapes about how to succeed as a professional. One of the most inspiring seminars I listened to was by Jack Canfield, co-creator of Chicken Soup for the Soul. At one point Jack revealed a simple but powerful way to get what you want: ask for it. "Did you know," he said to the audience, "that you can ask for a free upgrade to first class—and actually get it?" It sounded too good to be true, but I tried it out one day, and it worked.

Before you call it a day with your current job, give your boss the benefit of the doubt. Tell him what is bothering you and what it would take to turn things around. You may be pleasantly surprised by what you discover.

About the author

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

•Certification Corner•

In the July/August *FOCUS* I discussed the new CHFP certification program, including the information HFMA National provided regarding the new examination. Since that article I have had the opportunity to personally take the new exam and compare it to the old certification exams I took last fall. While the new exam covers some different material than the old exam(s), anyone who spent time preparing for the old certification exam should find that that the vast majority of the information they reviewed in preparation for the old exam is still relevant for the new test. The NJ Chapter is preparing an exam preparation course this fall, but anyone who wants to begin preparing on their own or feels they are ready to take the exam can register for either the review course or CHFP exam at the Certification section of hfma.org

While the CHFP program is aimed at individuals with a minimum of 3-5 years of hospital/healthcare system management experience, one of the benefits of the new certification process is that any current and active HFMA member who passes the certification exam is now a CHFP without regard to how long they have been an HFMA member. Earning the CHFP credential enhances your credibility, supports your professional development, demonstrates a high level of commitment to the field, and validates your skills and knowledge. What better way to demonstrate your comprehensive understanding of healthcare financial management to your current and potential employers? Begin the certification process today!

Reminder to Current CHFPs and FHFMAs

All certified members are required to maintain their certification by meeting two basic requirements:

- Remain an active HFMA member in good standing
- Complete 90 contact hours in eligible education programs every three years. In addition:
  - At least half (45) of these contact hours must in healthcare finance-related topics
  - At least 20 contact hours must be completed in each of the three years

Any educational programs sponsored by HFMA National are automatically recorded in your educational history. Any hours earned through the NJ Chapter or elsewhere must be self-reported utilizing the online reporting tool.

UNITED STATES POSTAL SERVICE®

Statement of Ownership, Management, and Circulation (Requester Publications Only)

1. Publication Title	2. Publication Number	3. Filing Date
Garden State Focus	1078-7038	10/01/11
4. Issue Frequency	5. Number of Issues Published Annually	6. Annual Subscription Price (if any)
Bi-monthly	6	N/A

7. Complete Mailing Address of Known Office of Publication *(Not printer) (Street, city, county, state, and ZIP+4®)* — Contact Person: Elizabeth Litten

C/O Fox Rothschild LLC, 997 Lenox Dr. Bldg 3, Lawrenceville, NJ 08648-2317 — Telephone *(Include area code)*: 609-895-3320

8. Complete Mailing Address of Headquarters or General Business Office of Publisher *(Not printer)*

Healthcare Financial Mgmt Association NJ Chapter, PO Box 6422, Bridgewater, NJ 08807

9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor *(Do not leave blank)*

Publisher *(Name and complete mailing address)*

Elizabeth Litten, C/O Fox Rothschild LLC, 997 Lenox Dr. Bldg 3, Lawrenceville, NJ 08648-2317

Editor *(Name and complete mailing address)*

Same as Publisher

Managing Editor *(Name and complete mailing address)*

Same as Publisher

10. Owner *(Do not leave blank. If the publication is owned by a corporation, give the name and address of the corporation immediately followed by the names and addresses of all stockholders owning or holding 1 percent or more of the total amount of stock. If not owned by a corporation, give the names and addresses of the individual owners. If owned by a partnership or other unincorporated firm, give its name and address as well as those of each individual owner. If the publication is published by a nonprofit organization, give its name and address.)*

Full Name	Complete Mailing Address
Healthcare Financial Mgmt Association NJ Chapter	C/O Elizabeth Litten, Fox Rothschild LLC, 997 Lenox Dr. Bldg 3, Lawrenceville, NJ 08648-2317

11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages, or Other Securities. If none, check box → ☐ None

Full Name	Complete Mailing Address

12. Tax Status *(For completion by nonprofit organizations authorized to mail at nonprofit rates) (Check one)*

The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes:

☑ Has Not Changed During Preceding 12 Months

☐ Has Changed During Preceding 12 Months *(Publisher must submit explanation of change with this statement)*

PS Form **3526-R**, September 2007 *(Page 1 of 3 (Instructions Page 3))* PSN: 7530-09-000-8855 **PRIVACY NOTICE:** See our privacy policy on www.usps.com

13. Publication Title: Garden State Focus	14. Issue Date for Circulation Data Below: July/August 2011	
15. Extent and Nature of Circulation	Average No. Copies Each Issue During Preceding 12 Months	No. Copies of Single Issue Published Nearest to Filing Date
a. Total Number of Copies *(Net press run)*	1266	1150
b. Legitimate Paid and/or Requested Distribution *(By Mail and Outside the Mail)* (1) Outside County Paid/Requested Mail Subscriptions stated on PS Form 3541. *(Include direct written request from recipient, telemarketing and Internet request from recipient, paid subscriptions including nominal rate subscriptions, employer requests, advertiser's proof copies, and exchange copies.)*	1182	1070
b. Legitimate Paid and/or Requested Distribution *(By Mail and Outside the Mail)* (2) In-County Paid/Requested Mail Subscriptions stated on PS Form 3541. *(Include direct written request from recipient, telemarketing and Internet request from recipient, paid subscriptions including nominal rate subscriptions, employer requests, advertiser's proof copies, and exchange copies.)*	0	0
b. Legitimate Paid and/or Requested Distribution *(By Mail and Outside the Mail)* (3) Sales Through Dealers and Carriers, Street Vendors, Counter Sales, and Other Paid or Requested Distribution Outside USPS®		
b. Legitimate Paid and/or Requested Distribution *(By Mail and Outside the Mail)* (4) Requested Copies Distributed by Other Mail Classes Through the USPS (e.g. First-Class Mail®)		
c. Total Paid and/or Requested Circulation *(Sum of 15b (1), (2), (3), and (4))* ▶	1182	1070
d. Nonrequested Distribution *(By Mail and Outside the Mail)* (1) Outside County Nonrequested Copies Stated on PS Form 3541 *(Include Sample copies, Requests Over 3 years old, Requests induced by a Premium, Bulk Sales and Requests including Association Requests, Names obtained from Business Directories, Lists, and other sources)*	63	45
d. Nonrequested Distribution *(By Mail and Outside the Mail)* (2) In-County Nonrequested Copies Stated on PS Form 3541 *(Include Sample copies, Requests Over 3 years old, Requests induced by a Premium, Bulk Sales and Requests including Association Requests, Names obtained from Business Directories, Lists, and other sources)*		
d. Nonrequested Distribution *(By Mail and Outside the Mail)* (3) Nonrequested Copies Distributed Through the USPS by Other Classes of Mail *(e.g. First-Class Mail, Nonrequestor Copies mailed in excess of 10% Limit mailed at Standard Mail® or Package Services Rates)*		
d. Nonrequested Distribution *(By Mail and Outside the Mail)* (4) Nonrequested Copies Distributed Outside the Mail *(Include Pickup Stands, Trade Shows, Showrooms and Other Sources)*		
e. Total Nonrequested Distribution (Sum of 15d (1), (2), and (3))	63	45
f. Total Distribution *(Sum of 15c and e)* ▶	1245	1115
g. Copies not Distributed *(See Instructions to Publishers #4, (page #3))* ▶	21	35
h. Total *(Sum of 15f and g)*	1266	1150
i. Percent Paid and/or Requested Circulation *(15c divided by f times 100)* ▶	94.94%	95.96%

16. Publication of Statement of Ownership for a Requester Publication is required and will be printed in the September/October 2011 issue of this publication.

17. Signature and Title of Editor, Publisher, Business Manager, or Owner — Date: 10/01/11

I certify that all information furnished on this form is true and complete. I understand that anyone who furnishes false or misleading information on this form or who omits material or information requested on the form may be subject to criminal sanctions (including fines and imprisonment) and/or civil sanctions (including civil penalties).

PS Form **3526-R**, September 2007 *(Page 2 of 3)*

The Prescription for Your Financial Health

Making Outsourcing Efficient and Affordable!

Specializing in the Collection of No-Fault and Workers Compensation Claims

*Experts in the Recovery of Third Party Receivables for Over **30** Years*

- *Day One Third Party Billing/Follow-Up*
- *No Fault/Workers Compensation Billing/Follow-Up*
- *Aged Third Party Rebilling*
- *Zero Balance Account Review*
- *Account Denial Reviews*

HIPAA Compliant

Contact: Michael Palumbo
516.227.6345
michaelp@mrbilling.com

MRB

MEDICAL RECEIVABLES BILLING GROUP

Representing Distinguished Medical Institutions Nationwide

Westbury, NY • www.mrbilling.com

Advertiser Focus

Please consider supporting our sponsoring companies

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

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

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

www.foxrothschild.com

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

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

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

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

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

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

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

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

Visit NJ SmartStart Buildings online at www.njsmartstartbuildings.com or call us toll free at 866-433-4479 for more information.

Medical Receivables Billing Group (MRB) was created in 1981 for the purpose of providing specialized No-Fault and Workers Compensation billing/follow-up services. MRB has expanded its services to include Day One and Aged Commercial Insurance billing/follow-up. MRB employs over 50 billing specialists to handle In-Patient, Outpatient, Physician, Radiology and Ambulatory accounts.

hfma new jersey chapter
healthcare financial management association

RESPONDING TO AN INDUSTRY IN TRANSITION

Fox Rothschild's Health Law Practice reflects an intimate knowledge of the special needs, circumstances and sensitivities of providers in the constantly changing world of health care. Because of our significant experience and comprehensive, proactive approach to issues, health care providers — including institutional, group and individual practices of all types and sizes — turn to us to successfully meet the challenges of their competitive, highly regulated environment.

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

Fox Rothschild LLP
ATTORNEYS AT LAW

Elizabeth G. Litten, Esq.
609.895.3320
elitten@foxrothschild.com

Princeton Pike Corporate Center
997 Lenox Drive, Building 3
Lawrenceville, NJ 08648-2311

www.foxrothschild.com

California Connecticut Delaware District of Columbia Florida Nevada New Jersey New York Pennsylvania

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

It's time to look at the
BVerified℠ - Screening and Verification℠ Solution!

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

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

Call BESLER Consulting - 877.4BESLER

BVerified℠ - ***Put the Power of Our Expertise in Your Hands***

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

Scan QR Code for More Information

www.besler.com/SanctionScreening.htm